

Blue Cross and Blue Shield of Minnesota Provider Policy & Procedure Manual

2021



**BlueCross BlueShield
of Minnesota**

An independent licensee of the Blue Cross and Blue Shield Association

Summary of Changes (2021)

Chapter 1 – At Your Service

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 2 – Provider Agreements

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 3 – Quality Improvement

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 5 – Health Care Options

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 6 – Blue Plus

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 7 – BlueCard

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 8 – Claims Filing

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 9 – Reimbursement/Reconciliation

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 10 – Appeals

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 11 – Coding Policies and Guidelines

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 1

At Your Service

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Introduction

Provider Policy and Procedure Manual

Blue Cross and Blue Shield of Minnesota developed the *Provider Policy and Procedure Manual* for participating health care providers and your business office staff. This manual provides information about our claims filing procedures, payments, provider agreements, managed care requirements, communications and other topics that affect patient accounts and patient relations. As policies and procedures change or clarification is needed, Blue Cross will keep you updated through *Provider Bulletins*, *Quick Points* and the *Provider Press*, found at bluecrossmn.com. Information in this manual is a general outline and is part of your provider contract. Provider and subscriber contracts determine benefits.

Blue Cross and Blue Shield Plans

Blue Shield plans for professional services began to form across the nation in the 1940s, after the successful Blue Cross movement of the 1930s was well underway. Today, there are many Blue Cross and Blue Shield Plans throughout the United States. Blue Cross and Blue Shield Plans may be separate companies or combined as one company. Each plan is an independent business organization and a nonprofit independent licensee of the Blue Cross and Blue Shield Association.

The Blue Cross and Blue Shield Association, headquartered in Chicago, is an association of independent Blue Cross and Blue Shield Plans. It sets performance standards and bids for national contracts and programs. It also organizes advertising campaigns, conducts research and coordinates legislative efforts on behalf of the association's subscribers.

Blue Plus

Blue Plus, an affiliate of Blue Cross, is a state-certified health maintenance organization (HMO). In most Blue Plus products, subscribers select a participating primary care clinic that coordinates all of the patient's medical care and authorizes treatment by specialists when necessary.

Because Blue Plus is an affiliate of Blue Cross, Blue Plus is subject to most of the same policies and procedures. For general information about Blue Plus, you may refer to Chapter 6 of this manual. Blue Plus primary care clinics should refer to the *Blue Plus Provider Manual* for specific Blue Plus guidelines. Blue Plus is a nonprofit independent licensee of the Blue Cross and Blue Shield Association.

CPT® Copyright

CPT codes copyright 2010 American Medical Association. All Rights Reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

How to Contact Us

Provider Services

A conversation with one of our service representatives often can solve a problem immediately or give you an answer to a claims question. The representatives answering the provider services numbers are available to assist you:

- Monday – Friday.....7 a.m. – 6 p.m.

Please have your provider number or NPI and if applicable, the subscriber's identification number, account number and claim number ready when you call. The provider services telephone numbers listed are for the **provider's use only**. Please refer subscribers to the customer service telephone number on the back of their subscriber identification (ID) card.

The general provider services phone numbers are **(651) 662-5200** (Twin Cities area) and **1-800-262-0820** and **1-888-420-2227**

The general provider services fax number is **(651) 662-2745**.

Minnesota Health Care Programs provider services phone numbers are as follows:

For eligibility and benefits, utilization management, or claims for dates of service beginning January 1, 2019: **1-866-518-8448**

For questions regarding your contract, credentialing, or demographic set up: **1-800-262-0820**

Federal Employee Program

Providers who are calling to check eligibility and benefits for Federal Employee Program subscribers can utilize the voice response unit specific to FEP.

Claim status is not available at this time. Providers will be prompted to speak to a service representative for all FEP claims questions. To access this service, call **(651) 662-5044** or **1-800-859-2128**. FEP subscribers are recognized by an "R" followed by eight numeric digits in their identification number.

Calls Not Handled by Provider Services

Calls for the accounts on the next page are not handled by provider services. Please use the phone numbers listed. In addition, calls from independent social workers who are working as patient advocates should call the customer service phone number on the back of the subscriber's ID card.

Calls Not Handled by
Provider Services
(continued)

Accounts and how to ID them	Phone Numbers
Federal Employee Program ID number starts with an R	(651) 662-5044 1-800-859-2128

BlueCard® Benefits and
Eligibility

To verify benefits or eligibility for BlueCard subscribers, call **1-800-676-BLUE (2583)**. Refer to *Chapter 7* for additional information.

Provider Claim
Adjustment/Status
Check

The [Provider Claim Adjustment/Status Check Form](#) is designed for non-Minnesota providers to fax or mail their inquiries to Blue Cross.

The applicable fax number is listed on the form or mail it to the general Blue Cross address (see below).

All the fields are required to be completed, if applicable. Make sure to clearly state the contact name, phone number and contact's fax number.

The inquiries can be an adjustment request or claim status request for regular or BlueCard business.

The form will not be returned to you unless Blue Cross needs clarification on your request. All adjustments that are completed will be found on a future remittance advice.

A sample of the [Provider Claim Adjustment/Status Check Form](#) can be found on our website, bluecrossmn.com.

General Address

The general address is:

Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560

(Claims adjustment request inquiries should be mailed to this address)

Claims Address

All claims must be submitted electronically. All Minnesota and out-of-state participating providers are required to electronically submit all claims according to Minnesota Statute 62J.536 and the participating provider contracts. Paper claims will be rejected to be resubmitted electronically. Blue Cross will not consider such paper claims to have been received until resubmitted electronically. Nonparticipating out-of-state providers may submit a scannable claim form to:

Blue Cross and Blue Shield of Minnesota Claims
P.O. Box 64338
St. Paul, MN 55164-0338

Availity Provider Portal

In lieu of faxing and calling, Providers are directed to create and inquire on the status of utilization management authorization requests electronically on our provider portal at [Availity.com](https://www.availity.com).

Out-of-state providers that participate with any Blue Cross and Blue Shield plan can access Availity through the out-of-area member router provided by each state's plan.

The Availity Authorization portal should be used for all required preservice inpatient and outpatient prior authorization requests. The Availity Authorization portal should also be used for admission notifications, unless your facility is submitting a 278 or ADT HL7 transaction (see Provider Bulletin P15-18 for more details).

Requests for medical necessity review of services that have already been provided cannot be submitted online and will not be accepted by phone or fax.

Questions?

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

Care Management
Numbers and
Addresses

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

Effective June 18, 2018, providers will have the ability to create, submit with attachments and inquire on status of utilization management authorizations electronically via the Availity portal at Availity.com. The Availity Authorization Portal should be used for all pre-service in-patient, pre-service out-patient authorization requests and admission notifications.

Providers will have the ability to request a concurrent review on an existing in-patient authorization via Availity Providers. Additionally, providers will be able to inquire on the status of utilization management requests and will also see a dashboard of authorization requests, including status, for authorizations entered via the Availity Authorization Portal.

The most current preauthorization (PA) list and current medical policies are located on the Blue Cross website: providers.bluecrossmn.com under “Tools and Resources”. Additional review guidelines are also found in chapter four of this manual, *Care Management*. Providers can also contact Provider Services at **1-800-262-0820** for assistance.

Area	Phone/Fax Numbers and Addresses
------	---------------------------------

Care Management
Numbers and
Addresses

Area	Phone/Fax Numbers and Addresses
<p>The following pre-service requests should be submitted on Provider self-service:</p> <ul style="list-style-type: none"> • Inpatient Precertifications • Admission Notifications • Outpatient Pre-Service Requests (Medical and Behavioral Health) • Home Health Services • Home Infusion Services • Hospice Care • Skilled Nursing Facility Requests • Transplant Requests <p>The following pre-service requests can be mailed or faxed:</p> <ul style="list-style-type: none"> • Predeterminations 	<p>Provider self-service: www.availity.com</p>
<p>Admission Notification and Inpatient Admission Pre-Certification Review</p> <p>For medical and behavioral health related inpatient admissions</p>	<p>General inquiries:</p> <p>Phone: (651) 662-5270 1-800-528-0934</p> <p>Fax: (651) 662-7006</p> <p>Fax: (651) 662-0622 or 1-855-315-4038</p>

Care Management
Numbers and
Addresses (continued)

Area	Phone/Fax Numbers and Addresses
<p>Minnesota Health Care Programs Inpatient Admission Pre-Certification Review</p>	<p>Emergent Inpatient Admissions</p> <p>Planned/Elective Admissions must receive prior approval at least 72 hours prior to the medical admission or scheduled procedure to ensure the proposed care is a covered benefit, medically necessary, and performed at the appropriate level of care.</p> <p>Authorizations can be submitted via phone or fax.</p> <p>Phone: 866-518-8448</p> <p>Fax:</p> <p style="padding-left: 40px;">Families & Children (F&C), MSC+, MNCare: 1-844-480-6839</p> <p style="padding-left: 40px;">MSHO: 1-866-959-1537</p> <p>Inpatient Pre-certification for BH Inpatient Psychiatric and Substance Use Disorder (SUD) Hospitalization Admissions:</p> <p>Submit the required appropriate form located on the website at:</p> <p>https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs</p>

Care Management
Numbers and
Addresses (continued)

Area	Phone/Fax Numbers and Addresses
<p>Skilled Nursing Facility Admission Review</p>	<p>General inquiries:</p> <p>Commercial</p> <p>Fax: (651) 662-1004</p> <p>Medicare Programs</p> <p>Phone: (651) 662-5540 (Initial review)</p> <p>Fax: (651) 662-4022</p> <p>(Concurrent review)</p> <p>Minnesota Health Care Programs</p> <ul style="list-style-type: none"> • Phone: 866-518-8448 <p>FAX:</p> <ul style="list-style-type: none"> • Blue Advantage MSC+: 1-844-480-6839 • SecureBlue MSHO: 1-866-959-1537 <p>PMAP communication form:</p> <p>Fax:</p> <ul style="list-style-type: none"> • Blue Advantage MSC+: 1-844-480-6839 • SecureBlue MSHO: 1-866-959-1537
<p>Behavioral Health Review (Outpatient)</p>	<p>General inquiries:</p> <p>Fax: (651) 662-0854</p> <p>Mail:</p> <p>Integrated Health Management Behavioral Health, R472 P.O. Box 64265 St. Paul, MN 55164-0265</p>

Care Management Numbers and Addresses (continued)

Area	Phone/Fax Numbers and Addresses
<p>Home Care Review</p> <p>The following pre-service requests should be submitted on Provider self-service:</p> <ul style="list-style-type: none"> • Home Health Services • Home Infusion Services • Hospice Care 	<p>General inquiries:</p> <p>Fax: (651) 662-1004</p> <p>Mail:</p> <p>Integrated Health Management Allied Team, R472 P.O. Box 64265 St. Paul, MN 55164-0265</p>
<p>Urgent Outpatient Medical Procedure Review</p> <p>Only submit requests that meet the federal definition of “Urgent” to this fax line: where applying the standard review time may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.</p>	<p>General inquiries:</p> <p>Fax: (651) 662-1624</p>
<p>Non-urgent Outpatient Medical Procedure Review</p>	<p>General inquiries:</p> <p>Fax: (651) 662-2810</p> <p>Mail:</p> <p>Integrated Health Management Utilization Management, R472 P.O. Box 64265 St. Paul, MN 55164-0265</p>

Other Numbers and Addresses

These phone numbers, fax numbers and addresses may be helpful to you.

Company	Phone Number	Address
BlueLink TPA SM	Refer to Subscriber’s ID card	BlueLink TPA SM P.O. Box 64668 St. Paul, MN 55164
Delta Dental [®] of Minnesota SM	(651) 406-5900 or 1-800-328-1188 Fax: (651) 406-5934	Delta Dental of Minnesota SM 3560 Delta Dental Drive Eagan, MN 55122
United Concordia Dental	(800) 332-0366	4401 Deer Path Road Harrisburg, PA 17110

Company	Phone Number	Address
		Or PO Box 69420 Harrisburg, PA 17106-9420
MII Life Inc. SM	(651) 662-5065 1-800-859-2144	MII Life Inc SM 3535 Blue Cross Road P.O. Box 64193 St. Paul, MN 55164-9828
Prime Therapeutics LLC	(612) 777 -4000 or 1-800-858-0723 Pharmacy help desk: 1-800-821-4795 (for pharmacist or doctor use only)	Prime Therapeutics® 2900 Ames Crossing Road Eagan, MN 55121
Customer Service	Refer the subscriber to their customer service number printed on the back of their subscriber ID card. They may also call (651) 662-8000.	
Fraud Hot Line	(651) 662-8363 or 1-800-382-2000 ext. 28363	
Medicare & More Customer Service	(651) 662-5020 or 1-800-531-6686	

Address Changes and Other Demographic Information

Promptly notify Blue Cross when any of your demographic information changes, including but not limited to your address, phone number, hospital affiliation or office hours. Use the Provider Demographic Change Form, available at providers.bluecrossmn.com. Enter “provider demographic change form” in the search window. Blue Cross uses your demographic information in provider directories, to help subscribers find you easily, mail important information to you, etc. Call **(651) 662-5200** or **1-800-262-0820** for telephonic assistance. fax completed forms to **(651) 662-6684** or mail them to:

Blue Cross and Blue Shield of Minnesota
PDO, R316
P.O. Box 64560
St. Paul, MN 55164-0560

- Blue Cross shall in its sole discretion, determine if a participating agreement will be extended to an acquired entity and/or additional locations of Provider.

EviCore Contact Information

Program	Fax Number
MN eviCore – Genetic Testing (Molecular/Genetic Lab) Program	844-545-9213
MN eviCore – Medical Oncology Program	866-699-8160
MN eviCore – Musculoskeletal (MSK) Program	800-540-2406
MN eviCore – Radiation Oncology (Radiation Therapy) Program	800-540-2406
MN eviCore – Advanced Imaging (Radiology/Cardiology) Program	800-540-2406
MN eviCore – Sleep Management Program	866-999-3510
MN eviCore – Post Acute Care (PAC) – Durable Medical Equipment	866-663-7740
MN eviCore – Post Acute Care (PAC) – Post Acute Care <ul style="list-style-type: none"> • Skilled Nursing Facility (SNF) • Long Term Acute Care (LTAC) • Inpatient Rehabilitation Facilities (IRF) • eviCore Customer Service Phone: 844-224-0494 	888-738-3916
MN eviCore – Post Acute Care (PAC) – Home Health <ul style="list-style-type: none"> • Aide • Diagnostic Lab • Occupational Therapy • Physical Medicine • Skilled Nursing Care • Social Worker • Speech Therapy 	866-506-3087

Amerigroup (AGP) Contact Information:

Effective 01/01/2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has entered in to a collaborative agreement with AmeriGroup Health Solutions (AGP), a subsidiary of Anthem, to operationally support subscribers who have coverage through Minnesota Health Care Program (MHCP) including Families and Children (F&C), MinnesotaCare (MnCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+)

Program	MSHO	MSC+	Families and Children (F&C)/MnCare
Inpatient Medical (Acute)	Fax: 866-959-1537 Phone: 866-518-8448	Fax: 844-480-6840 Phone: 866-518-8448	Fax: 844-480-6840 Phone: 866-518-8448
Inpatient SNF, LTAC, AIRS	Fax: 844-480-6842 Phone: 866-518-8448	Fax: 844-480-6840 Phone: 866-518-8448	Fax: 844-480-6840 Phone: 866-518-8448
Inpatient BH (including residential)	Fax: 877-434-7578 Phone: 866-518-8448	Fax: 877-434-7578 Phone: 866-518-8448	Fax: 877-434-7578 Phone: 866-518-8448
Outpatient Medical	Fax: 866-959-1537	Fax: 844-480-6839	Fax: 844-480-6839
Outpatient BH	Fax: 800-505-1193	Fax: 800-505-1193	Fax: 800-505-1193
Personal Care Attendant (PCA)	Fax: 866-959-1537 Phone: 866-518-8448	Fax: 844-480-6839 Phone: 866-518-8448	N/A
Private Duty Nursing (PDN) Home Care Nursing Services (HCN)	Fax: 866-959-1537	Fax: 844-480-3839	N/A
Outpatient Home Health (note PCA or PDN) <ul style="list-style-type: none"> • Home Health Nursing • Home Health Therapies (PT, OT, ST, RT, SW, Dietician) • Home Health Aide 	Fax: 866-959-1537	Fax: 844-480-6839	Fax: 844-480-6839

Program	MSHO	MSC+	Families and Children (F&C)/MnCare
(HHA)			
<p>Appeals & Claims</p> <p>Mail:</p> <p>Blue Cross and Blue Shield of Minnesota Blue Plus</p> <p>Attn: Consumer Service Ctr</p> <p>PO Box 64033 St. Paul, MN 55164-4033</p>	<p>Fax: 833-224-6929</p> <p>Phone: 888-740-6013</p>	<p>Fax: 833-224-6929</p> <p>Phone: 888-740-6013</p>	<p>Fax: 833-224-6929</p> <p>Phone: 888-740-6013</p>

BLUELINE

Introduction

BLUELINE is a voice response system for our health care providers. It furnishes immediate information regarding covered Blue Cross subscribers.

BLUELINE offers callers the following information:

- Pre authorization
- Subscriber specific claim*
- Subscriber specific eligibility*
- Subscriber specific benefit*
- Subscriber specific primary care clinic

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

BLUELINE Availability

BLUELINE is available 24 hours a day, seven days a week; except during scheduled maintenance.

Calling BLUELINE

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

If the information you are requesting is not available within BLUELINE, you will be automatically routed to a service representative during normal service hours:

Monday-Friday..... 7 a.m. – 6 p.m.

System Assistance

If you require assistance in accessing BLUELINE or have not received your fax, call technical support at **(651) 662-5555** or toll free at **1-800-711-9871** and select option three. 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
- Fax number, if applicable.

Provider Identification	<p>Provider identification is required for obtaining claim information or requesting a Fax back of claim information for a specific subscriber.</p> <p>BLUELINE will prompt you when necessary for your provider ID. Your choices will be “Blue Cross Blue Shield of Minnesota Provider ID,” “NPI” or “TAX ID.”</p> <p>You may request any of these options just by speaking the words – such as saying, “NPI.” BLUELINE will then prompt you for the actual numbers for just that ID. Just speak naturally, one character or number at a time.</p>
Subscriber Identification	<hr/> <p>When BLUELINE prompts you for the subscriber ID, just speak the numeric portion or enter it using your touch-tone keypad. For example, if the subscriber ID is XZA XZ1234567, just speak or enter 1234567, one digit at a time.</p>
Date	<hr/> <p>When BLUELINE prompts you for the date of birth or date of service, just say the date naturally, for example March 17, 1964 or 3-17-1964. You may also enter the date using your touch-tone keypad. If using the keypad, enter all eight digits – i.e. 03171964.</p>

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, pre-service requests, admission 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**.

Availity is an independent company providing claims administration services.

ID Cards

Introduction

Your patient's subscriber ID card contains information that is essential for claims processing. Blue Cross recommends that you look at the patient's ID card at every visit and have a current copy of the front and back of the card on file. There is a sample of some of the ID cards issued from Blue Cross on our website. Some of the following information may be found on the ID card:

- Name of the plan
- Subscriber's ID number including three-character (alpha/numeric) prefix
- Subscriber's name and group number
- Primary care clinic (PCC) name – for managed care plans only
- Blue Shield plan code
- Blue Cross plan code
- Prescription coverage
- Copay for prescription drugs
- Copay for office visits
- Dependent coverage indicator
- Claims submission information

ID Cards

Blue Cross and its affiliates do not use Social Security numbers for subscriber identification numbers

Helpful Tips

Blue Cross plans have the option of creating identifiers with any combination of up to 14 letters or digits following the three-digit alpha/numeric prefix.

- Verify the identity of Blue Cross and Blue Plus cardholders by asking for additional picture identification. If you suspect fraudulent use of a subscriber ID card, please call our fraud hot line at **(651) 662-8363**. You may remain anonymous.
- Ask subscribers for their current subscriber ID card and regularly obtain new photocopies (front and back). Having the current card will enable you to submit claims with the appropriate subscriber information and avoid unnecessary claims payment delays.
- Check eligibility and benefits by using provider web self-service, BLUELINE, or call **1-800-676-BLUE** (2583) and provide the alpha/numeric prefix for BlueCard eligibility.
- If the subscriber presents a debit card be sure to verify the copayment, deductible, or other amounts owed are accurate before processing payments. Subscribers cannot be required to make such payments in advance of the claims being processed.
- Do not use the card to process full payment up front. If you have questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Electronic Commerce

Overview

An important part of Blue Cross' cost containment strategy is automating the electronic exchange of information.

Electronic Transactions

Blue Cross accepts the submission and/or generates the following HIPAA compliant transactions:

- Health Care Claim (837 P, I and D)
- Health Care Claim Payment/Advice (835)
- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Health Care Claim Status Request and Response (276/277)
- Health Care Services Review- Request for Review and Response (278)

Blue Cross uses Availity for exchanging HIPAA mandated EDI transactions. You can get information on how to register and conduct electronic transactions through Availity by going to www.availity.com.

Electronic Data Interchange (EDI) Guidelines

- Minnesota Statute 62J.536 requires all Minnesota providers and Minnesota group purchasers to exchange three transactions electronically: Health Care Claims, Health Care Claim Payment/Advice and Health Care Eligibility Benefit Inquiry and Response. In addition, participating out-of-state providers are required by contract to adhere to these electronic requirements.
- All nonparticipating, out-of-state providers who do not have electronic claim submission capabilities must submit their claims on an optical character recognition scannable claim form.
- All nonparticipating, out-of-state providers who are receiving direct payment must access their remittance advice via use of the electronic transaction or provider web self-service.
- Blue Cross reserves the right to modify these guidelines with advance written notice.
- Providers are encouraged to obtain or develop EDI transaction software from the many sources available.

Remote Access Services

Providers may be permitted to use Blue Cross' remote access services, allowing them to obtain specific subscriber information and other information necessary for submitting claims and viewing claim status or payment information. Access may not be transferred to another entity by the provider and Blue Cross retains all rights to the computer software system. Providers may only use the system to:

- Verify health plan coverage benefits of their patients
- Verify claims status
- Verify cases (such as referrals and admission notifications)
- Create and update referrals (available only for primary care clinics)
- Create and update admission notifications (available only to primary care clinics and inpatient facilities)
- For external security delegated administration
- View remittance advice information
- Other purposes to be communicated by Blue Cross

Providers have certain responsibilities when using Blue Cross' remote access services. They include:

- Access is for the provider only, and third parties may not have access to the system without advance written approval of Blue Cross.
- Blue Cross is the sole and exclusive owner of the system and its components, and the provider does not have any rights to it, either intellectual property rights or other rights of any kind.
- The provider may not reverse assemble, decompile, duplicate or modify the system or any parts of it.
- At any time, Blue Cross may modify or enhance the system, or replace the system with an entirely new system.
- Provide all necessary components for using Blue Cross' system, such as compatible software, hardware, access to the Internet and any other necessary technology to access the system.
- Blue Cross may discontinue the provider's access to the system or terminate use of the system upon thirty (30) days advance written notice to the provider.

Remote Access
Services
(continued)

Providers may access Blue Cross' system via the Internet (or other technology as approved by Blue Cross) at any time, except when the system is undergoing maintenance or repairs, or due to interruptions beyond the control of Blue Cross. Providers are solely responsible for the necessary software, hardware, access to the Internet, and other technology or services necessary for providers to use the system.

Only authorized users may access the system and use its services.

- Authorized users are employees of the provider and others included in the provider's workforce (in accordance with 45 C.F.R. 160.103).
- The provider must designate authorized users and obtain access through Blue Cross for them to use the system, either through a user request form or directly entering into the system the information required on the user request form.
- Blue Cross will assign a user name upon acceptance of the user request form.
- Each individual user name and password and each Blue Cross assigned user identification number/code and password is used only by the respective authorized user and may not be shared with anyone.
- The provider must provide immediate written notification to Blue Cross whenever an authorized user terminates employment with the provider.
- The provider must also notify Blue Cross of any other changes, deletions and/or modifications to information originally submitted on the user request form.

Remote Access
Services
(continued)

Disclaimer: Provider's use of the services and the system and any information obtained there is subject at all times to instructions, notices and/or disclaimers appearing online on the system from time to time.

- The services and the system are provided "AS IS" and Blue Cross makes no representation or warranty that the system will meet provider's requirements or that the system will operate uninterrupted or error free, or that the information obtained is or will be accurate.
- Blue Cross makes no warranties of merchantability, fitness for a particular purpose, non-infringement or otherwise, all of which are expressly disclaimed.

Payment: Blue Cross reserves the right to require providers to pay remote access service fees. In such an event, Blue Cross will provide at least 90 days' advance written notice to providers. Such fees will be due and payable within 30 days of any invoice and late payments will be subject to interest at a rate of the lesser of (a) one and one-half percent per month or (b) the highest rate allowed by law.

Limitation of Liability: Blue Cross' entire liability to provider for any and all damages incurred by provider for any and all claims arising out of, or otherwise relating to remote access services described above shall in the aggregate not exceed 100 percent of the total remote access services fees received by Blue Cross. Blue Cross will not be liable for any damages caused by provider's failure to perform its responsibilities and/or for any indirect, special or punitive damages, even if Blue Cross has been advised of or is otherwise aware of the possibility of such damages.

Provider Communications

Provider Communications

Blue Cross publishes many communications for providers including those listed below. They are available on our website at providers.bluecrossmn.com.

Title	Description
<i>Provider Bulletins</i>	Blue Cross communicates immediate policy and procedure changes through Provider Bulletins. The Provider Bulletins are contractually binding. Portions of this manual will also be updated periodically to reflect policy and procedure changes.
<i>Provider Press</i>	The goal of this publication is to make your job easier and to improve our service to you. The categories that are featured in the Provider Press include claims tips, PMAP/MinnesotaCare, Coding Corner and a featured front page article.
<i>Provider Information Quick Points</i>	This is a communication tool that Blue Cross is using to get helpful information to you.
<i>Medical Policy Update</i>	Changes to Medical Policy impacting payment are communicated through Provider Bulletins and via changes to the applicable Medical Policy Manual. Blue Cross also includes updates in the Provider Press on a quarterly basis. The updates contain a summary of medical technologies that have been reviewed, revised, or are new to Blue Cross' investigative list. Provisions of the Medical Policy Manual are contractually binding. Pre authorization request requirements are also featured in this publication.
<i>Blue Plus Referral Network for Primary Care Clinics</i>	This is a listing of specialty providers for referral purposes.
<i>Blue Plus Manual</i>	The Blue Plus Manual provides additional information about the Blue Plus business, referrals, contacts, quality improvement and Minnesota Health Care Programs.

Subscriber Rights and Responsibilities

Health Plan
Subscribers have the
Following Rights

Blue Cross and Blue Shield of Minnesota Enrollee Rights and Responsibilities

YOU HAVE THE RIGHT AS A HEALTH PLAN SUBSCRIBER:

- To be treated with respect, dignity and privacy.
- To have available and accessible medically necessary covered services, including emergency services, 24 hours a day, and 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 event of incapacity).
- To refuse treatment.
- To have privacy of medical and financial records maintained by Blue Cross and its health care providers in accordance with existing law.
- To receive information about Blue Cross, its services, its providers and your rights and responsibilities.
- To make recommendations regarding these rights and responsibilities policies.
- To have a resource at Blue Cross or at the clinic that you can contact with any concerns about services.
- To file a complaint with Blue Cross and the Minnesota Commissioner of Commerce and receive a prompt and fair review.
- To initiate a legal proceeding when experiencing a problem with Blue Cross or its providers.

Health Plan
Subscribers have the
Following
Responsibilities

**YOU HAVE THE RESPONSIBILITY AS A HEALTH PLAN
SUBSCRIBER:**

- To know your health plan benefits and requirements.
- To provide, to the extent possible, information that Blue Cross and its providers need in order to care for you.
- To understand your health problems and work with your doctor to set mutually agreed-upon treatment goals.
- To follow the treatment plan prescribed by your provider or 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.
- 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.

Chapter 2

Provider Service Agreements

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Participation and Responsibilities

Advantages of Participation

Advantages of being a Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) participating provider include:

- Direct payment from Blue Cross reduces administrative expense and improves cash flow
- Blue Cross Subscribers have financial incentives to use participating providers.
- Participating providers' names are included in directories that Blue Cross publishes for its Subscribers
- Blue Cross Provider Service Agreements do not contain exclusivity clauses that prohibit providers from participating with other health plans
- Participating providers receive a *Statement of Provider Claims Paid* explaining how claims are processed
- Opportunity to attend provider seminars offered free of charge by Blue Cross
- Dedicated service staff available to assist participating providers
- Electronic options such as provider web self-service to obtain information

Responsibilities of Participating Providers

Responsibilities of being a participating provider include:

- Participating providers are required to electronically submit all claims. Paper claims will be rejected and will need to be submitted electronically. Blue Cross will not consider such paper claims to have been received until resubmitted electronically.
- Participating in the Blue Cross credentialing process.
- Participating in Blue Cross managed care programs.

Responsibilities of Participating Providers (continued)

- Submitting admission notifications or prior authorizations or Pre-certifications when required, must be submitted through Availity.
 - Exceptions to this are:
 - Admissions for BlueLink TPA Subscribers
 - If a clinic/facility does not have web access
 - For these exceptions only, PANs may be faxed to **(651) 662-6860**.
 - All PANs for Portico Benefit Services (prefixes ELP and PBR) are conducted by Quantum. Provider should contact Quantum directly using the number on the back of the ID card.
- Referring Subscribers to other participating Blue Cross providers and facilities
- Accepting payment provisions outlined in the Provider Service Agreement. If Blue Cross determines that Health Services are experimental, investigative, or not Medically Necessary, providers may not bill the Subscriber unless the provider gives the Subscriber written notification of non-coverage immediately before the Health Services are performed and the Subscriber agrees in writing to be responsible for the Health Services.
- Notifying Blue Cross of new programs prior to implementation (i.e., technology, new procedures being performed, services performed in a particular setting).
- Maintaining confidentiality of Blue Cross' contractual and financial arrangements.
- Health Services rendered by all providers must be within the scope of the provider's registration, license, and training and consistent with community standards for quality and utilization.
- Not billing Blue Cross for any professional services provided by Health Care Professionals to themselves, their immediate family members or those living in the same household. Immediate family members include the Health Care Professional's spouse, children, parents or siblings.
- Not billing Subscribers for missed scheduled appointments, except for missing a scheduled behavioral health appointment, provided the provider has notified the Subscriber in writing in advance that this is the provider's policy. Please note that PMAP, MinnesotaCare, and Medicare Subscribers may not be billed for missed appointments.

Responsibilities of
Participating Providers
(continued)

- Promptly furnishing at the provider's own expense any additional information that Blue Cross or the Plan Sponsor shall reasonably request as necessary to respond to claims, utilization review, audits, coordination of benefits, quality improvement and care management reviews, pre-certification reviews, admission notification, prior authorization, medical necessity reviews, credentialing, and medical abstract reports. The provider shall be responsible for obtaining any authorization required to release such information to Blue Cross or the Plan Sponsor.
- Collecting appropriate copayment amounts and not waiving these amounts.
- Billing the Subscribers for services listed as exclusions in the Subscriber Contract.
- Participating providers may not collect any difference between the amount billed and Blue Cross' allowance for Health Services from Subscribers or the Subscriber's employer.
- Charging the general public the same amounts as Blue Cross Subscribers (individual hardship cases are an exception).
- Billing only for Health Services personally performed by Provider's medical staff or other Health Care Professionals employed by Provider or facility that meet the eligibility criteria defined by Blue Cross.
- Providers who provide health, prescription drug or administrative services to Medicare subscribers must meet the Centers for Medicare & Medicaid Services (CMS) general compliance and fraud, waste and abuse (FWA) training. All Provider types are required to submit an attestation form annually. Training materials and the Attestation of Training completion form are available at providers.bluecrossmn.com, select Education center then Medicare education.

