New York Provider News

November 2020 Empire Provider News

Medicaid:

Medicare:

Reminder: Specialty Pharmacy Program expands Level of Care Reviews to NYC Hospital PPO Members

Published: Nov 1, 2020 - **Products & Programs**

What's new beginning with dates of service on and after November 1, 2020:
Empire BlueCross BlueShield's ("Empire") Specialty Pharmacy Level of Care Program launched July 2016 and was communicated in our April 2016 newsletter. Per our December 2019 newsletter, Empire is expanding the Specialty Pharmacy Level of Care Program, to include NYC Hospital PPO plan membership. Specialty Drugs inclusive in the program will be reviewed for both clinical appropriateness and the level of care against health plan clinical criteria (CG-Med-83) for dates of service beginning November 1, 2020.

Physician offices that currently administer Specialty Drugs in the office setting are not impacted by this change. We encourage you to discuss with your patients their level of care options, such as physician office, infusion center or home infusion therapy, as appropriate.

773-1120-PN-NY

URL: https://providernews.empireblue.com/article/reminder-specialty-pharmacy-program-expands-level-of-care-reviews-to-nyc-hospital-ppo-members

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Prior authorization updates for specialty pharmacy are available

Published: Nov 1, 2020 - **Products & Programs** / Pharmacy

Prior authorization updates

Effective for dates of service on and after February 1, 2021, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our prior authorization review process.

To access the Clinical Criteria information please click here.

Empire BlueCross BlueShield's ("Empire") prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Empire's medical specialty drug review team. *Review of specialty pharmacy drugs for oncology indications will be managed by AIM Specialty Health® (AIM), a separate company and are shown in italics in the table below.*

Clinical Criteria	HCPCS or CPT Code(s)	Drug
*ING-CC-0127	J9999, C9399	Darzalex Faspro

***** Non-oncology use is managed by Empire's medical specialty drug review team. O*ncology use is managed by AIM.*

Step therapy updates

Effective for dates of service on and after February 1, 2021, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process.

To access the Clinical Criteria information related to Step Therapy, please click here.

Empire's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Empire's medical specialty drug review team. *Review of specialty pharmacy drugs for oncology indications will be managed by AIM Specialty Health® (AIM), a separate company and are shown in italics in the table below.*

ING-CC-0011	Non-preferred		Ocrevus	J2350

***** Non-oncology use is managed by Empire's medical specialty drug review team. O*ncology use is managed by AIM.*

Correction to a prior authorization update

In the October 2020 edition of *Provider News,* we published a prior authorization update regarding clinical criteria **ING-CC-0174** on the drug Kesimpta.

- One HCPCS code has been added, J9302. This is the valid code for the drug Kesimpta.

743-1120-PN-NY

URL: https://providernews.empireblue.com/article/prior-authorization-updates-for-specialty-pharmacy-are-available-5

IngenioRx Introduces New Pharmacy Network in 2021

Published: Nov 1, 2020 - **Products & Programs** / Pharmacy

Starting **January 1, 2021**, IngenioRx, the pharmacy benefit manager for our affiliated health plans, will make its new standard pharmacy network available to your patients. The standard network will be made up of about 58,000 pharmacies nationwide, including well-known national chains like Costco, CVS, Kroger, Sam's Club, Target and Walmart.

With robust access, your patients can use any participating pharmacy across the country in the standard network to fill their prescriptions.

Network Notification Plan

Some of your patients covered by an Empire BlueCross BlueShield ("Empire") health plan may currently use pharmacies that are not in this new network. They'll need to transfer their active prescription(s) to a network pharmacy to ensure there is no interruption of their coverage.

Prior to the network effective date, we'll notify your patients by letter outlining the easy steps about transferring their prescriptions to another pharmacy in the network.

In addition, to help you easily send prescriptions to a participating pharmacy, we'll include messaging via your patients' electronic medical record. This message will appear if you attempt to submit a prescription to a pharmacy that's not included in the standard network. This will ensure your patients' prescriptions are properly routed to a network pharmacy and will help them continue to receive their medications worry-free.

If your patients would like to search for a network pharmacy prior to the new network effective date, they can log in to empireblue.com where instructions will appear with a helpful link to our online pharmacy search tool. They can enter their address/city/state or their zip code to begin searching.

Questions?
Please refer to our helpful Frequently Asked Questions for more details about the new standard network.

750-1120-PN-NY

Article Attachments

New Rx Network FAQs.pdf
application/pdf - 82.55 KB

URL: https://providernews.empireblue.com/article/ingeniorx-introduces-new-pharmacy-network-in-2021-5

Clinical Criteria updates for specialty pharmacy are available

Published: Nov 1, 2020 - **Products & Programs** / Pharmacy

Empire BlueCross BlueShield's ("Empire") pre-service clinical review of non-oncology specialty pharmacy drugs will be managed by Empire's medical specialty drug review team. Oncology drugs will be managed by AIM Specialty Health (AIM), a separate company.

The following Clinical Criteria documents were endorsed at the September 24, 2020 Clinical Criteria meeting. To access the clinical criteria information please click here.

New Clinical Criteria effective September 30, 2020
The following clinical criteria are new.

- ING-CC-0179 Blenrep (belantamab mafodotin-blmf)
- ING-CC-0180 Monjuvi (tafasitamab-cxix)

Revised Clinical Criteria effective September 30, 2020
The following current clinical criteria were revised to expand medical necessity indications or criteria.

- ING-CC-0063 Stelara (ustekinumab)
- ING-CC-0086 Spravato (esketamine) Nasal Spray
- ING-CC-0128 Tecentriq (atezolizumab)

Revised Clinical Criteria effective October 26, 2020
The following clinical criteria were revised to expand medical necessity indications or criteria.

- ING-CC-0081 Crysvita (burosumab-twza)

Reviewed Clinical Criteria effective October 26, 2020
The following clinical criteria were reviewed with no significant change to the medical necessity indications or criteria.

