COVID-19 FAQ

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BlueCross BlueShield Minnesota

An FAQ specific to Minnesota Health Care Programs (Blue Advantage Families and Children (F&C), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) is now available here.

Submitting Claims:

Q. What diagnosis codes should be used to identify a COVID-19 related claim?

A. Diagnosis coding should follow the guidelines set forth by the CDC.

CDC ICD-10-CM Official Coding Guidelines
ICD-10-CM Official Coding and Reporting Guidelines (4/1/20 through 9/30/20)

Q. What procedure codes should be used when billing for the COVID-19 diagnostic (e.g. PCR) testing?

A. The following HCPCS codes have been developed and should be used for billing COVID-19 laboratory testing.

U0001 – coronavirus testing using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel (Effective 2/4/2020)

U0002 – validated non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19) (Effective 2/4/2020)

U0003 - Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R. (processing more than 200 specimens per day) (Effective 4/14/2020)

U0004 - 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R (processing more than 200 specimens per day) (Effective 4/14/2020)

87635 – Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique (Effective 2/4/2020)

Q. How should the specimen collection be billed for the COVID-19 tests?

A. Three codes have been developed for the specimen collection are effective for date of service 3/1/2020:

G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source

G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

C9803 - Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source

Q. What code should be used to bill for the COVID-19 antibody test?

A. Codes 86328 and 86769 have been developed for the COVID-19 antibody tests and are effective for date of service 4/10/2020.

86328 - Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

86769 – Antibody testing using multiple-step method; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

Q. Is Blue Cross accepting claims submitted with Condition Code "DR" (Disaster Related)?

A. Yes, Blue Cross systems are ready to accept claims submitted with Condition Code "DR".

Q. Is Blue Cross accepting claims with procedure code modifier "CS" (Cost sharing for specified COVID-19 testing related services that result in an order for or administration of a COVID-19 test)?

A. Yes, Blue Cross systems are ready to accept claims submitted with procedure code modifier "CS" for dates of service effective 3/18/2020. The modifier will be used to assist in identifying COVID-19 related claims; however, the modifier itself will not be used to determine if a waiver of member cost share is applied.

Q. What claim information is Blue Cross using to identify a potential COVID-19 related claim?

A. Blue Cross is using multiple claim elements to assist in identifying potential COVID-19 related claims including:

- COVID-19 diagnoses codes (U07.1, B97.29, Z03.818, Z11.59, Z20.828)
- COVID-19 test codes, including the antibody tests
- COVID-19 specimen collection codes
- Modifier "CS"

Medical records may be requested if a claim is identified by the above information, but there are questions as to whether the claim is related to COVID-19.

Q. Is there a way to submit a claim attachment via a method other than fax or mail?

A. While faxed and mailed claim attachments can be processed more efficiently, for Commercial and Medicare lines of business, Blue Cross does have an e-mail box to accept claim attachments from providers that temporarily cannot fax or mail due to working from home. Claim attachments must be submitted with an AUC Claims Attachment coversheet to ensure appropriate routing. E-mail submissions should be sent to incoming.service.center@bluecrossmn.com. This option is not available for MHCP claim attachments.

Q. Is there a way to request information about a claim related to COVID-19 on Availity using the Messaging tool under Claims Status?

A. Yes, a new drop-down option has been added using the Claims Status Messaging tool to identify a message as related to COVID-19. This tool is not available for MHCP members.

Reimbursement:

Q. How will the new COVID-19 lab codes be reimbursed on a professional claim (837P)?

A. COVID-19 laboratory tests must be done at approved locations in accordance with CDC guidelines.

Blue Cross has updated the standard non-RVU fee schedule for COVID-19 testing as follows in accordance with the member's benefit plan for all lines of business:

- HCPCS U0001: $35.91 – effective 2/4/20 dates of service
- HCPCS U0002: $51.31 – effective 2/4/20 dates of service
- HCPCS U0003: $100.00 – effective 4/14/20 dates of service
- HCPCS U0004: $100.00 – effective 4/14/20 dates of service
- CPT 87635: $51.31 – effective 2/4/20 dates of service

These reimbursement rates are based upon rates that were recently released by the Centers for Medicare and Medicaid Services for COVID-19 testing and established by the local Medicare Administrative Contractor (MAC).

