Minnesota Hospital Association

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Minnesota Department of Commerce
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Commissioner Jan Malcolm
Minnesota Department of Health
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Attorney General Keith Ellison
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Submitted electronically to commissioner.commerce@state.mn.us; jan.malcolm@state.mn.us; and jillian.sully@ag.state.mn.us

Dear Commissioners Kelley and Malcolm and Attorney General Ellison:

On behalf of the 141 hospital and health system members of the Minnesota Hospital Association (MHA), I respectfully request that you take immediate action to prevent recent unilateral policies and practices imposed by Blue Cross Blue Shield of Minnesota (BCBS) from remaining in effect until your offices complete appropriate and thorough investigations and reviews.[1]

Upon completing your work, we respectfully ask that you prevent BCBS from reactivating the same or similar policies and practices to the extent doing so would violate state law, harm its subscribers, or negate or undermine its contractual obligations to health care providers. In addition, we ask that any remedies include requiring BCBS to reimburse providers the agreed upon negotiated payment rates for services provided to BCBS subscribers that have been wrongfully denied, delayed or reduced.

MHA does not raise these issues without trepidation and only after several attempts to resolve our concerns with BCBS directly. Also, although BCBS's actions at issue appear to violate state law, the information necessary to confirm those perceptions is not available to MHA. Instead, investigations and due review by your respective staff are necessary to obtain this information and then reach definitive conclusions.

[1] BCBS is subject to an array of state laws, the oversight and enforcement of which fall in purview of the Minnesota Departments of Commerce, Health and the Attorney General. Because it is difficult to discern which agency or office bears responsibility for enforcing the different provisions of these laws and because the underlying circumstances are the same, MHA is submitting this letter to the three of you to ensure that you receive the same information and have the opportunity to coordinate with one another to avoid duplicating efforts or, worse yet, reaching conflicting conclusions on the same or similar questions of state law.

We expect the due diligence required to conduct a fair and thorough investigation will take weeks or even months to complete. BCBS's actions, however, are already harming Minnesotans and hospitals. Some of these negative consequences may be irreversible and they will be compounded with every passing day. Examples of these outcomes include the following:

- Restricted access to life-saving health care procedures,
- Delays in receiving needed care,
- Improper burdens imposed on individuals and families,
- Limited health care resources being unnecessarily diverted to administrative and legal burdens rather than patient care,
- Lost revenues for already struggling hospitals and clinics, and
- Exacerbating clinicians' growing sense of burnout.

At the outset, the concerns discussed involve multiple issues that fall broadly into two categories: site of service policies and prior authorization policies and practices. Within these two broad categories, there are multiple policies or types of health care services at issue. Also, while some of the policies have already been imposed and are having negative impacts on patients, families and health care providers, others are scheduled to begin in the near future.

MHA requests, therefore, that your departments take immediate action to prevent the BCBS policies and practices at issue from remaining in effect until your investigations and reviews are completed, and that you ensure BCBS takes the necessary steps to redress the harms it has caused to its enrollees and their families, as well as to Minnesota's hospitals and clinics.

SITE OF SERVICE NONPAYMENT POLICY: BACKGROUND

On December 3, 2018, BCBS issued a bulletin to hospitals informing them that BCBS would no longer reimburse hospitals for seven forms of upper and lower gastrointestinal endoscopy (GI endoscopy), including colonoscopies for preventive colon cancer screenings, provided by the hospital to its commercially insured subscribers[2] if an ambulatory surgery center (ASC) exists within 25 miles of the hospital.[3] Despite direct communications between MHA and BCBS requesting more time and a better process, this new payment policy became effective on March 4, 2019.[4]

[2] The BCBS policy at issue does not apply to its coverage of Medical Assistance, MinnesotaCare or Medicare Advantage subscribers. To the extent BCBS applies its policy as a third-party administrator for self-insured employers' benefit plans, MHA understands that addressing those plans by your departments' may be pre-empted by federal law.

[3] *See* example bulletin and related notices to providers provided in Appendix A. MHA believes that 83 hospitals are exempt from the BCBS policy because no ASC exists within 25 miles.

[4] Originally, BCBS intended for its new policy to become effective in January but decided to delay implementation after MHA raised objections and several aspects of its approach proved to be too administratively cumbersome for BCBS to administer. For example, its initial policy would have precluded hospitals from receiving payment for these services if the patient lived less than 25 miles from an ASC, but BCBS discovered that it lacked the capacity to determine the distance from each and every subscriber's residence to an ASC and would not be able to distinguish

The medical procedures this new bulletin addresses are critically important for individuals' health as is reflected in several significant steps taken by the State of Minnesota. These procedures include colorectal cancer screening, for example, which the Minnesota Legislature regards as so important for the health of our population that it mandated health insurance companies to include coverage for this service in their policies.[5] More recently, the Minnesota Department of Health (MDH) invested approximately $500,000 in a widespread, multi-year public campaign to encourage Minnesotans to get this cancer screening. Clearly, limiting BCBS subscribers' access, making it more difficult for them to get these medically necessary treatments and diagnostic services, and increasing patients' delays and travel distances to have these procedures run counter to the State's underlying interest in public health and the general welfare of our residents.

It is important to highlight that BCBS has not terminated its contracts with hospitals or informed them or BCBS subscribers that the hospitals will no longer be considered in-network. Likewise, MHA is not aware of BCBS terminating its contracts with individual physicians who perform these procedures in hospitals or designating them as out-of-network providers. Instead, BCBS simply and unilaterally decreed that it will no longer pay for these covered services when delivered at in-network facilities by in-network providers.

To the best of MHA's knowledge, BCBS has not informed its subscribers about this new policy. Accordingly, individuals are unaware that their insurer will no longer pay for these services despite the fact that its enrollee chose a hospital and individual doctors and caregivers that are designated by BCBS as in-network providers. This puts providers in an awkward position of having to explain BCBS's policies to its enrollees.

For hospitals subject to the new policy, BCBS implied that they could continue to be paid for these services if they contacted BCBS and agreed to payment rates equivalent to those received by an ASC. Some hospitals are exempt from the policy because the distance between their facilities and an ASC exceeds 25 miles. Any differences in quality of care or availability of appointments between a hospital or an ASC in the region are entirely immaterial. If your hospital happens to be close enough to an ASC, BCBS will not pay the hospital for these services no matter what kind of quality outcomes it achieves, if the ASC has poor outcomes or higher infection rates, or whether the ASC has sufficient capacity to serve the needs of the community.

MHA and some of our individual members have communicated concerns about this policy to BCBS directly on several occasions. In addition, MHA suggested that BCBS and several hospital and health system leaders explore alternative, collaborative approaches to protect access to these critical services for BCBS subscribers while simultaneously addressing BCBS's purported interests in improving clinical outcomes and lowering total costs of care. BCBS indicated that it will not back down from this or similar site of service policies.

between claims from providers that should be approved from those that should be denied under the misguided policy. Also, BCBS has or is rolling out similar policies for other procedures such as infusions, hernia repairs and surgeries to address carpal tunnel pain, among others.