- ING-CC-0008 Subcutaneous Hormonal Implants
- ING-CC-0012 Brineura (cerliponase alfa)
- ING-CC-0013 Mepsevii (vestronidase alfa)
- ING-CC-0017 Xiaflex (collagenase clostridium histolyticum)
- ING-CC-0018 Lumizyme (alglucosidase alfa)
- ING-CC-0028 Benlysta (belimumab)
- ING-CC-0046 Zinplava (bezlotoxumab)
- ING-CC-0062 Tumor Necrosis Factor Antagonists

Revised Clinical Criteria effective February 1, 2021
The following clinical criteria were revised and might result in services that were previously covered but may now be found to be not medically necessary.

- ING-CC-0011 Ocrevus (ocrelizumab)
- ING-CC-0014 Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
- ING-CC-0021 Fabrazyme (agalsidase beta)
- ING-CC-0022 Vimizim (elosulfase alfa)
- ING-CC-0023 Naglazyme (galsulfase)
- ING-CC-0024 Elaprase (idursufase)
- ING-CC-0025 Aldurazyme (laronidase)
- ING-CC-0160 Vyepti (eptinezumab-jjmr)

759-1120-PN-NY

URL: https://providernews.empireblue.com/article/clinical-criteria-updates-for-specialty-pharmacy-are-available-10

Digital transactions cut administrative tasks in half

Published: Nov 1, 2020 - **Administrative**

Introducing the Empire Provider Digital Engagement Supplement to the provider manual

Using our secure provider portal or EDI submissions (via Availity), administrative tasks can be reduced by more than fifty percent when filing claims with or without attachments, checking statuses, verifying eligibility, benefits and when submitting prior authorizations electronically. In addition, it could not be easier. Through self-service functions, you can accomplish digital transactions all at one time, all in one place. If you are not already registered via the Availity EDI website or the secure Provider Portal via Availity.

Get payments faster

By eliminating paper checks, Electronic Funds Transfer (EFT) is a digital payment solution that deposits payments directly into your account. It is safe, secure and you can receive payments faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the secure provider portal or the EDI 835 remittance, which meets all HIPAA mandates - eliminating the need for paper remittances.

Member IDs go digital

Empire BlueCross BlueShield (“Empire”) members are transitioning to digital member identification cards making it easier for them and you. The ID card is easily emailed directly to you for file upload, eliminating the need to scan or print. In addition, the new digital member ID card can be directly accessed through the secure provider portal via Availity. Providers should begin accepting the digital member ID cards when presented by the member.

Empire makes going digital easy with the Provider Digital Engagement Supplement

From our digital member identification cards to EDI transactions, APIs to Direct Data Entry, we cover it all in our Provider Digital Engagement Supplement to the Provider Manual and on our secure provider portal through Availity. The Supplement outlines Empire provider expectations, processes and self-service tools across all electronic channels, including medical, dental, and vision benefits.

The Provider Digital Engagement Supplement to the provider manual is another example of how Empire is using digital technology to improve the health care experience. We are asking providers to go digital with Empire no later than January 1, 2021, so we can realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration. Read the Digital Engagement Supplement now.

Clinical Laboratory Improvement Amendments (CLIA) Number – Additional Information

Published: Nov 1, 2020 - **Administrative**

The purpose of this article is to provide additional information regarding submission of the CLIA number on claims for laboratory services that include QW or 90 modifiers. As a reminder, claims filed without the CLIA number are considered incomplete and will reject.

Both paper and electronic claim formats accommodate the CLIA number.

- On the CMS-1500 form, Box 23 (Prior Authorization) is reserved for the CLIA number.
- On the 837P, REF segments are available: REF (X4) in loops 2300 and 2400, and REF (F4) in loop 2400.

Note: The CLIA number for the Referring Clinical Laboratory should be included in REF (F4)

The following examples illustrate how the CLIA number as well as procedure code modifiers QW and 90 should be filed:

Claim Format	Location(s) Reserved for Procedure Modifier and CLIA #		
Modifier QW – diagnostic lab service is a CLIA waived test			
CLIA Waived Tests - simple laboratory examinations and procedures that have an insignificant risk of an erroneous result			
CMS-1500	Procedure modifier 'QW': Box 24d	CLIA #: Box 23 Prior Authorization	
837P	Procedure modifier 'QW': Loop 2400 SV101-3 (1st position)	CLIA #: Loop 2300 or 2400 REF X4	
Modifier 90 – Reference (Outside) Laboratory			
Referring laboratory – refers a specimen to another laboratory for testing Reference laboratory – receives a specimen from another laboratory and performs one or more tests on that specimen			
CMS-1500	Procedure modifier '90': Box 24d	CLIA #: Box 23 Prior Authorization	
837P	Procedure modifier '90': Loop 2400 SV101-3 – SV101-6	CLIA #: Loop 2300 or 2400 REF X4	CLIA # - Referring Facility Identification: Loop 2400 REF F4

Additional information regarding CLIA is available on the CMS website: https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/

If you have additional questions, please call the telephone number on the back of the member's identification card.

733-1120-PN-NY

URL: https://providernews.empireblue.com/article/clinical-laboratory-improvement-amendments-clia-number-additional-information-3

Availity Attachment Tools for Empire and Affiliate Payers – Live Webinars

Published: Nov 1, 2020 - **Administrative**

In this 60-minute webinar, you will learn how to use Availity's* Attachment tools to submit and track supporting documentation electronically to Empire and affiliate payers.

We will explore key workflow options to fit your organization’s needs, including how to:

- Work a request in the inbox of your Attachments Dashboard.
- Enter and submit a web claim including supporting documentation.
- Use EDI batch options to trigger a request in your inbox.
- Track attachments you submitted using sent and history lists in your Attachments Dashboard.
- Get set up to use these tools.

As part of the session, we’ll answer questions and provide handouts and a job aid for you to reference later.

Register for an upcoming webinar session:

1. In the Availity Portal, select Help & Training > Get Trained.
2. The Availity Learning Center opens in a new browser tab.
3. Search for and enroll in a session using one of these options:
    - In the Catalog, search by webinar title or keyword.
        - To find this specific live session quickly, use keyword ***medattach*.**
    - Select the **Sessions** tab to scroll the live session calendar.
4. After you enroll, you’ll receive emails with instructions to join the session.