Q. How will the new COVID-19 antibody test codes be reimbursed on a professional claim (837P)?

A. Blue Cross has updated the standard non-RVU fee schedule for COVID-19 antibody testing as follows in accordance with the member's benefit plan for all lines of business:

- CPT 86328: $45.23 – effective 4/10/2020 dates of service
- CPT 86769: $42.13 – effective 4/10/2020 dates of service

These reimbursement rates are based upon rates that were recently released by the Centers for Medicare and Medicaid Services for COVID-19 testing and established by the local Medicare Administrative Contractor (MAC).

Q. How will the new COVID-19 lab specimen collection codes be reimbursed on a professional claim (837P)?

A. Blue Cross has updated the standard non-RVU fee schedule for COVID-19 lab specimen collection as follows in accordance with the member's benefit plan for all lines of business:

- HCPCS G2023: $23.46 – effective 3/1/20 dates of service
- HCPCS G2024: $25.46 – effective 3/1/20 dates of service
- HCPCS C9803: $22.98 – effective 3/1/20 dates of service

These reimbursement rates are based upon rates that were recently released by the Centers for Medicare and Medicaid Services for COVID-19 lab specimen collection.

Q. Will the new COVID-19 lab and lab specimen collection codes be added to the Enhanced Ambulatory Patient Grouper (EAPG) for outpatient facility services?

A. The COVID-19 laboratory tests and lab specimen collection codes will be updated in April EAPG software releases.

Q. CMS is temporarily removing sequestration, will Blue Cross also remove it?

A. Yes, in alignment with CMS, Blue Cross will temporarily be removing sequestration for Medicare lines of business for dates of service 5/1/2020 to 12/31/2020 for providers both in and out of network. For facility claims, the suspension of sequestration will apply to claims with 'statement to' dates starting May 1, 2020 through December 31, 2020.

Q. Will Blue Cross implement the 20% bump in allowance for inpatient hospital claims for Medicare Advantage members?

A. Yes, in alignment with Medicare, Blue Cross will implement the 20% bump in allowance for certain inpatient hospital claims for Medicare Advantage members diagnosed with COVID-19 and discharged during the COVID-19 Public Health Emergency. The affected DRGs are 177-179, 207-208, 791-793 (neonates) and 974-976 (HIV patients). The pricing system will be updated to reflect this change on or after 5/22/2020. In the interest of getting payments to facilities as quickly as possible, Blue Cross will continue to process impacted claims at the current rate. Once the pricing system update is implemented, impacted claims will be reprocessed to reimburse the additional allowance.

Member Benefits:

Q. Do laboratory tests for COVID-19 assess member cost share?

A. Member cost share (co-pay, coinsurance, and deductible) is waived for eligible COVID-19 lab testing (U0001, U0002, U0003, U0004, and 87365) for Medicare, Minnesota Health Care Programs, and fully insured Commercial lines of business.

Q. Do specimen collections for laboratory tests for COVID-19 assess member cost share?

A. Member cost share (co-pay, coinsurance, and deductible) is waived for lab specimen collection for COVID-19 lab testing (G2023, G2024 and C9803) for Medicare and fully insured Commercial lines of business. Minnesota Health Care Programs does not reimburse for specimen collection at this time.

Q. Is member cost share assessed for a COVID-19 provider visit?

A. Blue Cross is waiving the member cost share for a COVID-19 provider visit for Medicare, Minnesota Health Care Programs (MHCP), and Commercial lines of business during the Public Health Emergency.

Q. Will member cost share be waived for other services provided at a COVID-19 provider visit?

A. In addition to waiving member cost share for the COVID-19 test and related provider visit, the following respiratory illness-related services provided during a COVID-19 provider visit will also have member cost share waived if an FDA approved COVID-19 lab is administered or ordered by the attending practitioner. This waiver is in effect for the duration of the Public Health Emergency. Blue Cross will continue to monitor this list.