Requirements of
Minnesota Law

Minnesota law requires participating providers to look to Blue Cross for payment of Health Services covered by the Subscriber Contract. Following are requirements:

- Providers may not bill Subscribers for Health Services covered by their Blue Cross health plan, but bill only in accordance with Minnesota law for the applicable coinsurance, copayment or deductible. Providers may not withhold treatment in the event that a Subscriber is unable to make payment in advance or prior to Blue Cross completing processing of the claim or adjustment.
- Providers may not refer a Subscriber's account to collection for nonpayment of services covered by the Blue Cross health plan. Copayments, coinsurance and deductibles can be coordinated through Provider's normal billing, and if applicable, its collections process.
- Interest on Health Services covered by Blue Cross may not be applied to a Subscriber's account.

Price Disclosure

Effective July 1, 2019, in accordance with Minnesota Statute 62J.81, Provider must provide the patient with information regarding other types of fees or charges that the patient may be required to pay in conjunction with a visit to the Provider, including but not limited to any applicable facility fees, within ten business days from the day of a completed request.

In addition, Provider shall maintain a list of the services over \$25 that correspond with the Provider's 25 most frequently billed current procedural terminology (CPT) codes. This list shall be updated annually and must be posted in the Provider's reception area of the clinic or office and made available on the Provider's Web site if the Provider maintains a Web site. No contract between a Provider and Blue Cross prohibits any of these price disclosures. Price disclosure is not a guarantee of final costs for Health Services received nor a final determination of eligibility of coverage.

Requirements of
Minnesota Law
(continued)

- Effective August 1, 2010, Minnesota Statute [62Q.751] allows:
 - Providers may collect deductibles and coinsurance from Subscribers at or prior to the time of service.
 - Providers may not withhold a service to a Subscriber based on a Subscriber's failure to pay a deductible or coinsurance at or prior to the time of service.
 - Overpayments by Subscribers to providers must be returned to the Subscriber by the provider by check or electronic payment within 30 days of the date in which the claim adjudication is received by the provider.

Blue Cross'
Responsibilities

Blue Cross' responsibilities include the following:

- Make payment directly to participating providers for covered Health Services, respond to inquiries and resolve claims in a timely manner
- Maintaining confidentiality of a provider's charge data in accordance with the terms of the Provider Service Agreement
- Establishing a peer-review process to make decisions about Medical Necessity
- Keeping Subscribers informed of participating providers through publication of directories
- Keeping providers informed of changes which are contractually binding through Provider Bulletins or other communications (e.g. Provider Policy & Procedure Manual)
- Effective April 26, 2017, Minnesota Statute [62Q.556] requires:
 - Blue Cross to provide coverage at the in-network level of benefits for billing of unauthorized provider services. Unauthorized provider services include services received from a nonparticipating provider at a participating hospital or ASC and services received from a participating provider that sends a specimen taken from a Blue Cross Subscriber to a nonparticipating facility without Subscriber's written consent. Emergency services are not considered unauthorized provider service.
 - Blue Cross to attempt to negotiate reimbursement for unauthorized provider services with a nonparticipating provider which includes an option to exercise binding arbitration in the event agreement cannot be reached.

Written Notification
and Provider Liability

If it is necessary to recommend that a Subscriber see a nonparticipating provider, the participating provider must give the Subscriber advance, written notification that the recommendation is to a nonparticipating provider. Once notice is given, the Subscriber is responsible for any increased liability if he or she decides to schedule the service.

If a Subscriber is not properly informed, the provider making the recommendation to a nonparticipating provider will be liable for increased costs that a Subscriber incurs. Please refer to *Waivers* in Chapter 4.

National Provider Numbers

Overview

Blue Cross works with many different types of providers through its Provider Service Agreements to establish networks of participating providers.

National Provider Number (NPI)

The Health Insurance Portability and Accountability Act-Administrative Simplification (HIPAA-AS) is the result of legislation passed by the U.S. Congress. The legislation mandates standards for business to business electronic data interchange and code sets, establishes uniform health care identifiers and seeks protection for the privacy and security of patient data.

The purpose of implementing the NPI is to improve the efficiency and effectiveness of the health care system by reducing the number of identifiers associated with any specific provider or provider facility. Implementation will simplify provider identification and billing processes across multiple third party payers (including government programs) and prevent fraud and abuse.

The NPI is a unique all numeric 10 digit number that is assigned by the Centers for Medicare & Medicaid Services (CMS). NPI eligible providers are to submit transactions with the NPI at the facility level as well as the practitioner level. Providers who are considered Atypical (not eligible for an NPI) are to submit transactions using their DHS assigned Unique Minnesota Provider Identifier (UMPI) or the Blue Cross proprietary identification number.

To register online or to find the NPI paper application form, access the CMS website at <http://nppes.cms.hhs.gov>.

It is a provider's responsibility to report its NPI to payers. To access the NPI submission instructions, go to bluecrossmn.com for health care providers, HIPAA/NPI Compliance.

Credentialing

Overview

Blue Cross and Blue Shield of Minnesota uses a credentialing process to provide Subscribers with a selection of Providers and Health Care Professionals which have demonstrated backgrounds consistent with the delivery of high quality, cost-effective health care. The credentialing criteria that Blue Cross has established serve as the foundation for determining eligibility in all Blue Cross networks. Providers and Health Care Professionals are expected to remain in compliance with credentialing criteria at all times.

Credentialing Requirements and Processes

To learn more about credentialing requirements and processes, please reference the Credentialing and Recredentialing Policy Manual, available at bluecrossmn.com. Credentialing requirements include, but are not limited to the following:

- Blue Cross may require credentialing no less than every three years. Recredentialing may occur as often as Blue Cross determines necessary. Providers may appeal adverse credentialing or recredentialing decisions through Blue Cross' established appeal process as specified in the Credentialing and Recredentialing Policy Manual.
- In the event one or more of Provider's Health Care Professionals are excluded from participation with Blue Cross, because he or she has not met the credentialing standards of Blue Cross or because Blue Cross has terminated or suspended the Health Care Professional as provided for in the Agreement, that Health Care Professional will be treated as a nonparticipating provider by Blue Cross. Provider agrees to provide prior written notice to any Subscriber receiving treatment from such Health Care Professional that he or she is nonparticipating. If such notice is not provided, neither Provider nor Provider's nonparticipating Health Care Professional may collect from the Subscriber more than the amount allowed by Blue Cross. Provider further agrees to be responsible for any applicable nonparticipating penalty payments required in Subscriber Contracts and to hold Subscriber harmless for these payments in such circumstances. Either the affected Health Care Professional or the Provider, on behalf of the affected Health Care Professional, may appeal a suspension or for cause termination as specified in the Blue Cross Credentialing and Recredentialing Policy Manual. This provision shall survive termination of this Agreement.

Credentialing
Requirements and
Processes (continued)

- Some participating Health Care Professionals are exempt from Blue Cross' credentialing and recredentialing process unless a potential quality of care issue arises, at which time Blue Cross will undertake a standard credentialing or recredentialing process. In all cases, Provider is responsible for verification that Health Care Professionals hold and maintain (a) a current and unrestricted license, registration, or certification appropriate to their practice; and (b) minimum malpractice coverage as detailed in the Provider Service Agreement and Credentialing Policy and Procedure Manual and to the extent the Health Care Professional is covered by a state or federal Tort Claim Liability statute. The Credentialing and Recredentialing Policy Manual contains a listing of Health Care Professional specialties for which credentialing is required. All Providers are subject to all federal and state statutes regarding licensure and credentialing including, but not limited to, Minnesota Statutes 62Q.121 and 245A.192.

Sanctions, Reprimands or Investigations

Blue Cross reserves the right to terminate the Provider Service Agreement upon 30 days' prior written notice to Provider with respect to any Provider or Health Care Professional of a Provider or a physician who assumes responsibility for overseeing or administering any medical services performed by the Provider who fails to complete the credentialing or recredentialing process or is sanctioned or reprimanded by any review organization, including but not limited to, any other health insurer or health plan, peer review organization, hospital medical staff or any state licensing board. Providers must immediately notify Blue Cross in writing of any such sanction or reprimand or any investigation of any Provider or Health Care Professional or Medical Director of which Provider is aware. If the sanction or reprimand is limited to a single Health Care Professional, then the termination shall be effective only to that Health Care Professional.

Questions about
Credentialing

Call provider services at **(651) 662-5200** or **1-800-262-0820**.

Accounting for Disclosure Request

Guidelines for the Accounting Disclosure Request

Blue Cross Subscribers have the right to an accounting of certain disclosures that are made of their protected health information (PHI) within six years prior to their request. Blue Cross will fulfill these requests with a Subscriber disclosure summary. Providers are requested to follow the guidelines listed below and forward required disclosures to:

Blue Cross and Blue Shield of Minnesota and Blue Plus
Attention: Compliance and Regulatory Affairs
P.O. Box 64560
St. Paul, MN 55164-0560

When to Use the Form

If a disclosure is subject to an accounting, Providers must use the Business Associate Accounting for Disclosures Report Form, available at **bluecrossmn.com** under forms: member. Disclosures which require an accounting include disclosures which are made:

1. pursuant to applicable law;
2. for cadaveric organ donation purposes;
3. to avert a serious threat to health or safety;
4. for certain marketing or fundraising exceptions; and
5. to the Secretary of Health and Human Services.

The form provides a more detailed list of those disclosures that must be accounted for. Not all disclosures of an individual's PHI are subject to an accounting.

Providers are not required to account for disclosures they make:

- before the privacy rules compliance date (April 14, 2003)
- to the individual
- to or for notification of persons involved in an individual's care
- for treatment, payment, or health care operations
- for national security or intelligence purposes
- to correctional institutions or law enforcement officials regarding inmates
- for research if it involves at least 50 records and we provide individuals with a list of all the research protocols and the researcher's name and contact information
- using de-identified health information

Disclosures Related to
Provider's Status as a
Business Associate

The Provider Service Agreement requires Provider to account for only those disclosures of records that it holds in its capacity as a business associate. Provider is Blue Cross' business associate because the Provider Service Agreement requires Provider to perform certain activities on Blue Cross' behalf. These business associate activities are:

- Compliance with and implementation of quality improvement/managed care requirements such as providing specific patient records for a quality study; and
- Receiving and resolving Subscriber complaints.

Thus, for example, if Provider reports a complaint to Blue Cross as required by the Provider Service Agreement, Provider is gathering that information and forwarding it to Blue Cross as a business associate. Provider does not have to report the disclosure to Blue Cross because it is part of health care operations. If, however, a regulator was to audit Blue Cross' compliance with handling Subscriber complaints, Provider must release correspondence or records to the regulator, as this is a disclosure Provider must account for. Another example would be records that Provider provided to Blue Cross for Child and Teen Checkups. If the Department of Health were to decide to monitor managed care plans for child and teen checkups, they may ask for all the information Provider provided to Blue Cross as part of the on-site audits. The disclosure is permitted to the Department of Health without authorization as a public health activity, but it must be accounted for.

Provider does not have to account for disclosure of records that it has in its capacity as a provider. For example, as discussed above, Provider might have medical records from providing a teen with a checkup. Subsequently, the teen is involved in a crime and the medical records are necessary for identification purposes. Provider may disclose the medical record to law enforcement authorities and must account to the teen for that disclosure. Provider does not, however, have to account to Blue Cross for that disclosure.

Carrier Replacement Law

Carrier Replacement

The Law

The Minnesota Carrier Replacement Law applies when a Subscriber group terminates its fully insured coverage with one carrier and replaces it with another fully insured group contract. This law dictates how Blue Cross determines liability for charges incurred by a Subscriber whose inpatient treatment occurred during this change in coverage.

How Carrier Replacement Works

- The carrier whose coverage is in effect when a Subscriber is admitted to a facility is liable for all institutional charges incurred by the Subscriber whose inpatient treatment spans the change in coverage.
- The carrier in effect at the time of admission is liable for all professional charges incurred up to the termination date of the coverage.
- The new carrier is liable for all professional charges incurred beginning on the effective date of the new coverage.
- The definition of “discharge” is the date the Subscriber is formally released from the inpatient facility with discharge papers completed.

Continuous Stay

Continuous stay occurs when the Subscriber is sent to another facility for services unavailable at the current facility and no discharge or admission papers are processed upon transfer.

- In the case of a Subscriber who is discharged and transferred to another facility, both the transportation and charges incurred at the new facility will become the liability of the new carrier.

When...	Then...
a new Subscriber was hospitalized prior to the effective date of Blue Cross coverage	Blue Cross pays the hospital claim on a pro rata basis beginning on the date coverage becomes effective.
a new Subscriber remains hospitalized on and after the first date of coverage	
the new Subscriber's other carrier stops paying for the hospitalization or there is no other carrier	

Public Programs	<p>DHS requires the health plan active at the time of Subscriber admission to be responsible for all services associated with an inpatient stay until the discharge date. This includes both facility and professional charges.</p> <ul style="list-style-type: none"> • All services occurring after the termination date of the contract for Individual contracts are denied as “No Coverage”. • Medicare supplement contracts will cover the Medicare inpatient deductible. However, Medicare Coinsurance Days are denied after the coverage termination.
Federal Employee Program	<p>When Federal Employee Health Benefits coverage ends, the employee and eligible dependents may receive an additional 31 days of coverage, for additional premium, when:</p> <ul style="list-style-type: none"> • enrollment ends, unless the employee cancels their enrollment or • the employee family members are no longer eligible <p>The employee may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy.</p>
InstaCare SM	<p>This Contract terminates at the end of the contract term selected on the Contract Schedule and Application, except in instances where the Subscriber or their covered dependents are confined to a hospital on that date. For that person, we will extend the contract term only for the condition causing the hospital confinement. The extension will end when the person is no longer confined to the hospital or when the lifetime maximum has been paid, whichever occurs first.</p>
Self-funded Groups and Minnesota Advantage Health Plan	<p>Carrier Replacement law does not apply to self-insured business.</p>

Governmental and Compliance Required Provisions

<p>Overview</p>	<p>Federal and state governmental agencies require health plans, such as Blue Cross, to inform providers of certain information. Additional requirements are also necessary for accreditation and other quality compliance.</p>
<p>Governmental Required Definitions</p>	<ul style="list-style-type: none"> • "Managing Employee" means an individual (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or any part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or any part thereof, as defined in 42 C.F.R. Section 455.101. • "Medicare Advantage" means Medicare Advantage programs as defined by Centers for Medicare and Medicaid (CMS), where Blue Cross is the payor for health services provided to Medicare Subscribers. • "Medicare Advantage Special Needs Plan" means a Medicare Advantage program as defined by CMS under which Blue Cross is the payor for health services provided to Medicare Subscribers with special needs. An example of such a plan is Minnesota Senior Health Options (MSHO). • "Minnesota Health Care Programs" means prepaid public programs including Medical Assistance, MinnesotaCare, Families and Children or other prepaid public programs in which Blue Plus provides coverage under a contract with any Minnesota County or with the Minnesota Department of Human Services (DHS). Participating provider's agreements apply to Health Services provided to Minnesota Health Care Program Subscribers where applicable. • "Minnesota Senior Health Options" (MSHO) means the Minnesota prepaid managed care program, pursuant to Minnesota Statutes, Section 256B.69, subd. 23, that provides integrated Medicare and Medicaid services for Medicaid eligible seniors, age sixty-five (65) and over. MSHO includes Elderly Waiver services for enrollees who qualify, and one hundred eighty (180) days of nursing facility care. • "Person with an Ownership or Control Interest" means a person or corporation that (1) has an ownership interest, directly or indirectly, totaling five percent or more in Blue Cross or a disclosing entity; (2) has a combination of direct and indirect ownership interests equal to five percent or more in Blue Cross or a disclosing entity; (3) owns an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by Blue Cross or a disclosing entity, if that interest equals at least five percent of the value of the property or assets of Blue Cross or a disclosing entity; or (4) is an officer or director of Blue Cross or a disclosing entity (if it is organized as a corporation) or is a partner in Blue Cross or a disclosing entity (if it is organized as a partnership).

Compliance with Laws	<p>In order to have a Provider Service Agreement with Blue Cross, Providers and Blue Cross are required to abide by all applicable state and federal laws, rules, regulations, orders and requirements that are related to providing health care and billing for health care.</p> <ul style="list-style-type: none"> <p>• Cooperation with Blue Cross.</p> <p>In addition to complying with all state and federal laws, rules, regulations, orders and requirements, Provider further agrees to cooperate with Blue Cross in its efforts to comply with any and all obligations imposed by state and federal laws, rules, regulations, orders and requirements. This includes 1) promptly notifying Blue Cross in the event the Provider transfers "substantial financial risk" (as defined in 42 C.F.R. Section 422.208) to any of the Health Care Professionals in its employment; and 2) notifying Blue Cross within 20 days of entering into any private contract with a Medicare beneficiary pursuant to Section 1802 of the Social Security Act (such notice to include a copy of the private contract and any other information reasonably requested by Blue Cross).</p> <p>• Minnesota Department of Human Services Disclosure Requirements.</p> <p>Disclosure of Agreements. Provider must ensure that no agreements exist between itself and an excluded entity or individual for the provision of items or health services under a Provider Service Agreement. Provider shall search the Medicare Exclusion Database (MED) or the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) databases on a monthly basis to insure that no providers, agents, Persons with an Ownership or Control Interest and Managing Employees are (a) excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act, or (b) have been convicted of a criminal offense related to involvement in any program established under Medicare, Medicaid or the Title XX services program. Provider shall notify Blue Cross within five days of identifying any subcontracting individuals or entities listed in (a) or (b) of this paragraph.</p> <p>• Minnesota Department of Human Services Enrollment Report</p> <p>Providers that provide Health Services to Minnesota Health Care Program Members must enroll with the Minnesota Department of Human Services (DHS). DHS provides the DHS provider enrollment report to Blue Cross. Blue Cross uses the DHS provider enrollment report to determine if a provider that is contracted with Blue Cross and providing Health Services to Minnesota Health Care Program Members is on the DHS provider enrollment report as required. Blue Cross continuously monitors the DHS provider enrollment reports. Blue Cross has the right to terminate contracts with providers that provide Health Services to Minnesota Health Care Program Members but do not enroll with DHS as required.</p> <p>• Providers can enroll with DHS by following this link:</p> <p>DHS Enrollment</p>
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Compliance with Laws (continued)

- **Disclosure of Ownership Information.** To assure compliance with 42 C.F.R. Section 438.610, Provider shall report the following information to Blue Cross prior to the effective date of the Agreement: (a) the name and address of each Person with an Ownership or Control Interest in a disclosing entity or in any subcontractor in which a disclosing entity has direct or indirect ownership of five percent or more; and (b) a statement as to whether any Person with Ownership or Control Interest is related to any other Person with an Ownership or Control Interest, listed in section (a) as a spouse, parent, child or sibling; and (c) the name of any other organization in which a Person with an Ownership or Control Interest in a disclosing entity also has Ownership or Control Interest.
- **Advance Directives.** Provider must make information available to Subscribers to aid them in completing advance directives, including but not limited to helping them to understand medical terminology, medical care options and referring them to appropriate resources such as the Minnesota Department of Health Website. Upon a Subscriber's request, Provider must maintain a copy of a Subscriber's advance directive in the medical record maintained by Provider.
- **CMS Regulations Regarding Subcontracting.** As set forth in 42 C.F.R Sections 422.504 and 422.505, Provider must comply with all Medicare statutes and regulations and CMS requirements as interpreted and applied by the CMS designated regional office and the CMS central office, including but not limited to Medicare Offshore Subcontracting Attestation and other requirements relating to activities performed outside the United States. Upon request, Provider must submit record of such compliance to Blue Cross. In addition, Medicaid payments must not be made (1) for services delivered or items supplied outside of the United States; or (2) to a provider, financial institution, or entity (including subcontractors) located outside of the United States. For purposes of compliance with this rule, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Items and services provided under a state plan that would be prohibited offshore can include but are not limited to telemedicine, pharmacy, and other services from providers.

Compliance
with Laws
(continued)

- **Cultural Competency Training and Accessibility Requirements.** In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers. Section 438.10 of the Managed Care Federal Regulation issued on May 6, 2016, requires that providers who provide health care services to MHCP members enrolled in a Managed Care Organization (MCO) annually confirm compliance with the requirement of cultural competency training and accessibility for people with disabilities. Therefore, providers must promptly complete and return an annual Blue Cross Provider Directory Questionnaire for all their provider locations for Cultural Competency Training and Accessibility. The questionnaire is located on the Blue Cross website at: [www/bluecrossmn.com](http://www.bluecrossmn.com)

HIPAA
Requirements

HIPAA Compliance. Pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") that are applicable to business associates, Provider agrees that it shall:

- Not use or further disclose Protected Health Information (PHI) other than as permitted or required by the Provider Service Agreement between Blue Cross and Provider, and further agrees that it shall not use or further disclose PHI in a manner that would violate requirements of HIPAA and its implementing regulations (45 C.F.R. parts 160-64) ("HIPAA Regulations") or the HITECH Act;
- Report to Blue Cross any use or disclosure of PHI not provided for by the Provider Service Agreement of which it becomes aware, within five (5) days after such discovery, and ensure that any agents, including any subcontractors, to whom it provides to or receives from PHI, agree to the same restrictions and conditions that apply to Provider with respect to such information;
- Upon any termination of the Provider Service Agreement, extend the protections of this Section to any PHI in the possession of Provider, and limit any further use and disclosure of such PHI to those purposes set forth in the Provider Service Agreement;

HIPAA
Requirements
(continued)

- Develop, implement, maintain and use appropriate administrative, technical and physical safeguards, in compliance with Social Security Act Sec. 1173(d) (42 U.S.C. Sec. 1320d-2(d)), 45 C.F.R. Sec. 164.530(c) and any other implementing regulations issued by the U.S. Department of Health and Human Services;
- Upon receipt of notice from Blue Cross, promptly amend or permit Blue Cross access to amend any portion of the PHI which the provider created or received from Blue Cross so that Blue Cross may meet its amendment obligations under 45 C.F.R. Sec. 164.526;
- Comply with all applicable federal laws, including, but not limited to 42 C.F.R. Part 2, governing confidentiality for people seeking treatment for substance abuse disorders from federally assisted programs, as well as all state laws not preempted pursuant to 45 C.F.R. Part 160, subpart B.
- With the exception of disclosures of PHI made for the purposes specified in 45 C.F.R 164.528(a)(1)(i)-(ix), document and report each disclosure, if any, the provider makes of any PHI Provider has created for Blue Cross or received from Blue Cross within five (5) days of the discovery of the disclosure. The provider shall cooperate with Blue Cross in investigating the disclosure and in meeting Blue Cross' obligations under the HIPAA regulations and HITECH Act. In the event of any such disclosure, the provider shall:
 - Identify the nature of the non-permitted access, use or disclosure, including the date of the breach and the date of discovery of the breach;
 - Identify the PHI accessed, used or disclosed as part of the breach (e.g. full name, social security number, date of birth etc.);
 - Identify who made the non-permitted access, use or disclosure and who received the non-permitted disclosure;
 - Identify what corrective action the provider took or will take to prevent further non-permitted access, uses or disclosures;

HIPAA Requirements (continued)

- Identify what the provider did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure; and
- Provide such other information, including a written report, as Blue Cross may reasonably request.

Provider acknowledges and agrees that in the event the Provider breaches this HIPAA requirements, Blue Cross may terminate the Provider Service Agreement upon written notice to the Provider and/or report such breach by the Provider to the United States Department of Health and Human Services.

HIPAA Security. The Provider agrees to the following:

- The Provider shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information ("e-PHI") that it creates, receives, maintains or transmits on behalf of Blue Cross, as required by 45 C.F.R. Part 164 (the "Security Rules").
- To ensure that any agent, including a subcontractor to whom it provides e-PHI agrees to implement reasonable and appropriate safeguards to protect it, and
- To report to Blue Cross any security incident involving e-PHI of which it becomes aware. The Security Rules define a "Security Incident" as an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, involving e-PHI that is created, received, maintained or transmitted by or on behalf of Provider or Blue Cross. Since the Security Rules include attempted unauthorized access, use, disclosure, modification or destruction of information, Blue Cross needs to have notification of attempts to bypass electronic security mechanisms. Provider and Blue Cross recognize and agree that the significant number of meaningless attempts to, without authorization, access use, disclose, modify or destroy e-PHI will make a real-time reporting requirement formidable for Provider. Therefore, Provider and Blue Cross agree to the following reporting procedures: Security Incidents that result in unauthorized access, use, disclosure, modifications or destruction of information or interference with system operations ("Successful Security Incidents") and for Security Incidents that do not so result ("Unsuccessful Security Incidents").

HIPAA Requirements (continued)

For Unsuccessful Security Incidents, Provider and Blue Cross agree that this paragraph constitutes notice of such Unsuccessful Security Incidents. By way of example, Provider and Blue Cross consider the following to be illustrative of Unsuccessful Security Incidents when they do not result in actual unauthorized access, use disclosure, modification or destruction of e-PHI or interference with an information system:

- Pings on the Provider's firewall.
- Port scans.

- Attempts to log onto a system or enter a database with an invalid password or username.
- Denial-of-service attacks that do not result in a server being taken off-line.
- Malware (worms, viruses, etc.).

For Successful Security Incidents, the Provider shall give notice to Blue Cross not more than five (5) business days after learning of the Successful Security Incident

Provider acknowledges and agrees to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the HITECH Act as detailed at:

[HITECH Act Enforcement Interim Final Rule](#)

<p>Non-interference</p>	<p>Provider agrees not to interfere in the business relationships of Blue Cross with its group purchasers, Subscribers, Plan Sponsors or other providers by discouraging or attempting to discourage group purchasers, Subscribers, Plan Sponsors, or other providers from initiating or maintaining their business relationship with Blue Cross. This provision does not prohibit normal business activities such as participation in other health plans. This provision prohibits Provider activity such as disclosing proprietary information, for example specific financial or other terms of the Provider Service Agreement (as well as specific financial information relating to any other agreement between a provider and Blue Cross), unless otherwise expressly authorized by Blue Cross in writing signed by an officer of Blue Cross or as required by law. This provision also prohibits the Provider from defaming Blue Cross for financial or participation purposes, including but not limited to attempting to collect payments from group purchasers, or suggesting other providers, group purchasers, Subscribers or Plan Sponsors terminate their relationship with Blue Cross. This provision is not intended to interfere with the provider-patient relationship or prohibit the Provider from communicating with Subscribers as provided by Minnesota Statutes Section 62J.71. Blue Cross encourages and permits open communication between the Provider and the patient regarding treatment options available to the patient regardless of benefit coverage limitations. Benefit coverage is always governed by the terms of the Subscriber Contract. Blue Cross similarly agrees not to interfere in the business relationships of the Provider with its group purchasers or other providers. This provision does not preclude Provider from adhering to network participation guidelines and requirements.</p>
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<p>Network Access Agreements</p>	<p>In addition to providing Health Services to Subscribers enrolled in health benefit plans underwritten or administered by Blue Cross, the Provider Service Agreement applies to health services provided in the following instances:</p> <ul style="list-style-type: none"> • Health Services provided to Subscribers for whom Blue Cross or its Affiliates provides access to a Blue Cross participating provider network, where no administrative or claims payment services are provided and neither Blue Cross nor its affiliates assume any financial risk or obligation with respect to claims. In all such network access arrangements, Blue Cross shall ensure that (a) Subscribers are directed to receive Health Services from a provider through benefit differentials outlined in the Subscriber Contract, (b) Subscribers are required to produce a membership card that identifies him/her as a Subscriber who is entitled to use the participating provider network, (c) the application of the Blue Cross fee schedule is clearly listed on the explanation of benefits furnished to the Subscriber, and (d) that the entity which has contracted with Blue Cross for access to the participating provider network agrees to comply with the prompt payment/prompt response provisions of the Provider Service Agreement. Blue Cross shall notify Provider of such network access arrangements and furnish information regarding any special requirements for the applicable Subscriber's contract.
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Termination of Provider Service Agreements

Required Notification

A Provider Service Agreement may be terminated according to any one or more of the following provisions. Termination determinations are not subject to appeal. Providers must send a termination request in writing via certified mail to Blue Cross, directed to: Blue Cross and Blue Shield of Minnesota, Attn: Provider Relations, R317, P.O. Box 64560, St. Paul, Minnesota 55164-0560.

- Without cause by either Party upon prior written notice to the other Party with termination to become effective 130 days after receipt of written notice. If the Agreement is so terminated, Blue Cross, at its discretion, may extend the terms of the current Agreement for a period of an additional 180 days, to allow Blue Cross proper notification to Subscribers and continuity of care practices. During such additional period of 180 days of participation, the Provider shall receive payment at the same rates that were in effect on the date termination notification was provided.
- By a Party upon prior written notice to the other Party in the event of a material breach of the Provider Service Agreement by such other Party and which breach remains uncured 30 days after written notice reasonably specifying the nature of the breach is given to the breaching Party, with termination to become effective on the 30th day after receipt of such written notice.
- Immediately upon written notice by Blue Cross to Provider in the event that Blue Cross acquires evidence of the potential for patient harm or of suspected fraudulent or illegal conduct on the part of Provider or any of Provider's Health Care Professionals with regard to the practice of medicine, claim submission, Health Care Professional eligibility, the delivery of care under the Provider Service Agreement, or in the event of any sanction by CMS under the Medicare program.
- By Blue Cross upon 30 days' prior written notice to Provider with respect to any Provider or Health Care Professional of Provider which fails to complete the credentialing or recredentialing process or is sanctioned or reprimanded by any review organization, including but not limited to, any other health insurer or health plan, peer review organization, hospital medical staff or any state licensing board. The Provider agrees to immediately notify Blue Cross in writing of any such sanction or reprimand or any investigation of any Provider or Health Care Professional of which Provider is aware. If the sanction or reprimand is limited to a single Health Care Professional, then the termination shall be effective as to that Health Care Professional only.

Required Notification
(continued)

- By Blue Cross of Provider's participation in benefit plans (including but not limited to the Minnesota Advantage Health Plan, political subdivisions, and Workers' Compensation) if Provider is determined by DHS to be out of compliance with Minnesota Statutes, Section 256B.0644 (requiring providers to accept medical assistance patients) or any other applicable laws. Provider shall notify Blue Cross immediately in event of such non-compliance. The termination shall be effective as of the first date of such non-compliance.
- In the event that Blue Cross does not receive any claims submitted by Provider for a 12 month period, Blue Cross will terminate the agreement upon the expiration of that 12 month period
- By Blue Cross upon 130 days' prior written notice to Provider if Provider's practice moves outside the contracting service area served by this Agreement. Provider shall immediately notify Blue Cross of any change to its address.
- For Minnesota Advantage Health Plan Subscribers only, if the Agreement terminates during the calendar year, all the terms of the Agreement will continue until the end of the current calendar year.
- By Blue Cross upon 60 days' notice to Blue Cross of Provider's addition to CMS Preclusion List.
- In the event of a Provider acquisition or expansion, Blue Cross shall in its sole discretion, determine if a participating agreement will be extended to the acquired entity and/or additional locations of Provider.

Chapter 3

Quality Improvement

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Introduction to Quality Improvement

General Overview

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

The QI program helps to ensure access to healthcare services using established quality improvement principles. Blue Cross 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 Member safety and confidentiality of Members
- Resolve any identified quality issues.

Basic Elements of a QI Program

Rationale:

Blue Cross subscribes to the philosophy of Quality Improvement (QI) and the multifaceted benefits it offers. All Providers associated with Blue Cross 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.

Basic Elements of a QI Program, continued

Blue Cross 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 Cross 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:

- Provide annual QI program report upon request to Blue Cross.

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 is a vital function 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 a 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.

