# Summary of Changes (2020)

## Chapter 1 – Introduction to Blue Plus

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<tr>
<td>1/17</td>
<td></td>
<td>Updated Care Coordination Guidelines for Nursing Home and Community</td>
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<tr>
<td>1/23</td>
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<td>Care Coordination for Nursing contact update</td>
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<td>Nursing Home Care Coordination Guidelines</td>
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</tbody>
</table>
# 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 ________________

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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 please refer below. Changes to this process may periodically occur. Reference the Blue Cross Provider Policy and Procedure Manual at:

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.
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.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definitions and Clarifications</th>
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<tbody>
<tr>
<td>Referrals</td>
<td>• 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.</td>
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<tr>
<td></td>
<td>• 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.</td>
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<tr>
<td></td>
<td>• 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.</td>
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<tr>
<td></td>
<td>• Subscribers may think that a Health Service is referred if they are told the service is Medically Necessary. Be clear when referring services.</td>
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<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>Term</td>
<td>Definitions and Clarifications</td>
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<tr>
<td>Referrals (continued)</td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• A verbal referral will not get the claim paid correctly. If PCC has authorized a referral, please make sure to notify Blue Plus (unless there is a referral bypass in place).</td>
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<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>Preauthorization (PA) or Pre-certification</td>
<td>• 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.</td>
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<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>Term</td>
<td>Definitions and Clarifications</td>
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<tr>
<td>Preadmission Notification (PAN)</td>
<td>• 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.</td>
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</table>
**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

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 www.availity.com. 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.

Please have PCC's provider number and, if applicable, the Subscriber's identification number, account number and claim number ready when calling. The provider services telephone numbers listed are for providers’ use only. Please 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

Calls Not Handled By Provider Service

The account listed below is not handled by provider service. Please use the phone number below. In addition, independent social workers who are working as patient advocates should call the customer service phone number on the back of the Subscriber’s ID
Blue Plus Employee Group
- Account # starts with EP136 or AR136
- Member ID card states: Blue Plus Employee Plan

Phone number
(651) 662-8304
Fax: (651) 662-2906

To verify benefits or eligibility for BlueCard Subscribers, call 1-800-676-BLUE (2583).

The general provider services fax number is (651) 662-2745.
### Provider Claim Adjustment/ Status Check/ Appeal Form

The [Minnesota Appeal Request Form](https://www.health.state.mn.us/facilities/auc/index.html) is designed for providers to fax or mail their inquiries and appeals to Blue Cross and Blue Shield of Minnesota.

Fax the form to the number listed on the form, or mail it to the general Blue Cross and Blue Shield of Minnesota address.

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.

Provider will receive written notification if its request is denied. All adjustments that are completed will be found on a future Remittance Advice.

The Minnesota Appeal Request Form can be found on the AUC website at [https://www.health.state.mn.us/facilities/auc/index.html](https://www.health.state.mn.us/facilities/auc/index.html).

### 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.

If calling after regular business hours, call **1-888-878-0139**, press option 1, and then enter the 5-digit extension.
The phone numbers for electronic data interchange are listed below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Electronic Data Interchange (EDI)</td>
<td>Technical Support at Availity [<a href="http://www.availity.com">www.availity.com</a>]</td>
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</table>

The phone and fax numbers and addresses for care management are listed below. Please note, if Provider has provider self-service, PANs should not be mailed or faxed.

<table>
<thead>
<tr>
<th>Area</th>
<th>Phone/ Fax Numbers and Addresses</th>
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<tbody>
<tr>
<td>Case Management</td>
<td>1-866-489-6947</td>
</tr>
<tr>
<td>Disease Management</td>
<td>1-866-489-6947</td>
</tr>
<tr>
<td>Preadmission Notification (PAN)</td>
<td>Provider self-service: [<a href="http://www.availity.com">www.availity.com</a>]</td>
</tr>
<tr>
<td>General inquiries</td>
<td>Phone: (651) 662-5270 1-800-528-0934 or call provider services</td>
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<tr>
<td></td>
<td>Fax: (651) 662-7006</td>
</tr>
<tr>
<td>Behavioral Health Review (Outpatient)</td>
<td>Fax: (651) 662-0854</td>
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<tr>
<td></td>
<td>Mail: Integrated Health Management Behavioral Health, R472 P.O. Box 64265 St. Paul, MN 55164-0265</td>
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<tr>
<td>Behavioral Health Review (Inpatient)</td>
<td>Phone: (651) 662-5270 or 1-800-528-0934</td>
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<tr>
<td></td>
<td>Fax: (651) 662-7006</td>
</tr>
<tr>
<td>Chiropractic Review</td>
<td>Fax: (651) 662-7816</td>
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<tr>
<td></td>
<td>Mail to: Integrated Health Management Allied Team, R472 P.O. Box 64265 St. Paul, MN 55164-0265</td>
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### Area

#### Medical Dental Review

Pre-service requests can be mailed or faxed

Fax: (651) 662-2810

Mail: Integrated Health Management Utilization Management, R472 P.O. Box 64265 St. Paul, MN 55164-0265

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#### Durable Medical Equipment Review

Pre-service requests can be mailed or faxed

Fax: (651) 662-2810

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#### Home Care Review

- Home Health Services
- Home Infusion Services
- Hospice Care
- PCA Services
- County Waivered Services

Pre-service requests can be mailed or faxed

Fax: (651) 662-1004

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

### Commercial & Government Programs

Fax: (651) 662-2810

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**Blue Essentials**

Fax: (651) 662-0622 or 1-855-315-4038

Mail: Integrated Health Management Utilization Management, R472 P.O. Box 64265 St. Paul, MN 55164-0265

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**Commercial & Government Programs**

Fax: (651) 662-1004

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**Blue Essentials**

Fax: (651) 662-0622 or 1-855-315-4038

Mail: Integrated Health Management Allied Team, R472 P.O. Box 64265 St. Paul, MN 55164-0265
## Care Management Numbers and Addresses (continued)

<table>
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<tr>
<th>Area</th>
<th>Phone/ Fax Numbers and Addresses</th>
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<tr>
<td><strong>Inpatient Admission Pre-Certification Review</strong></td>
<td>Commercial &amp; Government Programs</td>
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<tr>
<td></td>
<td>Phone: (651) 662-5270 or 1-800-528-0934</td>
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<tr>
<td></td>
<td>Fax: (651) 662-7006</td>
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<td></td>
<td>Blue Essentials</td>
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<td></td>
<td>Phone: (651) 662-0621 or 1-855-315-4037</td>
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<tr>
<td></td>
<td>Fax: (651) 662-0622 or 1-855-315-4038</td>
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<tr>
<td><strong>Outpatient Therapy Review</strong></td>
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<tr>
<td>(PT, OT, SLP)</td>
<td>Fax: (651) 662-7816</td>
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<td>Mail:</td>
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<td>Integrated Health Management</td>
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<td>Allied Team, R472</td>
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<td>P.O. Box 64265</td>
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<td>St. Paul, MN 55164</td>
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<tr>
<td><strong>Skilled Nursing Facility Admission Review</strong></td>
<td>Commercial</td>
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<td>Fax: (651) 662-1004</td>
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<td></td>
<td>Government Programs</td>
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<tr>
<td></td>
<td>Phone: (651) 662-5540 (Initial review)</td>
</tr>
<tr>
<td></td>
<td>Fax: (651) 662-4022 (Concurrent review)</td>
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<td>PMAP communication form:</td>
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<td></td>
<td>(651) 662-6054</td>
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<td>Blue Essentials</td>
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<td></td>
<td>Phone: (651) 662-0621 or 1-855-315-4037</td>
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<tr>
<td></td>
<td>Fax: (651) 662-0622 or 1-855-315-4038</td>
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### Care Management Numbers and Addresses (continued)

<table>
<thead>
<tr>
<th>Area</th>
<th>Phone/ Fax Numbers and Addresses</th>
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<tbody>
<tr>
<td>Transplant Review</td>
<td><strong>Commercial &amp; Government Programs</strong></td>
</tr>
<tr>
<td>Pre-service requests can be mailed or faxed</td>
<td><strong>Fax:</strong> (651) 662-1624</td>
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<tr>
<td></td>
<td><strong>Blue Essentials</strong></td>
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<tr>
<td></td>
<td><strong>Fax:</strong> (651) 662-0622 or 1-855-315-4038</td>
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<tr>
<td></td>
<td><strong>Mail:</strong> Integrated Health Management</td>
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<tr>
<td></td>
<td>Transplant Team, R472</td>
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<td>P.O. Box 64265</td>
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<td>St. Paul, MN 55164-0265</td>
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<tr>
<td>All Other Medical Procedure Review</td>
<td><strong>Commercial &amp; Government Programs</strong></td>
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<tr>
<td>Pre-service requests can be mailed or faxed</td>
<td><strong>Fax:</strong> (651) 662-2810</td>
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<td></td>
<td><strong>Blue Essentials</strong></td>
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<td></td>
<td><strong>Fax:</strong> (651) 662-0622 or 1-855-315-4038</td>
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<td><strong>Mail:</strong> Integrated Health Management</td>
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<td></td>
<td>Utilization Management, R472</td>
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<td>P.O. Box 64265</td>
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<td>St. Paul, MN 55164-0265</td>
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<tr>
<td>Referrals</td>
<td>Provider self-service:</td>
</tr>
<tr>
<td></td>
<td><strong><a href="http://www.availity.com">www.availity.com</a></strong></td>
</tr>
<tr>
<td></td>
<td><strong>Fax:</strong> (651) 662-6860</td>
</tr>
</tbody>
</table>
Other Numbers and Addresses

These phone and fax numbers and addresses may be helpful.

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Phone/Fax Numbers and Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
</tr>
<tr>
<td>Customer Service</td>
<td>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.</td>
</tr>
<tr>
<td>Fraud Hot Line</td>
<td>(651) 662-8363 or 1-800-382-2000 ext. 28363</td>
</tr>
<tr>
<td>Minnesota Health Care Programs (through DHS) Eligibility Verification System (EVS)</td>
<td>(612) 282-5354 or 1-800-657-3613</td>
</tr>
<tr>
<td>PC-ACE Connect</td>
<td>(651) 662-5742 or 1-866-251-6742</td>
</tr>
<tr>
<td>Prime Therapeutics, LLC</td>
<td>(612) 777-4000 or 1-800-858-0723</td>
</tr>
<tr>
<td>Public Programs Member Services (PMAP and MinnesotaCare)</td>
<td>(651) 662-5545 or 1-800-711-9862</td>
</tr>
</tbody>
</table>
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

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## 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.

<table>
<thead>
<tr>
<th>Subscriber PCC Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

### 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)

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1.   | **On-site resolution:**  
- Discuss problem with Subscriber; develop agreement to work together to resolve the situation  
- Document agreement and record follow-up action(s)  
- Explore possibility of Subscriber working with another physician within primary care practice  
- Document progress and any continued problems |
| 2.   | **If no resolution occurs in the first step:**  
- 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:  
  - Explain the rationale for the disenrollment  
  - Specifically state that the clinic will no longer be serving as the Subscriber's PCC  
  - Offer 30 days of emergency/urgent care service  
  - Advise the Subscriber to choose a new PCC  
  - 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.  
  - The PCC sends a copy of the letter to:  
    Blue Plus  
    Consumer Service Center, R3-35  
    P.O. Box 64179  
    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 PMAP, MinnesotaCare or Medicare. For further details in regards to missed behavioral health appointments, please refer to Bulletin P8-04, available at bluecrossmn.com.
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 **Select Network chiropractor**. They may receive eligible chiropractic services without a referral from the PCC. To receive the highest level of benefits, the Subscriber must use a Select 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.

If the Select chiropractor determines that additional Health Services of a specialist (e.g., neurologist or orthopedic surgeon) are needed, the Subscriber must return to their PCC for coordination of care.

**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.

Effective January 1, 2014, the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare DME network has changed. A number of DME providers will now be considered out of network. Hospital based DME providers are not impacted by this change. Subscribers will continue to have access to many providers in Minnesota. Please make sure you 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 Select Behavioral Health Network. Providers in this 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. However, those contracts that require the Subscriber to stay in the Select Behavioral Health Network would need a referral from Blue Plus to see a provider outside of that network. PCCs do not initiate referrals for Subscribers requiring behavioral health care.

- **Select Behavioral Health Network Providers**
  Subscribers have direct access to providers in this network. Mental Health/Chemical Dependency providers are responsible to coordinate Subscriber's mental health and chemical dependency 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.
The following chart outlines various levels of open access ob/gyn benefits available based upon the Health Service and where it is received.

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Received at the PCC</th>
<th>Received at an ob/gyn provider in Subscriber’s network</th>
<th>Received at neither Subscriber’s PCC nor an ob/gyn provider* in Subscriber’s network</th>
</tr>
</thead>
<tbody>
<tr>
<td>General ob/gyn care - see Specified Codes for Open Access Health Services</td>
<td>Highest level of Subscriber's benefits</td>
<td>Highest level of Subscriber's benefits</td>
<td>Processed as a self-referral benefit</td>
</tr>
</tbody>
</table>
| Non-ob/gyn Health Services                          | Highest level of Subscriber's benefits           | • If referred by the PCC: highest level of Subscriber's benefits  
  • 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)

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

* 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.

<table>
<thead>
<tr>
<th>Diagnosis Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>054.0-054.19 (ICD-9) A00.0-B00.9 (ICD-10)</td>
<td>Herpes simplex</td>
</tr>
<tr>
<td>078.81-078.89 (ICD-9) A88.1, A74.89, B33.8,</td>
<td>Other diseases due to viruses and chlamydia</td>
</tr>
<tr>
<td>R11.11 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>079.4 (ICD-9) B97.7 (ICD-10)</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>079.81-079.89 (ICD-9) A88.1, A74.89, B33.8,</td>
<td>Other specified viral and chlamydial infections</td>
</tr>
<tr>
<td>R11.11 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>099.0-099.9 (ICD-9) A55, A56.00, A56.19,</td>
<td>Syphilis and other venereal disease</td>
</tr>
<tr>
<td>A56.2-A56.4, A56.8, A57, A58, A63.8, A64,</td>
<td></td>
</tr>
<tr>
<td>M02.30, N34.1 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>112.0-112.9 (ICD-9) B37.0-B37.3, B37.49,</td>
<td>Candidiasis</td>
</tr>
<tr>
<td>B37.5-B37.7, B37.81-B37.82, B37.84, B37.89-</td>
<td></td>
</tr>
<tr>
<td>B37.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>127.4 (ICD-9) B80 (ICD-10)</td>
<td>Enterobiasis</td>
</tr>
<tr>
<td>131.00-131.9 (ICD-9) A59.00-A59.03, A59.09,</td>
<td>Trichomoniasis</td>
</tr>
<tr>
<td>A59.8-A59.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>132.2 (ICD-9) B85.3 (ICD-10)</td>
<td>Phthirus pubis</td>
</tr>
<tr>
<td>Diagnosis Code(s)</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>174.0-184.9 (ICD-9)</td>
<td>Malignant neoplasm</td>
</tr>
<tr>
<td>C50.10-C57.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>217-221.9 (ICD-9)</td>
<td>Benign neoplasm</td>
</tr>
<tr>
<td>D24.9-D28.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>233.0-233.9 (ICD-9)</td>
<td>Carcinoma in situ of breast and genitourinary system</td>
</tr>
<tr>
<td>D05.90-D09.19 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>236.0-236.99 (ICD-9)</td>
<td>Neoplasm of uncertain behavior of genitourinary system</td>
</tr>
<tr>
<td>D39.0-D41.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>239.3 (ICD-9)</td>
<td>Neoplasm of unspecified nature of breast</td>
</tr>
<tr>
<td>D49.3 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>239.5 (ICD-9)</td>
<td>Neoplasm of unspecified nature of other genitourinary organs</td>
</tr>
<tr>
<td>D49.5 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>256.0-256.9 (ICD-9)</td>
<td>Ovarian dysfunction</td>
</tr>
<tr>
<td>E28.0-E28.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>599.0 (ICD-9)</td>
<td>Urinary tract infection, site not specified</td>
</tr>
<tr>
<td>N39.0 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>610.0-611.9 (ICD-9)</td>
<td>Disorders of breast</td>
</tr>
<tr>
<td>N60.11-N64.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>614.0-616.9 (ICD-9)</td>
<td>Inflammatory disease of female pelvic organs</td>
</tr>
<tr>
<td>N70-N73.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>617.0-627.9 629.0-629.9 (ICD-9)</td>
<td>Other disorders of female genital tract, infertility</td>
</tr>
<tr>
<td>N80.0-N95.9, N94.89-N94.9 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>630-677 (ICD-9)</td>
<td>Complications of pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>O01.0-O94 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>698.1 (ICD-9)</td>
<td>Pruritus of genital organs</td>
</tr>
<tr>
<td>L29.3 (ICD-10)</td>
<td></td>
</tr>
</tbody>
</table>
### Specified Codes for Open Access Ob/Gyn Health Services (continued)

<table>
<thead>
<tr>
<th>Diagnosis Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>752.0-752.9 (ICD-9) Q50.31-Q55.9 (ICD-10)</td>
<td>Congenital anomalies of genital organs</td>
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<tr>
<td>780.01-780.99 (ICD-9) R40.20-R68.89 (ICD-10)</td>
<td>General symptoms</td>
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<tr>
<td>789.1-789.9 (ICD-9) R16.0-R19.8 (ICD-10)</td>
<td>Other symptoms involving abdomen and pelvis</td>
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<td>795.00-795.79 (ICD-9) R76.8, R97.8 (ICD-10)</td>
<td>Nonspecific abnormal histological and immunological findings</td>
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<tr>
<td>996.32 (ICD-9) T83.39XA- T83.39XS (ICD-10)</td>
<td>IUD complication</td>
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<tr>
<td>V01.6 (ICD-9) Z20.2 (ICD-10)</td>
<td>Contact with or exposure to venereal diseases</td>
</tr>
<tr>
<td>V07.4 (ICD-9) Z79.890 (ICD-10)</td>
<td>Postmenopausal hormone replacement therapy</td>
</tr>
<tr>
<td>V10.3 (ICD-9) Z85.3 (ICD-10)</td>
<td>Personal history of malignant neoplasm breast</td>
</tr>
<tr>
<td>V10.40-V10.44 (ICD-9) Z85.40-V85.44 (ICD-10)</td>
<td>Personal history of malignant neoplasm genital organs</td>
</tr>
<tr>
<td>V13.21-V13.29 (ICD-9) Z87.42 , Z87.410-Z87.412, Z87.51,Z87.59 (ICD-10)</td>
<td>Personal history of other genital system and obstetric disorder</td>
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## Specified Codes for Open Access Ob/Gyn Health Services (continued)

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

<table>
<thead>
<tr>
<th>Diagnosis Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V73.81 (ICD-9)</td>
<td>• Screening examination for human papillomavirus</td>
</tr>
<tr>
<td>Z11.51 (ICD-10)</td>
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<tr>
<td>V74.5 (ICD-9)</td>
<td>Special screening examination for venereal disease</td>
</tr>
<tr>
<td>Z11.3 (ICD-10)</td>
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</tr>
<tr>
<td>V76.10-V76.19 (ICD-9)</td>
<td>Special screening for malignant neoplasms of breast</td>
</tr>
<tr>
<td>Z12.31, Z12.39 (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>V76.2 (ICD-9)</td>
<td>Special screening for malignant neoplasms of cervix</td>
</tr>
<tr>
<td>Z12.4 (ICD-10)</td>
<td></td>
</tr>
</tbody>
</table>
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 (1-800-622-9524) 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.**

CPT codes copyright 2016 American Medical Association. All Rights Reserved. CPT is a trademark of the AMA
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 Mental Health and Chemical Dependency services, refer to Behavioral Health Select Network (referral not required).
- For Chiropractic services, refer to the Chiropractic Select Network (referral not required).
- 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

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Public Programs

General Overview
Public Programs consists of enrollees from four major Minnesota Health Care Programs: MinnesotaCare, Blue Advantage (PMAP/Families and Children), Minnesota Senior Health Options or SecureBlue SM (HMO SNP), and Minnesota Senior Care Plus (MSC+). The group number for these products begins with the letters MN.

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 (PMAP/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 is a health care program for people 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 Public Programs member services.

The toll-free telephone numbers for Blue Advantage (PMAP/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. Public Programs will coordinate enrollee benefits and Medical Assistance will always be the last payer.
**Enrollee Communications**

Mailings that are directed only to Public Programs enrollees require approval by DHS. If a provider plans to do this type of mailing contact Provider Services at 1-866-518-8448.

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**Enrollee Appeals and Grievances**

All enrollees of fully insured Blue Plus products have appeal rights mandated by the Minnesota Department of Health (MDH). Public 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.

**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.

**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 tell the member within 24 hours and will process the appeal under the standard timeframe.
**Enrollee Appeals and Grievances (continued)**

For post-service appeals requested by a member, a provider representing the member 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 if 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 member’s best interest. In this case, the member will be notified and will have the right to file an expedited grievance.

For MSHO member 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 member has the right to request a State Fair Hearing.

**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 Fair Hearing 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 Fair Hearing is resolved. If the enrollee loses the appeal or State Fair Hearing, 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.
Enrollee Rights with the Grievance Process (continued)

If the enrollee has seen a mental health provider who is part of the Blue Cross Behavioral Health Network and has been told that no structured mental 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 Select 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 mental health or chemical dependency provider, who does not need to be a Blue Cross Behavioral Health Select 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 mental health services.

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 (PMAP/Families and Children), MinnesotaCare, and MSC+ is 1-800-711-9862. SecureBlue members may contact member services at 1-888-740-6013.

- The enrollee can choose to appeal to the health plan or request a State Fair Hearing, or to do both at the same time. They do not have to finish one process before using another.

- 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 or request for State Fair Hearing. If they need help, contact Blue Plus member services or the State ombudsman.

- 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 enrollee will be contacted within 24 hours. If the enrollee disagree, enrollees may file an appeal with us or request a State Fair Hearing.
- 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
Consumer Service Center
P.O. Box 64033
St. Paul, MN 55164-4033

Toll-free 1-800-711-9862 Families and Children, MinnesotaCare and MSC+
1-888-740-6013 SecureBlue
State Fair Hearing

A State Fair Hearing is a hearing at the State to review a decision made by Blue Plus. The request must be submitted in writing.

- A Human Services Referee will hold a hearing. Enrollees may attend in person or by phone.
- Enrollees must request a State Fair Hearing in writing within 120 calendar days of receiving this notice.
- The enrollee’s State Fair Hearing 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 Fair Hearing 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

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 Ombudsman.

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

Blue Plus  
Consumer Service Center  
P.O. Box 64033  
St. Paul, MN  55164-4033

- **1-800-711-9862** Families and Children, MinnesotaCare and MSC+  
- **1-888-740-6013** SecureBlue

**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](mailto:health.mcs@state.mn.us)

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

Enrollees can send a request for a State Fair Hearing 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**
A State ombudsman may be able to help enrollees with their problem. The ombudsman can also help them file a grievance or an appeal to the health plan or the State. The enrollee can contact the ombudsman by calling or writing at:

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

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

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 get quality health care that is timely, accessible, and friendly.
- 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 get information about treatment, your treatment choices and how they may help or harm you whether the health plan would pay for these treatments.
- 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 Fair Hearing with the Minnesota Department of Human Services (also referred to as “the State”). You may request a State Fair Hearing before or at any time during the Blue Plus grievance or appeal process. You do not have to file a grievance or appeal with Blue Plus before you request a State Fair Hearing.
- To get a clear explanation of covered nursing home and 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.
- 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 Evidence of Coverage at least once a year.
- To recommend changes regarding Blue Plus’ rights and responsibilities policies.
**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 following information from us, if you ask for it:
  - Whether we use a physician incentive plan that affects the use of referral services;
  - The type(s) of incentive arrangement used;
  - Whether stop-loss protection is provided; and
  - Results of member survey if one is required because of our physician incentive plan.
- 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 Ombudsman for help in filing a grievance or appeal.
- To ask for a speedy hearing.

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

- Read your Evidence of Coverage 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 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 doctor to understand your total health condition. It is important to know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.
- To practice preventive health care. To have tests, exams and shots recommended for you based on your age and gender.
- To tell the clinic about changes in your name or address.
- To keep appointments for care or to give early notice if you need to cancel.

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 Public 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** | According to the *Minnesota Health Care Programs Manual*, available through DHS, 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 833-224-6929, 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 public program eligibility. 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 a member has a Medicaid product. Blue Cross Plan ID cards for MHCP members should not include the suitcase logo. They do include a disclaimer on the back of the ID card providing information on benefit limitations. For members 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, 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.

Effective April 17, 2016, if a provider submits a claim without enrolling, their Medicaid claims will be 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 member is enrolled in Medicaid, requires providers to enroll in their Medicaid program before the Plan can pay the provider.
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 member?**
   Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards may not always indicate that a member 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 members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members 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.
Public 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 members. 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 members, driving quality, safety, and affordability.

**American Indians**
American Indians enrolled in Blue Plus MinnesotaCare or Blue Advantage 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). These facilities may refer enrollees to Blue Plus specialists.

**Behavioral Health**
Enrollees can access services directly from any in network provider in either the Aware or Select BH Networks. 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 Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. This is federally mandated for children enrolled in Medical Assistance and Minnesota Care (Blue Advantage & 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.

C&TC screenings may be performed by the enrollee’s PCC, an in-network clinic/provider or a Blue Plus Public Program-contracted public health agency.

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
- Maternal 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 and critical congenital heart defect
- Laboratory tests or risk assessment including:
  - Blood lead test
  - Hemoglobin or hematocrit
  - Tuberculosis
  - Sexually transmitted infection (STI) risk assessment, with lab testing for sexually active youth
  - HIV screening lab test
  - Dyslipidemia risk assessment
- Vision screening (including visual acuity screening, plus lens, beginning at age 5)
- 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
Child and Teen Checkups (continued)

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

* **Very important:** 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 Department of Human Services standard recommendations on blood lead level screening and C&TC for members enrolled in Medical Assistance (Blue Advantage – PMAP/Families and Children) or MinnesotaCare.

No one is denied immunizations due to the inability to pay for vaccines; they are supplied by the Minnesota Department of Health.
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
  - C&TC Fact Sheets
- MHCP Provider Manual Link
- Approved DHS Screening Exceptions
- C&TC Metro Action Group Provider Resources

Providers will find links to information such as:

- Additional resources
- Fact sheets
- Billing guidelines
- Online training program(s)
- Community newsletter(s)
- Sport Physical Supplemental form, etc.

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

Public Programs enrollees have access to chiropractic service without a referral from their PCC. They must go to an in-network chiropractor.

Services eligible for coverage include spinal manipulations for the treatment of subluxation of the spine; radiological examinations needed to support a diagnosis of subluxation, and only one adjustment per day. Adjustments of more than one area of the spine are covered as one adjustment (the entire spine is considered one unit). Visits to the chiropractor are monitored and reviewed for Medical Necessity.

Dental Benefits

Dental benefits for Public Programs enrollees are coordinated through Delta Dental of Minnesota. They 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. Delta Dental® is an independent company that provides dental administrative services.

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 1-833-884-0387 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’s use of the service is voluntary. Phone care does not replace the role of the PCC.
New Baby, New Life

New Baby, New Life® is a proactive case management program for mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, pregnancy and delivery notification forms and self-referrals. Once pregnant members are identified, Blue Plus acts quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Blue Cross is requesting that providers complete the Maternity Notification Form and fax it to 1-800-964-3627 for newly identified pregnant women.

Blue Cross is requesting that providers complete the Newborn Notification of Delivery Form upon delivery and fax it to 1-800-964-3627.

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.

When it comes to pregnant members, Blue Plus is committed to keeping both moms and babies healthy.

All moms-to-be are encouraged to take part in the New Baby, New Life program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at high risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Rewards to keep up with prenatal and postpartum checkups.
**Maternity Management program (continued)**

As part of the New Baby, New Life program, enrollees are offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR), web or smartphone application. This program does not replace the high-touch case management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend the health education reach. The goal of the expanded outreach is to identify high-risk pregnant women, to facilitate connections between them and the case managers, and improve enrollee and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit [www.myadvocatehelps.com](http://www.myadvocatehelps.com).

Our case managers are here to help providers. If there is a member in your care that would benefit from case management, call Blue Plus at **1-866-518-8448**. Members can also call the 24/7 NurseLine at **1-800-711-9862**, 24 hours a day, 7 days a week.

**You and Your Baby in the NICU Program**

For parents with infants admitted to the neonatal intensive care unit (NICU), Blue Plus offers the You and Your Baby in the NICU program and a NICU Post-Traumatic Stress Disorder (NICU PTSD) program. Parents receive education and support, visit the NICU, interact with hospital care providers, and prepare for discharge. Parents are also provided with an educational resource outlining successful strategies that may deploy to collaborate with the care team.

The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents. This program will support families at risk for PTSD due to the stressful experience of having a baby in the NICU.
**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 contracts with Via Language. If an in-person interpreter is not available to interpret, the member can contact customer service with the number on the back of their Blue Plus card.

Blue Plus requires that all providers arrange for the provision of interpreter services provided to Blue Plus MHCP members 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.

MHCP members 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...
Interpretation Services (continued)

Auditing

The interpreter service agency must submit a quarterly report to Blue Plus. The report is due by the end of the month, following the last month of the quarter (April 30, July 31, October 31 and February 28/29). It must include all claims billed to Blue Plus within that quarter. It must be in Microsoft Excel format and include the following information.

A. Interpreter First Name
B. Interpreter Middle Name
C. Interpreter Last Name
D. Interpreter MDH Roster ID Number
E. Language Interpreted
F. Member relationship to Interpreter
G. Blue Plus Member Last Name
H. Blue Plus Member First Name
I. Blue Plus Member ID Number
J. Date of Service
K. Appointment start time
L. Appointment end time
M. Service Provider’s Name
N. Service Provider Address (Including City, State & Zip Code)
O. Type of Appointment/Service (face to face, ASL, cancellation, no show, phone, mileage).
P. Units Billed
Q. Amount Billed
SecureBlue (MSHO) and MSC+ (Minnesota Senior Care Plus) enrollees who are 65 and older and living 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 must first be faxed to 1-833-224-6928 before the claim is submitted. This includes eligible swing bed stays. Swing bed days do 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:

Nursing Facility (NF) Communication Form

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 members may qualify for both skilled and long-term care nursing home benefit through Blue Plus.

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

SecureBlue members 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 member is in the community at the time of enrollment in SecureBlue, the member is eligible for up to 180 days of long-term care nursing home benefits through Blue Plus. Members 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

Blue Plus-designated counties and private mental health providers shall be responsible for determining whether public program enrollees are eligible for Mental Health Targeted Case Management (MH-TCM), based on a diagnostic assessment and in compliance with criteria set forth in Minnesota Rules, Parts 9520.0900 to 9520.0926 (Rule 79) and Minnesota Statutes, Sections 245.461 to 245.486 and 256B.0625, subd. 20. 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 private provider can neither narrow nor broaden the eligibility criteria.

If the county or private provider determines that an individual is eligible for case management services, the county or private provider shall offer and refer the individual for case management services. Counties and private 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 Integrated Health Management at 844-429-7757. Blue Plus will inform the individual of the determination and their appeal rights.

Out of network providers must obtain a referral 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)

**Eligible Minnesota Health Care Programs**

<table>
<thead>
<tr>
<th>Product name</th>
<th>Group numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepaid Medical Assistance Program (Families and Children) and Minnesota Senior Care Plus (MSC+)</td>
<td>All group numbers that begin with MNPMF, MNPMA, MNPMN, MNPMP, and MNTEM</td>
</tr>
<tr>
<td>MinnesotaCare</td>
<td>All group numbers that begin with MNMNC, MNMNA, and MNTMP</td>
</tr>
<tr>
<td>MSHO – SecureBlue</td>
<td>All group numbers that begin with MN</td>
</tr>
</tbody>
</table>

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 preauthorizations required
- Members must be determined eligible for MH-TCM according to Rule 79 criteria
- Providers must be contracted and designated by Blue Plus

Out of network providers must obtain a referral prior to rendering services for Blue Plus members. Contact provider services at 1-866-518-8448 for assistance.