- Complete Blood Count (CBC) – 36591, 36592, 85025, 85027, 85048
- C-Reactive Protein Test – 86140
- Sedimentation Rate Tests – 85651, 85652
- Influenza Tests – 87275, 87276, 87279, 87400, 87501, 87502, 87503, 87804
- Respiratory Syncytial Virus (RSV) Tests – 87634, 87807, 87280
- Strep Tests – 87430, 87650, 87651, 87652, 87880
- Pregnancy Tests – 81025, 84702, 84703
- Chest X-Rays – 71045, 71046
- Specimen Collection – 36415, 36416, 36591, 36592, 36600, 99000, 99001
- In-Office Nebulizer Treatment – 94060, 94640, 94644, 94645, 94664, 94760, 94761
- Hydration Therapy – 96360, 96361

Q. Is member cost share assessed for the treatment of COVID-19?

A. Member cost share will be waived for fully insured commercial members, including members with an individual plan, Minnesota Health Care Programs (MHCP), and Medicare (Advantage, Cost, Supplement) members for inpatient and outpatient evidence-based treatment of COVID-19 provided by an in-network provider or facility under the member's specific benefit plan. The waiving of cost share is in effect for dates of service between 2/4/2020 and 9/30/2020 and will apply to facility claims with admission dates between 2/4/2020 and 9/30/2020. The cost share waiver excludes retail prescription drugs as there is no current FDA approved prescription treatment for COVID-19. On a professional claim, lines submitted without a confirmed COVID-19 diagnosis will be assessed a member cost share, if applicable.

Q. Will Blue Cross waive member cost share for COVID-19 testing prior to a procedure?

A. Blue Cross will cover pre-operative and pre-procedural COVID-19 testing without member cost share for FDA-approved tests ordered by a licensed practitioner.

Q. Will Blue Cross waive member cost share for COVID-19 antibody testing?

A. Yes, Blue Cross will cover FDA-approved antibody testing ordered by an attending practitioner with no member cost share.

Q. How is Blue Cross assisting Medicare Advantage members in getting needed care?

A. Blue Cross published a news release on 5/18/2020 to announce the waiving of member cost share for in-network primary care, mental health and substance use office visits for the duration of the public health emergency in 2020. Additionally, Medicare Advantage members will have expanded access to in-home wellness care and home test kits for some preventive screenings.

Q. Has Blue Cross waived member cost share for any other services?

A. Member cost share has been waived for eligible services provided by Doctor on Demand through June 14, 2020 for any diagnosis to encourage the use of virtual care in accordance with the member's benefit plan.

Q. How long will member cost share be waived?

A. Blue Cross will waive member cost share through the end of the National Health Emergency related to COVID-19, unless a date is specifically communicated for a specific benefit.

Q. Is there a way to request benefit information related to COVID-19 on Availity using the Messaging tool under Eligibility and Benefits?

A. Yes, a new drop-down option has been added within the Eligibility and Benefits Messaging tool to identify a message as related to COVID-19. This tool is not available for MHCP members.

Q. Who should I advise Blue Cross members to contact with benefit questions?

A. Members should contact Member Services at Blue Cross at the phone number on the back of the member's ID card.

Appeals:

Q. Will Blue Cross allow additional time to submit appeals?

A. Due to COVID-19's impact on provider offices, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is increasing the timely filing requirement for provider liability appeals. The timely filing requirement will be increased to 180 calendar days for provider liability appeals for claim remits dated March 1, 2020 and after for all lines of business. This is a temporary extension for the duration of the National Health Emergency related to COVID-19.

Q. How can a provider assist in identifying an appeal related to COVID-19?

A. Please ensure that the cover sheet or first page of the appeal clearly states "COVID-19" or "Coronavirus".

Q. Is there a way to submit an appeal via a method other than fax or mail?

A. While faxed and mailed claim appeals can be processed more efficiently, for Commercial and Medicare appeals, Blue Cross does have an e-mail box to accept appeals from providers that temporarily cannot fax or mail due to working from home. Appeals must be submitted with an AUC Appeals Request Form to ensure appropriate routing. E-mail submissions should be sent to isc.appeals@bluecrossmn.com. This option is not available for MHCP appeals.

Hospital-Based Post-Payment Claim Reviews

Q. Are there any extensions implemented for medical record requests for post payment audits of hospital claims?

A. Hospital-based retrospective claim reviews (APR-DRG and Inpatient Short Stay) have an increased timeframe of 60 days for medical records to be returned before the claim will be recouped for the duration of the National Health Emergency related to COVID-19. The letters requesting medical records will not be updated with the temporary timeframe due to the cost in making the changes to the letters.