Quality Improvement
Projects, continued

Often Providers choose to do one project that is clinical and one that is service-related. Blue Cross encourages Providers to conduct a survey or focus group of customers as it develops 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 Cross 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
Cross QI Program

Rationale:

Collaborative efforts need to mutually service Blue Cross' 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 Cross QI work, this may require additional information from Providers or participation in survey's.
- Collaborate on corrective action plan when Blue Cross quality thresholds are not met.

Telephone Service
Requirements: 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: In-
coming 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 Members information as outlined below.

- The name of the clinic that the Member 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 for obtaining medical care or advice.
- Blue Cross recommends that Providers audit their messages used outside of normal business hours, according to these guidelines, to make certain they are following the requirements.

Complaint Review
System

Rationale:

Member complaints, concerns 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 Cross share a joint commitment to Member satisfaction and to the improvement of care and services delivered to Blue Cross Members.

Requirements:

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

- Process to receive written and verbal complaints for Blue Cross 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 Cross within 30 days after the end of each calendar quarter that includes all complaints, oral and written, received by the clinic. Complaints should be submitted in a report format via the secured e-mail account, Quality.of.Care.Mailbox@bluecrossmn.com
- Submit a quarterly report even if the PCC does not receive any complaints for the quarter
- Notify Members of the right to complain and appeal to their health plan
- Track complaints by categories and report at least annually to an in-house committee.

Complaint Review System, continued

Clarification of terminology:

- **Inquiry** — A formal request for information or education from the patient (e.g., about billing, about a lab test).
- **Complaint** — An oral or written expression of dissatisfaction. All PCCs must receive, investigate and respond to complaints from Blue Cross Members who receive health services at their clinic.
- **Appeal** — A request to change a decision that has already been made. **Blue Cross has the sole accountability to handle appeals.** Direct any Blue Cross Member who requests an appeal to call Blue Cross 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 Cross.

Quality of Care Complaints

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

Access & Availability

Rationale:

Members' concept of the quality of care they receive often begins when they make an appointment. Blue Cross 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:

Patient 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.

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

Written Policies

Rationale:

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

Requirement:

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

Policy Required	Recommended Risk Management Elements
Advance Directives	<ul style="list-style-type: none"> • Information made available • Discussion is documented in medical record • Copies retained • Hospitals notified upon admission
Child and Teen Check-ups	<ul style="list-style-type: none"> • Eligibility defined (birth through age 20, MA, PMAP, MNCare children) • Forms for documentation addressed • Age-appropriate services defined • Documentation in medical record • Correct coding

Policy Required	Recommended Risk Management Elements
Communicable Disease Reporting	<ul style="list-style-type: none"> • Requirement to report communicable diseases by State Health Department • Reporting timeframe (within one day) • Responsibility of reporting defined • Forms, completion and submittal addressed
Complaint Management	<ul style="list-style-type: none"> • See Complaint Review System Section
Confidentiality	<ul style="list-style-type: none"> • 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 follow HIPAA guidelines • Reviewed annually
Confidentiality and Security of Medical Records	<ul style="list-style-type: none"> • Refer to the Medical Records section
Foreign Language Translation and Hearing-Impaired Services	<ul style="list-style-type: none"> • 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
Hazardous Materials and Waste Management	<ul style="list-style-type: none"> • Written plan in place and maintained • Hazardous material and waste defined • Mechanism in place for responding to a spill • MSDS (material safety data sheets) available • Hazardous materials and waste are identified and inventoried • Mechanism defined for responding to a spill/breach of containment • Chemical and regulated medical waste addressed • Hazardous gas and vapors addressed • Orientation and education of staff outlined

Policy Required	Recommended Risk Management Elements
Infection Control	<ul style="list-style-type: none"> • Basic overview of infection control and how it relates to controlling disease • Hand washing outlined, when and how • Universal precautions addressed, including glove use • Personal protection equipment addressed • Screening employees for TB • Vaccinating employees for Hepatitis B • Steps taken when employee is exposed to breach of infection control or exposure, how to report to OSHA
Medical Emergency	<ul style="list-style-type: none"> • Mechanism in place for responding • Medical emergency code is identified • Identify who directs activities • Identify who determines if 911 is called
Medication Management	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Mechanism in place for responding • Include power outages, weather emergencies, bomb threats, and both fire and fire drills
Treating Unaccompanied Minors Policy	<ul style="list-style-type: none"> • 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

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 Cross' Members. All Practitioners/Providers share a joint responsibility to ensure continuity and coordination of care.

Requirements 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 Cross is committed to establishing high standards of care for its Members. To assure these high standards, Blue Cross expects all participating Practitioner/Providers to be familiar with and actively involved in patient safety practices. Blue Cross supports the work of the Leapfrog Group, a national coalition of major employer groups, which has established patient safety standards. Blue Cross 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 Cross also works to ensure patient safety by monitoring and addressing quality-of-care issues identified through pharmacy utilization data, continuity and coordination of care standards, disease management program follow-up, and Member complaints.

Resources

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

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

- Agency for Healthcare Research and Quality (Dept of HHS)
 - <https://www.ahrq.gov/>
- Institute for Healthcare Improvement
 - www.ihl.org

Patient Safety
(continued)

- The Joint Commission International Center for Patient Safety
 - www.jcipatientsafety.org
- Leapfrog Group for Patient Safety
 - www.leapfroggroup.org
- Minnesota Alliance for Patient Safety
 - www.maps.org
- National Quality Forum
 - www.qualityforum.org

Provider Site Visits

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

- The Provider is unaccredited by a Blue Cross 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 on what is specifically 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 Cross requires its Practitioners/Providers to have a policy and procedure for confidentiality of health information and medical records that meet state and federal requirements.

Blue Cross expects strict adherence to state and federal laws with regards to maintaining Members' medical information and records in a confidential manner. Blue Cross 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 Practitioners/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 Cross, per contractual agreement with both the Member and Provider, has access to the Member's medical record for examination and evaluation. Blue Cross' 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 Cross Quality Council, which includes practicing physicians, establishes minimum patient medical record documentation standards.

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 telephone 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.
- 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.

Medical Record
Documentation
(continued)

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 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

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 Cross believes that the use of clinical practice guidelines is a key component of Quality Improvement. At least once every two years, Blue Cross's Quality Management Committee approves the adoption of select guidelines that are used to support various programs and initiatives. The guidelines do not substitute for sound clinical judgment; however, they are intended to assist clinicians in understanding key processes for improvement efforts.

Note about Coverage:

This information is not an offer of coverage, solicitation of coverage, summary of coverage or guarantee of coverage. All products and coverage guidelines are subject to applicable laws and regulations. Member or Practitioner/Provider coverage is contingent on all the applicable terms, conditions, limitations and exclusions of the Member's benefit book or Practitioner/Provider's agreement.

Many Blue Cross products cover some preventive care services without cost-sharing to align with Affordable Care Act recommendations.

Recommended Sources:

Blue Cross recognizes the following sources for Clinical Practice Guidelines for a variety of areas of clinical practice:

- USPSTF: U.S. Preventive Services Task Force
 - <http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations>
- HRSA: Health Resources and Services Administration
 - <http://www.hrsa.gov/index.html>
- ICSI: Institute for Clinical Systems Improvement
 - https://www.icsi.org/guidelines_more/
- APA: American Psychiatric Association
 - <http://psychiatryonline.org/guidelines>
- AAP: American Academy of Pediatrics
 - <https://www.aap.org/en-us/professional-resources/publications-and-journals/pages/publications-and-journals.aspx>
- ADA: American Diabetes Association
 - http://care.diabetesjournals.org/content/38/Supplement_1
- NHLBI: National Heart, Lung and Blood Institute
 - <http://www.nhlbi.nih.gov/>

Clinical Practice
Guidelines, continued

- AHA: American Heart Association
 - http://www.heart.org/HEARTORG/HealthcareResearch/Healthcare-Research_UCM_001093_SubHomePage.jsp
- NOF: National Osteoporosis Foundation
 - <https://www.nof.org/>
- ACIP: Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDC)
 - <http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

Specific Guidelines

Condition	Specific Guidelines	Population	Source / Guideline Link
Behavioral Health			
Attention Deficit Hyperactivity Disorder (ADHD)	Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents	Children 4 through 18 years of age	<u>AAP</u>
Depression	Treatment of Individuals with Major Depressive Disorder	Adults age 18 and over	<u>APA, ICSI</u>
Non-Preventive Acute or Chronic Conditions			
Diabetes	Prevention and Management of Diabetes	Children age 0-19 and Adults	<u>ADA</u>
Asthma	Diagnosis and Management of Asthma	Children 0-11, Youth 12-18 and Adults	<u>NHLBI</u>
Heart Failure	Management of Heart Failure	Adults	<u>AHA</u>
Hypertension	Management of High Blood Pressure	Adults	<u>JNC-8</u>
Osteoporosis	Prevention and Treatment of Osteoporosis	Adults	<u>NOF</u>

Preventive Care Guidelines			
Preventive Services	Preventive Services for Adults	Preventive Services for Adults	<u>USPSTF</u>
	Preventive Services Children and Adolescents	Children and Adolescents under age 18	<u>USPSTF</u>
	Routine Prenatal Care	All Women who are Pregnant	<u>USPSTF</u>

Quality Improvement for Behavioral Health Practitioner/Providers

General Overview

This section contains detailed information about the Blue Cross Quality Improvement (QI) program that is specific to Behavioral Health Practitioner/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 Cross QI Program

Rationale:

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

Requirements:

Actively participate in the following Blue Cross QI activities.

Standardized substance abuse screening in mental health assessment.

- Routinely incorporate a substance abuse screening questionnaire, e.g., CAGEAID, AUDIT, during mental health assessment of new patients age 12 and under.
- 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.
- Authorized 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' concept of the quality of care they receive often begins when they make an appointment. Blue Cross wants to ensure that Members are able to schedule appointments in a timely manner; commensurate with the level of care they need.

Requirements:

Routine initial appointments: 90% of 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 requests within 10 business days of the initial appointment.

Urgent appointment: 100% of 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 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/Provide 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 Providers to develop and implement written policies and procedures. Practitioner/Providers are encouraged to have policies that are specific to the location of practice and are signed, dated and reviewed annually.

Requirement:

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

Policy Required	Recommended Risk Management Elements
Behavioral Health Accessibility Standards	<ul style="list-style-type: none"> • Access to Behavioral Health appointments commensurate with clinical need • Access to follow-up appointments commensurate with clinical need • Crisis access to clinician 24 hours a day/7 days a week

Treatment Record
Documentation**Rationale:**

The patient Behavioral Health treatment record is a vehicle for documenting services and evaluating continuity and coordination of care. It also serves as legal protection for the patient and practitioner. Blue Cross, per contractual agreement with both the Member and Provider, has access to the Member's record for examination and evaluation. Blue Cross' 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 Cross Quality Management Committee establishes minimum record documentation standards.

Annually, Blue Cross audits a random sample of patient records from the Blue Cross 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.

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.

Treatment Record
Documentation,
continued

- 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., Family Skills Worker. 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.

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 must be documented which includes current and/or past major or chronic medical conditions and a current list of medications. 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 through age 17, a comprehensive developmental history must be documented that includes prenatal and perinatal events, achievement of developmental milestones, and psychological, social, intellectual, and academic history must be documented.
- For individuals 10 years and older, a substance use history must be documented. The history must include past and present use of tobacco, alcohol, illicit drugs and any 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 into the assessment of all new patients 12 years and older.

Treatment Record Documentation, continued

- 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, and impulse control must be documented.
- **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 any 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-5 multi-axial diagnostic system. The fifth digit of Axes I and II diagnoses must be listed when applicable.
- ICD-9-CM or ICD-10-CM codes must be used when submitting claims for payment.

Treatment Plan

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

Treatment Record
Documentation,
continued

Progress Notes

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

Medication Management

- Significant illnesses, clinical risks, and medical conditions are to be clearly noted and revised periodically.
- Current medications prescribed by all prescribing physicians must be listed. Dosages and dates of initial prescription and/or refills must be documented.
- Evidence of informed patient consent for the receipt of medication must be documented.

Laboratory orders and results must be documented as well as review of the results by the ordering physician. If abnormalities are found, follow-up plans must be documented.

Provider Specific Health Care Data

Release of Provider Data

Blue Cross is permitted to release Provider-specific health care data for the purpose of allowing Members, Plan Sponsors, Providers, 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, demographic information, utilization information, quality of care measures and initiatives, Health Service volumes, efficiency analysis, credentialing information, outcome measures, Member 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 Cross shall make a good faith effort to make available to the Provider a description of how Blue Cross intends to use Provider-specific data, the methodology used in collecting and analyzing the data and, a copy of the Provider data that Blue Cross intends to disclose. To the extent Provider can reasonably demonstrate, in writing, that any data that Blue Cross intends to disclose is inherently inaccurate, Provider shall notify Blue Cross of its specific concerns.

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

Chapter 4

Care Management

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Care Management

Introduction

The Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Provider Service Agreement requires Providers to comply with Care Management programs administered by Blue Cross. These Care Management programs are designed to ensure that the Health Services subscribers receive are reimbursable according to the Medically Necessary and Appropriate guidelines in subscriber Contracts. In addition, Blue Cross reviews experimental/investigative and new procedures/services for coverage determinations. Care Management programs also ensure the most cost-effective and appropriate use of the health care delivery system.

These programs may include:

- Prior Authorization or Notification of selected procedures, services, supplies, and drugs
- Admission Notification, Prior Authorization and concurrent reviews for selected inpatient admissions
- Retrospective review of claims and medical records
- Case, Condition/Disease Management and Maternity Management

To make utilization decisions, Blue Cross uses established utilization review decision criteria based on sound clinical evidence. The criteria used to evaluate an individual case are available, free of charge, upon request for Providers' review.

Any medical drug requests/claims reviewed will be assessed according to FDA approved drug labeling and indication, and/or CMS-recognized compendia for accepted off-label uses. If it is determined that a drug request/claim does not meet applicable criteria, the request/claim may be denied. Coverage may also be subject to pharmacy benefit management programs and formulary restrictions.

Objectives

Care Management programs are designed to:

- Maximize the coordination of care and health outcomes
- Ensure appropriate and efficient utilization of health care resources
- Promote efficient use of health care resources
- Define and agree upon appropriate standards of care
- Manage service for subscribers with complex care coordination needs
- Identify gaps in subscribers' care and navigation of resources
- Identification of subscribers with conditions that will benefit from self-care efforts, care intervention and communication

Provider Contractual Obligations – Important Program Points

The following points pertain to all of the Care Management programs. Any Medical Necessity denial determination may be discussed with a physician reviewer by telephone.

- Any Health Services denied using Blue Cross' Medical Necessity guidelines cannot be billed to the subscriber unless the Provider has specifically notified the subscriber **prior to the Health Services being rendered** that the Health Service is not Medically Necessary and will not be covered, and the subscriber has agreed in writing to pay for the Health Service. This applies to investigative services as well as some non-covered services for mental health. (Refer to Waiver Section.)
- The Care Management process is a review for Medical Necessity only. Payment for Health Services is still subject to all other terms of the subscriber Contract. Therefore, denials may occur for preexisting conditions, benefit maximums, coordination of benefits or riders in the subscriber Contract that supersede Medical Necessity.
- Blue Cross makes available provider portal self-service, Availity and the provider services center to verify subscriber coverage, benefits, eligibility and limitations. Service representatives will also verify which Care Management procedures apply to the subscriber Contract.
- Providers will be held financially liable for Health Services rendered that are determined to be not Medically Necessary during a review or an audit process, even if prior authorization and/or concurrent review is not recommended.

Care Management
Decision Making

Care Management including utilization management (UM) decision-making is based only on appropriateness of care, service and existence of coverage. Blue Cross does not compensate Providers, Health Care Practitioners or other individuals conducting utilization review decision-making activities for denials of coverage or service. Blue Cross does not offer incentives to decision-makers to encourage denials of coverage or service that would result in less than appropriate care or underutilization of appropriate care and services.

Blue Cross UM decision-making processes ensure that subscribers are not discriminated against in the delivery of Health Services consistent with the benefits covered in their subscriber Contract 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 Providers who make utilization management decisions of this philosophy and practice. This includes delegates conducting utilization management services on behalf of Blue Cross.

Utilization Management

Purpose

The purpose of the Utilization Management (UM) Program is to promote effective, appropriate and efficient use of medical and behavioral health care resources for our subscribers.

According to Minnesota statute, “Utilization review’ means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending health care professional, for the purpose of determining the medical necessity of the service or admission.”

The UM program is a set of continuously improving processes, designed to both meet subscribers' needs, as well as regulatory and accreditation requirements. The UM program includes processes for:

- Monitoring and analyzing utilization trends
- Identifying members with complex health issues that may benefit from case or disease management
- Ensuring UM procedures provide effectiveness and compliance with federal and state laws and accreditation requirements.

Care Management uses the UM program processes, procedures and criteria to review and coordinate subscribers' benefits to enhance the efficiency, affordability and quality of care.

Goals

The UM program purpose of promoting effective, appropriate, and efficient use of health care resources is accomplished by adhering to the UM processes described in this program. The program goals are to:

- Ensure objective and consistent utilization management decision-making
- Ensure that subscribers have access to appropriate and timely medical and behavioral health care across the provider network
- Improve service and claims processes to provide optimal handling of prior authorization and post-service payment
- Ensure timely resolution of identified problems
- Continually build and maintain collaborative relationships with medical and behavioral health care providers

Care Management
Medical and Behavioral
Health Clinical Staff

Care Management medical and behavioral health clinical staff are responsible for the coordination of utilization management functions for eligible subscribers. Clinical staff are required to maintain an active unrestricted health license in Minnesota. The Care Management medical and behavioral health clinical staff are permitted to approve requested authorizations based on plan documents, policies, procedures, and established medical and behavioral health clinical criteria. Physicians or appropriately licensed peer reviewers make necessary medical necessity denials.

Contractual benefits, Medical Necessity, appropriateness, and individual needs are evaluated during the review process to determine coverage of Health Services. All requests for services that do not meet Medically Necessary and Appropriate criteria are reviewed through the physician peer review process.

UM decision-making is based only on appropriateness of care and service, and existence of coverage. No financial incentive is awarded to clinical staff for denying requests for service or based on coverage decisions.

Medical Policy

Medical and Behavioral Health Policy Development

Blue Cross applies medical policies in order to determine benefits consistently for its members. Internally developed policies are subject to approval by our Medical Policy Committee, which is made up of independent community Physicians who represent a variety of medical specialties. The remaining policies are approved by other external specialists. For all policies, the health plan's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches.

Blue Cross makes its determination of experimental, investigative or unproven based upon a preponderance of evidence after the examination of the following reliable evidence, none of which shall be determinative in and of itself:

1. Whether there is final approval from the appropriate government regulatory agency, if approval is required;
2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers.

The committee considers a number of additional factors when evaluating each of the criteria. These factors include, but are not limited to: quality of the available peer-reviewed medical literature; safety, effectiveness, appropriateness of technology; Blue Cross and Blue Shield Association requirements and Medical Policies; and the relevant impact and consequences of coverage for the technology (for example, patient, Blue Cross, ethical, societal, legal).

The following definition of "Experimental/Investigative," based on member contracts, applies:

The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by Blue Cross to be medically effective for the condition being treated. Blue Cross will consider an intervention to be Experimental/Investigative if:

- the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s);
- or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes;

Medical and Behavioral
Health Policy
Development
(continued)

- or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies;
- or, the intervention does not improve health outcomes;
- or, the intervention is not proven to be applicable outside the research setting.

If an intervention, as defined above, is determined to be Experimental/Investigative at the time of the Service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, Prescription Drugs and other technologies. In turn, health care Plans must evaluate these technologies.

Blue Cross believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered Experimental/Investigative. Routine patient costs include items and Services that would be covered if the member was not enrolled in an approved clinical trial.

Medical Policy and
Behavioral Health
Policies

Medical and behavioral health policies are available for Providers' use and review at providers.bluecrossmn.com. From this site, there are two ways to access medical policy information depending on the subscriber's Blue Plan membership.

For Out-of-area Blue Plan subscribers

1. Select Medical Policy and Pre-Certification/Authorization Router
2. Click Go.
3. Select either medical policy or pre-certification/prior authorization.
4. Enter the subscriber's three-character alpha/numeric prefix (as found on their subscriber ID card)
5. Click Go.

After the disclaimer, the next page will show the subscriber's home Plan and provide information on Pre-certification/pre-authorization.

Medical Policy and Behavioral Health Policies (continued)

For local (Minnesota) Blue Cross Plan subscribers

1. Under the **Tools and Resources**, select “Medical Policy”
2. **Read and accept** the Blue Cross Medical Policy Statement
 - Select “+” next to ‘Medical and Behavioral Health Policies’ click on “Medical and Behavioral Health Policies” for access to all, currently, active medical policies.
 - The “**Upcoming Medical Policy Notifications**” section, on the website lists new, revised or inactivated policies approved by the Blue Cross Medical and Behavioral Health Policy Committee. They are effective, a minimum, 45 days from the date they were posted.

For Minnesota Health Care Programs subscribers

- Medical and Behavioral Health Policies may be accessed at: <https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs>

Prior Authorization & Notification Request Forms

Request forms are available at [providers.bluecrossmn.com](https://www.bluecrossmn.com/providers) under *Forms & Publications* in the “forms-precertification/preauthorization/notification” section.

Prior Authorization/Notification

Overview

The purpose of Prior authorization is to review Health Services prior to being rendered to determine if the Health Services are contractually eligible and Medically Necessary and Appropriate. Medical policy criteria and subscriber Contract language is used to assist in determining if benefits are available for the requested Health Service. **Prior Authorization for a Health Service, device or drug does not in itself guarantee coverage**, but notifies Provider that as described, the Health Service, device or drug meets the criteria for medical necessity and appropriateness. Services are only covered only if:

- The subscriber is enrolled in the health plan on the date of service
- The services or items are covered benefits
- The Provider is eligible for payment
- The Provider bills for the services that are approved

Payment for services and/or supplies Blue Cross approves in advance are also subject to the terms of the subscriber's coverage including any applicable copays and/or deductibles, contract exclusions and health plan allowed amounts.

A Notification is a notice of service that does not require medical necessity criteria review to be completed at the time of admission or onset of outpatient service. All covered services and admissions must be medically necessary and are subject to retrospective review or audit.

The Prior Authorization /Admission Notification lists found at bluecrossmn.com/providers/medical-policy-and-utilization-management identify various health services, procedures, prescription drugs, and medical devices that require Prior authorization or notification.

Please note: Commercial, FEP, Medicare Advantage, Platinum Blue and Minnesota Health Care Programs have different Prior authorization lists and requirements.

For behavioral health service requests, Blue Cross employs licensed behavioral health clinicians to conduct pre-certification/authorization reviews.

Blue Cross also uses eviCore to manage several types of specialty programs:

- Fully-Insured Commercial members:
Radiology/Cardiology, Musculoskeletal, Molecular Lab, Sleep, Medical Oncology and Radiation Therapy

Overview
(continued)

- Medicare Advantage members: Radiology/Cardiology, Musculoskeletal, Molecular Lab, Sleep, Medical Oncology, Radiation Therapy, Post-Acute-Care, DME and Home Health.

Reviews are completed by eviCore clinicians based on medical policies, processes and system applications that have been approved by Blue Cross.

The Blue Cross clinical reviewer uses local and national medical policy, Medicare guidelines, InterQual criteria, MHCP Guidelines, behavioral health criteria and subscriber Contract language to assist in determining if benefits are available for the request. Criteria are determined by the type of plan in which the subscriber is enrolled. Authorization for a Health Service, device, or drug does not in itself guarantee coverage but notifies Provider if the request meets the criteria for Medical Necessity and appropriateness. The Provider should always check with customer service to make sure the subscriber or patient has contract benefits and that the coverage is up to date.

Blue Cross will evaluate Provider's request for Prior Authorization and will make a determination once all the necessary medical information is received. Review decisions will be made and communicated within required time frames as defined by state and federal law.

Scope and Purpose

These policies are applicable to all commercial and Minnesota Health Care Programs; medical, surgical, and behavioral health services are included.

Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies. Medicaid products may have additional policies and prior authorization requirements, as well as some self and fully insured plans. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law.

Admission Notification Requirements

Admission Notification submissions are required to be submitted within 24 hours or on the next business day following a weekend or holiday, whichever is less, for both planned and urgent admissions. Admission notification is required for all inpatient admissions unless prior authorization is required for the admission. Continued stay notification is required for any admission that extends beyond the initially approved days. Providers are also required to notify Blue Cross when patients are discharged.

For Minnesota Health Care Programs (Blue Advantage Families and Children, MNCare, MSC+) and SecureBlue claims beginning with admission dates of June 1, 2017, if an admission notification is not submitted timely as articulated above, the inpatient facility claim will be administratively denied upon its submission for lack of notification. For inpatient facility claims submitted with observation hours, the admission notification submission timeframe requirement will be extended by the number observation hours submitted.

For Minnesota Health Care Programs (Blue Advantage Families and Children, MNCare, MSC+) and SecureBlue claims beginning with admission dates of January 1, 2019 an admission notification is not required.

Please see:

<https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs>

Please note: If an admission requires Prior Authorization, Admission notification is not required, and thus is not impacted by this requirement. A list of inpatient services that require prior authorization can be found in the Medical Policy section of the Blue Cross provider website under Utilization Management for each line of business.

Claims for the following scenarios are exempt from denial for lack of admission notification at this time:

- Coordination of Benefits scenarios when Blue Cross is not primary
- Normal Labor and Delivery
- Newborns (children less than 30 days old)

Please note that MHCP eligibility information can be found in the MN-ITS system provided by the MN Department of Human Services (DHS).

Decision Making and
Notification Time
frames

To ensure timely processing and assist us in meeting compliance with state and federal guidelines, please submit prior authorization requests at least 10 business days prior to any elective services being rendered.

Urgent requests will be reviewed as expeditiously as the subscriber's health condition warrants and for all requests we will notify you of the coverage decision within the time frame required by law.

Definition of Urgent Request

The federal regulations define an urgent request as:

- Requires immediate action to prevent a serious deterioration of a subscriber's health that results from an unforeseen illness or an injury, or
- Could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment, or
- In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

Care that has already been provided is not considered urgent.

Requests not meeting the conditions for an urgent request will be considered nonurgent. Both urgent and nonurgent requests will be reviewed and completed within current state and federal timelines.

For expedited requests, Blue Cross adheres to federal and state requirements for decision-making time frames. Blue Cross uses the following definitions to determine if a request is expedited:

For Commercial Plans

Requires immediate action to prevent a serious deterioration of a subscriber's health that results from an unforeseen illness or an injury, or

Could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment, or

In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

Requests not meeting the criteria for the urgent definition for an urgent request will be considered non-urgent. Providers submitting the request will be notified by Blue Cross that the request does not meet urgent criteria and will be managed according to non-urgent criteria. Both urgent and non-urgent requests will be reviewed.

Definition of Urgent Request (continued)

For Medicare Programs

Although it may not be a life-threatening circumstance, an urgent condition:

- Requires immediate action to prevent a serious deterioration of a subscriber's health that results from an unforeseen illness or an injury; or,
- Could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment; or,
- In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

If the need for service is for urgent care or services are required to prevent institutionalization, Blue Cross will evaluate the request for service and communicate the decision to the subscriber or authorized representative and the attending physician within an expedited timeline, not to exceed 24 hours.

Requests not meeting the criteria for the urgent definition for an urgent request will be considered non-urgent. Providers submitting the request will be notified by Blue Cross that the request does not meet urgent criteria and will be managed according to non-urgent criteria. Both urgent and non-urgent requests will be reviewed and completed within current state and federal timelines.

Utilization Management Services Requiring Prior Authorization/Notification

Overview

Medical and behavioral health policies are available for Provider's use and review on the Blue Cross website at **providers.bluecrossmn.com**. From this site, there are two ways to access Pre-Certification/Authorization/Notification requirements depending on the subscriber's Blue Plan membership (see below).

The Provider is expected to contact the Subscriber's Blue plan to request required prior authorizations.

The Provider is also responsible for completing admission notifications and/or prior authorizations for all inpatient admissions and may be liable for charges if notification to the home plan is not completed. When the length of an inpatient hospital stay extends past the previously approved days, any additional days must also be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials. To avoid delays in the processing of Provider's claims, please assure the necessary approval(s) are obtained in advance of services being rendered.

Prior Authorization Requirements for Out-of-area Blue Plan Patients

For Out-of-area Blue Plan subscribers

1. **Select** Medical Policy and Pre-Certification/Authorization Router
2. **Click** Go
3. **Select** pre-certification/pre-authorization
4. **Enter** the subscriber's three-character alpha/numeric prefix (as found on their subscriber ID card)
5. **Click** Go

After the disclaimer, the next page will show the subscriber's home plan and provide information on Pre-certification/pre-authorization.

Prior Authorization
Requirements for Local
Blue Cross Plan
Patients

1. Under the Tools and Resources, select “**Medical Policy**”
2. Read and accept the Blue Cross Medical Policy Statement
3. Select “+” sign next to “Utilization Management”.
4. Scroll to the link to the pre-certification/pre – authorization/notification list by line of business. These lists identify the services, procedures, prescription drugs, and medical devices that require pre-certification/authorization/notification.

Please note: Commercial, Minnesota Health Care Programs, Platinum Blue and Medicare Advantage, and Federal Employee Programs (FEP) products have different Pre-certification/authorization/notification lists and requirements.

Where to Send Requests

See *Chapter 1 – At Your Service* for the phone numbers, fax numbers or mailing addresses for Care Management.

Minnesota Health Care Programs Prior Authorization requirements can be accessed at:

<https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs>

Compliance Audit

Overview

The Provider Service Agreement includes certain quality assurance requirements. Pursuant to the Agreement, Blue Cross may conduct audits to evaluate Provider's compliance with Medical Necessity guidelines and standards of practice in the community. Such an audit could include post-service claims review, which may result in Provider liability if the care is determined to be not Medically Necessary or medically inappropriate.

Case & Condition/Disease Management

Overview

Mission Statement

The corporate mission of Blue Cross is to “Make a Healthy Difference in People’s Lives”.

Care Management staff supports this mission by working collaboratively with subscribers, providers, delegates, and the community to promote optimal health, and coordinate access to service across the continuum of care that is holistic, seamless and easily accessible. Blue Cross’ goal is to be responsive and respectful to those served by Blue Cross in order to decrease fragmentation of care, improve satisfaction and enhance quality of life. Blue Cross considers and supports the subscriber’s cultural and linguistic needs in order to achieve optimal health and overall subscriber satisfaction.

Clinicians

Licensed Nurses/Clinicians, using a collaborative process, advocate, assess, plan, implement, coordinate, monitor and evaluate options and services to meet an individual’s specific health care needs through education and communication of available resources to promote high quality, cost effective outcomes for subscribers with medical and behavioral conditions that require ongoing or intermittent care. Clinicians are required to maintain an active unrestricted health license in Minnesota.

Program Goals

- Maximize optimal health and functional outcomes.
- Identify gaps in care
- Reach out to the subscribers with the greatest need and educate them about their condition
- Support and encourage individual accountability for health and wellness (self-care management)
- Help subscribers coordinate their needs and navigate services in the health care system
- Tailor interventions and outreach to promote the appropriate use of health care services
- Improve subscriber’s satisfaction with the health plan and health care system

Referrals to Case, Maternity and Condition/Disease Management

Referrals to Commercial Case & Condition/Disease Management

A referral can be made by contacting the Nurse Guide Team at **1-866-489-6947**

A referral for stop smoking can be made to Blue Cross Wellness Coaching at 1-888-662-2583.

Condition/Disease Management

Condition/Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations who have or are at risk for, chronic medical and behavioral health conditions. Condition/Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as education and self-management. The process of disease management evaluates clinical, social/humanistic and economic outcomes with the goal of improving overall health of the whole person.