Webinar Dates:

DATE	DAY	TIME
November 4, 2020	Wednesday	Noon to 1 p.m. ET
November 17, 2020	Tuesday	2 p.m. to 3 p.m. ET
December 4, 2020	Friday	3 p.m. to 4 p.m. ET
December 15, 2020	Tuesday	3 p.m. to 4 p.m. ET

762-1120-PN-NY

URL: https://providernews.empireblue.com/article/availity-attachment-tools-for-empire-and-affiliate-payers-live-webinars

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US Antibiotic Awareness Week

Published: Nov 1, 2020 - **Administrative**

US Antibiotic Awareness Week is November 18-24, 2020! This is a one-week observance that gives organizations and providers an opportunity to raise awareness on the appropriate use of antibiotics and reduce the threat of antibiotic resistance. The Centers for Disease Control and Prevention (CDC) has over 10 hours of **free Continuing Education** available for providers at https://www.cdc.gov/antibiotic-use/community/for-hcp/continuing-education.html.

The CDC promotes *Be Antibiotics Aware*, an educational effort to raise awareness encouraging safe antibiotic prescribing practices and use. *Be Antibiotics Aware* has many resources for health care professionals (in outpatient and inpatient settings) including videos such as *The Right Tool* (https://www.youtube.com/watch?v=dETK7Jc-XWA) and *Antibiotics Aren't Always the Answer* (https://www.youtube.com/watch?v=byh75p7bf-U) that can be utilized in provider's waiting rooms.

722-1120-PN-NY

URL: https://providernews.empireblue.com/article/us-antibiotic-awareness-week-5

Get the full picture of your patient's health through their smartphone

Published: Nov 1, 2020 - **Administrative**

Empire BlueCross BlueShield ("Empire") is committed to creating innovative tools that help simplify health care. In pursuit of that commitment, we recently enhanced our digital tool that enables members to share their personal health data with physicians and hospitals. This tool, referred to as My Health Records, merges patient health records from providers who may have cared for an individual member and stores the data in one secure place that is accessible to the member via the Sydney Health mobile app and empireblue.com. My Health Records provides a new way for members to access their personal health information from multiple providers' databases then view, download and share their health data and medical records with doctors via their smartphone or computer.

My Health Records allows members to share important health information with physicians, such as:

- Lab results and historical insights with visualizations
- Medications, Conditions, Immunizations, Vaccinations
- Health records
- Health records of dependents (14 years and under)
- Easy access to provider information
- Personalized health data tracking over time
- Integration for member authorization to more health record data

The enhanced digital tool gives physicians and hospitals a holistic view of a member's up-to-date health data. This complete health data in one trusted place enables providers and members to feel more confident in making important life decisions easily and quickly.

*This tool is now available to Empire members in our Medicare, Individual, Small Group and Fully Insured Large Group business segments and will be available to members in our Large Group ASO and National Account business segments in early 2021.

763-1120-PN-NY

URL: https://providernews.empireblue.com/article/get-the-full-picture-of-your-patients-health-through-their-smartphone-5

Clinical Guideline Updates

Published: Nov 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

These updates list the new and/or revised Empire BlueCross BlueShield (“Empire”) medical policies, clinical guidelines and reimbursement policies*. The implementation date for each policy or guideline is noted for each section. Implementation of the new or revised medical policy, clinical guideline or reimbursement policy is effective for all claims processed on and after the specified implementation date, regardless of date of service. Previously processed claims will not be reprocessed as a result of the changes. If there is any inconsistency or conflict between the brief description provided below and the actual policy or guideline, the policy or guideline will govern.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and clinical guidelines (and medical policy takes precedence over clinical guidelines) and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that the services are rendered must be used. This document supplements any previous medical policy and clinical guideline updates that may have been issued by Empire. Please include this update with your Provider Manual for future reference.

Please note that medical policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Empire’s medical policies and clinical guidelines can be found at empireblue.com.

*Note: These updates may not apply to all ASO Accounts as some accounts may have non-standard benefits that apply.

Clinical Guideline Updates

Archived Clinical Guidelines Effective 12-08-2020

(The following adopted guidelines have been archived and have been replaced by AIM guidelines.)

- CG-REHAB-04 - Rehabilitative and Habilitative Services: Medicine/Physical Therapy
- CG-REHAB-05 - Rehabilitative and Habilitative Services: Occupational Therapy
- CG-REHAB-06 - Rehabilitative and Habilitative Services: Speech-Language Pathology
- CG-REHAB-11 - Cognitive Rehabilitation

Coding Updates

As a result of coding updates in the claims system, the claim system edits for the clinical guideline listed below will be revised. This will result in the review of claims for certain diagnoses before processing occurs to determine whether the service meets medical necessity criteria. As a result, these coding updates may result in a not medically necessary determination.

Effective February 13, 2021, we will be implementing coding updates in the claims system for the following clinical guideline listed below which may result in not medically necessary determinations for certain services.

- CG-SURG-09 - Temporomandibular Disorders

757-1120-PN-NY

URL: https://providernews.empireblue.com/article/clinical-guideline-updates-6

Reminder: Post-service reviews using AIM

Published: Nov 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

As previously communicated in the October 2017 edition of Network Update, Empire BlueCross BlueShield (“Empire”) uses AIM to administer pre-service clinical reviews for services noted below. AIM reviews requests in real time against evidence-based clinical guidelines and Empire medical policies. Providers are notified via letter or remit message when claims are submitted without the appropriate pre-service review by AIM. If such a letter or message is received, providers will need to obtain a post-service clinical review for the service via the AIM ***Provider****Portal*$_{SM}$. If documentation/post –service review request is submitted to Empire, Providers are notified via another letter or remit message to submit to AIM.