Care Management and Notification of Impacted Members:

Q. Does Blue Cross provide any care management support for Blue Cross members diagnosed with COVID-19?

A. Yes, there is care management support available. Blue Cross encourages providers to notify the Plan of all members with a diagnosis or suspected diagnosis of COVID-19. By providing this information, our Care Management nurses can assist with a smooth transition to home if admitted, or support them at home if under self-quarantine, ensuring essential needs are met. Providers can refer a member for care management needs related to COVID-19. To notify Blue Cross of impacted Commercial or Medicare Advantage members, please contact 1-855-579-7657, and for MHCP members, please contact 1-800-711-9862.

Members should contact Member Services using the phone number on the back of the Member's ID card.

Pharmacy:

Q. Can a member receive an early medication refill?

A. For members who have Prime Therapeutics as their Pharmacy Benefit Manager (PBM), Blue Cross will increase access to prescription medications by waiving early medication refill limits on 30-day prescription maintenance medications. Blue Cross encourages members to use the 90-day mail order benefit, if one exists. Members with PBMs other than Prime Therapeutics should contact their PBM for information.

A 90-day prescription for maintenance drugs is allowed for Minnesota Health Care Programs (MHCP) members; however, there isn't an allowance for an early refill of other 30 day medications.

Q. Is Blue Cross extending any prior authorizations for prescription drugs?

A. Blue Cross has extended the expiration date by 90 days for Pharmacy Benefit Drug Prior Authorizations for Commercial, Medicare, and Medicaid members with Prime Therapeutics as their Prescription Benefit Manager. This will apply to Drug Prior Authorizations that are set to expire between 4/1/2020 and the end of June 2020.

Virtual Care (Telehealth, E-Visits, Telephone Visits):

Q. Does Blue Cross reimburse E-Visits, Telehealth and Telephone Visits?

A. Blue Cross currently has policies that allow for reimbursement of eligible E-Visits, Telehealth and Telephone Visits in accordance with the member benefits. All Commercial Blue Cross members have a benefit that covers telehealth services as defined in the Telehealth Services Reimbursement Policy. Given the nature of the COVID-19 pandemic, seeking in-person medical care may lead to further spreading of the virus. Please refer to the links below for the most up-to-date policies:

Telehealth Services Reimbursement Policy (Revised 4/3/2020)
E-Visits Reimbursement Policy
Telephone Calls Reimbursement Policy (Revised 3/20/2020)

Many telehealth services are covered for Minnesota Health Care Programs members. Please refer to the MN DHS website for eligible services. Additionally, the 3 telehealth visit per week maximum has been waived for the duration of the National Health Emergency related to COVID-19.

Q. Will Blue Cross allow preventive care services to be provided via telehealth?

A. Yes, Blue Cross will temporarily allow preventive care services (99381-99387, 99391-99397) to be provided via telehealth during the National Health Emergency related to COVID-19. Providers may provide all or portions of a preventive medicine visit via telehealth that can be done so appropriately and effectively. Any services that require face-to-face interaction may be provided at a later date. Providers may only bill one preventive medicine code (99381-99387, 99391-99397) to cover both the portion done via telehealth and the face-to-face interaction. Codes for diagnostic services may be separately billed per standard coding guidelines. The Telehealth reimbursement policy has been updated to reflect the temporary addition and the Blue Cross claims system has been updated to allow the billing of preventive medicine codes with a telehealth place of service as of February 4, 2020.

Q. If professional services are always billed on an institutional claim (837I), how would the service be billed if the service is provided via telehealth?

A. Professional services that are always billed on an institutional claim (837I) that are provided via telehealth should continue to be billed as if they were provided face-to-face for the duration of the National Health Emergency. Please add modifier ‘GT’ or ‘95’ to services provided via telehealth.

Q. How should telehealth services be billed for commercial members on a professional claim?

A. Commercial claims for telehealth services submitted on a professional claim should be submitted with place of service 02. The procedure code should match the procedure code that would have been billed for a face-to-face service. The modifier -95 may be appended. For commercial members, telehealth services are reimbursed at the same rate as they would be for a face-to-face encounter in an office setting

(place of service 11), except for codes that are by definition provided in a facility (example: 99231 – Subsequent Hospital Care). Blue Cross will also accept commercial telehealth claims submitted in alignment with CMS, with the place of service that would have been used if the service was provided face-to-face, with modifier -95 appended to the procedure code.