Subscribers who receive Condition/Disease management services receive support from a case manager, who assists in facilitating the health of the whole person, not just their individual condition.

*Services are offered to subscribers, participation is optional.

*Subscriber eligibility for Condition/Disease management is determined by the subscriber Contract.

Condition/Disease
States

Commercial & Medicare Advantage *

- Asthma (Adult)*and Child)*
- Coronary Artery Diseases (CAD)*
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)*
- Depression*
- Diabetes (Adult)* and Child)*
- Heart Failure*
- Hyperlipidemia
- Hypertension
- Low Back Pain
- Maternity Management
- Metabolic Syndrome
- Migraine
- Musculoskeletal Pain
- Obesity (Child)
- Oncology
- Osteoporosis
- Upper GI

The Medicare Advantage Core and Choice plans, available as of January 1, 2018, have access to the programs noted with an asterisk (*) above.

Blue Cross provides behavioral health case and disease management for Blue Cross member s using Blue Cross documentation systems, Blue Cross medical policies, and Blue Cross internal policies and procedures.

Maternity
Management/Commercial

The Maternity Management program offers an expectant mother the tools and support needed throughout her pregnancy to help her make better informed decisions about her healthcare, in conjunction with her Provider. By enrolling in the Maternity Management program, the expectant mother will receive access to a case manager, who is a Registered Nurse (RN) with expertise in obstetrics and perinatal and comprehensive pregnancy and baby health education tools.

- A nurse or clinician may contact Provider's office for assistance with a Blue Cross subscriber's needs or to verify a subscriber's contact information. They may also send Provider a letter including subscriber goals and/or gaps in care to inform Provider on what Blue Cross is working with the subscriber to advance their health care needs. Blue Cross looks forward to working with its subscribers' Health Care Practitioners to make a healthy difference in the health of its subscribers.

The Maternity Management program is available to all Blue Cross subscribers. Subscribers who trigger for high risk will be actively outreached to by the Maternity Management specialty team of nurse case managers. All other subscribers may contact Blue Cross to opt-in to the program.

Referrals to Maternity
Management

To enroll, please instruct subscribers who are expecting a baby to see the back of their subscriber ID card for the appropriate contact number.

Minnesota Health Care
Programs/Maternity
Management

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

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.

Maternity
Management/Minnesota
Health Care Programs
(continued)

Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit 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/Minnesota
Health Care Programs

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.

Restricted Recipient Program

The Restricted Recipient program is a specialized program for Minnesota Health Care Program subscribers.

- Blue Plus subscribers include subscribers with coverage through: Minnesota Health Care Programs for Persons Under Age 65 (Blue Advantage Families and Children and MinnesotaCare Program Services (MNCare)).

Restrictions of Medicare services are not allowable per DHS contract 2.130. For subscribers who are on Medicare integrated product (SecureBlueSM [HMO SNP]), it is permissible to restrict Medicaid-only services. Blue Plus is not able to restrict Part D drug coverage and implement physician sole prescribers for Minnesota Health Care Programs subscribers with Medicare (MSC+). If a MSC+ subscriber is not Medicare eligible, restriction is permissible.

Restricted recipients are subscribers who have used Health Services at a frequency or amount that is not Medically Necessary and/or who have obtained Health Services in an inappropriate manner.

Nurses in Care Management review subscribers' medical and pharmacy claims for potential restriction. Subscribers who meet the program criteria are assigned to a specific physician for their primary care needs who, in turn, will coordinate all their care and medication needs. The subscriber will also be assigned to a single pharmacy and a single hospital. Access to specialty care may be discussed with the nurse assigned to the subscriber. The initial program restriction is for 24 months with potential re-enrollment for 36 months.

Providers need to verify if a subscriber has a restriction before providing Health Services.

Claims will be impacted if Provider renders Health Services to a subscriber enrolled in this program and Provider is not the assigned physician, pharmacy or hospital.

Eligible services provided to a subscriber in the program will be reimbursed only when one of the following criteria is met:

- The Health Service is provided by the subscriber's assigned provider
- The Health Service is of a provider type or type of service that is not listed as needing management
- This includes, but is not limited to, durable medical equipment (DME), home care, ambulance services, mental health or chemical health services

Nurses will refer suspect cases to the special investigation unit (SIU) as needed.

Focused Utilization Review

Overview

Focused utilization review programs contribute to Blue Cross' goals of containing health care costs by assuring that Health Services are contract benefits and appropriate. Blue Cross systematically monitors Health Services of providers for patterns of overuse, underuse, misuse and abuse in addition for obsolete or questionable practices.

Blue Cross has data warehousing and software programs that look for patterns outside established norms. The analysts review medical records and work with providers to resolve questions on coding, benefits and Medical Necessity and Appropriateness. On-site audits, using a sample of up to the last three years of claims history may be performed. Prompt response to medical records requests will speed up processing of claims under review. Claims are denied as Provider liability if the necessary information is not received.

During utilization review, claims are screened for Medical Necessity. Peer review agents or consultants deny claims only after careful evaluation. Slightly longer processing time is required for claims that must go through the utilization review process.

Participating Providers agree not to bill the subscriber for any services Blue Cross determines to be not Medically Necessary or investigative. Medical Necessity denials can be appealed within 30 days from the date Provider was notified. Blue Cross requests that Providers submit written appeals outlining the issues and ATTACH supporting documentation such as medical records, operative reports, and any medical information documenting unusual circumstances at the time of the request.

Special Investigations Blue Cross actively investigates possible fraudulent claims submissions from both subscribers and Providers. Fraud and abuse investigations conducted by Blue Cross' special investigations department are among the most thorough in the industry. Inconsistent charges forged or altered charges, or Health Services billed but never rendered are just a few examples of inappropriate practices that Blue Cross may verify when conducting its investigation. Blue Cross' investigation process may include, but is not limited to, record requests, audits, and survey letters.

Blue Cross often conducts its investigations and criminal proceedings in collaboration with outside agencies such as the state attorney general's office, the FBI, postal inspectors, or local authorities. Blue Cross' goal is to protect Blue Cross subscribers and Providers from losses due to fraudulent acts.

Information about any person's inappropriate use of a Blue Cross policy, subscriber ID card, or questionable billing practices should be reported by calling Blue Cross' fraud hot line. The phone number is listed in *Chapter 1 — At Your Service*. Callers may remain anonymous if they wish.

Documentation in the Medical Record

Documentation Requirements

To avoid denials for Medical Necessity, the patient's medical record must contain certain pertinent information that may be subject to Blue Cross' review. The Centers for Medicare and Medicaid Services (CMS) in conjunction with the American Medical Association (AMA) has developed guidelines for the medical documentation necessary to support a given level of evaluation and management service. Blue Cross adopted these guidelines to ensure that its subscribers receive quality care and that the Health Services are consistent with the health plan coverage provided.

The general guidelines are listed below:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
 - Plan of care; and
 - Date and legible signature of the practitioner.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response and changes in treatment, and revision of diagnosis should be documented.
- The CPT/HCPCS and ICD-10-CM procedure codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Charge slips, super bills, travel cards, or office ledgers are not considered supporting documentation for services provided to a patient.

Use of the term IBID (same as above) and/or the use of quotation marks to replace or repeat previously documented information is not acceptable. All information must be in date-sequence order.

Health Services not documented as indicated above are not covered by Blue Cross. Subscribers are not financially liable for Health Services that are denied for inadequate documentation.

Overview

Per the Provider Service Agreement, Provider may not bill:

- Any subscriber for medically unnecessary or investigative services.
- Minnesota Health Care Programs, including Blue Advantage Families and Children- and MinnesotaCare subscribers for Health Services that are not covered at Provider's office, but may be covered if the subscriber went to another provider.

Provider may bill the subscriber only if the following conditions are met:

- The subscriber is notified prior to the Health Service being rendered that it is not a covered service, etc.
- The subscriber agrees, by signing a waiver, to pay for the service.

In addition, Provider should not direct subscribers to nonparticipating or non-network providers (Refer to *Referrals to Nonparticipating Providers*).

For Minnesota Health Care Programs: One of the DHS regulations includes subscriber rights to notification of non-covered Health Services. General signed statement information is included in the *Blue Cross Provider Policy and Procedure Manual, Chapter 6*.

The signed statement is allowed only when the Health 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 subscriber for each date of service

If the signed statement is not signed by the Minnesota Health Care Programs subscriber prior to the Health Service, then according to DHS rules, the subscriber cannot be billed for the service. This includes Health Services that are investigative, not Medically Necessary, or excluded from coverage under the contract. Provider may bill a Subscriber for non-covered Health Services only when Minnesota Health Care Programs (MHCP) never covers the services and only if Provider informs the subscriber before Provider delivers the services that he/she would be responsible for payment. If MHCP normally covers a Health Service but the subscriber does not meet coverage criteria at the time of the service, Provider cannot charge the subscriber and cannot accept payment from the subscriber.

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

Overview (continued)

Blue Cross does not consider blanket (nonspecific) waivers sufficient notice to meet the subscriber notification requirements in the Provider Services Agreement. The waiver must be dated and must specifically identify the procedure or Health Service. The waiver must also advise the subscriber that he or she would not be liable for these charges unless the waiver is signed.

Medical Referrals to Nonparticipating or Non Network Providers

Providers are required to direct subscribers to Blue Cross participating providers, hospitals and other facilities to the highest degree possible. Directories of participating providers are available at bluecrossmn.com or upon request by contacting provider services at **1-800-262-0820** or **(651) 662-5200**. Blue Cross maintains stringent provider participation standards and credentialing requirements and directing a subscriber to a participating provider improves the likelihood that a subscriber will receive high quality Health Services. In addition, subscribers will incur reduced benefits and higher patient responsibility when using nonparticipating or non-network providers.

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 (access to care issue).

Note: For subscribers of Blue Plus who require managed care referrals, use the Referral Network directory available at bluecrossmn.com. Subscribers will receive the highest level of their benefits when receiving a referral to a participating provider for those specialty Health Services that require a referral.

If it is Medically Necessary to refer a Blue Plus subscriber to a nonparticipating provider, refer to Chapter 6 of this Provider Policy & Procedure Manual or contact the provider service center for further information at **1-800-262-0820** or **(651) 662-5200**. You may need to submit an out of network notification to the Health Plan. In all cases, Provider must give the subscriber advance, written notification that the referral is to a nonparticipating physician. Once notice is given, the subscriber is responsible for any increased liability if he or she decides to schedule the service except that Minnesota Health Care Programs subscribers cannot be held financially responsible for any increased liability regardless of the reason for the referral. If the subscriber is not properly informed, the provider making the referral to a nonparticipating provider will be liable for increased costs incurred by a subscriber.

For complete information on Minnesota Health Care Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

Sample Waivers

A sample waiver for use in Provider's office is available on Blue Cross' website. The waivers include the information required in order for Provider to hold the subscriber financially liable for services. The waiver should be incorporated into Provider's usual business forms and should be customized to include Provider's business letterhead.

Upgraded/Deluxe
Durable Medical
Equipment (DME)

Commercial Business

Participating durable medical equipment (DME) suppliers may bill subscribers for an equipment upgrade or deluxe charge if a waiver is on file and the DME charges are billed correctly to Blue Cross. Blue Cross continues to reimburse for Medically Necessary standard DME.

Minnesota Health Care Programs Business

For complete information on Minnesota Health Care Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

DME Waiver
Requirement

Participating DME suppliers must obtain a signed, written waiver from the subscriber that includes the cost for the deluxe features or upgrade. The waiver must also state the following:

- The standard piece of equipment or least costly alternative offered to the subscriber,
- The subscriber is aware and agrees that Blue Cross will only pay the standard allowance, and
- The subscriber will be responsible for the deluxe or upgrade charge in addition to his or her contractual obligation.

This waiver must be kept on file at Provider's office. If a prior authorization is required for the item being provided, please send the waiver form along with the request. For all services that do not require a Prior authorization, **do not send it to Blue Cross**. Blue Cross does, however, reserve the right to see it.

Sample DME Waiver

A sample waiver for use in Provider's office is available on Blue Cross' website. The waiver includes the information required in order to hold the subscriber financially liable for deluxe features or upgrades to a DME purchase. The waiver should be incorporated into Provider's usual business forms and customized to include Provider's business letterhead.

Chapter 5

Health Care Options

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Subscriber ID Cards/Health Coverage Options

Fully Insured Groups

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) fully insured contracts are available for employers that select our standard benefits. The employer can choose the deductible/coinsurance and copay amounts.

Fully insured contracts generally:

- offer consistent benefit options
- follow state mandates
- follow federal mandates
- have standard subscriber identification (ID) cards
- are regulated by the Department of Commerce (fee-for-service) or the Department of Health (managed care)

Self-Insured Groups

We also administer self-insured contracts in which the employer selects the benefits and assumes all or part of the financial risk. These may also be referred to as ASOs (Administrative Services Only). Self-insured contracts generally:

- offer many contract benefit options
- are not required to follow state mandates
- follow federal mandates
- have subscriber ID cards that may not be standard and may include the logo

Patients who belong to self-insured groups administered by Blue Cross are to be treated as any other subscriber for purposes of the provider contract. Because your office must bill us directly for these patients, it is important to check the back of the subscriber ID card to see if we are listed as the administrator of the health plan.

Subscriber ID Cards

Your patient's ID card contains information that is essential for claims processing. We recommend that you look at the ID card at every visit and have a current copy of the front and back of the card on file. There is a sample of some of the ID cards issued at Blue Cross on our website. Below are examples of the information you may find on an ID card:

- name of the plan
- patient's ID number including alpha prefix
- patient's name and group number
- primary care clinic (PCC) name – for managed care plans only
- prescription coverage
- copay for office visits, if applicable
- claims submission information

Subscriber ID Card Conversion

Blue Cross does not use Social Security numbers for ID cards; however, the Minnesota Department of Labor and Industry requires the use of social security numbers for anyone who has ever filed a worker's compensation claim.

Helpful Tips

- Ask patients for their current ID card and regularly obtain new photocopies (front and back) of the ID card. Having the current card will enable you to submit claims with the appropriate subscriber information (including alpha prefix) and group numbers to help avoid unnecessary claims payment delays.
- Check eligibility and benefits by using www.availity.com, BLUELINE or call **1-800-676-BLUE (2583)** and provide the alpha prefix.

Verify Identity of Cardholder

You should also verify the identity of Blue Cross cardholders by asking for additional picture identification.

If you suspect fraudulent use of a subscriber ID card, please call our fraud hot line at **(651) 662-8363**. You may remain anonymous.

Blue Cross and Blue Shield of Minnesota Coverage Options

Overview	<p>Blue Cross offers a variety of health coverage options. A high level summary of those benefit options available to employees follows in this chapter. All fully insured plans are compliant with Federal and State regulations. All benefits are subject to the terms of the subscriber's contract and/or certificate of coverage.</p> <p>Please use provider web self-service, or provider services to identify your patient's eligibility and benefits.</p>
Aware [®] PPO	Aware PPO is an open access product. Aware PPO is attractive to employers with employees in Minnesota and in other geographical areas.
BlueAccess SM	BlueAccess is a health plan for small employers. BlueAccess plans are open access and utilize the Aware [®] network. Some plans may include a health savings account (HSA) or health reimbursement arrangement (HRA). Plans include a range of cost-sharing options, including deductibles, copay and coinsurance.
High Value	High Value is a statewide plan for Large Group employers featuring high quality, low cost providers.
Metro MN	With a Metro MN plan, Large Group employers utilize a coordinated-care network. Metro MN provides a personalized, coordinated approach to health care with primary and specialty care providers through the Metro MN network.
Strive – Metro Region	With a Strive – Metro Region plan, Large Group and Small Group employers utilize a coordinated-care network. Strive – Metro Region provides a personalized, coordinated approach to health care with primary and specialty care providers through the Strive – Metro Region network.
Northeast MN	With a Northeast MN plan, Large Group employers utilize a coordinated-care network. Northeast MN provides a personalized, coordinated approach to health care with primary and specialty care providers through the Northeast MN network.
Southeast MN	With a Southeast MN plan, Large Group employers utilize a coordinated-care network. Southeast MN provides a personalized, coordinated approach to health care with primary and specialty care providers through the Southeast MN network.
Western MN	Western MN for Large Group employers utilize a coordinated care network. Western MN provides a personalized, coordinated approach to health care with primary and specialty care through the Western MN network.

Medicare
Supplemental Plans

Blue Cross offers a variety of Medicare supplement plans. Medicare supplement plans are designed to help fill the gaps in Medicare coverage.

In 2020, Blue Cross offers seven Medicare Supplement Plans: Basic Plan with optional riders, Senior Gold with optional riders, Extended Basic, Plan K, Plan L, Plan N and Medicare Supplement with High Deductible.

Under these plans, Medicare is the primary payer. Claims must be submitted to Blue Cross with a copy of the Medicare Remittance Advice (RA) form.

Platinum BlueSM (Cost) Platinum Blue, a Medicare-approved Cost plan, is an open access product for Medicare beneficiaries who are residents of Minnesota, offered through a contract with the Centers for Medicare and Medicaid Services (CMS).

No referrals are needed for in-network doctors, specialists or hospitals. Subscribers can receive plan benefits for services received outside of Minnesota, from any provider that accepts Medicare, when traveling for up to nine months per year (Travel Benefit). Travel benefit claims process as in-network, even though the subscribers are using out-of-network providers. Travel benefit claims process to Medicare first and crossover to Blue Cross as a secondary payer.

Travel benefits are not applied to out-of-network providers within the state of Minnesota. If, while in Minnesota, subscribers go to a provider outside of the Platinum Blue (Cost) network who accepts Medicare patients, subscribers are covered under Original Medicare and would pay the Part A and Part B deductibles and coinsurance.

Medicare Advantage MA and MAPD are Medicare Advantage Plans. They cover all Medicare Part A and B benefits (MAPD also covers Part D benefits). Services received outside of the network may not be covered or member costs may be higher. The plans do not require referrals and have out of pocket costs, including copayments and coinsurance.

HMO-POS (Strive) is a Health Maintenance Organization with a Point of Service Option. It is a Medicare Advantage Plan that has a network allowing members to seek care outside of the traditional HMO network under certain situations or for certain treatment. Services received outside of the network may not be covered or member costs may be higher. While typical HMO-POS plans require a PCC and a referral, Blue Cross is not enforcing those requirements. They cover all Medicare Part A, Part B and Part D benefits.

MedicareBlue Rx (PDP) This is a regional Medicare Part D Program product offered through the coordination of six Blue Cross plans covering seven states. The service area for this plan encompasses Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming.

This product offers two different benefit level options, both with a five tier formulary. Drugs in the formularies may be subject to change, step therapy, quantity limits or preauthorization.

PLEASE NOTE: Forms, formularies and provider information for MedicareBlue Rx can be found at:

[http://www.yourmedicareolutions.com /](http://www.yourmedicareolutions.com/)

This product is also available for fully insured employer groups to purchase for their Medicare eligible subscribers.

Guidelines for
Determining
Submissions to
Medicare or Blue Cross

For services provided to Medicare subscribers enrolled in our Medicare supplement or Platinum Blue plan that are eligible under Medicare Part A, Medicare is primary. CMS will continue to be the primary payor for these services with electronic claims crossing over from Medicare intermediaries. Blue Cross will serve as secondary payor for these services with subscribers being subject to Medicare coinsurance and deductibles.

Blue Cross is the administrator for Medicare Part B nonfacility-based services and any additional Platinum Blue benefits. Reimbursement for professional providers utilize Blue Cross' contracted fee schedule methodology. To ensure CMS compliance, follow the guidelines outlined in standard Medicare bulletins and the Provider Policy and Procedure manual.

For Medicare subscribers enrolled in our Medicare Advantage plans, Blue Cross replaces Medicare as primary payor for Part A and Part B services.

Inquiries and Claims
Platinum Blue (Cost)
and Medicare
Advantage

Provider claim and benefit inquiries for Platinum Blue can be directed to provider web self-service, BLUELINE or provider services at **(651) 662-5200** or **1-800-262-0820**. Please have your provider ID and the subscriber ID ready when you call.

As a Medicare contracted provider, Medicare expects providers to know both current NCDs and LCDs. NCDs describe whether Medicare pays for specific medical items, services, treatment procedures or technologies.

The [Medicare Coverage Database \(MCD\)](#) contains all NCDs and LCDs, local policy articles and proposed NCD decisions. You may find published [NCDs](#), view official versions of [LCDs](#) by contractor, state, or alphabetically and information related to [Medicare coverage, regulations, and processes](#) visit the CMS website.

Blue Plus Coverage Options

Blue Plus Metro MN	With a Blue Plus Metro MN plan, individuals utilize a coordinated-care network that provides a personalized, coordinated approach to health care with primary and specialty care providers through the Blue Plus Metro MN network.
Blue Plus Western MN	Blue Plus Western MN plans provide a coordinated-care network with a personalized, coordinated approach to health care with primary and specialty care providers through the Blue Plus Western MN network.
Blue Plus Northeast MN	Individuals utilize a coordinated-care network with St. Luke's which provides a personalized, coordinated approach to health care with primary and specialty care providers through the Blue Plus Northeast MN network.
Blue Plus Strive – Metro Region	Individuals utilize a coordinated-care network with Fairview Health System and North Memorial Health which provides a personalized, coordinated approach to health care with primary and specialty care providers through the Blue Plus Strive – Metro Region network.
High Value / Blue Plus Minnesota Value	High Value / Blue Plus Minnesota Value is a statewide plan for Small Group employers / individuals featuring high quality, low cost providers. It is referred to as High Value for Small Group employers and Blue Plus Minnesota Value for Individuals.
Blue Plus Southeast MN	Individuals utilize a coordinated-care network with Mayo Clinic which provides a personalized, coordinated approach to health care with primary and specialty care through the Blue Plus Southeast MN network.
Medicare Select Product	Medicare is primary for all services. For the highest level of benefits, all care must be provided or referred by the subscriber's primary care clinic. There are no benefits under the Medicare Select contract for services outside the network, although coverage through Medicare for eligible services is still available to the subscriber. Medical emergencies, however, are covered whether a subscriber is at home or traveling. The applicable Medicare deductible and coinsurance amounts are the subscriber's responsibility. Enrollment in Medicare Select is closed.

Blue Cross Medical Assistance Coverage Options

Minnesota Senior Health Options (MSHO) Secure BlueSM (HMO SNP)

Blue Plus offers a Minnesota Senior Health Options (MSHO) product called SecureBlueSM (MHO SNP) 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 and Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS) that creates an alternative delivery system for acute and long-term care services and integrates Medicare and Medicaid funding.

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

A care coordinator will work closely with individual SecureBlue members to assist them in achieving optimal medical and social stability.

For SecureBlue members, Blue Plus is billed as primary not Medicare. SecureBlue members can be identified by ID numbers beginning with “JTM”. Enrollment eligibility may change monthly. Providers must verify eligibility through any electronic data system currently being used to access Medical Assistance eligibility such as Medifax, the Department of Human Services Eligibility Verification System (EVS), www.availity.com, or Blue Cross provider services, toll free at:1-866-518-8448.

SecureBlue is responsible for paying a total of 180 days of nursing home room and board. Some members are eligible for Elderly Waiver services. The only copays for SecureBlue members are for prescriptions. Members must designate a primary care clinic however, referrals are not required for services at participating providers. Services are coordinated through the members care coordinator. Providers should file their claims with Blue Plus

For complete information on Government Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

Families and Children and Minnesota Senior Care Plus (MSC+)/Blue Advantage

The Blue Advantage Families and Children and Minnesota Senior Care Plus (MSC+) are Minnesota health care programs funded jointly by the state and federal governments. Families and Children program for enrollees under age 65. Blue Plus has a contract with DHS to provide services for Medicaid enrollees (MSC+ is for seniors 65+) in specific counties. MSC+ includes Elderly Waiver services for Enrollees who qualify, and one hundred and eighty (180) days of Nursing Facility care, based on the 1915 (b) and (c) waiver authority.

Members can be identified by ID numbers beginning with “LMN.” Enrollment eligibility may change monthly. Providers must verify eligibility through any electronic data system currently being used to access Medical Assistance eligibility such as Medifax, the Department of Human Services MN-ITS, www.availity.com, or Blue Cross provider services.

When enrolling into managed care, members designate a primary care clinic to provide or coordinate their care. If no clinic is selected, one will be assigned for them.

For questions, call the number on the back of the subscriber’s ID card, or call **1-800-711-9862**. Providers should file their claims with Blue Cross. Please refer to Chapter 3 of the Blue Plus Manual for more detailed information on Government Programs.

For complete information on Government Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

MinnesotaCare Program

MinnesotaCare is a state-subsidized health program. It is funded by subscriber premiums, the state of Minnesota, a tax on health care providers and some federal matching dollars. It is open to all Minnesotans who meet program and income guidelines and do not have access to health insurance.

MinnesotaCare members can be identified by ID numbers beginning with “LMN. Enrollment eligibility may change monthly. Providers must verify eligibility through any electronic data system being used to access Medical Assistance eligibility such as Medifax, the Department of Human Services MN-ITS, www.availity.com, or Blue Cross provider services.

Subscriber ID cards look similar to cards for Families and Children.

Benefits for children under 21 and pregnant women are the same as the Families and Children benefits except for common carrier transportation. Adults have a reduced benefit set and have some copays. Members must designate a primary care clinic and referrals are not required if within the participating provider network. Providers should file their claims with Blue Cross.

See Chapter 3 of the Blue Plus Provider Manual for more complete information.

Federal Employee Program

Federal Employee Program (FEP)

The Federal Employee Program (FEP), one of the health benefit plans available to federal government employees and their dependents, is administered by Blue Cross and Blue Shield plans throughout the country. Enrollment, eligibility, and claims records for all FEP subscribers are maintained in Washington, D.C. We have access to the records through a national telecommunications system.

The unique federal ID number, which always begins with an “R” and is followed by eight digits, identifies FEP subscribers.

Federal employees may choose Basic Option or Standard Option coverage. Providers should file all claims for FEP benefits within the local plan, (that is, Minnesota providers submit to Blue Cross and North Dakota providers submit to Blue Cross and Blue Shield of North Dakota).

Providers can call a new automated voice response unit (VRU) to check eligibility and benefits for FEP subscribers. To access this service, call **(651) 662-5044** or **1-800-859-2128**. Claim status is currently not available through the VRU.

Provider Statements

Your Statement of Provider Claims Paid and Statement of Institutional Claims Paid for FEP subscribers will be posted on a separate remit. You will also receive a separate check titled “Federal Employee Program” with the Blue Cross logo for your FEP subscribers. Recoupments and credit claim activities for FEP subscribers will be reflected on a separate Accounts Receivable Recoupment Report, which will be titled “Federal Employee Program.”

Benefit Changes

Visit www.fepblue.org for current benefit information.

BlueLink TPA

BlueLink TPA

BlueLink TPA is a third party administrator affiliate of Blue Cross and an independent licensee of the Blue Cross and Blue Shield Association serving residents and businesses of Minnesota.

Self-insured employers and plan sponsors contract with BlueLink TPA to administer highly customized employer-driven benefit plans that use selected Blue Cross networks of participating providers.

Please use provider web self-service at www.availity.com to verify eligibility for a patient and confirm the benefits covered under the subscriber's contract.

File electronic claims to Blue Cross. For inquiries, adjustments or appeals contact the employer or third-party administrator directly.

BlueLink TPA
P.O. Box 64668
St. Paul, MN 55164

United Concordia Dental

History	Medical/dental services eligible under member's medical plan will utilize the United Concordia Dental network effective for Individual, Commercial, Individual Medicare Advantage FEP and Employee plans.
Inquiries	888-587-2447

Delta Dental

History

Delta Dental of Minnesota offers access to Minnesota Select Dental Network. Delta Dental operates pursuant to an administrative service agreement with Blue Cross.

Dental services are provided through Delta Dental of Minnesota, which is independent from Blue Cross and Blue Shield of Minnesota. Delta Dental provides administrative services for dental benefits, including access to the Minnesota Select Dental network

Inquiries

Delta Dental inquiries may be directed to:

Delta Dental of MN
Professional Services Appeal and Grievance

P.O. Box 30416 Lansing, MI 48909

Phone: 1-800-774-9049, TTY: 711

Website: www.deltadentalmn.org

Davis Vision

History

Davis Vision provides administrative services and access to the Davis Vision network, including Vision Works, for Blue Cross Vision products offered on a standalone basis.

Inquiries

Provider Services: 888-773-2847

Prime Therapeutics LLC

Pharmacy Benefits
Manager

Prime Therapeutics, LLC is Blue Cross' pharmacy benefits manager (PBM). The PBM works to maintain the highest standards in therapeutic safety and effectiveness and may offer both name brand and generic equivalents as well as specialty drugs.

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

Formularies

Blue Cross and Blue Plus offers formulary options to meet customer and subscriber needs. Check with your patient which formulary applies to their pharmacy coverage, or call Provider Service.

Workers' Compensation, No-Fault Auto & Subrogation

Overview

Following is a Question and Answer guide to assist you in reimbursement of Workers Compensation, No-Fault Auto and Subrogation claims.

Workers' Compensation, No-Fault Auto & Subrogation

1. **What does Blue Cross need if the workers' compensation carrier, or the automobile carrier/third-party liability carrier denies?**

We need a letter from the other carrier, stating the specific date of service on the claim they are wanting paid and the reason the other carrier is not paying claims.

2. **Why do claims deny when they are not marked work/auto/subro related?**

Once we have identified a workers' compensation or automobile or subrogation claim, an indicator is placed on the patient's file. All claims that are possibly related to the indicated injury are denied.

3. **Why do claims continue to deny when a denial has been sent in?**

The denial must be valid in order for Blue Cross to pay the claims under the health benefits. The denial is not valid unless it specifies why the other insurance carrier is denying and they provide a specific reason behind the denial such as doctor's opinion, IME, etc. If the denial is date specific, only the dates listed on the denial are adjusted.

4. **Why does Blue Cross need a denial from the workers' compensation carrier if the doctor states it is not work related?**

A notification from the workers' compensation carrier is needed if the treatment is similar to the work injury. The workers' compensation carrier must make the final determination.

5. **Why do some claims pay and some deny?**

If the diagnosis is non-specific (like pain in a limb) and we are unable to determine what is being treated the claim may deny. If we have limited information on what the injury is, some claims may pay while others may deny.

Workers'
Compensation, No-
Fault Auto &
Subrogation
(continued)

6. When does Blue Cross need chart notes to adjust claims?

The chart notes should indicate what the patient was treated for. If the chart notes indicate the treatment was not related to the work injury, the motor vehicle accident or the third-party accident, then claims can be adjusted. If chart notes are non-specific or treatment is similar to the accepted injury, a valid denial is needed from the other insurance carrier.

7. If there is an intervention case does Blue Cross pay claims?

Depending on the circumstances surrounding the litigation, Blue Cross may or may not pay claims. If you have case specific questions you should contact the Special Services Unit directly at **1-866-229-7398**.

8. If the subscriber has a pre-paid medical or MNCare group can we bill them?

No. As a provider you need to bill the other insurance carrier. If you do not know who the other insurance carrier is, then you must try to contact the subscriber three times for this information. If you are unable to get a response from the subscriber, then Blue Cross will adjust claims to pay, under the health benefit, once the documentation is received showing the three attempts to contact the subscriber.

9. What are the no-fault laws for Minnesota and surrounding states?

Minnesota and North Dakota have mandatory medical pay laws. This means all drivers insured in Minnesota or North Dakota have medical pay on their auto insurance. Minnesota has a \$20,000 medical pay limit. North Dakota has a \$30,000.00 medical pay limit. South Dakota, Iowa and Wisconsin are optional states which means the subscriber can choose to either have or not to have medical pay on their auto policy.