Billing

MH-TCM is a professional service billed on an 837P transaction. When billing for MH-TCM, submit the contracting provider NPI number currently on file with Blue Plus. In addition, an individual rendering NPI number is required, except when billed by social service agencies (provider specialty SS).

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifiers</th>
<th>Brief Description</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2023 HE, HA</td>
<td>HE, HA</td>
<td>Face-to-face contact between case manager and recipient under age 18 years</td>
<td>1 unit per month</td>
</tr>
<tr>
<td>T2023 HE</td>
<td>HE</td>
<td>Face-to-face contact between case manager and recipient age 18 years or older</td>
<td>1 unit per month</td>
</tr>
<tr>
<td>T2023 HE, U4</td>
<td>HE, U4</td>
<td>Telephone contact (recipient age 18 years or older)</td>
<td>1 unit per month</td>
</tr>
<tr>
<td>T1017 HE, HA</td>
<td>HE, HA</td>
<td>Face-to-face</td>
<td>Per encounter</td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>Modifiers</td>
<td>Brief Description</td>
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<tr>
<td><strong>Mental Health –</strong>&lt;br&gt;<strong>Targeted Case Management Eligibility Determination (continued)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1017 For IHS/638 and FQHC billing only</td>
<td>HE</td>
<td>Face-to-face encounter (age 18 years or older)</td>
<td>Per encounter</td>
</tr>
</tbody>
</table>

**Questions?**

If you have any questions, please contact provider services at 1-866-518-8448.
Minnesota Vaccines for Children Program

The Minnesota Vaccines for Children Program (MnVFC) is an enhanced version of the federally funded Vaccines for Children (VFC) program with the goal of ensuring affordable vaccine for all children in the state. MnVFC uses supplemental state and federal funds so more Minnesotans are eligible for vaccines provided through the program.

Minnesota law requires that all Minnesota Health Care Programs (MHCP) providers who administer pediatric vaccines be enrolled in the MnVFC program. MHCP include MinnesotaCare and Prepaid Medical Assistance Programs (PMAP/Families and Children). All providers enrolled in Public Programs networks are eligible to participate in the MnVFC program. 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 administration code 90460, 90461, 90465, 90466, 90467, 90468, 90470, 90471, 90472, 90473 and/or 90474 and/or G9141 (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](http://www.health.state.mn.us/divs/idepc/immunize/mnvfc/index.html)
Billings Guidelines for Reference and Outside Lab Services

Blue Cross will follow MHCP billing guidelines for laboratory (lab) tests sent to an outside lab for completion. This only impacts professional providers. Institutional (facility) providers are excluded. This change is effective for all Prepaid Medical Assistance Program (PMAP/Families and Children), Minnesota Senior Care Plus (MCS+) and MinnesotaCare 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 (PMAP/Families and Children) or MinnesotaCare will be automatically enrolled in Blue Plus. The newborn’s effective date with Blue Plus will be the first day of their birth month. It is important that the mother notify her local agency (if Blue Advantage (PMAP/Families and Children) or MinnesotaCare) of the birth of her child for the enrollment process to begin.

The baby’s claims will not be processed until Blue Plus receives the enrollee enrollment information from DHS and the baby is active in our system.

**OB/ GYN**

Public 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 Blue Plus Blue Advantage (PMAP/Families and Children), MSC+, MinnesotaCare, or SecureBlue members 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 members 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.

Please note, although other members of Blue Plus Minnesota Health Care programs require a referral only to out of network providers, **all services provided to a restricted recipient other than from the designated Primary Care Physician 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

Managed Care Referral Form

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.

<table>
<thead>
<tr>
<th>Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic name</td>
<td>PCC name</td>
</tr>
<tr>
<td>Contact person</td>
<td>Person Blue Plus can contact if it has a question</td>
</tr>
<tr>
<td>Primary Care Doctor</td>
<td>PCP that member is restricted to</td>
</tr>
<tr>
<td>Clinic address</td>
<td>The address of PCC</td>
</tr>
<tr>
<td>Phone number</td>
<td>Number where Blue Plus can contact PCC if it has a question</td>
</tr>
<tr>
<td>Fax number</td>
<td>Fax number where Blue Plus can fax information or concerns back to PCC</td>
</tr>
<tr>
<td>Patient name</td>
<td>Patient's name, not the contract-holder’s name</td>
</tr>
<tr>
<td>Member ID number</td>
<td>Patient’s Blue Plus ID number.</td>
</tr>
<tr>
<td>Member DOB</td>
<td>Patient’s date of birth</td>
</tr>
<tr>
<td>Clinic/hospital name that patient is</td>
<td>The name of the clinic/hospital</td>
</tr>
<tr>
<td>being referred to</td>
<td></td>
</tr>
<tr>
<td>Clinic/hospital address that patient</td>
<td>The street address of the clinic/hospital</td>
</tr>
<tr>
<td>is being referred to</td>
<td></td>
</tr>
<tr>
<td>Referred Provider Name (If known)</td>
<td>Name of the provider the member is being referred to (If known).</td>
</tr>
<tr>
<td>NPI# of Referred Provider</td>
<td>NPI# for provider the member is being referred to.</td>
</tr>
<tr>
<td>Information</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ICD-10 Diagnosis</td>
<td>Submit the appropriate ICD-10 diagnosis code</td>
</tr>
<tr>
<td></td>
<td>If no ICD-10 diagnosis code is submitted, R6889 will be used</td>
</tr>
<tr>
<td>Date of service:</td>
<td>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.</td>
</tr>
<tr>
<td>from <strong>/</strong>/__ to <strong>/</strong>/__ for ___ days</td>
<td></td>
</tr>
<tr>
<td>Number of visits approved</td>
<td>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</td>
</tr>
<tr>
<td>Prescribing Rights</td>
<td>Clearly label if referred provider is able to prescribe medications to the member</td>
</tr>
<tr>
<td>Comment codes</td>
<td>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.</td>
</tr>
</tbody>
</table>
Verification of the Restricted Recipient status of a member 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:


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 mental 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 mental 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 844-841-5661.

All smoking cessation products are covered with a prescription. Some of these products include nicotine patch, gum, pill, oral inhaler, lozenge, or nicotine nasal spray. No preauthorization is required.

Blue Plus encourages enrollees to seek smoking cessation services from their PCC or a hospital-based outpatient program. Enrollment in smoking cessation classes is a decision the enrollee and their practitioner must make together. Although we encourage 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)

Payment exceptions to timelines:

- Emergency abdominal surgery – when an individual is sterilized at the time of emergency, abdominal surgery payment will be made if at least 72 hours have passed since he or she signed the consent form.

  Note: An emergency C section is not considered emergency abdominal surgery.

- Premature delivery – when an individual is sterilized at the time of premature delivery, payment will be made if at least 72 hours have passed since she signed the consent form and the consent form was signed by the individual at least 30 days before the expected date of delivery.

Consent forms may be obtained by contacting DHS. Use requisition form DHS-0121-ENG and request form DHS-2510 for women or DHS-2511 for men. Forms are also included in the booklets, “Information for Women: Your Sterilization Operation” and “Information for Men: Your Sterilization Operation.”

Timely Filing Exception

Due to the unique nature of the services provided, Blue Plus has made a change to the timely filing contract provision for providers exclusively in network with Blue Cross to serve MHCP subscribers. These providers have a 180-day timely filing period. This means that claims must be submitted no later than 180 days from the date of service.

The 180-day timely filing period applies to the following providers: Common Carrier Transportation, Community Support Services, Interpreter, Licensed Traditional Midwife, Medication Therapy Management, Mental Health Rehab Professional, Optician, Personal Care Agency, Public Health Nursing Clinic, Social Service Agency and Special Transportation Services.
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.

- Provider Specialty TS and TV
- Participating in network 069
- 837P Transaction
- Atypical provider

BlueRide schedules Common Carrier Transportation requests for rides to and from medical and dental appointments with providers if the member has no other means of transportation. A BlueRide representative will talk to members 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 (PMAP/Families and Children, MSC+), SecureBlue and some MNCare Subscribers.
Members 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 need to be received at least two business days prior to the day the ride is needed. Other restrictions may apply. Members are allowed 1 Short Notice Ride (SNR) per month. The BlueRide team will handle these issues and schedule these rides. On weekends, holidays and after hours; phone calls roll over to the afterhours Nurse Line. The Nurse Line is only able to assist members with same day transportation needs for the following:

- Emergency room discharge
- Urgent Care
- Hospital discharge

All other medical/dental transportation needs can be addressed by calling BlueRide during regular business hours at (651) 662-8648 or toll-free number 1-866-340-8648.

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.

**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 Subscriber. 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 and must be pre-approved by BlueRide. Wait time can only be authorized by BlueRide staff. If wait time could not be foreseen, requests must be submitted the next business day. It is expected that wait time requests will be infrequent. Wait time is not reimbursable for the first hour.
Common Carrier Codes

A0080 - Non-emergency transportation, per mile-vehicle provided by a volunteer
A0100 - Non-emergency transportation, taxi
A0110 - Non-emergency transportation and bus, intra or inter-state carrier
A0120 - Non-emergency transportation-minibus, mountain-area transports, or other transportation systems
A0170 - Parking Tolls and Fees
T2007 - Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments

Each procedure code must be billed by units.

Units of Service

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit of Service</th>
</tr>
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<td>T2007</td>
<td>Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments</td>
<td>1 per 30 minutes</td>
</tr>
<tr>
<td>A0080</td>
<td>Non-emergency transportation, per mile-vehicle provided by volunteer</td>
<td>1 per mile</td>
</tr>
<tr>
<td>A0100</td>
<td>Non-emergency transportation, taxi</td>
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<td>A0120</td>
<td>Non-emergency transportation-minibus, mountain area transports, or other transportation systems</td>
<td>1 per leg</td>
</tr>
</tbody>
</table>
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 (for more than one modifier on the same line item, the first position indicates the origin and the second position indicates the destination):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Diagnostic or therapeutic site other than ‘P’ or ‘H’ when these are used as origin codes</td>
</tr>
<tr>
<td>E</td>
<td>Residential, domiciliary, custodial facility (other than an 1819 facility)</td>
</tr>
<tr>
<td>G</td>
<td>Hospital based ESRD facility</td>
</tr>
<tr>
<td>H</td>
<td>Hospital</td>
</tr>
<tr>
<td>I</td>
<td>Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport</td>
</tr>
<tr>
<td>J</td>
<td>Freestanding ESRD facility</td>
</tr>
<tr>
<td>N</td>
<td>Skilled nursing facility (SNF)</td>
</tr>
<tr>
<td>P</td>
<td>Physician’s office</td>
</tr>
<tr>
<td>QM</td>
<td>Ambulance service provided under arrangement by a provider of services.</td>
</tr>
</tbody>
</table>

**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. |

**NOTE:** Institutional-based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly.
### Transportation Services (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Residence</td>
</tr>
<tr>
<td>S</td>
<td>Scene of accident or acute event</td>
</tr>
<tr>
<td>X</td>
<td>Intermediate stop at physician’s office on way to the hospital (destination code only)</td>
</tr>
</tbody>
</table>
Transportation Services (continued)

Billing of Mileage and Base Rate

Effective January 1, 2019, 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 with LogistiCare 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 (A/B/C).

Example:

Correct billing for round-trip ride from home to provider’s office, 10 miles each leg.

Base (Per Leg)
A0100 - RP – 1 UOS - $11.00
A0100 - PR – 1 UOS - $11.00

Mileage (Per Leg)
A0080 – 10 UOS - $13.00
A0080 – 10 UOS - $13.00

Incorrect billing for round-trip ride, 10 miles each leg.

Base Rate
A0100 - PR  1 UOS - $11.00
A0100 - RP  1 UOS - $11.00

Mileage Rate
A0080 – 20 UOS - $26.00

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 LogistiCare. Reimbursement for approved services listed above will be bundled in to the claim line for the initial base leg of the trip.
Example of deadhead billing and payment

Provider Billing Including Deadhead

Base (Per Leg)
A0100 - RP – 1 unit of service - $11.00
A0100 - PR – 1 unit of service - $11.00

Mileage (Per Leg)
A0080 – 10 unit of service - $13.00
A0080 – 10 unit of service - $13.00
Deadhead
A0080 Modifier TP – 10 UOS - $5.40

LogistiCare Processing and Reimbursement on 835 Remit

Base (Per Leg)
A0100 - RP – 1 UOS - $16.40 ($11.00 base reimbursement + $5.40 deadhead reimbursement)
A0100 - PR – 1 UOS - $11.00

Mileage (Per Leg)
A0080 – 10 UOS - $13.00
A0080 – 10 UOS - $13.00
Deadhead
A0080 - TP – 10 UOS - $0.00 (reimbursement was bundled with A leg base rate. See above.)
RUCA (Rural Urban Comminuting Area)

RUCA is applied by Blue Plus when the claims reflect zip codes that fall into the RUCA areas. Non-Emergency Transportation Providers are not required to apply RUCA prior to the claims 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.

No Shows

Blue Plus requires transportation providers to report all no shows to BlueRide by submitting to the minnesotatransbebs@logicare.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.
Transportation Services (continued)

Legal References

MS 144E.16 (Eligible provider licensing)
MS 174 (Department of Transportation)
MS 174.29-174.30 (Coordination of STS)
MS 256B.0625, subd.17 (transportation costs)
MS 256B.0625, subd.17a (payment for ambulance services)
MS 256B.0625, subd.18 (bus or taxicab transportation)
MS 256B.0625, subd.18a (access to medical services)
Minnesota Rules 8840.5925 (Vehicle Equipment)
Minnesota Rules 9505.0315 (Medical Transportation)
Minnesota Rules 9505.0445 (Payment Rates)

Per Contract:

Verification of Eligibility:

All provisions of the Provider Service Agreement continue to 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.

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141019#
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 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 toll-free at (651) 662-8648 or toll-free number 1-866-340-8648. Although BlueRide will occasionally schedule same-day rides depending on provider availability, we require 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 via fax from the BlueRide staff.

Only the enrollee or legally authorized representative (such as a guardian with proper paperwork) can schedule a ride. The member 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.
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 subscribers who need to schedule a ride to an eligible medical or dental appointment should call BlueRide toll free at (651) 662-8648 or toll-free number 1-866-340-8648.
Additional information

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.

Remember that in all cases, 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.

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

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.
Special Transportation Services (continued)

**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 Subscriber in the vehicle. No-Load Miles cannot be billed to the Subscriber. 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 and must be pre-approved by BlueRide. Wait time can only be authorized by BlueRide staff. Wait time should be approved ahead of the non-emergency medical ride. If wait time could not be foreseen, requests must be submitted the next business day. It is expected that wait time requests will be infrequent. Wait time is not reimbursable for the first hour.

**Non-emergent, scheduled transport codes**

- A0130 - Non-emergency transportation; wheelchair van;
- S0209 - Non-emergency transportation; wheelchair van, mileage per mile
- S0215 - Non-emergency transportation; mileage, per mile;
- T2001 - Non-emergency transportation; patient attendant/escort;
- T2003 - Non-emergency transportation; encounter/trip;
- T2005 - Non-emergency transportation; non-ambulatory stretcher van;
- T2049 - Non-emergency transportation; non-ambulatory stretcher van mileage;
- T2007 - Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments
- A0170 - Parking Tolls and Fees

Each procedure code must be billed by units.
## Special Transportation Services (continued)

### Units of Service

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<td>A0420</td>
<td>Transportation waiting time, non-ambulatory stretcher vehicles only</td>
<td>1 per 30 minutes</td>
</tr>
<tr>
<td>A0130</td>
<td>Non-emergency transportation; wheelchair van</td>
<td>1 per leg</td>
</tr>
<tr>
<td>S0209</td>
<td>Non-emergency transportation; wheelchair van, mileage per mile</td>
<td>1 per mile</td>
</tr>
<tr>
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<td>T2001</td>
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<td>1</td>
</tr>
<tr>
<td>T2003</td>
<td>Non-emergency transportation; encounter/trip</td>
<td>1 per leg</td>
</tr>
<tr>
<td>T2005</td>
<td>Non-emergency transportation; non-ambulatory stretcher van</td>
<td>1 per leg</td>
</tr>
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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** (for more than one modifier on the same line item, the first position indicates the origin and the second position indicates the destination):

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</tr>
<tr>
<td>N</td>
<td>Skilled nursing facility (SNF)</td>
</tr>
<tr>
<td>P</td>
<td>Physician’s office</td>
</tr>
<tr>
<td>QM</td>
<td>Institutional based providers only. Ambulance service provided under arrangement by a provider of services</td>
</tr>
<tr>
<td>QN</td>
<td>Institutional based providers only. Ambulance service furnished directly by a provider of services</td>
</tr>
<tr>
<td>R</td>
<td>Residence</td>
</tr>
<tr>
<td>S</td>
<td>Scene of accident or acute event</td>
</tr>
<tr>
<td>X</td>
<td>Intermediate stop at physician’s office en route to the hospital (destination code only)</td>
</tr>
</tbody>
</table>
Billing of Mileage and Base Rate

Effective January 1, 2019, 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 with LogistiCare 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 (A/B/C).

**Example:**

Correct billing for round-trip ride from home to provider’s office, 10 miles each leg.

**Base (Per Leg)**
- A0100 - RP – 1 UOS - $11.00
- A0100 - PR – 1 UOS - $11.00

**Mileage (Per Leg)**
- A0080 – 10 UOS - $13.00
- A0080 – 10 UOS - $13.00

Incorrect billing for round-trip ride, 10 miles each leg.

**Base Rate**
- A0100 - PR 1 UOS - $11.00
- A0100 - RP 1 UOS - $11.00

**Mileage Rate**
- A0080 – 20 UOS - $26.00

**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 LogistiCare. Reimbursement for approved services listed above will be bundled in to the claim line for the initial base leg of the trip.

**Example of deadhead billing and payment**
<table>
<thead>
<tr>
<th><strong>Special Transportation Services (continued)</strong></th>
<th><strong>Provider Billing Including Deadhead</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base (Per Leg)</strong></td>
<td><strong>A0100 - RP</strong> - 1 unit of service - $11.00</td>
</tr>
<tr>
<td><strong>A0100 - PR</strong> - 1 unit of service - $11.00</td>
<td></td>
</tr>
<tr>
<td><strong>Mileage (Per Leg)</strong></td>
<td><strong>A0080</strong> - 10 unit of service - $13.00</td>
</tr>
<tr>
<td><strong>A0080</strong> - 10 unit of service - $13.00</td>
<td></td>
</tr>
<tr>
<td><strong>Deadhead</strong></td>
<td><strong>A0080 Modifier TP</strong> - 10 UOS - $5.40</td>
</tr>
</tbody>
</table>

**LogistiCare Processing and Reimbursement on 835 Remit**

| **Base (Per Leg)** | **A0100 - RP** - 1 UOS - $16.40 ($11.00 base reimbursement + $5.40 deadhead reimbursement) |
| **A0100 - PR** - 1 UOS - $11.00 |
| **Mileage (Per Leg)** | **A0080** - 10 UOS - $13.00 |
| **A0080** - 10 UOS - $13.00 |
| **Deadhead** | **A0080 - TP** - 10 UOS - $0.00 (reimbursement was bundled with a leg base rate. See above.) |
RUCA (Rural Urban Comminuting Area)

RUCA is applied by Blue Plus when the claims reflect zip codes that fall into the RUCA areas. Non-Emergency Transportation Providers are not required to apply RUCA prior to the claims 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. 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.

Per Contract:

Verification of Eligibility:

All provisions of your Provider Service Agreement continue to 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 Public Programs network. Enrollees must choose from frames costing $40 or less. If an enrollee chooses more expensive frames, there will be no benefit. The enrollee may not purchase more expensive frames and be billed for the difference. Some MNCare 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.

Covered services include:

- Eye exams
- Routine refractions
- Frames costing $40.00 or less
- 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 Elderly Waiver (EW) services. Products impacted are SecureBlue, Minnesota Senior Care Plus (MSC+), Blue Advantage Prepaid Medical Assistance Program (PMAP/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 begins with the letter MN.

SecureBlue

Minnesota Senior Health Options (MSHO)
Blue Plus offers a Minnesota Senior Health Options (MSHO) product called 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 personal Care Coordinator will work closely with individual SecureBlue members 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 members and reduce fragmentation of care delivery for our members
- 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 https://www.bluecrossmn.com/sites/default/files/DAM/2018-12/P11GA_16835746.pdf?ReturnTo=/.
**Care Coordination**

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

Care Coordinators can work with the member’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 member will be assigned a Care Coordinator and receive a comprehensive assessment (medical, behavioral, social, environmental) and treatment plan. Care Coordinators are familiar with the community supports, waivered services, and fee-for-service arrangements available at the local level. 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 members will be able to maintain the providers and care patterns to meet member healthcare needs and goals.

Care Coordinators are able to assess a member’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 a member enrolls in the program. Providers may also receive communication from the Care Coordinators by phone to collaborate and coordinate for plans of care.

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.

To identify the Care Coordinator assigned to the member, call Provider Services. For additional information on Care Coordination, see the Care Coordination Guidelines at the end of this chapter.

Enrollment is voluntary for this program. Enrollees must meet eligibility requirements, as verified by the state and federal government. Eligible enrollee’s effective date of enrollment is the 1st day of the month following health plan receipt of complete enrollment application.
<table>
<thead>
<tr>
<th>Customer Service</th>
<th>SecureBlue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blue Plus customer service staff understand the importance of enrollee engagement for better health.</td>
</tr>
<tr>
<td></td>
<td>Customer service is offered to help members with questions toll free at 1-888-740-6013.</td>
</tr>
<tr>
<td></td>
<td>Sunday through Saturday including holidays: 8:00 am to 5:00 pm. CST</td>
</tr>
</tbody>
</table>

| Open Access | SecureBlue is an open access plan, meaning enrollees can access in network specialty care without the need for referrals. Open access allows members 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 Blue Plus and 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). Most enrollees are eligible for both Medicare and Medicaid (Duals). For those who are Medicare-eligible, additional Medicare appeal rights are also available. For those who are only Medicaid-eligible, the Medicaid/DHS appeal rights are 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.

For quality of care problems, enrollees with Medicare 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 KEPRO. Blue Plus must help KEPRO 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.
Appeals (continued)

• 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.

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 Plus 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
Attention: Consumer Service Center
P.O. Box 64033
St Paul, MN 55164-4033
Fax: 1-833-224-6929

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)
8:00 a.m. – 5:00 p.m. seven days a week (CT)

Fax: 1-833-224-6929

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 Fair Hearing 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 Fair Hearing**  
The enrollee or their authorized representative can ask for a State Fair Hearing. 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 Ombudsman 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 Referee 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 Fair Hearing.

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 Fair Hearing 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 Fair Hearing is resolved. If the enrollee loses the health plan appeal or State Fair Hearing, 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.

If the enrollee has seen a mental health provider who is part of Blue Plus’ network and has been told that no structured mental 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 mental 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. We must consider the second opinion but do not have to accept a second opinion for medical or mental 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 Ombudsman
Additional Rights
Provided Under the Medicaid Program

A State ombudsman 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 Fair Hearing by writing to:

Minnesota Department of Human Services Ombudsman 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.

http://www.dhs.state.mn.us/managedcareombudsman

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
Community Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

Updated January 2020
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</thead>
<tbody>
<tr>
<td>Behavioral Health Crisis Line: 1-844-410-0745</td>
<td>• For members in crisis who need support from a clinician specializing in mental health</td>
</tr>
</tbody>
</table>
| BlueRide Transportation                         | • Contact to arrange medical transportation  
• Email address to send requests to exceed 30/60 mileage limits  
• Care Coordinator portal for scheduling medical or dental rides |
| For members: 651-662-8648 or 1-866-340-8648      |                                                                                                                                 |
| For Care Coordinators: 855-933-6991 or          |                                                                                                                                 |
| bluerideintake@logisticare.com                 |                                                                                                                                 |
| LogistiCare’s TripCare Portal                  |                                                                                                                                 |
| https://tripcare.logisticare.com/login          |                                                                                                                                 |
| Bridgeview Company                              | • Elderly Waiver service agreement questions  
• EW Claims Processing  
• https://www.bluecrossmn.com/healthy/public/bridgeview/home/ |
| 1-800-584-9488                                   |                                                                                                                                 |
| EWProviders@bluecrossmn.com                    |                                                                                                                                 |
| CaregiverCornerMN.com                           | • BCBS hosted site with helpful information and resources for caregivers  |
| Care Coordination Website                       |                                                                                                                                 |
| www.bluecrossmn.com/carecoordination            | • Access to Care Coordination communications, guidelines, forms, letters, resources, and trainings  
• Links to Amerigroup resources               |
| Delta Dental                                    |                                                                                                                                 |
| For Members: 651-406-5907 or 1-800-774-9049     | • Assistance with finding dental providers  
• Scheduling assistance                      |
| For Care Coordinators: 651-994-5198 or 1-866-303-8138 |                                                                                                                                 |
| Member Services                                 |                                                                                                                                 |
| MSHO: 651-662-6013 or 1-888-740-6013            | • Benefit questions  
• Interpreter services  
• Assistance finding an in-network providers  
• Billing questions/grievances               |
<p>| MSC+: 651-662-5545 or 1-800-711-9862            |                                                                                                                                 |
| TTY: 711                                        |                                                                                                                                 |</p>
<table>
<thead>
<tr>
<th>Department</th>
<th>Questions</th>
</tr>
</thead>
</table>
| Nurse Line                                     | • Health questions answered by an RN  
• Available 24 hours a day, seven days a week  
• Members need to choose “talk to a nurse” option when calling.                        |
| MSHO 651-662-6013 or 1-888-740-6013            |                                                                                                                                 |
| MSC+ 651-662-5545 or 1-800-711-9862           |                                                                                                                                 |
| Partner Relations Consultant Team             | • Blue Plus liaison for MSHO and MSC+ Care Coordination contracts  
• Primary contact for care coordination program and process questions including but not limited to:  
• Member specific issues  
• LTSS/Elderly Waiver  
• Health Risk Assessment/Care Planning  
• Care Coordination audits  
• Care Coordination program operations |
| Stormy Church, Manager                        |                                                                                                                                 |
| Melinda Heaser, LSW, CCM 651-662-9533         |                                                                                                                                 |
| Kim Pirkl, LSW, CCM 651-662-3074              |                                                                                                                                 |
| Nissa Roberts, MA, MBA, MHP, LGSW 651-662-7613 |                                                                                                                                 |
| Ricky Vang, RN, BSN, PHN, MHA 651-662-4523    |                                                                                                                                 |
| Partner.Relations@bluecrossmn.com Fax: 651-662-0015 |                                                                                                                                 |
| Pharmacist                                     | • Speak with a Blue Plus pharmacist about medication concerns                                                                           |
| MSHO Donna Boreen, Clinical Pharmacist 651-662-1264 or 1-800-711-9868 ext. 21264 |                                                                                                                                       |
| Donna.boreen@bluecrossmn.com                  |                                                                                                                                 |
| MSC+ Adrienne Matthews Clinical Pharmacist 651-662-1053 ext. 21053 |                                                                                                                                       |
| Adrienne.Matthews@bluecrossmn.com             |                                                                                                                                 |
| Prime Therapeutics                            | • Pharmacy assistance  
• Available 24/7 to assist with prior authorizations                                                                 |
| 1-800-509-0545                                 |                                                                                                                                 |
| Provider Services                              | • Provider assistance (not including EW)  
• Contract/provider access questions                                                           |
| 1-866-518-8448                                 |                                                                                                                                 |
| SecureBlue MSHO Enrollment                     | Care Coordinator’s should refer members to the following for assistance with MSHO enrollment:  
• County Financial Worker  
• Senior Linkage Line: 1-800-333-2433                                                   |
Definitions

**Care Coordination**: Blue Plus’s contracts with the Department of Human Services for Care Coordination for both MSHO and MSC+. Care Coordination for MSHO members means “the assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO Enrollees, and who coordinates services to an MSHO Enrollee. For MSC+ members this means “the assignment of an individual who coordinates the provision of all Medicaid health and long-term care services for MSC+ Enrollees, and who coordinates services to an MSC+ Enrollee. This coordination is among different health and social service professionals and across settings of care. This individual (the Care Coordinator) must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.”

The Care Coordinator is key to supporting the member’s needs across the continuum of care by leveraging member involvement, Blue Plus and County case management, and program referral processes. The Care Coordinator works closely with both the member, via face to face meetings, phone contact, and written communication and with other members of the Interdisciplinary Care Team (ICT). The ICT is unique to each member’s specific needs, but at a minimum consists of the member and/or a family designated representative, and healthcare provider. This team ensures development of an individualized holistic plan of care that is member centric.

The Care Coordinator conducts the initial assessment, and periodic re-assessment as necessary, of supports and services based on the member’s strengths, needs, choices and preferences in life domain areas. It is the Care Coordinator’s responsibility to arrange and/or coordinate the provision of all Medicare and Medicaid funded preventive, routine, specialty, and long-term care supports and services as identified in the Enrollee’s Care Plan whether authorized by the Care Coordinator, County, or Blue Plus. The Care Coordinator is expected to work closely with other Case Managers and agencies involved with the MSHO/MSC+ member. To do this, they should collect, review, and coordinate the Blue Plus Care Plan with other member care plans, as appropriate (i.e., hospice care plans and/or home care agency’s care plans, etc.). The member’s Care Plan should be routinely updated, as needed, to reflect changes in the member’s condition and corresponding services and supports. The Care Coordinator must also ensure access to an adequate range of choices for each member by helping the member identify culturally sensitive supports and services. Care Coordinators must also arrange for interpreter services if needed.

The Care Coordinator also participates in on-going performance improvement projects that are designed to achieve significant favorable health outcomes for Blue Plus members. Finally, Care Coordinators work with Social Service Agencies and Veteran’s Administration to coordinate services and supports for members as needed.

**Delegate**: is defined as the agency, such as counties, private agencies and clinics, that are contracted to provide Care Coordination services for Blue Plus. Delegates are responsible for periodic reporting to Blue Plus as requested and needed to meet business requirements. Examples include but are not limited to: Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential services tools, and late screening document entry follow up.
**Model of Care (MOC):** is Blue Plus’s plan for delivering coordinated care to SecureBlue (MSHO) members. The Center for Medicare and Medicaid Services (CMS) requires all Special Needs Plans (SNPs) to have a MOC. The Model of Care (MOC) documents the staff, systems, procedures, and improvement activities Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members. The MOC also describes how Care Coordination delegates work together with Blue Plus providers and staff to coordinate access and delivery of all preventive, primary, specialty, acute, post-acute, and long-term care services, including discharge planning, among different health and social service professionals and across health settings. Care Coordination delegates are required to complete annual training on the MOC included as part of Blue Plus’s Annual Fall Training.

**New Enrollee:** is defined as member who is newly enrolled in Blue Plus. Members who switch products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO) or vice versa) are considered new enrollees. All requirements related to new enrollees is applicable in all these scenarios. Note: a change in rate cell only does not mean the member is newly enrolled even if it results in a change in Care Coordination.

**ID Prefix’s:** are now included in front of the members ID number. The prefixes are JTM for MSHO and LMN for MSC+. These prefixes are prior to the ID number. (i.e. JMN####)  

**Bridgeview ID:** This number will be 8+PMI for identification in Bridgeview. This is not the member’s ID number on their medical card.

**AGP/Blue Cross Member ID:** Members will continue to have a member ID number assigned by Amerigroup (i.e. 726xxxxxx, 727xxxxxx).

**Transfer:** is defined as an existing (already enrolled) Blue Plus member who has been transferred to a new Blue Plus delegate.

**Required Caseload per worker:** for Community Well, Nursing Facility, and Elderly Waiver is as follows: Elderly Waiver/Community Well mix = 40-70, Nursing Facility only = 90-120, and Community Well only = 75-100.