To help prevent delays in claim processing and post-service reviews, ordering providers submit pre-service request to AIM in one of the following ways:

- Access AIM ***Provider****Portal* directly at providerportal.com available 24/7 to process orders in real-time
- Access AIM via the Availity web portal at availity.com

As a reminder, AIM reviews the following services for clinical appropriateness:

- Advanced diagnostic imaging
- Cardiology tests and procedures (e.g. MPI, echocardiography, PCI, cardiac catheterization)
- Medical oncology treatments through the Cancer Care Quality Program
- Radiation oncology treatments (e.g. IMRT, brachytherapy)
- Sleep testing, treatment and supplies
- Genetic testing
- Musculoskeletal (e.g., spine and joint surgeries, pain management)
- Rehabilitative services (physical, speech and occupational therapy)
- Surgical Site of Care (e.g., gastroenterology, other surgeries will be implemented which will be communicated via provider newsletter)

Services performed in an emergency or inpatient setting are excluded from AIM programs. This update applies to local fully-insured Empire members and members who are covered under a self-insured (ASO) benefit plan, with services medically managed by AIM. It does not apply to BlueCard, Medicare Advantage, Medicaid, Medicare Supplement, Federal Employee Program (FEP).
For more information please contact the phone number on the back of the member ID card.

711-1120 PN-NY

URL: https://providernews.empireblue.com/article/reminder-post-service-reviews-using-aim-5

Documentation Standards for Episodes of Care (Professional)

Published: Nov 1, 2020 - **Policy Updates** / Reimbursement Policies

The new professional reimbursement policy for Documentation Standards for Episodes of Care will be effective February 1, 2021. This policy will replace the current Documentation Guidelines for Adaptive Behavior Assessments and Treatment for Autism Spectrum Disorder and Documentation Guidelines for Central Nervous System Assessments and Tests policies. Those policies will be retired as of February 1, 2021. The Documentation

Standards for Episodes of Care policy will be considered an administrative policy and will serve as an overarching documentation standards policy.

For more information about this policy, visit the Reimbursement Policy page at empireblue.com/provider.

748-1120-PN-NY

URL: https://providernews.empireblue.com/article/documentation-standards-for-episodes-of-care-professional

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Modifier Rules (Professional)

Published: Nov 1, 2020 - **Policy Updates** / Reimbursement Policies

Beginning with dates of service on or after February 1, 2021, Empire BlueCross BlueShield ("Empire") policy language has been updated to add Modifier FB to the related coding section and indicate that when used in the adjudication of a claim reimbursement may be affected.

Modifier FB is defined as an item provided without cost to provider, supplier or practitioner, or full credit received for replaced device.

For more information about this policy, visit the Reimbursement Policy page at empireblue.com/provider.

751-1120-PN-NY

URL: https://providernews.empireblue.com/article/modifier-rules-professional

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Bundled Services and Supplies (Professional)

Published: Nov 1, 2020 - **Policy Updates** / Reimbursement Policies

Beginning with dates of service on or after February 1, 2021, Empire BlueCross BlueShield ("Empire") will update Bundled Services and Supplies Section 2 Coding list to indicate that

the following codes:

- 43281 - laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh,
- 43282 - laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh,
- 43283 - laparoscopy, surgical, esophageal lengthening procedure,
- 43332 - repair paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis, and
- 43333 - repair paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis, *are not eligible for separate reimbursement* when reported with bariatric procedure codes 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887 and 43888.

Additionally, the Bundled Services Section 2 coding list will be updated to include the telehealth originating site facility fee HCPCS code (Q3014) when reported with an E&M code in place of service 11.

For more information about this policy, visit the Reimbursement Policy page at empireblue.com/provider.

754-1120-PN-NY

URL: https://providernews.empireblue.com/article/bundled-services-and-supplies-professional-8

Attention: Updated laboratory fee schedule

Published: Nov 1, 2020 - **State & Federal** / Medicaid

Effective January 1, 2021, Empire BlueCross BlueShield HealthPlus (Empire) will update the *Reference Laboratory Fee Schedule* for Empire. This change is applicable to providers who are reimbursed, either in whole or in part, based on the fee schedule for laboratory services for Medicaid.

The actual impact to any particular provider will depend on the codes most frequently billed by that provider.

The updated fee schedule will be available on the **Availity Portal*** on the effective date of January 1, 2021.

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-800-450-8753**.

NYE-NU-0211-20 November 2020

URL: https://providernews.empireblue.com/article/attention-updated-laboratory-fee-schedule-2

Transition to AIM Rehabilitative Service Clinical Appropriateness Guidelines

Published: Nov 1, 2020 - **State & Federal** / Medicaid

This communication applies to the Medicaid and Medicare Advantage programs for Empire BlueCross BlueShield (Empire).

Empire previously communicated that AIM Specialty Health®* (AIM) would transition the clinical criteria for medical necessity review of certain rehabilitative services to *AIM Rehabilitative Service Clinical Appropriateness Guidelines* as part of the AIM Rehabilitation Program beginning October 1, 2020. Please be aware that this transition has been delayed. The new transition date will be in December 1, 2020.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Empire BlueCross BlueShield.

NYE-NU-0260-20
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URL: https://providernews.empireblue.com/article/transition-to-aim-rehabilitative-service-clinical-appropriateness-guidelines-6

Digital transactions cut administrative tasks in half

Published: Nov 1, 2020 - **State & Federal** / Medicaid

This communication applies to the Medicaid and Medicare Advantage programs for Empire BlueCross BlueShield (Empire).

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Member ID cards go digital

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Empire makes going digital easy with the Provider Digital Engagement Supplement

From our digital member ID cards, EDI transactions, application programming interfaces and direct data entry, we cover everything you need to know in the *Provider Digital Engagement Supplement* to the provider manual, available by going to **https://mediproviders.empireblue.com/ny/pages/communications-updates.aspx** > Communications & Updates > Communications and Updates > Provider Digital Engagement**,** and on the secure **Availity Provider Portal**. The supplement outlines our provider expectations, processes and self-service tools across all electronic channels Medicaid, including medical, dental and vision benefits.

The *Provider Digital Engagement Supplement* to the provider manual is another example of how Empire is using digital technology to improve the health care experience. We are asking providers to go digital with Empire no later than January 1, 2021, so we can realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration. Read the *Provider Digital Engagement Supplement* now by going to **https://mediproviders.empireblue.com/ny/pages/communications-updates.aspx** > Communications & Updates > Communications and Updates > Provider Digital Engagement, and go digital with Empire.