10. What are some uncommon injuries that may be covered by the workers' compensation carrier?

The workers' compensation carrier may cover injuries that occur when an employee trips or falls at work, is injured in the parking lot, is hurt volunteering or is hurt when traveling for work. If you have specific questions regarding a potential work related injury contact the Special Services Unit.

Workers' Compensation, No-Fault Auto & Subrogation (continued)

11. What are some uncommon injuries that maybe covered by the automobile or third-party insurance?

The automobile or third-party insurance may cover injuries that occur while the individual is at someone else's home, on someone else's private property, at a place of business, due to a dog bite, or when they are a pedestrian or bicyclist injured by a motor vehicle.

12. Does health insurance coordinate with auto/third-party or workers' compensation insurance?

No. In most circumstances the other insurance is primary. Once the other insurance carrier has exhausted their payments, claims may be payable under the health insurance policy.

13. Who should claims be filed to if the patient is working and has an auto accident?

The claims should first be filed to the workers' compensation carrier. If they deny stating the employee was not in the scope of their employment, then the claim should be filed to the auto insurance carrier. If the auto insurance carrier denies or benefits are exhausted, the claim should be billed to Blue Cross with a copy of both the workers' compensation denial and the auto carriers exhaust letter, EOB, or payment log.

14. What should be done if a claim was paid by both Blue Cross and another insurance company?

Option 1: Request a void/replacement claim. Refer to Chapter 10 for information regarding submission of void/replacement claims. Note that effective July 15, 2009, only out-of-state, nonparticipating providers are allowed to submit paper claim forms per Minnesota Statute 62J.536 and the Blue Cross provider contracts.

Information indicating if the patient's condition is related to employment, auto or other accident, or workers' compensation should be indicated on the replacement claim.

For professional claims (HICF-1500 or 837P) complete the items indicated below.

HICF 1500 Form Locator 837P				
Item #	Title	Loop ID	Segment	Notes
10a	Is Patient's Condition Related to: Employment	2300	CLM11	Titled Related Causes Code in the 837P

HICF 1500 Form Locator 837P				
Item #	Title	Loop ID	Segment	Notes
10b	Is Patient's Condition Related to: Auto Accident	2300	CLM11	Titled Related Causes Code in the 837P
10c	Is Patient's Condition Related to: Other Accident	2300	CLM11	Titled Related Causes Code in the 837P
10d	Reserved for local use	2300	K3	This is specific for reporting Workers' Compensation Condition Codes.
14	Date of Current Illness, Injury, Pregnancy	2300	DTP03	Titled in the 837P: a. Onset of current illness or injury date. b. Acute manifestation date. c. Accident date. d. Last menstrual period date.

For institutional claims (UB-04 or 837I) report the appropriate occurrence code. Occurrence codes and dates are entered in Form Locator(s) 31-34, 35-36 on the UB-04 or in Loop 2300 of the 4010A1 837I transaction. The following occurrence codes may be submitted as appropriate.

01:Accident/Medical Coverage

Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.

02: No-Fault Insurance Involved - Including Auto Accident/Other

Code indicating the date of an accident, including auto or other where state has applicable no-fault liability laws (that is, legal basis for settlement without admission or proof of guilt).

Workers'
Compensation, No-
Fault Auto &
Subrogation
(continued)

03: Accident/Tort Liability

Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.

04: Accident/Employment-Related

Code indicating the date of an accident allegedly relating to the patient's employment.

OPTION 2: Contact the Third Party Liability Unit at **1-866-251-6691** and request the claim is adjusted.

15. Should claims that are related to a work/auto/third-party injury be billed to Blue Cross?

Claims that are related to a work/auto/third-party injury should be billed to the liable insurance carrier and not to Blue Cross. If the other insurance carrier denies, then the claim should be billed to Blue Cross with a copy of the other insurance carrier's denial and/or EOB attached.

On occasion the other insurance carrier may not process the claim in a timely manner and due to Blue Cross timely filing guidelines, you may need to bill to Blue Cross prior to getting an EOB or denial from the other carrier. If this occurs, you should submit the claim to Blue Cross and note in the HICF 1500, form locator 10 or the 837P for professional claims (as noted under 14. above) or the appropriate occurrence code for institutional claims. Occurrence codes and dates are entered in Form Locator(s) 31-34, 35-36 on the UB-04 or in Loop 2300 of the 4010A1 837I transaction.

16. How can I reach the Special Services Unit if I have other questions or concerns related to a work/auto/third-party injury?

The Third Party Liability Unit can be reached by direct dial at **1-866-251-6691**, Monday through Thursday 8:00 am - 4:30 pm, Friday 9:00 am - 4:30 pm, CT.

Networks: The following is a summary of the largest networks currently in effect. It is not an all-inclusive list of all networks

Blue Cross (Aware)	An extensive open-access network that includes nearly every physician and hospital in Minnesota. This network is used with major medical plans and open access/preferred provider-type products.
High Value / Blue Plus Minnesota Value	High Value is a statewide network for Large Group and Small Group employers and individuals featuring high quality, low cost providers. In the individual market, the network is referred to as Blue Plus Minnesota Value.
BlueCard® PPO	A national network managed by the Blue Cross and Blue Shield Association. Local Blue plans can sell national account business by leveraging the 50-state Blues provider network.
BlueCard Worldwide®	BlueCard Worldwide® is a medical assistance program connecting subscribers traveling or living outside the United States, Puerto Rico and U.S. Virgin Islands to a network of hospitals and healthcare professionals around the world. Through the BlueCard Worldwide Service Center, the program provides subscribers with claims support, referrals to providers, translation services, and medical monitoring 24 hours a day, 365 days a year.
Blue Distinction Centers®	A national centers of excellence program that enables subscribers to make more informed health care decisions to improve outcomes. Facilities must meet strict clinical criteria to earn the Blue Distinction Centers designation.
	<p>Note: Designation as Blue Distinction Centers means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered, please call Blue Cross.</p>

Chapter 6

Blue Plus

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Subscriber Information

Introduction to Blue Plus®

This chapter was developed for all Blue Plus Providers and their business staff. The information contained in this chapter will give the referral (specialty care) Providers access to Blue Plus information. The Blue Plus Provider Manual for participating primary care clinics (PCCs) details the information necessary for the PCC to conduct business with Blue Plus and is intended as a complement to this manual.

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

Because Blue Plus is an affiliate of Blue Cross and Blue Shield of Minnesota, Blue Plus is subject to most of the same policies and procedures as Blue Cross and Blue Shield of Minnesota.

Blue Plus Network Participation

To be listed as a participating Blue Plus Provider, Providers need to have a signed Blue Plus Referral Health Professional Provider Service Agreement. After participation is established in the Aware® network, Providers can make a written request for a Blue Plus Referral Health Professional Provider Service Agreement. Send this request to:

Blue Cross and Blue Shield of Minnesota
Blue Plus Contracting
P.O. Box 64560
St. Paul, MN 55164-0560

Blue Plus will review the request and make a written response.

Note: Blue Plus will not offer Blue Plus Referral Health Professional Provider Service Agreements to all requesting health care providers.

Department of Health

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

Subscriber Rights and Responsibilities

Blue Plus Subscriber Rights and Responsibilities. Blue Plus Subscribers receive the following statement of rights:

Your rights as a health plan member:

- To be treated with respect, dignity and privacy.
- To receive quality health care that is friendly and timely.
- To have available and accessible medically necessary covered Health 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 Blue Plus' 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.
- To initiate a legal proceeding when experiencing a problem with Blue Plus or its providers.

Subscriber Rights and Responsibilities
(continued)

- 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.

Subscriber Rights and
Responsibilities
(continued)

Minnesota Health Care Programs member Rights and Responsibilities:

You have the right to know about your rights and responsibilities. If you have any questions, please call member services at **(651) 662-5545** or toll free at **1-800-711-9862**.

Your rights as a health plan member:

- To get quality health care that's 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 or not 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.
- 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.
- 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 after exhausting the Blue Plus appeal process. The State Fair Hearing must be requested no later than 120 days from the appeal decision.
- To get a clear explanation of covered nursing home and home care service.

Subscriber Rights and Responsibilities
(continued)

- 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 constraints or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To request a copy of the Certificate of Coverage at least once a year.
- To recommend changes regarding Blue Plus’ rights and responsibilities policies.
- 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 the 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.

Subscriber Rights and Responsibilities
(continued)

- 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 Certificate of Coverage and know which services are covered under the Plan and how to get them.
- To show your Blue Plus member 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.
- 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 customer service at (651) 662-5545, toll free at 1-800-711-9862 (voice), or (651) 662-8700 or 1-888-878-0137 (TTY), or 711, or through the Minnesota Relay Service at 1-877-627-3848 (speech-to-speech relay service).

Subscriber Benefits

Subscribers' benefits depend upon their type of contract. Benefits for Blue Plus' standard fully insured contracts may vary from self-insured contracts. Because Subscribers' benefits will vary, please use BLUELINE, www.availity.com, or contact provider services for specific Subscriber benefits.

- **Highest level of benefits** – Subscribers generally receive the highest level of benefits when they receive their services from their PCC or when the PCC authorizes a referral to a specialist. A list of participating referral providers which is online at www.availity.com is available in the Referral Network for PCCs directory or at bluecrossmn.com.
- **Self-referral** Subscribers may decide to manage their own health care without involving their PCC. Blue Plus considers this a 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 if the Subscriber has a self-referral option.
- **Referral bypass** – There are some Health Services that will be paid at the highest level of the Subscriber's benefits without a referral from the PCC. This is known as a referral bypass or referral exception. For a listing of referral bypasses, please refer to the Referral Not Required section of this chapter.
- **PCC/Care System - 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 Health Service to be paid at the highest level of benefits without the Provider communicating a referral to Blue Plus. For additional information regarding a PCC specific referral bypass, please contact provider services. These requests are handled on an individual basis and must be implemented by Blue Plus and the PCC.
- **Open access** – Some Subscriber Contracts have open access for specified Health Services. The Subscriber usually uses a designated participating network provider and will receive the highest level of benefits without a referral from the PCC. Some examples include vision, chiropractic, obstetrics/gynecology (ob/gyn), or behavioral health care.

Subscriber PCC Selection	<p>Subscribers are responsible for selecting their primary care clinic (PCC). Every member in the family may select their own PCC; they are not required to select the same PCC. Subscribers may also change their designated PCC. To do so they must contact Blue Plus customer service. The phone number is on the back of the Subscriber's ID card.</p> <p>The effective date assigned to all PCC changes will be generally the first day of the month following Blue Plus's receipt of the request. This provision may be waived under certain situations.</p> <p>The effective date of the change will be communicated on the instructions mailed with the-Subscriber's ID card.</p>
Claim Processing	<hr/> <p>When a claim is received for specialty care (not by the PCC), Blue Plus will review ITS records for a referral. If a referral has not been received or does not match an open referral in Blue Plus' records, Blue Plus will process the claim as a self-referral if the Subscriber has a self-referral option. If the Subscriber does not have a self-referral option, Blue Plus may contact the PCC to inquire if a referral is desired. If no referral is authorized, then the claim will be denied or processed at the lower level of benefits.</p>
Statement of Provider Claims Paid Form	<hr/> <p>Providers will be notified of claims processing details as outlined in <i>Chapter 10-Reimbursement/ Reconciliation Programs</i> of this manual for more details regarding the Blue Plus <i>Statement of Provider Claims Paid</i> and reimbursement.</p>

Quality of Care Complaint

A 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 reduced. Some examples of quality of care complaints are listed below. Subscribers may file a complaint if they believe:

- 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 was rude or discourteous
- The Provider is unable to diagnosis or treat their condition

Blue Plus immediately supplies the Provider with a copy of the complaint and involves the Provider in the solution. Blue Plus is required by the Department of Health to complete these complaints in 30 days, therefore; Blue Plus requires the Provider's expedited attention to any request it may have.

Referrals

Overview

When Blue Plus Subscribers are referred by their PCC to other providers, Blue Plus needs to be notified by the PCC in order for claims to process correctly. **A referral is not a guarantee of payment, but allows the Subscriber to seek medical care outside the PCC.** A referral does not negate the necessity of a prior authorization or preadmission notification, if they are required. Referrals are in addition to both of these procedures for managed care products.

Once the referral is received from the PCC, Blue Plus will generate a referral letter depending on the type of referral (see *Referral Letter*).

It is the referred provider's responsibility to communicate medical assessments and proposed treatment plans to the PCC. To best coordinate the Subscriber's care, the PCC must have complete medical information. PCCs may request the information in the format of their choice.

Referral Policy

The referral process occurs when a PCC determines that the Subscriber's condition requires care outside his or her PCC. A referral is initiated by the PCC and is limited to a 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*). A prior authorization may be necessary. See the section on Prior Authorization, Section 6-16. Policies for Government Programs may have different requirements. See Chapter 3 in the Blue Plus Provider Manual.

The goal of the referral process is to ensure continuity of care through coordination with the PCC. When care needs are identified which cannot be appropriately provided by the PCC, care is referred.

The objectives of referrals are:

- To promote coordination of care and communication between Subscribers, PCCs and specialty providers.
- To promote appropriate use of referral care, thereby reducing under-utilization or over-utilization of services.
- To promote seamless, quality of care delivery by facilitating the use of a select, coordinated network of primary care and specialty providers.

Referral Points

Remember these important points about referrals:

- PCCs must have an established referral process.
- PCCs must notify Blue Plus of authorized referrals via the **www.availity.com** product at **www.availity.com**.
- The Subscriber may receive Health Services only from the clinic named in the referral or standing referral.
- The referral provider or specialist may not refer Subscribers to other providers without written consent from the PCC. If no referral is given, Subscribers will be responsible for any reduced benefits. Exceptions are made for Minnesota Health Care Program Subscribers.
- In some cases, Blue Plus will request a second referral if information from the referred provider's claim does not match information received on the initial referral.
- 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 of the PCC change. The Subscriber's new PCC must now coordinate the Subscriber's care.

Referral Required

If the PCC authorizes the care outside the PCC, referrals are required to be communicated to Blue Plus for:

- Home health care/home IV
- Outpatient surgery
- Psychological testing submitted with a medical diagnosis
- Visits to a 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

There are times when a referral is appropriate for behavioral Health Services. If this is the case, Providers may call Provider Services at **1-800-262-0820** or local **(651) 662-5200** to discuss referral needs. This phone number may also be used to see which providers are in the behavioral health network. Minnesota Health Care Program Subscribers have direct access to network providers. In rare instances, out-of-network exceptions may be considered. Call the above numbers for further information.

There also may be exceptions in situations where the Subscriber has open-access benefits for a particular type of Health Services.

For complete information on Government Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

Referral Not Required

Blue Plus does not require referrals for the Health Services listed below. Claims will process at the highest level of coverage, as if they were referred, without the 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 Subscriber Contract or PCC. For complete information about Minnesota Health Care Programs requirements, see Chapter 3 in the Blue Plus Provider Manual.

- Abortion and sterilization
- Allergy serum when injection is done in the PCC
- Ambulance transportation
- Anesthesia and assistant surgeon, if medically necessary (if the outpatient surgery or inpatient admission is referred)
- Covered services by dentists, endodontists, periodontists, orthodontists, prosthodontists, and oral and maxillofacial surgeons.
- Diagnostic X-ray and laboratory services only (except MRI)
- Durable medical equipment (DME)
- Emergency services
- Inpatient consultation (if the inpatient admission is referred)
- Inpatient consultation (if the inpatient admission is referred)
- Inpatient delivery/maternity, and related services, including prenatal and complications of pregnancy
- Inpatient treatment of a medical emergency
- Magnetic Resonance Imaging (MRI)

Referral Not Required
(continued)

- One postpartum 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 emergency room services and associated services
- Outpatient observation room
- Prescription drug (pharmacy)
- 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 may contact Blue Plus to implement a PCC-specific referral bypass for their managed care Subscribers. This is beneficial when a PCC continually refers to a specific provider.

Standing Referral

Minnesota law provides for 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. PCCs 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 in the Subscriber's network
- A degenerative disease or disability
- Any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist

Routine standing referrals are still at the discretion of the PCC. 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 on the Subscriber's medical condition. If the PCC has the specialist within its clinic/care system, the PCC may request that the Subscriber receive services there. PCCs must communicate referrals to Blue Plus prior to referred services being rendered.

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

Clarifications of Terms Clear communication between Blue Plus, the PCC, specialist, and the Subscriber is very important. At times, definitions and understanding of words may differ. To best serve Subscribers, a clear understanding of the meaning of the terms referral, prior authorization, and preadmission notification is necessary. Listed are some clarifications and further explanations that are helpful to fully understand.

Referral:

- A referral is the authorization from the PCC for its Subscriber to seek medical care outside the PCC and receive the highest level of the Subscriber's benefits.
- A referral does not mean the Health Service is approved for admission notification or prior authorization, which is separate from the referral process.
- A referral does not mean the Health Service is eligible under the Subscriber's Contract. Even if the Health Service is referred, it must be eligible under the Subscriber's Contract to be eligible for reimbursement.
- Subscribers may think that a Health Service is referred if the Provider tells them the Health Service is Medically Necessary. Be clear when referring to Health Services.
- A denied referral does not mean that the Health Service is not Medically Necessary. It may simply mean that the PCC may be able to handle the Health Service within its clinic/care system or at a different referral provider with which the PCC has developed a relationship.
- Referrals are not created by Blue Plus. Referrals from one provider to another are established standard practice. Blue Plus simply requests to be communicated with so that claims may be processed correctly. For complete information about Minnesota Health Care Programs, see Chapter 3 of the Blue Plus Provider Manual.
- A verbal referral is not sufficient. If the PCC authorized a referral, it needs to be communicated to Blue Plus (unless a referral bypass is in place).
- Referrals should be authorized to the entity billing for the Health Service (for instance, practice, facility or contracting provider), not the Health Care Practitioner who is performing the service.

Clarifications of Terms
(continued)**Prior Authorization:**

- A prior authorization does not mean that the Health Service is referred. If a prior authorization is required and a provider other than the PCC is performing the Health Service, a referral is also required.
- An approved prior authorization does not mean the Health Service is covered under the Subscriber's plan. Subscribers' benefits may change.

Admission Notification:

- An admission notification does not mean the Health Service is referred. If an admission notification is required and the PCC wishes the Health Service to be referred, a referral must be done in addition to the admission notification. However, when an admission notification is communicated to Blue Plus for an inpatient hospital stay and the admitting physician is part of the Subscriber's PCC, Blue Plus will assume that a referral is authorized.

Referral Letter

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

If the referral is...	Then...
To a specialist (not within the PCC)	a copy is sent to: <ul style="list-style-type: none"> • The referral specialist only if they do not have access to www.availity.com • The Subscriber, and • PCC only if it does not have access to www.availity.com
For an outpatient procedure	a copy is sent to: <ul style="list-style-type: none"> • The Subscriber, and • PCC only if it does not have access to www.availity.com
For an inpatient procedure	no copies are mailed

Referral Letter
(continued)

Please note that if the PCC or the referred specialist has access to **www.availity.com**. Referral letters will not be mailed because they have access to the information electronically.

[Date]

Patient Referral Notice

[Name of patient]

Patient:

[Address of patient]

Identification #:

Member #

Copy to:

Relation to subscriber:

[Name of secondary provider]

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 #:
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TO THE REFERRAL SPECIALIST

You or the primary care clinic must approve any hospitalization, tests or special treatments. Check with the referring physician to determine the participating hospital the clinic uses. Do not place yourself or the patient at financial risk by performing services not eligible for coverage under the patient's health plan, outside the dates specified or for more than the number of visits approved on this referral, or by admitting to a facility not authorized by the referring physician.

Special instructions from the referring physician:

Please use the space below to provide a written report of services to the referring physician at:
[address of referring physician]

Special Benefits

Overview	<p>This section details some of the special benefits for Blue Plus. It will assist in answering questions regarding the benefits. Information in this Provider Policy & Procedure Manual is a general outline. Provider Service Agreements and Subscriber Contracts determine benefits.</p>
Chiropractic Benefits	<p>Most Subscribers have open-access to a Select Network chiropractor. They may receive eligible chiropractic services without a referral from their PCC. To receive the highest level of the Subscriber's benefits, the Subscriber must use a chiropractor in the Select Network.</p>
Continuity of Care After Facility Discharge	<p>Patient care can easily become fragmented and compromised as patients pass from a hospital/facility stay back to the care of their primary care provider. The Joint Commission has two Continuum of Care standards that directly address the follow-up care process of patients that are discharged. The Joint Commission states that the need for appropriate follow-up plans include:</p> <ul style="list-style-type: none"> • Providing continuing care based on the patient's needs • Exchanging of appropriate information when a patient is accepted, referred, transferred, or discharged to receive further care or services <p>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. Re-admissions can be caused by gaps in the follow-up process.</p>
Continuity of Care After Facility Discharge (continued)	<ul style="list-style-type: none"> • Subscriber role: Subscribers must identify a PCC or follow-up provider that will coordinate their care after facility discharge. • Hospital/facility role: Hospitals/facilities are encouraged to develop systems that capture and communicate the PCC, share information 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 follow-up provider. • PCC or follow-up provider role: PCCs or follow-up providers need a process in place to receive and file medical information into a patient's clinic chart in a timely manner.
Durable Medical	<p>Subscribers can use any DME Provider in the applicable Blue</p>

Equipment

Cross and Blue Shield of Minnesota network.

Behavioral Health and
Chemical Dependency
Services

Blue Plus Subscribers may coordinate their evaluation/management (E/M) or medication management services for behavioral Health Services through their PCC or a behavioral health provider in their network. E/M and medication management services performed by another provider will require a referral from the Subscriber's PCC in order to receive the highest level of benefits.

Most Subscriber Contracts do not require referrals for claims to process at the highest level. However, Subscriber Contracts that require the Subscriber to stay in the Select behavioral health network require authorization from Blue Plus to see a provider outside of that network. PCCs do not need to initiate referrals for Subscribers requiring mental health/chemical dependency care.

Open Access to
OB/GYN Health
Services

State legislation provides for many Subscribers to seek specified ob/gyn Health Services without a referral from a PCC. The benefit would be detailed in the Subscriber Contract. When a Subscriber requires those specified ob/gyn Health Services, she may go to her PCC or elect to seek care directly from any ob/gyn provider in her network without being referred by the PCC and receive the highest level of her benefits. This benefit is effective for fully-insured groups. 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.
-

Necessary Health Care beyond OB/GYN Health Services

Direct access does not extend beyond ob/gyn Health Services. If a Subscriber who has directly accessed ob/gyn Health Services requires specialized health care beyond the specified open-access ob/gyn benefits, the Subscriber must be directed back to her PCC or be referred by her PCC in order for the care to be coordinated.

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 Subscriber Contract may not allow for self referral to an oncologist and in most cases, a referral provider may not refer to another referral provider. The open access benefit is only for Health Services provided by ob/gyn providers.

For those Subscribers who have an open access benefit, eligible inpatient and outpatient hospitalization and related ob/gyn Health Services are covered at the Subscriber's highest benefit level. In such cases, the ob/gyn provider must coordinate the ob/gyn Health Services. Blue Plus may not be able to identify these claims during initial processing. Adjustments to claims may be requested by calling Provider Service.

Specified Codes for Open Access OB/GYN Health Services

Claims submitted with the following codes by an-ob/gyn provider do not require a referral if the Subscriber has ob/gyn open-access benefits and the Provider is in the Subscriber's network.

Note: All diagnoses must be reported to the highest specificity.

OB/GYN Open Access Diagnosis

Diagnosis (DX) Code	Description
054.0-054.19 (ICD-9-CM) A60.00- A60.01, A60.04, A60.09, B00.0 (ICD-10-CM)	Herpes simplex
078.81-078.89 (ICD-9-CM) A88.1, A74.89, B33.8, R11.11 (ICD-10-CM)	Other diseases due to viruses and Chlamydiae

Diagnosis (DX) Code	Description
079.4 (ICD-9-CM) B97.7 (ICD-10-CM)	Human papillomavirus
079.81, 079.89 (ICD-9-CM) A74.89, B33.4, B34.3, B34.8, B97.21, (ICD-10-CM)	Other specified viral and chlamydial infections
099.0-099.9 (ICD-9-CM) A63.8, A64, A65, A66.19, A66.2, A66.3, A66.4, A66.8, A67, A68, M02.30, N34.1, (ICD-10-CM)	Syphilis and other venereal disease
112.0-112.9 (ICD-9-CM) B37.0-B37.3, B37.49, B37.5-B37.7, B37.81-B37.82, B37.84, B37.89, B37.9 (ICD-10-CM)	Candidiasis

OB/GYN Open Access
Diagnosis (continued)

Diagnosis (DX) Code	Description
127.4 (ICD-9-CM) B80 (ICD-10-CM)	Enterobiasis
131.00-131.9 (ICD-9-CM) A69.00- A69.03, A69.09, A69.8-A69.9 (ICD-10-CM)	Trichomoniasis
132.2 (ICD-9-CM) B85.3 (ICD-10-CM)	Phthirus pubis
174.0-184.9 (ICD-9-CM) C50.11-C57.9 (ICD-10-CM)	Malignant neoplasm
217-221.9 (ICD-9-CM) D24.9-D28.9 (ICD-10-CM)	Benign neoplasm
233.0-233.9 (ICD-9-CM) D05.90- D09.19 (ICD-10-CM)	Carcinoma in situ of breast and genitourinary system

OB/GYN Open Access
Diagnosis (continued)

Diagnosis (DX) Code	Description
236.0-236.99 (ICD-9-CM) D39.0-D41.9 (ICD-10-CM)	Neoplasm of uncertain behavior of genitourinary system
239.3 (ICD-9-CM) D49.3 (ICD-10-CM)	Neoplasm of unspecified nature of breast
239.5 (ICD-9-CM) D49.5 (ICD-10-CM)	Neoplasm of unspecified nature of other genitourinary organs
256.0-256.9 (ICD-9-CM) E28.0-E28.9 (ICD-10-CM)	Ovarian dysfunction
599.0 (ICD-9-CM) N39.0 (ICD-10-CM)	Urinary tract infection, site not specified
610.0-611.9 (ICD-9-CM) N60.01-N64.9 (ICD-10-CM)	Disorders of breast
614.0-616.9 (ICD-9-CM) N70.01-N73.9 (ICD-10-CM)	Inflammatory disease of female pelvic organs
617.0-627.9 (ICD-9-CM) N80.0-N95.9 (ICD-10-CM)	Other disorders of female genital tract, infertility

OB/GYN Open Access
Diagnosis (continued)

Diagnosis (DX) Code	Description
630-677 (ICD-9-CM) O01.0-O94.9 (ICD-10-CM)	Complications of pregnancy, childbirth and the puerperium
698.1 (ICD-9-CM) L29.3 (ICD-10-CM)	Pruritus of genital organs
752.0-752.9 (ICD-9-CM) Q50.39-Q55.9 (ICD-10-CM)	Congenital anomalies of genital organs
780.01-780.99 (ICD-9-CM) R40.0-R68.89 (ICD-10-CM)	General symptoms
788.0-788.9 (ICD-9-CM) N23, R30.0-R39.9 (ICD-10-CM)	Symptoms involving urinary system
789.1-789.9 (ICD-9-CM) R16.0-R19.8 (ICD-10-CM)	Other symptoms involving abdomen and pelvis
795.00-795.79 (ICD-9-CM) R76.0-R87.619 (ICD-10-CM)	Nonspecific abnormal histological and immunological findings
996.32 (ICD-9-CM) T83.39xA , T83.39xD, T83.39xS (ICD-10-CM)	IUD complications

OB/GYN Open Access
Diagnosis (continued)

Diagnosis (DX) Code	Description
V01.6 (ICD-9-CM) Z20.2 (ICD-10-CM)	Contact with or exposure to venereal diseases
V07.4 (ICD-9-CM) Z79.890 (ICD-10-CM)	Postmenopausal hormone replacement therapy
V10.3 (ICD-9-CM) Z85.3 (ICD-10-CM)	Personal history of malignant neoplasm breast
V10.40- V10.44 (ICD-9-CM) Z85.40-Z85.44 (ICD-10-CM)	Personal history of malignant neoplasm female genital organs
V13.21- V13.29 (ICD-9-CM) Z87.410- Z87.412, Z87.42, Z87.51 (ICD-10-CM)	Personal history of pre-term labor Other genital system and obstetric disorders
V15.7 (ICD-9-CM) Z92.0 (ICD-10-CM)	Other personal history presenting hazards to health-contraception
V16.3 (ICD-9-CM) Z80.3 (ICD-10-CM)	Family history of malignant neoplasms of breast

OB/GYN Open Access
Diagnosis (continued)

Diagnosis (DX) Code	Description
V16.40- V16.49 (ICD- 9-CM) Z80.41-Z80.49 (ICD-10-CM)	Family history of malignant neoplasms of genital organs
V22.0-V28.9 (ICD-9-CM) Z34.00-Z36 (ICD-10-CM)	Normal pregnancy Supervision of high-risk pregnancy Postpartum care and examination Contraceptive management Procreative management Outcome of delivery Antenatal screening
V45.51- V45.52 (ICD- 9-CM) Z97.5(ICD-10- CM)	Presence of intrauterine contraceptive device Intrauterine contraceptive device Presence of subdermal contraceptive implant
V61.5-V61.7 (ICD-9-CM) Z46.0, Z46.1 (ICD-10-CM)	Multiparity Illegitimacy or illegitimate pregnancy Other unwanted pregnancy
V67.00-V67.9 (ICD-9-CM) Z08, Z09 (ICD-10-CM)	Follow-up examination
V70.0-V70.9 (ICD-9-CM) Z00.00-Z00.8 (ICD-10-CM)	General medical examination

Diagnosis (DX) Code	Description
OB/GYN Open Access Diagnosis (continued) V71.5 (ICD-9-CM) Z04.41 (ICD-10-CM)	Observation following alleged rape or seduction
V72.31- V72.42 (ICD-9-CM) Z01.419, Z01.42, Z32.00- Z32.01. Z32.02 (ICD-10-CM)	Gynecological examination Pregnancy examination or test, pregnancy unconfirmed
V74.5 (ICD-9-CM) Z11.3 (ICD-10-CM)	Special screening examination for venereal disease
V76.10- V76.19 (ICD-9-CM) Z12.31, Z12.39 (ICD-10-CM)	Special screening for malignant neoplasms of breast
V76.2 (ICD-9-CM) Z12.4 (ICD-10-CM)	Special screening for malignant neoplasms of cervix

Vision Care

Fully insured Subscribers have direct access to general eye care Health Services rendered by optometrists and ophthalmologists in the participating network. Appropriate ophthalmologist Health Services including eye examinations and Evaluation and Management (E/M) procedure codes as well as CPT codes 65205, 65210, 65220, 65222, and 68761 are eligible. Some self-insured groups also include this benefit. Major surgical procedures and follow-up care will continue to be coordinated through the Subscriber's PCC.

Chapter 7
BlueCard®

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BlueCard Introduction

Overview

The BlueCard Program links health care providers and the independent Blue Cross and Blue Shield plans (Blue plans)* across the country and abroad with a single electronic network for professional, outpatient, inpatient claims processing and reimbursement. The program allows Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Providers in every state to submit claims for Blue Cross Subscribers to their local Blue plan, eliminating the need to track receivables from multiple Blue plans.

Through the BlueCard program, Providers can submit claims directly to Blue Cross for Subscribers who have coverage with a Blue plan other than Blue Cross. Blue Cross will be Providers' contact for medical records submission, claims payment, problem resolution and adjustments.

BlueCard is a national program that enables Blue plan Subscribers to obtain Health Services wherever they are in the United States. The program links participating healthcare providers with all the Blue plans across the nation through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

In addition to Health Services provided to Subscribers enrolled in health benefit plans underwritten or administered by Blue Cross, the Provider Service Agreement applies to Health Services provided to Subscribers enrolled in benefit plans underwritten or administered by other Blue plans approved by the Blue Cross and Blue Shield Association; provided, however, that any Provider that has entered into a separate agreement with another Blue plan operating in a territory adjoining that of Blue Cross shall be entitled to the rights and privileges of that agreement where applicable and provided further, however, that to the extent Health Services are provided by Provider to a Subscriber in Minnesota or in a county of Iowa, North Dakota, South Dakota or Wisconsin, and which county is directly adjacent to Minnesota, the terms and provisions of the Provider Service Agreement shall be applicable to, and control with respect to, such Health Services.