[5] Minn. Stat. sec. 62A.30, subd. 2.

The results for BCBS subscribers are predictable, especially for those who have procedures scheduled at their local hospital. Some BCBS subscribers may discover weeks, or as much as twelve months, after their procedure that their insurance company refused to pay the costs, even though the service is included as a covered benefit under their policy, they were treated by an in-network physician, and went to an in-network hospital. Ultimately, hospitals shoulder the entire loss and receive no reimbursement whatsoever.

Other subscribers will learn from the hospital that their upcoming scheduled service suddenly evaporated from coverage under their BCBS health insurance policy. Instead, if they want to receive the benefits of coverage, they must make a new appointment at an ASC regardless of any pre-existing relationship with the hospital and its providers, potential differences in quality and safety between the hospital and the ASC, availability of appointments, delays, convenience or travel costs.

In some cases, MHA members have reported that BCBS is applying the policy and refusing to pay for procedures performed in the hospital because an ASC is located nearby, even though the ASC's physicians do not provide these services. This effectively leaves BCBS subscribers in the area without a local option for receiving care and forcing them to go without services or travel even longer distances to a different location which, ironically, might be a hospital that is exempt from the policy.

In addition to the endoscopy site of service policy, BCBS has unilaterally imposed similar policies for infusion therapies, and ENT procedures such as adenoidectomies. BCBS has indicated future policies will include services such as carpel tunnel surgeries, cataract surgeries, gynecologic procedures, hernia repair and urology procedures, among others.

SITE OF SERVICE NONPAYMENT POLICY: PATIENT SCENARIOS FOR PUTTING THE IMPLICATIONS OF BCBS'S POLICY IN CONTEXT

Without an investigation by your agencies, Minnesota's hospitals do not have the information necessary to determine how many people have had care delayed, did not receive the appropriate care at all or had negative outcomes because they were unable to receive needed care from the hospital.

However, to explain the health and financial peril BCBS has put its subscribers in, consider the following situations involving two hypothetical Minnesotans. Dan Smith and Sue Olson are BCBS subscribers in BCBS commercial health insurance products through their employers. They have appointments for preventive colonoscopies on August 1 at hospitals subject to BCBS's new site of service nonpayment policy.

After her physician ordered the colonoscopy and helped schedule the procedure at the hospital, Sue takes steps to make sure that her exposure to any out-of-pocket costs will be as low as possible. First, she checks with BCBS to see if the procedure is a covered benefit and, of course, it is as required by law.

Next, Olson calls her hospital's billing department to ask if the hospital is in-network under her specific BCBS policy and learns that, yes, it is an in-network hospital. Perhaps duplicating her efforts but wanting to be absolutely certain, she looks online at BCBS's website, and again, she is assured that her hospital is listed as in-network.

Then, Olson contacts the hospital's GI department and finds out which individual providers are scheduled to be involved in her upcoming procedure. She then goes back to BCBS to check whether each clinician is in network. Again, she is relieved to learn that BCBS lists each of these individual physicians as an in-network provider under her policy.

Having taken these consumer protection steps and with these assurances, Olson goes forward with the procedure on August 1 confident that her out-of-pocket costs will be minimal by making sure (a) the procedure her doctor ordered is a covered benefit under her policy, (b) the hospital where her doctor referred her is in network, and (c) the individual providers who will perform the colonoscopy are also in network.

The providers who delivered the service will bill BCBS and be paid because its site-of-service policy does not apply to the professional fees portion of the procedure. The hospital, however, unbeknownst to the doctor who referred Sue to the hospital and the specialty group who performed the colonoscopy, will have its entire claim denied by BCBS. Although BCBS attempts to couch this denial as a "medical necessity" determination, the fact of the matter is that the colonoscopy was medically necessary as shown by BCBS's payment to the physicians. However, BCBS attempts to wedge a cost-cutting effort to withhold or clawback payments due under its contracts with hospitals into the guise of medical necessity.

Dan Smith has a different and more tragic experience. Two days before his scheduled colonoscopy on August 15, he receives a call from one of his hospitals' three new employees hired to contact every BCBS-insured patient scheduled for a GI procedure. Each subscriber is warned that their BCBS health insurance may not cover the service, even though BCBS might have assured them that it was covered by their policy before they contacted the hospital to schedule their appointments. Smith is grateful for the hospital telling him about this new BCBS policy before his procedure, although he is irritated because he specifically checked to make sure his hospital was in BCBS's network before choosing his plan from his employer's options.

Smith contacts BCBS and learns that, in fact, BCBS will not cover this preventive care procedure at the hospital, even though he received his last colonoscopy there. If he still wants to have a preventive colonoscopy, he is instructed to go to the ASC 20 miles away. When Smith calls the ASC, he learns that he cannot get an appointment for three months.

Later, Smith is assigned to be at an out-of-state meeting for work the day of his appointment, so he calls the ASC to reschedule. The ASC's receptionist tells him that their physicians' schedules have been getting booked out later and later, and their first available appointment is in February.

Smith said that he needs the appointment in this calendar year so that any costs are counted toward his 2019 deductible. He is given an appointment in February and placed on a waiting list in case an earlier appointment opens up.

Smith has a colonoscopy at the ASC in February 2020. The ASC contacts him with news that he has an aggressive form of colon cancer and will need immediate surgery. Despite his good spirits and his oncologist's best efforts, Dan Smith succumbs to the cancer and dies in September 2021. Although they will never know for sure, his family believes Smith would have had a better chance of survival if the cancer was detected in August at his originally scheduled appointment.

SITE OF SERVICE NON-PAYMENT POLICY: CASE EXAMPLE

The example below was provided by a member of MHA without patient-identifying information. Due to concerns of retaliation by BCBS, MHA agreed to leave the individual hospital unnamed.

Hospital A
Hospital provided endoscopy services for a BCBS subscriber. BCBS paid the claim. Then, BCBS retroactively recouped the payment because an ASC exists within 25 miles of the hospital. The ASC, however, is not in-network under the subscriber's policy. A patient should not face the choice of getting a colonoscopy at a hospital that will not be covered by his insurer, getting it at an ASC that is not in-network subjecting him to a higher deductible and the costs not applying to his in-network deductible or not getting the procedure at all.

PRIOR AUTHORIZATION: BACKGROUND

In addition to its site of service nonpayment policies, BCBS has dramatically increased the number of services that it will not cover or pay for without a prior authorization. Without question, BCBS will claim that interjecting this prior authorization requirement between the patient and physician's decision-making process is necessary to better ensure high-quality care, avoid unnecessary care and reduce costs.

BCBS outsources its prior authorization function to Evicore, a for-profit company. The process is set up and managed in a way that appears to be intentionally designed to delay care for patients, create maximum frustration, wasted time for health care providers, and enable BCBS to deny payment for as many covered services as possible.