**Blue Plus SecureBlue Model of Care (SNP-MOC) Policies and Procedures**

The SecureBlue Model of Care ensures that Blue Plus, in partnership with its contracted providers, meets the unique needs of the SecureBlue-MSHO (Minnesota Senior Health Options) population. The Blue Plus Policy & Procedure Manual, Blue Plus Provider Manual, and Care Coordination Delegation Guidelines describe the services, practices, procedures, and systems necessary to successfully deliver coordinated care consistent with the SecureBlue Model of Care.

In accordance with the Blue Plus Provider Service Agreement, all contracted providers agree to support the implementation of the Blue Plus Model of Care by adhering to the policies and procedures contained in the Blue Plus Policy and Procedure Manual and the Blue Plus Care Coordination Delegation Guidelines. Care Coordination Delegates further agree to comply with all Minnesota Department of Human Services (DHS) requirements and statutes and Center for Medicare and Medicaid Services (CMS) rules and regulations related to the completion of a
comprehensive initial health risk assessment of the beneficiary's physical, psychosocial, and functional needs, as well as annual health risk re-assessment.

Care Coordinators should use professional judgement interpreting the following guidelines and policies to make decisions related to the care and treatment of Blue Plus members:

- MN rules and statutes
- DHS policies and training
- County program training and guidelines
- Provider training and guidelines
- Medicare coverage criteria
- Disease Management protocols
- Blue Plus Certificates of Coverage

**Special Needs Plans Model of Care (SNP-MOC) Training**

The Centers for Medicare & Medicaid Services (CMS) requires all providers and appropriate staff who see beneficiaries of a fully integrated dual eligible Special Needs Plan (SNP) on a routine basis to complete initial and annual Special Needs Plan-Model of Care (SNP-MOC) training. Providers and appropriate staff required to complete the training include anyone who may participate in a SecureBlue member's Interdisciplinary Care Team be responsible for implementation of the member's Collaborative Care Plan or manage planned or unplanned transitions of care.

Blue Plus utilizes annual, in-person Fall Training to meet the CMS SNP-MOC training requirement for Care Coordination delegates. Care Coordinators are expected to attend training in person or by sending delegates from each county or care system to attend the training and then train the remaining Care Coordinators that did not attend. Additionally, Care Coordination delegates are responsible for ensuring all newly hired Care Coordinators complete training on the SNP-MOC.

Blue Plus will maintain attendance records for in-person training. Care Coordination delegates must document and maintain MOC training completion records for those Care Coordinators who did not attend the in-person training. At a minimum, training completion records must include the Care Coordinator’s name and the date the training was completed. Upon request, Care Coordination delegates must provide training completion records to Blue Plus to validate that the SNP-MOC training has been completed.

The SecureBlue SNP-MOC training is available online as a PowerPoint presentation. All contracted Care Coordination Delegates and staff are required to view this training annually and save a copy of their attendance logs.

Blue Plus is committed to maintaining strong, collaborative partnerships with our care coordination delegates to ensure they have easy access to the information and tools necessary to provide the highest quality, evidence-based care. We therefore work with our delegate partners to validate that mandated and regulated activities such as Model of Care Training occur and
assist providers in identifying and overcoming any barriers to training completion. Your Blue Plus Provider Service Agreement reflects these commitments. Because compliance is critical, if a provider fails to complete the CMS required training and remains noncompliant, they may be required to develop a Corrective Action Plan or be subject to other remediation activities.

**Person-Centered Practice and Planning Requirements**

The implementation of person-centered values, principles and practices is a requirement of several state and federal authorities. It is our expectation that all members receiving Home and Community Based Services have the same access and opportunity as all other members. A member’s unique life experiences such as culture, ethnicity, language, religion, gender and sexual orientation should be embraced in the planning process to enhance the member’s quality of life.

**Person-centered requirements apply to all but not be limited to:**

- Assessment/re-assessment
- Planning process
- Creation of service plans
- Review of services plans and collaborative care plans
- Transitions

**Members and or authorized representatives should be encouraged to:**

- Direct their own services and supports, when desired
- Include preferences, strengths, skills, and opportunity to promote dignity and respect
- Include community presence, participation and connections

**Delegate Responsibilities upon Notification of Enrollment**

Blue Plus is notified of enrollment by Department of Human Services (DHS) twice a month via enrollment tapes. Blue Plus then generates the following reports via Bridgeview to communicate enrollment with our Care Coordination Delegates. Delegates will receive an email notifying them that the reports are available from the SecureBlue enrollment e-mail box.

**New CAP:** List of members who are newly enrolled to MSHO or MSC+ and is available in Bridgeview the first week of each month. Occasionally this report is ready a few days prior to the enrollment month. Do not start care coordination activities until on or after the 1st of the enrollment month.
**Full Detail:** A comprehensive list of all members assigned to the Delegate agency available in Bridgeview by the 15th of each month which includes the following flags:

- **NEW:** Enrollees who enrolled after the DHS capitation
- **REINSTATED:** Members who were going to term but were reinstated with no lapse in coverage
- **TERMED:** Coverage termed
- **PRODUCT CHANGE:** Changed from MSC+ to MSHO or vice versa (these members are treated as brand new enrollees and will need a new HRA)
- **TRANSFER:** Existing enrollee who transferred to you. Official notification is via form 6.08 Transfer in Care Coordination Delegation.
- **TERMED FUTURE:** Lists Month/Year. Member will be termed at the end of the month listed. CC should follow up to determine if the reason for disenrollment requires mediation (i.e., MA paperwork not submitted yet).
- **GRACE PERIOD ENDING:** Lists Month/Date/Year which will be 30/60/90 days out from the enrollment month. These are MSHO members whose MA has termed but continue to have MSHO coverage for 90 days. See 90 Day Grace Period (MSHO only) section of the guidelines for care coordinator tasks.

**Daily Add:** Includes new enrollees who were retroactively enrolled by DHS after both the New CAP and Full Detail reports were received by DHS and processed; these could come late in the month.

**Upon notification, the Delegate:**

1. Reviews the “New CAP” list to check for discrepancies (i.e. member is incorrectly assigned to your agency) and reports them to Secureblue.Enrollment@bluecrossmn.com no later than the 15th of the enrollment month.

2. Compares the “Full Detail” list to the previous month’s Full Detail list to check for discrepancies and reports them to Secureblue.Enrollment@bluecrossmn.com no later than the 15th of the enrollment month.

3. Reviews the Daily Add report for discrepancies and reports them to SecureBlue.Enrollment@bluecrossmn.com no later than 15 days from notification. The Delegate will receive an email if there’s a Daily Add report and be directed to log into Bridgeview to access it. These members are new enrollees for the month and Guidelines should be followed for timely assessment within 30 or 60 days of notification, as applicable.

**Note:** For discrepancies not reported by the 15th of the enrollment month, the assigned care coordination delegate must initiate care coordination and is responsible to complete all applicable Blue Plus Care Coordination tasks prior to transferring the member the first of the following month.

4. Assigns a Care Coordinator per Delegate’s policy.
5. Informs the member of the name, number, and availability of the Care Coordinator within **10 days** of notification of enrollment.

6. Enters the name of the Care Coordinator assigned in Bridgeview.

7. Documents any delays of enrollment notification in case notes.

**Blue Plus Members Living in a Veteran Administration Nursing Home**

For MSHO and MSC+ members living in a Veteran’s Administration Nursing Home, the Care Coordinator should follow the processes and timelines outlined in the Care Coordination Guidelines for Members in the **Nursing Home**.

**Note:** Please be aware these members are designated by DHS as a Rate Cell A (Community Well) and will show up as a Rate Cell A on your enrollment reports instead of Rate Cell D like other members in the nursing home. The Delegate should be aware of this and proceed as they would other Rate Cell D nursing home members.

**Members with Another Case Manager**

Members who are on non-EW waivers (DD, CAC, CADI or BI); are living in an ICF/DD; or a DD member living in the community already benefit from intensive assessment and care planning by the HCBS waiver or DD case manager. While the primary case management responsibility will remain with the HCBS waiver or DD case manager, the MSHO/MSC+ Care Coordinator must collaborate with the other case manager. Members open to another HCBS waiver will show on your enrollment list as Community Well/Rate Cell A or those residing in an ICF will show as rate cell D. These members should be assessed following these community guidelines. Completion of these requirements can only be refused by the member or their representative. If the member or guardian refuses completion of DHS 3428H, follow the steps above under “CW Refusals”.

**The Care Coordinator must complete the following Care Coordination responsibilities:**

- Required contacts with member and physician
- Completion of DHS 3428H and 6.17 Care Plan – ICF/DD and HCBS Waivers.
- Enter assessment into Bridgeview.
- Semi-annual member contact and monitoring of goals completed on 6.17 Care Plan – ICF/DD and HCBS Waivers
- Transition of Care activities
- Blue Plus Care Coordinator is responsible for authorizing state plan home care services, including PCA, and must follow the process in the Home Health Care Authorization section in coordination with the other Case Manager.
- MSHO supplemental benefit discussion (as applicable)
- MSHO enrollment with MSC+ enrollees (as applicable)
• Sign and date 6.17 Care Plan – ICF/DD and HCBS Waivers
• Obtain member/responsible party signature on 6.17 Care Plan – ICF/DD and HCBS Waivers
• Provide a copy of 6.17 Care Plan – ICF/DD and HCBS Waivers to the member and other waiver Case Manager
• Provide a copy of 6.17 Care Plan – ICF/DD and HCBS Waivers or a care plan summary letter to the physician.
• Enter Screening Document(s) following the directions as outlined in DHS Instructions for Completing and Entering the LTCC Screening Document in MMIS for the MSHO and MSC+ Programs (DHS-4669). Refer to section: Entry of LTC Screening Document information into MMIS.
• For members on other waivers (DD, CAC, CADI & BI), do not enter waiver service agreements into Bridgeview.
• Care Coordinators are responsible to authorize MA home care and/or PCA authorizations. All authorizations are faxed using the “Care Coordinator Request for Service Authorization Form” to AGP UM Operations at 1-844-429-7763.

Complete a new MN Health Risk Assessment Form (DHS 3428H) and 6.17 Care Plan – ICF/DD and HCBS Waivers within 365 days.

**Contact Requirements**

**Member Contact**

Assessments required for:

• Annual
• Initial
• Significant Health Change
• Product Change
• Health Plan Change
• Refusal
• Unable to Reach (see below)
• Member Request (HRA needs to be completed within 20 calendar days of member’s request.)
### Contact Requirements

<table>
<thead>
<tr>
<th>Contact/year</th>
<th>MSHO CW</th>
<th>MSHO EW</th>
<th>MSC+ CW</th>
<th>MSC+ EW</th>
</tr>
</thead>
</table>
| **Initial Assessment*  
(includes product changes)** | CC contact info given w/in 10 days  
Face-to-Face w/in 30 days | CC contact info given w/in 10 days  
Face-to-Face w/in 30 days | CC contact info given w/in 10 days  
Face-to-Face w/in 60 days | CC contact info given w/in 10 days  
Face-to-Face w/in 30 days |
| *due after notification of enrollment* | *Transitional HRA’s may be done telephonically.*  
*DHS 3428H may be offered for CW members who refuse a Face-to-Face.* | | | |
| **Annual Assessment** | Face-to-Face within 365 days | Face-to-Face within 365 days | Face-to-Face within 365 days | Face-to-Face within 365 days |
| **Semi-annual Contact** | Minimum—phone contact | Face-to-Face | Minimum—phone contact | Minimum—phone contact |
| **New/Change in Care Coordinator** | CC contact info given w/in 10 days of the change | | | |
| **As Needed Contact** | Contact for significant change in member’s health status or as requested | | | |

### Physician Contact Requirements

**New Member:** Send Intro to Doctor letter within 90 days of notification of enrollment (8.28 or 8.29)

- Send 8.28 Intro to Doctor letter OR
- Send 8.29 Care Plan Summary Letter – Intro to Doctor; which combines the Intro and Summary letter. This letter can be used in lieu of 8.28 Intro to Doctor letter if the face-to-face visit and this letter is mailed within 90 days of notification of enrollment.
Re-assessment and Significant Changes:

- Send 8.29 Care Plan Summary Letter to Doctor or a copy of the care plan (not required for members who have refused an HRA).
- As needed for updates to care plan following a Transitions of Care (TOC)
- When there is any change in Care Coordinator, provide new Care Coordinator contact information to the doctor.
- For clinic delegates, notification to primary care physician documented per clinic process.

Initial Contact with New MSHO and MSC+ Enrollee

1. The Delegate is responsible to verify member’s eligibility prior to delivering Care Coordination services

2. Use the following optional checklists: MSHO CW EW Checklist or MSC+ CW EW Checklist.

3. Delegate will inform the member of the name, number, and availability of the Care Coordinator within 10 calendar days of notification of enrollment

4. Welcome call/letter (8.22 Intro Letter) to member within 30 calendar days after notification of enrollment

5. Explanation of Care Coordinator’s role. Optional resource: 6.01 Welcome Call Talking Points.

6. Have the following discussions:

   **MSHO Enrollees:**
   
   - Explain MSHO supplemental benefits using resource 6.26 Explanation of Supplemental Benefits.
   - Document this discussion on the checklist(s), in your case notes, or on the assessment/care plan if available.

   **MSC+ Enrollees:**
   
   - Discuss SecureBlue MSHO product and provide enrollment resources, if applicable. See SecureBlue MSHO Enrollment Resources page on the website.
   - Document this discussion or ineligibility for MSHO on the checklist(s), in your case notes, or on the assessment/care plan if available.
   - Information about enrollment, including resources, can be found in the MSHO enrollment link on the care coordination website.

7. Confirm the correct Primary Care Clinic (PCC). A PCC may have been chosen by the member or auto-assigned if one was not indicated at the time of enrollment.

   **To change a member’s PCC:**
The Care Coordinator must update the PCC field in Bridgeview. The field includes a list of all PCC’s from our Primary Care Network Listing (PCNL) in a drop-down format. You must choose a clinic from one that is listed. If the member’s PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Please contact Member Services or your Partner Relations Consultant with any PCC network questions.

**Determine if a Change in PCC requires a transfer in Care Coordination:**

The member’s PCC may determine the Blue Plus delegate that provides care coordination (see list below). Changing the PCC in Bridgeview alone will not transfer care coordination.

The following PCC’s provide primary care and care coordination:

- Bluestone Physicians (also responsible for: HealthEast and Fairview Partners)
- Essentia Health
- Genevive (MSHO only in select nursing facilities)
- Lake Region Health Care Clinic (MSHO members in select Nursing Facilities in Otter Tail County)

If the CC needs to confirm who the new Care Coordination Delegate will be, refer to 9.07 Care Coordination Delegate Listing and Contact Table on the care coordination website or contact your Partner Relations Consultant.

**Health Risk Assessment**

(See Contact Requirements above for HRA timelines and required member and physician letters)

**Health Risk Assessment Options**

- **LTCC (DHS 3428)** Health Risk Assessment tool for initial and annual assessments.
- **6.28 Transitional HRA**
  - Optional HRA tool for newly enrolled members or product changes who have had an LTCC or MnCHOICES Assessment within 365 days of enrollment and who have not experienced a significant change.
  - May also be used for members who have had a 3428H and Care Plan within the last 365 days.
• **Minnesota Health Risk Assessment Form (DHS 3428H)**
  - HRA for members on non-EW waivers (DD, CAC, CADI or BI); are living in an ICF/DD; or DD member living in the community.
    - 6.17 Care Plan – ICF/DD and HCBS Waivers
  - HRA for members who consent to a telephonic health risk assessment (CW members who have previously refused a face-to-face HRA)
    - 6.40 Care Plan- Telephonic: care plan to be used with telephonic HRA.

**Community Well (CW) Refusals**
Members not open to a waiver or receiving home care services who refuse completion of an HRA. Care Coordination is still required for refusals.

**Community Well (CW) Unable to Reach**
Members who the Care Coordinator has not been able to reach. CC has made three contact attempts and sent a letter (total of 4 contact attempts) to offer an HRA.

**Health Risk Assessment Requirements**

**LTCC (DHS Form 3428)**
- The Care Coordinator will thoroughly complete all sections of the Minnesota Long Term Care Consultation Services Assessment Form (LTCC) DHS-3428. As a result of the LTCC Assessment, if the member is determined to be at risk, or needs referrals for specialty care, other home care services or assessments, the Care Coordinator will make all appropriate referrals. For example, if the member is at risk for falls, a PT referral can be completed. If the member experiences incontinence, a referral to their primary physician should be completed. If the MSHO member needs to increase physical activity, enrollment into Silver & Fit may be appropriate.
- Document any delays in scheduling of the assessment
- Documents any delays of enrollment notification
- Enter the assessment type and date into the Bridgeview Company’s web tool (refer to Bridgeview manual) by the 10th of the following month.
- Enter an LTC Screening Document in MMIS (See Entry of LTCC screening document information into MMIS section)
- Re-assessment is due within 365 days of the date of this LTCC.
6.28 Transitional HRA

The 6.28 Transitional Health Risk Assessment can be used in the following circumstances.

1. For new enrollees who have had an LTCC/MnCHOICES within 365 days.

   Care Coordinator reviews and obtains:
   a. LTCC or MnCHOICES Assessment
   b. Current care plan:
      • Collaborative Care Plan or
      • Coordinated Services and Supports Plan (CSSP)

   Care Coordinator enters the following into Bridgeview:
   • Assessment prior to enrollment (LTCC or MnCHOICES)
   • 6.28 Transitional HRA

   **Reference Bridgeview Care Coordination Delegate User Guide: LTCC/MnCHOICES completed prior to enrollment (Transitional HRA entry)

2. For members who have had a product change and have had an LTCC/MnCHOICES or a MN Health Risk Assessment DHS 3428H in the last 365 days.

   Care Coordinator obtains and reviews:
   a. LTCC or MnCHOICES Assessment or DHS 3428H
   b. Current care plan:
      • 6.02.01 Collaborative Plan of Care
      • Coordinated Services and Supports Plan (CSSP)
      • 6.17 Care Plan – ICF/DD and HCBS Waivers
      • 6.40 Care Plan- Telephonic

   Care Coordinator enters the following in Bridgeview:
   • 6.28 Transitional Health Risk Assessment.

Additional notes related to use of the Transitional HRA:

- The above assessments/care plans can be reviewed either telephonically or in person to ensure the information has not changed and the care plan is addressing the member’s needs. If any portion of the paired documents is missing or unsigned, the Care Coordinator is responsible for obtaining the missing information. If unable to obtain the missing information, the Care Coordinator must complete a new assessment and care plan.
• The next re-assessment is due within 365 days of the LTCC/MnCHOICES assessment or the DHS 3428H not the date of the Transitional HRA.

Minnesota Health Risk Assessment Form - DHS 3428H

HRA for members on non-EW waivers (DD, CAC, CADI or BI); are living in an ICF/DD; or DD member living in the community.

• 6.17 Care Plan – ICF/DD and HCBS Waivers: care plan to be used with members open to other waivers

See section Members with another Case Manager above.

Note: Some of these members may be designated by DHS as a Rate Cell D (nursing home) and will show up as Rate Cell D on the enrollment report. The Delegate should be aware of this and proceed with the responsibilities as outlined in these community guidelines.

Telephonic Health Risk Assessment – DHS 3428H

Care Coordinators should always offer a face-to-face HRA which is the preferred option. DHS 3428H is only for use with Community Well members (Rate Cell A) who refuse a face-to-face assessment and who are not receiving EW or home care services. If the member still refuses to be seen in person, the Care Coordinator should ask if they would be willing to consent to a telephone health risk assessment using DHS 3428H.

If the member agrees, the Care Coordinator should do the following:

1. A case note should be entered into the member’s record stating that the member refused a face-to-face health risk assessment.
2. Complete DHS 3428H over the phone with the member or the guardian following the contact requirements.
3. Complete 6.40 Care Plan- Telephonic.
4. Mail a copy to the member for their records and a copy of the signature page they can return to the Care Coordinator with their signature.
5. Enter the HRA date into Bridgeview recording the date you completed the telephonic HRA (DHS 3428H).
6. Complete an MMIS LTC Screening Document following instructions in section Entry of LTC Screening Document information into MMIS.

• Enter screening document type “H” using the following codes:
  • Activity Type 01 (telephone screen)
  • Assessment Result 35 (MSHO/MSC+)
  • Program Type 18
**Product Changes:** if a member changes product (MSC+ to MSHO or vice versa), they are considered a new enrollee and an HRA is required. To complete the required HRA for those who have previously agreed to and completed DHS 3428H telephonically:

- Contact the member and offer a Face-to-Face assessment again per the process outlined in the Initial Contact section.
- If the member continues to refuse the Face-to-face, review the current 3428H Health Risk Assessment and 6.40 Care Plan-Telephonic with the member by phone.
- Complete a Transitional HRA and attach to the current DHS-3428H Health Risk Assessment and 6.40 Care Plan- Telephonic.
- Enter the HRA date into Bridgeview recording the date you completed the Transitional HRA.
- Complete an MMIS LTC Screening Document following instructions in section Entry of LTC Screening Document information into MMIS.
  - Enter screening document type “H” using the following codes:
  - Activity Type 01 (telephone screen)
  - Assessment Result 35 (MSHO/MSC+)
  - Program Type 18

**Reminder:** Re-assessments must be completed within 365 days of the previous DHS 3428H Health Risk Assessment and 6.40 Care Plan- Telephonic.

**Community Well (CW) Refusals**

Refusals can only be made by the member or responsible party. If a face to face HRA is refused, offer the option of completing the DHS 3428H which can be done telephonically. Community well members receiving Home Care or PCA services cannot refuse the HRA and continue to receive services.

If the member refuses both telephonic and face-to-face assessment, the CC should do the following:

- Document in the member record a case note stating that the member refused the health risk assessment.
- Enter a SD using the Refusal code in MMIS
- Enter the refusal in Bridgeview following instructions found in the Bridgeview manual.
- Continue to reach out at minimum, every six months either by mail or phone.
Community Well (CW) Unable to Reach

If you are not able to reach the member or their authorized representative for their assessment the Care Coordinator must:

1. Make a total of four attempts to contact the member via phone, e-mail, or letter to offer an HRA. The fourth and final attempt must be mailing 8.40 Unable to Contact Letter to the member.

2. Document the dates for each of these attempts in Bridgeview following the process outlined in the Bridgeview manual.
   a. The assessment date should be the same as the date the final letter was sent.

3. Enter into MMIS, a screening document type “H” with assessment result “50”
   a. This should be the same as the assessment date entered into Bridgeview.
   b. For initial, complete within 45 days of enrollment.
   c. For re-assessments, within 365 days of the previous assessment screening document.

Important tips for Unable to Reach:

- Follow-up contacts need to be started with plenty of time to accommodate all attempts before the initial or 365-day deadline.
- If applicable, CCs should be reaching out to other contacts to obtain a working phone number. You may document those dates in Bridgeview as phone contacts.
- You may enter the same date in BV if your attempts occurred on the same date.
- Your final attempt must be a letter which is the activity date entered into Bridgeview and MMIS.

Re-assessments

The following steps are to be completed with each re-assessment for EW and CW. If the member is temporarily in nursing home or hospital at the time re-assessment is due, an HRA is still required within 365 days. CC should use professional judgement to complete an assessment within the timeframes. Document any delays in re-assessments.

1. The Delegate is responsible to verify member’s eligibility prior to delivering Care Coordination services.

2. Within 365 days of the last assessment, the Care Coordinator will thoroughly complete all sections of the Minnesota Long Term Care Consultation Services Assessment Form (LTCC) DHS-3428.

3. For members on other disability waivers, in an ICF/DD or DD member living in the community, complete the Minnesota Health Risk Assessment Form DHS 3428H.
4. The Care Coordinator shall complete the applicable care plan within 30 calendar days of the HRA:
   - 6.02.01 Collaborative Care Plan
   - 6.17 Care Plan – ICF/DD and HCBS Waivers
   - 6.40 Care Plan- Telephonic

5. Enter the assessment type and date into the Bridgeview Company’s web tool by the 10th of the following month.

6. The Care Coordinator will complete 8.29 Care Plan Summary Letter to Doctor or send a copy of the care plan.

7. If state plan home care services are needed, see Home Health Care Authorizations section.

8. Enter Screening Documents following the process and timeframes as outlined in section, Entry of LTC Screening Documents.

9. Discuss SecureBlue MSHO product and assist the member to enroll if applicable.

10. Document this discussion in the assessment if available or in your case notes. If member is not eligible for MSHO and the discussion did not take place, document this in the assessment if available or in your case notes.

Information about enrollment, including both Care Coordinator and Member resources, can be found in the SecureBlue MSHO Enrollment link on the care coordination website.

**Screening Document Activity Type 10**

DHS Bulletin #18-25-05 Service Update Activity Type- Elderly Waiver and Alternative Care Programs provides instruction re: using Activity Type 10- Service Change on the LTC Screening Document. Activity type 10 was initially created to help streamline the process for fee-for-service clients when an update was needed but there wasn’t a need for a whole new MnCHOICES assessment.

Blue Plus Care Coordinators should **not** use Activity Type 10. Care Coordinators are required to complete a new LTCC for a change in condition. If you have questions, please contact your Partner Relations Consultant.
Entry of LTC Screening Document information into MMIS

Follow the directions as outlined in the DHS Instructions for Completing and Entering the LTCC Screening Document in MMIS for the MSHO and MSC+ Programs (DHS-4669).

MMIS Reminders:

- The LTCC CTY field for all Blue Plus screening entries is BPH
- Upon entry of the Screening Document (SD) prior to saving, review the SD for edits and document status (do not leave the SD in a Suspended status).
- Case Manager Comment Screen is used for the Care Coordinator to add additional comments regarding the screening or assessment visit, as applicable.
  - When using 05/98, in the comment screen clarify the purpose of the screening document i.e. Care Coordinator change, THRA, etc.
- DHS Comment Screen is used to communicate back to the Care Coordinator.
- SD type H: Cannot be used to open or reopen program eligibility nor extend or close program eligibility

Timeline for MMIS entry

Community Well (non-Elderly Waiver) enrollees

- **MSHO CW**: Enter SD within 45 days of enrollment date and within 45 days of re-assessment
- **MSC+ CW**: Enter SD within 75 days of enrollment date and within 45 days of re-assessment

Assessment entry for all members on EW

Re-assessments and screening documents must be entered by the cut-off dates listed below. When MMIS entry is late and results in EW closure, the member reverts to rate cell A (community well) status. The member will get a new ID card and potentially have co-pays. It may also impact their medical spenddown, if applicable. When the waiver span lapses, Blue Plus continues to pay out EW claims for these members without the correct reimbursement from DHS.
SD must be entered into MMIS by these cut-off dates:

<table>
<thead>
<tr>
<th>When the first month of the waiver eligibility span is:</th>
<th>Last Day to enter timely screening document into MMIS is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2020</td>
<td>12/20/19</td>
</tr>
<tr>
<td>February 2020</td>
<td>1/23/20</td>
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<tr>
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<td>2/20/20</td>
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<tr>
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<td>10/22/20</td>
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<tr>
<td>December 2020</td>
<td>11/18/20</td>
</tr>
<tr>
<td>January 2021</td>
<td>12/22/20</td>
</tr>
</tbody>
</table>

Assessment entry for community members opening to EW for the first time (assessment result 01)

Enter SD in MMIS within 60 days of your assessment date or no later than 365 days from the member’s previous face to face assessment, whichever date comes first.

Community Well members

For CW members assessed using LTCC and not receiving PCA:

- Enter SD type “L”
  - Activity Type 02 face to face
  - Assessment Result 03 (person will remain in, or return to, the community without services)
  - Program Type 18
For CW members receiving PCA services and not on a HCBS waiver:

- Enter SD type “L”
- Select value 21 PCA Health Care for “Reason for Referral” field
- Activity Type 02 (community face to face)
- Assessment result 02 (in community without waiver or AC services)
- Program Type 18 (MSHO/MSC+ Community)
- Service Plan summary: select 18 (personal care) or 80 (home care nursing) with funding source code F (formal)

For CW members on another Waiver (CADI, CAC, BI, DD) assessed using 3428H Health Risk Assessment and 6.17 Care Plan – ICF/DD and HCBS Waivers, enter SD type “H” with the following codes:

- Activity Type 01 (telephone screen) or 02 face to face
- Assessment Result 35 (MSHO/MSC+)
- Program Type 18

**CW Refusals**

Enter SD within 45 days of the enrollment date using the screening document type “H”:

- Activity type 07
- Refusal code 39
- Program Type 18

**CW Unable to Reach**

Enter SD within 45 days of the enrollment date using the screening document type “H”:

- Activity type 07
- Assessment Result 50
- Program Type 18

**CW Refusing face to face visit but consents to telephonic HRA using DHS 3428H**

Enter SD within 45 days of enrollment date. Enter screening document type “H”

- Activity Type 01 (telephone screen)
- Assessment Result 35 (MSHO/MSC+)
- Program Type 18
Instructions for updating MMIS Entry for Transitional HRA or Transfers only

The delegate is responsible for updating an existing LTC Screening Document in MMIS for either EW or CW populations when the member:

- moves from another Health Plan to Blue Plus
- switches products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO))
- moves from FFS to Blue Plus
- when there is a change in Care Coordinator

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Transitional HRA for New Enrollee (includes product changes)</th>
<th>Transitional HRA for New Enrollee (includes product changes)</th>
<th>Change in Care Coordinator</th>
<th>Change in Care Coordinator</th>
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</thead>
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<td>Community Well</td>
<td>Elderly Waiver</td>
<td>Community Well</td>
<td>Elderly Waiver</td>
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<tr>
<td>Activity Type:</td>
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<td>05</td>
<td>05</td>
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</tr>
<tr>
<td>Activity Date:</td>
<td>Date Transitional HRA is completed</td>
<td>Date Transitional HRA is completed</td>
<td>Date delegate assumed Care Coordination responsibility</td>
<td>Date delegate assumed Care Coordination responsibility</td>
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<td>n/a</td>
</tr>
<tr>
<td>Case Managers Name and UMPI Number</td>
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<td>Use your MCO UMPI number</td>
<td>Use your MCO UMPI number</td>
<td>Use your MCO UMPI number</td>
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<td>Assessment Result:</td>
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<tr>
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<tr>
<td>Program Type Note: program type cannot be changed with 05 SD</td>
<td>18</td>
<td>03 or 04</td>
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</table>
Comprehensive Care Plan (CCP)

Care Coordinators shall develop a comprehensive care plan in collaboration with the member, caregiver, and/or other interested persons at the member’s request, within 30 calendar days of completing the member’s Health Risk Assessment.

Completion of a care plan would not apply to the following:

- 6.28 Transitional Health Risk Assessment (unless there is not an attached CSSP/CCP)
- Unable to Reach
- Community Well Refusal

The care plan options include the following:

- 6.02.01 Collaborative Care Plan: to be used following completion of the LTCC assessment DHS 3428 (refer to resource 6.02.02 Instructions for the Collaborative Care Plan)
- 6.17 Care Plan – ICF/DD and HCBS Waivers: to be used following completion of the Minnesota Health Risk Assessment Form DHS 3428H for members on non-EW waivers (DD, CAC, CADI or BI); living in an ICF/DD; or a DD member living in the community
- 6.40 Care Plan - Telephonic: to be used following completion of the Minnesota Health Risk Assessment Form DHS 3428H via telephone. All CW members who were previously refusals should be offered completion of DHS 3428H and 6.40 Care Plan - Telephonic

Care Planning Requirements

The Care Coordinator must:

1. Complete all sections of the appropriate care plan.
2. Sign the care plan.
3. Obtain the member’s signature. Provide a complete copy of the care plan to the member and any care team members chosen by the member.
4. Mail 8.25 (SB) or 8.25.01 (MSC+) Care Plan Cover Letter which includes the Medicare and/or Medicaid Member Rights and Complaint information.
5. Send a copy of the care plan or care plan summary (8.29 Care Plan Summary Letter) to the member’s physician.
6. Obtain necessary provider signatures (see Provider and Member Signature Requirements in next section).
7. Create goals that are person-centered.
8. Evaluate and update any changes to the member’s condition and corresponding services and supports, at minimum every 6 months.
9. Care Coordinators are expected to monitor and document progress of the member goals. Review and document outcomes on each specific goal every 6 months, as needed, and at reassessment.