NYE-NU-0261-20 October 2020
514554MUPENMUB

URL: https://providernews.empireblue.com/article/digital-transactions-cut-administrative-tasks-in-half-14

Update: Notice of changes to the AIM Musculoskeletal Program prior authorization requirements and setting determinations

Published: Nov 1, 2020 - **State & Federal** / Medicaid

As you know, AIM Specialty Health® (AIM)* administers the Musculoskeletal Program, which includes the medical necessity review of certain surgeries of the spine and joints and interventional pain treatment. For certain surgeries, the review also includes a consideration of the level of care.

Effective November 1, 2020, according to the AIM Level of Care guideline, it is generally appropriate to perform joint codes (CPT® codes 27130, 29871, 29892) and four spine codes (CPT codes 22633, 22634, 63265 and 63267) in a hospital outpatient setting. To avoid additional clinical review for these procedures, providers requesting prior authorization should either choose *hospital observation* admission as the site of service or Hospital Outpatient Department (HOPD). If the provider determines that an inpatient stay is necessary due to postoperative care requirements, they can initiate a concurrent review request for inpatient admission with the health plan by contacting the number on the back of the member ID card.

We will review requests for inpatient admission and will require the provider to substantiate the medical necessity of the inpatient setting with proper medical documentation that demonstrates one of the following:

- Current postoperative care requirements are of such an intensity and/or duration that they cannot be met in an observation or outpatient surgical setting.
- Anticipated postoperative care requirements cannot be met, even initially, in an observational surgical setting due to the complexity, duration or extent of the planned procedure and/or substantial preoperative patient risk.

Peer-to-peer conversations are available to a provider at any time to discuss the applicable clinical criteria and to provide information about the circumstances of a specific member.

Providers should continue to submit pre-service review requests to AIM using one of the following ways:

- Access AIM ***Provider****Portal*$_{SM}$ directly at **http://providerportal.com**. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal* at **https://www.availity.com**.
- Call the AIM toll-free number at **1-800-714-0040** Monday through Friday 8:30 a.m. to 7 p.m. ET.

If you have questions, please contact provider services at **1-800-450-8753**.

NYE-NU-0240-20 August 2020

URL: https://providernews.empireblue.com/article/update-notice-of-changes-to-the-aim-musculoskeletal-program-prior-authorization-requirements-and-setting-determinations-8

Aspire Health telehealth palliative care program for Medicaid members in need of telephonic palliative care

Published: Nov 1, 2020 - **State & Federal** / Medicaid

The Aspire Health* telehealth program provides an additional layer of telephonic support to patients facing a serious illness. The program is focused on helping ensure patients understand their diagnosis, facilitating conversations with patients and their families around the patient's goals of care, and helping ensure patients receive care aligned with their goals and values.

The program begins with an initial 30- to 60-minute telephonic assessment by a specially trained Aspire social worker with the conversation focused on building rapport and completing a comprehensive assessment, including understanding the patient's perception of his or her illness and current treatment plan. Follow-up calls occur every 2 to 4 weeks, typically lasting 15 to 45 minutes, with the exact frequency based on a patient's individual need. Aspire's social worker is supported by Aspire's full interdisciplinary team of board-certified palliative care physicians, nurses and chaplains who provide additional telephonic support to patients and their families as needed. Patients enrolled in the telehealth program have access to Aspire's 24/7 on-call support. The average patient is enrolled in the program 6 to 8 months, with key outcomes being the ability for patients to *teach-back* their current medical situation, articulate their health and quality-of-life goals, and establish a future care plan through either the completion of advance care planning documents and/or a transition to hospice when appropriate.

More information is available at **www.aspirehealthcare.com** or by calling the 24/7 Patient & Referral Hotline at **1-844-232-0500.**

NYE-NU-0242-20 September 2020

URL: https://providernews.empireblue.com/article/aspire-health-telehealth-palliative-care-program-for-medicaid-members-in-need-of-telephonic-palliative-care

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Medical drug benefit Clinical Criteria updates

Published: Nov 1, 2020 - **State & Federal** / Medicaid

On February 21, 2020, May 15, 2020, and June 18, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Empire BlueCross BlueShield HealthPlus. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider website, and the effective dates will be reflected in the ***Clinical Criteria Web Posting June 2020***. Visit ***Clinical Criteria*** to search for specific policies.
If you have questions or would like additional information, use this **email**.

NYE-NU-0244-20 September 2020

URL: https://providernews.empireblue.com/article/medical-drug-benefit-clinical-criteria-updates-71

Reimbursement Policy: Nurse Practitioner and Physician Assistant Services (Professional)

Published: Nov 1, 2020 - **State & Federal** / Medicaid

(Effective 04/24/20)
Empire BlueCross BlueShield HealthPlus continues to allow reimbursement for services provided by nurse practitioner (NP) and physician assistant (PA) providers. Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- The service is considered a physician's service.
- The service is within the scope of practice.
- A payment is consistent with NP fees schedule rates.
- New York does not allow separate reimbursement for PA providers.

Services furnished by the NP or PA should be submitted by the supervising physician.

This article is to inform you that there is now a separate and specific professional reimbursement policy to reference for Nurse Practitioner and Physician Assistant Services.

For additional information, please review the Nurse Practitioner and Physician Assistant Services professional reimbursement policy at **www.empireblue.com/nymedicaiddoc**.

NYE-NU-0245-20 September 2020

URL: https://providernews.empireblue.com/article/reimbursement-policy-nurse-practitioner-and-physician-assistant-services-professional

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Coding spotlight: tips and best practices for compliance

Published: Nov 1, 2020 - **State & Federal** / Medicaid

Need for coding compliance
Coding compliance refers to the process of ensuring that the coding of diagnosis, procedures and data complies with all coding rules, laws and guidelines.

All provider offices and health care facilities should have a compliance plan. Internal controls in the reimbursement, coding, and payment areas of claims and billing operations are often the source of fraud and abuse, and have been the focus of government regulations.