By its own admission, BCBS states that an extraordinarily high percentage of requests for prior authorizations are approved. In other words, in the vast majority of situations, physicians and patients are making appropriate, evidence-based decisions.

To get a prior authorization, however, a physician or other clinician has to complete a cumbersome and time-consuming process on the computer, call and wait on hold for inordinately long periods of time, and try to navigate conflicting messages. Hospitals report that obtaining prior authorization can take as long as 14 days. Meanwhile, the patient is not receiving medically necessary and, ultimately, approved care.

Adding salt to the wound, BCBS is unilaterally declaring that some of its denials of payment based on lack of prior authorization or site of service cannot be appealed by providers, even though the denials are often made in error. In other words, if a provider does not obtain a prior authorization, the claim will be denied and BCBS will not allow the provider to appeal the denial on the grounds that the care or service, in fact, was medically necessary.

With the rapid expansion of services requiring prior authorization, the numerous continuing problems in BCBS's and its vendors' ability to process prior authorization requests and adjudicate claims accurately or timely, Minnesota's hospitals and health systems are overwhelmed with the number of payment denials they are receiving from BCBS. This volume of unpaid bills is making it difficult, if not impossible, for hospitals to sort through and figure out which BCBS policies are being applied to which claims, what grounds BCBS or its vendors are alleging as the basis for the payment denials, and which payment denials can or cannot be appealed under these policies. In the meantime, BCBS continues to enforce its timely filing and appeals deadlines so hospitals and health systems are either not allowed to appeal a denial at all or, in other situations, BCBS rejects the appeal because it was untimely even though BCBS's own failures are at the root of the delays.

Most recently, and perhaps most troubling if it is allowed to go into practice, BCBS notified hospitals on or about May 22, 2019, that it will require "precertification" for all planned acute inpatient admissions. If a subscriber receives a service without a precertification, BCBS will deny payment for those services and its decision cannot be appealed by the hospital. However, it is important to emphasize that even though an inpatient procedure might be planned or scheduled does not mean that the patient in need of this high level of care can wait, possibly up to 14 days or more, to receive the needed treatment.

PRIOR AUTHORIZATION: CASE EXAMPLES[6]

The examples below were provided by several of MHA's members without patient-identifying information. Due to concerns of retaliation by BCBS, MHA agreed to leave the individual hospitals' unnamed.

Hospital A

A patient in the midst of cancer treatment needed a bone marrow transplant that had to be completed in a narrow window of time based on the sequencing of his chemotherapy. To prepare for the surgery, the hospital needed to conduct several types of imaging scans which require prior authorization from BCBS. When the hospital evaluated the patient and confirmed that the window of time had arrived, it submitted prior authorization requests to BCBS and scheduled the scans to occur four days later, which would allow enough time to evaluate the scans before the procedure. Despite the hospital's efforts to get prior authorization and the four-day delay, BCBS still had not responded to the requests for prior authorization.

[6] The examples used were provided by Minnesota hospitals without patient-identifying information. Due to concerns of retaliation by BCBS, MHA agreed to leave the individual hospitals unnamed.

Faced with either proceeding with the scans without prior authorization or missing the patient's window of time for life-saving care, the hospital moved forward and completed the. BCBS later denied the hospital's prior authorization requests. A week after the denials, the patient contacted the hospital reporting that he was informed that BCBS denied coverage for the scans. Naturally, he was extremely upset and worried about his financial exposure to the costs. The hospital assured him that he would not be financially responsible.

To the best of MHA's knowledge, BCBS has not agreed to pay the hospital for the medically necessary care it provided in order to save the patient's life.

Hospital B

A woman about to have her second child by caesarean section had coordinated with her physician and local hospital to have her baby on March 13. Nature, however, had other plans and the woman came to the hospital in labor on March 7. A C-section was performed, and the mother and baby are both healthy.

BCBS denied the hospital's bill for the C-section because it did not obtain prior authorization. The hospital resubmitted its claim with the prior authorization documentation it obtained for the scheduled March 13 birth, and BCBS denied the claim because the prior authorization was not for delivery on March 7.

Hospital C

A patient was admitted and hospitalized for six days. After medical review, BCBS approved the admission because the patient planned to end his life by hanging.

Seventeen days after being discharged, the patient returned to the hospital and was admitted again because he planned to end his life by "using a knife to cut an artery." This case was also reviewed by a medical director and payment was denied because BCBS determined that inpatient care was unnecessary.

Hospital D

BCBS denied claims for which the hospital had obtained approved prior authorization and included the numbers for that authorization on its bill on grounds that the hospital did not obtain prior authorization.

BCBS denied claims because the hospital did not include physical therapy, occupational therapy or speech therapy modifiers in its claim. The hospital was not billing for any such services.

BCBS denied claims for lack of prior authorization on services that do not require prior authorization.

Hospital E

BCBS denied claims for six routine deliveries based on the lack of prior authorization. The hospital called to challenge the denials and received the following responses:

- "The decision for authorizations have been delayed till next spring (2019)"
- "Routine deliveries need notification with faxed form."
- "The denials of deliveries are a mistake, you need to appeal. They have always been exempt [from prior authorization requirement]."

Hospital F
A provider was going to prescribe Bevacizumab for a patient. In reviewing the appropriate website, the doctor learned that BCBS required prior authorization for that drug. The doctor used BCBS's online software to request prior authorization, but the program said that prior authorization was not required. The doctor called BCBS and was informed that, in fact, prior authorization is required, and he needs to complete the prior authorization request process through the computer. Again, the computer refused to provide a prior authorization approval number stating that prior authorization is not required.

BCBS denied the claim for payment. The doctor attempted to obtain authorization retroactively and was denied.

Hospital G
BCBS denied payment for a surveillance CT scan because it will only approve of one such scan every three months. The patient's last scan occurred more than three months ago, yet BCBS denied the claim because the appointment for the CT scan was made prior to three months passing. In other words, if the patient makes the call prior to three months passing, BCBS will deny payment even though the timing of the service was beyond the three-month requirement.

Hospital H
Hospital provided a service to a BCBS subscriber after obtaining prior authorization. BCBS denied the hospital's claim for payment by sending its denial letter to an independent physician who participated in delivering the service. When the hospital learned of the denial, BCBS stated that the time to appeal had lapsed and, therefore, it would not reverse its decision.

Hospital I
Hospital obtained prior authorization through BCBS's computer process and printed out approval before the patient had a CT scan. BCBS denied payment for the scan stating that it did not have prior authorization. BCBS will not allow hospital to appeal the decision.

