# Blue Plus Provider Manual

## 2024

BlueCross BlueShield BluePlus of Minnesota

Independent licensees of the Blue Cross and Blue Shield Association

# Summary of Changes (2024)

### Chapter 1 – Introduction to Blue Plus

| Date | Page(s) | Summary of Change |
|---|---|---|
| 1/2 | 7, 11 - 20 | Medicaid Migration changes |
| | | |
| | | |

### Chapter 2 – Blue Plus Members

| Date | Page(s) | Summary of Change |
|---|---|---|
| 1/2 | 3, 6-8, 17-18 | Medicaid Migration Changes |
| | | |

### Chapter 3 – Government Programs

| Date | Page(s) | Summary of Change |
|---|---|---|
| 1/2 | 2, 6-8, 29, 34, 38, 39, 43, 49, 51, 54, 60, 73 | Medicaid Migration Changes |
| 3/25 | 23-24 | Added Moving expenses, Procedure code and per eligible expense. |
| | | |

### Chapter 4 – Referrals

| Date | Page(s) | Summary of Change |
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| | | |

### Chapter 5 – Quality Improvement

| Date | Page(s) | Summary of Change |
|---|---|---|
| | | |

## Chapter 1

# Introduction to Blue Plus

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# Utilization Management (UM) Statement

**Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage. Blue Cross and Blue Shield of Minnesota and Blue Plus do not compensate providers, practitioners or other individuals conducting UM decision-making activities for denials of coverage or service. Blue Cross and Blue Shield of Minnesota and Blue Plus do not offer incentives to decision-makers to encourage denials of coverage or service that would result in less than appropriate care or under-utilization of appropriate care and services.**

**Blue Cross UM decision-making processes ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their health coverage plan based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment through the use of specific clinical criteria and consideration of the individual needs of each case.**

**This statement exists to inform and remind providers, their employees, their supervisors, upper management, medical directors, UM directors or managers, licensed UM staff, and other personnel and UM staff employed by participating providers, who make utilization management decisions of this philosophy and practice.**

Please print your name and title

Signature Date Signed

# Introduction to Blue Plus

## General Overview

The *Blue Plus Provider Manual* is a general guide for participating primary care clinics' (PCCs') business office staff. This manual is a supplement to the Blue Cross and Blue Shield of Minnesota *Provider Policy & Procedure Manual.* When used in combination, these, along with the Provider Service agreement, will serve as a helpful resource to providers and business office staff.

The *Blue Plus Provider Manual* includes information about Blue Plus' referral policies, Subscriber benefits, care management, quality improvement and other topics that affect patient accounts and patient relations. The manual is designed to be accurate for Blue Plus' fully insured employer plans and there may be differences for Blue Plus' self-insured employer plans. For a definition of fully insured and self-insured plans see below. Changes to this process may periodically occur. Reference the Blue Cross Provider Policy and Procedure Manual at: https://www.bluecrossmn.com/sites/default/files/DAM/2019-04/BCBSMN%20Provider%20Policy%20and%20Procedure%20Manual.pdf

The Provider Bulletins will also include any updates to this process.

## Blue Plus

Blue Plus, an affiliate of Blue Cross and Blue Shield of Minnesota (Blue Cross), is a state-licensed health maintenance organization (HMO). Subscribers select a participating PCC that coordinates the Subscriber's medical care and authorizes treatment by specialists when necessary.

## Fully and Self-Insured Contracts

Blue Plus has **fully insured contracts** available for employers that select standard Blue Plus benefits. In general, fully insured contracts:

- Have few benefit variances within each contract option
- Follow state mandates
- Follow federal mandates
- Have standard member ID cards
- Are regulated by the Department of Health
- May not have standard member ID cards and may include the employer name and/or logo

## Fully and Self-Insured Contracts (continued)

**Self-insured contracts** are those in which the employer selects the benefits and assumes all or part of the financial risk. They may also be referred to as Administrative Services Only (ASO) contracts. In general, self-insured contracts:

- Have substantial variances to the contract benefits
- Are not required to follow state mandates
- Follow federal mandates

## Member Rights and Responsibilities

Blue Plus Member Rights and Responsibilities:

**Your rights as a health plan member:**

- To be treated with respect, dignity and privacy.
- To have available and accessible medically necessary covered services, including emergency services, 24 hours a day, seven (7) days a week.
- To be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment
- To participate with your health care providers in decisions about your treatment.
- To give your provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity).
- To name the person who can make health care decisions for you in the event of your incapacity.
- To refuse treatment.
- To have privacy of medical and financial records maintained by Blue Plus and its health care providers in accordance with existing law.
- To receive information about Blue Plus, its services, its providers, and your rights and responsibilities.
- To make recommendations regarding these rights and responsibilities policies.
- To have a resource at Blue Plus or at the clinic that you can contact with any concerns about services.
- To file a complaint with Blue Plus and the Commissioner of Health and receive a prompt and fair review.

**Member Rights and Responsibilities (continued)**

- To initiate a legal proceeding when experiencing a problem with Blue Plus or its providers.
- Medicare enrollees have the right to voluntarily disenroll from Blue Plus. Blue Plus may not encourage or request you to disenroll except in circumstances specified in federal law.
- Medicare enrollees have the right to a clear description of nursing home and home health care benefits covered by Blue Plus.

**You have the responsibility as a health plan member:**

- To know your health plan benefits and requirements.
- To provide, to the extent possible, information that Blue Plus and its providers need in order to care for you.
- To participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- To follow the treatment plan prescribed by your provider or to discuss with your provider why you are unable to follow the treatment plan.
- To provide proof of coverage when you receive services and to update the clinic with any personal changes, such as name and address.
- To pay copays at the time of service and to promptly pay deductibles, coinsurance and, if applicable, charges for services that are not covered.
- To keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

## Definitions and Clarifications

Clear communication between Blue Plus, the PCC and the Subscriber is very important. At times definitions and understanding of words may differ. To provide the best Health Services for Subscribers, it is necessary to have a clear understanding of the meaning of the terms "referral," "preauthorization" and "preadmission." Listed below and on the following pages are some definitions and clarifications that should prove helpful.

| Term | Definitions and Clarifications |
|---|---|
| **Referrals** | • **A referral is the authorization from the PCC for their patient to seek medical care outside the PCC and receive the highest level of the Subscriber's benefits.**<br>• **A referral does not mean the Health Service is approved for admission notification or preauthorization.** Preauthorization for required procedures and admission notification is separate from the referral process.<br>• **A referral does not mean the Health Service is eligible under the Subscriber's Contract.** Even if the service is referred, it must be eligible under the Subscriber's Contract to be eligible for reimbursement.<br>• **Subscribers may think that a Health Service is referred if they are told the service is Medically Necessary.** Be clear when referring services.<br>• **A denied referral does not mean that the Health Service is not Medically Necessary**. It simply means that the PCC can handle the service within its clinic/care system or at a different referral provider than that which PCC has developed a relationship. |

**Definitions and Clarifications (continued)**

| Term | Definitions and Clarifications |
|---|---|
| **Referrals (continued)** | • **Referrals are not created by Blue Plus.** Referrals are generated by PCCs. Blue Plus generates referrals as appropriate to address appeals from Subscribers. Referrals from one provider to another are the established standard practice. Blue Plus needs notification of the referral to process claims correctly.<br>• **A verbal referral will not get the claim paid correctly.** If PCC has authorized a referral, Blue Plus must be notified (unless there is a referral bypass in place).<br>• **Referrals should be authorized to the entity billing for the Health Service** (contracting provider), not to the Health Care Professional who is performing the service. |
| **Preauthorization (PA) or Pre-certification** | • **A Pre-certification or preauthorization (PA) does not mean the Health Service is referred.** If a PA is recommended and PCC wishes the service to be referred, a referral must be communicated to Blue Plus in addition to the PA.<br>• **An approved preauthorization does not mean the Health Service is covered under the Subscriber's Contract.** A Subscriber's benefits may change as an employer renews the contract. Also, the Subscriber may leave employment or change their contract. This must be taken into consideration when the service is performed. |
| **Preadmission Notification (PAN)** | • **An admission notification does not mean the Health Service is referred.** If an admission notification is required and PCC wishes the service to be referred, a referral must be done in addition to the admission notification. However, when an admission notification for an inpatient hospital stay is communicated to Blue Plus and the admitting physician is part of the Subscriber's PCC, Blue Plus will assume that a referral is authorized. |

**Department of Health**

The Minnesota Department of Health regulates Health Maintenance Organizations (HMOs) licensed in Minnesota. It governs fully insured HMO products, which includes Blue Plus. The Department of Health is involved in approving or monitoring contract changes, provider network access and changes, appeals, identification cards, quality improvement and much more.

**Provider Checklist**

As a Blue Plus PCC, there are standards that should be adhered to. Listed in the *Quality Improvement* section of this manual are standards that deal with: access and availability of care, physical plant and policies, care delivery and quality improvement process requirements.

**Welcome Letter**

Blue Plus encourages PCCs to send an informational "Welcome letter" to new or existing Blue Plus Subscribers. The example letter on the next page provides a general outline of information the Subscriber will need to know, but should be customized to meet the needs of the PCC.

Dear Patient:

Thank you for selecting _____.

As your primary care clinic, we are prepared to coordinate all aspects of your health care. As (family physicians, internists, pediatricians), we are able to diagnose and treat most problems, and will seek appropriate consultation when necessary. We encourage you to develop an ongoing relationship with one primary physician within our clinic. (We have enclosed some additional information about our staff that may help you in making a decision about a physician.)

As your primary care clinic, we are responsible for delivering and coordinating all of your health care. Occasionally you may need the services of a specialist who we feel can provide you with the care you need. After receiving care from a referral specialist, it is important to keep us informed of any additional services that are being considered. Additional services will be covered only if they are authorized in advance through our clinic.

Please remove the important information outlined below and keep it in a place convenient for quick reference.

If you have questions or concerns about your care at our clinic, please contact _____ at _____. If you have any questions regarding your contract benefits, please contact the Blue Plus customer service department by calling the number listed on the back of your member ID card.

Sincerely,

Clinic Manager/Medical Director

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**Blue Plus Guidelines**

*** Primary Care Clinic:** _____
*** Appointment Phone No:** _____
*** Clinic Hours:**
Mon - Fri _____
Sat _____
*** After Hours:**
Emergency or urgent care: call _____
Life-threatening emergency: go to _____
(notify primary care clinic within 48 hours)
*** Out-of-Area Care:**
Go to nearest facility
Call your primary care clinic within 48 hours
Primary care clinic must coordinate follow-up care
*** Mental Health Care/Chemical Dependency Treatment:**
Provider _____
Phone No _____

# Provider Web Self-Service

## Availity

Blue Cross contracted with Availity to give providers more HIPAA 5010 self-serve resources. Providers can access Subscriber eligibility, benefits, network, claim status and remittances, coordination of benefit information, referrals, preadmission notifications, PCCs, and recoupments. The portal is available at **https://www.availity.com/essentials**. Providers must complete the registration process for specific electronic transactions.

The system is available 24 hours a day, 7 days a week, except for scheduled maintenance times.

To register, contact **www.availity.com** or call **1-800-AVAILITY**.

The Availity® Health Information Network encompasses business and clinical services, and supports nationwide real-time website and batch electronic data interchange via the Web and through business-to-business integration.

# General Resources

**Provider Services**

A conversation with a Blue Cross service representative can often solve a problem immediately. The representatives answering the provider services numbers are available:

- Monday through Friday ..... 7:00 a.m. - 6:00 p.m.

When calling Provider Services, be prepared with the PCC's provider number and, if applicable, the Subscriber's identification number, account number and claim number ready. The provider services telephone numbers listed are for providers' use only. Refer Subscribers to the customer service telephone number on the back of their member ID card.

For quick access to Subscriber benefits, eligibility, claim status and designated PCC, use BLUELINE® (voice response unit) or **www.availity.com**.

The general **provider services phone numbers are (651) 662-5200** or **1-800-262-0820** and **1-888-420-2227**. Listen for the current phone options when calling as the options are subject to change based on business needs.

**General Address**

The general address is:

Blue Plus
P.O. Box 64560
St. Paul, MN 55164-0560

Claim adjustment requests can be completed by going to provider self-service or by filling out the Provider Inquiry Form (page 1-14) and faxing it to **(651) 662-2745**.

**Claims Address**

Submit claims electronically whenever possible. All Minnesota and contracted providers are required to electronically submit all claims.

Paper claims submitted by Minnesota and contracted providers outside Minnesota will be rejected and must be resubmitted electronically. Blue Cross will not consider such paper claims to have been received until resubmitted electronically. For out of state, nonparticipating providers mailing a scannable claim form, use the address listed below:

Blue Plus Claims
P.O. Box 64338
St. Paul, MN 55164-0338

| | |
|---|---|
| **BlueCard® Benefits and Eligibility** | To verify benefits or eligibility for BlueCard Subscribers, call **1-800-676-BLUE (2583)**. |
| **General Provider Services Fax Number** | The general provider services fax number is **(651) 662-2745**. |
| **Provider Claim Adjustment/Status Check/Appeal Form** | The Minnesota Appeal Request Form is designed for providers to fax or mail their inquiries and appeals to Blue Cross and Blue Shield of Minnesota.<br><br>Fax the form to the number listed on the form, or mail it to the general Blue Cross and Blue Shield of Minnesota address.<br><br>All the fields are required to be completed, if applicable. Make sure to clearly state the contact name, phone number and fax number on all correspondence.<br><br>Provider will receive written notification if its request is denied. All adjustments that are completed will be found on a future Remittance Advice.<br><br>The Minnesota Appeal Request Form can be found on the AUC website at Appeals Request Form – Fillable (state.mn.us) |
| **Toll-Free Numbers** | Unless a specific toll-free number is listed for long distance calls Provider may use Blue Cross' general toll-free number, **1-800-382-2000** and then ask for the appropriate extension (the last five digits of the local phone number). Callers may also select option 3 and enter the appropriate 5-digit extension.<br><br>If calling after regular business hours, call **1-888-878-0139**, press option 1, and then enter the 5-digit extension. |

## Electronic Data Interchange Numbers

The phone numbers for electronic data interchange are listed below.

| Area | Phone Number |
|---|---|
| Electronic Data Interchange (EDI) | Technical Support at Availity www.availity.com |

## Care Management Numbers and Addresses

The phone and fax numbers and addresses for care management are listed below.

| Area | Phone/Fax Numbers and Addresses |
|---|---|
| **Case Management** | **Phone: 1-855-552-2583** |
| **Preadmission Notification (PAN)**<br>General inquiries: | Provider self-service:<br>www.availity.com<br>MHCP:<br>Phone: 1-866-518-8448 |
| **Behavioral Health Review (Outpatient)** | MHCP:<br>Phone: 1-866-518-8448<br>Fax: **(651) 662-6284** |
| **Behavioral Health Review (Inpatient)** | MHCP:<br>Phone: 1-866-518-8448<br>Fax: **(651) 662-6283** |
| **UM Inpatient Prior Authorizations (Standard)** | MHCP:<br>Phone: 1-866-518-8448<br>Fax: (651) 662-6283 |
| **UM Outpatient Prior Authorizations (Standard)** | MHCP:<br>Phone: 1-866-518-8448<br>Fax: (651) 662-6284 |

**Care Management Numbers and Addresses (continued)**

| Area | Phone/Fax Numbers and Addresses |
|---|---|
| **UM Priority Faxes (Inpatient and Outpatient)** | MHCP:<br>Fax: (651) 662-6285 |
| **Restricted Recipient Program** | MHCP: 651-662-5062<br>Fax: (651) 662-6286 |

## Other Numbers and Addresses

These phone and fax numbers and addresses may be helpful.

| Area | Phone Number | Address |
|---|---|---|
| **BlueLink TPA** | Refer to member ID card | BlueLink TPA<br>P.O. Box 64668<br>St. Paul, MN 55614 |
| **Healthy Start®**<br><br>**Prenatal Support** | **(651) 662-1818**<br>**1-866-489-6948** | Healthy Start<br>P.O. Box 64560<br>St. Paul, MN 55164 |
| **Delta Dental® of Minnesota** | **(651) 406-5900** or<br>**1-800-328-1188**<br>Fax: **(651) 406-5934** | Delta Dental of Minnesota<br>3560 Delta Dental Dr<br>Eagan, MN 55122 |

| Area | Phone/Fax Numbers and Addresses |
|---|---|
| **Availity** | **www.availity.com** |
| **Customer Service** | Refer the Subscriber to their customer service number printed on the back of their ID card and also on their *Explanation of Health Care Benefits*. They may also call **(651) 662-8000**. |
| **Fraud Hot Line** | **(651) 662-8363** or<br>**1-800-382-2000 ext. 28363** |
| **Minnesota Health Care Programs (through DHS) Eligibility Verification System (EVS)** | **(612) 282-5354** or<br>**1-800-657-3613** |
| **Prime Therapeutics, LLC** | **(612) 777-4000** or<br>**1-800-858-0723** |
| **Minnesota Health Care Programs Member Services (Families & Children, MNCare and MSHO)** | **(651) 662-5545** or<br>**1-800-711-9862** |

# BLUELINE

**Introduction**

BLUELINE, is a voice response system for Blue Cross providers. It furnishes immediate information regarding Blue Cross Subscribers.

BLUELINE offers callers the following information:

- Preauthorization
- Subscriber specific claim*
- Subscriber's specific eligibility*
- Subscriber's specific benefit*
- Subscriber's specific PCC

**BLUELINE Availability**

*A fax back of this information is available by following the menu options within BLUELINE.

**Calling BLUELINE**

Provider can access BLUELINE by calling **(651) 662-5200** or **1-800-262-0820.**

If the information being requested is not available within BLUELINE, Provider will be automatically routed to a service representative during normal service hours which are:

Monday-Friday – 7:00 a.m. – 6:00 p.m.

**System Assistance**

If Provider requires assistance in accessing BLUELINE or has not received its fax, call technical support at **(651) 662-5555** or toll free at **1-800-711-9871** and select option 3. Blue Cross will need the following information: provider number and name, date and time of occurrence, caller's name and telephone number, description of the problem, and fax number if applicable.

**Provider Identification**

Provider identification is required for listening to claim information or for requesting a fax back of claim information for a specific Subscriber.

BLUELINE will supply a prompt when a provider ID is needed. Choices will be "Blue Cross Blue Shield of Minnesota Provider ID," "NPI" or "tax ID." Any of these options may be requested just by speaking the words – such as saying, "NPI." BLUELINE will then prompt callers for the actual numbers for just that ID. Just speak it naturally, one character or number at a time.

**Member Identification**

When BLUELINE supplies a prompt for the member ID, just speak the numeric portion or enter it using a touch-tone keypad. For example, if the member ID is XZA XZ1234567, just speak or enter 1234567, one digit at a time.

**Date**

When BLUELINE supplies a prompt for the date of birth or date of service, just say the date naturally, for example March 17, 1964, or 3-17-1964. The date may also be entered using a touch-tone keypad. If using the keypad, enter all eight digits – i.e. 03171964

## Chapter 2

# Blue Plus Subscribers

## Table of Contents

# Subscriber Information

**General Overview**

This chapter contains information regarding Blue Plus Subscribers. It will assist in explaining how the Subscriber can request a Primary Care Clinic (PCC) change, some specific benefits and how Subscribers may access care for a particular benefit.

**Subscriber PCC Changes**

Subscribers are responsible for selecting their PCC. Every member in the family may select their own PCC; they are not required to select the same PCC. Subscribers may change their designated PCC at any time. To do so they must contact Blue Plus Member Services at the phone number listed on the back of the member ID card.

The effective date assigned to all PCC changes will be the first day of the month following Blue Plus' receipt of the request.

**Clinic-Requested Discontinuation of Subscriber Health Services**

The following procedures are to be followed when a concern or problem with a Subscriber that is not related to the Subscriber's health status develops. Examples of such cases include:

- Subscriber is abusive
- Subscriber has a pending malpractice case against the primary care physician
- Subscriber consistently ignores medical advice
- Subscriber fails to pay copayments or Subscriber liability amounts

To use this process, the concern or problem must have occurred at the time the Subscriber was covered under a Blue Plus plan. For example, outstanding debts for services prior to the start of the Subscriber's Blue Plus coverage would not be within the guidelines of this process. In addition, a clinic may not use this process due to a concern or problem with a patient who is not covered under a Blue Plus plan, but the patient has a family member who is a Blue Plus Subscriber.

## Clinic-Requested Discontinuation of Subscriber Services (continued)

| Step | Action |
|---|---|
| 1. | **On-site resolution:**<br>• Discuss problem with Subscriber; develop agreement to work together to resolve the situation<br>• Document agreement and record follow-up action(s)<br>• Explore possibility of Subscriber working with another physician within primary care practice<br>• Document progress and any continued problems |
| 2. | **If no resolution occurs in the first step:**<br>• The PCC has the option to disenroll the Subscriber. The PCC must send a certified letter to the Subscriber, which provides the Subscriber with a 30-day notification of disenrollment. The letter should:<br>  • Explain the rationale for the disenrollment<br>  • Specifically state that the clinic will no longer be serving as the Subscriber's PCC<br>  • Offer 30 days of emergency/urgent care service<br>  • Advise the Subscriber to choose a new PCC<br>  • Direct the Subscriber to contact the Blue Plus customer service number listed on the back of their member ID card to assist in choosing a new PCC. The Subscriber should be advised to do this as soon as possible to ensure continuity of care.<br>• The PCC sends a copy of the letter to:<br>Blue Plus<br>Consumer Service Center, R3-35<br>P.O. Box 64179<br>St. Paul, MN 55164 |

**Note:** Unless there is an issue with PCC's disenrollment request, Blue Plus will not respond to PCC's letter. It is not necessary for Blue Plus to "approve" disenrollment.

## Missed Appointments

Participating providers agree to not bill Subscribers for missed scheduled appointments, unless it is for a behavioral health appointment. For behavioral health appointments, the Subscriber can be billed for missed appointments unless they have Families & Children, MinnesotaCare, Minnesota Senior Health Options or Medicare.

## Quality-of-Care Complaints Reviewed by the Plan

The quality-of-care complaint is an additional right of Blue Plus Subscribers. Subscribers may complain if they feel the quality of their care has been compromised.

Some examples of when a Subscriber may file a complaint are:

- They are not receiving an appointment in a reasonable amount of time
- The PCC is not referring them to a specialist when it is necessary
- The provider/provider office staff was rude or discourteous
- The provider is unable to diagnosis or treat their condition
- There is a delay in communicating test results
- Confidentiality or privacy concern
- Incorrect test ordered or performed
- Infection control
- Equipment malfunction, cleanliness

Blue Plus immediately supplies the provider with a copy of the Subscriber's complaint and involves the provider in the solution. PCCs are subject to the requirements detailed in the Provider Service Agreement and are to take action consistent with these requirements when addressing the complaints. Blue Plus is required by the Department of Health to acknowledge these complaints in 30 days; therefore, Blue Plus requires PCC's expedited attention to all requests.

# Subscriber Benefits

## General Benefits

Subscribers' benefits depend on their type of contract. Benefits for fully insured contracts may vary from self-insured contracts. **Because Subscribers' benefits will vary, go to www.availity.com, or contact provider services for specific Subscriber benefits.** For additional details regarding the types of coverage available, please refer to the *Blue Cross Provider Policy & Procedure Manual*.