**Collaborative Care Plan components**

The Care Plan must employ an interdisciplinary/holistic approach incorporating the unique primary care, acute care, long term care, mental health and social services needs of the individual with appropriate coordination and communication across all providers and at minimum should include:

- Case mix/caps
- Collaborative input with the Interdisciplinary Care Team which, at a minimum, consists of the member and/or his/her representative, the Care Coordinator, and the primary care practitioner/physician (PCP).
- Assessed needs
- Member strengths and requested services
- Accommodations for cultural and linguistic needs
- Care Coordinator/Case Manager recommendations
- Formal and informal supports
- Person-centered goals and objectives, target dates, on-going monitoring of outcomes through regular follow-up.
- Identification of any risks to health and safety and plans for addressing these risks. This should include informed choices made by the member.
- Discussion of Medical Management telephonic programs. Members or their caregivers have access to additional case and disease management to receive education and support for situations involving catastrophic illness, high medical costs, frequent hospitalizations, out-of-state providers, or when additional education or support is requested by a member’s caregiver. Make a referral to these programs by sending in the MSHO MSC+ Case and Disease Management Referral Form available on the care coordination website.
- Advanced Directives discussions. The care coordinator can also use the optional resource 9.19 BCBSMN Advance Directive and cover letter 8.27 Advanced Directive Letter to Member
- Preventive discussions to educate and communicate to member about good health care practices and behaviors which prevent putting their health at risk.
- Documentation that member has been offered choice of HCBS and nursing home services and providers.
Provider and Member Signature Requirements (See 9.15 Provider Signature FAQ Resource)

Provider signature requirements apply only to members on Elderly Waiver.

The Care Coordinator must discuss, with member or representative, the CMS requirement of sharing their care plan and service information with EW and PCA providers (only if on EW). EW and PCA providers must sign to indicate their acknowledgement of the services and supports in the plan and their agreement to deliver them as outlined. The Care Coordinator must follow the process outlined in 6.02.02 Instructions for the Collaborative Care Plan—number 51 and 60.

Members can choose to have their care plan shared with their service provider(s) or just a summary letter. Care Coordinators can use 8.52 Provider Care Plan Cover Ltr for members who agree to send the entire care plan or 8.51 Provider Care Plan Summary Ltr which includes information about individual services only.

Both letters need to be returned to the Care Coordinator with provider signatures.

1. Signatures required for:
   - Initials
   - Annuals
   - Changes to the plan that affect how the Elderly Waiver and PCA (if applicable) service is provided (i.e., changes in hours/units, change in provider, or addition of a new provider). The member must sign acknowledging their agreement to the change. The Care Coordinator will follow the process outlined in the Instructions for the Collaborative Care Plan, number 60.

2. Signatures not required for:
   - Members not on EW
   - MA State Plan Home Care Services: Home Health Aide and Skilled Nursing Visits (only required for MA State Plan PCA)
   - Community Well members who have PCA
   - Approval-option: purchased-item services
   - Consumer Directed Community Supports (CDCS)
   - Residential Services (RS) Tool and Individual Community Living Services (ICLS) Service Planning tool. The CC can send the RS tool or ICLS Service Planning tool (DHS-3751) to the provider in lieu of the entire care plan if the member makes an informed choice to do so. Both the RS tool and ICLS Service Planning tool include a provider signature field.
Home Health Care Authorization Processes

Medicare skilled home care services and Medical Assistance state plan home care services must be provided by a Blue Plus participating provider.

This section will cover the process for home care service authorizations except PCA. See PCA Authorization Processes section for more information.

Medicare Skilled Home Care Services

Medicare billable skilled home care services do not require prior authorization or notification to Blue Plus Utilization Management (UM). The home care agency determines if the member qualifies for Medicare covered skilled home care services. If Blue Plus is notified of Medicare eligible skilled home care services, Blue Plus will advise the home care agency to contact the Care Coordinator to assure continuity of services.

Medical Assistance State Plan Home Care Services

The following information relates to all members receiving Medical Assistance state plan home care services, including those on other HCBS waivers (ICF/DD, CAC, CADI, BI). Care Coordinators may approve a prescribed amount of state plan home care services which requires a notification only to Blue Plus UM. Amounts exceeding what is allowed for Care Coordinator approval will require prior authorization from Blue Plus. Both types of requests require the Care Coordinator to fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.

Blue Plus will not accept requests for authorization of services received directly from a home care provider. The provider will be advised to contact the Care Coordinator to review and make the request following the processes outlined below.

State plan home care services include:

- Skilled Nurse visits (SNV)
- Home Health Aide visits (HHA)
- Home Care Nursing (formerly Private Duty Nursing/PDN)
- Physical, Occupational, Respiratory, and Speech Therapy
- Personal Care Assistance (PCA)

Care Coordinator Role:

1. Coordinate service needs with the provider including initial authorizations, acute changes in a member’s condition requiring additional services, or at re-assessment.

2. Send the Care Coordinator Request for Service Authorization Form to AGP UM Operations at 1-844-429-7763.
3. When an initial determination is made to authorize a service, Care Coordinators must provide notification to the requesting provider by phone and document the notification in their case notes.

4. Consider the following in your home care decision making process:
   - Follow the guidelines outlined in the Home Care chapter of the Community Based Services Manual (CBSM).
   - For members on another waiver (CAC, CADI, ICF/DD, or BI) the Care Coordinator is responsible for authorizing state plan home care services and must follow these processes in coordination with the other case manager.
   - Authorization should coincide with the member’s current waiver span or assessment year if not on a HCBS waiver.

**Process for Care Coordinator Approval of Home Care Authorizations**

Care Coordinators may approve without UM review up to the following prescribed amounts. Care Coordinators will send in service authorization using the Care Coordinator Request for Service Authorization Form for the following:

- Up to 52 Skilled Nurse Visits per year (not to exceed 2 visits per week)
- Up to 156 Home Health Aide visits per year (not to exceed 3 visits per week)
  - if the member does not live in Adult Foster Care or Customized Living
  - if the member is not receiving PCA services
- Up to 20 visits per discipline per year of MA home therapy: physical, occupational, speech, or respiratory therapy
- Personal Care Assistant (PCA) Services

**Note:** For an initial assessment done by the home care provider to determine home care service eligibility, the Care Coordinator can wait until after the initial visit to create the authorization. This visit should be included with the total number of visits needed in addition to any PRN (as needed) visits.

**Blue Plus UM will:**

1. Notify member and home care provider of the authorization via letter
2. The Care Coordinator can view Authorizations in Member360 in the Member Care Summary tab.

**Process for Care Coordinator Request for Review for Blue Plus Home Care Authorizations**

Blue Plus requires prior authorization to determine medical necessity for home care service amounts exceeding what is allowed for approval by the Care Coordinator. Care Coordinators will select “Request for Review” on the Care Coordinator Request for Service Authorization Form for the following:
• Any visits exceeding notification limits above.
• Home Health Aide visits for members in Customized Living or Adult Foster Care (attach a copy of the member’s Residential Services (RS) tool)
• Home Health Aide in conjunction with PCA Services
• Home Care Nursing (formerly PDN)
• Acute changes in condition requiring more visits than currently authorized if they are beyond the limits or scope of what the Care Coordinator may authorize

Upon receipt of the prior authorization request, UM will:

1. Conduct a medical necessity/clinical review following the guidelines outlined in the Home Care chapter of the CBSM and applicable State Statutes. Per statute, authorization is based upon medical necessity and cost-effectiveness when compared with other options.

2. Request any necessary medical information needed directly from the home care agency. Submitting clinical documentation is the home care agency’s responsibility.

3. Contact the Care Coordinator if additional input from the Care Coordinator is required

4. Make a coverage determination within 10 business days or 14 calendar days

5. Notify member and home care provider of the decision via letter

6. The Care Coordinator can view completed authorizations in Member360.

New enrollees with previously approved state plan home care services

If the member is new to Blue Plus with previously approved state plan home care services, for continuity of care, the CC should honor the current authorization until a new assessment is completed. If the provider is not in network, a temporary authorization may be approved for up to 120 days. The CC should assist the member with transitioning to an in-network provider before the temporary authorization expires.

The CC should notify Blue Plus by faxing the Care Coordinator Request for Service Authorization Form to AGP UM Operations at 1-844-429-7763.

Members on Elderly Waiver receiving state plan home care services

For members open to Elderly Waiver, the following state plan home care services must count towards and fit under their EW cap:

• Personal Care Assistance (PCA)
• Home Health Aide (HHA)
• Skilled Nurse Visit (SNV)
• Home Care Nursing (formerly Private Duty Nursing)
In addition to sending the UM authorizations to AGP, Care Coordinators must enter the grand total of these services in Bridgeview under MA Plan Services in the LTCC & Case Mix section. (including Care Coordination and Case Aide amounts). See the Bridgeview Manual for entry instructions.

The following state plan home care services do NOT need to fit under the EW cap:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

**Elderly Waiver Extended Home Care Services**

To be eligible for extended home care services, the member must be accessing state plan home care service benefits under Medical Assistance. If they need additional services than what is allowed under state plan, the Care Coordinator may approve extended home care services under EW as allowed within the member’s EW budget. The Care Coordinator may only use extended services for the same services already authorized under the medical benefit (i.e., Home Health Aide is approved under the medical benefit, then the EW extended home care service must also be Home Health Aide). Extended home care services are not subject to Blue Plus prior authorization and notification guidelines.

**PCA Authorization Processes**

The Care Coordinator is responsible for the completion of activities associated with assessing PCA and authorizing services for all members eligible for the PCA services under the MSHO/MSC+. All requests for PCA assessments or re-assessment will be routed to, managed, and completed by the assigned Care Coordinator.

To be eligible for PCA services, the recipient must:

- Have a stable medical condition not needing hospitalization and require PCA to live in the community
- Live in their home, not a hospital, nursing facility, ICF/MR, foster care setting with more than 4 residents, or any facility licensed by the Minnesota Department of Health (MDH).

**Requesting a PCA Assessment:**

A request for PCA can be made by numerous sources for an MSC+/MSHO member, including but not limited to:

- the member,
- the member representatives
- public health nurses,
• treating practitioners,
• and other providers of service.

All SecureBlue (MSHO) and MSC+ members receiving or requesting PCA services will be required to be assessed using the DHS tools:

• Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244-ENG) which must be completed by RN or PHN, or
• LTCC in conjunction with the DHS tool Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3428D-ENG) which can be completed by a social worker, RN or PHN. Blue Plus will not accept the LTCC Assessment tool without the supplemental form.

In addition to completing the required PCA assessment, Care Coordinators must also do the following:

• Obtain the member’s signature (and interpreters if applicable) on the PCA assessment.
• Provide the member with a copy of the PCA assessment in addition with a copy of the MSHO or MSC+ Language Block available on the Care Coordination portal (new requirement)

**PCA Services for members open to non-EW waiver:**

If a member is on a DD, CAC, CADI, BI waiver, it is the responsibility of the Care Coordinator to authorize PCA following the authorization processes below. The Care Coordinator must coordinate/communicate with the other waiver case manager and Blue Plus.

The need for PCA services will be determined by the other Case Manager from their MnCHOICES assessment. The other waiver Case Manager should communicate the assessed PCA needs with the Care Coordinator who will request the authorization from AGP UM using the Care Coordinator Request for Service Authorization Form.

**New enrollees with existing PCA authorizations:**

Determine if the PCA provider is in the Blue Plus network by verifying with the PCA provider directly or calling Member Services.

• If in network, the Care Coordinator will fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.
• For PCA providers not in our network, Care Coordinator will fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. CC should note on the request the reason for the out of network provider, such as continuity of care. CC should work with the member to transition to an in-network provider within 120 days.
**New PCA authorization requests for current enrollees:**

1. Upon completion of the PCA assessment, the CC is responsible for providing a copy of the completed PCA Assessment and Service Plan to the member and PCA provider within 10 days of the assessment.

2. Current enrollees must use an in-network PCA provider. Determine if the PCA provider is in the Blue Plus network by verifying with the PCA provider directly or calling Member Services.

3. Prior to starting services, the CC/assessor must fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. The Care Coordinator should align the PCA date span with the EW date span, if applicable.

**Re-assessment PCA Authorization Requests:**

1. Complete the PCA Assessment and Service Plan prior to the end of the authorization period.

2. Provide a copy of the completed PCA Assessment and Service Plan to the member and PCA provider within 10 days of the assessment.

3. At least 10 business days prior to the end of the current authorization, the CC must fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. The Care Coordinator should align the PCA date span with the EW date span, if applicable.

**Change in PCA Provider:**

1. If member has a current PCA but wishes to change PCA providers, the CC must confirm the new PCA provider is in network by verifying with the PCA provider directly or calling Member Services.

2. If the new provider is in network, the Care Coordinator will fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.

**PCA Temporary Start/Temporary Increase:**

If a member has immediate or acute PCA needs prior to being assessed or re-assessed, Care Coordinators can authorize up to 45 days of PCA. CC must fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.

**Extended PCA Requests for Members on EW:**

For Blue Plus members open to EW, extended PCA hours may be authorized by the Care Coordinator in Bridgeview. Extended PCA services cannot be a “stand-alone” PCA service. To be eligible for extended PCA, the member must first be accessing PCA services under their medical benefits. If the medical benefits alone do not meet the member’s care needs, extended
PCA services may be authorized by the Care Coordinator under EW as allowed within the member’s EW budget. The Care Coordinator should assess for appropriateness of extended PCA. UM does not review extended PCA as it is not based on medical necessity criteria.

**Enhanced PCA Rate**

Members who receive PCA services may qualify for a higher reimbursement rate for PCA for work that is both:

- Provided by a worker who has completed qualifying trainings
- Provided to a person who is eligible for 12 or more hours of state plan PCA per day and/or has the home care rating ‘EN’

PCA Choice agencies and FMS providers must pass on the enhanced rate percentage to the specific worker who completed the trainings in the form of wages and/or benefits. PCA agencies and FMS providers may find instructions for doing so in the MHCP PCA Manual.

**Service Authorization Errors**

If the Care Coordinator learns of a MA Home Care or PCA service authorization error, you must complete the Service Authorization Error Form and fax to AGP UM operations to make the correction.

**Elderly Waiver Authorizations**

When authorizing EW services, the Care Coordinator is expected to be compliant with all EW program rules. Care Coordinators should follow all appropriate bulletins related to EW, and follow directions found in the MN Health Care Program (MHCP) Provider Manual Chapter 26A: Elderly Waiver and Alternative Care and directions found in the Community Based Services Manual (CBSM). A link to these manuals is in the Resource section of the Care Coordination website.

All EW Service Agreements are created in Bridgeview.

**When an initial determination is made to authorize a service, Care Coordinators must provide notification to the requesting provider by phone and document the notification in their case notes.**

**MHCP Enrolled Providers**

EW services must be delivered by a provider enrolled with Minnesota Health Care Programs (MHCP). Blue Plus does not contract directly with any Elderly Waiver providers. Providers must enroll directly with DHS to ensure EW payment for Blue Plus members. Care Coordinators should ensure EW providers are enrolled with DHS prior to authorizing services.
Providers should visit the Bridgeview website for more information.

Care Coordinators must ensure members are given information to enable them to choose among available DHS enrolled providers of HCBS. Care Coordinators may share with members the statewide listing of enrolled HCBS providers from the Minnesotahelp.info website. If the Care Coordinator uses a local list of Elderly Waiver providers, the list must indicate that additional providers from other areas of the state are available and include the phone number of the Care Coordinator to call for assistance.

**Approval-Option Service Providers**

A group of basic EW services can be delivered by an MHCP-enrolled provider or a qualified vendor approved by a lead agency. These are referred to as Approval-Option Services.

Blue Plus contracts with Delegates who have agreed to bill in a “pass-through” capacity for approval-option service providers (direct delivery services and purchased item services). We expect the need for this will be limited. An example might be a chore service such as a neighbor snow shoveling or an environmental modification contractor. For more information on becoming a contracted pass-through entity, contact your Partner Relations Consultant.

Enter Service agreements for Approval Option Services within Bridgeview.

See the DHS CBSM for more information about Approval-Option Services and lead agency requirements.

**Service Agreements**

Bridgeview processes all Elderly Waiver provider claims and Service Agreements for MSHO/SecureBlue and MSC+/Blue Advantage.

Care Coordinators will enter Service Agreements directly into Bridgeview. Care Coordinators are also responsible for EW Provider inquiries related to their Service Agreement entries.

**Service Agreement Errors**

If the Care Coordinator learns of a service agreement error after entering the authorization in Bridgeview, the Care Coordinator can modify it within Bridgeview.

**Waiver Obligation**

Information regarding a member’s waiver obligation, if they have one, will be displayed in Bridgeview. Waiver obligations may change retroactively, and any questions should be referred to the member’s county financial worker. Questions regarding which provider was assigned the waiver obligation for a specific month may be directed to Bridgeview.

Inquiries related to EW claims and Service Agreements should be directed to Bridgeview.
MA Services Included in EW Case Mix Cap

Care Coordinators must calculate the following services in addition to the cost of all EW services into the monthly case mix budget cap:

1. State plan home care services including:
   - Skilled Nurse visits (SNV)
   - Home Health Aide visits (HHA)
   - Home Care Nursing (HCN) (Formerly PDN)
   - Personal Care Assistance (PCA) and

2. Monthly Care Coordination and

3. Case Aide billing, if applicable

Requests to Exceed Case Mix Budget Cap

If a member has a unique set of assessed needs that require care plan services above their EW budget cap, a request for a higher monthly case mix budget cap may be submitted to Blue Plus for review and consideration. It is expected that the Care Coordinator has a discussion with the member/authorized rep and has already considered reducing various services to keep all service costs within the Case Mix Cap before submitting a request. The Care Coordinator must consult with their supervisor if they decide they wish to submit a request to exceed. Care Coordinators may also consult with their Partner Relations Consultant prior to submitting the request.

Notes related to requests to exceed:

- If the member has requested to exceed the EW Case Mix Cap and the Care Coordinator determines there is no assessed need, the Care Coordinator must request a DTR by faxing in the Care Coordinator Request for DTR form and notify the member within 24 hours of determination.
- Requests to exceed published Customized Living or 24 Customized Living rate limits are unallowable unless as part of an approved Conversion rate request.
- First-time requests must take place prior to the service initiation.
- A reauthorization request of a previously approved rate must be made at least 30 days prior to the end of the current authorization period.
Process to request an exception to Case Mix Budget Cap

Provide the following information to the EW Review Team via a secure email to Partner.Relations@bluecrossmn.com.

- 6.27 Request to Exceed Case Mix Cap/Conversion Request form
- Care Coordination case notes for previous 2 months
- Current LTCC (reviewed within the previous 60 days)
- Current Care Plan
- A copy of Residential Services tool, if applicable (CL rate must be within CL rate limits except for EW Conversion rate requests)
- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team
- A description of other options within the member’s current budget which have been considered and why they are not possible must be included on the 6.27.

The EW Review Team will:

1. Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents

2. Confer with the Care Coordinator if the documentation provided does not support the requested level of service

3. Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed

4. Consult with the Medical Management Medical Director as needed

5. Approve, deny, or recommend a change in the budget rate request

6. If request is approved, Review Team will determine the length of time for the approval. Requests to exceed the case mix cap approval period will be determined based on the member needs and reason for exception, not to exceed a twelve-month period.

If approved, the EW Review Team will:

1. Send notification to Care Coordinator via email

2. EW Review Team will notify Bridgeview.
The Care Coordinator must:

Place the full CAP amount (rather than the approved amount that exceeds case mix cap) in the Case Mix/DRG Amount field on the LTC screening document.

If not approved, the EW Review Team will:

1. Advise the Care Coordinator on how to assist the member to look at other options which may include adjusting the level of service to more appropriately reflect the documented need and/or explore other provider options.

2. Request a DTR
   - UM will issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 business days/14calendar days, whichever is sooner, of the receipt of all the required information/documents.

3. Notify the Care Coordinator within 24 hours of the determination.

Withdrawal of a request to exceed case mix cap

If at any time the Care Coordinator decides to withdraw the Request to Exceed Case Mix Budget Cap prior to the authorized end date, the Care Coordinator must:

1. Communicate the withdrawal request in writing to Partner.Relations@bluecrossmn.com

   Be sure to include:
   - Member Name
   - Member ID number
   - Date of initial request
   - Request to Exceed Case Mix Cap Z end date
   - Reason for withdrawal (Examples: no changes in services but due to DHS Annual COLA increase the member no longer exceeds their case mix cap; member initiated a reduction in current services; member expired and no longer needs request to exceed case mix cap, etc.)

2. Update the member’s service agreement(s) in Bridgeview for the remainder of the EW span date after the withdrawal effective date.
**EW Conversion Requests**

A monthly conversion budget limit is an exception to the monthly case mix budget caps for an EW participant leaving a nursing facility.

- First-time conversion requests must take place prior to the service initiation.
- A reauthorization request of a previously approved rate must be made at least 30 days prior to the end of the current authorization period.

**Process to request EW Conversion Rate**

To request Conversion rate, the Care Coordinator must provide the following information to the EW Review Team via a secure email to Partner.Relations@bluecrossmn.com:

- DHS-3956 Elderly Waiver Conversion Rate Request or DHS -3956A Elderly Waiver Consumer Directed Community Supports (CDCS) Conversion Rate Request (both available on DHS e-Docs, fax all conversion rate requests forms to 651-662-6054, do not fax or send to DHS)
- 6.27 Request to Exceed Case Mix Cap/Conversion Request form
- Care Coordination case notes for previous 2 months
- Current LTCC
- Current Care Plan
- A description of other options within the member’s current budget which have been considered and why they are not possible must be included on the 6.27.
- A copy of Residential Services tool, (if applicable)
- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team

**The EW Review Team will:**

1. Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents
2. Confer with the Care Coordinator if the documentation provided does not support the requested level of service
3. Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
4. Consult with the Medical Management Medical Director as needed
5. Approve, deny, or recommend a change in the budget rate request

6. If request is approved, EW Review Team will determine the length of time for the approval.

   - **Initial Conversion Rate** for members transitioning out of a nursing facility, authorization will be given for a six-month period. This will allow the Care Coordinator and the EW Review team time to determine if the member is stable in their new community environment and if services and rates need to be adjusted to meet any changes in the identified needs of the member.

   - **Reauthorization without Change in Level of Service:** If the EW Review team agrees with the level of services authorized for members who have previously transitioned to the community using an approved EW conversion budget, Blue Plus will reauthorize the budget for a twelve-month period. This applies to current and newly enrolled MSC+/MSHO members.

   - **Reauthorization with Change in Level of Service:** If the EW Review Team assesses the member to need a different level service than what was previously authorized for a member who has transitioned to the community using an approved EW conversion budget, the authorization period will be for six months. This will allow the Care Coordinator and the EW Review Ream time to determine if the member is stable with the new service levels and if services and rates need to be adjusted to meet any changes in the identified needs of the member.

**If approved, the EW Review Team will:**

1. Send notification to Care Coordinator via email.
2. EW Review Team will notify Bridgeview.

**The Care Coordinator must:**

1. Place the full CAP amount (rather than the higher conversion rate) in the Case Mix/DRG Amount field on the LTC screening document.
2. For approved Conversion Requests when a member will/reside in Customized Living, the Care Coordinator must complete the “Conversion Limit” tab in the CL workbook.

**If the request is not approved, the EW Review Team will:**

1. Advise the Care Coordinator on how to assist the member to look at other service options.
2. Request a DTR
   - UM will then issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 business days/14calendar days, whichever is sooner, of the receipt of all the required information/documents.
3. Notify the Care Coordinator within 24 hours of the determination.
Process to withdrawal EW Conversion Rate

If at any time the Care Coordinator decides to withdraw the Conversion request prior to the authorized end date, the Care Coordinator must:

1. Communicate the withdrawal request in writing to PartnerRelations@bluecrossmn.com

   Be sure to include:
   - Member Name
   - Member ID number
   - Date of initial request
   - Reason for withdrawal (Examples: no changes in services but due to DHS Annual COLA increase the member no longer exceeds their case mix cap; member initiated a reduction in current services; member expired and no longer needs request to exceed case mix cap, etc.)

2. Update the member’s service agreement(s) in Bridgeview for the remainder of the EW span date after the withdrawal effective date.

The EW Review Team will notify the Care Coordinator via a confirmation notification email.

Elderly Waiver Services

Consumer Directed Community Supports (CDCS)

*CDCS* is a service option available under the Elderly Waiver which gives members more flexibility and responsibility for directing their services and supports including hiring and managing direct care staff. Refer to the Department of Human Services website for additional information regarding CDCS. CDCS policy information can be found here.

Members can:

- Choose or design the services and supports that fit their assessed needs
- Decide when to receive services and supports and
- Hire the people they want to deliver those services and supports.
The CDCS plan must:
- Address the needs that were assessed in the LTCC
- Address health and safety needs
- Meet MHCP and waiver criteria
- Be member-specific and person-centered
- Include goal(s) for each identified service or support

Care Coordinators must:
- Be familiar with Care Coordination/Case Management CDCS requirements
- Approve and monitor CDCS plans
- Make sure members comply with state and federal law
- Communicate CDCS budget increases with the 6633A CDCS Community Support Plan Addendum
- Maintain Blue Plus Care Coordination responsibilities

DHS offers a CDCS course for lead agency staff which includes:
- CDCS Basics
- Roles & responsibilities
- Reviewing a Community Support Plan
- Allowable goods and services
- Guidelines about paying spouses
- Involuntary exits from CDCS

The course is available on TrainLink. See the Blue Plus Care Coordination website under the Resources tab for more information.

Notes on authorizing CDCS:
1. There should only be 1 approved/active service agreement for the CDCS budget for the FMS provider for the waiver span.
2. Entry of CDCS service agreements is within Bridgeview. See the Bridgeview manual for entry details.
3. Authorize mandatory Case Management by creating a separate service agreement under code T2041. Care Coordination and Case Aide are billed under this service agreement. This is not included in the member’s CDCS budget.
4. Any MA home care including PCA, HHA or SNV need to be accounted for in the CDCS budget, if applicable.
5. PCA, HHA and SNV will be authorized under a separate home care service agreement, if applicable.

6. CDCS Background Checks (if applicable) should be separate service agreements from the CDCS service agreement in Bridgeview and are not included in the member’s CDCS budget.

7. There should not be any other separate service agreements authorized in combination with CDCS (besides mandatory Case Management, CDCS background and MA homecare if applicable).

8. The CDCS plan must include all services that will be paid out of the CDCS budget.
   - In the event of a change to the member’s budget (including COLA increases from DHS), the Care Coordinator is required to complete DHS-6633A CDCS Community Support Plan Addendum and provide to both the member and the FMS provider.

9. Goals must include language about how the goal will be implemented and how the results will be measured.

Choosing CDCS does not change the Care Coordinator’s responsibilities under the health plan.

The Care Coordinator remains responsible for the completion of the Health Risk Assessment (LTCC) and Collaborative Care Plan (CCP) within the required timeframes. The CCP should coordinate with the CDCS community support plan created by the member or their representative.

Please refer Bridgeview manual or contact your Partner Relations Consultant directly with questions.

**Home and Vehicle Modifications**

The Care Coordinator may authorize Home and Vehicle Modifications under EW in Bridgeview without submitting a prior authorization request to Blue Plus. The Care Coordinator must follow the guidelines as outlined in the Environmental Accessibility Adaptations chapter of the MHCP manual.

- Adaptations and modifications are limited to a combined total of $20,000.00 per member waiver year and must fit within member’s EW budget cap.
- Care Coordinators must use an enrolled HCBS provider or have a contract with Blue Plus to act as a billing “pass-through” for approval option service providers
- It is recommended that the Care Coordinator obtains bids from a minimum of two contractors or vendors.
- All services must be provided according to applicable state and local building codes.
- If the Care Coordinator determines that all criteria are met and the bid for the work is reasonable, they should enter a line item and amount on the member’s service agreement in Bridgeview as allowed within the budget.
- If the modification exceeds the case mix budget, refer to the Requests to Exceed Case Mix Budget Cap.
**EW Specialized Equipment and Supplies (T2029)**

Prior to the Care Coordinator authorizing Specialized Supplies and Equipment under Elderly Waiver in Bridgeview, the CC must determine that EW is the appropriate payor. For coverage determination complete the following:

1. Review DHS-3945 Long-Term Services and Supports Service Rate Limits to ensure item fits within member’s assessed case mix cap
2. Review MHCP Supplies/Equipment Coverage Guide
3. Review Medicare.gov for coverage determination
4. If an item can potentially be covered under Medicare/MA, the Care Coordinator should not enter a service agreement in Bridgeview until the CC has received confirmation the item is not eligible for coverage under the medical benefit.

**T2029 Eligibility Coverage Guide**

For assistance with determining utilization of T2029 under EW, refer to the Elderly Waiver Services Specialized Supplies and Equipment (T2029) Eligibility Coverage Guide (also known as EW T2029 Guide). This tool is to be used as a resource for determining EW coverage and primary payer source. **This Guide is not all inclusive** and is updated regularly. It is available on the Care Coordination and Bridgeview websites.

If an item is not listed on the EW T2029 Guide and the Care Coordinator is uncertain if it meets the EW Service Criteria as outlined in the MHCP and CBSM Manuals, contact your Partner Relations Consultant.

Items marked as “No” in the “EW T2029 Eligible” column of the T2029 Guide cannot be approved or covered.

Items marked with an *asterisk* may be eligible for coverage. If the item meets the criteria for EW coverage per the MHCP and CBSM Manuals, the Care Coordinator must include in the service agreement:

1. a description of the item
2. if the item costs $500 or more, the service description must also include notes detailing the case was reviewed with Supervisor and/or Partner Relations Consultant and approved
3. If the DME provider says the member does not meet Medicare and/or Medicaid criteria for the item, the service description must also include the specific reason the member did not meet Medicare/Medicaid criteria.

- **Example:** *EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per the DME provider. This specific reason must be indicated in the service description.*
**EW T2029 authorization process for: Single EW items less than $500**

For single item is **less than $500** that the Care Coordinator approves, the Care Coordinator should:

1. Enter a Service Agreement in Bridgeview including a description of the item
2. If the DME provider says the member does not meet Medicare and/or Medicaid criteria for the item, the service description must also include the specific reason the member did not meet Medicare/Medicaid criteria.
   - **Example:** *EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per the DME provider.* This specific reason **MUST** be indicated in the service description.
3. Document the item on the member’s Collaborative Care Plan budget worksheet.

If the Care Coordinator does not approve, follow the DTR process to deny the item.

**EW T2029 authorization process for: Single EW items over $500**

For EW T2029 single items over $500 the Care Coordinator should determine if the item is medically or remedially necessary and meets the criteria outlined in the CBSM manual. Care Coordinators must consult with supervisor and/or with Partner Relations Consultant prior to authorization. Coordinator should also:

1. Enter a Service Agreement in Bridgeview
2. Include a description of the item and notes detailing that the case was reviewed and approved by the Supervisor and/or Partner Relations Consultant and approved.
3. If the DME provider says the member does not meet Medicare and/or Medicaid criteria for the item, the service description must also include the specific reason the member did not meet Medicare/Medicaid criteria.
   - **Example:** *EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per the DME provider.* This specific reason **MUST** be indicated in the service description.
4. Document the item on the member’s Collaborative Care Plan budget worksheet

If the Care Coordinator does not approve, follow the DTR process to deny the item.

**Authorization Process for Lift Chairs**

DME Providers, Care Coordinators and Blue Plus Utilization Management (UM) all have a role in the process of obtaining authorization for lift chairs for members on EW. Coordination and communication are key.
**Lift Mechanism Process:**

If the DME provider determines the member meets Medicare/Medicaid criteria for coverage of the lift mechanism portion of the chair, the DME provider must:

1. Submit a claim to the member’s medical benefit
2. If the cost of the lift mechanism is greater than $400, the DME provider must request prior authorization following the authorization process as outlined in the BluePlus Provider Policy and Procedure Manual.
3. If prior authorization is needed, UM will review the request and make a coverage determination within 10 business days and notify the appropriate parties of the approval or denial determination as follows:

   **If approved under the Medicare benefit:**
   
   Notification will be sent to:
   
   - The member
   - Durable Medical Equipment Provider
   - Care Coordinator

   UM will enter an authorization into the claims payment system.