Q. How should telehealth services be billed for Medicare lines of business? (See the following Q&As for RHC and FQHC specific instructions.)

A. In order to obtain payment parity for clinic services, telehealth claims for Medicare members should be submitted with the place of service that would have been used if the service was provided face-to-face with modifier -95 appended to the procedure codes. If place of service 02 is submitted, the claim will apply the facility place of service allowance.

Q. How should Rural Health Clinics (RHCs) submit telehealth services for Medicare lines of business?

A. For dates of service 1/27/2020 through 6/30/2020, HCPCS G2025 should be billed with revenue code 052X and modifier 'CG' for telehealth services provided by RHCs to Medicare members. Modifier '95' may also be submitted.

For dates of service beginning 7/1/2020, HCPCS G2025 should be billed with revenue code 052X for telehealth services provided by RHCs to Medicare members. Modifier 'CG' should *not* be submitted. Modifier '95' may be submitted.

Coding for commercial members should follow the instructions above regarding billing telehealth for commercial members on a professional claim.

Please remember, if CMS performs "mass" claim adjustments on claims for which Blue Cross is secondary, Blue Cross does not receive crossover mass adjustments claims. Providers must submit a replacement claim that reflects the new processing in these cases. Your Medicare remittance advice will indicate if the claim has crossed over to Blue Cross.

Q. How should Federally Qualified Health Centers (FQHCs) submit telehealth services for Medicare lines of business?

A. For telehealth services provided by an FQHC for Medicare members for dates of service 1/27/2020 through 6/30/2020, submit code G0466, G0467, G0468, G0469, or G0470 along with a qualifying payment code, such as 99213 with modifier '95', and HCPCS G2025 with modifier '95'. All three codes should be billed with revenue code 052X.

For dates of service beginning 7/1/2020, only HCPCS G2025 should be billed with revenue code 052X and modifier '95' for telehealth services provided by FQHCs to Medicare members.

Coding for commercial members should follow the instructions above regarding billing telehealth for commercial members on a professional claim.

Please remember, if CMS performs "mass" claim adjustments on claims for which Blue Cross is secondary, Blue Cross does not receive crossover mass adjustments claims. Providers must submit a replacement claim that reflects the new processing in these cases. Your Medicare remittance advice will indicate if the claim has crossed over to Blue Cross.

Q. Can telehealth be provided over the telephone with no visual connection?

A. Blue Cross is waiving the policy requirement of a visual component for the duration of the National Health Emergency related to COVID-19, allowing telehealth services to be provided over the telephone.

Q. If services are provided solely over the telephone, do telephone consult codes need to be submitted?

A. A telephone visit is a patient-initiated telephone encounter between a provider and an established patient conducted over the phone billed with telephone consult procedure codes (please reference the Blue Cross Telephone Visit Reimbursement Policy). If providers are providing care over the phone that typically had been performed face-to-face, providers should reference the Blue Cross reimbursement policy for Telehealth to review the codes that can be submitted. Providers should submit eligible procedure codes that would have been used if the services were performed face-to-face with Place of Service 02.

Q. Can telehealth and telephone visits be provided to a new patient?

A. During the timeframe of the National Health Emergency related to the COVID-19 pandemic, Blue Cross is waiving the restriction of providing telehealth and telephone visits to established patients to allow the services to be provided to new patients.

Q. What are the requirements for the audio-visual applications being used for telehealth?

A. In accordance with CMS and to increase the availability of telehealth to members, Blue Cross will waive the HIPAA security requirements and allow common audio-visual apps, such as Skype and Facetime, to be used for telehealth visits.

Q. Do participating providers need any additional contracts to provide virtual care services?

A. No additional contracting is needed. The eligible coding and billing requirements are listed in each reimbursement policy.

Q. Do providers need to submit any information regarding practitioners that will begin providing virtual care services?

A. No additional credentialing or updates are needed for practitioners to begin providing telehealth services. Practitioners must be licensed in the state where the patient is located when receiving services.