- **Highest level of benefits –** Subscribers generally receive the highest level of benefits when they receive Health Services from their PCC or when the PCC authorizes a referral to a specialist. A list of participating referral providers is available in the *Referral Network for PCCs* directory, which is online at **www.availity.com** or **bluecrossmn.com**.
- **Self-referral –** Subscribers may decide to manage their own health care without involving their PCC. Blue Plus considers this self-referral. In doing so, Subscribers usually take on additional financial responsibilities. A claim may be paid at a lesser benefit or completely denied, depending on whether the Subscriber has a self-referral option. Medical emergency care as defined by the applicable Subscriber Contract is generally provided at the highest level of benefits.
- **Referral bypass –** There are some Health Services that will be paid at the highest level of benefits without a referral from the PCC. This is known as a referral bypass or referral exception. For a listing of referral bypasses, refer to Chapter 4 of this manual.
- **PCC/Care System specific referral bypass –** There may be situations where a particular PCC or care system has communicated their wish to have a referral bypass implemented for a particular situation. This allows the specified service to be paid at the highest level of benefits without PCC communicating a referral to Blue Plus. If PCC has questions regarding a PCC-specific referral bypass, please contact provider service. These requests are handled on an individual basis and must be implemented by Blue Plus and a person authorized by PCC.
- **Open access –** Some Subscriber Contracts have open access for specified Health Services or for certain Subscribers. The Subscriber usually must use a designated participating network provider and will receive the highest level of benefit without a referral from PCC. Some examples of this may be vision, chiropractic, ob/gyn, or behavioral health care.

### Chiropractic Benefits

Most Subscribers have open access to a **contracted chiropractor.** They may receive eligible chiropractic services without a referral from the PCC. To receive the highest level of benefits, the Subscriber must use an in network chiropractor for Medically Necessary services. The Subscriber may inform the PCC about the services; however, the PCC does not need to make a referral.

### Continuity of Care After Facility Discharge

Patient care can easily become fragmented and compromised as patients pass from a hospital or facility stay back to the care of their PCC.

The Joint Commission identifies two Continuum of Care standards that directly address the follow-up care process of patients that are discharged: providing continuing care based on the patient's needs, and the exchange of appropriate information when a patient is accepted, referred, transferred, or discharged to receive further care or Health Services.

State Regulatory Agencies and The National Committee for Quality Assurance (NCQA) standards require that managed care organizations monitor the continuity and coordination of care that Subscribers receive across practices and provider sites. A smooth transition and continuity of care after discharge is a need and challenge in every episode of care. Readmissions can be caused by gaps in the follow-up process.

The Centers for Medicare and Medicaid Services (CMS) give specific legislative and regulatory authority to health plans that participate in Special Needs Plans (SNPs). The health plan manages the care coordination for the chronic disease Subscribers thereby reducing unnecessary hospitalizations which facilitates helping the Subscriber move from high risk to lower risk on the care continuum.

**Subscriber role:** Subscribers need to identify a PCC or follow-up provider who will coordinate their care after facility discharge.

**Continuity of Care After Facility Discharge (continued)**

**Hospital/facility role:** Hospitals/facilities are encouraged to develop systems that capture and communicate to the Subscriber's PCC. The information should be shared in a timely manner with the follow-up provider after discharge, provide the Subscriber with instructions for care after discharge, educate the Subscriber as needed and obtain permission from the Subscriber to share information with the provider.

**PCC or follow-up provider role:** PCCs or follow-up providers need a process in place to receive and file records and information into a Subscriber's clinic chart in a timely manner.

**Durable Medical Equipment Providers**

Durable medical equipment (DME) providers are not required to participate in the Blue Plus Referral Network. Subscribers can use any DME provider in the applicable Blue Cross and Blue Shield of Minnesota network. Communicating a referral to Blue Plus is not necessary because DME is on a referral bypass.

Providers should make sure to check Subscriber's benefits for eligibility of specific DME prior to providing services.

Generally, there is no coverage for services that a subscriber receives from an out of network provider. If a Subscriber is unable to obtain services from a network provider, services may be covered by a non-network provider. Service authorization would be required. Please refer the member to Blue Plus customer service or their Evidence of Coverage for further details on the process.

## Mental Health/Chemical Dependency Services

Most Subscribers have open access to providers in the Behavioral Health Network. Providers in the network will render or coordinate Subscribers' mental health and chemical dependency services.

- **PCC Responsibilities**

  Blue Plus Subscribers may coordinate their Evaluation and Management (E/M) or medication management services through their PCC or their behavioral health provider. E/M and medication management services performed outside of their PCC or designated behavioral health network provider will require a referral in order to receive the highest level of benefits.

  Most groups do not require referrals for mental health/chemical dependency claims to process at the highest level. PCCs do not initiate referrals for Subscribers requiring behavioral health care.

## Ob/Gyn Health Services

State legislation requires open access for specified ob/gyn Health Services under fully insured managed care contracts. When a Subscriber obtains ob/gyn Health Services, she may go to any ob/gyn provider in her network without a referral from the PCC and receive the highest level of benefits in accordance with her Subscriber Contract. As with any other state legislation, this benefit is optional for self-insured groups.

- **Eligible open access ob/gyn Health Services –** The Subscriber may go to any ob/gyn provider in her network for any of the Health Services listed below in the "Specified Codes for Open Access OB/GYN Health Services" section.
- **Eligible ob/gyn providers –** The ob/gyn providers in the Subscriber's network include many ob/gyn specialists and clinics across the state Subscribers have access to a directory that lists open access ob/gyn providers.
- **Ob/gyn Health Services –** The Subscriber's PCC can render the Health Services or the Subscriber can go to an ob/gyn provider in the Subscriber's network for eligible ob/gyn Health Services and receive the highest level of her benefits without a referral.

If the ob/gyn provider identifies a need that requires additional care by a provider with a different specialty, **this care needs to be coordinated with the Subscriber's PCC**. For example, if the ob/gyn provider identifies ovarian cancer and the Subscriber needs to see an oncologist, the Subscriber must be directed back to her PCC because the open access benefit may not apply to specialties beyond ob/gyn.

For those Subscribers who have the open access benefit, eligible inpatient and outpatient hospital and related ob/gyn Health Services are covered at the Subscriber's highest benefit level. An open access ob/gyn provider must coordinate the services. Blue Plus may not be able to identify these claims during initial processing. Please contact provider services to request an adjustment if the claim did not process at the highest level of the Subscriber's benefits.

Some Subscribers have benefits for self-referrals to an ob/gyn provider not in the Subscriber's network. These claims will be paid at the reduced benefit.

## Benefit Levels for Ob/Gyn Health Services

The following chart outlines various levels of open access ob/gyn benefits available based upon the Health Service and where it is received.

| Health Service | Received at the PCC | Received at an ob/gyn provider in Subscriber's network | Received at neither Subscriber's PCC nor an ob/gyn provider* in Subscriber's network |
|---|---|---|---|
| General ob/gyn care - see Specified Codes for Open Access Health Services | Highest level of Subscriber's benefits | Highest level of Subscriber's benefits | Processed as a self-referral benefit |
| Non-ob/gyn Health Services | Highest level of Subscriber's benefits | • If referred by the PCC: highest level of Subscriber's benefits<br>• If not referred by the PCC: self-referral level of benefits* | Processed as a self-referral benefit* |
| Inpatient charges for delivery and maternity care, including related Health Services | Highest level of Subscriber's benefits | Highest level of Subscriber's benefits | Generally processed as a self-referral benefit* |

**Benefit Levels for Ob/Gyn Health Services (continued)**

| Health Service | Received at the PCC | Received at an ob/gyn provider in Subscriber's network | Received at neither Subscriber's PCC nor an ob/gyn provider* in Subscriber's network |
|---|---|---|---|
| Ob/gyn care recommended by ob/gyn provider in Subscriber's network | Highest level of Subscriber's benefits | Highest level of Subscriber's benefits** | If referred by the PCC: highest level of benefits<br><br>If not referred by the PCC: self-referral level of benefits* |
| Non-ob/gyn care recommended by ob/gyn provider in Subscriber's network | Highest level of Subscriber's benefits | Processed as a self-referral benefit* | If referred by the PCC: highest level of benefits<br><br>If not referred by the PCC: self-referral level of benefits* |

* If the Subscriber does not have a self-referral level of benefits, the claim will generally be denied.

** If an ob/gyn provider in the Subscriber's network recommends ob/gyn care by a provider who is not part of the Subscriber's network, benefits will be processed as a self-referral.

### Specified Codes for Open Access Ob/Gyn Health Services

Claims submitted with the following codes from an ob/gyn provider in the Subscriber's network do not require a referral if the Subscriber has the ob/gyn open access benefit.

| Diagnosis Code(s) | Description |
|---|---|
| 054.0-054.19 (ICD-9)<br>B00.0-B00.9 (ICD-10) | Herpes simplex |
| 078.81-078.89 (ICD-9)<br>A88.1, A74.89, B33.8, R11.11 (ICD-10) | Other diseases due to viruses and chlamydia |
| 079.4 (ICD-9)<br>B97.7 (ICD-10) | Human papillomavirus |
| 079.81-079.89 (ICD-9)<br>A88.1, A74.89, B33.8, R11.11 (ICD-10) | Other specified viral and chlamydial infections |
| 099.0-099.9 (ICD-9)<br>A55, A56.00, A56.19, A56.2-A56.4, A56.8, A57, A58, A63.8, A64, M02.30, N34.1 (ICD-10) | Syphilis and other venereal disease |
| 112.0-112.9 (ICD-9)<br>B37.0-B37.3, B37.49, B37.5-B37.7, B37.81-B37.82, B37.84, B37.89-B37.9 (ICD-10) | Candidiasis |
| 127.4 (ICD-9)<br>B80 (ICD-10) | Enterobiasis |
| 131.00-131.9 (ICD-9)<br>A59.00-A59.03, A59.09, A59.8-A59.9 (ICD-10) | Trichomoniasis |
| 132.2 (ICD-9)<br>B85.3 (ICD-10) | Phthirus pubis |

**Specified Codes for Open Access Ob/Gyn Health Services (continued)**

| Diagnosis Code(s) | Description |
|---|---|
| 174.0-184.9 (ICD-9)<br>C50.10-C57.9 (ICD-10) | Malignant neoplasm |
| 217-221.9 (ICD-9)<br>D24.9-D28.9 (ICD-10) | Benign neoplasm |
| 233.0-233.9 (ICD-9)<br>D05.90-D09.19 (ICD-10) | Carcinoma in situ of breast and genitourinary system |
| 236.0-236.99 (ICD-9)<br>D39.0-D41.9 (ICD-10) | Neoplasm of uncertain behavior of genitourinary system |
| 239.3 (ICD-9)<br>D49.3 (ICD-10) | Neoplasm of unspecified nature of breast |
| 239.5 (ICD-9)<br>D49.5 (ICD-10) | Neoplasm of unspecified nature of other genitourinary organs |
| 256.0-256.9 (ICD-9)<br>E28.0-E28.9 (ICD-10) | Ovarian dysfunction |
| 599.0 (ICD-9)<br>N39.0 (ICD-10) | Urinary tract infection, site not specified |
| 610.0-611.9 (ICD-9)<br>N60.11-N64.9 (ICD-10) | Disorders of breast |
| 614.0-616.9 (ICD-9)<br>N70-N73.9 (ICD-10) | Inflammatory disease of female pelvic organs |
| 617.0-627.9 629.0-629.9 (ICD-9)<br>N80.0-N95.9, N94.89-N94.9 (ICD-10) | Other disorders of female genital tract, infertility |
| 630-677 (ICD-9)<br>O01.0-O94 (ICD-10) | Complications of pregnancy, childbirth and the puerperium |
| 698.1 (ICD-9)<br>L29.3 (ICD-10) | Pruritus of genital organs |

**Specified Codes for Open Access Ob/Gyn Health Services (continued)**

| Diagnosis Code(s) | Description |
|---|---|
| 752.0-752.9 (ICD-9)<br>Q50.31-Q55.9 (ICD-10) | Congenital anomalies of genital organs |
| 780.01-780.99 (ICD-9)<br>R40.20-R68.89 (ICD-10) | General symptoms |
| 788.0-788.9 (ICD-9)<br>N23, N39.3, N39.41-N39.45- N39.46, N39.498, R30.0-R39.89(ICD-10) | Symptoms involving urinary system |
| 789.1-789.9 (ICD-9)<br>R16.0-R19.8 (ICD-10) | Other symptoms involving abdomen and pelvis |
| 795.00-795.79 (ICD-9)<br>R76.8, R97.8 (ICD-10) | Nonspecific abnormal histological and immunological findings |
| 996.32 (ICD-9)<br>T83.39XA- T83.39XS (ICD-10) | IUD complication |
| V01.6 (ICD-9)<br>Z20.2 (ICD-10) | Contact with or exposure to venereal diseases |
| V07.4 (ICD-9)<br>Z79.890 (ICD-10) | Postmenopausal hormone replacement therapy |
| V10.3 (ICD-9)<br>Z85.3 (ICD-10) | Personal history of malignant neoplasm breast |
| V10.40-V10.44 (ICD-9)<br>Z85.40-V85.44 (ICD-10) | Personal history of malignant neoplasm genital organs |
| V13.21-V13.29 (ICD-9)<br>Z87.42, Z87.410-Z87.412, Z87.51, Z87.59 (ICD-10) | Personal history of other genital system and obstetric disorder |

**Specified Codes for Open Access Ob/Gyn Health Services (continued)**

| Diagnosis Code(s) | Description |
|---|---|
| V15.7 (ICD-9)<br>Z92.0 (ICD-10) | Other personal history presenting hazards to health-contraception |
| V16.3 (ICD-9)<br>Z80.3 (ICD-10) | Family history of malignant neoplasms of breast |
| V16.40-V16.49 (ICD-9)<br>Z80.41-Z80.49 (ICD-10) | Family history of malignant neoplasms of genital organs |
| V22.0-V28.9 (ICD-9)<br>Z34.00-Z36 (ICD-10) | • Normal pregnancy<br>• Supervision of high-risk pregnancy<br>• Postpartum care and examination<br>• Contraceptive management<br>• Procreative management<br>• Outcome of delivery<br>• Antenatal screening |
| V45.51-V45.59 (ICD-9)<br>Z97.5 (ICD-10) | • Presence of contraceptive device<br>• Intrauterine contraceptive device<br>• Subdermal contraceptive implant |
| V61.5-V61.7 (ICD-9)<br>Z64.1 (ICD-10) | • Multiparity<br>• Illegitimacy or illegitimate pregnancy<br>• Other unwanted pregnancy |
| V67.00-V67.9 (ICD-9)<br>Z09 (ICD-10) | Follow-up examination |
| V70.0-V70.9 (ICD-9)<br>Z00.00-Z00.8 (ICD-10) | General medical examination |
| V71.5 (ICD-9)<br>Z04.41 (ICD-10) | Observation following alleged rape or seduction |
| V72.31-V72.42 (ICD-9)<br>Z01.42, Z32.00-Z32.02, Z40.11, Z40.419 (ICD-10) | • Gynecological examination<br>• Pregnancy examination or test, pregnancy unconfirmed |

**Specified Codes for Open Access Ob/Gyn Health Services (continued)**

| Diagnosis Code(s) | Description |
|---|---|
| V73.81 (ICD-9)<br>Z11.51 (ICD-10) | • Screening examination for human papillomavirus |
| V74.5 (ICD-9)<br>Z11.3 (ICD-10) | Special screening examination for venereal disease |
| V76.10-V76.19 (ICD-9)<br>Z12.31, Z12.39 (ICD-10) | Special screening for malignant neoplasms of breast |
| V76.2 (ICD-9)<br>Z12.4 (ICD-10) | Special screening for malignant neoplasms of cervix |

**Vision Care**

Fully insured Subscribers have direct access to general eye care Health Services rendered by participating optometrists and ophthalmologists in the Aware network. Appropriate ophthalmologist Health Services include eye examinations and Evaluation and Management (E/M) procedure codes, as well as CPT codes 65205, 65210, 65220, 65222 and 68761. As self-insured groups renew, they will have the opportunity to also choose the direct access option or remain with the current referral process. Major surgical procedures and related follow-up care will continue to be coordinated through the Subscriber's PCC.

**24-Hour Nurse Advice Line**

24-Hour Nurse Advice Line is a telephone-based nurse advice line for Blue Plus Subscribers. Subscribers may call the toll-free service (**1-888-275-3974**) anytime they are experiencing symptoms or need health care information. The service is staffed by registered nurses who will assess callers' symptoms and direct them to the best possible care. The nurses will:

- Ask callers about symptoms, using proven algorithms
- Help Subscribers determine how to handle their situation
- Recommend emergency, urgent, or primary care when needed
- Provide appropriate self-care advice
- When appropriate, offer to call back to see how the person is feeling

Nurse phone care may improve the quality of care through early identification of serious medical conditions; direction to the appropriate level of care; and consistent, documented advice in response to every call. It increases cost-effectiveness by reducing or redirecting inappropriate medical visits, including trips to the emergency room or doctor's office. Fully insured groups are automatically signed up for the Nurse Advice Line, but self-insured groups must purchase this option.

Subscribers' use of the service is voluntary. **Phone care does not replace the role of the PCC**.

**Limited Provider Networks**

Blue Plus reserves the right to implement or discontinue limited provider networks (e.g. tiered networks, "Select Networks" or other limited or customized networks), or services provided by such networks for certain Health Services or for certain Subscriber Contracts. Such limited provider networks may or may not include PCC. Current limited provider networks and categories of Health Services are listed below. When Subscribers are in need of the categories of Health Services listed below, PCC agrees to refer or instruct Subscribers that they may self-refer where applicable, only to the limited provider networks designated below. PCC agrees to require any referral providers to which PCC refers Subscribers to refer or instruct Subscribers that they may self-refer where applicable, only to the limited provider networks designated below.

- For organ transplant services, a referral is required. A fully executed Provider Service Agreement separate from the Blue Plus Primary Care Clinic Provider Service Agreement is required between Blue Plus and the PCC for organ transplant services, except in the case of kidney or cornea transplant.
- For bariatric surgery services, a referral is required. PCC must contact the Blue Plus Referral Coordinator when it is necessary to make a referral for bariatric surgery services.

If assigned limited provider networks providers cannot or will not provide such services because it is not feasible for them to do so due to a lack of resources or the unusual nature of the situation, another provider may be used. Such alternative provider will be coordinated between the PCC and Blue Plus.

## Chapter 3

# Government Programs

## Table of Contents

# Minnesota Health Care Programs

**General Overview**

Minnesota Health Care Programs (MHCP) consists of Enrollees from four major Minnesota Health Care Programs: **MinnesotaCare, Blue Advantage (Families and Children), Minnesota Senior Health Options or SecureBlue℠ (HMO SNP), and Minnesota Senior Care Plus (MSC+).** Any services that were provided by the Minnesota Department of Human Services (DHS) on a fee-for-service basis, prior to the Enrollee becoming prepaid (managed care), will be provided by Blue Plus. Although Blue Plus is required to cover the same benefit set as the medical assistance fee-for-service model, Blue Plus may administer and deliver the services differently from DHS. If the provider feels a service should be covered and it has been denied or you are questioning how a service is covered, please contact Blue Plus provider services.

**Definitions**

**Blue Advantage (Families and Children)** is managed health care programs established to provide Medical Assistance (MA) to eligible Enrollees. DHS requires Blue Plus to meet stringent criteria for utilization and care management, provider contracting, and quality improvement when providing coverage for Enrollees. DHS also determines eligibility for coverage.

**Minnesota Senior Care Plus (MSC+)** is a health care program for people who are age 65 and older who qualify for Medical Assistance (Medicaid). Eligibility is determined by DHS.

**Minnesota Senior Health Options (MSHO)** is a program that provides health care for people who are age 65 and older, enrolled in Medicare Parts A & B and eligible for Medical Assistance. Eligibility is determined by DHS.

**MinnesotaCare** is a state subsidized program for low-income families and adults without children who do not qualify for MA and do not have access to health insurance. MinnesotaCare Enrollees pay a monthly premium to DHS based on their household income. Eligibility for coverage is determined by DHS.

**Member Services**

Enrollees who need assistance from us should call Minnesota Health Care Programs Member services.

The toll-free telephone numbers for Blue Advantage (Families and Children), MinnesotaCare, and MSC+ is **1-800-711-9862**.

The toll-free telephone number for SecureBlue is **1-888-740-6013**.

Enrollees should have their Subscriber identification (ID) numbers available.

**Coordination of Benefits**

If an Enrollee has other insurance coverage, the other insurance is primary. Minnesota Health Care Programs will coordinate Enrollee benefits and Medical Assistance will always be the last payer.

**Minnesota Health Care Programs Enrollment**

Providers that provide Health Services to Minnesota Health Care Program Enrollees must enroll with the Minnesota Department of Human Services (DHS). DHS provides the DHS provider enrollment report to Blue Cross. Blue Cross uses the DHS provider enrollment report to ensure that Blue Cross contracted providers who provide services to Minnesota Health Care Program Enrollees are on the report. Blue Cross continuously monitors the DHS provider enrollment reports. Blue Cross has the right to terminate contracts with Providers that provide Health Services to Minnesota Health Care Program Enrollees but do not enroll with DHS as required.

Providers can enroll with DHS by following this link:

Enrollment with Minnesota Health Care Programs (MHCP) (state.mn.us)

**Enrollee Communications**

Mailings that are directed only to Minnesota Health Care Programs Enrollees require approval by DHS. If a provider plans to do this type of mailing, contact Provider Services at **1-866-518-8448**.

**Enrollee Appeals and Grievances**

All Enrollees of fully insured Blue Plus products have appeal rights mandated by the Minnesota Department of Health (MDH). Minnesota Health Care Programs Enrollees have additional DHS appeal rights because the plan is regulated by DHS as well as MDH.

Blue Plus is required to provide DHS appeal and grievance rights. Therefore, it is important that providers are aware of general guidelines to assist Blue Plus in meeting them when the provider is involved in an appeal or grievance.

**Enrollee Appeals and Grievances (continued)**

### Oral Grievance Procedure

The oral grievance procedure is initiated by an Enrollee on the telephone or in person. Blue Plus will make a determination within 10 calendar days from the date of the receipt of the oral grievance. If the oral grievance is about an urgently needed service, we will respond within 72 hours, or within 24 hours for grievances related to a denial for an expedited MSHO appeal.

### Written Grievance/Oral or Written Appeal Procedure

The written grievance/oral or written appeal procedure must be initiated by the Enrollee, Provider, or authorized representative on behalf of the Enrollee with the Enrollee's written consent. Blue Plus must send written acknowledgement to the Enrollee within 10 calendar days of receiving the request for a written grievance/oral or written appeal. Blue Plus may combine it with the notice of resolution if a decision is made within 10 calendar days. Blue Plus will conduct a formal review with a determination to be made within 30 calendar days from the date of receipt of the written grievance/oral or written appeal.

For urgent requests, a decision will be provided within 72 hours. If Blue Plus does not agree that the request qualifies for the urgent timeframe, Blue Plus will inform the Enrollee within 24 hours and will process the appeal under the standard timeframe.

For post-service appeals requested by an Enrollee, a provider representing the Enrollee or a non-contracted provider on their own behalf, Blue Plus will provide a response within 60 calendar days. Non-contracted providers must sign a Waiver of Liability prior to filing a post-service appeal.

Blue Plus may take up to an additional 14 days for urgent or standard pre-service appeals if more information is needed or the extension is in the Enrollee's best interest. In this case, the Enrollee will be notified and will have the right to file an expedited grievance.

For MSHO Enrollee appeals, Blue Plus provides one level of appeal internally. If Blue Plus upholds the denial and the appeal involved Medicare services, then the case will be forwarded to an Independent Review Entity (IRE). If Blue Plus upholds the denial and the appeal involves Medicaid services, the Enrollee has the right to request a State Appeal.

## Enrollee Rights with the Grievance Process

A copy of the Enrollee Rights regarding the grievance process has been included for reference. Providers may be asked to assist Enrollees in filing a grievance or appeal.

**Enrollees Rights**

If the Enrollee decides to file a grievance or appeal, it will not affect their eligibility for medical benefits. There is no cost to the Enrollee for filing a grievance or appeal with the health plan or the State.