STATE LAW PROVISIONS POTENTIALLY VIOLATED BY BCBS

I. BCBS's site of service non-payment policy unlawfully restricts coverage between hospital and ASC services.

Minnesota law prohibits health insurance companies from issuing policies that include coverage for hospital services to subscribers "unless the policy, plan or contract specifically provides coverage for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, ***whether or not the facility is part of a hospital***."[7] Hospitals provide the GI endoscopy services at issue on an outpatient basis at facilities equipped to perform these services and, therefore, BCBS cannot legally maintain a health insurance policy that does not cover and pay for the services regardless of whether they are performed at a facility that is part or is not part of a hospital.

[7] Minn. Stat. § 62A.153 (emphasis added). *All subsequent statutory references are to Minn. Stat. (2018).*

To be even more clear, this statute goes on to require that a health insurance company's coverage of services at an ASC "shall be on the same basis as coverage provided for the same health care treatment or service in a hospital."[8] In other words, BCBS's health insurance policies must cover a service at an ASC under the same basis or terms as it covers the same service at a hospital. If BCBS covers GI endoscopy services at a hospital, it must cover them at an ASC *and vice versa*. A health insurance carrier cannot restrict a subscriber's access to or choice of providers of covered services to only a hospital or only an ASC.

Accordingly, if BCBS decides that it will not reimburse a hospital for these services if an ASC is within 25 miles, then it must mirror that basis of coverage with respect to ASCs that are within 25 miles of a hospital. This, of course, would lead to disastrous results by effectively limiting access to these services to only those ASCs and hospitals that are more than 25 miles from another ASC or hospital. This would leave a large percentage of BCBS subscribers without any access to these covered services.

It is clear from this short statutory provision that the Minnesota Legislature intended to prohibit the very situation BCBS has created: health insurance companies preventing subscribers from having access to care in one setting or another when a service is available in both a hospital and an ASC setting. BCBS's policy contravenes this legislative intent and the statutory language.

II. BCBS's site of service non-payment policy and its prior authorization policies and practices constitute unfair and deceptive trade practices

State law prohibits health insurance companies from engaging in a wide range of unfair or deceptive practices. These laws recognize that health insurance companies are in a unique and powerful position to manipulate those who pay premiums – both individual subscribers and employers – as well as health care providers. In its most succinct and sweeping form, the Minnesota Legislature stated that health insurance companies may not "cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive."[9] Minnesota law also prohibits health insurance companies from "engaging in fraudulent, coercive, or dishonest practices in connection with the insurance business."[10]

BCBS disseminates to employers, their employees and residents who purchase coverage on the individual market an array of advertising and solicitations. Meanwhile, as an integral part of its business, BCBS negotiates with health care providers to determine whether they will be in- or out-of-network, on occasion, how they will be tiered relative to similar providers, and how much they will be paid when they deliver covered services to BCBS's subscribers. BCBS's new payment policy constitutes false representations, or fraudulent or deceptive practices in both directions of its business: in materials and information provided to employers and subscribers and in its health insurance business dealings with hospitals.

[8] *Id.*
[9] § 62D.12, subd. 1.
[10] § 72A.20, subd. 18(b).

A. BCBS's site of service non-payment policy renders its advertising, solicitation and communications with employer and subscribers untrue and misleading.

For employers and subscribers, BCBS has marketed its health insurance products with the promise that in return for the employers' and subscribers' monthly premium payments, BCBS will reimburse health care providers, including hospitals, for services received by subscribers.

BCBS's advertising materials and information for employers and subscribers explain that it will not reimburse for *any* service. Instead, BCBS's materials explain that it will pay providers only if the services received by its subscribers are within its covered benefit set. All of the GI endoscopy services at issue fall within the set of covered services in BCBS's advertising, solicitation and other information available for employers and subscribers. In fact, state law mandates that BCBS include some of these services in its coverage.[11]

Similarly, BCBS's advertising materials and information for employers and subscribers explain that it will not reimburse for services received from *any* health care provider, and that subscribers' out-of-pocket costs will vary based on the provider from whom they choose to receive services. BCBS's advertising, solicitation and other information describe and define those providers it has designated as in-network. Other providers, however, are not designated as in network. If subscribers choose to receive services from out-of-network providers, BCBS will not reimburse the provider at all and the subscriber will be responsible for the entire costs of care and/or the costs of care will not be applied to the subscriber's in-network deductible.

BCBS's advertising, solicitations and information given to employers and subscribers when it sold commercial health insurance policies for the current coverage year did not include descriptions or categories of services that are covered but are nevertheless ineligible for reimbursement and the costs will not be applied to subscribers' in-network deductibles even though the services are received from in-network providers.

Stated differently, employers and subscribers entered into contracts with BCBS to pay premiums in return for BCBS to reimburse in-network providers for covered services within the applicable benefit set and apply any out-of-pocket costs for those services to the subscribers' in-network deductibles.

With respect to hospital services specifically, BCBS materials categorize hospitals as in-network or out-of-network. To the best of MHA's knowledge, none of BCBS's advertising, solicitations, or consumer-facing information describe a category of hospitals that are in-network for a select, itemized list of services and out-of-network for other specified services. Likewise, MHA is not aware of BCBS decreasing the premiums it charges to employers and subscribers to reflect the decreased access to care they will have after March 4, 2019, when the new policy went into effect, as compared to the access they were led to believe would be covered when making their health insurance carrier decisions during the open enrollment period.

[11] § 62A.30, subd. 2.

From the advertising and information BCBS gave to employers and subscribers, hospitals are either entirely in-network or entirely out-of-network. Implementing this new policy, after employers and subscribers made their insurance decisions for the year, contradicts these representations and decreases the value of the health insurance policy that purchasers selected. Therefore, BCBS's refusal to reimburse in-network hospitals for these covered services, its denial of access to in-network hospital-based care for its subscribers, and its shifting of in-network costs of care to subscribers by causing them to be billed directly and/or refusing to apply their expenses to their in-network deductibles all constitute deceptive or unfair, if not fraudulent, practices. Moreover, they result in BCBS's marketing and advertising being untrue and misleading.

B. <u>BCBS's endoscopy site of service non-payment policy is deceptive, unfair and coercive with respect to its health insurance business interactions with hospitals</u>.

BCBS's implementation of this new GI endoscopy non-payment policy is a deceptive, unfair and coercive trade practice with respect to its relationship with hospitals. BCBS and hospitals negotiate contracts regarding BCBS's conditions of payment and payment rates to hospitals for services they deliver to its insurance subscribers. In these negotiations, hospitals and BCBS agree to terms including whether the hospital will be included in BCBS's network, the amount BCBS will pay for each hospital service received by BCBS subscribers, and the circumstances those services will be covered. Hospitals negotiate in good faith and rely on their reasonable expectations that once contract terms are reached and agreed to by both parties, that BCBS will adhere to the terms of the contract.

In this case, however, BCBS unilaterally decided not only that it would no longer pay the amount negotiated and agreed to by the hospital for these endoscopy services, but that it would not pay for the service *at all*. BCBS did not decide to terminate the hospitals' contracts, ask to renegotiate their pricing structures or take action to exclude the hospital from its networks. Instead, it selected specific services with contracted reimbursement amounts and declared that it would no longer pay the hospital if it provided those services to BCBS subscribers. The bizarre outcome of this policy in practical terms is that hospitals are "kind of" in-network but treated akin to putting the hospital out-of-network just with respect to these specified services.