Compliance plan benefits:

- More accurate payment of claims
- Fewer billing mistakes
- Improved documentation and more accurate coding
- Less chance of violating state and federal requirements including self-referral and anti-kickback statutes.

Compliance programs can show the provider practice is making an effort to submit claims appropriately and send a signal to employees that compliance is a priority.

Medical records documentation
All medical records entries should be complete and legible, and should include the legible identity of the provider and date of service.

Each encounter in the medical record must include the patient's full name and date of birth. Documentation integrity is at risk when there is wrong information on the wrong patient health record because it can affect clinical decision-making and patient safety.

Providers' signatures and credentials are of the utmost importance in all documentation efforts. The signature is an attestation from the treating and documenting provider that certifies the written document as reflecting the provider's intentions regarding the services performed during the encounter, and the reason(s).

Specific information is required to describe the patient encounter each time he or she presents for medical services.

Each encounter generally will need to contain the following:

- The chief complaint
- The history of present illness

- The physical examination
- Assessment and care plan.

Common coding and billing risk areas
The following billing risks are commonly subject to Office of Inspector General (OIG) investigations and audits:

- Billing for items or services not rendered or not provided as claimed
- Double billing, resulting in duplicate payment
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary
- Billing for non-covered services
- Knowingly misusing provider identification numbers, which results in improper billing
- Unbundling
- Failure to properly use modifiers
- Upcoding the level of service.

Evaluation and Management (E&M) claims are typically denied for two reasons:

- Incorrect coding, such as the code not matching the documentation, and insufficient documentation, which can include a lack of a provider signature or no record of the extent and amount of time spent in counseling.
- Coordination of care when it is used to qualify for a particular level of E&M service.

There are several strategies on how to prevent E&M claims being denied:

- In addition to the individual requirements for billing a selected E&M code, providers should also consider whether the service is reasonable and necessary (for example, a level 5 office visit for a patient with a common cold and no comorbidities will not be reasonable and necessary).
- Remember the following when selecting codes for E&M services:
    - Patient type (new or established)
    - Setting/place of service

- The level of service provided based on the extent of the history, the extent of the examination, and the complexity of the medical decision making (for example, the number and type of the key components performed).

Best practices to avoid common documentation mistakes

Providers need to formulate a complete and accurate description of the patient's condition with a detailed plan of care for each encounter. Listing problems without a corresponding plan of care does not confirm physician management of that problem and could cause a downgrade of complexity. Listing problems with a brief, generalized comment (for example, diabetes management (DM), chronic kidney disease (CKD), congestive heart failure (CHF): Continue current treatment plan) equally diminishes the complexity and effort put forth by the physician.

The care plan needs to be documented clearly. The care plan represents problems the physician personally manages, along with those that must also be considered when he or she formulates the management options, even if another provider is primarily managing the problem. For example, one provider can monitor the patient's diabetic management while the nephrologist oversees the chronic kidney disease (CKD).

Pathology service, laboratory testing, radiology and medicine-based diagnostic testing contributes to diagnosing or managing patient problems.

Documentation tips:

- Specify tests ordered and document rationale in the medical record
- Document test review by including a description in the note (for example, elevated glucose levels)
- Indicate when images, tracings, or specimens are personally reviewed; be sure to include a comment on the findings
- Summarize any discussions of unexpected or contradictory test results with the provider performing the procedure or diagnostic study.

Patient risk in E&M is categorized as minimal, low, moderate or high based on the presenting problem, diagnostic procedures ordered and management options selected. Chronic conditions with exacerbations and invasive procedures offer more patient risk than acute, uncomplicated illnesses or noninvasive procedures. Stable or improving problems are considered less risky than progressing problems; conditions that pose a threat to life/bodily function outweigh undiagnosed problems where it is difficult to determine the patient's prognosis.

To determine the right complexity of the patient's problems, providers should:

- Document the status for all problems in the plan of care and identify them as stable, worsening, or progressing (mild or severe), when applicable; do not assume that the auditor or coder can infer this from the documentation details.
- Document all diagnostic or therapeutic procedures considered.
- Identify surgical risk factors involving co-morbid conditions that place the patient at greater risk than the average patient, when appropriate.

Frequent auditing is key to medical coding compliance

To ensure your organization's E&M services are coded appropriately, it is important to periodically review your charts to check for insufficient documentation, miscoding, upcoding and downcoding. Conducting audits of your medical coding process and procedures can help give you an understanding of recurring risk areas and key improvement opportunities. Using these insights, you can then incorporate best practices and address any bad habits, lessening the chances of negative consequences.

Resources

1. *CPT® Professional Edition, 2020*. AMA
2. *Compliance Guidance*. Office of Inspector General. **https://oig.hhs.gov/compliance/compliance-guidance/index.asp**
3. *Risk Adjustment Documentation & Coding, 2nd edition*. American Medical Association

NYE-NU-0247-20 September 2020

URL: https://providernews.empireblue.com/article/coding-spotlight-tips-and-best-practices-for-compliance-3

Inhaled nitric oxide reviews for diagnosis-related group admissions

Published: Nov 1, 2020 - **State & Federal** / Medicaid

This is a notification regarding inhaled nitric oxide.
The purpose of this notification is to inform participating hospitals that the use of inhaled nitric oxide (iNO) during an inpatient stay will be reviewed for medical necessity using our *Clinical Utilization Management (UM) Guideline* for Inhaled Nitric Oxide, CG-MED-69. iNO is a covered service for eligible members when the use of iNO meets medical necessity criteria. To view the *Clinical UM Guideline* for INO, visit our **www.empireblue.com/nymedicaiddoc**.

This also requires that the facility notify Empire BlueCross BlueShield HealthPlus (Empire) of the use of iNO during the course of an inpatient review, and it must be reviewed and approved at some point prior to discharge to avoid exclusion of charges for iNO from the claim payment. If we are not alerted to the use of iNO and, therefore, medical necessity cannot be determined, and charges for iNO are included in the claim submission, the charges for iNO will not be considered in calculation of reimbursement for the stay.

When iNO is used, providers are required to submit an itemized list of charges with the claim for the inpatient stay.