If Blue Plus stops or reduces a service, Enrollees can keep getting the service if they file a health plan appeal or a State Appeal within ten days of getting the notice, or before the service is stopped or reduced, whichever is later. The treating provider must agree that the service should continue. The service can continue until the health plan appeal or State Appeal is resolved. If the Enrollee loses the appeal or State Appeal, the Enrollee may have to pay for these services themselves.

If the Enrollee has seen a medical provider who is participating with Blue Plus and was told services are not needed, the Enrollee can get a second opinion, but must see another Blue Plus medical provider.

If the Enrollee has seen a behavioral health provider who is part of the Blue Cross Behavioral Health Network and has been told that no structured behavioral health treatment is needed, the Enrollee may get a second opinion. If the Enrollee has seen a chemical dependency assessor who is part of the Blue Cross Behavioral Health network and they disagree with the assessment, the Enrollee may get a second opinion. The second opinion must be approved by Blue Cross Behavioral Health Care Management and provided by a licensed behavioral health or chemical dependency provider, who does not need to be a Blue Cross Behavioral Health Network provider. Blue Cross Behavioral Health Care Management must consider the second opinion but does not have to accept a second opinion for medical or behavioral health services.

**Enrollee Rights with the Grievance Process (continued)**

Enrollees can have a relative, friend, advocate, provider, or lawyer help them with the grievance, health plan appeal or State Fair Hearing. A provider may appeal on the Enrollee's behalf with their written consent.

Enrollees may present their evidence and facts about the case in person, by telephone or in writing. They may need a decision quickly (for urgently needed services). If so, Enrollees have a limited amount of time to get their information to the health plan or the State.

**How to Request a Health Plan Appeal or State Fair Hearing**

If the Enrollee asks to see their medical records, or wants a copy, their provider or health plan must provide them to the Enrollee. They may need to put their request in writing.

Below are some suggestions Blue Plus has regarding this process:

- The Enrollee may contact Member services first to talk about the decision but is not required to do so. The toll-free phone number for Blue Advantage (Families and Children), MinnesotaCare, and MSC+ is **1-800-711-9862**. SecureBlue Members may contact Member services at **1-888-740-6013**.
- The Enrollee must first choose to appeal to the health plan and receive notice that the denial has been upheld by the health plan prior to requesting a State Fair Hearing.
- In the Enrollee's request, they need to explain why they disagree with the decision. If they need a decision quickly, they must state that in their appeal. If they need help, contact Blue Plus Member services or the State ombudsperson.
- The Enrollee can consent to have the provider appeal on their behalf with the Enrollee's written consent.

## Appeal

An appeal is an oral or written request to Blue Plus for review of an action. This request may also be from a provider acting on the Enrollee's behalf with their written consent. Enrollees must appeal within 60 days of receiving this notice.

- If their appeal is about an urgently needed service, Blue Plus will give them an answer within 72 hours. If Blue Plus does not agree that the service is urgently needed, the health plan will contact the Enrollee verbally within 24 hours of the decision and send a written notice within 2 calendar days. If the Enrollee disagrees, Enrollees may file an appeal with us.
- Within 10 calendar days Blue Plus will tell the Enrollee that their appeal was received. A decision will be provided within 30 calendar days. Blue Plus may take up to 14 extra calendar days if more information is needed and it is in the Enrollee's best interest. Blue Plus will tell the Enrollee extra time is needed and why.
- Enrollees may see the provider's case file, including medical records and other documents considered by Blue Plus during the appeal process. They may request the provider's case file any time before or during the appeal.

Enrollees can write or call in their appeal to Blue Plus at the address and phone number below:

Blue Plus
Appeals and Grievances

P.O. Box 982816

El Paso, TX 79998-2816

Families and Children, MinnesotaCare and MSC+ **1-800-711-9862**

SecureBlue **1-888-740-6013**

## State Appeal

A State Appeal is a hearing filed according to an Enrollee's written request with the State to review a decision made by Blue Plus. The request must be submitted in writing.

- A human services judge will hold a hearing. Enrollees may attend in person or by phone.
- Enrollees must request a State Appeal in writing within 120 calendar days of receiving this notice.
- The Enrollee's State Appeal may involve a medical decision. If so, the Enrollee may ask for an expert medical opinion. This will be from a separate review entity. There is no cost to them.

Enrollees can send a request for a State Appeal to the Department of Human Services by fax or by mail at:

Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

Fax: **(651) 431-7523**

File online at: DHS-0033-ENG (Appeal to State Agency) (mn.gov)

## Filing a Grievance

A grievance is an expression of dissatisfaction about any matter other than an action. This includes, but is not limited to, dissatisfaction with quality of care or services provided or failure to respect Enrollees' rights.

- If the Enrollee calls Blue Plus a decision will be given within 10 calendar days.
- If the Enrollee's grievance is about an urgently needed service, Blue Plus will give them an answer within 72 hours.
- If the Enrollee sends Blue Plus a written grievance, the Enrollee will be notified within 10 calendar days that their written grievance has been received. A decision will be given within 30 calendar days.

**Filing a Grievance (continued)**

If the Enrollee does not agree with Blue Plus' decision, a written grievance can be submitted to Blue Plus, or the Enrollee can request further review from the Minnesota Department of Health or the Managed Care Ombudsperson

Enrollees can file their grievance by writing or calling Blue Plus at:

Appeals and Grievances

P.O. Box 982816

El Paso, TX 79998-2816

Families and Children, MinnesotaCare and MSC+ **1-800-711-9862**

SecureBlue **1-888-740-6013**

**Filing a Complaint to the Minnesota Department of Health (MDH)**

Enrollees can file a complaint to MDH by writing or calling them at:

Minnesota Department of Health
Health Policy and Systems Compliance Division
Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882
**(651) 201-5100**-or toll free **1-800-657-3916** (greater Minnesota)

Fax: **(651) 201-5179**

Email: health.mcs@state.mn.us

**Requesting a State Appeal from the Department of Human Services (DHS)**

Enrollees can send a request for a State Appeal to the Department of Human Services by fax or by mail at:

Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

**(651) 431-3600** or toll free **1-800-657-3510**
TTY/TDD: **1-800-627-3529**

Fax: **(651) 431-7523**

File online at: DHS-0033-ENG (Appeal to State Agency) (mn.gov)

**Ombudsperson**

A State ombudsperson may be able to help Enrollees with their problem. The ombudsperson can also help them file a grievance or an appeal to the health plan or the State. The Enrollee can contact the ombudsperson by calling or writing at:

Minnesota Department of Human Services
Ombudsperson for Public Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

**(651) 431-2660** or toll free **1-800-657-3729**

**Fax to: (651) 431-7472**

**Enrollees' Rights and Responsibilities**

You have the right to know about your rights and responsibilities. If you have any questions, please call Member services toll free at **1-800-711-9862 (**Families and Children, MinnesotaCare or MSC+) or **1-888-740-6013** (SecureBlue).

**Your rights as a health plan Member:**

- To be treated with respect, dignity, and consideration for privacy.
- To get medically necessary covered services, including emergency services, 24 hours a day, seven (7) days a week.
- To be told about your health problems.
- To have an open discussion to get information about appropriate or medically necessary treatment options for your conditions including how treatments will help or harm you, regardless of cost or benefit coverage.
- To receive information about our organization, our services, our practitioners and providers, and member rights and responsibilities.
- To participate with your providers in the decisions about your health care.
- To participate in understanding your health problems and developing your treatment goals.

**Enrollees' Rights and Responsibilities (continued)**

- To refuse treatment. To get information about what might happen if you refuse treatment.
- To refuse care from specific providers.
- To expect that we will keep your medical and financial records private according to the law.
- To request and receive a copy of your medical records. You also have the right to ask to correct the records.
- Get notice of our decisions if we deny, reduce, or stop a service, or deny a payment for a service.
- To file a grievance or appeal with Blue Plus. You can also file a complaint with the Minnesota Department of Health.
- To request a State Appeal with the Minnesota Department of Human Services (also referred to as "the State").
- To get a clear explanation of covered home care services.
- Give written instructions that inform others of your wishes about your health care. This is called a "health care directive." It allows you to name a person (agent) to decide for you if you are unable to decide, or if you want someone else to decide for you.
- To choose where you will get family planning services, diagnosis of infertility, sexually transmitted disease testing and treatment services, and AIDS and HIV testing services.
- To get a second opinion for medical, mental health and chemical dependency services.
- To be free of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To request a copy of the Member Handbook at least once a year.
- To recommend changes regarding Blue Plus' rights and responsibilities policies.
- To get the following information from us, if you ask for it:
  - Whether we use a physician incentive plan that affects the use of referral services, and details about the plan if we use one.
  - Results of an external quality review study from the state
- The professional qualifications of health care providers

**Enrollees' Rights and Responsibilities (continued)**

- To freely exercise your rights. The exercise of your rights will not badly affect the way you are treated.
- Get the results of an external quality review study from the State, if you ask for them.
- To be told when a health care provider cancels their contract with Blue Plus. You may choose from the rest of Blue Plus providers.
- To have a person at Blue Plus or at the clinic to contact with any concerns about services.
- To get information about Blue Plus, our services, network of providers and your rights and responsibilities.
- To start a legal proceeding when having a problem with Blue Plus or our providers.
- To file a grievance or appeal with Blue Plus and receive a prompt and fair review.
- To contact the State Ombudsperson for help in filing a grievance or appeal.
- To ask for a speedy hearing.

**Your responsibilities as a health plan Member:**

- Read your Member Handbook and know which services are covered under the Plan and how to get them.
- To show your Blue Plus ID card and your Minnesota Health Care Programs card every time you go for health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.
- To establish a relationship with a Blue Plus primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.

**Enrollees' Rights and Responsibilities (continued)**

- To give information that Blue Plus and our providers need to give care or services to you. Share information about your health history.
- To follow all your doctor's instructions. If you have questions about your care, you should ask your doctor.
- Work with your primary doctor to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. If you have questions about your care, ask your primary care doctor.
- To practice preventive health care. To have tests, exams and shots recommended for you based on your age and gender.
- Know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.

**This information is available in other forms to people with disabilities by calling Blue Plus Member services toll free at 1-800-711-9862 (Families and Children, MinnesotaCare, or MSC+), or 1-888-740-6013 (SecureBlue).**

**Signed Statement**

One important DHS rule includes Enrollee rights to notification of non-covered services. Providers may bill an Enrollee for non-covered services only when Minnesota Health Care Programs (MHCP) never covers the services and only if the provider informs the Enrollee before services are delivered that he/she would be responsible for payment. If MHCP normally covers a service but the Enrollee does not meet coverage criteria at the time of the service, the provider cannot charge the Enrollee and cannot accept payment from the Enrollee.

For example, if an Enrollee did not receive a referral for a service that required one, the service is not eligible for a signed statement; and, the provider **cannot** bill the Enrollee for the service.

The signed statement is only allowed when the service provided is a non-covered service, and must be:

- Specific to the procedure/service (including the cost)
- Specific to a date of service
- Signed and dated by the Enrollee for each date of service

**Signed Statement (continued)**

If the signed statement is not signed by the Minnesota Health Care Programs Enrollee prior to the service, then according to DHS rules, the Enrollee cannot be billed for the service. This includes services that are investigative, not medically necessary, or excluded from coverage under the contract.

When submitting claims, indicate with a –**GA** on the 837 electronic transaction in the procedure modifier loop those services that have a valid signed statement on file.

**Missed Appointments**

MHCP Enrollees cannot be billed for missing scheduled appointments.

**When Enrollee Fails to Give Necessary Information**

Providers are required to make three valid attempts to obtain information from an Enrollee (that are at least 30 days apart). Sending letters or making phone calls are valid attempts if supported in the documentation.

Supporting documentation should be faxed to 651-662-6288, using a fax coversheet asking for the claim to be adjusted. The fax coversheet needs to include the requestor's contact information and be sent to the attention of "Blue Plus 3 Attempt Adjustment Consideration". It would not be appropriate to send these requests on an AUC Appeal form.

Providers will receive a corrected remit if the claim is adjusted and Blue Plus will notify DHS advising that the Enrollee is in danger of losing their eligibility for Minnesota Health Care Programs. If Blue Plus is able to validate that another carrier is primary, the claim will not be adjusted, and the provider will receive communication with additional information.

**Medicaid Claims Handling for Out of State Medicaid Members**

Blue Cross and Blue Shield Plans currently administer Medicaid programs in California, Delaware, Hawaii, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, and Wisconsin as a Managed Care Organization (MCO), providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each BCBS Plan. Medicaid Members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out-of-state, or a lack of specialists in the Member's home state, a Medicaid Member may receive care in another state, and generally the care requires prior authorization.

**Medicaid Claims Handlings for Out of State Medicaid Members (continued)**

**Identifying Medicaid Members to Determine Eligibility and Benefits:** Blue Cross Plan ID cards do not always indicate that an Enrollee has a Medicaid product. Blue Cross Plan ID cards for MHCP Enrollees do not include the suitcase logo. They do include a disclaimer on the back of the ID card providing information on benefit limitations. For Enrollees with such ID cards, providers should obtain eligibility and benefit information and prior authorization for services using the same methods as you would for other Blue Cross Members.

- Submit an eligibility inquiry by calling Provider Services at 866-518-8448
- Submit an eligibility inquiry by sending a 270 electronic HIPAA transaction, or by using the Availity portal website at Availity.com.

**Provider Enrollment Requirements**

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. **Program enrollment is required for BCBS plans in the following states: Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New Mexico, Pennsylvania, South Carolina, Tennessee, Texas, and Virginia.**

If a provider is requested to enroll in another state's Medicaid program, the provider should receive notification upon submitting an eligibility or benefit inquiry. Insurance Type Code EB04. Providers should check enrollment requirements in that state's Medicaid program before submitting the claim.

A provider that submits a claim without enrolling, will have their Medicaid claims denied, and they will receive the following CARC 96 (non-covered) and RARC N193 (Specific federal/state/local program may cover this service through another payer) on your provider remittance. This indicates that the state where the Enrollee is enrolled in Medicaid, requires providers to enroll in their Medicaid program before the Plan can pay the provider.

**Medicaid Claims Handlings for Out of State Medicaid Enrollees (continued)**

**Commonly Asked Questions**

1. **How do I submit Medicaid claims?**
   Medicaid claims should be submitted to your local BCBS Plan in the same manner as you submit claims for other BCBS Members.

2. **How do I know that I am seeing a Medicaid Enrollee?**
   Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards may not always indicate that an Enrollee is enrolled in a specific Medicaid program.

   - Providers should always submit an eligibility inquiry if the Plan ID card has no suitcase logo and includes a disclaimer with benefit limitations, using the same tools available for BlueCard.
   - Submit an eligibility inquiry by calling the BlueCard Eligibility Line at 1-800-676-BLUE.
   - Submit an eligibility inquiry by sending a 270 electronic HIPAA transaction, or by using the Availity portal website at Availity.com.

3. **I do not often see Medicaid Enrollees from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid Enrollees in other states?**

   - Some state Medicaid programs require providers to enroll before reimbursement may be provided by the Plan. If you do not enroll with the state where required, the claim could be denied.

# Minnesota Health Care Programs Special Benefits

| | |
|---|---|
| **Purpose** | As stewards of healthcare expenditures for our Subscribers, Blue Plus is charged with ensuring the highest quality, evidence-based care for our Enrollees. One method for doing so is through care coordination and the prior authorization process. The primary purpose is to ensure that evidence-based care is provided to our Enrollees, driving quality, safety, and affordability. |
| **American Indians** | American Indians enrolled in Blue Plus MinnesotaCare or Blue Advantage Families and Children have the option of seeking services at their primary care clinic (PCC) or an Indian Health Services (IHS) facility, or a tribal facility (known as a 638 facility). |
| **Behavioral Health** | Enrollees can access services directly from any provider in the Aware Network. See the behavioral health information in Chapter 2, *Blue Plus Enrollees* for more information. |
| **Child and Teen Checkups** | Child and Teen Check-ups (C&TC) is the program in Minnesota for the federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. This is federally mandated for children enrolled in Medical Assistance and Minnesota Care (Blue Advantage Families and Children & MinnesotaCare for Blue Plus). C&TC provide eligible children and young teens enrolled in Medical Assistance from newborn through age 20 years quality well-child preventive and comprehensive health services. These checkups are designed to allow early discovery and treatment of health-related problems.<br><br>C&TC screenings may be performed by the Enrollee's PCC, an in-network clinic/provider, or a Blue Plus contracted public health agency.<br><br>Refer to the Minnesota Child and Teen Checkups Schedule of Age-Related Screening Standards, document DHS 3379 for the age-related **minimum** recommendations and requirements. |

**Child and Teen Checkups (continued)**

To be considered a comprehensive C&TC screen, the provider must assess and document the following:

- Health education (anticipatory guidance)
- Physical growth and measurement (height, weight, head circumference, weight for length percentile and BMI at appropriate ages)
- Health history, including social determinants of health and nutrition
- Developmental health
- Social-emotional or mental health
- Autism spectrum disorder screening
- Postpartum depression screening
- Tobacco, alcohol, or drug risk assessment
- Physical examination (includes but not limited to: Pulse, respiration, blood pressure, exam of head, eyes, ears, nose, mouth, pharynx, neck, chest, heart, lungs, abdomen, spine, genitals, extremities, joints, muscle tone, skin and neurological condition)
- Immunizations and review of immunizations
- Newborn screening follow-up: blood spot, hearing and pulse oximetry (critical congenital heart disease) screening
- Laboratory tests or risk assessment including:
  - Blood lead test
  - Hemoglobin or hematocrit screening lab test
  - Hepatitis C virus screening lab test
  - Tuberculosis risk assessment
  - Sexually transmitted infection (STI) risk assessment, with lab testing for sexually active youth
  - Human immunodeficiency virus (HIV) screening lab test
  - Dyslipidemia risk assessment

**Child and Teen Checkups (continued)**

- Vision screening (including visual acuity screening beginning at 3 years, and plus lens screening beginning at age 5 years)
- Hearing screening (including 6000 Hz screening for age 11 and over)
- Oral health, including:
  - fluoride varnish application (FVA) starting at eruption of the first tooth through the age of 5 years
  - silver diamine fluoride (SDF) application when necessary

It is helpful to flag patients' charts for visual reminders of when a visit is due and which components are necessary to be completed. Outreach and notification reminders to the parent(s) or patient is ideal.

At a minimum a C&TC should be completed as follows:

- Between birth and 1 month
- 2 months*
- 4 months
- 6 months
- 9 months
- 12 months (Lead Screening) **
- 15 months
- 18 months
- 24 months (2nd Lead Screening)
- 30 months
- 3 years
- Annually after 3 years of age through age 20

*** <u>Very important</u>: Please make sure to ask parents about the results of the Hearing Screening from the hospital and to follow up to make sure they were correct.**

****Children must have 6 C&TC visits by the time they reach 13 months of age.**

Blue Plus follows Minnesota Department of Health, Centers for Disease Control and the Minnesota Department of Human Services standard recommendations on blood lead level screening and C&TC for Members enrolled in Medical Assistance (Blue Advantage Families and Children) or MinnesotaCare.

**Child and Teen Checkups (continued)**

Additional resources about C&TC program:

- DHS-3379 Age-Related Screening Standards (Periodicity Screening Schedule)
- Minnesota Department of Health Child and Teen Checkups (C&TC) Link
- Child and Teen Checkups Fact Sheets - MN Dept. of Health (state.mn.us)MHCP Provider Manual Link
    - Including DHS Approved Screening Exceptions
- C&TC Metro Action Group Provider Resources

**Coding information:**

- Providers should bill separately for each service performed and documented at the C&TC screening. This usually includes a preventive evaluation and management (E&M) service, labs, vision and hearing screenings and any immunizations scheduled for the patient's age.
- Blood lead level (BLL) testing must be completed at 12 and 24 months. Administering a lead risk questionnaire without a BLL test at 12 and 24 months of age does not meet C&TC requirements. BLL test completed between 9 and 15 months can fulfill the 12-month screening requirement. BLL between 16 and 30 months fulfills the 24 months screening requirement. If a BLL was not completed at 12 or 24 months, a BLL must be completed once for children up to 6 years of age. CPT code **83655** must be included on the claim for this service.

**Child and Teen Checkups (continued)**

- Universal HIV screening - offering HIV blood testing to all youth is required at least once between 15 and 18 years of age, regardless of risk factors. It is not necessary to note test results on the C&TC visit record. Ensure results are documented in the patient's health record. If the patient declines the blood test or if their HIV status is already known, document the reason that the HIV blood test was not completed.

  Blue Plus will pay providers an additional fee for performing a full C&TC. To receive this additional reimbursement, all required components must be completed and documented with the recommended standardized tools for each age-related C&TC component in the patient's health record. Procedure code **S0302** must be submitted with the referral code on the claim. Providers must complete the CRC (EPSDT Referral) segment on the 837P electronic claims transaction. The referral code must be submitted for each full C&TC checkup claim. Valid referral codes are:

- -NU – No referral was made
- -ST – Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screen provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (does not include dental referrals)
- -S2 – Patient is currently under treatment for referred diagnostic or corrective health problem
- -AV – Patient refused referral

**For more details** refer to your Child & Teen Checkups Provider Guide available from your county outreach worker or at the website link listed above.

## Chiropractic Benefits

Minnesota Health Care Programs Enrollees have access to chiropractic service without a referral from their PCC. They must go to an in-network chiropractor.

Visits to the chiropractor are monitored and reviewed for Medical Necessity.

Services eligible for coverage include:

- Manual spinal manipulation to treat subluxation (incomplete or partial dislocation), determined to be medically necessary by generally accepted chiropractic standards of care
- Evaluation and management services for new and established patients
- X-rays needed to support a subluxation diagnosis
- Acupuncture for pain and other specific conditions, for qualified providers

## Dental Benefits

Dental benefits for Minnesota Health Care Programs Members are coordinated through Delta Dental of Minnesota. Enrollees may see any dentist that participates in the MN Select Dental network. For complete benefit information, please contact Delta Dental at **(651) 406-5900** or **1-800-328-1188**.

**24-Hour Nurse Advice Line**

This is a telephone-based nurse advice line for Blue Plus Enrollees. Enrollees may call the toll-free service at **1-888-275-3974** anytime they are experiencing symptoms or need health care information. The service is staffed by registered nurses who will assess the caller's symptoms and direct them to the appropriate level of care. The nurses will:

- Ask callers about symptoms, using proven algorithms
- Help Enrollees determine how to handle their situation
- Recommend emergency, urgent, or primary care when needed
- Provide appropriate self-care advice
- When appropriate, offer to call back to see how the person is feeling

Nurse phone care may improve the quality of care through early identification of serious medical conditions; direction to the appropriate level of care; and consistent, documented advice in response to every call. It increases cost-effectiveness by reducing or redirecting inappropriate medical visits, including trips to the emergency room or doctor's office.

Enrollee use of the service is voluntary. Phone care does not replace the role of the PCC.

**Maternity Management program**

Experienced case managers work with Members and providers to establish a care plan for the highest risk pregnant Members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, breastfeeding support and counseling.

Our case managers are here to help providers. If there is an Enrollee in your care that would benefit from case management, call Blue Plus at **1-800-711-9862**. Members can also call the 24/7 NurseLine at **1-888-275-3974**, 24 hours a day, 7 days a week.

**NICU Care Management Program**

Blue Plus offers case management services to families of babies admitted to the NICU. Families receive education and support, care coordination, and resources to ensure the family and baby is prepared for discharge. Babies are identified through admission notification data sent to Blue Plus. This allows the Health Plan to proactively outreach to the families to offer support.

If you would like more information about the NICU Care Management program or have a patient who would benefit, please call Blue Plus at **1-800-711-9862**. Members can also call the 24/7 NurseLine at **1-888-275-3974**, 24 hours a day, 7 days a week.