In some instances, hospitals completed their negotiations with BCBS and signed new contracts only weeks before receiving notice that these services will no longer be covered.

BCBS has tried to forcibly shoehorn its justification of this site-of-service nonpayment policy into the context of "medical necessity."

The services subject to BCBS's policy are medically necessary and BCBS's payment denials are not based on a review of the patient's condition or medical history. It is based exclusively on the location of the facility where the service was performed. Stated differently, if a medical service is not medically necessary, it is not medically necessary in a hospital or in an ASC. Receiving the service in a particular facility does not render the service medically necessary.

Further proof that this is not a question of medical necessity is that fact that the policy allows payment to a hospital if an ASC is not located within 25 miles. So, BCBS's policy is attempting to say that the same service for two people with the same condition and medical history can be medically necessary or not medically necessary based on the community in which the person lives. In one community, the service is medically necessary and the patient's provider of choice will be reimbursed for the service. In another community, the same service in the same type of facility is not medically necessary and BCBS denies payment to the provider.

Whether an ASC is within 25 miles of a hospital makes absolutely no difference to determining whether a particular service or treatment is medically necessary for a patient; only the patient's health status, diagnosis and medical history are relevant factors for evaluating medical necessity. Under state law and evidence-based medical guidelines, a colonoscopy is medically necessary to screen for colon cancer for an individual of a given age regardless of how close a hospital and ASC are located to one another. Medical necessity determinations are not subject to geography.

Even more troubling, as Minnesota struggles to address disparities in health outcomes for people with different socio-economic characteristics, allowing a health insurance company to prohibit payment for services or assess medical necessity of health care services based on where the patient lives or what types of health care resources are in his/her community, is an extremely dangerous precedent. It is foreseeable how allowing a tortured definition of medical necessity to be used in this manner could easily lead to policies with discriminatory impacts or coverage decisions that exacerbate disparities. People with the same health condition do not have different "medical necessity" based on the distance between one medical facility and another.

Instead, BCBS's policy is a thinly veiled attempt to further narrow and limit its provider network without abiding by its legal obligations to notify all subscribers or have its network subject to regulatory review under state law.

BCBS's next likely argument will be to point to some provision in its contracts that appears to give it unfettered power to change the terms of the provider's contract. Most often, BCBS contracts are constructed and modified over and over again through a series of amendments and bulletins, amendments to amendments, etc. that have occurred over several years or even decades. As a result, most providers do not have a single consolidated contract or the means to be able to determine whether a particular provision in an amendment has been changed by subsequent amendments or bulletins.

Despite any such provision appearing to authorize BCBS to change contract terms, a unilateral decision to carve out a service line and refuse to pay hospitals for delivering agreed upon services to BCBS subscribers constitutes a deceptive and unfair practice both in terms BCBS's actions and statements during contract negotiations, as well as its treatment of providers after agreeing and committing itself to the terms agreed upon in those contracts. Quite simply, a negotiated contract for reimbursement of agreed upon rates for particular services that can be changed unilaterally by one party is a deceptive and unfair trade practice. It is a basic element of contract law, equity and fair business practices that a contract cannot contain terms leaving providers bound to the rates and

conditions of payment they negotiated in good faith while the other party to the agreement can and does change the terms and conditions – including terms and conditions that result in the provider delivering covered services to subscribers without any reimbursement whatsoever — its whim.

In its notification of this new policy sent to hospitals, BCBS suggests that hospitals contact BCBS if they want to provide these endoscopy services at a reimbursement rates equivalent to those that BCBS pays to ASCs.[12] This also reflects a deceptive and unfair trade practice. BCBS negotiates reimbursement rates for all of a hospital's services, executes a contract agreeing to pay those rates for the respective services, and then tells the hospital that it has two options: (1) get paid nothing, or (2) get paid an amount agreed to by a third party. Neither of these options reflect the terms of the contract.

It is important to note the imbalance of power between hospitals and BCBS in this situation. BCBS unilaterally refuses to pay the negotiated rates for these services. However, hospitals cannot exercise reciprocal powers by notifying BCBS that they are unilaterally increasing rates for other services. In other words, BCBS's actions and treatment of its contractual obligations to hospitals flow in only one direction: BCBS refuses to pay what it is contractually obligated to pay at its whim, whereas hospitals must adhere to the contract terms and are unable to adjust their rates until the next round of contract negotiations. Compounded by unilateral prior authorization policies and eviscerating providers' ability to appeal inappropriate denials of payment, this treatment of contractual terms in BCBS's health insurance business constitutes coercive and unfair trade practices.

C. BCBS's prior authorization policies and practices amount to "engaging in fraudulent, coercive, and dishonest practices in connection with the health insurance business."

BCBS imposes unilateral prior authorization requirements with full knowledge that it cannot and will not provide timely or appropriate prior authorizations. For its subscribers, BCBS provides policies and materials that appear to constitute "evidence of coverage" but this appearance is deceptive because subscribers are being denied care or having care inappropriately delayed that BCBS described as a covered benefit.

For providers, the prior authorization policies and practices constitute "fraudulent, coercive, or dishonest practices" because BCBS negotiates contracts with providers, claims that it will cover services its subscribers receive, but then imposes an administrative and procedural labyrinth that effectively coerces providers into either withholding needed medical care from BCBS subscribers or proceeding to deliver the care without payment to which they are entitled.

Even when providers jump through all of BCBS's hoops or get prior authorization before treating a BCBS subscriber, BCBS's steps to prohibit providers from appealing denials of claims, many of which appeals providers were prevailing on before BCBS decided it would no longer entertain appeals, is fraudulent and deceptive. BCBS has orchestrated a system in which it can choose arbitrarily whether to pay a claim without any concern for whether that decision is correct or authorized under its contract with providers or under its legal obligations to cover certain services and benefits.

[12] *See* Appendix A (containing Dec. 3, 2018 Bulletin and related materials).

III. BCBS's refusal to cover services provided at in-network hospitals may violate network adequacy requirements.

Minnesota law requires health insurance companies to demonstrate that their provider networks "include a sufficient number and type of providers . . . to ensure that covered services are available to all enrollees without unreasonable delay."[13] The law places responsibility for enforcing provider network adequacy standards on the Minnesota Department of Health (MDH).[14] If MDH determines that a health insurance company does not provide sufficient access, MDH develops a corrective action plan that the company must follow. Elements of that plan could include requiring the company to pay out-of-network providers for services received by its subscribers, stopping the company from enrolling any new subscribers in that area, and reducing the area in which the company is permitted to issue coverage.[15]

The provider network BCBS submitted to the Minnesota Department of Commerce and MDH before selling its policies to employers and subscribers included in-network hospitals without any indication that some of those hospitals or some of their services would be unavailable to its subscribers in those geographic areas. Accordingly, your departments evaluated the sufficiency of BCBS's networks on the assumption that these endoscopy services would be available to subscribers at both in-network hospitals and in-network ASCs. Now, however, BCBS is eliminating subscribers' access to in-network hospitals, which provide these services to thousands of BCBS subscribers every year.