* Each Blue plan is an independent licensee of the Blue Cross and Blue Shield Association.

Identifying BlueCard® Subscribers

BlueCard Subscribers can easily be identified by the three alpha characters preceding their identification (ID) number and the suitcase logos; either empty, or with letters “PPO” inside, on their cards. Although the format of the identification number may vary from Blue plan to Blue plan, Provider can always recognize the trusted Blue Cross and Blue Shield emblems. Providers are encouraged to make a copy of both the front and back of the Subscriber’s ID card. When submitting claims, enter the Subscriber’s ID number exactly as it appears on the card, including the alpha prefix.

Although all Blue plans participate in the BlueCard Program, there are some programs that are exempt such as Medicaid. If the Subscriber is carrying a current Blue Cross ID card and there is no suitcase logo on the card, but there is an alpha prefix, claims should still be filed to Blue Cross as any other claim. Blue Cross will facilitate the processing of that claim on Provider's behalf.

Identifying BlueCard®
Subscribers
(continued)


Important facts concerning-Subscriber IDs:


- A valid Subscriber ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that Provider may see cards with ID numbers between 6 and 14 numbers/letters following the alpha prefix.
- Do not add/delete characters or numbers within the Subscriber ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue plan.
- Subscribers who are part of the Federal Employee Program will have the letter "R" in front of their Subscriber ID number.

Examples of ID numbers:

ABC1234567

 Alpha
Prefix

ABC1234H567

 Alpha
Prefix

ABC12345678901234

 Alpha
Prefix

Providers servicing out-of-area Subscribers, may find the following tips helpful:

- Ask the Subscriber for the most current ID card at every visit. Since new ID cards may be issued to Subscribers throughout the year, this will ensure that the most up to date information is available in the Subscriber's file.
- Verify with the Subscriber that the ID number on the card is not his/her Social Security number. If it is, call the BlueCard eligibility line **1-800-676-BLUE** to verify the ID number.
- Make a copy of the front and back of the Subscriber's ID card and pass this key information on to Provider's billing staff.

NOTE: Subscriber ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the Subscriber ID numbers.

Identifying BlueCard®
Subscribers
(continued)

Alpha Prefix

The three-character alpha prefix at the beginning of the Subscriber's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue plan or national account to which the Subscriber belongs. It is critical for confirming a Subscriber's Blue Plan membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, Provider may experience a delay with the claim processing. Do not make up alpha prefixes.

Do not assume that the Subscriber's ID number is the Social Security number. All Blue plans replaced Social Security numbers on Subscriber ID cards with an alternate, unique identifier.

Identifying BlueCard®
Subscribers
(continued)

Sample Member ID Cards



The “suitcase” logo may appear anywhere on the front of the card.

The three-character alpha prefix.



Definitions

Terms that Provider will hear when dealing with BlueCard Subscribers:

Term	Definition
BlueCard Program	A program that enables Subscribers to obtain Health Services while traveling or living in another licensee's service area and receive the benefits of their Blue Cross Subscriber Contract.

How the Program Works

The BlueCard Program is designed to work as follows:

1. A Subscriber having Blue plan coverage receives services at Provider's office.
2. Provider submits the claim to Blue Cross.
3. Blue Cross will price the claim according to Provider's Provider Service Agreement and send the claim electronically to the Subscriber's Blue plan for benefit determination.
4. The Subscriber's Blue plan applies the Subscriber's benefits and sends the information back to Blue Cross. Blue Cross communicates the outcome of the claim to the Subscriber.
5. Blue Cross will send the *electronic remittance advice* and payment for eligible benefits to Provider.
6. Deductible and coinsurance collection from Subscribers can occur once the claim is adjudicated and Provider receives its *electronic remittance advice (835)* or views its remittance advice on **www.availity.com**.

BlueCard Service

Claims Questions

The site **www.availity.com** should be used to check the status of a BlueCard claim. Enter only the Subscriber's Blue Cross ID number without the alpha prefix and the dates of service.

Claim status is also available by calling provider services. Status is available via a FAX or automated voice response.

Blue Cross encourages Provider to use automated and web-based resources whenever possible. Provider can obtain eligibility, benefits and claim status for Subscribers through its fax-back feature by calling **1-800-262-0820** or **(651) 662-5200**. More detailed information can also be obtained at **www.availity.com**. To register for access to this multi-payer provider portal, please visit the website or call **1-800-AVAILITY**.

Use of these resources for most inquiries ensures that provider services phone staff is available to assist with questions or concerns regarding more complicated benefits, claims and problem resolution.

Please pay special attention to the phone prompts to ensure connection to the correct representative within Blue Cross provider services.

BlueCard claims cannot be viewed on BLUELINE.

Benefits and Eligibility

Providers may contact BlueCard for benefits and eligibility at **1-800-676-BLUE (2583)** for information concerning other Blue plans' Subscribers. If the automated system on the BlueCard eligibility line cannot identify the three digit alpha prefix that is being stated, after the second failed attempt, the caller will automatically be transferred to a BlueCard agent. The BlueCard agent will need one of the following in order to validate:

1. Alpha prefix
2. Plan code
3. Name of Blue plan
4. Employee name
5. State in which the Subscriber's Blue plan is located (can be found on the back of the Subscriber's ID card)

The BlueCard agent will ask for the alpha prefix on the ID card and will then transfer to the subscriber's Blue plan. They will provide the information requested.

Providers may also submit a 270 request via provider web self service for benefits and eligibility information. In addition, Provider can send an electronic request (EDI) via Availity, but must be registered to do so. * Be sure to include:

1. ID number, including alpha prefix
2. Subscriber's full name
3. Date of birth

* Availity registration information: www.availity.com.

BlueCard Preferred Provider Organization (PPO)

The BlueCard PPO program is a national program that offers Subscribers the PPO level of benefits when outside their Blue plan area, allowing them to obtain services from a physician or hospital designated as a PPO provider.

Provider will immediately recognize these PPO Subscribers by the special "PPO in a suitcase" logo on their ID cards.

Blue Cross utilizes the Aware® provider network as its BlueCard PPO network. Subscribers can access information about providers in this network via the toll free number: **1-800-810-BLUE (2583)** or on the BlueCard website, bcbs.com.

Prior Authorization and Admission Notification

Any required prior authorizations and/or admission notifications for Subscribers covered by a Blue plan other than Blue Cross and Blue Shield of Minnesota must go through the Subscriber's home plan. The Provider is expected to contact the Subscriber's Blue plan to request required prior authorizations for these services using the phone number listed on the back of the Subscriber's ID card or by accessing the Medical Policy/Precertification/Prior Authorization Router via Availity or at **providers.bluecrossmn.com**.

The Provider is also responsible for completing required prior authorizations for outpatient services for Subscribers of other Blue plans who receive services outside of their home plan's service area.

The Provider is also responsible for completing admission notifications and prior authorizations for all inpatient admissions and may be liable for charges if notification to the home plan is not completed.

When the length of an inpatient hospital stay extends past the previously approved days, any additional days must also be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials. To avoid delays in the processing of Provider's claims, please assure the necessary approval(s) are obtained in advance of services being rendered.

BlueCard Claims

Claims Submission

Be sure to include the complete alpha prefix and ID number when submitting claims. The alpha prefix should have at least three letters, but may have more, as a portion of the ID number. Provider must submit these claims directly to Blue Cross (see exclusions below). Once Blue Cross processes the claim Provider will receive claims information and any appropriate payment on its *electronic remittance advice (835)*.

Some Subscribers have been issued identification cards with an alpha prefix, but for various reasons the claims cannot process through the BlueCard program. Provider should still submit these claims to Blue Cross, which will forward them to the Subscriber's plan for processing. Blue Cross will notify Provider of this on its weekly *electronic remittance advice (835)*. Even though Provider has been notified that the Subscriber's Blue plan will be processing the Subscriber's claim directly, Provider should still direct all inquiries regarding that claim to Blue Cross. Blue Cross will act as Provider's single point of contact for that claim. See *Claims Processed by the Subscriber's Plan*, later in this chapter.

Submit the claim to Blue Cross when:

- Providing Health Services to a Subscriber from Minnesota, **or**
- Providing Health Services to a Subscriber who has coverage with a Blue plan in another part of the country and Provider is located in Minnesota.

Note: Providers who have Provider Service Agreements with both Blue Cross and another Blue plan should consult with Blue Cross about the handling of non-Minnesota Subscriber claims.

Exclusions

The following are exclusions to the BlueCard program. Please submit these claims as instructed on the ID card:

- Dental services covered under a stand-alone dental contract.
- Drug claims billed by a pharmacy.
- Federal Employee Program (FEP).

Electronic Data Interchange (EDI) Submission

For Electronic Data Interchange submission:

- All BlueCard claims must be sent electronically using the Minnesota Uniform Companion Guide. Refer to Chapter 8, *Claims Filing*, for more information regarding electronic submission of claims.
- Be sure to include the alpha prefix with no spaces between the prefix and the ID number.
- Be sure to send the Subscriber's ID number as it appears on the ID card.
- Be sure to include accurate Subscriber and patient information.
- Be sure to use the correct patient relationship.

Paper Submission

- Effective July 15, 2009, all claims from Minnesota providers must be submitted electronically due to Minnesota Statute - 62J.536. (Provider Quick Points QP7-09). Refer to Chapter 8, *Claims Filing*, for more information regarding claims submission.

Coding

Code claims as the same as for local claims. Refer to Chapter 11, *Coding Policies and Guidelines*, for more coding information.

Medical Records

There are times when the Subscriber's Blue plan will require medical records to review the BlueCard claim. In such cases, Blue Cross will notify Provider. Should Provider receive a request for medical records directly from the Subscriber's Blue plan, forward the requested medical records to Blue Cross. Blue Cross will coordinate with the Subscriber's Blue plan. Always include the Subscriber's Blue plan ID number with the alpha prefix. In accordance with the Provider Service Agreement, Provider shall not bill Blue Cross or the Subscriber for medical records.

Managed Care

It is generally the responsibility of the Subscriber's Blue plan to approve or deny claims. This is also true for managed care reviews. Provider will **not** be responsible, and the Subscriber may be billed as indicated on Provider's remit for the following denials when applicable to a Subscriber with coverage through a Blue plan other than Blue Cross:

- Investigative services
- Care management charges or penalties
- Medical Necessity

Claims Processed by Blue Cross

Claims Notification

Blue Cross will issue claims payment and notification directly to Provider via standard *electronic remittance advice (835)* or by *posting Provider's remittance to www.availity.com*. Statements have been sorted to provide a separate section for BlueCard business for providers billing on the CMS-1500 form or the 837P electronic format. For those providers billing on the CMS-1450 (UB-92) or the 837I electronic format, the claims will not be separated.

Subscribers' *Explanation of Benefits (EOB)* will be issued to them by the Blue plan. Should there be a discrepancy between the Subscriber's EOB and Provider's remittance, please send a copy of both to Blue Cross provider services for review.

Policies

When submitting a BlueCard claim to Blue Cross:

- Providers shall comply with all provisions of the Provider Service Agreement. Subscribers may not be billed as follows, except as otherwise allowed by law:
 - prior to the submission of the claim
 - for any contractual reductions, **or**
 - prior to the finalization of their claims

- Providers will not be responsible for, and Subscriber may be billed, for the following denials by the Subscriber's Blue plan:
 - Investigative services
 - Care management charges or penalties
 - Medical Necessity
 - Non-covered services
 - BlueCard program exempt services (stand-alone dental, drug claims billed by a pharmacy)

Adjustments

Contact Blue Cross if an adjustment is required. Blue Cross does need to work with the Subscriber's Blue plan for adjustments; however, Provider's workflow should not be different. Provider may continue to contact Blue Cross provider services for any questions or status on adjustments for BlueCard claims.

Claims Processed by the Subscriber's Blue Plan

Claims Notification	<p>If the Subscriber's Blue plan is processing the claim because it cannot go through BlueCard processing, Provider will be notified on its weekly <i>electronic remittance advice</i> (835).</p> <p>The claim will be documented and the remark message will read, "<i>This claim has been forwarded to the subscriber's home plan for processing.</i>" Contact Blue Cross for any information regarding this claim, and Blue Cross will contact the Subscriber's Blue plan. Provider may bill the Subscriber for these services.</p>
Policies	<hr/> <p>Since this is not a BlueCard eligible claim, the Blue Cross Provider Service Agreement generally does not apply.</p>
Adjustments	<hr/> <p>Communicate adjustment requests to Blue Cross, which will contact the Subscriber's Blue plan on Provider's behalf.</p>
Appeals	<hr/> <p>Please refer to Chapter 10 for information regarding appeals.</p>

Medical Records

Overview

Medical Records

Blue plans around the country have made improvements to the medical records process to make it more efficient. Blue Cross is now able to send and receive medical records electronically with other Blue plans. This new method significantly reduces the time it takes to transmit supporting documentation for out of area claims, reduces the need to request records multiple times and eliminates lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area subscribers?

1. As part of the pre-authorization process—If Provider receives requests for medical records from other Blue plans *prior to rendering Health Services*, as part of the pre-authorization process, Provider will be instructed to submit the records directly to the Subscriber's Blue plan that requested them. This is the only circumstance where Provider would not submit them to Blue Cross.
2. As part of *claim review and adjudication*—These requests will come from Blue Cross in a form of a letter requesting specific medical records and including instructions for submission.

BlueCard medical record process for claim review

1. An initial communication, generally in the form of a letter, should be received by Provider's office requesting the needed information.
2. A remittance may be received by Provider's office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records Provider submits might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is **not** a duplicate request for medical records. If Provider submitted medical records previously, but received a remittance advice indicating records were still needed, please contact Blue Cross to ensure the original submission was received and processed. This will prevent duplicate records being sent unnecessarily.

Overview (continued)

3. If Provider received only a remittance advice indicating records are needed, but Provider did not receive a medical records request letter, contact Blue Cross to determine if the records are needed from Provider's office.
4. Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful ways Provider can assist in timely processing of medical records

1. If the records are requested following submission of the claim, forward all requested medical records to Blue Cross.
2. Follow the submission instructions given on the request, using the specified address or FAX number. The address or FAX number for medical records may be different than the address used to submit claims.
3. Include the cover letter Provider received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Cross.
4. Please submit the information to Blue Cross as soon as possible to avoid further delay.
5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Coordination of Benefits (COB) Claims

Guidelines

Coordination of benefits (COB) refers to how Blue Cross ensures Subscribers receive full benefits and prevents double payment for Health Services when a subscriber has coverage from two or more sources. The Subscriber's Contract explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Provider agrees to make a good faith effort to secure information on the sources of third party coverage available to each Subscriber and forward such information to Blue Cross or the plan sponsor. Provider agrees to coordinate benefits with other payers in accordance with Blue Cross' or the Plan Sponsor's procedures, and to submit copies of all applicable claims including the applicable payment information received on previous payers remittances to Blue Cross or the Plan Sponsor. Blue Cross or the Plan Sponsor shall use its best efforts to coordinate Health Services due a Subscriber in accordance with the provisions of the Subscriber Contract, and to exercise any subrogation in regard to Health Services provided to Subscriber. Provider shall provide any reasonably requested assistance to this effort. Blue Cross or the Plan Sponsor will administer coordination of benefits consistent with applicable law. When Blue Cross or the Plan Sponsor is the secondary payer, Blue Cross shall make payment according to the terms of the Subscriber Contract, except that payment by Blue Cross shall not exceed the amount that Blue Cross would make if it had Primary Coverage Responsibility. If Medicare is primary, Blue Cross shall coordinate benefits according to the coordination of benefits provisions of the Subscriber Contract.

If Provider discovers the Subscriber is covered by more than one health plan, **and:**

- Blue Cross or any other Blue plan is the primary payer, submit other carrier's name and address with the claim to Blue Cross. If Provider does not include the COB information with the claim, the Subscriber's Blue plan will have to investigate the claim. This investigation could delay Provider's payment or result in a post-payment adjustment, which will increase Provider's volume of bookkeeping.
- Other non-Blue plan is primary and Blue Cross or any other Blue plan is secondary, submit the claim to Blue Cross only after receiving payment from the primary payer, including the explanation of payment

Guidelines
(continued)

from the primary carrier. If Provider does not include the COB information with the claim, the Subscriber's Blue plan will have to investigate the claim. This investigation could delay Provider's payment or result in a post-payment adjustment, which will increase Provider's volume of bookkeeping.

Coordination of Benefits Questionnaire

To streamline Blue Cross' claims processing and reduce the number of denials related to coordination of benefits, a COB questionnaire is now available to Provider at **providers.bluecrossmn.com** that will help Provider and Provider's Subscribers avoid potential claim issues. The COB form is in the "Other Forms" section in the Forms and Publications area.

When Provider provides Health Services to any Blue Plan Subscribers and is aware that Subscriber might have other health insurance coverage (e.g. Medicare), give a copy of the questionnaire to the Subscriber during their visit. Ask the Subscriber to complete the form and send it to the Subscriber's Blue plan as soon as possible. Subscribers will find the address on the back of their member identification card or by calling the customer service numbers listed on the back of the ID card. Collecting COB information from Subscribers before filing a claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

Claim Payment

Guidelines

- If Provider has not received payment for a claim, do not resubmit the claim; it will be denied as a duplicate. This also causes Subscriber confusion because of multiple Explanations of Benefits (EOBs). Blue Cross' standard time for claims processing is 17 days. However, claim processing times at various Blue plans vary.
- If Provider does not receive payment or a response regarding payment, please call Blue Cross provider services at **(651) 662-5200** or **1-800-262-0820** or visit www.availity.com to check the status of the claim.
- In some cases, a Subscriber's Blue plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from Provider, Blue Cross may either ask Providers for the information or give the Subscriber's Blue plan permission to contact Provider directly.

Claim Status Inquiry

Overview

Blue Cross of Minnesota is Provider's single point of contact for all claim inquiries.

Claim status inquiries can be done by:

- Phone—call provider service at **(651) 662-5200** or **1-800-262-0820**.
- Electronically—send a HIPAA transaction 276 (claim status inquiry) to Blue Cross via EDI.

Calls from Subscribers and Others with Claim Questions

Overview

If Subscribers contact Provider, advise them to contact their Blue plan and refer them to their ID card for a customer service number.

The Subscriber's Blue plan should not contact Provider directly regarding claims issues, but if the Subscriber's Blue plan contacts Provider and asks Provider to submit the claim to them, refer them to Blue Cross.

Traditional Medicare-Related Claims

Guidelines

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is primary payer, submit claims to Provider's local Medicare intermediary.
- As of January 1, 2008, all Blue plan claims are set up to automatically crossover to the Subscriber's Blue plan after being adjudicated by the Medicare intermediary.

How do I submit Medicare primary / Blue plan secondary claims?

- For Subscribers with Medicare primary coverage and Blue plan secondary coverage, submit claims to the Provider's Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that the Provider enters the correct Blue plan name as the secondary carrier. This may be different from the local Blue plan. Check the Subscriber's ID card for additional verification.
- Include the alpha prefix as part of the Subscriber identification number. The Subscriber's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership, coverage and key to facilitating prompt payments.

When receiving remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on the Provider's behalf to the appropriate Blue plan and the claim is in process. There is no need to resubmit that claim to Blue.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Blue Cross with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on the claim.
- For claim status inquiries, contact Blue Cross through **www.availity.com**

Guidelines (continued)

When should I expect to receive payment?

Claims submitted to the Medicare intermediary will be crossed over to the Blue plan only after they have been processed. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue plan for processing about the same time Provider receives the Medicare remittance advice. As a result, it may take additional 14-30 business days for Provider to receive payment from the Blue plan.

What should I do in the meantime?

If Provider submitted the claim to the Medicare intermediary/carrier, and hasn't received a response to its initial claim submission, don't automatically submit another claim. Rather, Provider should:

- Review the automated resubmission cycle on its claim system.
- Wait 30 days.
- Check claims status before resubmitting.

Sending another claim, or having a billing agency resubmit claims automatically, slows down the claim payment process and creates confusion for the Subscriber.

Who do I contact if I have questions or to check claim status?

If Provider has questions, please contact Blue Cross through **www.availity.com**.

Medicare Advantage Claims through BlueCard

Overview

“Medicare Advantage” (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (for example, enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which Subscribers typically receive a set of predetermined and prepaid services provided by a network of Health Care Practitioners and hospitals. Generally (except in urgent or emergency care situations), Health Services are only covered when provided by in network providers. The level of benefits and the coverage rules may vary by Medicare Advantage plan.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows Subscribers to determine—at the point of service—whether they want to receive certain designated Health Services within the HMO system, or seek such Health Services outside the HMO's provider network (usually at greater cost to the Subscriber). The Medicare Advantage POS plan may specify which Health Services will be available outside of the HMO's provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows Subscribers who enroll access to Health Services provided outside the contracted network of providers. Required Subscriber cost-sharing may be greater when covered Health Services are obtained out of network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the Subscriber may go to any Medicare approved Health Care Practitioner or hospital that accepts the plan's terms and conditions of participation. Acceptance is “deemed” to occur where the provider is aware, in advance of furnishing services, that the Subscriber is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays Health Care Practitioners and providers on a fee-for-services basis for services rendered to such Subscribers. Subscribers are responsible for cost-sharing, as specified in the plan.

Types of Medicare Advantage Plans (continued)

Medicare Advantage PFFS varies from the other Blue products Provider might currently participate in:

- Provider can see and treat any Medicare Advantage PFFS Subscriber without having a Provider Service Agreement with Blue Cross.
- If Provider does provide Health Services, Provider will do so under the terms and conditions of that Subscriber's Blue plan.
- Please refer to the back of the Subscriber's ID card for information on accessing the plan's terms and conditions. Provider may choose to render Health Services to a MA PFFS Subscriber on an episode of care (claim-by-claim) basis.
- MA PFFS terms and conditions may vary for each Blue plan and Provider is advised to review them before servicing MA PFFS Subscribers.
- Submit MA PFFS claims to Blue Cross.

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible; The other part is a special savings account where Medicare deposits money to help Subscribers pay their medical bills.

Eligibility Verification

- Verify eligibility by contacting **1-800-676-BLUE (2583)** and providing an alpha prefix or by submitting an electronic inquiry to **www.availity.com** and providing the alpha prefix.
- If Provider experiences difficulty obtaining eligibility information, please record the alpha prefix and report it to Blue Cross.

Medicare Advantage
Claims Submission

- Submit all Medicare Advantage claims to Blue Cross.
- Do not bill Medicare directly for any Health Services rendered to a Medicare Advantage Subscriber.
- Payment will be made directly by a Blue.

Reimbursement for
Medicare Advantage
PPO, HMO, POS

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if Provider accepts Medicare assignment and renders Health Services to a Medicare Advantage Subscriber for whom is no obligation to provide services under Provider's Provider Service Agreement with a Blue plan, Provider will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount Provider would collect if the beneficiary were enrolled in traditional Medicare).

MedicareBlue PPO and Group MedicareBlue PPO are regional Medicare Advantage plans with a Medicare contract.

MedicareBlue PPO and Group MedicareBlue PPO coverage is separately issued by one of the following plans:

- Wellmark Blue Cross Blue Shield of Iowa
- Blue Cross Blue Shield of Minnesota
- Blue Cross Blue Shield of Montana
- Blue Cross Blue Shield of Nebraska
- Blue Cross Blue Shield of North Dakota
- Wellmark Blue Cross Blue Shield of South Dakota
- Blue Cross Blue Shield of Wyoming.

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan or its branded member's affiliate. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amount from the Subscriber at the time of service, and may not otherwise charge or balance bill the Subscriber.

Note: Subscriber payment responsibilities can include more than copayments (e.g., deductibles).

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

Reimbursement for
Medicare Advantage
PPO, HMO, POS
(continued)

Services for local and regional Medicare Advantage Subscribers

Situation below is where Provider has a Provider Service Agreement with Blue Cross for MA and provides Health Services to a Blue Cross MA Subscriber.

If Provider accepts Medicare assignment and renders Health Services to a local or regional Medicare Advantage Subscriber for whom Provider has an obligation to provide services under its Provider Service Agreement with a Blue plan, Provider will be considered a contracted Provider and be reimbursed per the Provider Service Agreement.

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amounts from the Subscriber at the time of service, and may not otherwise charge or balance bill the Subscriber.

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual plan contractual arrangements.

Services for out-of-area Medicare Advantage Subscribers

Situation below is where Provider has a Provider Service Agreement with Blue Cross for local and regional MA and provides Health Services for out-of-area MA Subscribers.

If Provider accepts Medicare assignment, has a Blue plan Provider Service Agreement to provide Health Services for local and regional Medicare Advantage Subscribers only, and renders Health Services to out-of-area Medicare Advantage Subscribers, Provider will be reimbursed at the Medicare allowed amount (i.e., the amount Provider would collect if the Subscriber were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual plan contractual arrangements.

Reimbursement for Medicare Advantage PPO, HMO, POS (continued)

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amounts from the Subscriber at the time of service and may not otherwise charge or balance bill the Subscriber.

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

Reimbursement for Medicare Advantage Private-Fee-for-Service (PFFS)

Health Services for out-of-area Medicare Advantage PFFS Subscribers

Situation below is where Provider renders Health Services for out-of-area MA PFFS-Subscribers.

If Provider has rendered Health Services for an out-of-area Medicare Advantage PFFS Subscriber but is not obligated to provide services to such Subscriber under a provider service agreement with a Blue plan, Provider will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount Provider would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amounts from the Subscriber at the time of service and may not otherwise charge or balance bill the Subscriber.

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

Chapter 8

Claims Filing

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Administrative Simplification

Introduction

Minnesota Statute 62J.536 requires health care providers and group purchasers (payers, health plans) to exchange eligibility requests, claims and remittances electronically using standard formats. The intent of the law is to reduce costs, simplify and speed up health care transactions, and to give providers and health plans one set of rules to follow for electronic transactions. This statute applies to all health care providers in Minnesota, regardless of participating status.

Web-based Claim Submission, Eligibility and Remittance Tool

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) offers a no-cost, web-based tool through Availity to comply with Minnesota Statute 62J.536. Availity, an independent company, also provides no-cost solutions to obtain eligibility and benefits as well as allows Provider to view its remittance information. Availity, an independent company, is a one stop shop that optimizes information exchange between multiple health care stakeholders through a single secure network. Provider may also take advantage of a range of optional, value-added services for a nominal cost. For more information contact Availity at **availity.com** to register for its no-cost web-based tools.

Pharmacy and Dental Claims

The requirement to submit all claims electronically includes dental and pharmacy formatted claim types.

Dental Providers should submit 837D transactions through Availity. For more information regarding electronic claim submission and to register, contact Availity at www.availity.com.

Medical Pharmacy and MTM: The requirement to submit all claims electronically will include pharmacy formatted claims.

Pre-system Edits

Blue Cross has aligned its pre-system edits with the rules published in the Uniform Claims Companion Guides found on the Administrative Uniformity Committee (AUC) website at health.state.mn.us/auc.

Claims with Attachments

Blue Cross accepts claims with attachments electronically. The claim must adhere to the electronic rules found in the Uniform Companion Guides and include the appropriate populated data as indicated in section 4.2.3.4 of the guides. The related attachment may be faxed to Blue Cross at **1-800-793-6928** or mailed to:

Blue Cross and Blue Shield of Minnesota
P.O. Box 64338
St. Paul, MN 55164-0338

The attachment cover sheet found on the AUC website must be used as the first page on each claim attachment. Instructions for completing the attachment cover sheet are also available on the AUC website.

Blue Cross has compiled a list of questions and answers in response to providers' inquiries regarding sending attachments on electronic claim transactions.

Questions and Answers

1. My clinic has a policy of covering all documentation with an internal cover sheet to protect PHI. Should I be covering the attachments I am sending with this cover sheet?

No. Per the AUC Guidelines the only acceptable cover sheet for attachments is the AUC Uniform COVER SHEET For Health Care Claim Attachments. This form can be modified to include a PHI message on the bottom of the page if the provider desires, but is the ONLY acceptable cover sheet when sending attachments.

Claims with
Attachments
(continued)

2. Can I send appeals, adjustment requests, status checks and general correspondence using the AUC Uniform COVER SHEET For Health Care Claim Attachments?

No. The AUC Uniform COVER SHEET For Health Care Claim Attachments is ONLY for use when submitting attachments for first time claims that have been sent electronically. It is not to be used for appeals, adjustment requests, status checks or general correspondence. There are separate forms and fax numbers for these types of correspondence. Please use the appropriate cover sheet for each type of correspondence. Below is a list of the forms and fax numbers for each type of correspondence:

- AUC Uniform COVER SHEET For Health Care Claim Attachments: **1-800-793-6928** (use for attachment to original claims only)
- AUC Appeal Request Form: **(651) 662-2745** (use to submit claim appeals)
- Blue Cross and Blue Shield of Minnesota Provider Claim Adjustment/Status Check Form: **(651) 662-2745** (used by non-Minnesota providers to submit adjustment requests or to request a status check. Minnesota providers may contact Provider Service)
- For further reference on the submission of attachments, please visit the AUC website: health.state.mn.us/auc

3. Can I change or remove the AUC Logo on the AUC Uniform COVER SHEET For Health Care Claim Attachments?

No. Blue Cross' automated intake process looks for the AUC Logo when preparing to scan the attachment. If the LOGO is missing or has been changed, the automated process cannot take place. This causes delays in the imaging of the document and ultimately can lead to delays in the processing and payment of the claim. This is another reason why providers must not use an internal cover sheet. Providers must also fax attachments head-up or top of the page first as the recognition software only scans the top third of the page for the LOGO.

Claims with
Attachments
(continued)

4. If I have the Other Insurance Carrier payment information in the 837 electronic claim transaction, do I also have to send the EOB in an attachment or notify Blue Cross that it is in my office?

No. Per the AUC Guidelines, submit the Other Insurance Carrier payment information within the 837. HIPAA regulations forbid populating the claim record with Other Insurance Carrier information and sending the same information in an attachment. They further forbid sending data in an attachment that can be codified within the claim record.

5. Can I send the attachment before I send the 837 claim transaction?

Yes, provided the provider completes the PWK segment on the 837 with the appropriate information from the AUC Uniform COVER SHEET For Health Care Claim Attachments. The PWK segment must include the Report Type code, Report Transmission Code and the Transaction Control Number (the Attachment Control Number on the AUC Uniform COVER SHEET For Health Care Claim Attachments). Failure to include this information on the 837 will cause delays in processing and payment and may result in a denial of the claim.

Claims with
Coordination of
Benefits

Blue Cross accepts electronic claims with previous payer payment information populated per the requirements in the Minnesota Uniform Companion Guides. For proper adjudication claims must contain all previous payer group codes, ANSI Claim Adjustment Reason Codes and Remittance Advice Remark Codes as they were received from the previous payer. These claims do not require an attachment when populated within the claim record. Refer to the Minnesota Uniform Companion Guides, section 4.2.3.5 for more information.

Provider agrees to make a good faith effort to secure information on the sources of third party coverage available to each Subscriber and forward such information to Blue Cross or the Plan Sponsor. Provider agrees to coordinate benefits with other payers in accordance with Blue Cross' or the Plan Sponsor's procedures, and to submit copies of all applicable claims including the applicable payment information received on previous payers remittances to Blue Cross or the Plan Sponsor. Blue Cross or the Plan Sponsor shall use its best efforts to coordinate Health Services due a Subscriber in accordance with the provisions of the Subscriber Contract, and to exercise any subrogation in regard to Health Services provided to Subscriber. Provider shall provide any reasonably requested assistance to this effort. Blue Cross or the Plan Sponsor will administer coordination of benefits consistent

with applicable law. When Blue Cross or the Plan Sponsor is the secondary payer, Blue Cross shall make payment according to the terms of the Subscriber Contract, except that payment by Blue Cross shall not exceed the amount that Blue Cross would make if it had Primary Coverage Responsibility. If Medicare is primary, Blue Cross shall coordinate benefits according to the coordination of benefits provisions of the Subscriber Contract.