## Housing Stabilization Services

Housing Stabilization Services are non-waivered services for eligible Enrollees with disabilities and for seniors to find and keep stable housing as approved by the Minnesota Department of Human Services (DHS). Approvals for the Housing Consultation, Transition/Sustaining, Moving Expenses services and any exceptions are determined by DHS.

Providers must be enrolled with DHS as either Housing Consultation or Housing Transition/Sustaining. Although not a requirement for reimbursement, Providers are encouraged to request a provider contract from Blue Plus. For interpreter and transportation services, providers must follow Blue Plus network guidelines.

The Housing Stabilization Services benefit consist of four services:

- **Housing Consultation** – service to develop a person-centered plan for people without MA case management services
- **Housing Transition** – service that supports a person to find housing
- **Housing Sustaining** – service that supports a person to maintain housing
- **Moving Expenses** – reimbursement for eligible moving expenses for members in Housing Transitions

Housing Stabilization Services Moving Expenses:

Moving Expenses are for people receiving Housing Stabilization – Transition Services and are transitioning out of a Medicaid – funded institution or leaving a provider-operated living arrangement and moving into their own home.

- Moving Expenses are limited to $3,000 annually for eligible expenses.
- Providers are responsible to pay up front for deposits, furnishings, and other moving-related items and submit claims for reimbursement.
- Providers must submit receipts to show proof of transaction.
- For additional information access MHCP Provider Manual.

## Housing Stabilization Services (continued)

**The services are billable as follows:**

| Service Description | Procedure Code | Unit |
|---|---|---|
| Housing Consultation | T2024 U8 | Per session |
| Housing Transition | H2015 U8/TS | Per 15-minute unit |
| Housing Sustaining | H2015 U8 | Per 15-minute unit |
| Moving Expenses | T2038-U8 | Per Eligible Expense* |

*Each Moving Expense item should be billed on a separate line EXCEPT for multiple purchases on the same day. In this case, the total amount of the purchases should be billed on one line as one unit.

**Eligible Diagnosis Codes for Housing Stabilization Services:**

| Service Description | Procedure Code |
|---|---|
| Developmental Disability | F84.9 |
| Learning Disability | F81.89 |
| Mental Illness | F99 |
| Physical Illness, Injury, or Impairment | R69 |
| Chemical Dependency | F19.20 |

Housing Transition services are limited to 150 hours per transition.

Housing Sustaining services are limited to 150 hours annually.

Providers may request an additional 150 hours beyond these limits and DHS will determine necessity.

## Interpretation Services

Blue Plus provides interpretive services to our limited English proficient (LEP) MHCP Enrollees. Multi-lingual Member services staff dedicated to the Blue Plus team and an over-the-phone interpreter service are available when LEP Enrollees call Member services.

Blue Plus requires that providers arrange and bill for the provision of interpreter services provided to Blue Plus MHCP Enrollees for appointments at the time that the appointment is scheduled. Home Health Agencies, care coordinators and county agencies are exempt from this requirement. These providers must schedule appointments with the contracted interpreter agencies. The interpreter agency will bill Blue Plus for the service.

**Interpretation Services (continued)**

MHCP Enrollees must inform the clinic that an interpreter will be needed for their scheduled visit when they call to schedule the appointment. Providers may use their own qualified face-to-face interpreters, virtual services, or language lines to satisfy this requirement.

1. Interpreter services are not covered in the following situations:
    - Services provided at inpatient hospitals and long-term care facilities.
        - Interpreter services are not separately reimbursable in an inpatient facility place of service, as the interpreter services are included in the facility's reimbursement.
    - No shows or cancellations
    - Services provided to any family member or friend, including but not limited to all interpreters working on behalf of agency (family members are defined as the interpreter's parents, spouse, domestic partner, children, grandparents, sibling, mother-in-law, father-in-law, brother-in-law, or sister-in-law).
    - Services if the primary caregiver and/or other clinic staff speak the patient's language.
2. Services provided by a Personal Care Assistance (PCA) Agency. PCA's are required to speak the same language as the Enrollee

**Long-Term Care**

SecureBlue (MSHO) and MSC+ (Minnesota Senior Care Plus) Enrollees who live in a community setting may qualify for long-term care nursing home benefits through Blue Plus. A referral is not required.

After Medicare has processed the claims, Blue Plus will cover 180 days (100 custodial days are included in the 180 days) of health plan responsible care. If Medicare is not an eligible payer, claims can be sent directly to Blue Plus. For any claims payable by Blue Plus under this provision, the Nursing Facility (NF) Communication Form (DHS-4461) must first be faxed to **651-662-6285** before the claim is submitted. This includes eligible swing bed stays. Swing bed days count towards the 180-day benefit. If the Enrollee is eligible for the 180-day skilled nursing facility benefit, and using a swing bed in the hospital, a Nursing Facility (NF) Communication Form must be faxed to Blue Plus and can be found on the DHS website at:

Nursing Facility (NF) Communication Form

**Long-Term Care (continued)**

Blue Plus is responsible for 180 days of nursing home care, but the days need not be consecutive. It is important to check MN-ITS to determine who is responsible for payment of the nursing home day. An individual may be reassigned another 180 days of benefit if they have met a 180-day separation period since their last nursing home stay. This eligibility is determined by DHS.

SecureBlue Enrollees may qualify for both skilled and long-term care nursing home benefits through Blue Plus.

Under SecureBlue, an Enrollee has both Medicare and Medicaid (Medical Assistance) benefits administered through Blue Plus. No claims for nursing facility services are sent to Medicare.

SecureBlue Enrollees are eligible for the Medicare skilled nursing facility benefit through Blue Plus. Eligibility for the skilled services follows Medicare criteria and regulations.

If a SecureBlue Enrollee is in the community at the time of enrollment in SecureBlue, the Enrollee is eligible for up to 180 days of long-term care nursing home benefits through Blue Plus. Enrollees who are already admitted to a nursing facility at the time of their enrollment in SecureBlue have their long-term care nursing facility benefit managed through DHS.

**Mental Health – Targeted Case Management Eligibility Determination**

Contracted County Agencies and Behavioral Health providers determine whether Minnesota Health Care Programs Enrollees are eligible for Mental Health Targeted Case Management (MH-TCM), based on a diagnostic assessment and in compliance with criteria as identified in the Minnesota Health Care Programs Provider Manual at Mental Health - Adult Mental Health Targeted Case Management (AMH-TCM) and Children's Mental Health Targeted Case Management (CMH-TCM) (state.mn.us)

Individuals (or the parents or legal guardian of a minor) must consent to or request the services. For persons who are civilly committed, a court may order a MH-TCM case manager be assigned. The Blue Plus-designated county or behavioral health provider can neither narrow nor broaden the eligibility criteria.

If the county or behavioral health provider determines that an individual is eligible for case management services, the county or behavioral health provider shall offer and refer the individual for case management services. Counties and behavioral health providers designated to determine eligibility must notify Blue Plus within one business day of the determination if an individual requesting MH-TCM is determined not eligible for case management services. The Mental Health Targeted Case Management Notification of Potential Denial, Termination, or Reduction form must be faxed to Blue Plus at **651-662-6285**. Blue Plus will inform the individual of the determination and their appeal rights.

Out of network providers must obtain an authorization prior to rendering services for Blue Plus Member. Contact provider services at 1-866-518-8448 for assistance or fax the BH Outpatient Treatment Request form to **1-844-429-7757**.

Children must meet SED criteria per Minnesota Statute, Section 245.4871, subdivision 6 (Definitions) to be determined eligible for TCM.

**Mental Health – Targeted Case Management Eligibility Determination (continued)**

**Adults must meet SPMI criteria per** Minnesota Statute, Section 245.462, subdivision 20 (Definitions) **to be determined eligible for TCM**.

**Access to Services**

Members have direct access to contracted MH-TCM providers.

- No prior authorization required
- Members must be determined eligible for MH-TCM according to Rule 79 criteria
- Providers must be contracted and designated by Blue Plus

**Billing**

MH-TCM is a professional service billed on an 837P transaction. Standard billing rules apply.

| Procedure Codes | Modifiers | Brief Description | Service Limitations |
|---|---|---|---|
| T2023 | HE, HA | Face-to-face contact between case manager and recipient under age 18 years | 1 session per month |
| T2023 | HE | Face-to-face contact between case manager and recipient age 18 years or older | 1 session per month |
| T2023 | HE, U4 | Telephone contact (recipient age 18 years or older) | 1 session per month |
| T1017 For IHS/638 and FQHC billing only | HE, HA | Face-to-face encounter (child under age 18 years) | 1 encounter per day |

**Mental Health – Targeted Case Management Eligibility Determination (continued)**

| Procedure Codes | Modifiers | Brief Description | Service Limitations |
|---|---|---|---|
| T1017 For IHS/638 and FQHC billing only | HE | Face-to-face encounter (age 18 years or older) | 1 encounter per day |

**Minnesota Vaccines for Children Program**

The Minnesota Vaccines for Children (MnVFC) program is Minnesota's version of the federal Vaccines for Children program which works to make all vaccines accessible and affordable for all children. The MnVFC program provides public purchased vaccines for children ages 0-18 years at no cost. These vaccines meet the recommendations of the Advisory Committee on Immunization Practices (ACIP) and are approved by the Centers for Disease Control and Prevention (CDC).

Minnesota law requires that all Minnesota Health Care Programs (MHCP) providers who administer pediatric vaccines be enrolled in the MnVFC program. MHCP includes MinnesotaCare and Blue Advantage Families and Children subscribers. If the vaccine is supplied by the MnVFC program, providers will be paid only for the administration of the vaccine. Submit the vaccine code, with the SL modifier, indicating that the vaccine was free. Submit a $0 charge for the vaccine code. This charge is for internal purposes only and will be denied. In addition to the vaccine, submit one administration code per vaccine (follow the CPT guidelines for submission of multiple vaccines).

Some free vaccines are also available for MHCP adults under the MnVFC. The eligible vaccines must be utilized for MHCP Enrollees. A complete list of vaccines available through the MnVFC program is listed on the following:

- Department of Human Services website: MHCP Provider Manual Immunizations and Vaccinations
- Minnesota Department of Health website: www.health.state.mn.us/divs/idepc/immunize/mnvfc/index.html

**Billing Guidelines for Reference and Outside Lab Services**

Blue Cross follows MHCP billing guidelines for laboratory (lab) tests sent to an outside lab for completion. This impacts professional providers only. Institutional (facility) providers are excluded. This includes lab charges for all Blue Advantage – Families and Children, MinnesotaCare and Minnesota Senior Care Plus (MSC+) and Subscribers. **Blue Cross will not reimburse providers for lab tests that are sent to an outside lab. Claims containing lab tests submitted with modifier 90, indicating the specimen was sent to an outside lab, will be denied as provider liability. Providers should not include lab services they did not perform on their claim.**

**Newborn Enrollment**

Babies born to mothers enrolled in Blue Advantage (Families and Children) or MinnesotaCare will be enrolled in Blue Plus for their birth month. The newborn's effective date with Blue Plus will be the first day of their birth month. The mother must notify her local agency of the birth of her child for the enrollment process to begin.

The newborn's claims cannot be submitted until enrollment and eligibility has been established. Blue Plus cannot accept claims until the enrollment information is received from DHS and the baby is active in the Blue Plus membership files.

Although Blue Cross encourages submission of claims as quickly as possible but no longer than 180 days from date of service, for newborn services, providers have 12 months from date of birth to submit related claims.

**OB/GYN**

Minnesota Health Care Programs has a benefit that allows direct access to specified OB/GYN network providers without a referral from the Enrollee's PCC. Please refer to Chapter 2, the *Enrollee Benefits* section for more information.

**Referrals**

Referrals are not required for Minnesota Health Care Programs Enrollees when services are rendered by a participating provider, with the exception of restricted recipients.

## Referrals Needed for Restricted Recipients

Under the Minnesota Restricted Recipient Program, either DHS or Blue Plus identifies Enrollees of Blue Plus Minnesota Health Care Programs (MHCP) who have used Medicaid services, most often prescription drugs or emergency rooms visits for non-emergent reasons, at a frequency or amount that is not medically necessary and/or who have used health services that resulted in unnecessary costs to the program. Once identified, such recipients will be placed under the care of a primary care physician and/or other designated providers who will coordinate their care for a 24-month or a 36-month period.

**All services provided to a restricted recipient other than from the designated Primary Care Physician, Hospital or Pharmacy require a referral.**

Placement in the Restricted Recipient Program means that for a period of twenty-four (24) or thirty-six (36) months of eligibility the Enrollee must obtain health services from:

- A designated Primary Care Provider located in the Enrollee's or Recipient's local trade area
- A hospital used by the Primary Care Provider
- A designated pharmacy

The restriction may include any other type of health service as a designated provider, including a Blue Plus in network Personal Care Provider Organization (PCPO)

DHS and the health plans have developed universal restriction, which is put in place by either DHS or a health plan and stays in effect for the entire period of restriction, regardless of whether the recipient:

- Changes health plans;
- Moves from fee-for-service to a health plan; or
- Moves from a health plan to fee-for-service.

**Referrals Needed for Restricted Recipients (continued)**

### Managed Care Referral Fax Form for the Restricted Recipient Program

PublicContentServlet (bluecrossmn.com)

### Referral Form Information

Blue Plus must have the following information to complete the referral. The information listed is in the same order as it appears on the *Managed Care Referrals* fax form.

| Information | Description |
|---|---|
| Clinic name | PCC name |
| Contact person | Person Blue Plus can contact if it has a question |
| Primary Care Doctor | PCP Enrollee is restricted to |
| Clinic address | The address of PCC |
| Phone number | Number where Blue Plus can contact PCC if it has a question |
| Fax number | Fax number where Blue Plus can fax information or concerns back to PCC |
| Patient name | Patient's name, not the contract-holder's name |
| Member ID number | Patient's Blue Plus ID number. |
| Member DOB | Patient's date of birth |
| Clinic/hospital name that patient is being referred to | The name of the clinic/hospital |
| Clinic/hospital address that patient is being referred to | The street address of the clinic/hospital |
| Referred Provider Name | Name of the provider the Enrollee is being referred to (If known). |
| NPI# of Referred Provider | NPI# for provider the Enrollee is being referred to. |

**Referrals Needed for Restricted Recipients (continued)**

| Information | Description |
|---|---|
| ICD-10 Diagnosis | Submit the appropriate ICD-10 diagnosis code<br><br>If no ICD-10 diagnosis code is submitted, R6889 will be used |
| Date of service: from__/__/__ to __/__/__ for __days | Date PCC determines that further care is needed. This date must be on or before the first visit to the specialist. Also report the date the referral care must be completed. If the referral end date is not specified, the referral will be defaulted to one year. |
| Number of visits approved | Number of services/visits that PCC authorizes the specialist to perform. If the referral provider requires more services/visits than authorized, the specialist must contact PCC for further authorization and PCC may report this on another referral |
| Prescribing Rights | Clearly label if referred provider is able to prescribe medications to the Enrollee |
| Comment codes | For communication with the referral provider. Additional comment codes may be used to qualify the referral. For more information on this, please see *Comment Codes,* which follows. |

**Referrals Needed for Restricted Recipients (continued)**

Verification of the Restricted Recipient status of an Enrollee can be completed through Blue Plus provider services or through MN-ITS. Typically, a recipient is restricted to one primary care physician, pharmacy, and hospital. A recipient may also be restricted to other designated providers or referred by the primary care physician to other providers, if appropriate. Recipients may receive services that are not subject to restriction from any in network provider. Long term care facility services are not subject to restriction.

**Claims Reimbursement**

Services provided to a restricted recipient will be reimbursed when:

- The service is provided by the recipient's primary care physician or his/her designee;
- The primary care physician has made a referral to another provider; or
- The service is of a provider type or type of service that is not listed as restricted on the recipient's file.

Providers may access more information about the Minnesota Restricted Recipient Program on the DHS website with the following link:

Health Care Programs and Services (state.mn.us)

If you have questions about the above information, please call provider services at **1-866-518-8448**.

**Second Opinions**

If an Enrollee does not agree with or is concerned with an opinion received from a health care provider, the Enrollee has a right to receive a second medical opinion.

For medical conditions, the second opinion must be from another Blue Plus provider.

For behavioral health services, the second opinion will be from an out-of-plan provider. For chemical dependency services, the second opinion will be from a different qualified assessor who is not a Blue Plus in network provider. Second opinions of behavioral health and chemical dependency providers will be authorized by Behavioral Health.

**Smoking Cessation**

All Blue Plus Enrollees have access to *free* Stop-Smoking Support. For more information, or to refer a Blue Plus Enrollee, call **1-844-841-5661**.

All smoking cessation products are covered with a prescription, including drugs to treat tobacco and nicotine addiction or dependence, and drugs to help individuals discontinue use of tobacco and nicotine products. Some of these products include nicotine patch, gum, pill, oral inhaler, lozenge, or nicotine nasal spray. No prior authorization is required.

Blue Plus encourages Enrollees to seek smoking cessation services from their PCC or another eligible program. Enrollment in smoking cessation classes is a decision the Enrollee and their practitioner must make together. Although Blue Plus encourages Enrollees to register for classes, payment for smoking cessation products will not be restricted if they do not attend.

**Sterilization**

Enrollees may go to the provider of their choice for voluntary sterilization. The individual to be sterilized must sign a consent form at least 30 days in advance, except in the case of premature delivery, when the 30-day requirement may be waived. At least 30 days, but not more than 180 days, must pass between the date the individual signed the consent form and the date of surgery. Enrollees must be at least 21 years old at the time of signing.

Enrollees may not consent to sterilization when in labor or childbirth, when seeking to obtain or obtaining an abortion, or when under the influence of alcohol or other substances that affects their state of awareness or in a situation where the provider believes that the recipient is unable to give informed consent. Under no circumstances may anyone sign the consent form for another person, including a court-ordered sterilization of a mentally incompetent person.

**Sterilization (continued)**

The Consent for Sterilization form must be completed for all Enrollees to reimburse providers for performing sterilization procedures. Blue Plus follows MHCP guidelines for eligibility for sterilization procedures. The facility or provider must complete a Consent for Sterilization form for each Enrollee who requests a sterilization procedure.

Consent forms may be obtained by contacting DHS or accessing the form at: Consent for Sterilization: Form HHS-687

If a facility or provider needs to reformat the Consent for Sterilization form, a disclaimer must be added in the top left corner of the header that states the following:

**"___(insert facility or provider name)_____ certifies the text contained in this Sterilization Consent Form complies with the text in 42 CFR Part 441, Subpart F Appendix."**

**Payment exceptions to timelines:**

- Emergency abdominal surgery – when the enrollee to be sterilized requires emergency abdominal surgery, the sterilization may be covered at the time of emergency abdominal surgery if at least 72 hours have passed since the member signed the consent form.
- **Note:** An emergency C section is not considered emergency abdominal surgery.
- Premature delivery – when the Enrollee to be sterilized goes into premature delivery, the sterilization may be covered if at least 72 hours from the "From date" of admission have passed since the member signed the consent form and the member signed it at least 30 days before the expected date of delivery.

**Timely Filing Limits**

Blue Cross implemented a permanent change to the claims timely filing limit for all providers and lines of business to 180 days beginning February 1, 2023.

For MHCP newborns, providers are encouraged to submit claims as quickly as possible but no later than 12 months from the newborn's date of birth.

## Transportation Services

### BlueRide: Common Carrier and Volunteer Transportation

Blue Plus Providers have an obligation to strictly adhere to all rules and requirements as summarized in the Provider Service Agreement, the Provider Policy and Procedure Manuals, and as required by the Minnesota Department of Human Services (DHS). Blue Plus Providers must follow all documentation and billing requirements. Blue Plus will be conducting random audits to assure adherence to all requirements in order to be responsible stewards of our health care requirements for our Subscribers.

- 837P Transaction
- Atypical provider

BlueRide schedules Common Carrier Transportation requests for rides to and from medical and dental appointments with providers if the Enrollee has no other means of transportation. A BlueRide representative will talk to Enrollees to make sure they are eligible for transportation. Providers of common carrier transportation offer ambulatory transportation, which may include buses, taxis, specialized transportation services for ambulatory riders, or volunteer driver vehicles. Children ages 12 or younger must be accompanied by an adult.

The benefit is available to Blue Advantage (Families and Children, MSC+), SecureBlue and some MNCare Subscribers.

Enrollees needing to schedule a ride to a medical or dental appointment must be directed to call BlueRide at **(651) 662-8648 or** toll-free number **1-866-340-8648**. BlueRide phones are answered between the hours of 8:00 am to 5:00 pm Monday through Friday. For scheduling purposes, Common Carrier transportation requests must be received at least two business days prior to the day the ride is needed. Other restrictions may apply.

Only the Enrollee or legally authorized representative (such as a guardian with proper paperwork) can schedule a ride. The Enrollee must be present to give verbal authorization to anyone acting on their behalf at the time of the call unless there is a Power of Attorney (POA) form on file and signed by the Enrollee or other appropriate legal paperwork such as guardianship papers that allows the individual to act on the Member's behalf.

**Transportation Services (continued)**

**Base Rate:** Blue Plus allows one base rate (transport code) for each leg of the trip.

**No-Load Miles (DeadHead):** Medical transportation miles driven without the Subscriber in the vehicle. These cannot be billed to the Enrollee. DeadHead mileage may be covered on a case-by-case basis and must be pre-approved by BlueRide. Authorization must be requested prior to the non-emergency medical ride being provided. BlueRide reserves the right to work with the most cost-effective form of transportation.

**Wait Times:** Wait time requests are considered on a case-by-case basis. Wait time can only be authorized by BlueRide staff. It is expected that wait time requests will be infrequent. Wait time is not reimbursable for the first hour.

Each procedure code must be billed by units.

**Transportation Services (continued)**

## Common Carrier Procedure codes and Units of Service

| Code | Description | Unit of Service |
|---|---|---|
| T2007 | Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments | 1 per 30 minutes |
| A0080 | Non-emergency transportation, per mile-vehicle provided by volunteer | 1 per mile |
| A0100 | Non-emergency transportation, taxi | 1 per leg |
| A0110 | Non-emergency transportation and bus, intra or inter-state carrier | 1 per leg |
| A0120 | Non-emergency transportation-minibus, mountain area transports, or other transportation systems | 1 per leg |
| A0170 | Parking Tolls and Fees | 1 Unit<br>**Requires a narrative |

**Transportation Services (continued)**

**Modifiers-use proper codes with the following modifiers**

For approved Deadhead miles, use modifier TP

The TP modifier should be used with the mileage code. The actual loaded miles should be billed as a separate line of mileage code with the approved miles. The miles will equal the units of service.

**HCPCS Origin / Destination Codes** (the first position indicates the origin and the second position indicates the destination):

| Code | Description |
|---|---|
| D | Diagnostic or therapeutic site other than 'P' or 'H' when these are used as origin codes |
| E | Residential, domiciliary, custodial facility (other than an 1819 facility) |
| G | Hospital based ESRD facility |
| H | Hospital |
| I | Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport |
| J | Freestanding ESRD facility |
| N | Skilled nursing facility (SNF) |
| P | Physician's office |
| QM | Ambulance service provided under arrangement by a provider of services.<br><br>**Note**: Institutional based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly. |
| QN | Ambulance service furnished directly by a provider of services.<br><br>**Note**: Institutional-based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly. |
| R | Residence |
| S | Scene of accident or acute event |
| X | Intermediate stop at physician's office on way to the hospital (destination code only) |

**Transportation Services (continued)**

### Billing of Mileage and Base Rate

Reimbursement for mileage will be calculated based on the mileage sent to the transportation provider via the trip confirmation. Any mileage discrepancies should be reconciled prior to submitting the claim.