Q. Can a member be located at home when they receive telehealth services?

A. Yes, a member can be located at home when they receive telehealth services.

Q. Can the practitioner be located at home and provide telehealth or telephone visits?

A. Yes, a practitioner can provide telehealth or telephone services while being located at their home.

Reference Labs:

Q. What labs should providers refer labs to?

A. Providers are required to use FDA approved labs and should refer to a participating lab whenever possible.

DME:

Q. Will Blue Cross require DME Suppliers to receive a signature as proof of delivery during the National Health Emergency?

A. Due to limitations on individuals entering facilities and to reduce face-to-face contact, Blue Cross will waive the patient signature requirement as proof of delivery.

Prior Authorizations:

Q. Will any prior authorization requirements be waived?

A. Blue Cross and eviCore will waive prior authorizations for diagnostic tests and other covered services (such as CT imaging, respiratory DME and post-acute care: SNF, Home health) that are medically necessary and consistent with CDC Guidance, for members diagnosed with COVID-19. In the event a prior authorization is submitted to eviCore for COVID-19 related diagnosis and treatment, the prior authorizations will be auto-approved. Providers should include information as part of the prior authorization request if COVID-19 has been diagnosed and/or suspected.

Blue Cross and eviCore will have clinical staff available to address inquiries related to medical services to ensure timeliness of responses related to COVID-19. Blue Cross may require medical records if unable to determine if the claim is related to COVID-19 or to determine the medical necessity of the services and items.

Q. Are there any changes to the prior authorization requirements and/or process for DME for patients without COVID-19?

A. eviCore will auto-approve DME codes in the following categories for Medicare Advantage members with COVID-19 and non-COVID-19 diagnoses:

- Oxygen
- Nebulizers
- Ventilators
- Chest wall precursors
- Cough stimulating devices and all associated accessories
- Continuous Positive Airway Pressure (CPAP) devices for non-sleep related respiratory issues

Prior authorization is not typically required for DME in these categories for commercial members.

Q. Are there any changes to the prior authorization requirements and/or process for Post-Acute Care services?

A. Blue Cross and eviCore will approve all home health care services and skilled nursing facility (SNF) admissions for Medicare Advantage and commercial members with COVID-19 and non-COVID-19 diagnoses as follows:

- Home Health: Initial home health requests will be approved for 60 days. Home health extension requests will be approved for 30 days at a time until the pandemic has passed.
- Skilled Nursing Facilities: Admissions from acute care facilities to skilled nursing facilities (SNF) will be approved for the first 7 days to help free up hospital beds.

The provider will still need to notify Blue Cross or eviCore of the request so the admission can be approved and tracked for follow up throughout the length of stay.

Q. How will Blue Cross and eviCore accommodate approved prior authorizations for non-urgent and elective services that have been postponed or delayed due to the COVID-19 outbreak?

A. eviCore and Blue Cross will be working to proactively extend prior authorizations for services that may be impacted by COVID-19.

- Blue Cross will extend PAs for 180 days for medical and surgical procedures requested on or after 1/1/2020 that are due to expire prior to 12/31/2020.
- eviCore will extend all PAs requested on or after 3/1/2020 for 180 days.
- The member and provider will receive a new letter with the extended approval time period. This information will also be reflected within the Auth/Referral Dashboard in the Availity portal. The extension process has started, however letters and authorizations will be updated and re-issued in a phased approach.
- Authorizations for any type of service not automatically extended by Blue Cross can be extended on a case by case basis.
- Starting March 26, Blue Cross and eviCore will also ensure all newly approved PAs will include at least a 180-day timeframe.

Referrals:

Q. Will Blue Cross waive the referral requirement for commercial managed health plans during the National Health Emergency?

A. The referral requirement will be waived for any services provided by participating providers for dates of service starting 4/1/2020 through 5/31/2020 that would otherwise require a referral during the National Health Emergency for all commercial managed health plans, except the MN Advantage Plan for state employees and the Public Employee Insurance Plan (PEIP).

For the MN Advantage Plan for state employees and PEIP, the referral requirement is waived only for COVID-19 testing and related office visit or for an initial office visit with COVID-19 symptoms when no test is performed due to availability or not meeting the current requirements for testing.