BCBS's bulletin materials states that it confirmed with its in-network ASCs that they have capacity to meet the needs of all of its subscribers in their respective areas. Have your departments agreed with this assessment or were you even notified that the networks reviewed and approved have materially changed for these services?

Several of MHA members have reported that their endoscopy providers are at or near capacity, as are the ASCs in their area. They do not believe that eliminating access to hospital-based services will allow BCBS subscribers to obtain these services from local ASCs without unreasonable delays.

MHA respectfully requests that your departments revaluate BCBS's provider networks to ensure that the number of providers in the impacted hospitals' geographic areas are sufficient to ensure that BCBS subscribers have access to these potentially life-saving services without unreasonable delay. If you determine that BCBS's ASC-only provider networks are insufficient, we suggest that MDH's corrective action plan include requirements for BCBS to pay its contracted rates for services delivered at hospitals that BCBS identified as in-network in the materials it submitted to your departments previously.

[13] Minn. Stat. § 62K.10, subd. 4. *See also* § 62D.121, subd. 7 (requiring adequate number of providers to ensure that enrollees have access to services in a geographic area).
[14] Minn. Stat. § 62D.121, subd. 7; § 62D.124, subd. 5; § 62K.10, subd. 8.
[15] Minn. Stat. § 62D.121, subd. 7.

IV. Implementing BCBS's site of service non-payment policy may violate statutory notice requirements.

Minnesota Statutes section 62Q.56 sets forth multiple notice requirements and other steps a health plan company with limited or narrow provider networks must complete before terminating a contract with primary care, specialist or general hospital providers who are currently in-network.[16] These requirements include, for example, informing subscribers about the provider no longer being in network at least 30 days before ending the contract with the provider, telling subscribers how the company will assist them in finding a new in-network provider, and giving them information about which in-network providers are available to them.[17]

To the best of MHA's knowledge, BCBS has provided no notice whatsoever to its subscribers about this change. Accordingly, its subscribers, many of whom likely have scheduled appointments for critical, possibly life-saving cancer screenings, have not had any notice that their preferred in-network hospital is no longer covered by their plan, nor have they been provided with any information about how BCBS will assist them, let alone actually received any such assistance.

This statute poses some ambiguities for regulators to clarify. On one hand, BCBS has not "terminated its contract" with hospitals and, therefore, will likely argue that this statutory requirement has not been triggered. On the other hand, the clear intent of the statute is to provide people – especially those who have an ongoing care relationship with a primary care physician, specialist or hospital – who enrolled in a health plan with a given set of covered services and in-network providers to be notified if their providers are no longer treated as in-network.

BCBS should not be able to deny coverage for covered services at an in-network hospital without notice to its subscribers on the grounds that the hospital remains in-network for other services. Taken to its extreme, a health insurance company could tell potential subscribers that every physician in the state is considered in-network and then deny coverage for every service except youth sports physicals. As discussed earlier, BCBS is twisting the logic of its policies and practices for the purpose of circumventing the laws, consumer protection standards, subscriber notice requirements, provider network adequacy standards, and other obligations before making changes to its provider networks.

MHA hopes that your departments will clarify this ambiguity in favor of protecting subscribers' right to receive advance notice and assistance in transitioning providers when BCBS decides in the middle of their enrollment year to stop paying for a long-standing hospital-based service at an in-network hospital.

[16] § 62Q.56, subd. 1(a).
[17] *Id.* at subd.1(a)(1)-(2).

V. BCBS's application of its prior authorization requirements in its HMO products appears to violate state law prohibiting denial of claims for medically necessary care solely on the basis of prior authorization.

Minnesota Statutes governing health maintenance organizations (HMOs) prohibits those organizations from denying or limiting "coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained."[18] Stated more simply, if a BCBS enrollee receives a covered service that is medically necessary, BCBS cannot deny payment or coverage of the service solely because the enrollee or its provider did not obtain prior authorization in advance. The Minnesota Legislature has prohibited the conduct BCBS appears to be engaged in on a widespread basis: denying payment for services that are medically necessary because the provider or enrollee did not obtain prior authorization.

BCBS's plans to implement a new "precertification" requirement for planned or scheduled inpatient services would add more violations of even more expensive services to the list of problems hospitals, health systems and individual providers already face today. According to the announcement of its policy, BCBS stated that it will not reimburse providers for planned inpatient admissions if precertification, which is a synonym with prior authorization for purposes of this statutory prohibition, is not obtained before the admission. Again, if the admission is medically necessary and the services are covered by the policy, BCBS is legally prohibited from denying providers' claims solely on the grounds that there wasn't precertification.

VI. BCBS's application of its prior authorization requirements may violate state law prohibiting denial of benefits for emergency care.

Minnesota Statutes section 62A, states "No policy . . . may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment." As described in the examples above, BCBS's denial of payment for the care provided to a woman in labor because her labor began days before a planned C-section. And, BCBS and its subcontractor's inability to timely process prior authorization requests effectively creates emergency situations for its subscribers, such that subsequent denial of payment for needed and time-sensitive services also violates this statutory provision.

CONCLUSION

The State of Minnesota has placed a high priority on ensuring that our residents have virtually unfettered access to GI endoscopy services. Minnesota requires health insurance companies to include these services in their covered benefits. MDH spent a significant amount of money encouraging people to get these services. Yet, despite these public actions and existing laws that should prevent these policies, BCBS unilaterally placed its own financial interests in front of those of its subscribers and Minnesotans.

[18] Minn. Stat. sec. 62D.12, subd. 19.

Endoscopy services are only the beginning for BCBS. It has already taken the same steps to restrict access to other covered, medically necessary services such as infusions and has a list of more to come. All of these policies are blocking access to care, creating patient and provider confusion, and adding unnecessary costs to the health care system.

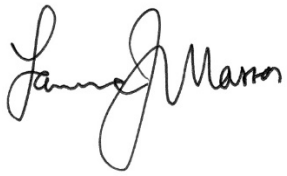
Likewise, BCBS takes the same cavalier attitude toward state law and the health of its subscribers in its prior authorization polices and practices. It uses these policies to disrupt and interfere with the patient-provider relationship; to deny or delay medically necessary care for its enrollees; to intentionally frustrate, and delay and deny payments to providers for medically necessary care.

BCBS has a staggering amount of power and influence in Minnesota's overall health care system. Nevertheless, it must abide by the law. It appears that its financial interests and perception of its own power have led it to make unfortunate and seemingly unlawful decisions that will put some of its subscribers' lives in grave danger, and Minnesota's hospitals and health systems in an ongoing and escalating scramble to retain their physicians, secure payments for care they provide and ultimately maintain financial sustainability so they can continue serving their patients and communities.