Base and mileage rates for round-trip and multi-leg rides must be billed on separate lines for each leg of the ride.

### Deadhead, Wait Time, Extra Attendant and Parking Fee Payments

Deadhead, wait time, extra attendant and parking fees are billed on a separate line when approved by Blue Plus.

### RUCA (Rural Urban Comminuting Area)

RUCA is applied by Blue Plus when the point of pick-up zip code reflects RUCA. Non-Emergency Transportation Providers are not required to apply RUCA prior to the claim's submission. RUCA is applied following DHS and MN State Legislation around transportation.

### Point of Pick up ZIP Code

Transportation providers must submit the point-of-pickup ZIP code on all claims. This information should be submitted on an 837P transaction in the 2310E loop. If this information is not submitted, the services will be denied.

### Confirmation of all scheduled rides through BlueRide

The trip confirmation number must be submitted in the authorization line in the loop 2300 on the 837P. This is required for all Transportation claims to be paid.

**Transportation Services (continued)**

**No Shows**

Blue Plus requires transportation providers to report all no shows to BlueRide by submitting to the Transportation.Liaison@bluecrossmn.com. No Shows must be reported to Blue Plus by the following business day. No Shows are non-covered service under Blue Plus. No Shows should never be billed to Blue Plus.

**Common Carrier Transportation Trip Sheet**

Common Carrier providers must maintain a common carrier transportation service trip sheet documenting each ride that is provided to eligible MHCP Members. The trip sheet must be complete, comprehensive and contain all required elements in the document. Trip sheet must have all required fields from the Department of Human Service Trip Log or the Blue Plus Trip Log.

**Per Contract:**

**Verification of Eligibility:**

All provisions of the Provider Service Agreement apply to transportation services including verifying the eligibility of the Subscriber on Minnesota Department of Human Services (MN-ITS) system before providing Health Services and coordinating the service through BlueRide.

## Special Transportation Services

Blue Plus Providers have an obligation to strictly adhere to all rules and requirements as summarized in this section and as required by the Minnesota Department of Human Services (DHS). Blue Plus Providers must follow all documentation and billing requirements. Blue Plus will be conducting random audits to assure adherence and be responsible stewards of our health care requirements and our Subscribers.

All Special Transportation rides must be scheduled through the BlueRide staff.

BlueRide will schedule the rides and fax/email the information to the STS providers directly with the detailed information regarding the rides. It is imperative that STS providers keep all administrative information up to date at Blue Plus.

BlueRide can be reached at **(651) 662-8648 or** toll-free number **1-866-340-8648**. Although BlueRide will occasionally schedule same-day rides depending on provider availability, BlueRide must be contacted at least 24 hours in advance in the metro area and two business days in advance for greater Minnesota.

STS providers will be notified of scheduled rides from the BlueRide staff.

Only the Enrollee or legally authorized representative (such as a guardian with proper paperwork) can schedule a ride. The Enrollee must be present to give verbal authorization to anyone acting on their behalf at the time of the call unless there is a Power of Attorney (POA) form on file and signed by the Enrollee or other appropriate legal paperwork such as guardianship papers that allows the individual to act on the Enrollee's behalf.

**Special Transportation Services (continued)**

### Special Transportation Level of Need (LON)

Blue Plus has updated the Level of Need (LON) requirement and process for Special Transportation providers.

State law prohibits reimbursement of Special Transportation for MHCP recipients without a current and approved (LON) form signed by the attending physician, nurse practitioner, clinical nurse specialist, or physician assistant working under the delegation of the attending physician.

All rides must continue to meet the criteria for special transportation services and be scheduled through BlueRide. MHCP Enrollees who need to schedule a ride to an eligible medical or dental appointment should call BlueRide at **(651) 662-8648 or** toll-free number **1-866-340-8648**.

Signed forms will be valid for one year from date of the medical provider's signature. Any LONs that are incomplete or unreadable will be considered invalid, rejected, and returned to the STS provider. LONs must be faxed by the STS provider to BlueRide at **(651) 662-2844** before transportation is provided.

The transportation ride must meet the criteria for special transportation services for an eligible appointment even if the LON is no longer required.

Claims submitted for services provided without a valid LON on file at Blue Plus will not be paid. MSHO and MSC+ Enrollees are exempt from the LON requirement.

Medical providers are NOT obligated to sign a LON. The medical provider will use their professional judgment to determine if the Enrollee requires special transportation and indicate that on the LON.

**Special Transportation Services (continued)**

### Special Transportation Trip Sheet

STS providers must maintain a special transportation services trip sheet documenting each ride that is provided to eligible MHCP Members. The completed trip sheets must be filed in the STS provider's office and available for inspection and review by Blue Plus. Trip sheet must have all required fields from the Department of Human Service Trip Log or the Blue Plus Trip Log.

### Reimbursement

Reimbursement for services will only be allowed, and should only be billed, when the transportation is to or from a covered medical or dental service for an eligible MHCP Member. Some examples of covered medical services are clinic visits, therapies, eye exams, etc. Appropriate modifiers must be used when billing for services.

An eligible MHCP Member is defined as a Member who is physically or mentally impaired in a manner that keeps him/her from safely accessing and using common carrier transportation.

### Point of Pick up ZIP Code

STS providers must submit the point-of-pickup ZIP code on all claims. This information should be submitted on an 837P transaction in the 2310E loop. If this information is not submitted, the services will be denied.

**Base Rate:** Blue Plus allows one base rate (transport code) for each leg of the trip.

**No-Load Miles (Deadhead):** Medical transportation miles driven without the Enrollee in the vehicle. No-Load Miles cannot be billed to the Enrollee. Deadhead mileage may be covered on a case by case basis and must be pre-approved by BlueRide. Authorization must be requested prior to the non-emergency medical ride being provided. BlueRide reserves the right to work with the most cost-effective form of transportation.

**Wait Times:** Wait time requests are on a case-by-case basis. Wait time can only be authorized by BlueRide staff. It is expected that wait time requests will be infrequent. Wait time is not reimbursable for the first hour.

Each procedure code must be billed using the accurate unit of services per the definition of the code.

**Special Transportation Services (continued)**

**Non-emergent, scheduled transport codes and Units of Service**

| Code | Description | Unit of Service |
|---|---|---|
| T2007 | Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments | 1 per 30 minutes |
| A0420 | Transportation waiting time, non-ambulatory stretcher vehicles only | 1 per 30 minutes |
| A0130 | Non-emergency transportation; wheelchair van | 1 per leg |
| S0209 | Non-emergency transportation; wheelchair van, mileage per mile | 1 per mile |
| S0215 | Non-emergency transportation; mileage, per mile | 1 per mile |
| T2001 | Non-emergency transportation; patient attendant/escort | 1 |
| T2003 | Non-emergency transportation; encounter/trip | 1 per leg |
| T2005 | Non-emergency transportation; non-ambulatory stretcher van | 1 per leg |
| T0249 | Non-emergency transportation; non-ambulatory stretcher van mileage | 1 per mile |
| A0170 | Parking Tolls and Fees | 1 |

**Special Transportation Services (continued)**

**Modifiers-use proper codes with the following modifiers**

For approved Deadhead miles, use modifier TP.

The TP modifier should be used with the mileage code. The actual loaded miles should be billed as a separate line of mileage code with the approved miles. The miles will equal the units of service.

**HCPCS Origin / Destination Codes** (first position indicates the origin and the second position indicates the destination):

| | |
|---|---|
| D | Diagnostic or therapeutic site other than 'P' or 'H' when these are used as origin codes |
| E | Residential, domiciliary, custodial facility (other than an 1819 facility) |
| G | Hospital based ESRD facility |
| H | Hospital |
| I | Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport |
| J | Freestanding ESRD facility |
| N | Skilled nursing facility (SNF) |
| P | Physician's office |
| QM | Institutional based providers only. Ambulance service provided under arrangement by a provider of services |
| QN | Institutional based providers only. Ambulance service furnished directly by a provider of services |
| R | Residence |
| S | Scene of accident or acute event |
| X | Intermediate stop at physician's office en route to the hospital (destination code only) |

**Special Transportation Services (continued)**

### Billing of Mileage and Base Rate

Reimbursement for mileage will be calculated based on the mileage sent to the transportation provider via the trip confirmation. Any mileage discrepancies should be reconciled before submitting the claim.

Base and mileage rates for round-trip and multi-leg rides must be billed on separate lines for each leg of the ride.

### Deadhead, Wait Time, Extra Attendant and Parking Fee Payments

Deadhead, wait time, extra attendant and parking fees are billed on a separate line when approved

### RUCA (Rural Urban Comminuting Area)

RUCA is applied by Blue Plus when the claims point of pickup zip code reflects RUCA. Non-Emergency Transportation Providers are not required to apply RUCA prior to the claim's submission. RUCA is applied following DHS and MN State Legislation around transportation.

### Confirmation of all scheduled rides through BlueRide

The trip confirmation number must be submitted in the authorization line in the loop 2300 on the 837P. This is required for all Transportation claims to be paid.

### No Shows

Blue Plus requires transportation providers to report all no shows to BlueRide by submitting the No Show Form to Transportation.Liason@bluecrossmn.com. No Shows must be reported to Blue Plus by the following business day. No Shows are non-covered service under Blue Plus. No Shows should never be billed to Blue Plus.

**Special Transportation Services (continued)**

**Per Contract:**

**Verification of Eligibility:**

All provisions of your Provider Service Agreement apply to transportation services including verifying the eligibility of the Subscriber on Minnesota Department of Human Services (MN-ITS) system before providing Health Services and coordinating the service through BlueRide.

**Vision Care and Supplies**

For eye care services, Enrollees have direct access to Aware optometrists and ophthalmologists.

Eyewear must be purchased from an optician participating in the Minnesota Health Care Programs network. Enrollees may select any MHCP approved standard frame. The Enrollee may not purchase more expensive frames and be billed for the difference. Some Enrollees have a copay for a pair of eyeglasses. Replacement of one or both lenses due to loss, damage or theft is not subject to a copayment and should be billed with code **92370 or 92371**.

Covered services include:

- Eye exams
- Routine refractions
- MHCP approved standard frames
- Eyeglasses when medically necessary
- Replacement or repair of eyeglasses, when eligible
- Eye prostheses
- Services must be billed using CPT codes **92002-92396, 92340 - 92354** or HCPCS codes **V2020-V2499**. One dispensing fee may be submitted only when a complete set of frames and lenses is dispensed. Use appropriate CPT code **92340-92354**.

**Tuberculosis Case Management**

TB case management claims must be submitted to Blue Cross with the narrative description of TB Case Management along with HCPCS code T1016. This information is submitted in Loop 2400/SV101. A narrative is needed to identify that the services are for TB case management and not SecureBlue or MSC+ care coordination services. Products impacted are SecureBlue, Minnesota Senior Care Plus (MSC+), Blue Advantage (Families and Children) and MinnesotaCare.

# SecureBlue (Special Needs Plans)

**General Overview**

Blue Plus offers a Medicare Advantage Special Needs Plan; SecureBlue. This program is an integrated Special Needs Plan offered under Medicare Advantage via a Medicare contract and through the State of Minnesota, under the Minnesota Senior Health Options (MSHO) program. The group number for this product is MNMSHO01.

**SecureBlue**

**Minnesota Senior Health Options (MSHO)**

Blue Plus offers a Minnesota Senior Health Options (MSHO) product, SecureBlue, for dual eligible seniors. SecureBlue is a Special Needs Plan (SNP) offered under Medicare Advantage by Blue Plus. Blue Plus has a contract with both the Centers for Medicare & Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS) for SecureBlue that creates an alternative delivery system for acute and long-term care services and integrates Medicare and Medicaid funding.

SecureBlue combines the services and benefits of Medicare Parts A and B, including Part D prescription drug coverage, and Medicaid benefits.

A Care Coordinator will work closely with individual SecureBlue Enrollees to assist them in achieving optimal medical and social stability.

**Model of Care**

Special Needs Plans (SNPs) are required by the Centers for Medicare and Medicaid Services (CMS) to provide annual training to providers on the Model of Care. Providers must document and maintain training completion records and provide such records to Blue Plus upon request to validate that the training has been completed.

- Goal is to simplify access to healthcare for our Enrollees and reduce fragmentation of care delivery for our Enrollees
- Focus on coordinating access and delivery of all preventive, primary, specialty, acute, post-acute and long-term care services among different health and social service professionals and across settings of care

For more detail information on the Model of Care, refer to QP43-23 FINAL MSHO Annual Training Requirement.pdf (bluecrossmn.com)

## Care Coordination

Each SecureBlue Enrollee is assigned a Care Coordinator who encourages independent living and care in the least restrictive setting.

Care Coordinators can work with the Enrollee's practitioners to monitor and reinforce health care goals, such as:

- Self-management of their condition
- Preventive health needs
- Behavioral health needs
- Social, environmental and safety needs
- Rehabilitative needs

Within 30 days of enrollment, each Enrollee will be assigned a Care Coordinator and offered a comprehensive assessment (medical, behavioral, social, environmental) and treatment plan. Care Coordinators are familiar with waivered services, and local resources. Blue Plus case managers provide enhanced clinical case management services as necessary. The extensive Blue Plus provider network and open access policy will ensure that Enrollees will be able to maintain the providers and care patterns to meet Enrollee healthcare needs and goals.

Care Coordinators are able to assess an Enrollee's living environment and identify factors that may interfere with successful implementation of treatment plans by meeting the Enrollee face-to-face in their home.

Primary care providers will be receiving a welcome letter from the Enrollee's Care Coordinator after an Enrollee joins the plan. Providers may also receive communication from the Care Coordinators by phone to collaborate and coordinate plans of care.

| | |
|---|---|
| **Care Coordination (continued)** | This connection between the primary care provider, Enrollee and Care Coordinator is vital for ensuring all members of the care team are aware of the other services the Enrollee may be already receiving or that are available. Please call your patient's Care Coordinator to discuss concerns or communicate changes in treatment plan. This communication can assist in ensuring that necessary changes are accomplished successfully, and concerns are addressed.<br><br>To identify the Care Coordinator assigned to the Enrollee, call Provider Services.<br><br>Care Coordination guidelines are periodically updated by Blue Plus. Care Coordination guidelines are located at Care Coordination – Care Coordination (bluecrossmn.com) |
| **Enrollment Processing** | Enrollment is voluntary for this program. Enrollees must meet eligibility requirements, as verified by the state and federal government. |
| **Member Service** | **SecureBlue**<br><br>• Blue Plus Member service staff understand the importance of Enrollee engagement for better health.<br>• Member service is offered to help Members with questions toll free at **1-888-740-6013 TTY:711**.<br>• Member services is available 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. |
| **Open Access** | SecureBlue is an open access plan, meaning Enrollees can access in network specialty care without the need for referrals. Open access allows Enrollees to access the health care they need and helps providers to effectively advocate for their patients. Some services may require prior authorization. |
| **Definition of Grievances** | A grievance is any complaint, other than one that involves a request for an organization determination, a coverage determination, or an appeal. If you want to make a complaint, it is called "filing a grievance." |

## Enrollee Appeals and Grievances

Enrollees of SecureBlue have appeal rights pursuant to Minnesota law as well as access to a Grievance and Appeal System required by the Minnesota Department of Human Services (DHS). Additional Medicare appeal rights are also available.

Blue Plus is required to provide Enrollees with appeal and grievance rights. Therefore, it is important that providers are aware of the general guidelines to assist Blue Plus in meeting these guidelines when providers are involved. Provider appeals procedures are described in detail in the Appeal chapter of the Blue Cross Provider Policy and Procedure Manual.

## Grievances

### Oral Grievances

An oral grievance may be initiated by an Enrollee on the telephone or in person. A determination will be sent within 10 calendar days from the date of the receipt of the oral grievance. If the oral grievance is about an urgently needed service, a response will be sent within 72 hours.

### Written Grievances

A written grievance may be initiated by the Enrollee, provider or authorized representative on behalf of the Enrollee with the Enrollee's written consent. Blue Plus must send written acknowledgement to the Enrollee within 10 calendar days of receiving the request. Blue Plus may combine it with the notice of resolution if a decision is made within 10 calendar days. Blue Plus will conduct a formal review with a determination to be made within 30 calendar days from the date of receipt of the written grievance.

### Expedited Grievances

Enrollees have the right to ask for an "expedited grievance." Blue Plus will respond to oral or written grievances within 24 hours if the Enrollee does not agree with the decision:

- To not provide an expedited initial decision (expedited organization determination or expedited coverage determination) or an expedited appeal; or
- To take an extension to make an initial decision for medical care or a decision for an appeal regarding the denial of coverage for a medical service.

**Grievances (continued)**

**For quality of care problems, SecureBlue Enrollees may also complain to the QIO**

Enrollees may complain about the quality of care received under Medicare, including care during a hospital stay. They may complain to Blue Plus using the grievance process, to an independent review organization (Quality Improvement Organization QIO), or both. In Minnesota, the QIO is Livanta. Blue Plus must help Livanta resolve the complaint.

**Appeals**

**Oral and Written Appeals**

Oral and written appeals must be initiated by the Enrollee, provider or authorized representative on behalf of the Enrollee with the Enrollee's written consent. Blue Plus must send written acknowledgement to the Enrollee within 10 calendar days of receiving the request. For oral appeals, the Enrollee needs to sign and return the written acknowledgement. Blue Plus may combine it with the notice of resolution if a decision is made within 10 calendar days. Blue Plus will conduct a formal review with a determination to be made within 30 calendar days from the date of receipt of the oral or written appeal.

**Types of Appeals**

- Standard (30 calendar days)

  Blue Plus will acknowledge in writing within 10 calendar days of receiving an appeal and will make a decision no later than 30 calendar days. An extension of 14 calendar days is available if requested by the Enrollee or if we need additional information and the extension benefits the Enrollee.

- Expedited (72 hours review)

  An appeal may be expedited if it is regarding a request for a medical service and if the Enrollee or physician believes that the Enrollee's health could be seriously harmed by waiting too long for a decision. Blue Plus must decide on an expedited appeal no later than 72 hours after our receipt of the appeal.

**Appeals (continued)**

Blue Plus may extend this time by up to 14 calendar days if the Enrollee requests an extension, or if additional information is needed and the extension benefits the Enrollee. If Blue Plus does not agree that the service is urgently needed, -the Enrollee will be notified within 24 hours and follow up with a written notice within 2 calendar days. If the Enrollee disagrees, they may file an expedited grievance with Blue Plus

- If any physician asks for an expedited appeal on behalf of an Enrollee, or supports them in asking for one, and the physician indicates that waiting for 30 calendar days could seriously harm the Enrollee's health, Blue Plus will automatically conduct an expedited appeal.
- If an Enrollee asks for an expedited appeal without support from a physician, Blue Pluss will decide if the Enrollee's health requires an expedited appeal. If it does not, Blue Plus will make a decision within 30 calendar days preserving the first filing date of the expedited appeal request.

## Filing an Appeal

### Standard Appeals

The Enrollee or their authorized representative can file an appeal orally (by calling Member Services toll free at **1-888-740-6013**, 8:00 a.m. – 5:00 p.m. seven days a week) or in writing. Blue Plus may document Enrollee's oral appeal in a letter and ask the Enrollee to sign and return the letter before a final decision can be made OR the Enrollee or their authorized representative can mail, fax or deliver their written appeal to:

Blue Plus
Appeals and Grievances

P.O. Box 982816

El Paso, TX 79998-2816

- Fax: 651-662-6287

In addition, the attending Health Care Professional may appeal utilization review decisions with Blue Plus without the written signed consent of the Enrollee in accordance with Minnesota Statutes 62M.06

### Expedited Appeals

The Enrollee or their authorized representative should contact us at:

**1-888-740-6013** (toll free)

**1-888-740-6014** 8:00 a.m. – 5:00 p.m. seven days a week (CT)

**1-888-740-6015** Fax: 651-662-6287

## What Happens After an Appeal is Filed

Blue Plus reviews its decisions on appeals. If any of the services or claims payments requested are still denied, the Enrollee or authorized representative can request a State Appeal with the Minnesota Department of Human Services. For a Medicare covered service, Medicare will provide a new and impartial review of the case by an Independent Review Entity (IRE) external to Blue Plus.

If the Enrollee disagrees with the decision, they have further appeal rights and will be notified of those appeal rights if this happens.

**Requesting a State Appeal**

The Enrollee or their authorized representative can ask for a State Appeal. They must send a request in writing within 120 days. If their hearing is about an urgently needed service, the Enrollee or their authorized representative should tell the Judge or the Ombudsperson when they call or write to them.

Appeals Office/Department of Human Services
P.O. Box 64941
St. Paul, MN 55164-0941
Fax: **(651) 431-7523**

A Department of Human Services Judge from the State Appeals Office will hold a hearing. The Enrollee may attend the hearing in person or by telephone. The Enrollee will be asked to tell the State why they disagree with the decisions made by Blue Plus. Enrollees can ask a friend, relative, advocate, provider, or lawyer to help with their appeal. The process can take 30-90 days. If the hearing is about a medical necessity denial, the Enrollee may ask for an expert medical opinion from an outside reviewer. There is no cost to the Enrollee.

**Do Not Agree with the State's Decision**

If the Enrollee does not agree with the State's decision about their appeal, they can appeal to the district court judge in the county in which they reside.

**Additional Rights Provided Under the Medicaid Program**

If the Enrollee decides to appeal it will NOT affect their eligibility for medical benefits. There is no cost to the Enrollee for filing a health plan appeal or State Appeal.

If Blue Plus is stopping or reducing a service, the Enrollee can ask to receive the service when they file a health plan appeal or request a State Appeal within ten days after Blue Plus sends them the notice or before the service is stopped or reduced, whichever is later. The treating provider must agree the service should continue. The service can continue until the health plan appeal or State Appeal is resolved. If the Enrollee loses the health plan appeal or State Appeal, the Enrollee may be billed for these services.

If the Enrollee has seen a medical provider who is part of Blue Plus' network and was told services are not needed, a second opinion may be obtained, but the Enrollee must see another Blue Plus medical provider.

**Additional Rights Provided Under the Medicaid Program (continued)**

If the Enrollee has seen a behavioral health provider who is part of Blue Plus' network and has been told that no structured behavioral health treatment is needed, they may get a second opinion. If they have seen a Blue Plus chemical dependency assessor and disagree with the assessment, they may get a second opinion. The second opinion must be provided by a licensed behavioral health provider or chemical dependency assessor. The assessor does not need to be a Blue Plus provider but must be prior approved by Blue Plus. Blue Plus must consider the second opinion but do not have to accept a second opinion for medical or behavioral health services.

An attending provider may appeal a Utilization Management decision without the Enrollee's consent.

Enrollees may present written comments, any documents, or other information relating to the appeal. They may request to see or have copies of all documents that relate to their appeal. If they ask to see their medical records, or want a copy, their provider or Blue Plus must provide them at no cost. They may need to put their request in writing.

**State Ombudsperson Additional Rights Provided Under the Medicaid Program**

A State ombudsperson may be able to help Enrollees with their problem. The ombudsman can help the Enrollee file the appeal to Blue Plus or to the State, or request a State Appeal by writing to:

**Minnesota Department of Human Services Ombudsperson for Managed Health Care Programs**

P.O. Box 64249
St Paul, MN 55164-0249
Local: **(651) 431-2660**
Toll free: **1-800-657-3729**
TTY: 711

8:00 a.m. – 4:30 p.m.