Impact on the diagnosis-related group (DRG) payment
The charges for iNO that are determined to be not medically necessary will not be considered and could impact the DRG outlier payment, as the stay may not reach outlier status as soon as it would with inclusion of these charges. If the case reaches the outlier threshold, we will adjudicate the claim consistent with the financial terms of the contract for outliers, without inclusion of charges for iNO that are not medically necessary or the use of which was not disclosed.

Providers should direct questions regarding this guideline or in relation to the Utilization Management review process to the health plan numbers listed below:

- **1-800-450-8753**

Providers should fax new prior authorization requests for physical health inpatient services to **1-866-494-5635**.

Fax submissions of clinical documentation as requested by the Empire Inpatient Utilization Management department supporting medical necessity reviews for inpatient concurrent reviews to **1-866-494-5635**.

NYE-NU-0248-20 September 2020

URL: https://providernews.empireblue.com/article/inhaled-nitric-oxide-reviews-for-diagnosis-related-group-admissions-1

Provider transparency update

Published: Nov 1, 2020 - **State & Federal** / Medicaid

A key goal of the provider transparency initiatives of Empire BlueCross BlueShield HealthPlus (Empire) is to improve quality while managing health care costs. One of the ways this is accomplished is through our value-based programs (for example, the Provider Quality Incentive Program, the Provider Quality Incentive Program Essentials, Risk and Shared Savings, etc.), known as *the Programs*.

Value-Based Program Providers (also known as Payment Innovation Providers) in our various value-based programs receive quality, utilization and/or cost data, reports and information about other health care providers (Referral Providers). The Value-Based Program Providers can use that information in selecting Referral Providers for their patients covered under the Programs. If a Referral Provider is higher quality and/or lower cost, this component of the Programs should result in the provider getting more referrals from Value-Based Program Providers. If Referral Providers are lower quality and/or higher cost, the converse should be true.

Providing this type of data, including comparative cost information, to Value-Based Program Providers helps them make more informed decisions about managing health care costs, and maintaining and improving quality of care. It also helps them succeed under the terms of the Programs.

Empire will share data on which we relied in making these quality/cost/utilization evaluations upon request, and will discuss it with Referral Providers, including any opportunities for improvement. If you have questions or need support, please refer to your local market representative or care consultant.

NYE-NU-0253-20 September 2020

URL: https://providernews.empireblue.com/article/provider-transparency-update-37

New specialty pharmacy medical step therapy requirements (Herceptin)

Published: Nov 1, 2020 - **State & Federal** / Medicaid

Effective for dates of service on and after January 1, 2021, the following specialty pharmacy drugs and corresponding codes from current *Clinical Criteria* will be included in our medical step therapy precertification review process. Step therapy review will apply upon precertification initiation or renewal, in addition to the current medical necessity review of all drugs noted below.

The *Clinical Criteria* below will be updated to include the requirement of a preferred agent effective January 1, 2021.

Clinical Criteria	**Preferred drug**	**Nonpreferred drug**
ING-CC-0166	Herzuma (Q5113), Kanjinti (Q5117), Ogivri (Q5114), Ontruzant (Q5112), Trazimera (Q5116)	Herceptin (J9355)

Clinical Criteria is publicly available on our provider website at **www.empireblue.com/nymedicaiddoc**.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at **1-800-450-8753**.

NYE-NU-0257-20 September 2020

URL: https://providernews.empireblue.com/article/new-specialty-pharmacy-medical-step-therapy-requirements-herceptin

New specialty pharmacy medical step therapy requirements (Avastin)

Published: Nov 1, 2020 - **State & Federal** / Medicaid

Effective for dates of service on and after January 1, 2021, the following specialty pharmacy drugs and corresponding codes from current *Clinical Criteria* will be included in our medical step therapy precertification review process. Step therapy review will apply on precertification initiation or renewal in addition to the current medical necessity review of all drugs noted below.

The clinical criteria below will be updated to include the requirement of a preferred agent effective
January 1, 2021.

Clinical criteria	Preferred drug	Nonpreferred drug
ING-CC-0107	Mvasi (Q5107), Zirabev (Q5118)	Avastin (J9035)

The *Clinical Criteria* is publicly available on http://www.empireblue.com/nymedicaiddoc.

What if I need assistance?
If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at **1-800-450-8753**.

NYE-NU-0258-20 September 2020

URL: https://providernews.empireblue.com/article/new-specialty-pharmacy-medical-step-therapy-requirements-avastin

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Keep up with Medicaid news

Published: Nov 1, 2020 - **State & Federal** / Medicaid

Please continue to check Medicaid Provider Communications &
updates at www.empireblue.com/nymedicaiddoc for the latest Medicaid information, including:

- New specialty pharmacy medical step therapy requirements
- Evaluation and management services correct coding

URL: https://providernews.empireblue.com/article/keep-up-with-medicaid-news-45

Transition to AIM Rehabilitative Service Clinical Appropriateness Guidelines

Published: Nov 1, 2020 - **State & Federal** / Medicare

This communication applies to the Medicaid and Medicare Advantage programs for Empire BlueCross BlueShield (Empire).

Empire previously communicated that AIM Specialty Health®* (AIM) would transition the clinical criteria for medical necessity review of certain rehabilitative services to *AIM Rehabilitative Service Clinical Appropriateness Guidelines* as part of the AIM Rehabilitation Program beginning October 1, 2020. Please be aware that this transition has been delayed. The new transition date will be in December 1, 2020.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Empire BlueCross BlueShield.

NYE-NU-0260-20
513917MUPENMUB

URL: https://providernews.empireblue.com/article/transition-to-aim-rehabilitative-service-clinical-appropriateness-guidelines-7

Provider Chat — A fast, easy way to get your questions answered

Published: Nov 1, 2020 - **State & Federal** / Medicare

You now have a new option to have questions answered quickly and easily. With Empire BlueCross BlueShield HealthPlus (Empire) Chat, providers can have a real-time, online

discussion through a new digital service, **available through Payer Spaces on Availity**.* Provider Chat offers:

- Faster access to Provider Services for all questions.
- Real-time answers to your questions about prior authorization and appeals status, claims, benefits, eligibility, and more.
- An easy to use platform that makes it simple to receive help.
- The same high level of safety and security you have come to expect with Empire.