   **If denied under Medicare benefit:**

   - UM will send a DTR to the member and the provider and will notify the Care Coordinator via secure email.
   - The Care Coordinator may review for authorization of the lift mechanism under the EW benefit.
   - If the Care Coordinator approves the lift mechanism under EW, the lift mechanism and chair portion should be entered as two service agreements in Bridgeview.

If the DME provider determines the member does NOT meet Medicare/Medicaid criteria for coverage of the lift mechanism portion of the chair, the DME provider must:

1. Provide the Care Coordinator detailed reason for not meeting criteria.
2. Care Coordinator should enter the service agreement in Bridgeview and include the provider’s reason in the service description:
   
   **Example:** EW member does not qualify for coverage under Medicare/MA as member is unable to ambulate once standing. This specific reason MUST be indicated in the service description.
Chair Portion Process:

Once it has been determined if Medicare/MA will cover the lift mechanism, the Care Coordinator can enter an authorization for the lift chair in Bridgeview:

- If lift mechanism is being paid for by Medicare/MA benefits, authorize the total cost of only the chair portion in Bridgeview.
- If lift mechanism is NOT being paid by Medicare/MA benefits, authorize the total cost of both the lift mechanism and chair portion on two separate service agreements in Bridgeview.

If the chair portion of the lift chair costs over $950, the Care Coordinator must consult with their supervisor and/or the Partner Relations Consultant prior to authorizing in Bridgeview including notes in the service description the case was reviewed and approved by the Supervisor and/or Partner Relations Consultant.

Customized Living and Foster Care

See DHS bulletin #16-25-02 for the Comprehensive Policy on Elderly Waiver (EW) Residential Services.

Customized Living and Adult Foster Care are residential settings covered under the Elderly Waiver. Residential services are individualized and consist of covered component services designed to meet the assessed needs and goals of an EW participant. Residential service providers are required to be approved and enrolled through DHS.

The Care Coordinator will assist members who are moving to a registered Housing with Services establishment obtain a verification code. MMIS auto-generates the necessary verification code after SD entry.

Care Coordinators are required to use the DHS Residential Services Workbook (RS tool) for residential service planning and rate-setting in addition to submitting the tool to DHS. Refer to the DHS website below for the details including DHS bulletins, most recent versions of the tool, and instructions for completion and submission of the tool. With the member’s permission, care coordinators must send a complete RS tool to the provider.

Effective 8/1/18, Care Coordinators must complete “Person’s Evaluation of Foster Care, Customized Living, or Adult Day Service” DHS-3428Q-ENG form at each assessment for those residing in residential care or receive adult day services. See DHS bulletin #18-25-04 for specific details. More information on Elderly Waiver Residential Services can be found on the DHS page.
A face-to-face assessment determines Nursing Facility Level of Care (NF LOC). For Blue Plus members, this assessment is the LTCC.

If a member loses NF LOC, which determines EW eligibility, the NF LOC statute requires a minimum of 30 days advance notice for termination of services. The Care Coordinator will follow the instructions outlined in section: DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services.

Members that lose NF LOC should be offered alternative services including: State Plan Home Care or PCA if they are eligible.

**Essential Community Supports**

Care Coordinators may continue to have members who qualified for ECS program following the NF LOC changes effective January 2015. Members can participate in ECS if they continue to meet ECS criteria and do not exit the ECS program.

Members may not receive ECS services if they are eligible for personal care assistance (PCA) services. A member must live in their own home or apartment as ECS cannot be provided in Board and Lodge; non-certified boarding care or corporate or family foster care.

Services provided through ECS include: Homemaker, chore, caregiver training and education, PERS, home-delivered meals, service coordination, community living assistance (CLA), adult day services.

See the Essential Community Supports section of the CBSM for complete details.

**On-Going Care Coordination Responsibilities**

**Primary Care Clinic (PCC) Change**

Blue Plus must be notified when a member changes their Primary Care Clinic (PCC). This is especially important if the PCC change also results in a change in Care Coordination delegation.

1. To change a member’s PCC:

   The Care Coordinator must update the PCC field in Bridgeview. The field includes a list of all PCC’s from our Primary Care Network Listing (PCNL) in a drop-down format. You must choose a clinic from one that is listed. If the member’s PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Please contact Member Services or your Partner Relations Consultant with any PCC network questions.

2. Determine if Change in PCC requires a transfer in Care Coordination:

   If the member’s PCC is contracted with Blue Plus to provide care coordination (See list below), the change in PCC may also trigger a change in who provides Care Coordination for the member. Send notification to SecureBlue.Enrollment@bluecrossmn.com for enrollment miss-assignments or follow the process outlined in section: Transfers in Care Coordination to
another Delegate, which includes sending in form 6.08 Transfer in Care Coordination Delegation.

The member’s PCC may determine the Blue Plus delegate that provides care coordination (see list below). Changing the PCC in Bridgeview alone will not transfer care coordination.

The following PCC’s provide primary care and care coordination:

- Bluestone Physicians (also responsible for: HealthEast and Fairview Partners)
- Essentia Health
- Genevive (MSHO only in select nursing facilities)
- Lake Region Health Care Clinic (MSHO members in select Nursing Facilities in Otter Tail County)

If the CC needs to confirm who the new Care Coordination Delegate will be, refer to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.

Transitions of Care (TOC)

The Blue Plus Care Coordinator is key to supporting the member’s needs across the continuum of care. Regular engagement and contact with the member and their service providers allows the Care Coordinator to be informed of health care service needs and supports, thus allowing active management of planned and unplanned transitions. The goal of the TOC process is to reduce incidents related to fragmented or unsafe care and to reduce readmissions for the same condition.

***Transitions of Care engagement and follow up is required regardless of how or when the Care Coordinator learns of the transition. One way the CC may learn of the transition is through Blue Plus notice of inpatient admissions.

If the member has an additional case manager (i.e. CADI waiver case manager), the Care Coordinator may communicate applicable information about the transition(s) with them.

However, the Care Coordinator is responsible for completing all required tasks related to the transition(s) of care.

Definitions:

- **Transition:** Movement of a member from one care setting to another as the member’s health status changes. Returning to usual setting of care (i.e. member’s home, skilled nursing facility, assisted living) is considered a care transition and the required tasks need to be completed.
- **Care Setting:** The provider or place from which the member receives health care and health-related services. Care settings may include home, acute care, skilled nursing facility, and rehabilitation facility, etc.
• **Planned transition:** Planned transitions include scheduled elective procedures, including outpatient procedures performed in a hospital or outpatient/ambulatory care facility; discharges from the hospital to long-term care or rehabilitation facility; or a return to the member’s home (usual care setting) after an unplanned transition. Change in level of care (i.e. move from SNF to customized living) is also considered a planned transition of care.

• **Unplanned transition:** Unplanned transitions are most often urgent or emergent hospitalizations.

**Care Coordination TOC Documentation Responsibilities:**

   - Use 6.22.01 Transitions Log Instructions for detailed information on the completion of the log.

2. TOC logs are required if the CC learns of a transition while the member is in any phase of the transition process.

3. If the CC begins TOC interventions/log, they should complete the process through to discharge back to usual care setting even if the CC learns of the discharge back to the usual care setting 15 calendar days or more after it occurred.

   **Note:** **TOC logs are not required when the Care Coordinator finds out about all transition(s) 15 calendar days or more after the member has returned to their usual care setting. The Care Coordinator should still follow-up with the member to discuss the transition, any changes to their health status and plan of care and provide education about how to prevent future admissions. Document this discussion in contact notes.

4. **Planned Transitions:** The Care Coordinator should contact the member prior to the admission day to ensure they have the Care Coordinator’s phone number and understand how the Care Coordinator will assist during the member’s care transitions.

5. **Member is admitted to New Care Setting:** Share essential information with the receiving facility (discharge planner, Social Worker, etc.) within 1 business day of learning of the admission. Refer to 9.16 TOC Talking Points for Hospital staff.

   **Note:** If the member’s usual care setting is a long-term care facility or other supportive living setting, staff at this setting usually shares relevant care plan information with the receiving facility. However, it is the Care Coordinator’s responsibility to confirm this task has been completed by the facility staff and document the date they confirmed it on the transition of care log. If sharing of information has not been completed by the facility, the Care Coordinator must facilitate the completion of this task and document the date this was done on the transition of care log.

6. Notify the Primary Care Physician and/or Specialty Care Physician of all transitions including the transition to home, within 1 business day of learning of the transition. Optional form: 6.22.02 Fax Notification of Care Transition.
7. **Member Returns to Usual Care Setting:** The Care Coordinator is required to reach out to the member or authorized representative within one business day after the member returns to their usual care setting or “new” usual care setting or within 1 business day of learning of the transition and should discuss the following:

- Care transition process including the role of the Care Coordinator. For MSHO members offer post discharge resources. Refer to [Post Discharge Resources for SecureBlue Members](#).

- Changes to health status.

- Discuss and update any changes to plan of care. If the member’s usual care setting is a nursing facility, the Care Coordinator should confirm that necessary changes were applied to the care plan and offer input, if applicable, and provide support/reinforcement of the updated care plan.

- The Care Coordinator shall address the “Four Pillars for Optimal Transition: Care Coordinators should refer to 9.12 TOC Resource Toolkit for information on the four pillars:
  - Timely follow up appointment.
  - Medication Self-Management.
  - Knowledge of red flags
  - Use of a Personal Health Record

**Note:** Communication with the Customized Living or Nursing Facility staff does not replace the requirement to contact the member/member’s representative.

- Provide education about how to prevent unplanned transitions/readmissions. This education should be tailored to the member’s specific needs, diagnoses, health issues, etc. and should be in a format that best works for the member based on their abilities. Members with chronic conditions who are frequently hospitalized can still benefit from educational discussions about their conditions, appropriate care, treatment options and relationship building with the Care Coordinator. Members in a nursing facility can benefit from an opportunity to reinforce or develop what is in their nursing facility plan of care.
Pre-Admission Screening Activities

Pre-Admission Screening activities are done by an internal team at Amerigroup.

A referral for all members discharging from a hospital to a nursing home for any length of time must be made by the hospital to the Senior Linkage Line. The Senior Linkage Line (SLL) identifies that the person is a Blue Plus member and forwards the referral to Blue Plus for processing.

For CW members entering a nursing facility:

Delegate will be sent a secure email notification that a PAS was completed by AGP on a CW member. Blue Plus will send the OBRA Level I and required documents to the NF.

For EW members entering a nursing facility:

Delegate will be contacted via secure email by AGP with instructions to send a completed OBRA Level I to the designated NF if an EW member is being discharged to a nursing facility for ANY length of stay (including short rehab stays).

If AGP staff is unable to determine level of care based on the information obtained by the hospital, the delegate will be contacted with instructions that a face-to-face LTCC assessment is required. The assigned Care Coordinator or back-up staff will conduct the face-to-face assessment before discharge to the NF.

For CW members who have been determined to need an OBRA level II evaluation, AGP will make the referral to the county where the hospital or clinic is located for members with MI diagnosis, and the County of Financial Responsibility for those with DD diagnosis. For EW members the CC should make a referral to the same for OBRA level II evaluation if they determine a referral is appropriate.

Nursing Facility Level of Care must be re-established 90-days after Nursing Facility admission. Most frequently, this is done using the Minimum Data Set (MDS) completed by the Nursing Facility. If it cannot be determined using the MDS, a referral for an in-person LTCC assessment must be made, which is completed by the Care Coordinator. If, after the assessment, the member does not meet Nursing Facility Level of Care, the member is eligible for assistance with discharge planning by the Nursing Facility, through Transition support by Senior Linkage Line, Relocation Services Coordination, and Care Coordination as well as receiving a DTR submitted by the Care Coordinator to AGP.
Transfers

The term “transfer” refers to an existing Blue Plus enrollee who’s Care Coordination is transferring from one contracted Blue Plus Delegate to another contracted Blue Plus Delegate. This can be the result of a move, change in living arrangement, or a change in primary care.

New enrollees moving from straight Medicaid or another health plan and are new to Blue Plus are not considered transfers. Care Coordinators must follow the steps outlined in the Initial Contact with New MSHO and MSC+ Enrollee section of these guidelines.

Transfers of Care Coordination to Another Blue Plus Delegate

When a Care Coordinator becomes aware that a member is moving from their service area or the member chooses a PCC that impacts care coordination, the CC must:

1. Confirm the new Care Coordination Delegate by referring to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.
2. Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly to the new Delegate.
3. Update the member’s address, county of residence and/or PCC in Bridgeview.
4. Notify the member’s financial worker by completing the DHS 5181.
5. Keep copies of all forms and letters related to the transfer for your records.

The change in Care Coordination will be effective on the first of the month following the date of notification unless previously agreed upon with Blue Plus enrollment staff. It is expected that the current and receiving Care Coordinator work together to avoid gaps in care during the transition.

For a list of all tasks associated with a transfer, refer to Transfer in Care Coordination Delegation Checklist.

**Important:** If at the time of transfer it is known the member’s MA is terming and will not be reinstated, do not transfer the case. The current Care Coordinator should continue to follow the member until the member’s coverage terminates.

Responsibilities of the Care Coordination Delegate who is initiating the transfer:

1. Confirm the current and/or new PCC with the member, authorized rep, or customized living/nursing facility. This is especially important if the change in PCC triggers a change in care coordination delegation. For example, the following PCCs also provide care coordination to our members:
   - Bluestone Physicians (also responsible for: HealthEast and Fairview Partners)
   - Essentia Health
   - Genevive (MSHO only in select nursing facilities)
- Lake Region Health Care Clinic (MSHO members in select Nursing Facilities in Otter Tail County)

If the CC needs to confirm who the new Care Coordination Delegate will be, refer to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.

2. If the PCC needs to be changed, follow the PCC change process as outlined in the Primary Care Clinic (PCC) Change section.

**Note:** The official transfer of care coordination assignment is the first of the month following the notification date on this form unless previously agreed upon with Blue Plus enrollment staff.

**Responsibilities of the transferring Care Coordination Delegate:**

1. Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly to the new Delegate.

2. The **transferring** Care Coordinator is required, at a minimum, to share the following **directly** with the new delegate:
   - The next face-to-face assessment date (within 365 days of previous assessment)
   - Current Health Risk Assessment
   - Care Plan; including plan signature page and provider signature documentation
   - A copy of the Residential Services tool
   - My Move Plan Summary

3. The **transferring** Care Coordinator should communicate the following to the member’s financial worker:
   - Address change
   - EW eligibility

4. If the member is open to EW, the **transferring** Care Coordinator should:
   - Keep the waiver span open in MMIS if the member remains eligible for EW
   - Keep all active service agreement(s) in Bridgeview open, if services will continue with the same provider. Be sure to share this information with the new delegate.
   - Close service agreement(s) that are no longer applicable.

5. If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the **transferring** Care Coordinator should proceed with the transfer process outlined here and change the PCC (if applicable).
6. Transitions of Care responsibility: If this transfer of Care Coordination is the result of a change in level of care (i.e. a permanent move from SNF to Customized Living, etc.), the transferring delegate will need to finish up the Transitions of Care (TOC) responsibilities. This includes documenting this move on the Individual Transitions Log.

Responsibilities of the Care Coordination Delegate who is receiving the transfer:

The receiving delegate will receive the 6.08 Transfer in Care Coordination Delegation form for review and as notification of the transfer.

1. Assign a Care Coordinator and notify the member by the 10th of the month the change is effective. The 8.30 CM Change Intro letter may be used to notify the member of a change in Care Coordinator.

2. Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the Bridgeview Manual.

3. Update the Screening Document to reflect the change in Care Coordinator.

4. Notify the financial worker of the assigned Care Coordinator’s name.

5. Notify the physician using 8.28 Intro to Doctor Letter.

6. Confirm the PCC is correct in Bridgeview. If not, please update following the process outlined in the Primary Care Clinic (PCC) Change section of these Guidelines.

7. The Care Coordinator is now responsible for the content of the transferred assessment and care plan. The CC must review the assessment and care plan received from the previous Delegate. If applicable, document any updates and complete any areas that are not complete.

8. Follow the process for completing the health risk assessment and care plan if no current Health Risk Assessment/Care Plan is received from the transferring Delegate.

9. Keep copies of all forms and letters related to the transfer for your records.

Optional: Either Delegate may update the address and County of Residence in Bridgeview. This will be done automatically after the Financial Worker makes their changes; however, those changes may take up to a month to reach Bridgeview. Changing the address and county of residence manually will update the current month’s enrollment report. Follow the process outlined in the Bridgeview manual to make these manual changes.

Note: Manual changes made to the member information except the PCC in Bridgeview are saved for only 90 days. You must notify the financial worker to permanently change the member’s information.

Moving out of the Blue Plus service area

Do not follow the Transfers process. Instead, please communicate directly with the new Care Coordinator to send appropriate documentation.

Implications of a move outside Blue Plus service area should be discussed with the member ahead of time if possible. Resource 9.01 Blue Plus Service Area Map can be used to determine if a move will take the member out of our service area.
Member questions related to selecting a new health plan and/or Part D plan can be directed to either the member’s county financial worker or the Senior Linkage Line at 1-800-333-2433.

**Important:**

- Blue Plus will continue to pay for services, including Customized Living, until the member’s disenrollment.
- The Blue Plus Care Coordinator is responsible for all care coordination activities until the case is transitioned and until the member is disenrolled from Blue Plus. This includes all assessments, care plans, CL tools, service agreement entry, and TOC activities unless coordinated in advance with the receiving county/agency.
- If the Blue Plus Care Coordinator needs assistance with determining who to contact to coordinate the transition at the new county, contact your Partner Relations Consultant for assistance.

The following process should be followed to provide our member with a smooth transfer of care coordination services for transfers outside of the Blue Plus service area:

1. The **transferring** Care Coordinator is required, at a minimum, to share the following **directly** with the new Care Coordinator:
   - Completed DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form. Refer to DHS Bulletin 15-25-10 for complete details.
   - The next face-to-face assessment date (within 365 days of previous assessment)
   - Send the following documents, if applicable:
     - HRA/Long Term Care Consultation (LTCC)/MnCHOICES assessment/summaries
     - Care Plan; including plan signature page and provider signature documentation
     - A copy of the Residential Services tool
     - Any state plan service authorization information and
     - My Move Plan Summary.

2. Communicate the following to the member’s financial worker via DHS 5181:
   - Address change
   - EW eligibility

3. If the member is open to EW, the Care Coordinator should:
   - Keep the waiver span open in MMIS if the member remains eligible for EW
   - Keep all active service agreement(s) in Bridgeview open until disenrollment date.
   - If there is a time span that the member is still open to Blue Plus and has a new EW service provider who is not enrolled with, the Care Coordinator should provide contact information so that they may register for claims to process.
Transfers of Care Coordination within your agency

If there is a change in Care Coordinator within the Delegate agency, the Delegate agency must:

- Inform member of the name, number, and availability of new Care Coordinator within 10 calendar days (new CC may use 8.30 CM Change Intro letter)
- Update the Care Coordinator assigned in Bridgeview
- Enter a Screening Document into MMIS
- Notify the financial worker of the change in Care Coordinator.
- Notify the physician using 8.28 Intro to Doctor Letter.

My Move Plan Summary

The My Move Plan Summary (DHS-3936) helps to clarify role expectations before, during and after a move. It is a tool to communicate all key elements of the plan.

The summary is not required for temporary placements or for members who are not on a waiver.

The My Move Plan Summary must be offered in the following scenarios:

1. When a member who is on EW is moving to a new residence,
2. When a member who is expected to go on EW (i.e. from the nursing home) is moving to a new residence
3. When a member who is on EW or expected to go on EW expresses interest in moving to a new residence.

The My Move Plan Summary is optional in the following scenarios:

1. EW members who are permanently moving into a nursing facility
2. CW members who are moving residences
3. NH members who are moving residences and not going on EW

If the member is on a disability waiver, the Care Coordinator should ensure that the waiver CM completes the My Move Plan Summary form with the member. If not done by the CM, the Care Coordinator will be responsible for the My Move Plan Summary and can provide a copy to the other CM as appropriate.
The Care Coordinator is responsible to:

1. Evaluate the member’s needs,
2. Build and share the Summary with the member,
3. Update the My Move Plan Summary,
4. Update the Collaborative Care Plan (if applicable)
5. Communicate information to others involved (if applicable), and
6. Sign and keep a copy of the completed document in the member’s file.

The My Move Plan Summary form includes identification of “my follow up support” person. This person may be the Care Coordinator, or another identified support person. The “Follow Up person” is responsible to ensure the My Move Plan is implemented and the follow up contacts are made with the member including contact:

1. on the day of the move,
2. within the first week of the move,
3. within the first 45 days of the move,
4. and provide an on-going review of the plan as needed.

If the My Move Plan Summary was not completed, the Care Coordinator should indicate the reason on DHS-3936 and retain a copy in member’s case file:

1. CC was not aware of the move, or
2. Member declined to complete a move plan summary, or
3. Other reason.

Please see the DHS Person Centered Protocol for more information about the My Move Plan Summary form and Person-Centered Practices.

**EW re-assessments and Termination of MA Eligibility**

Care Coordinators are required to complete re-assessments for Elderly Waiver members who lose MA eligibility for up to 90 days when it is expected that the member’s MA will be reinstated during the 90-day period. This applies to all EW members in both MSHO and MSC+ and is usually due to members not renewing their MA timely. These members may show on the enrollment report flagged with a “future term” date. In these cases, the Care Coordinator should follow up with the member and confirm the reason for the term.
*This requirement does not apply to those who lose eligibility for moves out of state, who exceed income or asset limits, or for whose MA is not expected to be reinstated within the 90 days.

If the member’s annual EW re-assessment is due during the 90-day term window and it is expected that the MA will be reinstated during this time, the Care Coordinator must complete and retain the following documents in the member’s file:

1. LTCC Screening Tool DHS 3428,
2. Collaborative Care Plan, and
3. OBRA Level I.

The Care Coordinator should work with the member and their financial worker to reinstate the MA as quickly as possible. The LTC Screening Document DHS 3427, must be entered in MMIS when the member’s MA is reinstated.

*See instructions below for Care Coordinator case closure responsibilities and tasks associated with term due to lapse in MA coverage for EW members

Refer to DHS 6037A HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form: Scenarios for People on AC, EW, or ECS for more information.

**Case Closure Care Coordination Responsibilities**

Activities required when closing a member’s case depends on the reason for the termination. If you have any questions, always contact your Partner Relations Consultant. Care Coordinators should be referring to the DTRs—Coordination of Potential Denials, Terminations, and Reductions of Services section to determine if a DTR is needed. Here are some common “termination” scenarios (not all inclusive):

**Term Due to Death**

1. No need to notify Blue Plus
2. Must send notification to the Financial Worker via DHS 5181
3. May enter date of death into Bridgeview, however, this is not mandatory
4. Close service agreements in Bridgeview back to the date of death, (EW only)
5. Close member to EW in MMIS (EW only)

**Term Due to a Move out of the Blue Plus Service Area**

Refer to Moving out of the Blue Plus Service Area section of the guidelines
Term Due to a Move Out of State or Out of Country

1. Close member to EW in MMIS (EW only)
2. Close service agreements in Bridgeview (EW only).
3. Notify Financial Worker via DHS 5181

Term Due to Lapse in MA Coverage for Elderly Waiver (EW) Members

1. Keep case open as member may reinstate within 90 days
2. Keep waiver span open in MMIS and Bridgeview
3. Keep all service agreements open Bridgeview
4. Send DHS form #6037 to the County of Residence (COR) by Day 60 if MA has not been re-established and you anticipate the member will term by Day 90.
5. If the member is due for re-assessment during the lapse, see EW re-assessments and termination of MA section above.
   • Refer to DHS resource 6037A Scenario 10 for more information
   If the member is reinstated:
   • Enter assessment screening document, if applicable
   • Adjust service agreement(s) as applicable
   If the member is not reinstated after 90 days, you can close the member’s case.
   • Close member to EW in MMIS back to MA closure date
   • Close Service Agreements in Bridgeview back to MA closure date
   • Enter Screening Document into MMIS to exit member from EW

Term Due to Lapse in MA Coverage for Community Well (CW) Members with State Plan Home Care Services

MSHO

1. Continue Care Coordination activities if member is on MSHO through 90-day grace period.
2. Notify MA State Plan service Providers and member of the change in payer and the effective date.
3. Send DHS form #6037 and necessary transfer documents to the County of Residence (COR) by day 60 if member’s MA is not re-established and member is not reinstated to Blue Plus (MA active with no prepaid health plan).
MSC+
1. Notify MA State Plan service Providers and member of the change in payer and the effective date.
2. Send DHS form #6037 and necessary transfer documents to the County of Residence (COR) by day 60 if member’s MA is not re-established and member is not reinstated to Blue Plus (MA active with no prepaid health plan).

MA Closing and Will Not Reopen
1. Close member to EW in MMIS (EW only)
2. Close service agreements in Bridgeview (EW only)
3. Refer member to Senior Linkage Line for assistance with finding other insurance or Part D prescription coverage if needed.

Term Due to Health Plan Change
1. Confirm health plan change in Mn-ITS
2. Send DHS Form 6037 to the new health plan
3. If on EW, do not close waiver span in MMIS
4. Close service agreements in Bridgeview (EW only)
## Case Closure Care Coordination Responsibilities

<table>
<thead>
<tr>
<th>Reason for Term</th>
<th>Product</th>
<th>DHS Form 5181 Notification to Financial Worker required?</th>
<th>DHS Form 6037 Notification to County of Residence (COR) required?</th>
<th>Close Service Agreements in Bridgeview (EW only)</th>
<th>Close waiver span in MMIS (EW only)</th>
<th>Provider notification via phone</th>
<th>Other tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>CC’s are not required to notify BluePlus of terms or death.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td>MSHO &amp; MSC+</td>
<td>Yes</td>
<td>No</td>
<td>Yes, back to date of death.</td>
<td>Yes, back to date of death.</td>
<td>No</td>
<td>Share all documents with new CC including: HRA, care plan, RS tool, home care auth’s, etc. See <em>Moving out of the Blue Plus service area</em> above.</td>
</tr>
<tr>
<td><strong>Move out of the BluePlus Service Area in MN</strong></td>
<td>MSHO &amp; MSC+</td>
<td>Yes</td>
<td>Yes – send to new health plan/Care Coordinator</td>
<td>Yes, when member officially terms from Blue Plus.</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MSHO &amp; MSC+</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Move out of state or out of country</strong></td>
<td>MSHO &amp; MSC+</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Term due to lapse in MA coverage for members open to Elderly Waiver (EW)</strong></td>
<td>MSHO</td>
<td>No</td>
<td>Yes, by day 60 if MA has not been renewed and its anticipated member will term by day 90.</td>
<td>Keep SA’s open in Bridgeview. Close if member does not reinstate.</td>
<td>No (unless MA is not renewed)</td>
<td>Yes</td>
<td>Member will show termed in Mn-ITS but enrolled due to 90-day grace period. CC tasks are required during the grace period.</td>
</tr>
<tr>
<td></td>
<td>MSC+</td>
<td>No</td>
<td>Yes, by day 60 if MA has not been renewed and its anticipated member will term by day 90.</td>
<td>Keep SA’s open in Bridgeview. Close if member does not reinstate.</td>
<td>No (unless MA is not renewed)</td>
<td>Yes</td>
<td>Member will show termed in Mn-ITS and on enrollment. If member is due for reassessment, CC must complete an HRA to maintain EW</td>
</tr>
</tbody>
</table>
### 90 Day Grace Period (MSHO only)

If a SecureBlue/MSHO member has Medicare and loses eligibility for Medical Assistance, Blue Plus may continue to provide Medicare-covered plan benefits for up to three months. The three-month grace period may not be applicable in all cases where an MSHO member loses MA. Member’s in a 90-day grace period will show as termed in Mn-ITS but will continue to appear on your enrollment. If applicable, you must continue to provide Care Coordination services during this time.

1. Contact the member’s financial worker with questions about MA disenrollment.
   - Coverage during the 90-day grace period does not include Elderly Waiver services.

<table>
<thead>
<tr>
<th>Reason for Term</th>
<th>Product</th>
<th>DHS Form 5181 Notification to Financial Worker required?</th>
<th>DHS Form 6037 Notification to County of Residence (COR) required?</th>
<th>Close Service Agreements in Bridgeview (EW only)</th>
<th>Close waiver span in MMIS (EW only)</th>
<th>Provider notification via phone</th>
<th>Other tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>CC’s are not required to notify BluePlus of terms or death.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>eligibility.</td>
</tr>
<tr>
<td>Term due to lapse in MA coverage Community Well (CW) members</td>
<td>MSHO</td>
<td>No</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
<td>Member will show termed in Mn-ITS but enrolled due to 90-day grace period. CC tasks are required during the grace period.</td>
</tr>
<tr>
<td></td>
<td>MSC+</td>
<td>No</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>MA closing and will not re-open</td>
<td>MSHO &amp; MSC+</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Refer member to Senior Linkage Line for assistance with finding other insurance or Part D drug coverage if needed.</td>
</tr>
<tr>
<td>Term due to health plan change</td>
<td>MSHO &amp; MSC+</td>
<td>No</td>
<td>Yes, to the new health plan</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

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**Care Coordination Delegation Guidelines for Blue Plus MSHO/MSC+ Community Members**
Keep case open as member may reinstate within 90 days
Keep waiver span open in MMIS and Bridgeview
Keep all service agreements open Bridgeview (NEW) as most cases are re-instated.
Notify all MA State Plan and Elderly Waiver Providers of MA closure

2. If the member is reinstated:
• Enter assessment screening document, if applicable
• Adjust service agreement(s) as applicable

3. If the member is not reinstated after 90 days:
• Close member to EW in MMIS back to MA closure date
• Close Service Agreements in Bridgeview back to MA closure date
• Enter Screening Document into MMIS to exit member from EW

4. No DTR is needed since EW services are closing due to MA ineligibility.

5. During their 90-day grace period, if the member has a product change or is due for a re-assessment, the CC must make an attempt to complete the assessment timely per the member contact requirements. The CC must continue to follow the member until they officially term off the enrollment report. The only exception to this is if the member moves out of state.

6. Coverage with Blue Plus will term after three months if the member has not regained Medical Assistance. At that time, the member will need to choose a new Part D plan to continue getting coverage for Medicare covered drugs. If the member needs assistance, they can call the Senior Linkage Line at 1-800-333-2433.

See DHS Bulletin #09-24-01 for more information.

**DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services**

AGP Utilization Management (UM) will review all notifications of Denial, Termination, and Reduction of Services or eligibility for State Plan and Elderly Waiver Programs.

If the Care Coordinator, not the provider, recommends a DTR of State Plan Home Care Services or Elderly Waiver Services, the Care Coordinator must notify AGP UM, the service Provider and the member within 24 hours of a determination. AGP UM will review the request and if a DTR is needed, will email a copy of the DTR to the Care Coordinator and mail a copy to the provider and member.

In addition to notifying AGP UM of the need for a DTR, the CC will need to complete the following:
• EW services agreements: Update any service agreements within Bridgeview with the effective date provided from AGP UM (typically 10 business or 14 calendar days from the date of determination).
• State Home Care Services and PCA reductions:
  • AGP UM will automatically update any current service authorizations with the reduced amount.

**Denials**

**Definition:** When a Care Coordinator is denying the request for an existing service authorization or a requested service not currently authorized.

**Existing services:** When the Care Coordinator is making the decision to deny an existing service authorization (Elderly Waiver or state plan), the CC must notify AGP UM operations of the need for a DTR using the Care Coordinator Request for DTR form and fax it to AGP UM Operations at 1-844-429-7763.

**Denying an increase to a service:** When the Care Coordinator is making the decision to deny an increase to an existing service authorization (Elderly Waiver or state plan), the CC must notify AGP UM operations of the need for a DTR using the Care Coordinator Request for DTR form and fax it to AGP UM Operations at 1-844-429-7763.