**State Ombudsperson Additional Rights Provided Under the Medicaid Program (continued)**

**Contact Information**

For information or help, call Blue Plus at:

Toll Free **1-888-740-6013**
TTY **711**

8:00 a.m. – 5:00 p.m. 7 days a week

**Other Resources to Help for Enrollees with Medicare:**

Medicare Rights Center:

Toll Free: **1-888-HMO-9050**
Elder Care Locator
Toll Free: **1-800-677-1116**
1-800-MEDICARE (**1-800-633-4227**)
TTY: **1-877-486-2048**

# Notification of Hospital Discharge Appeal Rights

**Notification of Hospital Discharge Appeal Rights**

Original Medicare has changed its process for hospital discharge notifications. On July 1, 2007, Medicare's NODMAR form, which was referenced in Provider Bulletin P9-07 dated May 15, 2007, was replaced with a standardized document entitled "Important Message from Medicare" also referred to as the "IM." The IM must be issued by the hospital to all Original Medicare beneficiaries and all Medicare Advantage and Medicare Cost Enrollees upon admission or within two days after admission. Livanta, a Center for Medicare and Medicaid Services (CMS) contracted quality improvement organization, is working directly with hospitals across the state to implement this new CMS requirement, the IM process. When an Enrollee files a request for immediate review, Livanta will contact the impacted parties.

**Who is Affected by This Change?**

This bulletin is directed to acute care hospitals participating in the Blue Cross and Blue Shield of Minnesota's Medicare Advantage products offered or administrated by Blue Plus. These programs include SecureBlue and Minnesota Senior Care Plus.

**Hospital Discharge Forms**

**Hospitals use three forms:**

1. **Important Message from Medicare (IM)** – This form is used by the hospital to notify:
   - Inpatients of their rights for appeal if they do not agree with the hospital discharge date.
   - Providers are responsible for delivering this form to patients and keeping a copy on file.
   - Specific health plan information must be on the form. The IM form can be found on CMS's website at http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

**Hospital Discharge Forms (continued)**

2. **Detailed Explanation of Non-Coverage (DENC)** – Providers must issue the DENC to Enrollees and provide a copy to the Quality Improvement Organization QIO (Stratis) no later than close of business (typically 4:30 P.M.) the day of the QIO's notification that the Enrollee requested an appeal, or the day before coverage ends, whichever is later. This form is attached to this bulletin and can be found on our website **bluecrossmn.com** in the Forms and Publications area of the Health Care Provider section.

3. **Notice of Denial of Medicare Coverage (NDMC)** – This form is only used when benefits are exhausted or if services are not covered by Medicare. Blue Cross has delegated the delivery of this form to the provider when they are making this determination. This form is attached to this bulletin and can be found on our website **bluecrossmn.com** in the Forms and Publications area of the Health Care Provider section.

**Additional Comments**

For additional information on document retention, refer to the overall provision in the Amendment to the Agreement in Medicare Programs which states providers will maintain medical, financial and administrative records for ten (10) years.

**Questions?**

If you have any questions, please contact provider services at **1-866-518-8448**.

# Claims Submission: Drugs

**Claims Filing Requirements: Drugs**

The majority of our Enrollee contracts contain basic drug coverage. Drug claims are either processed by Blue Cross or Prime Therapeutics. To determine if a drug claim should be submitted to Blue Cross or Prime Therapeutics for processing, check the Member's ID card. If the Member has drug processing through Prime Therapeutics, the medical identification (ID) card will indicate RxPCN (the carrier code) "MCAIDMN," "SBPARTD," or "SBPARTB." A Prime Therapeutics provider must be used.

Prime Therapeutics, LLC is an independent company that provides pharmacy benefit management services.

**Drug Claims Submission**

Providers within the Prime Therapeutic network must submit claims electronically.

For more information, please call the Prime Therapeutic pharmacy help desk at **1-844-765-5940 for Blue Advantage** or **1-800-648-2778 for SecureBlue**.

**Prescribing Physician's NPI**

The physician's NPI (National Provider Identifier) number must be entered on all electronic or paper claims submitted for payment. This information is used for drug utilization review aimed at improving the quality of health care delivered to our Enrollees. Leaving this data element out or use of a dummy NPI number constitutes an incomplete pharmacy claim.

**Prior Authorization – Minnesota Health Care Programs**

**CoverMyMeds prior authorization request service**

CoverMyMeds (CMM) is a free service for providers, which allows quick and easy submissions of PA requests for various drug plans.

CMM is accessed at covermymeds.com. Select Help (top right of the web page) to view FAQs and Support tutorials, which describe how to get started (3-5 minutes). Providers may choose to set up an account within CMM, to familiarize yourself with the features. After opening your account, there are three easy steps for using CMM:

1. **Find the right PA form –** Enter the state, drug, and Blue Cross drug plan and click Start request. The appropriate PA forms will display.

**Preauthorization – Minnesota Health Care Programs (continued)**

2. **Share the PA form (optional step) –** Begin to populate the PA form then use the systems to fax or email the form to another health care provider for completion.
3. **Submit the PA form –** Upon completion of the form, the PA can be printed, signed, and faxed, or the physician can sign it digitally and submit it via the CMM fax feature.

**Prior Authorization - Medicare Part D drugs**

For Enrollees of products with Medicare Part D coverage (identified by RxPCN carrier code "SBPARTD" or on their ID cards)

1. Preauthorization information and forms can be located at www.MyPrime.com.
2. Select "**BCBS Minnesota,**" then "**Yes**" for Medicare Part D Members. Select health plan type.
3. Select **Forms** from the bar at the top of the page.
4. Click on the **Part D Coverage Determination or Appeals** link, under the topic Forms & Related Information.
5. Click "**Prior Authorization**" This will bring you to a list of drugs requiring prior authorization.
6. Click on the name of the drug for which you are making the request and you will be taken to the appropriate form.

**Injectable Drugs**

Most prescription benefit plans allow injectable processing online. Be sure to use the appropriate NDC and submit your claim electronically to the processor.

Medicare requires that many vaccines (and the fees for administering them) be paid under the Enrollee's Medicare Part D drug coverage. For SecureBlue Enrollees, most vaccines are covered under the Part D formulary. Both the vaccines and administration fees that are covered by Part D can be billed through Prime's normal pharmacy billing system by pharmacies or by medical providers through www.edispense.com.

### Pharmacies Submitting Claims for DME

For durable medical equipment (DME), the pharmacy must follow the normal process for claims submission utilizing the electronic 837P claim transaction.

It is the responsibility of the participating pharmacy to submit the claims for all such eligible DME services to Blue Plus on behalf of the Enrollee. The pharmacy can bill the Enrollee for applicable copayments at the time of purchase. The provider shall not charge the individual Enrollee for covered health services prior to submitting the claim to Blue Plus for processing. After the claim is processed by Blue Plus, the remittance advice will indicate the proper amount to bill the Enrollee.

# Claim Processing: Drugs

| | |
|---|---|
| **NDC Numbers** | The NDC numbers submitted on the pharmacy claim must be taken from the container from which the drug was dispensed. The NDC number must match the manufacturer and package size. |
| **Copays/Coinsurance** | The drug copay/coinsurance amount varies for each Enrollee. Rely on "claim response" to correctly identify the amount to collect from the Enrollee. |
| **Vacation Prescription Requests** | Requests for additional drug quantities may be made by the Enrollee, physician, or pharmacist. The Enrollee would contact the Member services number listed on the back of their Subscriber ID card. The physician or pharmacist would contact the pharmacy help desk. Please keep in mind that some medications are controlled substances that may have different treatment than non-controlled substances. |
| **Prescription Cost Less than Copay** | If the cost of the prescription is less than an Enrollee's copay, the Enrollee should pay the lesser of the allowed amount as shown on the claim's response. |
| **Collection of Copay Inability to Pay** | Copays must not be collected from Enrollees of Blue Plus Minnesota Health Care Programs plans who are unable to pay. According to Minnesota Department of Human Services (DHS) and federal requirements, Blue Plus must ensure that no provider denies covered services to an Enrollee because of the Enrollee's inability to pay the copayment pursuant to 42 CFR §447.53. |
| **Pharmacy Audits** | Blue Plus performs comprehensive pharmacy program integrity audits to ensure compliance with its programs. |

# Drugs

## Drug Formulary

Blue Plus promotes the use of the Enrollee's specified drug formulary. The formularies have been developed to provide a listing of drugs that are safe, effective, high-quality and economical.

- **BCBSMN Medicaid GenRx:** This is the formulary for Medicaid.
- **Platinum Blue:** This is the formulary for Medicare-Platinum Blue.
- **Secure Blue:** This is the formulary for Medicare-Secure Blue.

**Definitions:**

- **Formulary** is a list of preferred drugs with coverage under the plan. This list may change during the year.
- **Preferred drug** is a drug that is covered under the plan because it is included on the formulary drug list.
- **Non-preferred drug** is a drug not on the formulary drug list, but could be covered under an open pharmacy benefit plan design.
- **Open pharmacy benefit plan design** is a benefit design that covers most drugs regardless of the status (preferred or non-preferred) on the formulary drug list. The Subscriber's financial responsibility will vary based on formulary status and benefit design.
- **Closed pharmacy benefit plan design** is a benefit design that covers only drugs on the formulary drug list. A Subscriber can get a non-preferred drug, but is responsible for 100 percent of the cost unless a formulary exception is submitted and approved.

| | |
|---|---|
| **Drug Formulary (continued)** | • **Requesting to add a drug to the formulary:**<br>Any participating health care provider may request the addition of a drug to a formulary by sending a letter to Blue Plus. Include the following:<br>• Name of Prescribing MD<br>• Clinic Name<br>• Clinic Phone Number<br>• Clinic Fax Number<br>• Name of Drug<br>• Name of Manufacturer<br>• Rationale for adding the drug<br><br>A new FDA-approved drug is not considered to be on the drug formulary until it has been approved by the formulary committee. To view the formularies, go to: **Prescription Drugs**, select "**Search a Drug List**" |
| **Drugs with a Non-Formulary Status** | Physicians may request coverage of a non-formulary medication for a Blue Plus Enrollee by completing and submitting the Formulary Exception (myprime.com) Enrollee liability for non-formulary medications is subject to the Enrollee's specific benefit design. |
| **Compounded Prescriptions** | Use of the compound indicator for compounded prescriptions is reserved for prescriptions requiring the pharmacist to combine two or more ingredients. |
| **Over-the-Counter Drugs** | Consult Drug Formularies |
| **Dispense as Written (DAW)** | DAW will not be accepted for override of formulary for drugs for Enrollees of Blue Plus plans. In order to receive a non-formulary drug, the Enrollee's physician must request a formulary exception. |
| **Investigative Drug Use** | Investigative drugs are not eligible for reimbursement. |
| **Medical Injectables** | Medical Injectables: Drugs that are prescribed by a medical professional that are injected by a medical professional into the skin or muscle of an Enrollee. These drugs are billed under the Enrollee's medical benefits not pharmacy benefits.<br><br>Additional information regarding medical policies pertaining to drugs can be found on the website: Medical and behavioral health policies \| Blue Cross MN |

## Formulary Exception Process for Minnesota Health Care Programs

Blue Plus requires a formulary exception approval for Enrollees in Blue Advantage (Families and Children/MSC+), MNCare, SecureBlue (MSHO) non-Medicare Members without exception.

Members or medical providers can find the request forms at the following link: Formulary Exception (myprime.com)

### Anti-psychotic Drugs

For anti-psychotic drugs prescribed to treat a diagnosed mental illness or emotional disturbance that are not on the Blue Cross Medicaid GenRx formulary, the health care provider prescribing the drug must certify the following to Blue Cross in writing:

1. The provider has considered all equivalent drugs on the formulary and has determined that the drug prescribed will best treat the patient's condition
2. The drug must be dispensed as written (DAW)

### All Other Drugs

For all other drugs not on the Medicaid GenRx formulary: the health care provider prescribing the drug must follow formulary exception procedures to request an exception. The health care provider prescribing the drug must do one of the following:

1. Attest that the formulary drug causes an adverse reaction in the patient
2. Attest that the formulary drug is contraindicated for the patient
3. Attest that the patient has tried and failed at least three (or as many as available, if fewer than three) formulary alternatives for the diagnosis being treated with the requested medication
4. Demonstrate in writing to Blue Cross that the provider has considered all equivalent drugs on the formulary and has determined that the drug prescribed will best treat the patient's condition

The prescriber may be required to submit medical records that support the medical necessity for the prescribed nonformulary drug.

Per Minnesota Statute 62.184, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will accept Step Therapy Override Requests for Medical Injectables and Step Therapy Override Appeal Requests for Medical Injectables.

**Formulary Exception Process for Minnesota Health Care Programs (continued)**

Members, or their medical providers, may request one or both of these services.

**DAW for Nonformulary Drugs**

Prescriptions entered with a DAW for nonformulary drugs will not process at the point of sale until the prescriber has also completed the second part of the process. Enrollees will be directed to work with their provider to determine if a formulary drug may work for them. If the provider determines that the nonformulary drug will best treat the Enrollee's condition, a formulary exception request must be submitted on the Enrollee's behalf.

**What does this mean for the Enrollee?**

Prescriptions written as DAW will not process at point of sale until the certification or demonstration has been received. Enrollees will be directed to contact their provider to determine if a formulary drug may work for them. If the provider determines that the nonformulary drug will best treat the Enrollee's condition, a formulary exception request must be submitted on the Enrollee's behalf.

**What steps should be taken?**

Determine which of your patients' current prescription drugs written as DAW are not on the BCBSMN Medicaid GenRx drug list.

To determine which drugs are on the formulary:

1. Go to **providers.bluecrossmn.com**
2. Select "**Prescription drugs**" under "Tools & Resources."
3. Click on "**Search the drug list.**"
4. Select "**No**" to question are you a Medicare Part D Member
5. Select **Blue Cross Medicaid GenRx** drug list.

## Formulary Exception Process for Minnesota Health Care Programs (continued)

**What if an Enrollee tries to fill a DAW prescription for a drug not listed in Medicaid GenRx drug list?**

The prescription will not be filled by the pharmacy until the certification or demonstration has been received and approved. The Enrollee will be referred to the prescribing physician for a new prescription and/or a formulary exception submission on their behalf.

## Drug Programs

**Specialty Drugs**

- Specialty drugs are used to treat serious or chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. They are typically injectable and can be self-administered by an Enrollee.

When an Enrollee receives their drugs from a specialty network supplier, they are assured quality while saving money and time. Contact provider services to verify if the Enrollee's plan has the specialty drug program as an available benefit.

**Quality**

The specialty network supplier and experts in supplying drugs and services to patients with complex health conditions.

**Convenience**

The Subscriber can order their specialty drug each month from a specialty drug supplier, play their health plan's applicable in-network copay or coinsurance amount and eliminate the expense of driving or having to find transportation to a pharmacy to pick up their drugs.

**Specialty Drug List**

The Specialty Drug List is available at www.myprime.com

**Other prescription drugs**

Only select drugs are available through the specialty drug program. Subscribers will need to continue to get their other prescription drugs through their local pharmacy.

**More information**

Additional information is available on bluecrossmn.com regarding the specialty drug network.

**Drug Programs (continued)**

**Specialty Network Suppliers**

The specialty drug benefit program offers these choices in professional specialty drug suppliers:

Accredo Health Group, Inc.

Toll free: 1-866-470-2245, TTY 1-800-716-3231 This call is free.

Fax: 1-888-302-1028

Customer service line is open 24 hours a day, seven days a week

*Children's Home Care (for hemophilia medications only)

Toll free 1-866-656-1020, TTY 711 This call is free.

Fax: (877) 828-3939

Monday through Friday from 8 a.m. to 5 p.m. Central Time

Fairview Specialty Pharmacy Service

1-800-595-7140, TTY 711 This call is free.

Fax: (877) 828-3939

Monday through Friday from 8 a.m. to 7 p.m., Saturday from 8 a.m. to 4 p.m. Central Time

North Memorial Health Pharmacy – Specialty Center 3435

W. Broadway Ave.

Robbinsdale, MN 55422

Pharmacists available by phone 24/7 at 1-877-520-5307 (toll free), TTY 711 or (763) 581-6333

This call is free.

Fax: 763-581-2814

**Drug Programs (continued)**

Monday through Friday from 8 a.m. to 5 p.m. Central Time

Thrifty White Specialty Pharmacy

Pharmacists available by phone 24/7 at (855) 611-3399, TTY 711
This call is free.

Fax: 855-423-8300

Monday through Friday from 8 a.m. to 8 p.m., Saturday from 9 a.m. to 5 p.m. Central Time

*Children's Home Care can only fill prescriptions for Hemophilia medications.

The specialty network suppliers were selected for their outstanding customer service and dedication to patients. These suppliers are experts in handling the types of drugs you are taking.

# Elderly Waiver Programs

## Elderly Waiver

Elderly Waiver (EW) is a federal Medicaid waiver program that funds home and community-based services for people 65 years old and older who are eligible for Medical Assistance (MA), require the level of care provided in a nursing home and choose to live in the community.

Blue Cross and Blue Shield of MN and Blue Plus (Blue Cross) follows the MN Department of Human Services (DHS) Minnesota Health Care Programs (MHCP) billing guidelines and payer specific requirements.

Blue Plus's internal Bridgeview team processes EW claims. Information regarding the EW program at Blue Plus can be found at https://bridgeview.bluecrossmn.com/. The Bridgeview customer service team may be reached by telephone at **1-800-584-9488** 8:00am - 4:30pm Monday through Friday or via email at EWProviders@Bluecrossmmn.com.

For Elderly Waiver claim payment dispute or questions regarding payment results, contact Bridgeview customer services at **1-800-584-9488** or email your questions to EWProviders@bluecrossmn.com. A customer service representative will follow up with your questions within 24 hours of receipt date.

Appeals may be submitted to the Bridgeview company by completing the AUC (The Minnesota Administrative Uniformity Committee) Appeal Request form.

- The form is located on the Bridgeview website at Elderly Waiver Program Documents – Bridgeview Company (bluecrossmn.com)Fill out form completely.
- Include the payer claim numbers that are appealed and the reason.
- Email to EWProviders@Bluecrossmn.com mailbox OR fax to **218-740-4616**.
- Bridgeview has sixty (60) days to respond to the appeal
- A response to the appeal letter will be in writing and mailed to person requesting the appeal.

# Cultural Diversity and Linguistic Services

**Cultural Diversity and Linguistic Services**

Blue Plus recognizes that providing health care services to a diverse population can present challenges. It is important to continually increase a provider's knowledge of, and ability to support, the values, beliefs, and needs of diverse patients. These challenges arise when Providers need to cross a cultural divide to treat Enrollees who may have different behaviors, attitudes and beliefs concerning health care. Differences in Enrollees' ability to read may add an extra dimension of difficulty when providers try to encourage follow through on treatment plans.

Blue Cross offers learning experiences and techniques to assist providers in the individualized care every patient deserves regardless of their diverse backgrounds. Providers can access this information at: Education Center | BCBSMN (bluecrossmn.com)

Chapter 4

# Referrals

## Table of Contents

# Introduction to Referrals

## General Overview

Being a primary care provider for Subscribers with managed care products requires the coordination of care with specialty providers and hospitals. This section provides information about referral procedures and includes helpful suggestions.

## Goals

The goal of the referral process is to ensure continuity of care through coordination with the PCC. When care needs are identified that cannot be appropriately addressed by the PCC, care should be referred. The PCC coordinates and authorizes all needed care for each of their Blue Plus Subscribers. In general, the PCC will not make a referral for Health Services that the PCC can provide. The PCC is responsible for providing or referring all necessary Health Services.

## Objectives

The objectives of referrals are to promote:

- Coordination of care and communication between Subscribers, PCCs and specialty providers
- Appropriate use of referral care, thereby reducing underutilization or over-utilization of services
- Seamless, quality care delivery by facilitating the use of a select, coordinated network of primary care and specialty providers

To facilitate these objectives:

- Communicate the clinic referral process to Subscribers when discussing referral care needs
- Offer Subscribers the option to appeal if they are not comfortable with the referral process or are dissatisfied with the outcome. This option is available by calling Blue Plus customer service.

## Policy

When Blue Plus Subscribers are referred by their PCC to other providers, Blue Plus needs to be notified to ensure correct claims processing. **A referral is not a guarantee of payment, but allows the Subscriber to seek medical care for eligible Health Services outside the PCC and receive their highest benefit level.**

In the role of coordinating a Subscriber's care, Provider works closely with referral providers. Provider may use the *Provider Finder Tool* as a guide to selecting specialty providers. The guide is available at **bluecrossmn.com** or the **www.availity.com** website; use the 'Blue Cross Aware' network of providers. To remain involved in coordinating the Subscriber's care, carefully select the length of time and number of visits to authorize. Blue Plus allows a referral time frame to span up to a maximum of 365 days.

It is the "referred to" provider's responsibility to communicate medical assessments and proposed treatment plans back to the PCC. To best coordinate the Subscriber's care, Provider must have complete medical information. Provider may request the information in the format of its choice. However, the back of the referral letter that Blue Plus mails to Subscribers may be used. Referral providers do not receive a paper copy of the referral letter, if they have access to provider web self-service.

Once the referral is received, Blue Plus will generate a letter to the Subscriber and possibly the referring provider and specialists, depending on the type of referral (See *Patient Referral Authorization* letter).

Remember these important points about referrals:

- PCCs must have an established referral process.
- Notify Blue Plus of referrals authorized by the PCC, via provider web self-service at **www.availity.com.**
- The Subscriber may receive Health Services only from the clinic named in the referral or standing referral.
- The referral provider or specialist may not refer the Subscriber to other providers without written consent from the PCC. The Subscriber is responsible for any reduced benefits for services received from a provider for whom no referral was provided by their PCC. Exceptions are made for Minnesota Health Care Programs Subscribers.

Policy (continued)

- In some cases, Blue Plus will request a second referral if information from the referral provider's claim does not match information received from the PCC (See *Information Requests on page 4-15*).
- If a Subscriber who has a referral or standing referral changes PCCs, the referral or standing referral will no longer be valid as of the date the PCC was changed. The Subscriber's new PCC must establish a new referral or standing referral.

PCC/Care System Guidelines

Blue Plus has guidelines regarding referrals and other aspects of managed care. Because PCCs are responsible to manage their Subscribers' care, they may implement unique rules and workflows. Blue Plus generally encourages and supports unique rules unless they interfere with the Subscriber's benefits or rights.

For example:

- **Referral providers:** Provider web self-service at **www.availity.com** and Blue Plus' website at **bluecrossmn.com** list the specialty providers in the Blue Plus referral network that PCCs may refer Subscribers to. Some PCCs may choose to refer to only specific providers or have their Subscribers receive Health Services from specialists within PCC's care system. Some PCCs create a list of preferred referral providers.
- **Referral process:** Blue Plus has general workflows to process referrals communicated to Blue Plus. However, many PCCs incorporate their own workflows for their clinics. As long as the referrals are communicated to Blue Plus when necessary, Blue Plus generally does not oppose them.
- **Referral bypass:** Blue Plus has standard referral bypasses that allow claims to process at the highest level of the Subscriber's benefits without a referral.
- **PCC referral bypass:** PCCs can contact Blue Plus to implement a PCC-specific referral bypass for their managed care Subscribers. This may be requested when a PCC system continually refers to a specific provider for a Health Service. PCCs may or may not request that Blue Plus communicate their bypasses to Subscribers. Blue Plus recommends that PCC communicate its workflows to Subscribers when appropriate.

## Process

PCCs are required to have a referral process. The PCC coordinates and authorizes medical care for each of its Blue Plus Subscribers. The referral process occurs when a PCC determines that the Subscriber's condition requires care outside of the PCC. When a Subscriber requires referred Health Services, Blue Plus processes claims based upon PCC's authorization for Health Services eligible under the Subscriber Contract.

A referral is initiated by the PCC and is limited to the specific duration and number of visits, as determined by the PCC. There are some situations where a referral is not required (see *Referrals not required*). Referrals are required to be entered through provider web self-service at **www.availity.com**.