Q. Will Blue Cross waive the referral requirement for Restricted Recipients during the National Health Emergency?

A. No, the referral requirements for Restricted Recipients remain in place. If appropriate and necessary, a referral can be submitted by the primary care provider after the referred care has been performed.

Business Resiliency:

Q. Does Blue Cross have any concerns with timely processing of claims that will negatively impact provider payment?

A. Blue Cross has plans in place to ensure timely processing of claims and does not anticipate any delay.

Q. If a provider is unable to submit claims timely due to staffing impacts as a result of COVID-19, will Blue Cross allow additional time?

A. Blue Cross will continue to monitor how the COVID-19 pandemic impacts core business operations for providers. In the event, Blue Cross makes any changes to accommodate delays in claims submissions, Blue Cross will notify providers.

Q. What assistance exists for providers experiencing financial hardship?

A. Emergency funding and loan assistance for providers was included in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that was signed into law on March 27, 2020. The law directs $100 billion to an emergency fund accessible by eligible healthcare providers and provides additional low-interest and small business loan support to businesses combatting the COVID-19 outbreak. Other key provisions boost Medicare and Medicaid reimbursement for COVID-19-related inpatient services and provide funding for key community-based initiatives. We encourage providers to review the CARES Act to determine eligibility for funding relief through the various programs available.

Practitioner Credentialing and Enrollment:

Q. What is Blue Cross doing to facilitate quicker practitioner credentialing and enrollment?

A. Blue Cross has moved all new credentialing applications and practitioner add requests to our top priority.

Additionally, Blue Cross will implement a provisional credentialing process to more quickly credential providers and will follow the NCQA change from a 60 day to a 180-day time frame for the provisional status. To be considered for provisional credentialing:

1) Complete a current and signed application including the Authorization and Release form and Disclosure Questions and submit them to credentialing@bluecrossmn.com with the subject line "Provisional Credentialing Requested". If you submit your credentialing applications through the MCC, please continue to do so and additionally, submit an email to credentialing@bluecrossmn.com with the subject line "Provisional Credentialing Requested" and include the practitioner's name and that the application was submitted via the MCC.
2) The practitioner must have a valid license to practice.

3) The practitioner must pass a 5-year history of malpractice claims or National Practitioner Data Bank (NPDB) query.
4) Practitioners with adverse actions will not be eligible for provisional credentialing as they are subject to further review.

Please note that practitioners who are provisionally credentialed must complete full credentialing within 180 days of the signature on the credentialing application.

For provisionally credentialed practitioners only, the claims effective date will be the date that the provider lists on the application. *Prior to submitting claims, however, providers need to wait to hear from the Provider Data Operations area that the practitioner has been set up for billing in the system.*

Q. Is Blue Cross extending the timeframe for recredentialing?

A. Blue Cross will follow the NCQA recommendation to extend the recredentialing cycle from 36 months to 38 months to allow providers additional time to complete recredentialing.

Q. What will happen if a practitioner needs to work at a different location from one which they are currently enrolled? How can claim denials be limited for this scenario?

A. If providers need to practice at different locations than currently set up, there are three potential options to limit claim denials for this situation (these options only apply to practitioners that do not require credentialing or are current with credentialing):
- Submit the site of care as their primary clinic location even if care is not rendered at that clinic
- Notify us of the additional clinic location and these requests will be worked as a priority
- Notify us post care and we will back date the effective date to the first date care was provided

Q. Will Blue Cross allow out-of-state healthcare providers to render services to its members during this time?

A. Blue Cross will accept out-of-state licenses for practitioner types that are engaged with a participating clinic or healthcare system and would otherwise be licensed through either the Minnesota Board of Medical Practice or the Minnesota Board of Nursing.

Q. Will Blue Cross allow out-of-state mental health providers to render telehealth services to its members during this time?

A. Blue Cross will accept out-of-state licenses for mental health practitioners that are engaged with a participating clinic or healthcare system and would otherwise be licensed through one of the following Minnesota licensing boards: Psychology, Social Work, Marriage and Family Therapy, or Behavioral Health and Therapy.

Q. If I am unemployed due to COVID-19-related changes, will that impact my future credentialing?

A. No, Blue Cross does not consider a period of unemployment when reviewing a practitioner's credentialing application to determine eligibility**.**