**Requested services:** When the Care Coordinator is making the decision to deny a service requested by the member which does not have a current authorization, the CC must notify AGP UM of the need for a DTR using the Care Coordinator Request for DTR form and fax it to AGP UM Operations at 1-844-429-7763.

**Terminations**

**Definition:** When the member requests or the Care Coordinator makes the decision to terminate service authorization(s) (Elderly Waiver or state plan), the CC must notify AGP UM operations of the need for a DTR using the Care Coordinator Request for DTR form and fax it to AGP UM Operations at 1-844-429-7763.

**Reductions**

**Definition:** When the member requests or the Care Coordinator makes the decision to reduce an existing authorization of services (Elderly Waiver or state plan), the CC must notify AGP UM operations of the need for a reduction using the Care Coordinator Request for DTR form and fax it to AGP UM Operations at 1-844-429-7763.
## DTR Decision Guide

<table>
<thead>
<tr>
<th>Situation</th>
<th>Care Coordinator Request for DTR?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Medical Assistance eligibility ends for any reason</td>
<td>Not required</td>
</tr>
<tr>
<td>Member moves out of the Blue Plus service area</td>
<td>Not required</td>
</tr>
<tr>
<td>Member switches to another health plan or fee-for-service</td>
<td>Not required</td>
</tr>
<tr>
<td>Member dies</td>
<td>Not required</td>
</tr>
<tr>
<td>Change in service provider (no change in authorized service or number of units)</td>
<td>Not required</td>
</tr>
<tr>
<td>Member’s EW/State Plan services are temporarily on hold for 30 consecutive days or less and the plan is for the member to resume services. (i.e., short term NF admission, vacation out of area, short term hospitalizations, etc.)</td>
<td>Not required</td>
</tr>
<tr>
<td>(For additional details see Reference Guide for Hospital and Nursing Home Stays, below)</td>
<td></td>
</tr>
<tr>
<td>Member’s EW/State Plan services are on hold for more than 30 consecutive days</td>
<td>Required</td>
</tr>
<tr>
<td>(For additional details see Reference Guide for Hospital and Nursing Home Stays, below)</td>
<td></td>
</tr>
<tr>
<td>Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he is not requesting services</td>
<td>Not required</td>
</tr>
<tr>
<td>Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he is requesting services</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to terminate all EW services and close to EW</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to reduce a currently authorized EW or state plan service</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to terminate currently authorized EW or state plan service</td>
<td>Required</td>
</tr>
<tr>
<td>Member elects to use less PCA than was assessed.</td>
<td>Required</td>
</tr>
<tr>
<td>CC is making decision to reduce or terminate services (EW or state plan) or closing EW</td>
<td>Required</td>
</tr>
<tr>
<td>Situation</td>
<td>Care Coordinator Request for DTR?</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Customized Living/24 Hour Customized Living/Adult Foster Care rate is reduced due to a reduction or termination of a CL/AFC service</td>
<td>Required</td>
</tr>
<tr>
<td>Member no longer qualifies for EW due to no longer meeting NF Level of Care</td>
<td>Required</td>
</tr>
<tr>
<td>Home care agency provides services without Prior Auth from Care Coordinator. Provider requests the CC submits a request for PA after services are rendered and the CC does not agree that the services were necessary</td>
<td>Required</td>
</tr>
<tr>
<td>Member is requesting an item or service that is not covered by Medicare or Medicaid.</td>
<td>Required</td>
</tr>
</tbody>
</table>

### DTR Reference Guide for Hospital or Nursing Home Stays

<table>
<thead>
<tr>
<th>Situation</th>
<th>Action Needed</th>
<th>Care Coordinator Request for DTR?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member goes into a hospital for acute care (less than 30 days)</td>
<td>Notify providers of admission</td>
<td>Not required</td>
</tr>
<tr>
<td>Members goes into the hospital for more than 30 consecutive days</td>
<td>Close the waiver as of the hospital admission date</td>
<td>Fax DTR form on day 31 or within 24-hours of the determination that the hospital stay will exceed 30 consecutive days</td>
</tr>
<tr>
<td>Members goes into a nursing facility (from community or short-term hospital stay) for acute care/rehab (less than 30 days)</td>
<td>Notify providers of admission</td>
<td>Not required</td>
</tr>
<tr>
<td>Member goes into a nursing facility (from community or shorter-term hospital stay) for more than 30 consecutive days</td>
<td>Close the waiver as of the NF admission date</td>
<td>Fax DTR form on day 31 or within 24 hours of the determination that they NF stay will exceed 30 consecutive days</td>
</tr>
</tbody>
</table>

### PCA Denial, Termination, Reduction (DTR):

1. Reduction or termination in PCA services requires a 10-day notice prior to the date of the proposed action.
2. The Care Coordinator is required to notify the member and PCA Provider within 24 hours of determination.

3. If the DTR notification is due to a PCA re-assessment indicating a need for fewer hours, submit Care Coordinator Request for DTR to AGP within 24hr of the decision.

4. If services are reduced, the current authorization will be extended to accommodate the 10-day notification period. The new authorization will be entered for services beyond the 10 days with the new number of units approved.

If a member loses Nursing Facility (NF) Level of Care (which allows EW eligibility) the NFLOC statute requires a minimum of 30 days advance notice for termination of services. The Care Coordinator will fax the Care Coordinator Request for DTR form to Amerigroup.

UM will process the request and send the Care Coordinator a copy of the Denial Termination Reduction letter which will include the effective date (which is 30 days from the date of processing). This effective date will be used as the date of EW closure and the last date services are covered.

The Care Coordinator will duplicate the effective date given by UM to:

1. Notify the member and service Provider within 24 hours of the determination.

2. Send DHS 5181 to the Member’s Financial Worker.

3. Enter a screening document to exit elderly waiver into MMIS following instructions outlined in Bulletin 14-25-12

4. Close the service agreement in Bridgeview with the effective date provided by AGP UM.

Grievances/ Complaints Policy and Procedure

Definitions

Grievance

Grievances are verbal or written expressions of dissatisfaction about any matter other than an Action (see definition below), including but not limited to, the quality of care or services provided or failure to respect the member’s rights. Some examples of grievances include: the quality of home delivered meals (food is cold), transportation providers being late, dislike of a roommate in the nursing home, impolite staff, in ability to access services appointment, missed or delayed diagnosis, or lack of treatment. Grievances can be filed either orally or in writing.

Grievant

The grievant is the person that is submitting the grievance for consideration. This may be a member, any individual acting on behalf of the member, or a provider with the member’s written consent.
**Action**

An action is a denial or a limitation of an authorization of a requested service, which includes:

- The type or level of service,
- the reduction, suspension or termination of a previously approved service
- the denial, in whole or in part for the payment for a service
- The failure to provide services in a timely manner
- The failure of the health plan to act within the required timeframes for resolution of appeals and grievances.
- For a resident of a rural area with only one Health Plan, the denial of a Medicaid member’s request to exercise services outside of the network.

**Appeal**

An appeal is a request to change a previous decision or action made by the health plan. Appeals may be filed orally or in writing. Anyone, including a care coordinator, who is making an appeal on behalf of a member may need an Authorized Release of Information signed by the member.

**Authorized Representative**

An authorized representative is an individual that is authorized by the member, or a surrogate who is acting in accordance with State law on behalf of the member to obtain an organization determination or deal with any level of the appeals process.

**Delegate Responsibilities**

The delegate must have a Policy and Procedure and system in place for handling grievances for MSHO/SecureBlue, and MSC+/Blue Advantage. A copy of written grievances, if submitted to the Delegate, must also be retained in the member’s file.

A contact person will need to be established by each delegate for grievances. The contact person will be responsible to obtain any necessary information to resolve written or oral grievances submitted directly to us. The delegate must be able to retrieve records within two business days.

**Oral Grievances**

Care Coordinators should direct members to report all oral grievances to Blue Plus by calling member services, seven (7) days a week 8:00 a.m. to 8:00 p.m. Central Time.

Care Coordinators may also call Blue Plus to report an oral grievance on behalf of the member if the member requires assistance.

- MSHO 1-888-740-6013 (Calls to this number are free)
- TTY users call: 711 (Calls to this number are free)
• MSC+ 1-800-711-9862 (Calls to this number are free)
• TTY users call: 711 (Calls to this number are free)

**Written Grievances**

If a member requests the assistance of the Care Coordinator in filing a written grievance, the grievance should be transcribed in the member’s words and faxed to Amerigroup within one business day of the receipt of the grievance. Care Coordinators may use the MSHO MSC+ Care Coordinator Verbal Appeal Grievance Form located on the Care Coordination website.

The information faxed to Blue Plus should include both the written grievance and all other pertinent information or documentation related to the grievance. Amerigroup may contact the delegate for additional information during investigation of the grievance. Documentation should be maintained on file by the Delegate.

**Member and Provider Appeals**

Member and provider appeals received by Blue Plus are managed by Amerigroup. Amerigroup will notify care coordination delegates via email of appeal determinations for the following situations:

• Appeal Determinations prior to services being rendered—Informational only
• State Fair Hearing. While this is intended as an informational communication, a Care Coordinator may contact AGP to participate in the hearing. AGP contact information will be included in the notice.
• State Fair Hearing Determinations—Informational only

**Interpreter Services**

The Blue Plus contract with the Minnesota Department of Human Services requires that persons with limited English proficiency receive language assistance as necessary. If a Blue Plus member does not speak English as their primary language and has a limited ability to read, speak, write or understand English, the Care Coordinator may initiate the use of an interpreter to assist in assessment, care planning and on-going care coordination. Blue Plus prefers the use of a formal interpreter over a family member, as best practice.

When engaging interpreter services, Care Coordinators should use the most cost-effective means. Care Coordinators are encouraged to use over the phone interpretation as a first option when possible. The following are available to support and assist Care Coordinators when providing services to our members.
Over the Phone Interpretation: contact your Partner Relations Consultant for complete details.

- My Accessible Real Time Trusted Interpreter, or MARTTI
- United Language Group

**Video/Virtual:** Video service provides effective web-based interpretation. This can be done on a laptop, tablet or smartphone.

- My Accessible Real Time Trusted Interpreter, or MARTTI

**Face-to Face Care Coordination visits**

- Delegate agency may work with any interpreter agency registered with DHS, pay the interpreter agency directly and submit claims for payment on the member service claim.

If a Blue Plus member is requesting information about the use of an interpreter for their medical appointments (such as a clinic visit), the member should be directed to Member Services.

**Note:** All providers are responsible for arranging for interpreter services for Blue Plus MHCP members at the time the appointment is scheduled.

**Relocation Targeted Case Management**

As part of their usual role, Care Coordinators provide relocation services to members planning on returning to the community from a Nursing Facility. However, if a new member has been receiving Relocation Targeted Case Management services at the time of initial enrollment to Blue Plus, the member must be given the choice to continue to work with their current Relocation Targeted Case Manager. If the member chooses to continue to work with this individual, the Care Coordinator is expected to work with the Relocation Targeted Case Manager on the member’s plan of care. It remains the Care Coordinator’s responsibility to ensure all activities included in the Care Coordination Guidelines are completed within the necessary timeframes. If a member does not wish to work with their Relocation Targeted Case Manager, the Care Coordinator will provide all necessary relocation service coordination.

**Moving Home Minnesota**

Moving Home Minnesota (MHM) is Minnesota’s Money Follows the Person Rebalancing Demonstration. The goal of this program is to promote transitions for people living with chronic conditions and disabilities residing in qualifying institutions an opportunity to return to the community.

When deciding if MHM is right for a member, Care Coordinators must evaluate and prepare to first use services under the member’s medical coverage and/or the Elderly Waiver. If the services
under the medical benefit and Elderly Waiver do not meet all the identified transitional needs of the member, the Care Coordinators may explore MHM services.

The member must meet the MHM eligibility criteria below to apply for the program. With permission from the member, some referrals may come into DHS MHM Intake by someone other than the Care Coordinator (i.e. nursing home, family member, etc.). When this occurs, a member of the Partner Relations Team will reach out to the Care Coordinator for more information. Referrals from a Care Coordinator should be sent using secure email to Partner.Relations@bluecrossmn.com for consultation and next steps.

**MHM eligibility criteria:**

1. Member has resided for a minimum of 90 consecutive days in one or more of the following settings:
   - Hospitals, including community behavioral health hospitals; or
   - Institutions for Mental Disease (i.e. Anoka Metro Regional Treatment Center); or
   - Intermediate care facility for individuals with developmental disabilities (ICF/DD); or
   - Nursing facility;

   and

2. Member meets eligibility requirements for MA at time of discharge; and
3. MA has paid for at least one day of institutional services prior to leaving the facility; and
4. Member opens to the Elderly Waiver at the time of discharge; and
5. Member is transitioning to one of the following settings:
   - Home owned or leased by the individual or individual’s family member; or
   - Apartment with an individual lease with lockable access and egress which includes living, sleeping, bathing, and cooking areas over which the individual or individual’s family has domain and control; or
   - A residence in a community based residential setting in which no more than four unrelated individuals reside.

Blue Plus will notify the Care Coordinator when the MHM request has been approved and will provide additional instructions. **Do not start MHM services until you receive confirmation from a member of the Partner Relations Team.** After the MHM provider has been selected, the Care Coordinator will collaborate with the **MHM Transition Coordinator** to create a plan and arrange supports and services. Monthly member updates must be provided to the Partner Relations Consultant Representative.
Note: MHM services do not count towards the member’s monthly Elderly Waiver case mix budget. Do not enter service agreements into Bridgeview. A member of the Partner Relations Team will reach out to the Care Coordinator with additional instructions for entering service agreements upon confirmation of the MHM services delivered.

See MHM Program Manual for more information.

**Out-of-Home Respite Care—Community Emergency or Disaster**

In the event of a community emergency or disaster that requires an emergency need to relocate a member, and a currently licensed out-of-home respite provider is not available, out-of-home respite services may be provided in an unlicensed facility/home. Contrary to normal out-of-home respite practice, a caregiver may reside in the same temporary location as the member. The primary caregiver may not be paid to provide respite services. Requests for out-of-home respite services in these rare circumstances must be approved by Blue Plus.

To request out-of-home respite care for a member because of a community disaster:

1. Care Coordinator contacts their Partner Relations Consultant to discuss the specific situation of any member(s).
2. Partner Relations Consultant works with DHS staff to present situation and request the necessary approvals.
3. Partner Relations Consultant communicates decision to Care Coordinator.

Note: The DHS Commissioner must approve all requests as a necessary expenditure related to the emergency or disaster. The DHS Commissioner may waive other limitations on this service to ensure that necessary expenditures related to protecting the health and safety of members are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

**Other Care Coordination Responsibilities**

1. **QIPs**—The Care Coordinator will participate in the on-going performance improvement projects that are designed to achieve significant favorable health outcomes for members. These projects incorporate standards and guidelines outlined by the Centers for Medicare and Medicaid (CMS) with input by the Minnesota Department of Human Services (DHS).

2. **Vulnerable Persons Reporting.** It is the duty of mandated reporters to report suspected maltreatment of a vulnerable adult or child. Minnesota has a new central system for reporting suspected maltreatment of vulnerable adults. Call 844-880-1574 or go to the MAARC Mandated Reporter Form online.
Vulnerable Adults Mandated Training Web-based training is available at no cost to all mandated reporters here.

3. **Documentation**—The Care Coordinator shall document all activities in the member’s contact notes.

4. The Care Coordinator shall comply with any applicable Federal and State laws that pertain to member rights including HIPAA laws and the Minnesota Data Privacy Act and your organization’s confidentiality policy.

5. The Care Coordinator should be coordinating with local agency case managers (mental health, developmental disabilities, adult protection, etc), financial workers and other staff as necessary to meet the member’s needs. This includes using the Case Manager/Financial Worker Communication Form (DHS # 5181) when:
   - A member requests waiver service
   - A member receiving waiver services has a change in circumstances (exits waiver, moves to SNF, expires, etc.)
   - For more information refer to DHS Bulletin #07-21-09

**Blue Plus Network**

Blue Plus members must use in network providers. They do not have coverage for services received from a provider who is not in our network unless it is emergency or urgently needed care.

There is no coverage for care out of the state of Minnesota unless urgent or emergent.

There is no coverage for urgently needed care or any other non-emergency care received outside of the United States.

Members should contact member services with coverage questions. Providers should contact provider services. See Contact Information section.

**Audit Process**

The Blue Plus contract with DHS and CMS requires the auditing of care coordination activities on an annual basis.

**Delegate Systems Review:**

Each delegate will be asked to submit documentation related to the elements selected. Documentation may include Policies and Procedures, case load statistics, job descriptions, elderly waiver vendor lists, or other supporting documentation. Partner Relations staff will review the submitted documentation to determine it meets the contractual requirements. This review may be done on-site or as part of a desk review.
Audit Process:
Partner Relations Lead Auditor will conduct an annual Delegate audit. During the audit, the Auditor will conduct care coordination system and care plan audits for elderly waiver and community well members using the DHS approved MSHO and MSC+ EW Care Planning Audit Protocol. They will also conduct audits for nursing home members using a Nursing Facility Member Chart Review Audit Tool (if applicable).

Elderly Waiver:
Review of selected member files using an established statistical process of an 8/30 record review sampling methodology. If any element is missing or not met in the first 8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

Community Well and Nursing Home:
- Review of a random sampling of 5 records for each living arrangement. If any element is missing or not met in those 5 records, another 5 records will be reviewed in the areas not met in the initial sample.
- For Nursing Home Only Delegates, review of selected member files using an established statistical process of an 8/30 record review sampling methodology will be used. If any element is missing or not met in the first 8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

If a problem or findings are identified during assessment, the Delegate will be required to respond to Blue Plus with a Corrective Action Plan” (CAP) meaning a list of actions and an associated timetable for implementation to remedy a specific problem, which includes a root cause analysis, interventions, necessary tasks required for improvement, the person responsible for resolution and a timetable for resolution.

Findings are defined as an area of non-compliance discovered through assessment or other means related to a regulation, statute, policy, procedure, contract or sample review for a given requirement or obligation, including Care Coordination guideline and requirements.

Mandatory Improvements will also be noted and are defined as an action that must be taken to resolve an issue identified through auditing and monitoring, which does not meet the criteria for a CAP. These are required actions to prevent the risk of a future Finding. For example, unclear or incomplete Policies and Procedures or sample documentation.

A CAP may be assigned to resolve Findings or mitigate compliance risks when one or more of the following apply:
1. The 95.00% compliance standard for samples is not met
2. Policies and procedures are not documented
3. Beneficiary’s rights are impacted
4. There is a repeat finding from a previous assessment or monitoring
5. Compliance issues that are related to a high-risk area, where swift correction of the action is required.

Each Delegate will be required to provide a written response within 1 month of receipt of the written audit results if there are Findings or Mandatory Improvements. Interventions to make corrections for the finding areas, target end dates for completion and correction must be within 3 months of the start date of the described intervention. It is the responsibility of each delegate to alert Blue Plus with the completion dates of the corrective actions implemented.

**Records Retention Policy**

The Delegate must have policies and procedures to address record retention in accordance with DHS and Center for Medicare and Medicaid Services rules and regulations. Files, either in electronic or hard copy format, are to be kept for 10 years from the date the files are closed. After 10 years the files may be destroyed.

- File information includes patient identification information, provider information, clinical information, and approval notification information.
- All documents pertaining to pending litigation or a regulatory matter must be retained despite general disposal policy until Blue Plus advises that such documents may be returned to the general disposal policy.
Nursing Home Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

January 2020
## Contact Information

<table>
<thead>
<tr>
<th>Department</th>
<th>Questions</th>
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<tbody>
<tr>
<td>Behavioral Health Crisis Line: 1-844-410-0745</td>
<td>For members in crisis who need support from a clinician specializing in mental health</td>
</tr>
<tr>
<td>BlueRide Transportation</td>
<td>Contact to arrange medical transportation</td>
</tr>
<tr>
<td>For members: 651-662-8648 or 1-866-340-8648</td>
<td>Email address to send requests to exceed 30/60 mileage limits</td>
</tr>
<tr>
<td>For Care Coordinators: 855-933-6991 or <a href="mailto:bluerideintake@logisticare.com">bluerideintake@logisticare.com</a></td>
<td>Care Coordinator portal for scheduling medical or dental rides</td>
</tr>
<tr>
<td>LogistiCare’s TripCare Portal</td>
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<tr>
<td><a href="https://tripcare.logisticare.com/login">https://tripcare.logisticare.com/login</a></td>
<td></td>
</tr>
<tr>
<td>Bridgeview Company</td>
<td>Elderly Waiver service agreement questions</td>
</tr>
<tr>
<td>1-800-584-9488  <a href="mailto:EWProviders@bluecrossmn.com">EWProviders@bluecrossmn.com</a></td>
<td>EW Claims Processing</td>
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<tr>
<td></td>
<td>view/home/</td>
</tr>
<tr>
<td>CaregiverCornerMN.com</td>
<td>BCBS hosted site with helpful information and resources for caregivers</td>
</tr>
<tr>
<td>Care Coordination Website</td>
<td>Access to Care Coordination communications, guidelines, forms, letters, resources, and trainings</td>
</tr>
<tr>
<td><a href="http://www.bluecrossmn.com/carecoordination">www.bluecrossmn.com/carecoordination</a></td>
<td>Links to Amerigroup resources</td>
</tr>
<tr>
<td>Delta Dental</td>
<td>Assistance with finding dental providers</td>
</tr>
<tr>
<td>For Members: 651-406-5907 or 1-800-774-9049</td>
<td>Scheduling assistance</td>
</tr>
<tr>
<td>For Care Coordinators: 651-994-5198 or 1-866-303-8138</td>
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</tbody>
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## Member Services

<table>
<thead>
<tr>
<th>MSHO</th>
<th>651-662-6013 or 1-888-740-6013</th>
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<tbody>
<tr>
<td>MSC+</td>
<td>651-662-5545 or 1-800-711-9862</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
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- Benefit questions
- Interpreter services
- Assistance finding an in-network providers
- Billing questions/grievances

## Nurse Line

<table>
<thead>
<tr>
<th>MSHO</th>
<th>651-662-6013 or 1-888-740-6013</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSC+ 651</td>
<td>662-5545 or 1-800-711-9862</td>
</tr>
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- Health questions answered by an RN
- Available 24 hours a day, seven days a week
- Members need to choose “talk to a nurse” option when calling.

## Partner Relations Consultant Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Stormy Church, Manager</td>
<td>651-662-1040</td>
</tr>
<tr>
<td>Melinda Heaser, LSW, CCM</td>
<td>651-662-9533</td>
</tr>
<tr>
<td>Kim Pirkl, LSW, CCM</td>
<td>651-662-3074</td>
</tr>
<tr>
<td>Nissa Roberts, MA, MBA, MHP, LGSW</td>
<td>651-662-7613</td>
</tr>
<tr>
<td>Ricky Vang, RN, BSN, PHN, MHA</td>
<td>651-662-4523</td>
</tr>
</tbody>
</table>

Partner.Relations@bluecrossmn.com  **Fax:** 651-662-0015

- Blue Plus liaison for MSHO and MSC+ Care Coordination contracts
- Primary contact for care coordination program and process questions including but not limited to:
  - Member specific issues
  - LTSS/Elderly Waiver
  - Health Risk Assessment/Care Planning
  - Care Coordination audits
  - Care Coordination program operations

## Pharmacist

<table>
<thead>
<tr>
<th>MSHO Donna Boreen, Clinical Pharmacist</th>
<th>651-662-1264 or 1-800-711-9868 ext. 21264</th>
</tr>
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<tbody>
<tr>
<td></td>
<td><a href="mailto:Donna.boreen@bluecrossmn.com">Donna.boreen@bluecrossmn.com</a></td>
</tr>
</tbody>
</table>

- Speak with a Blue Plus pharmacist about medication concerns

| MSC+ Adrienne Matthews Clinical Pharmacist | 651-662-1053 ext. 21053 |

## Prime Therapeutics

1-800-509-0545

- Pharmacy assistance
- Available 24/7 to assist with prior authorizations

## Provider Services

1-866-518-8448

- Provider assistance (not including EW)
- Contract/provider access questions

## SecureBlue MSHO Enrollment

Care Coordinator’s should refer members to the following for assistance with MSHO enrollment:

- County Financial Worker
- Senior Linkage Line: 1-800-333-2433
Definitions

**Care Coordination:** Per Blue Plus’s contract with the Department of Human Services, Care Coordination for MSHO and MSC+ members means “the assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO and MSC+ Enrollees, and who coordinates services to an MSHO and MSC+ Enrollee among different health and social service professionals and across settings of care. This individual (the Care Coordinator) must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.”

The Care Coordinator is key to supporting the member’s needs across the continuum of care by leveraging member involvement, Blue Plus and County case management, and program referral processes. The Care Coordinator works closely with both the member, via face-to-face meetings, phone contact, and written communication and with other members of the Interdisciplinary Care Team (ICT). The ICT is unique to each member’s specific needs, but at a minimum consists of the member and/or a family designated representative, and healthcare provider. This team ensures development of an individualized holistic plan of care that is member centric.

The Care Coordinator conducts the initial assessment, and periodic reassessment as necessary, of supports and services based on the member’s strengths, needs, choices and preferences in life domain areas. It is the Care Coordinator’s responsibility to arrange and/or coordinate the provision of all Medicare and Medicaid funded preventive, routine, specialty, and long-term care supports and services as identified in the Enrollee’s Care Plan whether authorized by the Care Coordinator, County, or Blue Plus. The Care Coordinator is expected to work closely with other Case Managers and agencies involved with the MSHO and MSC+ member. To do this, they should collect, review, and coordinate the Blue Plus Care Plan with other member care plans, as appropriate (i.e., hospice care plans and/or home care agency’s care plans, etc.). The member’s Care Plan should be routinely updated, as needed, to reflect changes in the member’s condition and corresponding services and supports. The Care Coordinator must also ensure access to an adequate range of choices for each member by helping the member identify culturally sensitive supports and services. Care Coordinators must also arrange for interpreter services if needed.

The Care Coordinator also participates in on-going performance improvement projects that are designed to achieve significant favorable health outcomes for Blue Plus members. Finally, Care Coordinators work with Social Service Agencies and Veteran’s Administration to coordinate services and supports for members as needed.

**Delegate** is defined as the agency, such as counties, private agencies and clinics, that are contracted to provide Care Coordination services for Blue Plus. Delegates are responsible for periodic reporting to Blue Plus as requested and needed to meet business requirements. Examples include but are not limited to monthly Nursing Home assessment tracking form, Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential service living tools, and late screening document entry follow up.

**Model of Care (MOC)** is Blue Plus’s plan for delivering coordinated care to SecureBlue (MSHO) members. The Center for Medicare and Medicaid Services (CMS) requires all Special Needs Plans (SNPs) to have a MOC. The Model of Care (MOC) documents the staff, systems, procedures, and improvement activities Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members. The MOC also describes how
Care Coordination delegates work together with Blue Plus providers and staff to coordinate 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 health settings. Care Coordination delegates are required to complete annual training on the MOC included as part of Blue Plus’s annual Fall Training.

**New Enrollee** is defined as member who is newly enrolled in Blue Plus. Members who switch products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO) or vice versa) are considered new enrollees. All requirements related to new enrollees are applicable in all these scenarios. Note: a change in rate cell only does not mean the member is newly enrolled even if it results in a change in Care Coordination.

**Transfer** is defined as an existing (already enrolled) Blue Plus member who has been transferred to a new Blue Plus delegate.

**Required Caseload per worker** for Community Well, Nursing Facility, and Elderly Waiver is as follows: Elderly Waiver/Community Well mix = 40-70, Nursing Facility only = 90-120, and Community Well only = 75-100.

**ID Prefix’s** are now included in front of the members ID number. The prefixes are JTM for MSHO and LMN for MSC+. These prefixes are prior to the ID number. (i.e. JMN#####)

**Bridgeview ID:** This number will be 8+PMI for identification in Bridgeview. This is not the member’s ID number on their medical card.

**AGP/Blue Cross Member ID:** Members will continue to have a member ID number assigned by Amerigroup. (i.e. 726xxxxxx, 727xxxxxx)

**Blue Plus SecureBlue Model of Care (SNP-MOC) Policies and Procedures**

The SecureBlue Model of Care ensures that Blue Plus, in partnership with its contracted providers, meets the unique needs of the SecureBlue-MSHO (Minnesota Senior Health Options) population. The Blue Plus Policy & Procedure Manual, Blue Plus Provider Manual, and Care Coordination Delegation Guidelines describe the services, practices, procedures, and systems necessary to successfully deliver coordinated care consistent with the SecureBlue Model of Care.

In accordance with the Blue Plus Provider Service Agreement, all contracted providers agree to support the implementation of the Blue Plus Model of Care by adhering to the policies and procedures contained in the Blue Plus Policy and Procedure Manual and the Blue Plus Care Coordination Delegation Guidelines. Care Coordination Delegates further agree to comply with all Minnesota Department of Human Services (DHS) requirements and Center for Medicare and Medicaid Services (CMS) rules and regulations related to the completion of a comprehensive initial health risk assessment of the beneficiary's physical, psychosocial, and functional needs, as well as annual health risk reassessment.

Care Coordinators should use professional judgement interpreting the following guidelines and policies to make decisions related to the care and treatment of Blue Plus members:

- MN rules and statutes
- DHS policies and training
- County program training and guidelines
- Provider training and guidelines
- Medicare coverage criteria
- Disease Management protocols
- Blue Plus Certificates of Coverage

### Special Needs Plans Model of Care (SNP-MOC) Training

The Centers for Medicare & Medicaid Services (CMS) requires all providers and appropriate staff who see beneficiaries of a Fully Integrated Dual Eligible Special Needs Plan (SNP) on a routine basis to complete initial and annual Special Needs Plan-Model of Care (SNP-MOC) training. Providers and appropriate staff required to complete the training include anyone who may participate in a SecureBlue member's Interdisciplinary Care Team, be responsible for implementation of the member's Collaborative Care Plan or manage planned or unplanned transitions of care.

Blue Plus provides annual, in-person training on the SNP-MOC to Care Coordination delegates. Care Coordinators are expected to attend training in person or by sending delegates from each county or care system to attend the training and then train the remaining Care Coordinators that did not attend. Additionally, Care Coordination delegates are responsible for ensuring all newly hired Care Coordinators complete training on the SNP-MOC.

Blue Plus will maintain attendance records for in-person training. Care Coordination delegates must document and maintain MOC training completion records for those Care Coordinators who did not attend the in-person training. At a minimum, training completion records must include the Care Coordinator’s name and the date the training was completed. Upon request, Care Coordination delegates must provide training completion records to Blue Plus to validate that the SNP-MOC training has been completed.

To complete the training, simply review the presentation.

The SecureBlue SNP-MOC training is available online as a PowerPoint presentation. All contracted Care Coordination Delegates and staff are required to view this training annually and save a copy of their attendance logs.

Blue Plus is committed to maintaining strong, collaborative partnerships with our care coordination delegates to ensure they have easy access to the information and tools necessary to provide the highest quality, evidence-based care. We therefore work with our delegate partners to validate that mandated and regulated activities such as Model of Care Training occur and assist providers in identifying and overcoming any barriers to training completion. Your Blue Plus Provider Service Agreement reflects these commitments. Because compliance is critical, if a provider fails to complete the CMS required training and remains noncompliant, they may be required to develop a Corrective Action Plan or be subject to other remediation activities.
Person-Centered Practice and Planning Requirements

The implementation of person-centered values, principles and practices is a requirement of several state and federal authorities. It is our expectation that all members have the same access and opportunity as all other members. A member’s unique life experiences such as culture, ethnicity, language, religion, gender and sexual orientation should be embraced in the planning process to enhance the member’s quality of life.

Person-centered practices apply to all but not be limited to:

- Assessment/reassessment
- Planning process
- Review of services and care plans
- Transitions

Members and or their responsible party should be encouraged to:

- Direct their own services and supports, when desired
- Include preferences, strengths, skills, and opportunity to promote dignity and respect
- Include community presence, participation and connections

Delegate Responsibilities upon Notification of Enrollment

Blue Plus is notified of enrollment by Department of Human Services (DHS) twice a month via enrollment tapes. Blue Plus then generates the following reports via Bridgeview to communicate enrollment with our Care Coordination Delegates. Delegates will receive an e-mail notifying them that the reports are available from the SecureBlue enrollment e-mail box.