MHA respectfully asks that you and your staff exercise your statutory authority and oversight responsibilities, and take action to prevent not only a large health insurance company from running afoul of state law and retain an unjust windfall by refusing to pay for medically necessary services its enrollees received, but even more importantly, to stop the foreseeable and irreparable impacts to Minnesotans who have played by the rules, paid BCBS's premiums and are entitled to their hospitals' and providers' services under the policies in which they are enrolled.

I expect that you and your staff will have questions, and I encourage you to contact me anytime.

Sincerely,



Lawrence J. Massa, M.S., FACHE
President & CEO

cc: Governor Tim Walz
Craig Samitt, M.D.

APPENDIX A

PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

July 2, 2018

New Site of Care Drug Management Program for Infused and Injectable Drugs Administered by a Health Care Provider

Effective September 3, 2018, select specialty medications that are already subject to prior authorization (PA) requirements for Commercial subscribers will be included in the Site of Care Drug Management Program. Within the program, infused and injectable specialty medications administered by a health care provider are required to be administered in a clinic, infusion center, or by a home infusion agency. Site of Care criteria will be added to existing drug policies and PA requirements and reviews can be submitted beginning August 20, 2018.

Infusions or injections administered in a hospital outpatient setting for medications subject to PA requirements are not eligible for reimbursement unless the medical necessity criteria have been met. No partial approvals will be granted.

Prior Authorizations requests must include the following additional information:

- Site of care location:
  - Infusion agency in the Home
  - Clinic/Office
  - Infusion Center
  - Hospital outpatient, if selected requires an exception reason to be provided based on medical policy criteria

Please check the subscriber's benefits and confirm the **in-network** site of care. All new requests and upon renewal, drug PAs will be subject to site of care management unless otherwise stated in the medical policy criteria.

List of Medications and the medical policy number:

- Abatacept, II-161
- Agalsidase Beta, II-26
- Alemtuzumab, II-184 (non-oncologic indications only)
- Alglucosidase Alfa, II-186
- Certolizumab Pegol, II-179
- Edaravone, II-178
- Golimumab (Simponi Aria), II-180
- Immunoglobulin Therapy, II-51
- Infliximab, II-97
- Natalizumab, II-49
- Ocrelizumab, II-185
- Rituximab, II-47 (non-oncologic indications only)
- Sebelipase Alfa, II-200
- Tocilizumab, II-181 (non-oncologic indications only)
- Ustekinumab, II-168
- Vedolizumab, II-182

Continued
Distribution: Available on website: https://www.bluecrossmn.com/healthy/public/personal/home/providers/forms-and-publications

For more information, please visit:
Procedures/Services/Drugs under the medical benefit:

- Go to: providers.bluecrossmn.com
- Under Tools and Resources, select "Medical Policy" and acknowledge the Acceptance statement
- Select the "+" plus sign next to the Medical and Behavioral Health Policies
- Under the "Medical Policy Supporting Documents", Click on the Site of Care link, available after August 1, 2018

Products Impacted

- This program only applies to commercial lines of business. As a reminder for a value network subscriber, please have the subscriber call Blue Cross at **(651) 662-5200** or **1-800-262-0820**.
- The changes do not impact subscribers who have coverage through Prepaid Medical Assistance Program (PMAP), MinnesotaCare, SecureBlue (MSHO), Minnesota Senior Care Plus (MSC+), Federal Employee Program (FEP), Medicare Advantage or Platinum Blue as those lines of business have separate PA requirements.

Submitting a Medical Drug PA Request
Providers must submit a PA request for approval for the medical specialty drugs listed above. If a provider does not obtain required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization. The requirement applies to subscribers starting drug therapy and to those already being treated with one of the medications above.

Before submitting a PA request, providers are asked to check the Medical Policy criteria and attach **all required clinical documentation** with the request including documentation of previous therapies tried and evidence of symptom improvement using the drug. PA requests will be reviewed when patient-specific, relevant medical documentation has been provided supporting the medical necessity of the drug**.** Failure to submit required information may result in review delays (if outreach is needed to obtain missing clinical information) or a denial of the request due insufficient information.

Providers can submit an electronic medical drug (ePA) request:

- Online via our free Availity provider portal – for Blue Cross to review
- Using a NCPDP standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can use the process above, the Minnesota Uniform Form for PA Request and Formulary Exceptions fax form located under the Forms section on the Blue Cross website, or submit the PA request to Blue Cross using their own form (secure fax: 651.662.2810).

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

PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

December 3, 2018

New Medical Policy for Upper and Lower Gastrointestinal Endoscopy Services Including Colonoscopies

Beginning March 4, 2019, upper and lower gastrointestinal endoscopy services (listed below), including colonoscopies, will be subject to a new Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) medical policy (XI-03-001). The policy states that these services must be redirected and performed in an in-network Ambulatory Surgical Center (ASC) when medical or geographic criteria for use of a hospital outpatient facility are not met, in order to ensure coverage. Many specialists in the Blue Cross network have already started redirecting patients to the ASC setting when clinically appropriate. Groups performing these procedures outside the hospital have shown evidence of safe, high quality outcomes at a lower cost, while maintaining an excellent patient experience.

Beginning March 4, 2019, upper and lower endoscopy procedures administered in a hospital outpatient setting that do not meet medical policy criteria will not be eligible for reimbursement. Post-service audits will be conducted for services taking place at an outpatient hospital setting using the following information to ensure policy criteria are met:

- Documentation of medical necessity to receive the procedure at an outpatient hospital setting rather than an ASC.

Geographic exclusions for post-service audits include:

- Services for patients living greater than 25 miles from an in-network ASC performing these procedures are excluded from this program.
- Hospital outpatient facilities that do not have an in-network ASC performing these procedures within 25 miles of the outpatient hospital setting are excluded from this program.

Please check the subscriber's benefits and confirm the **in-network** site of care.

List of Impacted Procedures and Associated CPT Codes:

- Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) (43235)
- Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple (43239)
- Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter) (43249)
- Colonoscopy, flexible; diagnostic, including collection of specime(s) by brushing or washing, when performed (separate procedure) (45378)
- Colonoscopy, flexible; with biopsy, single or multiple (45380)
- Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps (45384)
- Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique (45385)

Continued
Distribution: Available on website: https://www.bluecrossmn.com/healthy/public/personal/home/providers/forms-and-publications

Products Impacted
This program only applies to fully insured and self-insured commercial lines of business. As a reminder for an Accountable Care Organization (ACO) subscriber, please have the subscriber call Blue Cross at **(651) 662-5200** or **1-800-262-0820**

Predetermination Process for Providers:
If certain unforeseen clinical circumstances **not** outlined in the medical policy arise that dictate the member should receive care in an outpatient hospital setting, providers may submit a predetermination form to verify if a service listed above will be deemed appropriate prior to treatment. Predeterminations are **not** required and do not guarantee payment.