Exceptions to this are:

- Behavioral health referrals. Subscribers have direct access to in-network providers. In rare instances, out-of-network exceptions may be considered. Call the number on the back of the member ID card, or call **1-800-262-8020**, local: **(651) 662-5200**.
- PCC does not have provider web self-service web access.
- The provider to which PCC is referring the Subscriber is not a Blue Cross and Blue Shield of Minnesota and Blue Plus participating provider. However, PCCs must refer to a participating provider to the highest degree possible.

For information about provider web self-service, go to the website **www.availity.com**. If PCC does not have access to provider web self-service, referrals can also be communicated by fax. (Refer to fax numbers in Chapter 1)

## Standing Referrals

Minnesota law gives Subscribers the benefit of a standing referral. Standing referrals are for longer-term, ongoing care by a specialty provider. They may be established at any time at the PCC's discretion. Referrals must be communicated to Blue Plus prior to Health Services being rendered. Blue Plus' standard guidelines allow PCCs to determine the number of referral visits and the length, up to 365 days.

Mandatory standing referrals to a specialist qualified to treat the specific condition must be granted, upon request, to a Subscriber with any one of the following conditions:

- A chronic health condition
- A life-threatening mental or physical condition
- Pregnancy beyond the first trimester, if the Subscriber's plan does not offer open-access benefits to ob/gyn providers
- A degenerative disease or disability
- Any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist

This law permits specialists, in agreement with the Subscriber and PCC, to provide primary care Health Services, authorize tests and services and even make secondary referrals. If the PCC does not grant the Subscriber's standing referral request, the PCC must inform the Subscriber that he or she can file a complaint with Blue Plus by calling the telephone number on the back of their member ID card.

PCCs are not required to authorize a referral to accommodate personal preference, convenience or other non-medical reason. While mandatory standing referrals must be provided, the PCC can determine the total number of visits within the 12-month period based upon the Subscriber's medical condition. If the PCC has the specialist within its clinic/care system, the PCC may require that the Subscriber receive Health Services there. PCCs must communicate referrals to Blue Plus prior to referred Health Services being rendered.

## Claims Processing

Health Services provided at the PCC will generally be paid at the highest level of benefits. Use the grid below as a general guideline to determine benefits for Health Services not rendered at the PCC.

| Health Service | If referred by the PCC | If not referred by the PCC |
|---|---|---|
| Health Service not rendered by the PCC | Highest level of Subscriber's benefits | Self-referral benefit. If the Subscriber does not have a self-referral level of benefits, the claim will probably deny as Subscriber responsibility. |
| Medical emergency | Highest level of Subscriber's benefits | Highest level of Subscriber's benefits for inpatient and outpatient hospital services |
| Non-medical emergency | Highest level of Subscriber's benefits | Self-referral benefit. If the Subscriber does not have a self-referral level of benefits, the claim will probably be denied as Subscriber responsibility. Outpatient emergency room services will be paid at the highest level of the Subscriber's benefits. |
| Health Services on referral bypass | Highest level of Subscriber's benefits. Referrals are not required for Health Services on referral bypass. | Highest level of Subscriber's benefits. Referrals are not required for Health Services on referral bypass. |
| Open-access benefits | Open-access benefits level if the Subscriber obtains Health Services from a provider in the appropriate network. If the provider is not in that network, the benefits generally will be reduced or denied. | Subscriber's open-access benefit level if the Subscriber obtains Health Services from a provider in the appropriate network. If the provider is not in that network, the benefits generally will be reduced or denied. |

Claims Processing (continued)

Because contracts vary, benefits may vary. Some contracts have specialty network requirements for specific types of Health Services. These network benefits dictate where the Health Service must be rendered to be paid at the highest level of benefits. Refer to Chapter 3 of the Blue Plus Provider Manual for more information on Government Programs.

## Comment Codes

Use any of the comment codes listed below on your referral and the corresponding message will print on the referral letter.

| Comment Code | Message |
|---|---|
| CON | Referral authorized for one consultation only |
| DIA | Diagnostic evaluation only |
| DXL | Lab or X-ray services not authorized |
| HOS | Do not hospitalize without primary care authorization |
| LAB | No lab services are authorized |
| OUT | Outpatient services only |
| REP | Send a thorough written report when the consultation is complete |
| STA | Please send periodic status reports on this patient |
| THP | No therapy services are authorized |
| XRY | No X-ray services are authorized |

## Referral Tips

These tips may assist in getting claims paid quickly and accurately:

- Use the standard Managed Care Referral fax form, X12388-R7, and fax it to Blue Plus' referrals fax number. Referrals must be submitted electronically if PCC has the capability.
- Reduce or avoid retroactive referrals.
- Use an **individual** Blue Cross provider number in the field titled “your clinic physician’s individual number” and the **contracting** number in the field titled “Clinic/hospital provider number that the patient is being referred to.”
- Use black ink and complete all fields on the fax form if PCC does not have the capability of submitting electronically.
- Proofread the information for clarity and accuracy.
- If there are two Subscribers on the Subscriber Contract with the same name, include the birth date of the patient.
- If PCC is changing an existing referral, clearly indicate that it is a change.
- For behavioral health services, Subscribers should call **1-800-711-9862** directly.

## Patient Referral Authorization Letters

Referral letters are sent as described below. The reverse side of the referral letter may be used by the specialist to communicate to PCC the results of the Health Service provided.

| If the referral is... | then... |
|---|---|
| To a specialist (not in PCC's clinic/care system) | A copy is sent to:<br>• The referral specialist, only if they do not have access to provider web self-service<br>• The Subscriber<br>• PCC, only if PCC does not have access to provider web self-service |
| For an outpatient procedure | A copy is sent to:<br>• The Subscriber<br>• PCC, only if PCC does not have access to provider web self-service |
| For an inpatient procedure | No copies are sent |

## Sample Patient Referral Authorization Letter

Following is a sample of the referral letter that is mailed in the above situations.

[Date]

**PATIENT REFERRAL NOTICE**

[Name of patient]
[Address of patient]

Copy to:
[Name of secondary provider]

Patient:
Identification #:
Member #
Relation to subscriber:
Sex: Date of Birth:
Group #
Referral #

Dear [name of patient]

This letter is to confirm that your primary care clinic has requested a referral for you to [insert provider name], for care to be received from _____ through _____, up to a maximum of _____ visits.

Your Blue Cross/Blue Plus health plan will pay for its share of the health services described above, as defined by the terms of your health plan contract, provided that:

1. Your primary care clinic has requested a referral (this letter confirms that this requirement has been met); and
2. You are otherwise eligible to receive health plan benefits (for example, you are a currently enrolled member, you have not reached a lifetime or benefit maximum, and your contract covers the services provided).

Here is a list of other conditions that apply. If you have questions, please call the customer service number on the back of your health plan member ID card.

- A new referral request must be submitted by your primary care clinic for any care outside the dates listed or for more than the maximum number of visits noted above.
- This referral is valid only for care provided by [insert provider name].
- If you change your primary care clinic, this referral is no longer valid.
- Any health services related to services excluded in your contract (for example, benefit exclusions or investigative services) are not covered, even if ordered or provided by your primary care clinic or the provider to whom you have been referred.

| This referral has been made by: | Referral care must be provided by: |
|---|---|
| Physician: | Provider name: |
| Primary Care Clinic: | Provider # |
| Clinic Provider # | |

**Sample *Patient Referral Authorization* letter**

## Referral Network for Primary Care Clinics Directory

The *Referral Network for Primary Care Clinics* directory is available to view on provider web self-service site at **www.availity.com** or on Blue Plus' website at **bluecrossmn.com**. The directory includes a current list of specialists participating in the referral network. PCC may use the directory as a guide to select specialists when referral of Blue Plus Subscribers is necessary. In the directory, PCC will find:

- Physicians, grouped by specialty
- Clinics (contracting providers), listed alphabetically within each specialty category. The contracting provider number, address and phone number are also included. **Use the contracting provider number when submitting referrals to Blue Plus.**
- Individual provider names, listed alphabetically for each clinic along with their individual provider number.

PCC may refer outside the network only if PCC determines there isn't another network provider who is able to render the service. Directing patients to nonparticipating providers may be necessary, in limited situations, such as medical emergency, participating providers are not available within certain geographic areas, or quality of care or specialty care requires use of a nonparticipating provider.

Blue Plus recommends that PCC use provider web self-service for the most up-to-date referral information. The directory is updated once a year, but the web self-service is updated daily.

## Information Requests

Blue Plus will send PCC an information request, if it cannot match the referral provider's claim(s) with PCC's referral authorization. Generally, these information requests will only be sent if the Subscriber does not have a self-referral option in their contract. If they do have a self-referral level of benefits, then Blue Plus will process the claim with the self-referral benefits.

The information request will ask PCC to review the following situations:

- The Subscriber has made more than the authorized number of visits.
- Blue Plus either has no referral for the Subscriber, or the information from the referral does not match the referral provider's claim.
- The Subscriber received Health Services from a referral provider before or after the time period indicated on PCC's authorization form.

If PCC authorized the Health Service, then document the information on the form and return it to Blue Plus.

# Referral Requirements

## Referrals Required

Referrals are required for:

- Home health care/home IV
- Outpatient surgery
- Psychological testing submitted with a medical diagnosis
- Visit to specialty provider
- Inpatient admissions - including hospitals
- Inpatient hospital admissions - a referral will be assumed when the preadmission notification is completed, if the admitting physician is from the Subscriber's PCC
- All Health Services by nonparticipating providers (Public Programs only)

Please refer to the *Subscriber Benefits* section in Chapter 2 for additional details about exceptions pertaining to Subscriber's benefits (e.g., chiropractic services, ob/gyn Health Services).

## Referrals Not Required

Blue Plus does not require referrals for the services listed below. Claims will process at the highest level of coverage, as if they were referred, without PCC authorizing a referral. This process is known as a referral bypass or referral exception. The referral bypasses may be in place for ease of administration, legislative mandate or both. They may vary by employer contract or PCC.

- Abortion and sterilization
- Allergy serum when injection is done in the PCC
- Ambulance
- Anesthesia and assistant surgeon, if medically necessary (if the outpatient surgery or inpatient admission is referred)
- Behavioral Health: Subscribers have direct access to in-network providers. In rare instances, out-of-network exceptions may be considered. Call the number on the back of the member ID card, or call **1-800-262-8020**, local: **(651) 662-5200**.
- Dentists
- Diagnostic X-ray and laboratory services only
- Durable medical equipment (DME)
- Emergency services - inpatient and outpatient
- Endodontists

## Referrals Not Required (continued)

- Inpatient consultation (if the inpatient admission is referred)
- Inpatient delivery and maternity, and related services, including prenatal and complications of pregnancy
- Magnetic Resonance Imaging (MRI)
- One routine post-partum home care visit, if the visit follows an early discharge. Early discharge for a vaginal delivery would be within 48 hours of delivery and, for C-section, within 96 hours of delivery
- Oral and maxillofacial surgeons
- Orthodontists
- Outpatient observation room
- Periodontists
- Prescription drug (pharmacy)
- Prosthodontists
- Services for the diagnosis of infertility
- Testing and treatment of a sexually transmitted disease
- Testing for AIDS or other HIV-related conditions
- Voluntary planning of the conception and bearing of children

PCCs or care systems can contact Blue Plus to implement a PCC or care system-specific referral bypass for their managed care Subscribers. This is beneficial when PCC continually refers to a specific provider

## Medical Emergency Claims

Minnesota law has given Subscribers the benefit of seeking emergency medical care in instances when a reasonable layperson would believe that the circumstances require immediate medical care that could not wait until the next working day or the next available clinic appointment. Emergency medical care does not require referral authorization by the PCC.

### Non-Emergency Out-of-Area Service

A non-emergency out-of-area service is defined as a service performed more than 25 miles from the Subscriber's home and from the PCC that is not considered a medical emergency. Although PCC is responsible for coordinating the Subscriber's care, it is not reasonable to require PCC to do so, if the Subscriber is not within the area. PCC is not required to authorize a referral in this situation.

If PCC chooses to authorize a referral, the claim will process at the highest level of benefits. Otherwise, the claim will process according to the Subscriber's Contract. Under the MN Statute, emergency services must be paid whether the Health Services were provided within or outside the service area. This text may require revision to assure compliance with Minnesota Statutes. (Provided copy of statute 62Q-55-Emergency Services). Please advise the Subscriber to call the number on the back of their member ID card if they have questions regarding coverage. If there is a disagreement with the resolution of a claim, the PCC, provider of Health Service or Subscriber can request that the claim be reviewed.

Chapter 5

# Quality Improvement

## Table of Contents

# Introduction to Quality Improvement

## General Overview

This chapter contains detailed information about the Blue Plus Quality Improvement (QI) program and Provider/Practitioner requirements. Some requirements for Behavioral Health Providers/Practitioners are different than this section. Requirements that are different or more stringent for Behavioral Health Providers are detailed in the Quality Improvement for Behavioral Health Providers/Practitioners section. The material also explains what is expected from participating Providers/Practitioners regarding their quality programs and defines Provider/Practitioner requirements including medical record keeping practices.

The QI program helps to ensure access to healthcare services using established quality improvement principles. Blue Plus utilizes the Quality Improvement program to:

- Identify gaps of care or accessibility.
- Develop clinical guidelines and service standards where clinical performance is measured.
- Monitor and assess the quality and appropriateness of services given to our Members.
- Review medical qualifications of participating health care professionals.
- Enhance patient safety and confidentiality of Members.
- Resolve any identified quality issues.

## Basic Elements of a QI Program

**Rationale:**

Blue Plus subscribes to the philosophy of Quality Improvement (QI) and the multifaceted benefits it offers. All Providers associated with our Blue Plus networks must include quality improvement activities in their facilities. Striving to meet or exceed customer expectations should be a driver for a successful program. A well-established program enables Provider to discover root causes, use data to increase production and maximize available resources. A successful program has three basic elements: it must be customer-focused, data-driven and process-oriented.

Blue Plus supports the six aims for improvement identified in the Institute of Medicine's *Crossing the Quality Chasm.* These six aims are that care should be safe, effective, patient-centered, timely, efficient and equitable. All Blue Plus Providers are expected to incorporate these aims into their quality improvement programs.

Several models are available to guide and direct QI project efforts. Examples of these models include the Plan, Do, Check, Act (PDCA) Cycle, Six Sigma, Lean Thinking and the Seven-Step Process.

**Requirements:**

- Regular, documented discussion of quality issues at Practitioner/Provider staff meetings (or QI committee) at least twice a year (if Blue Plus enrollment is 2,000 or more in the first quarter)
- Provide annual QI program report upon request by Blue Plus

## Leadership

**Rationale:**

Leadership within an organization must support and embrace the philosophy of quality improvement for it to succeed. Advising, supporting and actively participating in the development and implementation of process improvement are vital functions of leadership.

Improving processes within an organization promotes better care and services to customers, creating a marketplace advantage.

**Requirement:**

- Designated QI Medical Director, who is a practicing physician and is either an MD or DO

## Quality Improvement Projects

**Rationale:**

Addressing problems or opportunities within a Provider's location of practice using the QI process offers distinct advantages. Quality improvement projects employ systematic analysis of current practices to reveal refined approaches to everyday operations. Using a defined model means that changes can be tested and adopted effectively.

Requirements and changes regarding QI reporting are distributed annually in the first quarter to all main site primary care providers.

Suggested project categories may include clinical guideline implementation or improvement, administrative or process-oriented improvements, or improvements based on customer feedback.

Often clinics choose to do one project that is clinical and one that is service-related. Blue Plus encourages Providers to conduct a survey or focus group of customers as you develop system changes. Projects may focus on primary care, the continuity of care within a system (from specialty care or hospital care back to primary care) or on specialty care.

Blue Plus does not routinely collect project information from Providers however, requirements remain the same. The requirements listed below should be followed if the Provider's location of practice chooses to implement improvement activities.

**Requirements:**

- Provide QI program description, contact information or project reports upon request.
- Clinical projects must be based on approved and established guidelines [i.e., Institute for Clinical Systems Improvement (ICSI)].
- Projects have completed a full PDCA Cycle or Seven-Step Process. Refer to the PDCA or Seven-Step Process information.

### Cooperation with Blue Plus QI Program

**Rationale:**

Collaborative efforts need to mutually service Blue Plus Members with excellent care and services.

**Requirements**:

- Quick access to medical records when requested.
- Consultation and cooperation to resolve individual Member complaints.
- Timely responses to queries during quality of care investigations.
- Participation in quality audits, including site visits and medical record standard reviews and Healthcare effectiveness data and information sharing Set (HEDIS) record review.
- Participate in other Blue Plus QI work, this may require additional information from Providers or participation in survey's.
- Collaborate on corrective action plan when Blue Plus quality thresholds are not met.

### Telephone Service Requirement: During Office Hours

**Rationale**:

Members need telephone access to medical care with a response time based on the urgency of their symptoms.

**Requirements:**

During office hours, Members calling a Practitioner/Provider will be assessed according to Member's care needs by a physician or designee. Response times are applicable to all members regardless of product type or plan:

- Immediately for emergencies, 100% of the time
- Within 30 minutes for urgent issues, 85% of the time
- Within 4 hours for all other call types, 85% of the time

### Telephone Service Requirements: Incoming Calls

**Rationale**:

A timely response to incoming phone calls promotes Member satisfaction.

**Requirements**:

- Calls answered in six rings or fewer
- On hold two minutes or less

## Telephone Service Requirements: After Hours

**Rationale**:

Members must have access to instructions for obtaining care 24 hours a day, 7 days a week, and 365 days a year. When Members call Practitioner/Provider's location of practice outside of routine business hours, it is important that they are able to receive directions on how to obtain care and get answers to their questions.

**Requirements:**

To achieve this, Practitioner/Providers must have a telephone number that is answered 24 hours a day by either a live person, or an answering system that will provide patients information as outlined below.

- The name of the clinic that the patient is calling is clearly stated.
- Specific instructions on what the Member should do if they feel their situation is a medical emergency. This is often stated, "If you feel this is a medical emergency please hang up and dial 911."
- Information regarding who the Member should call if it is not a medical emergency, but feel they need medical advice. Be certain to include the name, area code and telephone number of the individual or clinic to whom they are being directed.
- If the Member is directed to leave a message, Practitioner/Providers have standards for maximum allowable call-back times based on what is medically appropriate to each situation. Blue Cross recommends that Practitioner/Providers call their patients back within two hours. Time frame must be provided to the patient awaiting the return call.
- All instructions should be articulated slowly and clearly in terms understandable to non-health care professionals.

**Additional tips:**

- If an electronic answering system is being used to create a message, minimize excess background noise and make sure the recording volume is set to an appropriate level.
- If the Member is being asked to call another location, that location must also have a detailed message or someone answering the phone to provide the Member instructions on obtaining medical care or advice.
- Blue Plus recommends that Providers audit their messages used outside of normal business hours, according to these guidelines, to make certain they are in compliance with the requirements.

## Complaint Review System

**Rationale**:

Member complaints and grievances reflect their perceptions and expectations. Feedback, whether solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve the quality of care or service. Practitioner/Providers and Blue Plus share a joint commitment to Member satisfaction and to the improvement of care and services delivered to Blue Plus Members.

**Requirements**:

All Practitioner/Providers will have a policy and procedure in place detailing the following:

- Process to receive written and verbal complaints for Blue Plus Members
- Designate an individual to be the primary contact for complaint management, including the tracking of such complaints
- Document the substance of the complaint, the investigation and any actions taken
- Primary Care Clinics (PCC) should submit an aggregate quarterly written report to Blue Plus within 30 days after the end of each calendar quarter that includes all complaints, oral and written, received by the clinic. Complaints should be submitted in a report format via the secured e-mail account, Quality.of.Care.Mailbox@bluecrossmn.com
- Submit a quarterly report even if the PCC does not receive any complaints for the quarter
- Notify Members of the right to complain and appeal to their health plan
- Track complaints by categories and report at least annually to an in-house committee

Complaint Review System (continued)

**Clarification of terminology:**

- **Inquiry** — A formal request for information or education from the patient (e.g., about billing, about a lab test).
- **Complaint** — An oral or written expression of dissatisfaction. All PCCs must receive, investigate and respond to complaints from Blue Plus Members who receive health services at their clinic.
- **Appeal** — A request to change a decision that has already been made. Blue Plus has the sole accountability to handle appeals. Direct any Blue Plus Member who requests an appeal to call Blue Plus customer service for assistance. The phone number is on the back of the Member ID card.
- **Grievance** — A term commonly used to describe a request for the clinic to change a decision. A grievance would be considered an appeal by the Member and should be referred to Blue Plus.

Complaint Review System, Quarterly Reporting

**Rationale:**

All complaints, written and verbal, from Blue Plus Members regarding access, communication/behavior, coordination of care, technical competence/appropriateness, and facility/environment concerns affecting patient safety and/or comfort will be collected quarterly from primary care providers.

**Requirements:**

- Providers must submit quarterly reports to Blue Plus in January, April, July and October for the preceding three-month time period**.**
- Reports need to be received within 30 days after the end of each quarter**.**
- If there are zero complaints for a specific quarter**,** a report still needs to be submitted**.**

**Definitions of categories for reporting:**

- **Access** — Referrals, service timelines, appointment scheduling, wait times, access to medical information, availability of handicap services, geographic options and availability of culturally diverse Providers**.**
- **Communication/Behavior** — Rude, inappropriate, uncooperative, rushed, did not listen, abuse/neglect, lack of communication, lack of compassion, delay in communicating test results, Provider acts in culturally insensitive manner**.**

### Complaint Review System, Quarterly Reporting (continued)

- **Coordination of Care** — Failure to follow up, information not provided/available at time of care, Providers not communicating with each other, lack of coordination/integration of care.
- **Technical Competence/Appropriateness** — Failure to diagnose, inappropriate treatment, incorrect diagnosis, wrong test ordered or performed, procedural error, performing procedure/services outside scope of practice/expertise, failure to refer.
- **Facilities/Environment** — Facility does not physically accommodate patient needs, temperature of room, uneven sidewalks, environment not comfortable, equipment malfunction, infection control, cleanliness.

### Quality of Care Complaints

A quality of care complaints is an additional right of Blue Plus Members. Members may complain if they feel the quality of their care has been compromised. Examples of when Members may file a complaint are:

- They are not receiving an appointment in a reasonable amount of time.
- The PCC is not referring them to a specialist when it is necessary.
- The Practitioner/Provider office was rude or discourteous.
- The Practitioner is unable to diagnose or treat their condition.
- There is a delay in communicating test results.
- Confidentiality or privacy concern.
- Incorrect test ordered or performed.
- Infection control.
- Equipment malfunction, cleanliness.

Blue Plus may supply the Practitioner/Provider with a copy of the Member's complaint and involves the Practitioner/Provider in the solution. Blue Plus is required by Minnesota Statute to acknowledge these complaints within 10 calendar days of receipt; therefore, Blue Plus requires the Practitioner/Provider's expedited attention to any request Blue Plus may have.

## Access and Availability

**Rationale:**

Members' concept of the quality of care they receive often begins when they make an appointment. Blue Plus also wants to ensure that Members are able to schedule appointments within a timely manner, relative to the services they seek.

**Requirements:**

**Wait Times (Primary Care):**

- **Preventive Care** – within 30 days 85% of the time for well child exam, annual physical exam, etc.
- **Routine Primary Care** – within 7 days 85% of the time for non-urgent symptomatic conditions**.**
- **Urgent Care** – Same day 85% of the time for medically necessary care which does not meet the definition of emergency care**.**
- **Emergency Care** – Immediate 100% of the time for immediately life-threatening illnesses, injuries and conditions**.**
- **After-Hours Care –** Practitioner/Provider instruction should be available 100% of the time. If the Practitioner/Provider requires a Member to leave a message, a return call should be made within 2 hours.