1. New CAP: List of members who are newly enrolled to MSHO or MSC+ and is available in Bridgeview the first week of each month. Occasionally this report is ready a few days prior to the enrollment month. Do not start care coordination activities until on or after the 1st of the enrollment month.

2. Full Detail: A comprehensive list of all members assigned to the Delegate agency for the month and includes the following flags:

   - NEW: Enrollees who enrolled after the DHS capititation
   - REINSTATED: Members who were going to term but were reinstated with no lapse in coverage
   - TERMED: Coverage termed
   - PRODUCT CHANGE: Changed from MSC+ to MSHO or vice versa (these members are treated as brand new enrollees and will need a new HRA)
   - TRANSFER: Existing enrollee who transferred to you. Official notification is via form 6.08 Transfer in Care Coordination Delegation.
   - TERMED FUTURE: Lists Month/Year. Member will be termed at the end of the month listed. CC should follow up to determine if the reason for disenrollment requires mediation (i.e., MA paperwork not submitted yet).
   - GRACE PERIOD ENDING: Lists Month/Date/Year which will be 30/60/90 days out from the enrollment month. These are MSHO members whose MA has termed but continue to have MSHO coverage for 90 days. See 90 Day Grace Period (MSHO only) section of the guidelines for care coordinator tasks.
3. **Daily Add:** Includes new enrollees who were retroactively enrolled by DHS after both the New CAP and Full Detail reports were received by DHS and processed.

Upon notification, the Delegate:

1. Reviews the “New CAP” list to check for discrepancies (i.e., member is incorrectly assigned to your agency) and reports them to Secureblue.Enrollment@bluecrossmn.com no later than the 15th of the enrollment month.
2. Compares the “Full Detail” list to the previous months Full Detail list to check for discrepancies and reports them to Secureblue.Enrollment@bluecrossmn.com no later than the 15th of the enrollment month.
3. Reviews the Daily Add report for discrepancies and reports them to SecureBlue.Enrollment@bluecrossmn.com no later than 15 days from notification. The Delegate will receive an email if there’s a Daily Add report and be directed to log into Bridgeview to access it. These members are new enrollees for the month and = Guidelines should be followed for timely assessment within 30 or 60 days of notification, as applicable.

**Note:** For discrepancies not reported by the 15th of the enrollment month, the assigned care coordination delegate must initiate care coordination and is responsible to complete all applicable Blue Plus Care Coordination tasks prior to transferring the member the first of the following month.

4. Assigns a Care Coordinator per Delegate’s policy.
5. Informs the member of the name, number, and availability of the Care Coordinator within 10 days of notification of enrollment.
6. Enters the name of the Care Coordinator assigned in Bridgeview.
7. Documents any delays of enrollment notification in case notes.

**Blue Plus members living in a Veteran Administration Nursing Home**

For MSHO and MSC + members living in a Veteran’s Administration Nursing Home, the Care Coordinator should follow the processes and timelines outlined in the Care Coordination Guidelines for Members in the Nursing Home.

**Note:** Please be aware these members are designated by DHS as a Rate Cell A (Community Well) and will show up as a Rate Cell A on your enrollment reports instead of Rate Cell D like other members in the nursing home. The Delegate should be aware of this and proceed as they would other Rate Cell D nursing home members.

**Contact Requirements**

1. One face-to-face visit per year at minimum.
• If member is unable to fully participate in the assessment, the CC is required to reach out at a minimum one time to the member’s guardian, POA, or responsible party. The Care Coordinator documents this contact on the 6.15 NH Member Annual Assessment-Care Plan Review form.

2. One semi-annual member contact per year at minimum.
   • This contact may be face-to-face or over the phone with the member or responsible party, or at a care conference.
   • If the member is unable to fully participate in the assessment, the CC is required to reach out at a minimum one time to the member’s guardian, POA, or responsible party. The Care Coordinator documents this semi-annual contact on the 6.15 NH Member Annual Assessment-Care Plan Review form.

3. Contact as needed per significant changes in member’s health status.
   • These contacts can be documented in Case Notes.

4. Contact for new nursing home admission/determination of long-term placement:
   The Care Coordinator shall conduct the 6.15 NH Member Annual Assessment-Care Plan Review when a member transfers from the community to long-term placement in a skilled nursing facility. This assessment should be conducted:
   ➢ Within 45 days of notification of long-term placement; or,
   ➢ Within 45 days of the transfer effective date if the long-term placement results in a transfer of Care Coordination Delegation; or
   ➢ Within 365 days of the previous assessment, whichever is sooner.

**Physician Contact Requirements**

- **New Member**: Send Intro to Doctor Letter within 90 days of notification of enrollment
  - Send 8.28 Intro to Doctor letter OR
  - Send 8.29.01 NH Post Visit Summary Letter- Intro to Doctor Letter which combines both the Intro and Summary letters. This letter can be used in lieu of 8.28 Intro to Doctor letter if the face-to-face visit and this letter is mailed within 90 days of notification of enrollment.
- **Initial Assessment and Reassessment**: Within 90 days, send 8.29.01 NH Post Visit Summary Letter-Intro to Doctor Letter
- As needed for Transitions of Care
- When there is any change in Care Coordinator
- For clinic delegates, notification to primary care physician documented per clinic process using an EHR is acceptable.

**Initial Contact with New MSHO and MSC+ Enrollee**

**New Enrollee is defined as a:**
- member who is newly enrolled in Blue Plus, or a
- member who changes products within Blue Plus (i.e., MSC+ to MSHO or vice versa).
Complete the following requirements for all new enrollees:

1. Verify member’s eligibility prior to delivering Care Coordination services
2. Confirm the correct Primary Care Clinic (PCC).
3. Use optional checklist: MSHO MSC+ NH Checklist.
4. Inform the member of the name, number, and availability of the Care Coordinator within **10 calendar days** of notification of enrollment. This requirement can be met by sending the 8.22 Intro Letter.
5. Send welcome call/letter (8.22 Intro Letter) to member within 30 days after notification of enrollment. Optional resource: 6.01 Welcome Call Talking Points
6. Assign Care Coordinator to the member in Bridgeview.
7. Schedule a visit to the facility and complete the 6.15 NH Member Annual Assessment-Care Plan Review within **30 calendar days** for MSHO or **60 calendar days** for MSC+ of enrollment date, OR if delegate receives late notice of enrollment, within 30 or 60 calendar days of this notification.
8. Send Intro to Doctor Letter within 90 days of notification of enrollment
   a. Send 8.28 Intro to Doctor letter OR
   b. Send 8.29.01 NH Post Visit Summary Letter-Intro to Doctor Letter. This letter can be used in lieu of 8.28 Intro to Doctor letter if the face-to-face visit and this letter is mailed within 90 days of notification of enrollment.

For clinic delegates, notification to primary care physician documented per clinic process.

**Initial Assessment Responsibilities**

1. Complete the 6.15 NH Member Annual Assessment-Care Plan Review.

   The initial assessment should include but is not limited to the following:
   - Face-to-face assessment. If the member is unable to fully participate in the assessment, the CC is required to reach out at a **minimum one time** to the member’s guardian, POA, or responsible party.
   - Review of the member’s nursing home record including nursing facility’s care plan.
   - Review of the role of Care Coordinator.
   - Review explanation of Supplemental Benefits using 6.26 Explanation of Supplemental Benefits resource for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the checklist(s) or in your case notes.
   - Interview facility staff.
   - As a reminder, members residing in the nursing home do not have the ability to “refuse” Care Coordination.

2. Mail within **90 days of face-to-face visit** the:
   - 8.35 Nursing Home Visit Summary Letter to the member or if member was unable to participate to the guardian, POA, or responsible party. Letter should additionally be sent to parties identified by the member.
• 8.35.01 Unable to Reach-Nursing Home Visit Summary Letter to the POA or Responsible Party. To be sent if the Care Coordinator has been unable to reach the POA or Responsible Party.
• Send 8.29.01 NH Post Visit Summary Letter- Intro to Doctor Letter.

3. Enter the assessment information into Bridgeview by the 10th of the following month. (see Bridgeview Manual for entry instructions)

**Nursing Home Product Change**

Completion of a new 6.15 NH Member Annual Assessment-Care Plan Review is required for all new enrollees within 30 calendar days for MSHO or 60 calendar days for MSC+ from enrollment notification. A new enrollee is defined as member who is newly enrolled in Blue Plus and those members that have had a product change within Blue Plus (i.e., MSC+ to MSHO or vice versa)

Care Coordinators have two options for when a member has had a product change.

1. Perform a face-to-face visit and complete a new 6.15 NH Member Annual Assessment-Care Plan Review.
   • Enter the assessment information into Bridgeview. Next annual assessment is due 365 days from this assessment date.

2. Perform a face-to-face visit and complete the section on the 6.15 NH Member Annual Assessment-Care Plan Review called VI. 6.28.01 Nursing Home Transitional Health Risk Assessment for Product Change.
   • This option requires a review of the current 6.15 NH Member Annual Assessment-Care Plan Review called done in the last 365 days. In addition, the Care Coordinator must document any updates to the care plan and discussions with member and/or Responsible Party.
   • Enter the assessment information into Bridgeview. Next annual assessment is due 365 days from the last full assessment date.

**Review of Nursing Facility Plan of Care**

The Care Coordinator must review the nursing facility’s care plan and ensure that it both identifies the member’s needs in a way that maximizes the member’s inclusion, self-determination and choice and should incorporate an interdisciplinary, holistic, and preventive focus.
The Care Coordinator facilitates the integration of these concepts into the plan of care if they are found to be missing upon review. The Care Coordinator should complete thoroughly all sections of the 6.15 NH Member Annual Assessment-Care Plan Review called while reviewing the facility care plan, the Care Coordinator can determine if the facility care plan is addressing all the required elements listed below:

1. The member’s goals, interventions, and target dates for meeting their goals
2. The care plan should incorporate a preventive focus employing a thorough plan for addressing the health and safety needs of the members including, but not limited to diagnoses, medications, immunizations, nutritional needs, alcohol and tobacco usage, fall risk, etc. The care plan should have a person-centered focus and should include informal and formal supports as applicable.
3. The care plan or nursing facility member record should indicate advance directive planning for the member. The Care Coordinator should be prepared to initiate ongoing discussion with the member and/or authorized family members or guardians when the lack of a documented advance directive is identified through the care plan review process. The Care Coordinator can enlist the assistance of the primary care physician in helping the member with advance directive planning as well. The Care Coordinator may also use the resource optional 9.19 BCBSMN Advanced Directive and cover letters.
4. The Care Coordinator works in partnership with the member, authorized family members or guardians, primary care physicians and in consultation with other specialists and providers in caring for the member. The Care Coordinator should provide documentation of this consultation in the member’s file.

Semi-Annual Contact Responsibilities

The Care Coordinator’s semi-annual contact may be face- to- face, a care conference or over the phone. If member is unable to fully participate the CC should reach out to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA, or their responsible party. This should be documented as the Semi-Annual Contact on 6.15 NH Member Annual Assessment-Care Plan Review which includes a discussion of:

- recent acute episodes or hospitalizations
- significant changes in condition or level of care
- desires and/or ability to relocate back to the community or another facility
- unmet needs/care concerns

Reassessment Responsibilities

1. The Delegate is responsible to verify member’s eligibility prior to delivering Care Coordination services.
2. Annual reassessments must be a face-to-face visit conducted within 365 days of the previous assessment. If member is unable to fully participate in the assessment the CC should reach out to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA or their responsible party.
3. Complete 6.15 NH Member Annual Assessment-Care Plan Review. The annual assessment should include but is not limited to the following:
• Face-to-face assessment
• Review of the member’s nursing home record including the nursing facility’s care plan
• Review of the role of Care Coordinator
• Review explanation of Supplemental Benefits using 6.26 Explanation of Supplemental Benefits resource for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the checklist(s) or in your case notes.
• Interview facility staff.

4. Care Coordinator should also:
   • monitor progress and review any health status changes,
   • evaluate and adjust the timeliness and adequacy of the services the member is receiving
   • solicit and analyze relevant information from all sources
   • communicate with the member as well as the member’s interdisciplinary team

5. Mail within 90 days of face-to-face visit the:
   • 8.35 Nursing Home Visit Summary Letter to the member or if member was unable to participate to the guardian, POA, or responsible party. Letter should additionally be sent to parties identified by the member.
   • 8.35.01 Unable to Reach-Nursing Home Visit Summary Letter to the POA or responsible party. To be sent if the Care Coordinator has been unable to reach the POA or responsible party.
   • Send 8.29.01 NH Post Visit Summary Letter- Intro to Doctor Letter.

6. Enter the assessment information into Bridgeview by the 10th of the following month.

*If member is temporarily in the hospital at the time reassessment is due, an HRA is still required to be completed within 365 days. CC should use professional judgement to complete an assessment within the timeframes. Document any delays in reassessments in your case notes.

Transitions of Care (TOC) Activities:

The Blue Plus Care Coordinator is key to supporting the member’s needs across the continuum of care. Regular engagement and contact with the member and their service providers allows the Care Coordinator to be informed of health care service needs and supports, thus allowing active management of planned and unplanned transitions. The goal of the TOC process is to reduce incidents related to fragmented or unsafe care and to reduce readmissions for the same condition.

***Transitions of Care engagement and follow up is required regardless of how or when the Care Coordinator learns of the transition. One way the CC may learn of the transition is through Blue Plus notice of inpatient admissions.

If the member has an additional case manager (i.e. CADI waiver case manager), the Care Coordinator may communicate applicable information about the transition(s) with them. However, the Care Coordinator is responsible for completing all required tasks related to the transition(s) of care.
Definitions:

**Transition**: Movement of a member from one care setting to another as the member’s health status changes. Returning to usual setting of care (i.e. member’s home, skilled nursing facility, assisted living) is considered a care transition and the required tasks need to be completed.

**Care Setting**: The provider or place from which the member receives health care and health-related services. Care settings may include home, acute care, skilled nursing facility, and rehabilitation facility, etc.

**Planned transition**: Planned transitions include scheduled elective procedures, including outpatient procedures performed in a hospital or outpatient/ambulatory care facility; discharges from the hospital to long-term care or rehabilitation facility; or a return to the member’s home (usual care setting) after an unplanned transition. Change in level of care (i.e. move from SNF to customized living) is also considered a planned transition of care.

**Unplanned transition**: Unplanned transitions are most often urgent or emergent hospitalizations.

**Care Coordination TOC Documentation Responsibilities:**

1. Complete 6.22 Transitions of Care log.
   - Use 6.22.01 Transitions Log Instructions for detailed information on the completion of the log.

2. TOC logs are required if the CC learns of a transition while the member is in any phase of the transition process.

3. If the CC begins TOC interventions/log, they should complete the process through to discharge back to usual care setting even if the CC learns of the discharge back to the usual care setting 15 calendar days or more after it occurred.

   **Note**: TOC logs are **not** required when the Care Coordinator finds out about **all** transition(s) 15 calendar days or more after the member has returned to their usual care setting. The Care Coordinator should still follow-up with the member to discuss the transition, any changes to their health status and plan of care and provide education about how to prevent future admissions. Document this discussion in contact notes.

4. **Planned Transitions**: The Care Coordinator should contact the member prior to the admission day to ensure they have the Care Coordinator’s phone number and understand how the Care Coordinator will assist during the member’s care transitions.

5. **Member is admitted to New Care Setting**: Share essential information with the receiving facility (discharge planner, Social Worker, etc.) within 1 business day of learning of the admission. Refer to 9.16 TOC Talking Points for Hospital staff.

   **Note**: If the member’s usual care setting is a long-term care facility or other supportive living setting, staff at this setting usually shares relevant care plan information with the
receiving facility. However, it is the Care Coordinator’s responsibility to confirm this task has been completed by the facility staff and document the date they confirmed it on the transition of care log. If sharing of information has not been completed by the facility, the Care Coordinator must facilitate the completion of this task and document the date this was done on the transition of care log.

6. Notify the Primary Care Physician and/or Specialty Care Physician of all transitions including the transition to home, within 1 business day of learning of the transition. Optional form: 6.22.02 Fax Notification of Care Transition.

7. Member Returns to Usual Care Setting: The Care Coordinator is required to reach out to the member or authorized representative within one business day after the member returns to their usual care setting or “new” usual care setting or within 1 business day of learning of the transition and should discuss the following:

- Care transition process including the role of the Care Coordinator. For MSHO members offer post discharge resources. Refer to Post Discharge Resources for SecureBlue Members.
- Changes to health status.
- Discuss and update any changes to plan of care. If the member’s usual care setting is a nursing facility, the Care Coordinator should confirm that necessary changes were applied to the care plan and offer input, if applicable, and provide support/reinforcement of the updated care plan.
- The Care Coordinator shall address the “Four Pillars for Optimal Transition: Care Coordinators should refer to 9.12 TOC Resource Toolkit for information on the four pillars:
  - Timely follow up appointment.
  - Medication Self-Management.
  - Knowledge of red flags
  - Use of a Personal Health Record

NOTE: Communication with the Customized Living or Nursing Facility staff does not replace the requirement to contact the member/members representative.

- Provide education about how to prevent unplanned transitions/readmissions. This education should be tailored to the member’s specific needs, diagnoses, health issues, etc. and should be in a format that best works for the member based on their abilities. Members with chronic conditions who are frequently hospitalized can still benefit from educational discussions about their conditions, appropriate care, treatment options and relationship building with the Care Coordinator. Members in a nursing facility can benefit from an opportunity to reinforce or develop what is in their nursing facility plan of care.

**Transfers**

The term “transfers” refers to an existing Blue Plus enrollee who’s Care Coordination is transferring from one contracted Blue Plus Delegate to another contracted Blue Plus Delegate. This can be the result of a move, change in living arrangement, or a change in primary care.
New enrollees moving from straight Medicaid or another health plan and are new to Blue Plus are not considered transfers. Care Coordinators must follow the steps outlined in the Initial Contact with New MSHO and MSC+ Enrollee section of these guidelines.

**Transfers of Care Coordination to Another Blue Plus Delegate**

When a Care Coordinator becomes aware that a member is moving from their service area or the member chooses a PCC that impacts care coordination, the CC must:

1. Confirm the new Care Coordination Delegate by referring to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.
2. Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly to the new Delegate.
3. Update the member’s address, county of residence and/or PCC in Bridgeview.
4. Notify the member’s financial worker by completing the DHS 5181.
5. Keep copies of all forms and letters related to the transfer for your records.

The change in Care Coordination will be effective on the **first of the month** following the date of notification unless previous agreed upon with Blue Plus enrollment staff. It is expected that the current and receiving Care Coordinator work together to avoid gaps in care during the transition.

For a list of all tasks associated with a transfer, refer to Transfer in Care Coordination Delegation Checklist.

**Important:** If at the time of transfer it is known the member’s MA is terming and the member will not be reinstated, do **not** transfer the case. The current Care Coordinator should continue to follow the member until the member’s coverage terminates.

**Responsibilities of the Care Coordination Delegate who is initiating the transfer:**

1. Confirm the current and/or new PCC with the member, authorized rep, or customized living/nursing facility. This is especially important if the change in PCC triggers a change in care coordination delegation. For example, the following PCCs also provide care coordination to our members:
   - Bluestone Physicians (also responsible for: HealthEast and Fairview Partners)
   - Essentia Health
   - Genevive (MSHO only in select nursing facilities)
   - Lake Region Health Care Clinic (MSHO members in select Nursing Facilities in Otter Tail County)

   If the CC needs to confirm who the new Care Coordination Delegate will be, refer to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.

2. If the PCC needs to be changed, follow the PCC change process as outlined in the Primary Care Clinic (PCC) Change section.
Responsibilities of the transferring Care Coordination Delegate:

1. Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly to the new Delegate.

1. The transferring Care Coordinator is required, at a minimum, to share the following directly with the new delegate:
   - The next face-to-face assessment date (within 365 days of previous assessment)
   - Current Health Risk Assessment
   - Care Plan; including plan signature page and provider signature documentation
   - My Move Plan Summary

2. The transferring Care Coordinator should communicate the following to the member’s financial worker:
   a. Address change
   b. EW eligibility

3. If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the transferring Care Coordinator should proceed with the transfer process outlined here and change the PCC (if applicable).

4. Transitions of Care responsibility: If this transfer of Care Coordination is the result of a change in level of care (i.e. a permanent move from SNF to Customized Living, etc.), the transferring delegate will need to finish up the Transitions of Care (TOC) responsibilities. This includes documenting this move on the Individual Transitions Log.

Responsibilities of the Care Coordination Delegate who is receiving the transfer:

The receiving delegate will receive the 6.08 Transfer in Care Coordination Delegation form for review and as notification of the transfer.

1. Assign a Care Coordinator and notify the member by the 10th of the month the change is effective. The 8.30 CM Change Intro letter may be used to notify the member of a change in Care Coordinator.
2. Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the Bridgeview Manual.
3. Update the Screening Document to reflect the change in Care Coordinator
4. Notify the financial worker of the assigned Care Coordinator’s name.
5. Notify the physician using 8.28 Intro to Doctor Letter.
6. Confirm the PCC is correct in Bridgeview. If incorrect, update following the process outlined in the Primary Care Clinic (PCC) Change section of these Guidelines.
7. The Care Coordinator is now responsible for the content of the transferred assessment and care plan. The CC must review the assessment and care plan received from the previous Delegate. If applicable, document any updates and complete any areas that are not complete.
8. Follow the process for completing the health risk assessment and care plan if no current Health Risk Assessment/Care Plan is received from the transferring Delegate.
9. Keep copies of all forms and letters related to the transfer for your records.

Optional: Either Delegate may update the address and County of Residence in Bridgeview. This will be done automatically after the Financial Worker makes their changes; however, those changes may take up to a month to reach Bridgeview. **Changing the address and county of residence manually will update the current month’s enrollment report.** Follow the process outlined in the Bridgeview manual to make these manual changes.

*Note:* Manual changes made to the member information except the PCC in Bridgeview are saved for only 90 days. You must notify the financial worker to permanently change the member’s information.

**Transfers of Care Coordination within your agency**

If there is a change in Care Coordinator within the Delegate agency, the Delegate agency must:
- Inform member of the name, number, and availability of new Care Coordinator within 10 calendar days (new CC may use 8.30 CM Change Intro letter)
- Update the Care Coordinator assigned in Bridgeview
- Enter a Screening Document into MMIS
- Notify the financial worker of the change in Care Coordinator.
- Notify the physician using 8.28 Intro to Doctor Letter.

**Moving out of the Blue Plus service area**

Do not follow the Transfers process. Instead, please communicate directly with the new Care Coordinator to send appropriate documentation.

Implications of a move outside Blue Plus service area should be discussed with the member ahead of time if possible. Resource 9.01 Blue Plus Service Area Map can be used to determine if a move will take the member out of our service area. Member questions related to selecting a new health plan and/or Part D plan can be directed to either the member’s county financial worker or the Senior Linkage Line at 1-800-333-2433.

**Important:**
- Blue Plus will continue to pay for services, until the member’s disenrollment.
- The Blue Plus Care Coordinator is responsible for all care coordination activities until the case is transitioned and until the member is disenrolled from Blue Plus. This includes all assessments, care plans, and TOC activities unless coordinated in advance with the receiving county/agency.
• If the Blue Plus Care Coordinator needs assistance with determining who to contact to coordinate the transition at the new county, contact your Partner Relations Consultant for assistance.

To provide our member with a smooth transfer of care coordination services for transfers outside of the Blue Plus service area complete the following tasks:

1. Share a copy of the most recent MN NH Member Annual Assessment directly with the new Care Coordinator

2. Communicate the following to the member’s financial worker:
   • Address change
   • EW eligibility

On-going Care Coordination Responsibilities

Primary Care Clinic (PCC) Change

Blue Plus must be notified when a member changes their Primary Care Clinic (PCC). This is especially important if the PCC change also results in a change in Care Coordination delegation.

1. To change a member’s PCC:
   The Care Coordinator must update the PCC field in Bridgeview. The field includes a list of all PCC’s from our Primary Care Network Listing (PCNL) in a drop-down format. You must choose a clinic from one that is listed. If the member’s PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Please contact Member Services or your Partner Relations Consultant with any PCC network questions.

2. Determine if Change in PCC requires a transfer in Care Coordination:
   If the member’s PCC is contracted with Blue Plus to provide care coordination (See list below), the change in PCC may also trigger a change in who provides Care Coordination for the member. Send notification to SecureBlue.Enrollment@bluecrossmn.com for enrollment miss-assignments or follow the process outlined in section: Transfers in Care Coordination to another Delegate, which includes sending in form 6.08 Transfer in Care Coordination Delegation.

The member’s PCC may determine the Blue Plus delegate that provides care coordination (see list below). Changing the PCC in Bridgeview alone will not transfer care coordination.

The following PCC’s provide primary care and care coordination:

• Bluestone Physicians (also responsible for: HealthEast and Fairview Partners)
• Essentia Health
• Genevive (MSHO only in select nursing facilities)
• Lake Region Health Care Clinic (MSHO members in select Nursing Facilities in Otter Tail County)
If the CC needs to confirm who the new Care Coordination Delegate will be, refer to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.

**Discharge Planning**

The Care Coordinator shall coordinate an LTCC assessment within 20 calendar days of the member’s request for Home and Community Based Services (EW services).

If the Care Coordinator currently following the member does not administer the LTCC, they are responsible for contacting the local Blue Plus Delegate who conducts the assessment. If you are unsure who the local Assessor is, contact your Partner Relations Consultant.

It is Blue Plus’s expectation that both the nursing home Care Coordinator and the Assessor work together to complete all discharge planning.

The primary responsibilities of the Assessor are:
- Complete the LTCC and determining EW eligibility
- Develop the Collaborative Care Plan
- Coordinate any home care and EW services
- Complete Residential Services tool, if applicable
- Initiate the My Move Plan Summary if member will be going on the Elderly Waiver.

The Nursing Home Care Coordinator should:
- Complete TOC activities and TOC log
- Act as a resource and share information with the assessor as needed
- Upon discharge, initiate the transfer process
- update the PCC, if needed, in Bridgeview.
  Refer to Transfers section of the guidelines for complete details.

And, may assist the Assessor with the following tasks, if applicable:
- Locate another living arrangement
- Coordinate any physician discharge orders
- Assure member’s pharmacy needs are in place post discharge
- Arrange transportation for day of discharge
- Coordinate any post discharge follow up appointments
- Coordinate any medical supply or equipment needs

**Relocation Targeted Case Management**

As part of their usual role, Care Coordinators provide relocation services to members planning on returning to the community from a Nursing Facility. However, if a new member has been
receiving Relocation Targeted Case Management services at the time of initial enrollment to Blue Plus, the member must be given the choice to continue to work with their current Relocation Targeted Case Manager. If the member chooses to continue to work with this individual, the Care Coordinator is expected to work with the Relocation Targeted Case Manager on the member’s plan of care. It remains the Care Coordinator’s responsibility to ensure all activities included in the Care Coordination Guidelines are completed within the necessary timeframes. If a member does not wish to work with their Relocation Targeted Case Manager, the Care Coordinator will provide all necessary relocation service coordination.

Moving Home Minnesota

Moving Home Minnesota (MHM) is Minnesota’s Money Follows the Person Rebalancing Demonstration. The goal of this program is to promote transitions for people living with chronic conditions and disabilities residing in qualifying institutions an opportunity to return to the community.

When deciding if MHM is right for a member, Care Coordinators must evaluate and prepare to first use services under the member’s medical coverage and/or the Elderly Waiver. If the services under the medical benefit and Elderly Waiver do not meet all the identified transitional needs of the member, the Care Coordinators may explore MHM services.

The member must meet the MHM eligibility criteria below to apply for the program. With permission from the member, some referrals may come into DHS MHM Intake by someone other than the Care Coordinator (i.e. nursing home, family member, etc.). When this occurs, a member of the Partner Relations Team will reach out to the Care Coordinator for more information. Referrals from a Care Coordinator should be sent using secure email to Partner.Relations@bluecrossmn.com for consultation and next steps.

**MHM eligibility criteria:**

1. Member has resided for a minimum of 90 consecutive days in one or more of the following settings:
   - Hospitals, including community behavioral health hospitals; or
   - Institutions for Mental Disease (i.e. Anoka Metro Regional Treatment Center); or
   - Intermediate care facility for individuals with developmental disabilities (ICF/DD); or
   - Nursing facility;

   and

2. Member meets eligibility requirements for MA at time of discharge; **and**
3. MA has paid for at least one day of institutional services prior to leaving the facility; **and**
4. Member opens to the Elderly Waiver at the time of discharge; **and**
5. Member is transitioning to one of the following settings:
   - Home owned or leased by the individual or individual’s family member; or
   - Apartment with an individual lease with lockable access and egress which includes living, sleeping, bathing, and cooking areas over which the individual or individual’s family has domain and control; or
• A residence in a community based residential setting in which no more than four unrelated individuals reside.

Blue Plus will notify the Care Coordinator when the MHM request has been approved and will provide additional instructions. **Do not start MHM services until you receive confirmation from a member of the Partner Relations Team.** After the MHM provider has been selected, the Care Coordinator will collaborate with the MHM Transition Coordinator to create a plan and arrange supports and services. Monthly member updates must be provided to the Partner Relations Consultant Representative.

Note: MHM services do not count towards the member’s monthly Elderly Waiver case mix budget. Do not enter service agreements into Bridgeview. A member of the Partner Relations Team will reach out to the Care Coordinator with additional instructions for entering service agreements upon confirmation of the MHM services delivered.

See [MHM Program Manual](#) for more information.

**My Move Plan Summary**

The My Move Plan Summary (DHS-3936) helps to clarify role expectations before, during and after a move. It is a tool to communicate all key elements of the plan.

The My Move Plan Summary must be offered when a member who is expected to go on EW (i.e. from the nursing home) is moving to a new residence.

The My Move Plan Summary is optional in the following scenarios:

1. EW members who are permanently moving into a nursing facility
2. NH members who are moving residences and not going on EW

The Summary is not required for temporary placements or for members who are not on a waiver.

If the member is on a disability waiver, the Care Coordinator should ensure that the waiver CM completes the My Move Plan Summary form with the member. If not done by the CM, the Care Coordinator will be responsible for the My Move Plan Summary and can provide a copy to the other CM as appropriate.

The Care Coordinator is responsible to:

1. Evaluate the member’s needs,
2. Build and share the Summary with the member,
3. Update the My Move Plan Summary,
4. Update the Collaborative Care Plan (if applicable)
5. Communicate information to others involved (if applicable), and
6. Sign and keep a copy of the completed document in the member’s file.

The My Move Plan Summary form includes identification of “my follow up support” person. This person may be the Care Coordinator, or another identified support person. The “Follow Up person” is responsible to ensure the My Move Plan is implemented and the follow up contacts are made with the member including contact:

1. on the day of the move,
2. within the first week of the move,
3. within the first 45 days of the move,
4. and provide an on-going review of the plan as needed.

If the My Move Plan Summary was not completed, the Care Coordinator should indicate the reason on DHS-3936 and retain a copy in member’s case file:
- CC was not aware of the move, or
- Member declined to complete a move plan summary, or
- Other reason.

Please see the DHS Person Centered Protocol for more information about the My Move Plan Summary form and Person-Centered Practices.

Case Closure Care Coordination Responsibilities

Activities required when closing a member’s case depends on the reason for the termination. If you have any questions, always contact your Partner Relations Consultant. Here are some common “termination” scenarios (not all inclusive):

Term due to death:
1. No need to notify Blue Plus
2. Must send notification to the Financial Worker via DHS 5181

Term due to a move out of the Blue Plus Service area:
1. Refer to Moving out of the Blue Plus Service Area section of the guidelines

Term due to a move out of state or out of country:
1. Notify Financial Worker via DHS 5181

Term due to lapse in MA coverage:
1. Continue care coordination activities if member is on MSHO through 90-day grace period.