Chat is one example of how Empire is using digital technology to improve the health care experience, with the goal of saving valuable time. To get started, access the service through Payer Services on **Availity**.

* Availity, LLC is an independent company providing administrative support services on behalf of Empire BlueCross BlueShield HealthPlus.

EBSCARE-0459-20 September 2020
513641MUPENMUB

URL: https://providernews.empireblue.com/article/provider-chat-a-fast-easy-way-to-get-your-questions-answered-6

Medical drug benefit Clinical Criteria updates

Published: Nov 1, 2020 - **State & Federal** / Medicare

On February 21, 2020, May 15, 2020, and June 18, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Empire BlueCross BlueShield. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider websites, and the effective dates will be reflected in the ***Clinical Criteria Web Posting June 2020***. Visit ***Clinical Criteria*** to search for specific policies.
If you have questions or would like additional information, use this **email**.

EBSCRNU-0134-20 September 2020
512909MUPENMUB

AIM rehabilitation prior authorizations suspended for Group Retiree Solutions members until December 31, 2020

Published: Nov 1, 2020 - **State & Federal** / Medicare

Rehabilitation services (physical, occupational and speech therapy) for Group Retiree Solutions members for service dates August 10, 2020, to December 31, 2020, do not require prior authorization by AIM Specialty Health®* **at this time**. Please note that benefit limits, if applicable, still will be applied.

Alpha prefixes:

- AAN
- ABW
- ACJ
- AEI
- AFH
- ATM
- ATN
- BBH
- BIY
- CBH
- DAH
- IAA
- IAD
- MBL
- MEW
- MHG
- VAY
- VGD
- WSP
- WZV
- XLU
- XNS
- YAC
- YGZ
- YVK
- ZVR
- ZVZ
- ZDX
- ZMX

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Empire BlueCross BlueShield.

EBSCRNU-0136-20 September 2020
513168MUPENMUB

URL: https://providernews.empireblue.com/article/aim-rehabilitation-prior-authorizations-suspended-for-group-retiree-solutions-members-until-december-31-2020

FDA approvals and expedited pathways used — new molecular entities

Published: Nov 1, 2020 - **State & Federal** / Medicare

Empire BlueCross BlueShield (Empire) reviews the activities of the FDA's approval of drugs and biologics on a regular basis to understand the potential effects for both our providers and members.

The FDA approves new drugs/biologics using various pathways of approval. Recent studies on the effectiveness of drugs/biologics going through these different FDA pathways illustrates the importance of clinicians being aware of the clinical data behind a drug or biologic approval in making informed decisions.

Here is a list of the approval pathways the FDA uses for drugs/biologics:

- **Standard Review:** The Standard Review process follows well-established paths to make sure drugs/biologics are safe and effective when they reach the public. From concept to approval and beyond, FDA performs these steps: reviews research data and information about drugs and biologics before they become available to the public, watches for problems once drugs and biologics are available to the public, monitors drug/biologic information and advertising, and protects drug/biologic quality. To learn more about the Standard Review process, go **here**.
- **Fast Track:** Fast Track is a process designed to facilitate the development and expedite the review of drugs/biologics to treat serious conditions and fill an unmet medical need. To learn more about the Fast Track process, go **here**.
- **Priority Review:** A Priority Review designation means FDA's goal is to take action on an application within six months. To learn more about the Priority Review process, go **here**.
- **Breakthrough Therapy:** A process designed to expedite the development and review of drugs/biologics that may demonstrate substantial improvement over available therapy. To learn more about the Breakthrough Therapy process, click **here**.
- **Orphan Review:** Orphan Review is the evaluation and development of drugs/biologics that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. To learn more about the Orphan Review process, click **here**.
- **Accelerated Approval:** These regulations allowed drugs/biologics for serious conditions that filled an unmet medical need to be approved based on a surrogate endpoint. To learn more about the Accelerated Approval process, click **here**.

New molecular entities approvals — January to August 2020
Certain drugs/biologics are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active ingredients that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product; these products frequently provide important new therapies for patients.

Empire reviews the FDA-approved NMEs on a regular basis. To facilitate the decision-making process, attached is a list of NMEs approved from January to August 2020, along with the FDA approval pathway utilized.

Article Attachments

New Molecular Entities_Medicare.pdf
application/pdf - 223.98 KB

EBSCRNU-0138-20 September 2020
513586MUPENMUB

URL: https://providernews.empireblue.com/article/fda-approvals-and-expedited-pathways-used-new-molecular-entities-4

Preferred continuous glucose monitors

Published: Nov 1, 2020 - **State & Federal** / Medicare

On January 1, 2020, Empire BlueCross BlueShield (Empire) implemented a preferred edit on Medicare Part B eligible continuous glucose monitors (CGMs). The preferred CGM is **Freestyle Libre**.

Preferred CGM edits do not apply to the following plans/plan types:

- Employer Group Waiver Plans (EGWP) Medicare Advantage Part D (MAPD) through Empire
- Employer Group Waiver Plans (EGWP) Medicare Advantage (MA only) through Empire
- Individual Medicare Advantage Plans (MA only) through Empire

Delivery channels

Only members enrolled in a plan using preferred CGM edits will need to obtain their CGM systems from a retail or mail order pharmacy. Members on a plan without preferred CGM edits will be able to obtain their CGM systems through durable medical equipment (DME) providers in addition to retail and mail order pharmacies. Please check member and plan benefits to confirm the available delivery channels for accessing CGM products.

EBSCARE-0453-20 September 2020
512818MUPENMUB

URL: https://providernews.empireblue.com/article/preferred-continuous-glucose-monitors-3

Keep up with Medicare news

Published: Nov 1, 2020 - **State & Federal** / Medicare

Please continue to check Important Medicare Advantage Updates at empireblue.com/medicareprovider for the latest Medicare Advantage information, including:

- Prior authorization requirements
- AIM Musculoskeletal program expansion update

URL: https://providernews.empireblue.com/article/keep-up-with-medicare-news-167