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 providers.bluecrossmn.com
- Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
- Select the "+" (plus) sign next to "Medical and Behavioral Health Policies" to see the Upcoming Medical Policy Notifications section

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

Medical and Behavioral Health Policy Activity

Policies Effective: March 4, 2019 Notification Posted: December 3, 2018

Policy Developed

- **Site of Service for Selected Outpatient Procedures, XI-03**
  NOTE:
  - **This policy applies to commercial health plan members only.**
  - **See table below for outpatient procedures included in the site of service program.**
  - **When policy criteria for use of a hospital outpatient facility are <u>not</u> met, a non-hospital outpatient setting (e.g., ambulatory surgical center) should be used.**

I. Use of a hospital outpatient facility for an outpatient procedure, including but not limited to an endoscopic procedure, may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ANY** of the following criteria are met:

- Age <18 years;
- Nearest non-hospital outpatient facility with procedural capabilities is >25 miles from patient's home;
- Length of stay >24 hours;
- Anesthesia risk
  - American Society of Anesthesiologists (ASA) Physical Status (PS) Classification IV or higher (see definition);
  - History of complications from anesthesia (e.g., malignant hyperthermia);
  - Alcohol dependence at risk for withdrawal syndrome;
  - Recent history of drug abuse (e.g., cocaine) (<3 months);
  - Prolonged surgery (>3 hours);
- Increased cardiovascular risk, such as:
  - Uncompensated chronic heart failure (NYHA class III or IV) (see definition);
  - Recent history of myocardial infarction (MI) (<6 months);
  - Poorly controlled, resistant hypertension (requiring ≥3 drugs to control blood pressure);
  - Recent history of cerebrovascular accident or transient ischemic attack (<3 months);
  - Increased risk for cardiac ischemia (cardiac or vascular stent placed <1 year or angioplasty <90 days);
  - Symptomatic cardiac arrhythmia despite medication;
  - Moderate or severe valvular heart disease;
  - Implanted pacemaker or implantable cardioverter-defibrillator (ICD);
- Increased pulmonary risk, such as:
  - Chronic obstructive pulmonary disease (COPD) (FEV1 <50%);
  - Poorly controlled asthma (FEV1 <80% despite treatment);
  - Moderate to severe obstructive sleep apnea (OSA) (AHI or RDI ≥15);
  - Dependent on a ventilator;
  - Dependent on continuous supplemental oxygen;
- Increased liver risk, such as:
  - Advanced liver disease (MELD Score >8);
- Increased renal risk, such as:
  - End stage renal disease on dialysis;
- Other
  - Morbid obesity (BMI ≥40);
  - Brittle diabetes or severe hyperglycemia (blood glucose ≥350 mg/dL);
  - Pregnancy;
  - Bleeding disorder requiring replacement factor, blood products, or special infusion product (DDAVP/desmopressin does not meet this criteria);
  - Anticipated need for transfusion(s);

- Cannot transfer independently;
- Known or suspected foreign body in the gastrointestinal tract;
- Condition that warrants the use of restraints.

II. Use of a hospital outpatient facility for an outpatient procedure, including but not limited to an endoscopic procedure, when the criteria in section I are not met is considered **NOT MEDICALLY NECESSARY**.

Table. Outpatient Procedures Included in the Site of Service Program

CPT Codes
Upper & Lower Gastrointestinal Endoscopy
43235, 43239, 43249, 45378, 45380, 45384, 45385

Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-8000 / (800) 382-2000

BlueCross BlueShield Minnesota

May 22, 2019

[redacted]

Dear Blue Cross Network Provider:

As you know, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) began requiring pre-admission notification (PAN) for inpatient admissions for all members in early 2016, and currently requires precertification for inpatient admissions for Medicaid, Medicare Advantage and FEP members. In order to best support the coordination of care for our members, Blue Cross will implement a new policy requiring precertification for all *planned, acute inpatient admissions* for **Commercial** members. The policy will go into effect for dates of admission on or after **September 1, 2019**.

This process helps Blue Cross provide optimal care coordination for members by ensuring proposed services are medically necessary prior to treatment, while also ensuring effective discharge planning. While precertification will be required prior to the service being rendered, certain circumstances may make this difficult. Retrospective clinical review will be considered by Blue Cross in these circumstances for up to 48 hours from the time of inpatient admission and prior to the claim being submitted.

Beginning **January 1, 2020**, if a precertification is not submitted prior to the service, the claim will be denied administratively, and the provider will be held liable. An administrative denial cannot be appealed for medical necessity. Medical necessity appeals *will* be accepted for dates of service between September 1 and December 31, 2019, allowing additional time for providers to adjust to this change.

Exceptions/Exemptions:
Beginning January 1, 2020, an appeal may be submitted for limited administrative situations when a claim is denied due to lack of precertification. These exceptions are listed below and must be supported by submitted documentation:

- Blue Cross is the subscriber's secondary coverage and precertification is not required
- Another insurance company is identified as the payer and a claim was submitted to the other payer within the timely filing guidelines with Blue Cross subsequently identified as the patient's primary coverage
- The patient is identified as the payer and is billed for the service, but later the patient reports Blue Cross coverage for the date of service. Appeals for this exception must include notes about accounts receivable actions. For example, include notes documenting calls with the Blue Cross Service Center or notes that the subscriber was sent to collections within 120 days after date of service.
- The subscriber was enrolled in the plan retrospectively, after the date of admission
- Extenuating circumstances beyond the control of the facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g. natural disaster or Availity outage)

Additional Exceptions:

- All unplanned emergency admissions (including detox and labor and delivery admissions) will not require clinical review at the time of admission but will require notification to the plan.
- Admissions for newborns less than 30 days old that are not yet added to the subscriber's policy, observation stays and outpatient procedures/services do not require inpatient precertification or notification.

Summary:

CURRENT PROCESS (Commercial)	EFFECTIVE SEPTEMBER 1, 2019 (Commercial)	EFFECTIVE JANUARY 1, 2020 (Commercial)
A pre-admission notification must be submitted to Blue Cross when a member is admitted to an inpatient facility. No clinical review process is required.	Precertification must be submitted prior to planned inpatient admission. If approved, the claim will process according to the member's benefits. If no precertification is submitted, the claim will deny, and medical necessity appeal will be allowed.	Precertification must be submitted prior to planned inpatient admission. If approved, the claim will process according to the member's benefits. If precertification has not been received, claim payment will be denied. Limited administrative appeals will be accepted.

A provider bulletin regarding this change will be posted on June 3, 2019. We're sharing this information with you prior to that official communication to allow more time for preparation and to address any initial questions you might have.

If you have any questions, please contact provider services.

Sincerely,

Eric Hoag
Vice President, Provider Relations