Blue Cross has compiled a list of questions and answers in response to providers' inquiries regarding the electronic submission of Coordination of Benefits information.

Questions and Answers

- 1. I understand that there is information on the HIPAA 835 transaction that I have to include on the electronic 837 COB transaction. Can you tell me what I have to include so I can make sure I get paid accurately?**

It is important to use the Minnesota Uniform Companion Guides along with the HIPAA Implementation Guides to ensure the correct segments and elements are completed. The 2320, 2330A, 2330B, and the 2430 loops carry a good portion of the COB information a payer needs to process a secondary claim.

The HIPAA 835 transaction provides most of the necessary information to complete the appropriate segments and elements.

The HIPAA 835 transaction from the prior payer(s) should provide the CAS segments (loops 2100 and/or 2110), CLP segment (loop 2100), and the SVC segment (loop 2110), which are used to complete the 837 COB transaction.

- 2. I understand the CAS segment is important for the correct processing of my COB 837 transaction. Where do I get the CAS segment information from?**

Again, the CAS segment information on the 837 COB transactions should come directly from the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits. This information must never be altered or combined in any manner.

- 3. Do I need to do any combining of Claim Adjustment Reason Codes or change them to specific codes a Supplemental Insurer might want?**

No, when completing the COB information on the 837 use the information as it was provided on the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits. Never change or alter any of the prior payer(s) payment information including the Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes, and Remittance Advice Remark Codes. Changing codes is a violation of HIPAA and could result in payment errors or processing delays. Per the HIPAA Implementation Guide, "Codes and associated amounts should come from 835s (Remittance Advice) received on the claim." Payers utilize the codes to adjudicate based on the information sent.

Claims with
Coordination of
Benefits (continued)**4. I know there are Medicare primary claims that should have crossed over and Medicare has had some problems lately with not being able to cross claims over to supplemental payers. Should I send all my Medicare Primary COB claims just in case?**

No, “automatic” rebilling often results in duplicate claims, increases administrative costs, and delays processing. Please refer to *Medicare Primary COB Claim* section later in this chapter.

If the claim is not showing as crossed over on provider web self-service after 30 days from the date the provider received its Medicare payment, then the provider may submit the claim electronically populating the claim record with the COB information exactly as it was received on the Medicare ERA.

5. I have situations where my Medicare primary claims have been adjusted and Medicare is now paying on claims they have denied. How do I send these COB claims to my supplemental insurer?

These claims are COB adjustments to the original claim and should crossover to Blue Cross directly from Medicare. Again, please refer to *Medicare Primary COB Claim* section later in this chapter.

If the adjustment did not crossover as it should have within 30 days after the provider received the updated Medicare ERA, submit an adjustment/replacement claim.

6. I have a claim where Medicare paid first. They have now decided to pay one of the services on my three line claim. Should I just send in the COB claim for that one line for Blue Cross to pay the coinsurance and deductible?

No, never send a partial claim. This would be a violation of the rules in the Minnesota Uniform Companion Guides. Again, this could result in duplicate claims, increased administrative costs, and processing delays. If the prior payer has made a change to the original or prior claim processing outcome, the original or prior claim must be adjusted to ensure the secondary payment is correct. A “partial” claim should never be sent regardless of whether it is an original or adjustment. As noted in response to question #3 above, if the prior payer has adjudicated a claim with three services lines, all three service lines should be sent to the secondary payer. Never alter the charges and critical claim information when sending it to a secondary/tertiary payer for payment consideration.

Claims with
Coordination of
Benefits (continued)

7. I have talked with other providers and they tell me that a COB claim must balance. What must balance?

The claim paid amounts must be equal to or greater than the line level paid amounts. The CAS segments must always reflect exactly what the prior payer has indicated on HIPAA 835 transaction or Remittance Advice/Explanation of Benefits. Do not add or combine the CAS information. Typically, the professional claim allowed and paid amounts should not be greater than the billed amounts. More information regarding balancing is available in the HIPAA Implementation Guides available for purchase from Washington Publishing (wpc-edi.com).

8. When the prior payer is Medicare how do I list them as the primary payer? Do I list them by the Medicare Office, CMS, Federal Medicare, the name of the Medicare contractor, etc?

When Medicare is the prior payer, Blue Cross suggests listing the prior payer as “Medicare.”

9. I am sending COB in the 837 transaction and also sending the EOB as an attachment with the report type code EB and report transmission code AA. This is to make sure that you get the COB information.

In these situations, the Report of Transmission (PWK02) is AA indicating the EOB is available upon request at the provider office. The HIPAA 837 Implementation Guides, Report of Transmission (PWK Segment), states “The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope.” Therefore sending the information within the transaction and also sending the PWK would be non-compliant and result in a rejection.

Medicare/Uniform
Companion Guide
Coding Alignment

Blue Cross has made several system modifications to accept claims coded using the rules indicated by either Medicare or the Minnesota Uniform Companion Guides, Appendix A. Provider must code its claims to meet the specifications set forth in the Minnesota Uniform Companion Guides. Although claims must be standardly submitted, charges may not be covered due to Subscriber benefits or Blue Cross payment policy.

Questions

Questions regarding the content of the PA02 electronic reports or Availity payer reports should be directed to provider services at **(651) 662-5200** or **1-800-262-0820**. Questions regarding the payer electronic reports not being received should be directed to Provider's clearinghouse. If Provider's clearinghouse is Availity, please refer to their website at availity.com.

For questions regarding the attachment requirements, attachment cover sheet and related instructions, Coordination of Benefits or coding requirements, refer to the AUC website at health.state.mn.us/auc.

1500 HICF Form

Professional Claim Submission	<p>The paper 1500 Health Insurance Claim Form (HICF) (also referred to as the CMS 1500) is accepted only from out-of-state nonparticipating providers per Minnesota Statute 62J.536 and the Provider Service Agreement.</p> <p>The electronic transaction 837P is the only accepted claim submission format for professional claims.</p>
1500 HICF Manual	<hr/> <p>The National Uniform Claim Committee (NUCC) has a reference instruction manual detailing how to complete the 1500 HICF form. The purpose of this manual is to help standardize nationally the manner in which the form is being completed. A copy of the instruction manual is available on the NUCC website - nucc.org/.</p>
About the NUCC	<hr/> <p>The National Uniform Claim Committee is a voluntary organization whose members include representatives from major provider, payer, health researchers, and other organizations representing billing professionals, and electronic standard developers.</p> <p>The NUCC maintains the uniform data set known as the National Uniform Claim Committee Data Set designed for the non-institutional claims. The NUCC is also a signatory to a Memorandum of Understanding with five other organizations designated by the U.S. Department of Health and Human Services to collectively serve as the Designated Standard Maintenance Organizations (DSMO) to the HIPAA Transaction Standard Implementation Guides.</p>

UB-04 (CMS 1450) Form

Institutional Claim Submission

The paper UB-04 (also referred to as the CMS-1450) is accepted only from out-of-state nonparticipating providers per Minnesota Statute 62J.536 and the Provider Service Agreement.

The electronic transaction 837I is the only accepted claim submission format for institutional claims.

Provider and Blue Cross agree to abide by the provisions of the Aware Provider Service Agreement to the extent applicable when the Provider bills Blue Cross for Health Services provided by a Health Care Professional. Provider further agrees that such Aware Provider Service Agreement will apply whenever Providers are required by Blue Cross to bill for their Health Services separately. The preceding sentence shall not apply to Health Services provided by hospital-based physicians who bill Blue Cross separately for such Health Services. Payment for professional Health Services shall be made according to the then-current applicable fee schedule as set forth in the Aware Provider Service Agreement based on Provider's primary specialty code assigned by Blue Cross. Effective July 1 of each year, Blue Cross implements the most current Relative Value Units (RVUs) as published in the Federal Register and as implemented by Blue Cross. Payment for Health Services not assigned RVUs shall be calculated at the then current applicable fee schedule as set forth in the Aware Provider Service Agreement. Participating Providers may request a list of applicable rate allowances by submitting an e-mail request to Fee.Schedule.Allowance.Request@bluecrossmn.com up to twice annually. Your request must include the participating provider's NPI(s) and Blue Cross Internal Reference Number(s).

UB-04 Manual

The National Uniform Billing Committee (NUBC) publishes a manual containing the claim data specifications that are submitted on the 837I or UB-04 claim format and guidelines on completion of the UB-04 form.

About the NUBC

Established in 1975, the NUBC is the official data content body responsible for maintaining the data set for institutional health care providers. Representation includes provider, payer, electronic standards development organizations, public health data standards organizations, and others. The NUBC is also one of six Designated Standard Maintenance Organizations (DSMO) responsible for the maintenance and development of HIPAA administrative simplification transaction standards.

Note: Also see

http://www.nubc.org/INFORMATION_ON_UB-04.pdf

Ordering Forms and Manuals

HCPCS, CPT, ICD 9 CM, ICD-10-CM and ICD-10-PCS Manuals	HCPCS, CPT, ICD-9-CM, ICD-10-CM and ICD-10-PCS manuals can be purchased from major bookstores or publishers, such as the American Medical Association.
HIPAA Implementation Guides	<p>To order national Electronic Data Interchange Transaction Set Implementation guides on paper or electronic versions, contact Washington Publishing Company.</p> <p>1-800-972-4334</p> <p>Or visit their website at:</p> <p>www.wpc-edi.com</p>
Minnesota Uniform Companion Guides	<p>Minnesota Uniform Companion Guides containing instructions for electronic transactions are available free of charge on the AUC website under “Guides” at:</p> <p>health.state.mn.us/auc/</p>
1500 HICF (CMS-1500) UB-04 (CMS-1450) Forms	<p>To order 1500 HICF and UB-04 forms contact:</p> <p>U.S. Government Printing Office (202) 512-0455 or visit the website at: cms.hhs.gov/CMSForms/</p> <p>Provider may also contact form vendors or publishers, such as the American Medical Association or the American Hospital Association.</p>
UB-04 Manual	<p>To order the UB-04 Manual contact:</p> <p>National Uniform Billing Committee (NUBC) at nubc.org/become.html for more information and an order form, or call the American Hospital Association at (312) 422-3390 for questions.</p>
1500 HICF Manual	<p>The National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual is available at nucc.org/</p>

Professional/837P Billing

Zero Billed Charges

Blue Cross will allow zero-billing or no charge submission lines on claims.

Linking and Sequencing

It is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item. Adjudication is based on the first linked diagnosis.

Linking/sequencing rules:

- Sequence numbers relate to the ICD-9-CM and ICD-10-CM diagnosis codes as 1, 2, 3 and 4.
- The primary diagnosis is listed first in the sequence if more than one diagnosis is related.

Place of Service Codes

Only nationally assigned place of service codes are accepted. These codes are available at the following web address:

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Site of Service

Blue Cross is specifying, for clarity, the difference between a facility and a non-facility with respect to the place of service where a Health Service was rendered. For billing purposes, professional (837P) billers should use an appropriate place of service code to indicate where Health Services were rendered. Examples of facilities include hospitals and ambulatory surgery centers. Examples of non-facilities include a provider's office and all places not listed below.

The following is a current comprehensive list of facilities, as defined by Blue Cross:

Place of Service Code	Place of Service Name
19	Off-campus outpatient hospital
21	Inpatient hospital
22	On-campus outpatient hospital
23	Emergency room hospital
24	Ambulatory surgical center
26	Military treatment facility
31	Skilled nursing facility
34	Hospice

Site of Service
(continued)

Place of Service Code	Place of Service Name
41	Ambulance - Land
42	Ambulance - Air & Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility - Partial
53	Community Mental Health Center
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
60	Mass Immunization Center
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
99	Other Place of Service

Community Mental Health Center

Place of service 53 is defined as a Community Mental Health Center, which per the Centers for Medicare & Medicaid Services (CMS) is “a facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.”

It is expected that when a professional claim is submitted with place of service 53, that a facility claim will also be submitted for the same services. If a facility claim will not be submitted in addition to the professional claim, a non-facility place of service (for example, Office - place of service 11) would be expected on the professional claim.

Freestanding Ambulatory Surgery Center Billing

In order to streamline its administrative processes and comply with regulatory requirements, Blue Cross contracts with Freestanding Ambulatory Surgery Centers as professional submitters and requires the following guidelines and provisions:

- **Use of Professional Claims Submission Formats** — Freestanding Ambulatory Surgery Center providers submit claims utilizing a HIPAA 837P claims transaction, in compliance with Minnesota Statute 62J.52. Use national place of service code 24.
- **Adjudication of Services at the Claim Line Level** – Payment is calculated at the lesser of the percent of Provider’s Regular Billed Charges as detailed in the Provider Service Agreement or the Blue Cross fee schedule allowance, implemented at a claim line/service level.

Freestanding
Ambulatory Surgery
Center Billing
(continued)

- **Payment of Individual Procedures** – EAPG methodology determines which Health Services are included/excluded from separate reimbursement, including implants/devices and tissue. Professional services, including anesthesia, should not be billed under this agreement. Individual provider NPI numbers are not required.
- **Corneal tissue** – Claims that contain corneal tissue charges must be submitted with an attachment containing a copy of the invoice for that corneal tissue.
- **99199** – The code 99199 (unlisted special service, procedure or report) will not be considered for separate reimbursement when submitted by an ASC. 99199 will be denied as provider liability. No additional reimbursement will be considered on appeal.
- **EAPG Ancillary Packaging** – Means lower level ancillary services are packaged and not considered for additional reimbursement.
- **EAPG Base Rate** – Means the dollar rate per Relative Weight of One (1.0).
- **EAPG Multiple Services Discounting** – Means a reduction in payment rate for multiple significant procedures, tests or therapies performed on the same day, repeat ancillary EAPGs, bilateral procedures and terminated procedures.

K3 Segment Usage
Instructions for
Condition Codes

Condition Code

The NUBC has added condition codes to their code set to identify situations where Workers' Compensation requires duplicate or appeal submissions. The 837P format does not include a standardized way of reporting condition codes. To report applicable condition codes on a professional claim, the K3 segment should be used.

BG is the qualifier to indicate this value and should be followed by the appropriate condition code (refer to the NUBC Guide and Code Set available from the National Uniform Billing Committee at nubc.org).

Report at 2300 loop only.

Institution (837I)/Facility Billing

Claim Format Regulations

HIPAA Administrative Simplification code and transaction regulations dictate the standard claim format and codes for electronically submitted claims. Institutional claims are billed on the 837I electronic format. The paper equivalent is the UB-04 claim form.

Blue Cross considers the following providers as institutional and as such, should bill on the institutional claim format (837I).

Category	Definition
Home health agency	HHA is a public agency or private organization that is primarily engaged in providing skilled nursing services and other therapeutic Health Services, such as physical therapy, occupational therapy, medical social services and home health aide services. Home health agencies can be freestanding or hospital attached. Care is rendered in the home and is in lieu of hospital confinement.
Hospice	Hospice programs provide health care for terminally ill patients. Care may be done in the patient's home, at special hospice units, or a separate hospice care facility.
Hospital	An institution that provides medical, diagnostic and surgical care. Health Services can be rendered on an inpatient or outpatient basis.
Non-residential treatment center	This type of institution is the same as a residential primary treatment center with the exception that Health Services are rendered on an outpatient basis only.
Nursing home	A Skilled Nursing Facility provides skilled nursing care and related Health Services for patients who require medical or nursing care; or rehabilitation services for injured, disabled or sick people.

Claim Format
Regulations
(continued)

Category	Definition
Psychiatric hospital	A psychiatric hospital provides care to emotionally ill patients. These facilities must be licensed by the state in which they are located.
Residential primary treatment center (IP chem dep)	Residential treatment programs for chemical dependency are planned and purposeful sets of conditions and events for the care of inebriated and drug dependent persons which provides care and treatment for five or more inebriate or drug dependent persons on a 24-hour basis. Excluded for this definition are receiving (detoxification) centers.

Procedure Code
Regulations

The medical procedure code set for inpatient services is ICD-9-CM or ICD-10-PCS procedure codes. Procedure information will be reported on outpatient claims using HCPCS codes.

Revenue Codes (FL 42)

A revenue code identifies a specific accommodation and/or ancillary service or billing calculation. A revenue code is four characters. The first digit is usually a 0 (zero); however, there are codes that begin with numbers other than 0 (100X, 210X, 310X). It is important to report all four digits.

HCPCS/
Accommodation
Rates/HIPPS Rate
Codes (FL 44)

For inpatient bills, the accommodation rate relating to the room and board revenue code is entered.

For outpatient bills, report the HCPCS code, if applicable, to indicate the specific outpatient service. Some HCPCS codes or billing situations may require submission of modifiers. Modifiers are reported following the HCPCS code. Blue Cross accepts all valid modifiers. Although Blue Cross currently does not automatically adjudicate the claim/service based on modifiers, it is still important to submit all modifiers, if applicable.

Duplicate Billing

Blue Cross will only reimburse the professional or clinic Health Services when a Subscriber is seen in a clinic setting (POS 11). Facilities that have clinics physically located onsite or next to a hospital frequently bill an additional claim either electronically or on an 837I with a place of service 22 for the same Health Service that the physician is billing. In some cases, facilities submit revenue code 0361. Blue Cross considers this practice duplicate billing. Facility overhead is included in the professional reimbursement weighting and conversion factor; therefore, complete and final reimbursement will be made on the professional claim only.

Observation Room

Observation Care, billed under revenue code 0762, normally does not extend beyond 24 hours. However, claims for observation services over 24 hours will be allowed up to 48 hours. Excess services/observation time over 48 hours will be denied, with the exception of services for our Public Program members. Observation services/time between 49-72 hours will be reviewed for our Public Program members. All observation services over 72 hours will be denied.

Transfer Case

A transfer case is defined as a patient who is being discharged from one facility to another.

Patient status codes are a required field on the institutional claim (837I). This code indicates the patient’s status as of the “Through” date of the billing period. It is important to note that the patient status code indicates a destination and not a level or type of care received.

When a patient is transferred/discharged to another facility, patient status may affect reimbursement. All patient status codes are accepted but not all will result in a transfer case classification. The following patient status codes are used by Blue Cross to classify a transfer case.

Code	Definition
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
05	Discharged/Transferred to a Designated Cancer Center or Children’s Hospital Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at www3.cancer.gov/cancercenters/centerslist.html
43	Discharged/Transferred to a Federal Health Care Facility
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
70	Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List

Single facility claim submission

Blue Cross generally will **not** accept additional facility claims for the same encounter, normally referred to as late charges. To assure correct adjudication and payment of Health Services, Blue Cross requires all related services to be submitted on the same single facility claim (837I).

- **Late charges** – A late charge refers to those claims that Provider is submitting after an admit-through-discharge claim or for the same encounter. A late charge contains charges omitted from the original bill and the charges are submitted as an add-on to the original bill. A late charge bill is not allowed according to the Minnesota Uniform Companion Guide for Institutional Claims. It is also not allowed for paper claim submission.
- **Encounter** – Encounter means an instance of direct provider/practitioner to patient interaction, in an outpatient facility setting, for the purpose of diagnosing, evaluating or treating the Subscriber’s condition, and during which Health Services are rendered to the Subscriber.
- **Exceptions** – Exceptions that may justify separate claims may include:
 - **Separate ER visits** – separate emergency room visits on the same date of service
 - **Ambulance services**
 - **Late charges – unrelated diagnosis:** Outpatient charges with same date of service submitted as separate claims with unrelated diagnosis will no longer be denied as late charges. The duplicate review process has been updated with the following examples of exceptions to late charge (replacement claim) processing. Use these as a guide to determine if the claim situation meets the criteria as ‘unrelated.’
 1. Subscriber has a mammogram, subsequently, in another department, the Subscriber received chemotherapy (for other than breast cancer).
 2. Subscriber receives therapy, subsequently, in another department, the Subscriber has an electrocardiogram.
 3. Subscriber is seen for a radiation therapy, subsequently, in another department, the Subscriber is seen for routine screening.
 4. Subscriber receives therapy and subsequently visits the ER for a unrelated condition (for example, injury or acute illness unrelated to the therapy received)

Zero Billed Charges	Blue Cross will allow zero-billing or no charge submission lines on claims.
Lactation Education	<p>For billing purposes, lactation services are considered to be part of the mother's charges and should not be billed on the newborn's claim.</p> <p>Submit all claims for lactation education on the 837I claim form using revenue code 0942. These charges must be submitted on the mother's original maternity/delivery claim and require a narrative description.</p> <p>Claims for lactation services submitted under the infant's name or number will be rejected.</p> <p>If lactation education is necessary after discharge, it can be billed as part of the post-partum visit under the mother's identification number.</p>
0636 Drugs Requiring Prior Auth	<p>Revenue code 0636, by definition, is for drugs requiring detailed coding. A HCPCS code must always be submitted with 0636. However, some drugs that may be submitted under this revenue code also require prior authorization. The following are examples that require prior authorization:</p> <ul style="list-style-type: none"> • IVIG • Aminolevulinic Acid • Factor products
Present on Admission (POA)	<p>Blue Cross requires the present on admission (POA) indicator on all claims (Medicare and commercial, including the MedicareBlueSM PPO [Regional PPO] claims, Platinum BlueSM [Cost], SecureBlueSM [HMO SNP], and Blue Advantage) for inpatient admissions to general acute care hospitals.</p> <p>General Reporting Requirements</p> <ul style="list-style-type: none"> • The POA indicator is required for all claims involving Medicare and commercial inpatient admissions to general acute care hospitals. • The POA indicator is assigned to principal and secondary diagnoses.

Present on Admission
(POA) (continued)

- Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter while in the emergency room, under observation or during outpatient surgery are also considered as present on admission.
- If the condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current coding guidelines, then the POA would not be reported.
- The POA indicator is not required for the external cause of injury code unless it is being reported as an “other diagnosis.”
- Critical Access Hospitals, Maryland waiver hospitals, long-term care hospitals (LTCH), cancer hospitals and children’s inpatient facilities are exempt from this requirement.

Form Completion Instructions

For electronic claims using the 837I, refer to the Minnesota Uniform Companion Guide for the Institutional Electronic Health Care Claim Transaction (ANSI ASC X12 837I). Information on submission of the POA indicator is found in appendix D of the guide. The guide can be accessed at the following link: health.state.mn.us/auc/index.html. POA indicators should only be submitted along with correlating DX codes.

On UB-04 (CMS-1450) paper claims, the POA indicator is the eighth digit of Form Locator (FL) 67, Principal Diagnosis and the eighth digit of each of the Other Diagnosis fields FL 67 A-Q. One POA indicator is submitted per diagnosis. POA indicators should only be submitted along with correlating diagnosis codes.

Use the POA indicators as they would normally be submitted to Medicare. For more information, refer to cms.hhs.gov/HospitalAcqCond

Claims Filing

Timely Filing

Most Subscriber Contracts contain a time limit for claims submittal. The limit is usually 120 days after the date of service, with a few exceptions. Timely filing for Federal Employee Program (FEP) Subscribers can be found in Chapter 5- ID Cards/Coverage Options. Provider is required to submit original claims within 120 days of the date of service. Provider is liable for claims not submitted within the timely filing limit.

For medical care that involves follow-up, such as surgery and routine postoperative care, it is most efficient to bill Blue Cross after all Health Services have been completed, as long as it is within the time limit.

Exceptions

The following are exceptions to the 120-day timely filing limit.

- Blue Cross and Blue Shield of Minnesota is secondary
- Patient has died during timely filing period
- Patient has Medicare
- Original receipt date of service is within timely filing
- Claim is a Medicare replacement or provider replacement claim that has been converted to an original
- If another insurance company is identified as the payer and the provider bills the other payer within the timely filing guidelines. These claims would have to be appealed and supporting documentation is required.
- If the patient is identified as the payer and the provider bills the patient within the timely filing guidelines. These claims would have to be appealed and supporting documentation must include notes about accounts receivable actions. For example, include notes about documenting calls with the Blue Cross Service Center or notes that the member was sent to collections within 120 days after date of service.
- Retro enrollment into an Exchange product.
- Documentation attached to claim indicating one of the above situations exists and supports waiving the timely filing guidelines

Timely Filing
(continued)

Public Programs Claims Filing Exception

Due to the unique nature of the services provided, Blue Cross and Blue Plus has made a change to the timely filing contract provision for providers exclusively participating with Blue Cross to serve Minnesota Health Care Programs (MHCP) subscribers.

These providers will continue to have a 180-day timely filing period. This means that claims need to be submitted no later than 180 days from the date of service. This change is retroactive to January 1, 2013.

This exception applies, but is not limited to, the following Providers: Common Carrier Transportation, Community Support, Unlicensed Early Intensive Developmental & Behavioral Intervention (EIDBI), Interpreter, Licensed Traditional Midwife, Optician, Personal Care Agency, Public Health Nursing Clinic, Social Service Agency, Licensed Alcohol and Drug Counselors, Transportation and Housing Stabilization Services Providers.

Replacement Claims

Blue Cross' requirements for timely filing of replacement claims is six calendar months from the process date of the predecessor claim

There is no timely filing limit on cancel claims (claim frequency code of 8).

Provider-Submitted Appeals

Blue Cross' requirement for timely filing of provider-submitted appeals is 90 days from the remittance date of the claim.

In no event may Provider send a replacement claim with no data changes to the payer in order to extend the 90 days allowed from remittance date of the claim to appeal.

Claims Crossover for
Medicare and Medicare
Supplement

The claims crossover system reduces Provider's paperwork by using the Medicare claim form to process both Medicare and Medicare Supplement benefits. Through the crossover, Medicare generates a second claim automatically for Subscribers who have secondary or supplemental benefits with Blue Cross. Providers have only one claim form to submit—the 837P for Medicare Part B or the 837I for Medicare Part A.

While Blue Cross can only accept changes from the Subscriber, it encourages Providers who are aware of Health Insurance Claim Number (HICN) changes to assist their patients in communicating this information to Blue Cross.

Medicare Crossover

Blue Cross provides COBC a weekly eligibility file of all Blue Cross Subscribers enrolled for coverage under the Medicare program. When Medicare processes a claim, the Medicare

Subscriber's HICN will be compared to the HICNs on the eligibility file sent by Blue Cross. If found, the date of service on the Medicare claim will be compared to the Blue Cross coverage effective and cancel dates. If the claim's date of service falls within those dates, the claim will be crossed over to Blue Cross electronically.

837I Crossover
Information

The current message indicating the claim was sent to Blue Cross will continue to be displayed on the Subscriber's *Medicare Summary Notice (MSN)* or on the *Explanation of Medicare Benefits (EOMB)*. Medicare will indicate on Provider's Remittance Advice (RA) if the claim was sent to the supplemental insurer. On the Intermediary RA, claim status codes of 19, 20 or 21 indicate that the claim was crossed over. If the HICN is not found on the Blue Cross eligibility file, or if the date of service on the claim is outside the given Blue Cross coverage effective and cancel dates, the claim will not be forwarded to Blue Cross electronically.

837P Crossover
Information

A note associated with the ANSI remark code indicates which payer will receive the claim information. Provider will continue to see MA18 and the name of the payer on the Medicare RA when the payment information is forwarded to a single payer. However, code N89 will be used when the payment information is forwarded to multiple payers; only one of those payers will be named on the RA even though the payment information is forwarded to multiple payers.

Paper claims submitted to Blue Cross with the Medicare RA attached and the N89 remark code stating the payment information was forwarded to Blue Cross will be returned to Provider. Adjusted Medicare B claims will not be crossed over to Blue Cross.

If the claim is not forwarded, then:

- The statement or code indicating the claim was forwarded to Blue Cross will not appear on the MSN, EOMB or RA.
- The Subscriber or Provider must submit the electronic claim to Blue Cross populating Medicare's payment information within the claim record.

Duplicate Claims

Duplicate billing adds millions of dollars each year to health care administrative costs. Many providers operate under the erroneous assumption that frequent rebilling leads to faster payment. Unnecessary rebilling increases providers' overhead costs as well as those of Blue Cross. Below are several ways providers can help reduce duplicate claims costs:

- When filing the claim, be sure to tell Subscribers not to bill on their own.
- Eliminate “automatic” rebillings. Wait 30 calendar days for Blue Cross to process a claim.
- Before rebilling, use **www.availity.com**, call BLUELINE®, use a 276/277 transaction or call provider services for claim status information.
- Don't submit previously billed claims with new claims “just to be safe.” This only delays payment of all new claims.
- Upon receiving a Medicare RA showing that the claim has electronically been “crossed over” to Blue Cross, do not submit the paper RA as a claim.
- If a claim has been denied, resubmitting the paper RA will only result in a second denial. Either correct fields on the claim and submit a replacement claim or submit an appeal as appropriate.

Submission of Claims

Blue Cross' goal is to pay claims as quickly as possible. By following the above suggestions, providers can help hold down everyone's administrative costs.

To ensure the proper administration of benefits by Blue Cross, Provider shall submit claims to Blue Cross even when its claims have been paid in full by other third parties such as Medicare. When submitting claims in these cases, Provider shall populate the previous payer's payment information within the claim.

Provider shall submit claims to Blue Cross for all Health Services provided, even in cases when Provider suspects a Health Service will not be covered. This will ensure the proper administration of benefits and take advantage of changes in coverage that may occur after Provider checks benefits.

Provider must submit claims to Blue Cross electronically in most cases. Upon reasonable advance written notice to Provider, Blue Cross may refuse to process paper claims, or charge Provider for processing paper claims. Both Provider and Blue Cross are subject to Minnesota Statute, Section 62J.356 and other applicable laws, regulations or guidance that governs electronic claims submission.

Blue Cross reserves the right to verify the clinical accuracy of claims through its claims systems. All health plan administration including application of benefits and patient eligibility is applied after clinical correctness has been established. Provider must comply with coding and billing requirements based on coding rules of CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS, HCPCS, HIPAA mandated Technical Report Type 3 documents and/or Minnesota Department of Health Uniform Companion Guides, including any updates or changes to such coding rules and/or guides as applicable and as interpreted by Blue Cross and as set forth in the coding policies and guidelines of the Provider Policy & Procedure Manual. Provider further agrees to submit claims for Health Services to Blue Cross in the most cost effective manner when more than one billing option exists. Provider is responsible for obtaining any authorization required to release such information to Blue Cross and/or the Plan Sponsor.

Cancel/Void and Replacement Claims

Minnesota statute 62J.536, requires providers to submit all claims electronically. This requirement includes all cancel and replacement claims as well as original submissions. Cancel claims are claims that should not have been billed or where key claim information such as the billing provider or patient name were submitted incorrectly. Replacement claims are sent when data submitted on the original claim was incorrect or incomplete.

Minnesota providers and out of state providers who participate with Blue Cross are no longer allowed to submit adjustment requests via paper or through provider web self-service. Providers are required to adhere to the State of Minnesota Uniform Companion Guide requirements and the AUC Best Practices for replacement claims. Additionally, provider services will no longer accept requests to change data elements within a claim as these should be sent electronically as replacement claims. Provider services will still accept requests to adjust claims in situations where the claim processed incorrectly even though correct information was provided on the original submission.

Exceptions

Exceptions to this electronic replacement claims enforcement are as follows:

- Dental formatted adjustment requests will still be accepted if received on paper.
- Pharmacy formatted adjustment requests will still be accepted if received on paper.
- Nonparticipating providers that are located in counties that border Minnesota are exempt from the statute, therefore paper claims will still be accepted from these providers.
- Adjustment Requests received from the Veterans Administration (VA) and Indian Health Services.