**Wait Times (Specialty Care):**

- **Routine Care (established patients) –** within 30 days 85% of time
- **Routine Care (new patients) –** within 30 days 75% of the time

**Member Satisfaction (surveys):**

- **Primary Routine Care:** 83% of Members will usually or always be satisfied with when they get a routine care appointment (routine care is when the Member does not need to see a practitioner right away)
- **Primary Urgent Care:** 89% of Members will usually or always be satisfied with when they get an urgent care appointment (urgent care is when the Member needs to see a practitioner right away, for an illness, injury or condition)
- **Specialty Care:** 84% of Members will usually or always be satisfied with when they get a specialty care appointment

### Mechanism for Customer Feedback

**Rationale:**

Member feedback is an excellent resource that provides innovative and practical ideas for improving care or service. Analyzing feedback for the purpose of improving processes provides opportunities essential to maintaining customer loyalty.

Member feedback is collected in a variety of ways. Surveys provide needed information about particular areas, comment cards capture a patient's thoughts at the time of a visit, focus groups facilitate discussion and external surveys provide comparative statistics.

**Requirements:**

- Collection and analysis of customer feedback
- Action on collected feedback through the use of a multi-disciplinary team where appropriate to initiate system change

Blue Plus conducts a Consume Assessment of Health Plans (CAHPS) survey to assess Member satisfaction. The CAHPS survey assesses many but not all aspects of a Members satisfaction with his/her practitioner(s) and health plan.

### Physical Location of Practice

**Rationale:**

Blue Plus requires its Primary Care Clinics to provide a safe environment, which protects patient privacy and ensures handicap accessibility for disabled patients. Blue Plus will monitor and review primary care clinics' physical environment to evaluate conformity with regulatory, plan and accreditation standards.

**Requirements:**

Specific requirements exist for each of the following areas. For more detailed information for when site visits are required and for what specifically is reviewed, please refer to the Blue Cross Blue Shield Blue Plus of Minnesota (Blue Cross) Credentialing and Recredentialing Provider Policy Manual.

## Written Policies

**Rationale:**

To protect the safety and privacy of all Members, and for the protection of the Provider, Blue Plus requires all Providers to develop and implement written policies and procedures applicable to the services they provide. Providers are encouraged to have policies that are location of practice specific, signed, dated and reviewed annually.

**Requirement:**

Provider will have policies and procedures in place for the following topics that apply to the services provided in the location of practice.

| Policy Required | Recommended Risk Management Elements |
|---|---|
| Advance Directives | • Information made available<br>• Discussion is documented in medical record and updated annually<br>• Copies retained<br>• Hospitals notified upon admission |
| Child and Teen Check-Ups | • Eligibility defined (birth though age 20, MA, PMAP, MNCare children)<br>• Forms for documentation addressed<br>• Age-appropriate services defined<br>• Documentation in medical record<br>• Correct coding |
| Communicable Disease Reporting | • Requirement to report communicable diseases by State Health Department<br>• Reporting timeframe (within one day)<br>• Responsibility of reporting defined<br>• Forms, completion and submittal addressed |
| Complaint Management | See Complaint Review System section. |

Written Policies (continued)

| Policy Required | Recommended Risk Management Elements |
|---|---|
| Confidentiality | • Training, including how soon initial training occurs, when or how often refresher training occurs, verified by signatures of trainer and individual being trained, and on file for six years<br>• Accountability, including how control is maintained (i.e., who has keys, who is allowed into the location of practice and when)<br>• Protected health information (PHI) disposal<br>• Security of both paper and electronic PHI that follows HIPAA guidelines<br>• Reviewed annually |
| Confidentiality and Security of Medical Records | See Medical Records section. |
| Foreign Language Translation and Hearing-Impaired Services | • Assistance provided for both situations<br>• Interpreter available for phone calls and face-to-face interactions<br>• Members/family are notified that interpreter is provided<br>• Resources are identified |

Written Policies (continued)

| Policy Required | Recommended Risk Management Elements |
|---|---|
| Hazardous Materials and Waste Management | • Written plan in place and maintained<br>• Hazardous material and waste defined<br>• Mechanism in place for responding to a spill<br>• MSDS (material safety data sheets) available<br>• Hazardous materials and waste are identified and inventoried<br>• Mechanism defined for responding to a spill/breach of containment<br>• Chemical and regulated medical waste addressed<br>• Hazardous gas and vapors addressed<br>• Orientation and education of staff outlined |
| Infection Control | • Basic overview of infection control and how it relates to controlling disease<br>• Hand washing outlined, when and how<br>• Universal precautions addressed, including glove use<br>• Personal protection equipment addressed<br>• Screening employees for TB<br>• Vaccinating employees for Hepatitis B<br>• Steps taken when employee is exposed to breach of infection control or exposure, how to report to the U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) |
| Medical Emergency | • Mechanism in place for responding<br>• Medical emergency code is identified<br>• Identify who directs activities<br>• Identify who determines if 911 is called |

Written Policies (continued)

| Policy Required | Recommended Risk Management Elements |
|---|---|
| Medication Management | • Mechanism in place for procuring, storing, controlling and distributing medications<br>• Narcotics addressed, even if to say they are not kept at the location of practice<br>• Recalls addressed<br>• Emergency and sample drugs addressed<br>• Sign-out log covered<br>• Prescription pad accessibility addressed |
| Non-Medical Emergency Policy | • Mechanism in place for responding<br>• Include power outages, weather emergencies, bomb threats, and both fire and fire drills |
| Treating Unaccompanied Minors Policy | • Minor defined, exceptions covered<br>• Scheduling appointments addressed<br>• Mechanism in place to respond when an unaccompanied minor calls/arrives asking to be seen<br>• Sample of authorization to consent to treatment of a minor is provided (see appendix) |

## Continuity and Coordination of Care

**Rationale:**

Member continuity and coordination of care (COC) across settings, such as inpatient and ambulatory care and transition from specialty to primary care, is critical in ensuring the best care for Blue Plus's Members. All Practitioner/Providers share a joint responsibility to ensure continuity and coordination of care.

**Requirement for Health Records:**

- Establish a consistent location(s) for external communications from facilities and/or consultants including but not limited to discharge summaries or notes, consult letters, progress notes, and test or lab results.
- Communication is maintained in a chronological order.

**Requirements for Referrals:**

- Communicate with specialists/consultants the rationale for the referral (is the patient being referred for a consultation or ongoing care) and set expectations for future communications.
- Information, radiology, lab/test results, etc. are made available to the specialist/consultant in time for the patient's visit.

**Requirements for Specialty Care and Consultants:**

- Provide written communication to the patients' primary care provider including, but not limited to progress notes, consultation letters, and test or lab results.

**Requirements for Inpatient:**

- The attending physician copies all discharge summaries and discharge notes to the primary care provider.

**Requirements for Emergency and Urgent Care:**

- Correspondence regarding all emergency room and urgent care visits are copied to the primary care provider.

## Patient Safety

Blue Plus is committed to establishing high standards of care for its Members. To assure these high standards, Blue Plus excepts all participating Practitioners/Providers to be familiar with and actively involved in patient safety practices. Blue Plus supports the work of the Leapfrog Group, a national coalition of major employer groups, which has established patient safety standards.

Blue Plus also supports national health improvement initiatives, such as the Institute for Healthcare Improvement's Triple Aim – applying integrated approaches to simultaneously improve care, improve population health and reduce costs per capita.

Blue Plus also works to ensure patient safety by monitoring and addressing quality-of-care issues identified through pharmacy utilization data, continuity and coordination of care standards, disease management program follow-up, and Member complaints.

**Resources:**

Resources are available to Provider for information and to assist in the continuation of safe practices.

The following websites have patient safety programs and materials that Provider may find useful:

- Agency for Healthcare Research and Quality (Dept of HHS)
  - https://www.ahrq.gov/
- Institute for Healthcare Improvement
  - www.ihi.org
- The Joint Commission International Center for Patient Safety
  - www.jcipatientsafety.org
- Leapfrog Group for Patient Safety
  - www.leapfroggroup.org
- Minnesota Alliance for Patient Safety
  - www.maps.org
- National Quality Forum
  - www.qualityforum.org

## Provider Site Visits

Blue Plus requires Providers to participate in on-site evaluations if:

- The Provider is unaccredited by a Blue Plus approved accrediting agency.
- Triggered by a Member complaint that can only be resolved by an on-site visit.

The site visit may include evaluation of medical record keeping practices, physical environment & access, QI improvement activities, and medical policies. For more detailed information for when site visits are required and for what specifically is reviewed, please refer to the Blue Cross Blue Shield Blue Plus of Minnesota (Blue Cross) Credentialing and Recredentialing Provider Policy Manual.

## Medical Record Keeping Practices

**Rationale:**

Blue Plus requires its Practitioners/Providers to have a policy and procedure for confidentiality of health information and medical records that meets state and federal requirements.

Blue Plus will review Primary Care Clinics' medical record keeping practices, including areas affecting confidentiality, at the initial site visit and during triggered recredentialing site visits, or during routine audits.

Blue Plus expects strict adherence to state and federal laws with regards to maintaining Members' medical information and records in a confidential manner. Blue Plus requires medical records to be maintained in a manner that is current, detailed and organized. Practitioner/Providers must have a tracking process in place for ease of retrieval.

**Requirements:**

All Practitioner/Providers will have a policy and procedure in place to address the following:

- A written policy and procedure of medical record-keeping practices, which includes the confidentiality and security of medical records and release of information, is available**.**
- Medical records are kept in a secure or electronically secure location**.**
- Review of the confidentiality policy and procedure is performed at least annually with staff**.**
- A tracking system for medical records is in place**.**
- The medical record forms are available for release**.**

## Medical Record Documentation

**Rationale:**

The patient medical record is a vehicle for documenting services provided and evaluating continuity and coordination of care. It also serves as legal protection for the patient and practitioner. Blue Plus, per contractual agreement with both the Member and Provider, has access to the Member's medical record for examination and evaluation. Blue Plus' corporate confidentiality policy requires that the personal and health information of its Members be maintained as confidential information. All employees are required to attest to their knowledge of this policy and their intent to comply with it.

Medical record review is an essential component of a comprehensive Quality Improvement program. The Blue Plus Quality Management Committee, which includes practicing physicians, establishes minimum patient medical record documentation standards.

Blue Plus periodically audits a random sample of patient records from the Blue Plus population for compliance with required documentation elements. If potential deficiencies are identified at a given site, a more intensive review may occur. Results of the audit are shared aggregately through the Provider Press and may be shared with individual Providers for improvement opportunities.

**Requirements:**

All Practitioner/Providers will have a policy and procedure in place to address the following:

**Format**

- The content and format of the medical record is organized and includes patient's address and home and work phone numbers**.**
- Each page in the medical record contains the patient's name or identification number**.**
- All entries in the medical records contain the author's identification. Author identification may be a handwritten signature, a unique electronic identifier or a stamped signature verified with initials**.**
- Medical records are legible to someone unfamiliar with the author's handwriting**.**
- All encounters/entries are dated**.**

Medical Record Documentation (continued)

- Immunization status information for all ages is recorded on a single page location.
- A summary of preventive services screening is documented in a consistent place.

**Content**

- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Significant illnesses and medical conditions are indicated on a problem list.
- Past medical history (for patients seen three or more times) is easily identified and includes, as appropriate, significant family history, serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
- For patients 10 years and older, there is an appropriate notation concerning the use of tobacco, alcohol and other substances.
- The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints and includes medications.
- A notation as to the presence of an advance directive is prominently noted in the record.

**Assessment and Plan**

- Laboratory and other studies are ordered, as appropriate.
- Assessment of each encounter reflects patient's chief complaint.
- Treatment plans are consistent with diagnoses.

Medical Record Documentation (continued)

**Follow-up**

- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return is noted in weeks, months or as needed.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- If a consultation is requested, there is a note concerning this visit in the record.
- Consultation, lab and imaging reports filed in the chart are reviewed by the primary care physician.
- Clinically significant abnormal consultation results, lab or imaging study results have an explicit notation in the follow-up plans.

Clinical Practice Guidelines

Blue Plus believes that the use of clinical practice guidelines is a key component of Quality Improvement. See the Provider Policy and Blue Cross Procedure Manual for information on recommended guidelines.

# Quality Improvement for Behavioral Health Practitioner/Providers

## General Overview

This section contains detailed information about the Blue Plus Quality Improvement (QI) program that is specific to Behavioral Health Providers. The information in this section is in addition to or more specific than the requirements in the greater chapter. The material explains what is expected from participating Practitioner/Providers regarding their **quality** programs and defines Practitioner/Provider requirements.

## Cooperation with Blue Plus QI Program

**Rationale:**

Collaborative efforts need to mutually serve Blue Plus Members and Practitioner/Provider's patients with excellent care and services.

**Requirements:**

**Actively participate in the following Blue Plus QI activities.**

*Standardized substance abuse screenings in mental health assessment.*

- Routinely incorporate a standardized substance abuse screening questionnaire, e.g. CAGEAID, AUDIT, during assessment of new patients age 12 and older.
- Recommend or complete diagnostic assessment for a substance use disorder based on positive screening results and corroborating clinical information.

*Exchange of information with primary care physicians*

- Routinely ask new patients to authorize communication with their physician and document authorization or refusal.
- When authorized, document communication with the physician, e.g. report, letter, telephone or email. Communication should include diagnosis, general treatment plan, and if treated by a psychiatric practitioner, initial medication management information.

*Standardized treatment response monitoring for depression*

- Routinely administer the Patient Health Questionnaire-9 for adults with Major Depressive or Dysthymic Disorder to monitor treatment response.

## Access and Availability

**Rationale:**

Members' perceptions of the quality of care they receive often begin when they schedule an appointment. Blue Plus wants to ensure that Members can schedule appointments in a timely manner, commensurate with the level of care they need.

**Requirements:**

- **Routine initial appointments:** 90% of Member requests within 10 business days. Routine care is defined as a circumstance in which the individual does not present either emergent or urgent conditions and requests clinical services.
- **Follow-up appointment:** 90% of Member requests within 10 days business days of initial appointment.
- **Urgent appointment:** 100% of Member requests within 24 hours. Urgent care is defined as a circumstance in which the individual presents no emergency or immediate danger to self or others; however, the individual, clinician, or concerned party believes that the individual's level of distress and/or functioning warrants assessment as soon as possible. An urgent condition is a situation that has the potential to become an emergency in the absence of prompt treatment.
- **Non-life-threatening emergency appointment:** 100% of Member requests within 6 hours or refers the Member to the emergency room. A non-life-threatening emergency is defined as a circumstance in which the individual is experiencing a severe disturbance in mood, behavior, thought or judgment. There may be evidence of uncontrolled behavior and/or deterioration in ability to function independently that could potentially require intense observation, restraint, or isolation.
- **Emergency care:** 100% of Member requests immediately. An emergency is defined as a circumstance in which there is imminent risk of danger to the physical integrity of the individual; the individual cannot be maintained safely in his or her typical daily environment.

**Member Satisfaction (surveys) –**

- **Routine Care:** 87% of Members will usually or always be satisfied with when they get a routine care appointment (routine care is when the Member does not need to see a practitioner right away).
- **Urgent Care:** 67% of Members will usually or always be satisfied with when they get an urgent care appointment (urgent care is when the Member needs to see a practitioner right away, for an illness, injury or condition).

## Physical Location of Practice

**Rationale**:

Blue Cross requires Behavioral Health Providers to provide a safe environment, which protects patient privacy and ensures handicap accessibility for disabled patients. Blue Cross will monitor and review physical environment to evaluate conformity with regulatory, plan, and accreditation standards.

**Requirements**:

- Practitioner/Provider is open reasonable working hours
- Practitioner/Provider 24 hour/7day on-call coverage
- Accessibility for handicapped Members as defined by the *Americans with Disabilities Act, 1990*
- Controlled substances are secure in a locked cabinet or space and dispensation is logged
- A system is in place to ensure that all medications are within the expiration date

## Written Policies

**Rationale:**

To protect the safety and privacy of all Members, and for the protection of the Practitioner/Provider, Blue Cross requires all Behavioral Health Provider to develop and implement written policies and procedures. Practitioner/Providers are encouraged to have policies that are specific to the location of practice and are signed, dated and reviewed annually.

**Requirement**:

Each location of practice will have policies and procedures in place for the following topics in addition to policies listed previously in this chapter.

| Policy Required | Recommended Risk Management Elements |
|---|---|
| Behavioral Health Accessibility Standards | • Access to Behavioral Health appointments commensurate with clinical need<br>• Access to follow-up appointments commensurate with clinical need<br>• Crisis access to clinician 24 hours a day/7 day a week |

## Treatment Record Documentation

**Rationale:**

The patient Behavioral Health treatment record is a vehicle for documenting services and evaluating continuity and coordination of care. It also serves as legal protection for the patient and practitioner. Blue Plus, per contractual agreement with both the Member and Provider, has access to the Member's record for examination and evaluation. Blue Plus's corporate confidentiality policy requires that the personal and health information of its Members be maintained as confidential information. All employees are required to attest to their knowledge of this policy and their intent to comply with it.

Treatment record review is an essential component of a comprehensive Quality Improvement program. The Blue Plus Quality Management Committee establishes minimum record documentation standards.

Annually, Blue Plus audits a random sample of patient records from the Blue Plus population. The records are reviewed in accordance with the required documentation elements. If potential deficiencies are identified at a given site, a more intensive review may occur.

Treatment Record Documentation (continued)

**Requirements for Treatment Record Format and Content**

**Record organization**

- The format of the treatment record must be logical and organized.
- All forms used in the treatment process must be standardized and consistent for all records.
- The treatment record must contain the patient's current address, employer or school, home and work phone numbers, marital or legal status, appropriate consent forms and guardianship status information.
- **Special status situations, such as imminent risk of harm, suicidal or homicidal ideation, or elopement potential, must be prominently documented and updated.**
- There must be a signed patient authorization for all external persons with whom treatment information is exchanged. No treatment information can be exchanged without patient authorization or court order.
- Each page in the record must contain the patient's name or identifying number.
- All entries must be legible to someone unfamiliar with the author's handwriting.
- All entries must be dated and contain the author's name, professional degree/designation and relevant identification number, if applicable. If a non-degreed professional completes the entry, the title of the author must accompany the signature, e.g. Therapy Aid. Author identification may be a handwritten signature or unique electronic identifier. Initials alone are not an acceptable form of identification. Initials may be used in conjunction with a typed signature block that clearly identifies the author.
- Errors in documentation must be corrected with a single line drawn through the error with the author's initials.

Treatment Record Documentation (continued)

**Initial Assessment**

- Presenting problem(s), as well as relevant psychological or social conditions affecting the patient's medical or psychiatric status, must be documented.
- Presenting symptoms that are consistent with DSM-5 criteria must be clearly identified and documented, including the onset, duration and intensity of symptoms as well as functional impairment.
- A psychiatric history must be documented. The psychiatric history should include, if applicable, previous treatment dates, identification of former treating practitioner(s), therapeutic interventions and responses, relevant family psychiatric history, lab test results and consultation reports.
- A medical history which includes current and/or past major or chronic medical conditions and a current list of medications must be documented. Medication allergies and adverse reactions must be prominently noted. If the patient has no known allergies or history of adverse reactions, this must be noted.
- For children and adolescents age 17, a comprehensive developmental history that includes prenatal and perinatal events, achievement of developmental milestones, and psychological, social, intellectual and academic history must be documented.
- For individuals age 10 and older, a substance use history must be documented. The history must include past and present use (frequency and quantity) of tobacco, alcohol, illicit drugs, and misuse of prescription or over-the-counter drugs. Additionally, negative consequences of use and history of assessment and/or treatment should be documented.
- Standardized substance abuse screening questionnaire results should be incorporated in the assessment of all new patients age 12 and older.
- A social history that includes family history, current family status, history of physical, sexual, or mental abuse or trauma, current social network, and academic or vocational status must be documented.
- A mental status examination which includes, at minimum, information about appearance, speech, affect, mood, thought content, judgment, insight, attention, concentration, memory, intelligence level and impulse control must be documented.

Treatment Record Documentation (continued)

- **A risk assessment that identifies level of risk for harm, including suicidal, homicidal or elopement risk, must be predominantly documented.**
- Patient strengths and weaknesses that enable or inhibit the individual's ability to achieve treatment goals must be documented.
- An initial treatment plan must be documented.
- All Behavioral Health Practitioners must attempt consultation and coordination of treatment with the patient's primary care or treating physician. Patient authorization must be obtained prior to the release of information. If the patient does not wish to have treatment information exchanged, patient refusal must be documented.

**Diagnosis**

- A DSM-5 diagnosis must be documented. The diagnosis must be consistent with presenting problems, symptoms, clinical history, mental status exam, and other clinical data.
- All five axes must be documented according to the DSM-IV-TR multi-axial diagnostic system. The fifth digit of Axes I and II diagnoses must be listed when applicable.
- ICD-9-CM or ICD-10-CM codes must be used when submitting claims for payment.

**Treatment Plan**

- The treatment plan must be comprehensive, current and consistent with the diagnosis. The formal treatment plan must be completed within the first three visits.
- The treatment plan must contain clear, objective and measurable goals as well as the estimated timeframes for goal attainment or problem resolution. Interventions must be appropriate for the diagnosis and/or presenting problem(s).
- The patient must participate in the development of the treatment plan and should sign the initial plan and sign or initial all updates or revisions.

Treatment Record Documentation (continued)

**Progress Notes**

- All entries must contain the date, actual face-to-face contact time and current diagnosis.
- All entries must document the persons present during the visit without using the names of persons other than the identified patient.
- The interventions must be consistent with the diagnosis and correspond with current treatment goals.
- Recommendations or referrals for preventive or other external services, e.g. stress management, relapse prevention or community services, must be documented.
- The documentation of each entry must clearly state the chief complaint and current status of symptoms as well as patient strengths and limitations in reaching treatment goals.
- There must be a notation in each entry about need for follow-up care, plans for a return visit, or termination of treatment. The specific date or timeframe of a return visit must be noted.
- There must be documentation of patient cancellation or failure to show for a visit.
- Evidence of coordination of care with other relevant Behavioral Health Providers and/or medical professionals must be documented.
- Unresolved problems from previous visits must be addressed and the outcomes documented.
- **If safety or risk characteristics are identified, they must be prominently documented and addressed during each visit.**
- Phone conversations with persons relevant to treatment, e.g., referral sources, physicians or parents, must be documented.

**Medication Management**

- Significant illnesses, clinical risks and medical conditions are to be clearly noted and revised periodically.
- Current medications prescribed by all prescribing physicians must be listed. Dosages and dates of initial prescription and/or refills must be documented.
- Evidence of informed patient consent for the receipt of medication must be documented.
- Laboratory orders and results must be documented as well as review of the results by the ordering physician. If abnormalities are found, follow-up plans must be documented.

# Provider Specific Health Care Data

## Release of Provider Data

Blue Plus is permitted to release Provider-specific health care data for the purpose of allowing Members, Plan Sponsors and others to compare the cost and/or quality of care offered by the Provider. Provider-specific health care data may include, but shall not be limited to, the following: Provider demographic information, utilization information, quality of care measures and initiatives, Health Service volumes, small area analysis, credentialing information, outcome measures, patient satisfaction results, costs and similar data.

Provider agrees to provide or assist in the provision of such provider-specific data. Upon written request of the Provider, Blue Plus shall make available to the Provider a description of how Blue Plus intends to use Provider-specific data, the methodology used in collecting and analyzing the data and a copy of the Provider's data which Blue Plus intends to disclose. To the extent Provider can reasonably demonstrate, in writing, that any data that Blue Plus intends to disclose is inherently inaccurate, Provider shall notify Blue Plus of its specific concerns.

Blue Plus shall make a good faith effort to resolve Provider's concerns, provided, however, that Blue Plus shall have the sole and final discretion, responsibility and authority over the content, dissemination and release of such data.