MA closing and will not reopen:
1. Refer member to Senior Linkage Line for assistance with finding other insurance or Part D prescription coverage if needed.

Term due to health plan change:
1. Confirm health plan change in MN-ITS
2. Refer to Moving out of the Blue Plus Service Area section of the guidelines
Interpreter Services

The Blue Plus contract with the Minnesota Department of Human Services requires that persons with limited English proficiency receive language assistance as necessary. If a Blue Plus member does not speak English as their primary language and has a limited ability to read, speak, write or understand English, the Care Coordinator may initiate the use of an interpreter to assist in assessment, care planning and on-going care coordination. Blue Plus prefers the use of a formal interpreter over a family member, as best practice.

When engaging interpreter services, Care Coordinators should use the most cost-effective means. Care Coordinators are encouraged to use over the phone interpretation as a first option when possible. The following are available to support and assist Care Coordinators when providing services to our members.

Over the Phone Interpretation: contact your Partner Relations Consultant for complete details.
  - My Accessible Real Time Trusted Interpreter, or MARTTI
  - United Language Group

Video/Virtual: Video service provides effective web-based interpretation. This can be done on a laptop, tablet or smartphone.
  - My Accessible Real Time Trusted Interpreter, or MARTTI

Face-to Face Care Coordination visits
  - Delegate agency may work with any interpreter agency registered with DHS, pay the interpreter agency directly and submit claims for payment on the member service claim.

If a Blue Plus member is requesting information about the use of an interpreter for their medical appointments (such as a clinic visit), the member should be directed to Member Services.

Note: All providers are responsible for arranging for interpreter services for Blue Plus MHCP members at the time the appointment is scheduled.

90 Day Grace Period (MSHO only)

If a SecureBlue/MSHO member has Medicare and loses eligibility for Medical Assistance, Blue Plus may continue to provide Medicare-covered plan benefits for up to three months. The three-month grace period may not be applicable in all cases where an MSHO member loses MA. Member’s in a 90-day grace period will show as termed in Mn-ITS but will continue to appear on your enrollment. If applicable, you must continue to provide Care Coordination services during this time.

  - Contact the member’s financial worker with questions about MA disenrollment.
  - Coverage during the 90-day grace period does not include Elderly Waiver services.
  - During their 90-day grace period, if the member has a product change or is due for a reassessment, the CC must make an attempt to complete the assessment timely per the member contact requirements. The CC must continue to follow the member until they officially term off the enrollment report. The only exception to this is if the member moves out of state.
• Coverage with Blue Plus will term after three months if the member has not regained Medical Assistance. At that time, the member will need to choose a new Part D plan to continue getting coverage for Medicare covered drugs. If the member needs assistance, they can call the Senior Linkage Line at 1-800-333-2433.

See DHS Bulletin #09-24-01 for more information.

Member and Provider Appeals

Member and provider appeals received by Blue Plus are managed by Amerigroup. Amerigroup will notify care coordination delegates via email of appeal determinations for the following situations:

• Appeal Determinations prior to services being rendered—Informational only
• State Fair Hearing. While this is intended as an informational communication, a Care Coordinator may contact CSC to participate in the hearing. CSC contact information will be included in the notice.
• State Fair Hearing Determinations—Informational only

Grievances/Complaints Policy and Procedure

Definitions

Grievance
Grievances are verbal or written expressions of dissatisfaction about any matter other than an Action (see definition below), including but not limited to, the quality of care or services provided or failure to respect the member’s rights. Some examples of grievances include: the quality of home delivered meals (food is cold), transportation providers being late, dislike of a roommate in the nursing home, impolite staff, in ability to access services appointment, missed or delayed diagnosis, or lack of treatment. Grievances can be filed either orally or in writing.

Grievant
The grievant is the person that is submitting the grievance for consideration. This may be a member, any individual acting on behalf of the member, or a provider with the member’s written consent.

Action
An action is a denial or a limitation of an authorization of a requested service, which includes:
• The type or level of service,
• the reduction, suspension or termination of a previously approved service
• the denial, in whole or in part for the payment for a service
• The failure to provide services in a timely manner
• The failure of the health plan to act within the required timeframes for resolution of appeals and grievances.
• For a resident of a rural area with only one Health Plan, the denial of a Medicaid member’s request to exercise services outside of the network.

**Appeal**
An appeal is a request to change a previous decision or action made by the health plan. Appeals may be filed orally or in writing. Anyone, including a care coordinator, who is making an appeal on behalf of a member may need an Authorized Release of Information signed by the member.

**Authorized Representative**
An authorized representative is an individual that is authorized by the member, or a surrogate who is acting in accordance with State law on behalf of the member to obtain an organization determination or deal with any level of the appeals process.

**Delegate Responsibilities**
The delegate must have a Policy and Procedure and system in place for handling grievances for MSHO/SecureBlue, and MSC+/Blue Advantage. A copy of written grievances, if submitted to the Delegate, must also be retained in the member’s file.

A contact person will need to be established by each delegate for grievances. The contact person will be responsible to obtain any necessary information to resolve written or oral grievances submitted directly to us. The delegate must be able to retrieve records within two business days.

**Oral Grievances**
Care Coordinators should direct members to report all oral grievances to Blue Plus by calling member services, seven (7) days a week 8:00 a.m. to 8:00 p.m. Central Time. Care Coordinators may also call Blue Plus to report an oral grievance on behalf of the member if the member requires assistance.

- MSHO 1-888-740-6013 (Calls to this number are free)
- TTY users call: **711** (Calls to this number are free)
- MSC+ 1-800-711-9862 (Calls to this number are free)
- TTY users call: **711** (Calls to this number are free)

**Written Grievances**
If a member requests the assistance of the Care Coordinator in filing a written grievance, the grievance should be transcribed in the member’s words and faxed to Amerigroup within one business day of the receipt of the grievance. Care Coordinators may use the MSHO MSC+ Care Coordinator Verbal Appeal Grievance Form located on the Care Coordination website.
The information faxed to Blue Plus should include both the written grievance and all other pertinent information or documentation related to the grievance. Amerigroup may contact the delegate for additional information during investigation of the grievance. Documentation should be maintained on file by the Delegate.

**Member and Provider Appeals**

Member and provider appeals received by Blue Plus are managed by Amerigroup. Amerigroup will notify care coordination delegates via email of appeal determinations for the following situations:

- Appeal Determinations prior to services being rendered—Informational only
- State Fair Hearing. While this is intended as an informational communication, a Care Coordinator may contact AGP to participate in the hearing. AGP contact information will be included in the notice.
- State Fair Hearing Determinations—Informational only

**Out of Country Care—Medicaid**

Medicaid payments, will not be made:

1) For services delivered or items supplied outside of the United States; or
2) To a provider, financial institution, or entity located outside of the United States.

United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Reminder: Any Benefit questions should be directed to Member Services.

**Other Care Coordination Responsibilities**

1. **QIPs**—The Care Coordinator will participate in the on-going performance improvement projects that are designed to achieve significant favorable health outcomes for members. These projects incorporate standards and guidelines outlined by the Centers for Medicare and Medicaid (CMS) with input by the Minnesota Department of Human Services (DHS).

2. **Vulnerable Persons Reporting.** It is the duty of mandated reporters to report suspected maltreatment of a vulnerable adult or child. Minnesota has a new central system for reporting suspected maltreatment of vulnerable adults. Call 844-880-1574 or go to the [MAARC Mandated Reporter Form](#) online.
   Vulnerable Adults Mandated Training Web-based training is available at no cost to all mandated reporters [here](#).

3. **Documentation**—The Care Coordinator shall document all activities in the member’s contact notes.
4. The Care Coordinator shall comply with any applicable Federal and State laws that pertain to member rights including HIPAA laws and the Minnesota Data Privacy Act and your organization’s confidentiality policy.

5. The Care Coordinator should be coordinating with local agency case managers (mental health, developmental disabilities, adult protection, etc.), financial workers and other staff as necessary to meet the member’s needs. This includes using the Case Manager/Financial Worker Communication Form (DHS # 5181) when:
   • A member requests waiver service
   • A member receiving waiver services has a change in circumstances (exits waiver, moves to SNF, expires, etc.)
   • For more information refer to DHS Bulletin #07-21-09

Blue Plus Network

Blue Plus members must use in network providers. They do not have coverage for services received from a provider who is not in our network unless it is emergency or urgently needed care.

There is no coverage for care out of the state of Minnesota unless urgent or emergent.

There is no coverage for urgently needed care or any other non-emergency care received outside of the United States.

Members should contact member services with coverage questions. Providers should contact provider services. See Contact Information section.

Audit Process

The Blue Plus contract with DHS and CMS requires the auditing of care coordination activities on an annual basis.

Delegate Systems Review:
Each delegate will be asked to submit documentation related to the elements selected. Documentation may include Policies and Procedures, case load statistics, job descriptions, elderly waiver vendor lists, or other supporting documentation. Partner Relations staff will review the submitted documentation to determine it meets the contractual requirements. This review may be done on-site or as part of a desk review.

Audit Process:
Partner Relations Lead Auditor will conduct an annual Delegate audit. During the audit, the Auditor will conduct care coordination system and care plan audits for elderly waiver and community well members using the DHS approved MSHO and MSC+ EW Care Planning Audit Protocol. They will also conduct audits for nursing home members using a Nursing Facility Member Chart Review Audit Tool (if applicable).

Elderly Waiver:
   • Review of selected member files using an established statistical process of an 8/30 record review sampling methodology. If any element is missing or not met in the first
8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

Community Well and Nursing Home:

- Review of a random sampling of 5 records for each living arrangement. If any element is missing or not met in those 5 records, another 5 records will be reviewed in the areas not met in the initial sample.
- For Nursing Home Only Delegates, review of selected member files using an established statistical process of an 8/30 record review sampling methodology will be used. If any element is missing or not met in the first 8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

If a problem or findings are identified during assessment, the Delegate will be required to respond to Blue Plus with a Corrective Action Plan” (CAP) meaning a list of actions and an associated timetable for implementation to remedy a specific problem, which includes a root cause analysis, interventions, necessary tasks required for improvement, the person responsible for resolution and a timetable for resolution.

Findings are defined as an area of non-compliance discovered through assessment or other means related to a regulation, statute, policy, procedure, contract or sample review for a given requirement or obligation, including Care Coordination guideline and requirements.

Mandatory Improvements will also be noted and are defined as an action that must be taken to resolve an issue identified through auditing and monitoring, which does not meet the criteria for a CAP. These are required actions to prevent the risk of a future Finding. For example, unclear or incomplete Policies and Procedures or sample documentation.

A CAP may be assigned to resolve Findings or mitigate compliance risks when one or more of the following apply:

1) The 95.00% compliance standard for samples is not met
2) Policies and procedures are not documented
3) Beneficiary’s rights are impacted
4) There is a repeat finding from a previous assessment or monitoring
5) Compliance issues that are related to a high-risk area, where swift correction of the action is required.

Each Delegate will be required to provide a written response within 1 month of receipt of the written audit results if there are Findings or Mandatory Improvements. Interventions to make corrections for the finding areas, target end dates for completion and correction must be within 3 months of the start date of the described intervention. It is the responsibility of each delegate to alert Blue Plus with the completion dates of the corrective actions implemented.

**Records Retention Policy**

The Delegate must have policies and procedures to address record retention in accordance with DHS and Center for Medicare and Medicaid Services rules and regulations. Files, either in electronic or hard copy format, are to be kept for 10 years from the date the files are closed. After 10 years the files may be destroyed.

- File information includes patient identification information, provider information, clinical information, and approval notification information.
• All documents pertaining to pending litigation or a regulatory matter must be retained despite general disposal policy until Blue Plus advises that such documents may be returned to the general disposal policy.
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## Blue Plus Blue Advantage (PMAP / Families and Children / MSC+)

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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. KEPRO, 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, KEPRO 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.
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/BN1/12_HospitalDischargeAppealNotices.asp#TopOfPage](http://www.cms.hhs.gov/BN1/12_HospitalDischargeAppealNotices.asp#TopOfPage)

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 [blucrossmn.com](http://blucrossmn.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 [blucrossmn.com](http://blucrossmn.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 member 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 members. Leaving this data element out or use of a dummy NPI number constitutes an incomplete pharmacy claim.
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.

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 members of products with Medicare Part D coverage (identified by RxPCN carrier code “SBPARTD” or on their ID cards)

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 now requires that many vaccines (and the fees for administering them) be paid under the member’s Medicare Part D drug coverage. For members of SecureBlue who have Part D coverage, 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](http://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 subscriber. The pharmacy can bill the subscriber for applicable copayments at the time of purchase. The provider shall not charge the individual subscriber 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 subscriber.
# 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 member. Rely on “claim response” to correctly identify the amount to collect from the member.

## Vacation Prescription Requests
Requests for additional drug quantities may be made by the member, physician, or pharmacist. The member 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 a member’s copay, the member should pay the lesser of the allowed amount as shown on the claims response.

## Collection of Copay Inability to Pay
Copays must not be collected from members of Blue Plus Public 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 member’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.
- **Ideal**: This is the formulary for Medicare Advantage.

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.

**Requesting to add a drug to the formulary**:

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:

- Name of Prescribing MD
- Clinic Name
- Clinic Phone Number
- Clinic Fax Number
- Name of Drug
- Name of Manufacturer
- Rationale for adding the drug
### Drug Formulary (continued)
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 member by completing the Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions. Member liability for non-formulary medications is subject to the member’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 members of Blue Plus plans. In order to receive a non-formulary drug, the member’s physician must request a formulary exception.

### Investigative Drug Use
Investigative drugs are not eligible for reimbursement.
Blue Plus requires formulary exception procedures for members enrolled in Blue Advantage (PMAFamilies and Children/MSC+), MNCare, SecureBlue (MSHO) non-Medicare members without exception.

**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 Blue Cross 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.
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. Members 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 member’s condition, a formulary exception request must be submitted on the member’s behalf.

What does this mean for the member?

Prescriptions written as DAW will not process at point of sale until the certification or demonstration has been received. Members 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 member’s condition, a formulary exception request must be submitted on the member’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.

What if a member tries to fill a DAW prescription for a drug not listed in Blue Cross Medicaid GenRx drug list?

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

When a Subscriber receives their drugs from a specialty network supplier, they are assured quality while saving money and time. Contact provider services to verify if the subscriber’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:

- Fairview Specialty Pharmacy, LLC  
  1-800-595-7140  
  (612) 672-5262 (Fax)  
  www.fairviewspecialtyrx.org

- AllianceRx Walgreens Prime  
  1-877-627-6337  
  1-877-828-3939 (Fax)  
  www.walgreens.com/pharmacy/specialtypharmacy.jsp

- Children’s Home Care*  
  1-866-656-1020  
  (612) 813-7207 (Fax)

*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’re taking.

- AllianceRx Walgreens Prime is an independent company providing central specialty and mail service pharmacies.

- Fairview Specialty Pharmacy, LLC is an independent pharmacy providing specialty medications.
Elderly Waiver Programs Billing Requirements

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 Cross only enrolls EW providers that have already enrolled with DHS.

Provider enrollment information can be found on https://www.dhs.state.mn.us under the HCBS (Home and Community Based Services) tab. Providers should complete the enrollment information and send to DHS for registration.

All DHS registered EW providers must register with Blue Cross to bill and receive payment for services authorized within their provider service agreement. Service agreements are authorized and created by the member’s care coordinator and located in Availity under the Interactive Care Reviewer (ICR). Additional information regarding accessing service agreements via ICR is available in this manual. Contact Provider Services at 866-518-8448 or the member’s Care Coordinator for questions.

Provider Service Agreements will contain:

- Member Identification Number
- Service Agreement number
- Provider Name
- Provider Billing NPI / UMPI Number
- Care Coordinator Name and contact information
- Service HCPCS
- Authorized units
- Service frequency
- Authorized Dates of Service
- Total amount authorized
Below are additional guidelines:

- Providers who render or supervise services are responsible for submitting claims.
- Submit claims only after one or more EW covered services are provided.
- Only bill for dates of service when services were provided.
- Bill the rate that is listed on the service agreement or authorization letter.
- Only one calendar month of service can be billed per claim.
- The authorization number that is listed on the service agreement letter must be submitted on the claim.
- Submit claims electronically via Availity.

The EW Provider landing page can be accessed at: www.bluecrossmn.com/elderlywaiver

Providers will be able to obtain:

- Registration and change of information form
- W9 form
- EFT (Electronic Funds Transfer) form
- Additional provider educational resources

To register with Blue Cross, providers must complete the EW provider registration, W9, and EFT forms. Submit the completed forms via fax 1-833-224-6929 or email to EWProviders@amerigroup.com

- Banking verification must be included in the form of a voided blank check OR a letter from your banking institution.
**Interactive Care Reviewer (ICR)**

ICR is a tool for providers, available via the Amerigroup Availity portal, in which service agreements can be viewed and printed.

Training is available for all EW providers to learn about the functionality of ICR.

Providers are strongly encouraged to review training documents:

- Learn how to access ICR through the Availity Portal www.availity.com
- Learn how to access, review and print provider service agreements.
- Availity claims entry tutorial is available by going to www.Availity.com Go to www.bluecrossmn/elderlywaiver to review all Elderly Waiver trainings available.

**Elderly Waiver Claims Submission**


- Once services are rendered by the provider then billing for the services may occur.
- Providers must register with the Availity Clearinghouse to bill using the UMPI or NPI that is listed on the service agreement letter. If the NPI or UMPI is not correct on the service agreement letter, the provider must contact the care coordinator and get a revised service agreement, or all the claims submitted will deny
  - Select BCBSMN Blue Plus Medicaid Waiver with payer ID FS802 from the Payer drop-down menu to appropriately route the claim.

**Claim Payment**

- Amerigroup claims are processed weekly on Saturdays
- A provider may not request or accept payment from a recipient, recipient’s relative, the local human service agency or any other source, in addition to the amount allowed under the service agreement or authorization for services, unless the request is for one of the following:
  - Waiver obligation
  - LTC (long term care insurance), Medigap, Medicare or any other insurance supplement.
### Elderly Waiver Claims Submission (continued)

<table>
<thead>
<tr>
<th><strong>Non-Covered Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Room and board expenses are not covered</td>
</tr>
<tr>
<td>• EW funded homemaker, chore, and respite are not billable services during the period that the person is receiving Customized Living services</td>
</tr>
<tr>
<td>• EW providers, including Customized Living providers, cannot bill for days on which the client is absent</td>
</tr>
</tbody>
</table>

**Timely Billing**

- Timely filing limits are 12 months from the date of service.
- Submit claims correctly. Refer to the service agreement for the correct billing information such as service agreement number, provider billing NPI or UMPI (Unique Minnesota Provider Identifier), authorized date span, service codes and units of service authorized.
- Submit replacement claims so that Amerigroup receives them within 6 months from date of remittance advice.

**Electronic Remittance Advice (ERA)**

All providers who submit claims must be set up by Blue Cross/Amerigroup to access their remittance advice under Claims Management and Remittance Viewer on the Availity portal. The electronic remittance advice (ERA) is where providers will be informed of the adjudication status and payment amount on the claims submitted. If there are questions regarding the adjudication of the claim or to check the status, follow up directly with Blue Cross Provider Services at 1-866-518-8448.

The Remittance Viewer will list the provider payment made by Amerigroup via [www.availity.com](http://www.availity.com).

The remittance viewer allows you to search for and view electronic remittance advices (ERA) data from the 835 files that have been delivered to Availity.

Remit images are available for most Blue Cross:

- Images can be saved to the user’s computer or printed.
- Remittances are viewable for 15 months.
- Access to view online remittances will be dependent on the security assigned by your organization.
### Elderly Waiver Claims Submission (Continued)

#### Replacement/Void Claim

Examples of Reasons for Replacement Claim:

- Date of Service needs to be added
- Date of Service needs to be modified
- Diagnosis code change or addition
- Change to billed amount
- Change to units billed

#### Reasons for Voided Claims

- Member information changed
- Billing Provider Information changed
- HCPCS or Modifier is now incorrect due to revised Service Agreement
- Services billed to Amerigroup in error

Providers should only send replacement claims if a claim has already processed resulting in an adjudicated claim. Replacement claims are submitted to correct information that was originally submitted.

The claim payer number can be found on the ERA electronic remittance advice under Claim Information and Payer Claim number. If the original claim number is not included on the replacement claim, it will result in a denial.

#### Voided Claims

Providers that submit claims in error must use the voided claim process. When submitting a voided claim, it must be an exact match to the claim information that was originally submitted. If the information does not match, the void request will be denied. If the claim is not submitted as a void, it will be rejected as a duplicate claim.

The original claim number must be entered in the Payer Control Number (ICN/DCN.)

The claim number can be found on providers’ electronic remittance advice under Claim Information and Payer Claim number. Once the voided claim is received by Amerigroup, the claim will be voided as requested.
### Elderly Waiver Claim Payment Appeal/Dispute Process

If the Provider disagrees with the outcome of a claim, the Provider may begin the Blue Cross Appeal Process.

Claim-related issues that are not considered an appeal are:

- **Claim Inquiry:** A question about a claim, but not a request to change a claim payment.
- **Claims Correspondence:** When Blue Cross requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have.

### Claim Payment Appeal

If the Provider disagrees with the outcome of the Reconsideration, an additional review called the Claim Payment Appeal may be requested.

A Claim Appeal may be submitted for multiple reason(s) including:

- Contractual payment issues
- Disagreements over reduced or zero-paid claims
- Post-service authorization issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues*

*Timely filing issues. Blue Cross will consider reimbursement of a claim which has been denied due to failure to meet timely filing if the Provider can:

1. Provide documentation the claim was submitted within the timely filing requirements or
2. Demonstrate good cause exists.
The first step in the Blue Cross Claim Payment Appeal process is called the Reconsideration. It is the initial request to investigate the outcome of a finalized claim.

- Reconsideration requests may be submitted via fax, writing or verbally within 90 calendar days from the date on the explanation of payment (EOP).
- Reconsiderations filed more than 90 days from the remit will considered to be untimely and denied unless good cause can be established.
- When submitting Reconsiderations, the provider should include as much information as possible to substantiate the rationale that the claim was not paid as expected.
- If a Reconsideration requires clinical expertise, it will be reviewed by appropriate clinical professionals.
- Blue Cross will make every effort to resolve the claims payment reconsideration within 60 calendar days of receipt.
- A decision will be sent in a determination letter, which will include:
  1. A statement of the provider's Reconsideration request.
  2. A statement of what action Blue Cross intends to take or has taken.
  3. The reason for the action.
  4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
  5. An explanation of the provider’s right to request a Claim Payment Appeal within 60 days of the date of the Reconsideration determination letter.
  6. The options available to submit the Claim Payment Appeal

If the decision results in a claim adjustment, the payment and explanation of payment (EOP) will be sent separately.
**Elderly Waiver Claim Payment Appeal/Dispute Process (continued)**

- If the Provider is dissatisfied with the outcome of a Reconsideration determination, a Claim Payment Appeal may be requested.
- Blue Cross accepts Claim Payment Appeals through the Availability portal, in writing, or via fax within 60 calendar days of the date on the Reconsideration determination letter.
- Claim Payment Appeals received more than 60 calendar days from claims Reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.
- When submitting a Claim Payment Appeal, a provider should include as much information as available to help substantiate why the Reconsideration determination outcome is deemed incorrect. Blue Cross cannot process a Claim Payment Appeal without a Reconsideration on file.
- If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.
- Blue Cross will make every effort to resolve the Claim Payment Appeal within 30 calendar days of receipt.
- The Claim Payment Appeal determination letter will include:
  1. A statement of the provider's Claim Payment Appeal request.
  2. A statement of what action Blue Cross intends to take or has taken.
  3. The reason for the action.
  4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
- If the decision results in a claim adjustment, the payment and EOP will be sent separately.
How to Submit a Claim Payment Dispute

Blue Cross recommends providers submit Reconsiderations and Claim Payment Appeals via the secure Provider Availity portal, however there are several options when filing a Claim Payment Dispute.


You will receive immediate acknowledgement of your Web submission.

- **Phone (Reconsideration only):** Provider Services at 1-866-518-8448.

- **Written (Reconsideration and Claim Payment Appeal)**

  Written (Reconsideration and Claim Payment Appeal): Include the AUC Claim Payment Appeal Form located at (https://www.health.state.mn.us/facilities/auc/forms/index.htm #31) to send via:

  Blue Cross and Blue Shield of Minnesota
  Consumer Service Center
  ATTN: Elderly Waiver Services
  PO Box 64033
  St Paul, MN 55164-4033

  - Fax completed AUC Appeal Form to (Reconsideration and Claim Payment Appeal): 1-833-224-6929
  - Email completed AUC Appeal Form to EWProviders@amerigroup.com

- **Required Documentation for Claims Appeals**

  Blue Cross requires the following information when submitting a Claim Appeals (Reconsideration or Claim Payment Appeal):

  - Provider name, address, phone number, email, and either your TIN or UMPI.
  - The member’s name and their Blue Cross or Medicaid ID number.
  - A copy of the original Blue Cross decision
  - A listing of disputed claims, which should include the Blue Cross claim number and the date(s) of service(s).
  - All Supporting statements and documentation.
<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>1-866-518-8448</td>
</tr>
<tr>
<td></td>
<td>7:00 AM – 6:00 PM Monday through Friday</td>
</tr>
<tr>
<td>Member Services</td>
<td>Medicaid (MSC+):</td>
</tr>
<tr>
<td></td>
<td>1-800-711-9862</td>
</tr>
<tr>
<td></td>
<td>TTY for Hearing Impaired: 711</td>
</tr>
<tr>
<td></td>
<td>Medicare (MSHO):</td>
</tr>
<tr>
<td></td>
<td>1-888-740-6013</td>
</tr>
<tr>
<td></td>
<td>TTY for Hearing Impaired: 711</td>
</tr>
<tr>
<td>Availity</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
</tr>
<tr>
<td>Availity Solutions Helpdesk</td>
<td>1-800-282-4548</td>
</tr>
</tbody>
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Chapter 4
Referrals

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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](http://bluecrossmn.com) or the [www.availity.com](http://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](http://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](http://www.availity.com) and Blue Plus' website at [bluecrossmn.com](http://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.
Referrals

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.

<table>
<thead>
<tr>
<th>Health Service</th>
<th>If referred by the PCC</th>
<th>If not referred by the PCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service not rendered by the PCC</td>
<td>Highest level of Subscriber's benefits</td>
<td>Self-referral benefit. If the Subscriber does not have a self-referral level of benefits, the claim will probably deny as Subscriber responsibility.</td>
</tr>
<tr>
<td>Medical emergency</td>
<td>Highest level of Subscriber's benefits</td>
<td>Highest level of Subscriber's benefits for inpatient and outpatient hospital services</td>
</tr>
<tr>
<td>Non-medical emergency</td>
<td>Highest level of Subscriber's benefits</td>
<td>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.</td>
</tr>
<tr>
<td>Health Services on referral bypass</td>
<td>Highest level of Subscriber's benefits. Referrals are not required for Health Services on referral bypass.</td>
<td>Highest level of Subscriber's benefits. Referrals are not required for Health Services on referral bypass.</td>
</tr>
<tr>
<td>Open-access benefits</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.

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

**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.
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.

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

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

[Date]

[Name of patient]
[Address of patient]

Copy to:
[Name of secondary provider]

PATIENT REFERRAL NOTICE

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:
Physician:
Primary Care Clinic:
Clinic Provider #

Referral care must be provided by:
Provider name:
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.
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**

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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
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.

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.
Quality Improvement

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 Consumer Assessment of Health Plans (CAHPS) survey to assess Member satisfaction. The CAHPS survey assesses many but not all aspects of a Member’s 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.

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

<table>
<thead>
<tr>
<th>Policy Required</th>
<th>Recommended Risk Management Elements</th>
</tr>
</thead>
</table>
| 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  
• Accountability, including how control is maintained (i.e., who has keys, who is allowed into the location of practice and when)  
• Protected health information (PHI) disposal  
• Security of both paper and electronic PHI that follows HIPAA guidelines  
• Reviewed annually |
| Confidentiality and Security of Medical Records | See Medical Records section. |
| Foreign Language Translation and Hearing-Impaired Services | • Assistance provided for both situations  
• Interpreter available for phone calls and face-to-face interactions  
• Members/family are notified that interpreter is provided  
• Resources are identified |
# Written Policies (continued)

<table>
<thead>
<tr>
<th>Policy Required</th>
<th>Recommended Risk Management Elements</th>
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</thead>
<tbody>
<tr>
<td><strong>Hazardous Materials and Waste Management</strong></td>
<td>• Written plan in place and maintained</td>
</tr>
<tr>
<td></td>
<td>• Hazardous material and waste defined</td>
</tr>
<tr>
<td></td>
<td>• Mechanism in place for responding to a spill</td>
</tr>
<tr>
<td></td>
<td>• MSDS (material safety data sheets) available</td>
</tr>
<tr>
<td></td>
<td>• Hazardous materials and waste are identified and inventoried</td>
</tr>
<tr>
<td></td>
<td>• Mechanism defined for responding to a spill/breach of containment</td>
</tr>
<tr>
<td></td>
<td>• Chemical and regulated medical waste addressed</td>
</tr>
<tr>
<td></td>
<td>• Hazardous gas and vapors addressed</td>
</tr>
<tr>
<td></td>
<td>• Orientation and education of staff outlined</td>
</tr>
<tr>
<td><strong>Infection Control</strong></td>
<td>• Basic overview of infection control and how it relates to controlling disease</td>
</tr>
<tr>
<td></td>
<td>• Hand washing outlined, when and how</td>
</tr>
<tr>
<td></td>
<td>• Universal precautions addressed, including glove use</td>
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<tr>
<td></td>
<td>• Personal protection equipment addressed</td>
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<tr>
<td></td>
<td>• Screening employees for TB</td>
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<td></td>
<td>• Vaccinating employees for Hepatitis B</td>
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<tr>
<td></td>
<td>• 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)</td>
</tr>
<tr>
<td><strong>Medical Emergency</strong></td>
<td>• Mechanism in place for responding</td>
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<td></td>
<td>• Medical emergency code is identified</td>
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<td></td>
<td>• Identify who directs activities</td>
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<td></td>
<td>• Identify who determines if 911 is called</td>
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</tbody>
</table>
### Written Policies (continued)

<table>
<thead>
<tr>
<th>Policy Required</th>
<th>Recommended Risk Management Elements</th>
</tr>
</thead>
</table>
| **Medication Management** | • Mechanism in place for procuring, storing, controlling and distributing medications  
• Narcotics addressed, even if to say they are not kept at the location of practice  
• Recalls addressed  
• Emergency and sample drugs addressed  
• Sign-out log covered  
• Prescription pad accessibility addressed |
| **Non-Medical Emergency Policy** | • Mechanism in place for responding  
• Include power outages, weather emergencies, bomb threats, and both fire and fire drills |
| **Treating Unaccompanied Minors Policy** | • Minor defined, exceptions covered  
• Scheduling appointments addressed  
• Mechanism in place to respond when an unaccompanied minor calls/arrives asking to be seen  
• 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 expects 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/](https://www.ahrq.gov/)
- Institute for Healthcare Improvement
  - [www.ihi.org](http://www.ihi.org)
- The Joint Commission International Center for Patient Safety
  - [www.jcipatientsafety.org](http://www.jcipatientsafety.org)
- Leapfrog Group for Patient Safety
  - [www.leapfroggroup.org](http://www.leapfroggroup.org)
- Minnesota Alliance for Patient Safety
  - [www.maps.org](http://www.maps.org)
- National Quality Forum
  - [www.qualityforum.org](http://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/7 day 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.

<table>
<thead>
<tr>
<th>Policy Required</th>
<th>Recommended Risk Management Elements</th>
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<tbody>
<tr>
<td>Behavioral Health Accessibility Standards</td>
<td>• Access to Behavioral Health appointments commensurate with clinical need</td>
</tr>
<tr>
<td></td>
<td>• Access to follow-up appointments commensurate with clinical need</td>
</tr>
<tr>
<td></td>
<td>• Crisis access to clinician 24 hours a day/7 day a week</td>
</tr>
</tbody>
</table>
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.
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.