Additional Information

If Provider is unable to send electronic replacement and/or cancel claims, Blue Cross has secured the services of Availity to provide a free web-based tool for provider data entry of claims. To learn more about submitting claims using Availity's no-cost web-based tool, go to [availity.com](https://www.availity.com).

Cancel/Void and Replacement Claims (continued)

Blue Cross and its affiliates have completed system changes to accept and properly adjudicate electronic cancel and replacement claims.

Following are some of the common questions related to proper submission requirements. Section A contains general information, and section B is for specific handling of coordination of benefits (COB) related scenarios.

Section A – General Information**1. What is an example of a replacement claim? I have read the AUC description and would like some clarity on these claims.**

A replacement claim, to paraphrase the Minnesota Uniform Companion Guides for claims, is used to completely replace a previously submitted claim when data within the claim record is added, changed or deleted. An example would be a professional claim sent with all diagnosis pointers set to “1.” On review by the provider after original payment, it is determined the second procedure was done in reference to the third diagnosis on the claim. A replacement claim is sent to correct the diagnosis pointer on line 2.

See section 4.2.3.2 of the Minnesota Uniform Companion Guides and the related *AUC Replacement/Void Claims Best Practice* available on the AUC website at health.state.mn.us/auc.

2. Can I send a replacement claim if I have the wrong Subscriber ID on the previous submission?

No. According to the *AUC Replacement/Void Claims Best Practice*, “When identifying elements change, a void submission is required to eliminate the previously submitted claim.” Changes to identifying information related to the billing provider, patient, payer, Subscriber or statement covers period dates, require that a cancel claim transaction be submitted for the original claim and that a new claim with the corrected information be submitted to the payer. These requirements are similar to the Centers for Medicare & Medicaid Services (CMS) requirements.

3. Can I send an attachment on a replacement claim?

Yes, if it is relevant to the changes being made on the replacement claim or needed to support a particular coding change. For example, the addition of a -59 modifier to indicate that the Health Service being billed is a distinct procedure or service will require supporting medical documentation to be submitted with the replacement claim.

Cancel/Void and
Replacement Claims
(continued)

4. If Blue Cross denied my claim because the date of injury was required but not submitted in the claim, can I send an AUC Appeal Request Form to have the claim reconsidered and list the requested date of injury in the Reason for Appeal section?

No. It is necessary to submit a replacement claim with the corrected data (injury date) in the 837 transaction.

5. What is an appeal?

The Minnesota Uniform Companion Guides describe an appeal as “Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.” For example, the provider receives a claim denial because Blue Cross considered the procedure investigative. The provider's request to reconsider must be submitted on the AUC Appeal Request Form along with supporting documentation following the instructions in the AUC Submission of Appeals Best Practice. Fax the AUC Appeal Request Form and supporting documentation to Blue Cross at **(651) 662-2745**.

6. What are some examples of reasons for appeals?

The following is a list of reasons to send an appeal, according to the Minnesota Uniform Companion Guide(s) for Claims:

- Timely filing denial
- Payer allowance
- Incorrect benefit applied
- Eligibility issues
- Benefit accumulation errors
- Medical policy/medical necessity

7. All of the claim information was submitted correctly; however, it appears not all claim data I sent was recognized by the system. Is it acceptable for me to call Blue Cross to simply have my claim adjusted using what was previously submitted or do I need to appeal?

It is acceptable for providers to request the claim be adjusted to recognize the data within the submission through a phone call to provider services. It would also be acceptable for providers to submit a request using the AUC Appeal Request Form.

Cancel/Void and Replacement Claims (continued)

8. I am sending documentation in response to a request for additional documentation from Blue Cross. Do I need to send a replacement claim with the attached medical records?

If the provider is responding to an information request letter sent by Blue Cross, regardless of whether the provider also received a denial on its remittance, the provider should submit the requested information, along with a copy of the information request letter. Do not send an AUC Appeal Request Form. These same instructions are included on the letter that the provider receives.

9. I am sending documentation in response to a denial on my remittance advice from Blue Cross. Do I need to send a replacement claim with the supporting information needed?

If the provider is sending the additional documentation as a result of a denial on a remittance advice only, and not in response to an information request letter from Blue Cross, and the claim requires changes to claim data elements (such as date of injury, procedure code changes, diagnosis code changes, etc.), then a replacement claim must be sent which includes any necessary attachments.

If the provider is sending the additional documentation as a result of a denial on a remittance advice only and the claim does not require changes to claim data elements the provider also may send a replacement claim.

If the provider is sending additional documentation because it believes it did not receive correct payment and this documentation supports its position, the provider must send the AUC Appeal Request Form along with the documentation to support its request.

Section B – COB Related Scenarios

1. How do I send COB information when it was not included with the previous submission?

- **Scenario 1**

If the provider received a HIPAA compliant remittance advice (835), and the provider's system has the capability to populate the information within a secondary claim, the provider must submit a replacement claim with the data appropriately entered within the claim record.

Cancel/Void and
Replacement Claims
(continued)

- **Scenario 2**

If the provider has not received a HIPAA compliant remittance advice (835) from the previous payer, the provider may send a replacement claim transaction with the addition of the PWK segment and send the paper remittance advice from the previous payer as an attachment.

Note: All Minnesota Group Purchasers must provide a HIPAA and State of Minnesota compliant remittance advice, and providers are required by the Minnesota Uniform Companion Guides (section 4.2.3.5) to submit the previous payment information electronically using the proper fields within the claim transactions.

Additional Information

For additional information on these types of claims, please refer to the Minnesota Uniform Companion Guides and related Best Practice documentation on the AUC website at health.state.mn.us/auc/guides.htm.

Release of Medical Records

The Minnesota Statute that states “consent for the release of medical records are valid for only one year,” also provides that consents to release medical records to insurers for purposes of claims payment do not expire after one year. Since there are circumstances where such consents are only valid for one year, providers may wish to update their records on an annual basis.

Provider Assistance Requested

Provider is reminded that:

- Per the Provider Service Agreement, Blue Cross or the Plan sponsor may reasonably request any additional information that is needed to respond to claims.
 - HIPAA considers release of such records as required for “business operations.”
 - ARIs are required under Minnesota law.
 - Provider should gather information from Subscribers on an annual basis to facilitate timely processing of Subscribers claims.
-

Medical Records Management Process Improvement

Blue Cross is improving its medical records management process to better serve Providers.

- **Reduced requests** - Changes to the Blue Plan internal medical records procedures will eliminate unnecessary medical record requests and expedite claims processing for Subscribers from other Blue Plans.
 - **Clearer instructions** - A form will accompany all medical record requests to facilitate claims processing. The form should be returned with the requested records.
-

Verify Member Identity

Blue Cross has received a number of calls from its Subscribers who have stated that they did not receive certain Health Services that were billed under their Subscriber identification number.

Upon comparing consent for treatment forms with signatures on file it appears that such Health Services were provided to an imposter.

In order to prevent this occurrence, Provider should take appropriate steps to verify a Subscriber’s identity, such as viewing a government issued identification card and a Blue Cross Subscriber ID card at each encounter.

If a Provider suspects fraudulent use of a Subscriber ID card, please call Blue Cross' fraud hotline at **(651) 662-8363**. Callers may remain anonymous.

Verifying Patient Eligibility

Minnesota Statute 62J.536 requires health care providers and group purchasers (payers, plans) to exchange eligibility information electronically using a standard format. The intent of the law is to reduce costs, simplify and speed up health care transactions, and give providers and health plans one set of rules to follow for electronic transactions. This statute applies to all health care providers that request benefit or eligibility information regardless of participating status.

Rules for Checking Eligibility and Benefits

According to the Minnesota Department of Health, the compliant modes for initial eligibility inquiries and responses are either via **www.availity.com** or submission of the *Eligibility Inquiry and Response Electronic Transaction* (ANSI ASC X12 270/271). Utilization of the Integrated Voice Response system (IVR) is not considered compliant for this initial exchange. If, after an initial compliant exchange (via web or EDI), additional information or review is needed, other modes that are available may be used, including IVR or a phone call to a service representative.

The AUC has published a best practice related to checking eligibility and benefits for patients. The best practice covers 4 major areas:

- When and how to verify
- Preferred methods of eligibility inquiry
- Sharing eligibility information
- Data elements that should be used to update information systems

The recommendation of the AUC is that eligibility be checked for each patient once per calendar month since most eligibility changes occur at the beginning of a month. Please refer to the best practice at the following link for other helpful tips.

<https://www.health.state.mn.us/facilities/auc/bestpractices/index.htm>

Questions?

To register to receive the electronic eligibility (270/271) transaction, contact Availity at [availity.com](https://www.availity.com).

Basic Character Set Values in the Electronic Transaction

The AUC has published a best practice regarding utilization of the basic character set values within the transaction data.

The basic character set includes some punctuation characters and spaces. These values when used unnecessarily can cause issues with matching to the payers’ enrollment for Provider or the Subscriber; or may cause the data to be incorrectly extracted/interpreted within the payers’ applications.

If any of the punctuation characters within the basic character set are used as delimiters then they cannot be used in the transmitted data within a data element.

Punctuation and spaces should only be utilized within the elements when they add value to the data. They should not be used when their usage is not essential to the interpretation of the data content.

Basic character set: uppercase letters (A-Z), numeric digits (0-9), space (), exclamation point (!), double quote (“), single quote (‘), ampersand (&), right parenthesis, left parenthesis, asterisk (*), period (.), plus sign (+), comma (,), hyphen (-), forward slash (/), colon (:), semicolon (;), question mark (?), and equals sign (=).

Even though the “@” character is in the extended character set it is allowed for email addresses within the PER segment. This character must not be used as a delimiter.

Examples to illustrate best practice:

Description	Incorrect Examples	Correct Example
Name Titles (no period should be used).	JR. MR. PhD. M.D.	JR MR PHD MD
Address – no periods should be used as part of the address.	P.O. AVE.	PO AVE
Commas and periods should be used at the end of a sentence in a text field to separate from another sentence within the text field.	A PERIOD WITHIN A SENTENCE MAY HAVE VALUE DESCRIPTION OF SERVICE IS ABC	A PERIOD WITHIN A SENTENCE MAY HAVE VALUE. DESCRIPTION OF SERVICE IS ABC.

Basic Character Set Values in the Electronic Transaction (continued)

Description	Incorrect Examples	Correct Example
Hyphens and apostrophes should not be used within a last name field.	SMITH-JONES O'BRIEN	SMITHJONES OBRIEN
Leading and trailing spaces within fields should not be used.	Rendering practitioner last name = “_JONES” or “JONES_”	Rendering practitioner last name = “JONES”

Claim Service Dates Restricted to Same Calendar Month

The AUC has published a best practice regarding claim service dates in the same calendar month. The purpose of this best practice is to avoid split claims and rejections. Most eligibility changes occur at the beginning or end of a calendar month. Some payer systems require that claims contain only Health Services that are associated with a particular eligibility period. Current practice is to split these claims at the payer site to push through systems or to reject the claim.

On a professional claim, service date spans should only be within the same calendar month. Multiple claims may be submitted for different dates within the same calendar month based on the provider’s billing practices.

On an institutional outpatient claim, statement and service date spans should only be within the same calendar month. Observation, extended recovery and emergency department services beginning before and completing after midnight are exceptions to this best practice if performed during the same visit. Procedures beginning on one day and ending on another should be billed together.

This best practice does not apply to an institutional inpatient claim.

Pharmaceuticals should be billed with the administration/dispensed date rather than a span of dates.

Monthly equipment rental should be billed with the start date of the rental period only rather than the span of days.

Equipment rented on other than monthly basis needs both from and through dates. Units of service should be reported as one (1) per rental period. These service date spans should only be within the same calendar month. Example would be daily rental of equipment.

Supplies should be billed with the purchase date rather than the span of days.

Claim Service Dates
Restricted to Same
Calendar Month
(continued)

Refer to Appendix A of the MN Uniform Companion Guides for additional guidance on service date coding.

Examples to illustrate best practice:

Example 1 (equipment rental single month):

Equipment is rented for January 17 through February 16. Service date should be reported as January 17 with no end date.

DTP*472*D8*20080117~

Example 2 (equipment rental multiple months):

Equipment is rented for March 3 through May 15. Should be submitted as three separate claims, claim one would be reported as March 3 with no end date; claim two would be reported as April 3 with no end date; claim three would be reported as May 3 with no end date.

DTP*472*D8*20080303~

DTP*472*D8*20080403~

DTP*472*D8*20080503~

Reporting MNCare and
Sales Tax

Instructions for MNCare Tax billing only apply if Provider bills the group purchaser for MNCare Tax. Some providers do not bill the group purchaser for MNCare Tax. This document **DOES NOT** require them to do so but if they do identify the tax it must be done as follows. Some group purchasers may not reimburse MNCare Tax unless it is identified in the AMT. Sales tax instructions for professional claims are as follows:

- MNCare Tax must be reported as part of the line item charge and reported in the corresponding AMT tax segment on the lines.

Rural Health Clinics and Federally Qualified Health Centers

Billing for Medicare Primary

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) are Medicare provider designations. Medicare requires RHCs and FQHCs to bill services in an institutional format (837I).

Since billing as an RHC or FQHC would be secondary to Medicare, Blue Cross will only accept these clinic claims on the 837I.

The claim should be submitted following Medicare billing requirements (for example, TOB 071X and revenue code 0521 for a clinic visit to an RHC).

Billing Other Than Medicare Primary

If Medicare is not primary, Health Services must be billed to Blue Cross as a clinic, not as an RHC/FQHC, under Provider's Blue Cross clinic provider number or NPI and submitted as a professional claim 837P.

Coordination of Benefits (COB)

Overview

Third-party payers rely on Coordination of Benefits (COB) to eliminate duplicate payments when a Subscriber has more than one coverage for Health Services. Please complete the information under “other coverage” on claims for Blue Cross Subscribers. List the names of any other carriers and the Subscriber’s ID number, if possible. Blue Cross determines which carrier is primary payer and ensures that duplicate payments are not made for the same Health Services.

Primacy Determination

Blue Cross follows the National Association of Insurance Commissioners (NAIC) rules to identify the primary insurance carrier.

Coordination of Benefits Types

There are several types of coordinating benefits that are outlined below. The only way to determine what type of COB a Subscriber has is to contact provider services.

All seven types follow these first three steps:

1. The primary carrier pays appropriate benefits under its contract.
2. The claim is submitted to the secondary plan's carrier.
3. The secondary plan will never pay more than it would pay in the absence of coordination.

COB Type 1 and 2 (Standard Coordination)	COB Type 3 (Benefits less Other Insurance Benefits)	COB Type 4 (only with Medicare)
4. The secondary plan pays the difference between the higher allowed amount and what the primary plan paid.	4. The secondary plan processes up to the secondary plan's allowed amount . The secondary plan subtracts the amount the primary plan paid from the amount it would have paid without coordination.	4. The secondary plan's allowed amount is determined by subtracting Medicare's paid from Medicare's allowed.
5. The combined payment of the primary and secondary plans will not exceed the total incurred expenses.	5. If the primary plan paid less than what the secondary plan would have paid without coordination, the secondary plan pays the difference.	5. That amount is reduced by any applicable deductibles and coinsurance.
	6. If the primary plan paid more than what the secondary plan would have paid without coordination, the secondary plan pays nothing. (Integration)	6. The combined payment of the primary and secondary plans will not exceed the total incurred expenses.
	7. The combined payment of the primary and secondary plans will not exceed the total incurred expenses.	

COB Type 1 and 2 (Standard Coordination)	COB Type 3 (Benefits less Other Insurance Benefits)	COB Type 4 (only with Medicare)
<p>The result:</p> <p>The Subscriber would not be responsible for payment of a portion of his or her eligible medical expenses.</p>	<p>The result:</p> <p>The Subscriber is responsible for any applicable deductible or coinsurance amounts for eligible medical expenses under both plans.</p>	<p>The result:</p> <p>The Subscriber may be responsible for a portion of his or her eligible medical expenses.</p>

Note: When coordinating benefits with Medicare all COB Types coordinate up to Medicare's allowed amount when Provider accepts assignment and Provider is located within the state of Minnesota. The federal Medicare Secondary Payer (MSP) law dictates when Medicare pays secondary.

When coordinating benefits with another commercial carrier all COB types coordinate up to the higher allowed amount between the two plans except when integration is involved. Integration will coordinate up to Blue Cross' allowed amount.

It is important that all charges submitted to the primary payer be submitted to the secondary payer, even though charges were paid in full.

Workers' Compensation

In cases where an illness or injury is employment-related, Workers' Compensation is primary. If notification is received that the Workers' Compensation carrier has denied the claim, Provider shall submit the claim to Blue Cross regardless of whether the case is being disputed. It is also helpful to send the other carrier's denial statement with the claim.

No-fault Auto

The No-fault Automobile Insurance Act calls for automobile insurance coverage to be primary without regard to cause or fault for the accident. The health insurance carrier would be the secondary payer. If notification is received that the no-fault auto carrier has denied the claim, Provider shall submit the claim to Blue Cross regardless of whether the case is being disputed. It is also helpful to send the other carrier's denial statement with the claim.

Subrogation

Subrogation literally means the substitution of one person for another. It is the right to recover payments for a Subscriber whose personal injuries are caused by the negligence or wrongdoing of another person. Minnesota does not have specific statutes or laws that apply to subrogation. Some group health care coverage plans and Blue Plus do have subrogation in their certificates or Provider Service Agreements. For those groups, Blue Cross will initially pay the claim until the case is settled.

TEFRA	<p>The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) applies to employers with 20 or more employees. Under TEFRA, group health coverage becomes the primary payer and Medicare the secondary payer for active employees between ages 65 and 70. TEFRA applies to active employees from the first day of the month of their 65th birthday to the first day of the month following their 70th birthday.</p>
DEFRA	<p>Effective January 1, 1985, the Deficit Reduction Act (DEFRA) expands the TEFRA aged workers guidelines to include dependent spouses (ages 65 to 70) of actively employed workers under 70.</p>
COBRA	<p>On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) amended the Working Aged Provision to eliminate the age 69 limit. Medicare will no longer become primary payer when an employed person turns age 70 or the spouse of an employed person turns 70. The group remains primary payer until the employee retires.</p>
OBRA	<p>The Omnibus Budget Reconciliation Act (OBRA) of 1986 introduces the term “active individual” and defines it as the employee, the employer, or individual associated with the employer in a business or family relationship. Medicare will now be the secondary payer for disabled Medicare beneficiaries who elect to be covered by an employer-based group health plan, either as current employees or family of such employees. The minimum number of employees under this provision is set at 100. The employer’s insurance pays primary.</p>

Non-Physician Health Care Professionals

Introduction

Blue Cross will pay for reasonable and necessary Health Services performed by certain non-physician Health Care Professionals. Eligible Health Services are determined by the Health Care Professional's scope of practice and the Subscriber's Contract.

Eligibility Criteria

Below is the eligibility criteria for non-physician Health Care Professionals:

- Non-physician Health Care Professionals must meet applicable state or federal laws or licensing standards.
- When collaboration is required, non-physician Health Care Professionals in independent practice must work in collaboration with a physician licensed in the state where the Health Services take place.
- A non-physician Health Care Practitioner not eligible as an independent contractor must be an employee of a physician or limited-license practitioner (such as chiropractor or optometrist) licensed in the state where the Health Services took place. The employing provider must be legally and medically responsible for the supervised employee's services.
- Eligible non-physician Health Care Professionals must apply for and meet Blue Cross credentialing criteria.
- Non-physician Health Care Professionals must use their NPI or Blue Cross individual provider number when submitting claims.
- Health Services rendered by supervised employees who are not issued individual provider numbers must be submitted under the supervising physician's provider number or NPI. The -U7 modifier should be appended to the HCPCS code to indicate a non-physician Health Care Practitioner rendered the Health Service.
- Health Services must be provided in accordance with the provisions of the Provider Service Agreement.
- A countersignature of notes and orders by the employing or supervising physician is required if the non-physician Health Care Practitioner's licensure and/or scope of practice requires a signature.

Definitions

Centers for Medicare and Medicaid Services (CMS) guidelines are the basis for the following definitions. For added clarification, Blue Cross has further defined supervision as either direct or general.

Employment

As defined by CMS, the non-physician performing an “incident-to” service may be a part-time, full-time or leased employee of the supervising physician group practice or the legal entity that employs the supervising physician. A leased employee is a non-physician working under a written employee leasing agreement, which provides that:

- The non-physician, although employed by the leasing company, provides Health Services as the leased employee of the physician or other entity; and
- The physician or other entity has control over all actions taken by the leased employee with regard to medical Health Services rendered to the same extent that the physician or other entity would have such control if the leased employee were directly employed by the physician or other entity.

To satisfy the employment requirement, the non-physician must be considered an employee of the supervising physician or other entity under the common law test of an employer/employee relationship.

Health Services provided by auxiliary personnel not employed by the physician, physician group practice, or other legal entity are not covered as incident to a physician’s service.

Incident To

“Incident to” physician’s professional services means that the Health Services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment or an injury or illness.

- The Health Care Practitioner’s service must be furnished as an integral part of the physician’s personal professional service in the course of diagnosis or treatment of an illness or injury.
- An employee of the physician must render service under the physician’s direct supervision.
- The physician must perform the initial and subsequent service with a frequency that reflects his/her active participation in managing the course of treatment.

Health Care Professionals who are issued individual provider numbers are considered incident to the physician when performing Health Services within the same encounter on the same day as the physician.

Incident to services are applicable in the office place of service only.

Direct Supervision The physician must be present in the office suite and immediately available to assist and direct throughout the performance of the Health Service. Direct personal supervision does not mean that the physician must be present in the same room with the non-physician practitioner. A physician cannot provide direct or personal supervision via telemedicine. Direct supervision is only applicable in the office place of service.

General Supervision General supervision refers to Health Services furnished under the physician’s overall direction and supervision. The physician does not have to be physically present in the same office suite. He or she may provide general supervision by periodic review of the non-physician’s practice and availability either in person or through electronic communications (telemedicine, telephone, etc.).

**Collaboration/
Independent Practice** Certain Health Care Professionals are qualified to set up their own practice. Although these Health Care Professionals work independently and do not require physician supervision, they must work with or collaborate with a physician. For example, a physical therapist may perform therapy independently; however, the Subscriber’s physician makes the initial determination that the Subscriber requires or will benefit from physical therapy. The physical therapist works in collaboration with the physician.

**Chiropractic Doctors
and Multidisciplinary
Clinics** Chiropractic doctors must maintain separate Provider Service Agreements and provider numbers when practicing in a multidisciplinary clinic setting with medical doctors. Blue Cross does not allow chiropractors to bill services as “incident to” a physician’s services. Services performed by a chiropractor must bill under the chiropractor’s own provider number.

The assignment of a chiropractic provider number is fundamental to the appropriate processing of Blue Cross' Provider Service Agreements and Subscriber Contracts. It allows Blue Cross to identify the specialty of the individual providing the services. This is especially important to enable Blue Cross to correctly administer those Provider Service Agreements and Subscriber Contracts that have visit limitations, exclusions and other benefit variances.

A multidisciplinary clinic with medical and chiropractic doctors must adhere to the requirement that independently licensed chiropractors must maintain separate Provider Service Agreements with Blue Cross and bill appropriately. There are no exceptions to this policy. Any deviation from this billing requirement is a violation of the Blue Cross Provider Service Agreement.

Surgical Technicians and MBBS Practitioners	<p>Surgical technicians are considered to be hospital-based Health Care Professionals and as such cannot have an independent relationship with Blue Cross nor can their services be billed under a supervising physician's individual provider number. Surgical technicians are members of the operating team that prepare the patient and the operating room for surgery, transport patients, observe vital signs and check charts during surgery.</p> <p>Likewise, Bachelor of Medicine and Bachelor of Surgery (MBBS) practitioners are not recognized separately or allowable to bill for assistant surgery services and will be denied as ineligible.</p>
Mid-level Practitioners	<hr/> <p>Blue Cross defines mid-level practitioners according to their specialties. The practitioner's specialty is established based on their current state license and is appropriately determined during the credentialing process.</p> <p>The following is a comprehensive current list of mid-level practitioners:</p> <ul style="list-style-type: none">• Adult Nurse Practitioner• Certified Nurse Midwife• Certified Registered Nurse Clinical Specialist in Mental Health• Clinical Nurse Specialist• Family Nurse Practitioner• Gerontological Nurse Practitioner• Neonatal Nurse Practitioner• OB/GYN Nurse Practitioner• Pediatric Nurse Practitioner• Physician Assistant• Psychiatric Mental Health Nurse Practitioner• Registered Nurse First Assistant
Mid-Level Reduction Exemption	<hr/> <p>Retail Health providers and online care providers are exempt from the mid-level reduction as defined in the provider contract.</p>

Masters Level
Practitioners

Blue Cross defines masters level practitioners based on practitioner specialties. The practitioner's specialty is established based on their current state license and is appropriately determined during the credentialing process. The following is a comprehensive current list of masters level practitioners:

- Board Certified Behavioral Analyst (BCBA)
- Certified Marriage and Family Therapist
- Certified Professional Counselor
- Licensed Marriage & Family Therapist
- Licensed Nutritionist
- Licensed Prof. Clinical Counselor
- Licensed Professional Counselor
- Licensed Psychologist MA
- Registered Dietician
- Social Work

Chapter 9

Reimbursement/Reconciliation

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Reimbursement

Payment Methodology Additional information regarding payment methodology is available in the Provider Service Agreement.

Definitions:

"All Patient Refined DRGs" (APR-DRG)" means the 3M™ classification system that forms a clinically coherent set of severity of illness and risk of mortality adjusted patient groups, designed to describe the complete cross-section of patients seen in acute care hospitals as specified in the Attachment A Rate Table of the Provider Service Agreement, if applicable.

"Allied Case" (for child caring institutions, group homes, and residential primary treatment centers) means a single Subscriber inpatient admission to the Provider, including any readmissions on the day of, or day subsequent to discharge.

"APR-DRG Base Rate" means the negotiated dollar rate per Relative Weight of One (1.0) indicated in the Attachment A Rate Table of the Provider Service Agreement used to calculate the APR-DRG Case Rate for a given APR-DRG category.

"APR-DRG Case Rate" means the total amount paid for an Inpatient Case which is reimbursed using an APR-DRG and is either calculated by multiplying the APR-DRG Base Rate by the APR-DRG Relative Weight, or where an allowed amount has been specified for an APR-DRG, as specified in the Attachment A-Rate Table of the Provider Service Agreement. The APR-DRG Case Rate includes Blue Cross' payment and amounts due from all other parties and will not exceed Provider's allowed Regular Billed Charges.

Payment Methodology
(continued)

"APR-DRG Outlier Threshold" means the Outlier cost threshold established for each APR-DRG.

When the Case Cost for the APR-DRG exceeds the APR-DRG Outlier Threshold, additional reimbursement may be realized in addition to the calculated case payment. An example of calculating an additional payment for an Outlier Case is as follows:

- Case Cost: facility charge (\$124,968) x facility applicable RCC (0.29) = Case Cost (\$36,241).
- Outlier Payment: Case Cost (\$36,241) – Outlier Cost Threshold (\$21,256) = Outlier Payment (\$14,985).
- APR-DRG Case Rate: Case Weight (3.0654) x Facility Base Rate (\$13,905) = APR-DRG Case Rate (\$42,624).
- Final Outlier Case Payment: APR-DRG Case Rate (\$42,624) + Outlier Payment (\$14,985) = Total Outlier Case Payment (\$57,609).

"APR-DRG Relative Weight" means the weight assigned to a specific APR-DRG which is intended to reflect the relative resource consumption related to the procedures and/or diagnoses associated with that APR-DRG. The relative weight assigned to each APR-DRG is calculated by Blue Cross and assigned a version number. See Attachment A-Rate Table of the Provider Service Agreement, if applicable, for the then-current Blue Cross version number.

- **"Base Period"** means the 12 month period prior to the Contract Period.
- **"Blue Cross Negotiation Model"** means the financial model utilized by Blue Cross to calculate Reimbursement Rates which yield the Negotiated Reimbursement Adjustment.
- **"Charge Description Master Adjustment"** means the actual percent change of the charge description master on the Data Set.
- **"Contract Period"** means the term of the contract for which the Reimbursement Rates apply.

Payment Methodology
(continued)

- **“Data Set”** means the claims incurred during the Contract Period.
- **"Custodial Care"** means care and services for the primary purpose of allowing or assisting a Subscriber to meet her or his activities of daily living.
- **"Custodial Care" for Home Health Agencies and Skilled Nursing Facilities** means assistance with meeting a Subscriber's personal needs or activities of daily living that do not require the services of a physician, registered nurse, licensed practical nurse, chiropractor, physical therapist, occupational therapist, speech therapist, or other Health Care Professional, and includes without limitation, bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.
- **"Enhanced Ambulatory Patient Groups" (EAPG)** means the 3M™ visit-based patient classification and payment system for ambulatory care and Health Services used to organize and pay Outpatient Health Services with similar resource consumption across multiple settings. See Attachment A-EAPG Rate Table of the Provider Service Agreement if applicable for the then-current patient classification version number.
- **“EAPG Ancillary Packaging”** means lower level ancillary services are packaged and not considered for additional reimbursement.
- **"EAPG Base Rate"** means the negotiated dollar rate per Relative Weight of One (1.0) indicated in the Provider Service Agreement, if applicable.
- **"EAPG Multiple Services Discounting”** means a reduction in payment rate for multiple significant procedures, tests or therapies performed on the same day, repeat ancillary EAPGs, bilateral procedures and terminated procedures.

Payment Methodology
(continued)

- **"EAPG Relative Weight"** means weight assigned to a specific EAPG which is intended to reflect the relative resource consumption related to the procedures and/or diagnoses associated with that EAPG. The Relative Weight assigned to each EAPG is calculated by Blue Cross and assigned a version number. See Attachment A-Rate Table of the Provider Service Agreement, if applicable, for the then-current Blue Cross version.
- **Interim Billing** Claims submitted with a patient discharge status code of 30 (still a patient or expected to return for outpatient Health Services) for inpatient stays beyond 30 days will be reimbursed according to the facility's interim billing payment percentage as indicated in Attachment A-Rate Table of the Provider Service Agreement. Effective January 15, 2018, claims submitted with the discharge status code 30 for stays less than 30 days are subject to post payment audit and potential recoupment of payment.
- **"MS-DRG"** means the then current version (as set forth on Attachment A Rate Table of the Provider Service Agreement) of a Diagnostic Related Group as defined and published by the Centers for Medicare and Medicaid Services (CMS).
- **"MS-DRG Base Rate"** means the negotiated dollar rate per Relative Weight of One (1.0) indicated the Provider Service Agreement used to calculate the DRG Case Rate for a given DRG category.
- **"MS-DRG Relative Weight"** means the weight assigned to a specific DRG which is intended to reflect the relative resource consumption related to the procedures and/or diagnoses associated with that DRG. The Relative Weight, diagnoses and procedures assigned to each DRG are calculated by CMS and assigned a version number. See Attachment A Rate Table of the Provider Service Agreement, if applicable, for the then current CMS version number being applied.
- **"Major Diagnostic Category"** or "MDC" means a clinically coherent grouping of ICD-10-CM diagnoses by major organ system or etiology that is used in the first step in assignment of DRGs.

Payment Methodology
(continued)

- **"Medical Outpatient Visit"** (ambulatory surgery centers, hospital emergency departments and outpatient clinics) means all outpatient Health Services rendered within a single encounter or visit. If multiple outpatient Health Services are performed and submitted on a single claim with the same service date, it will be considered as one Medical Outpatient Visit. Claims with multiple dates of service will split into multiple Medical Outpatient Visits with the exception of emergency department, recovery and direct admit for observation claims. All claims must be submitted in accordance with Claims Submission Guidelines.
- **"Negotiated Outpatient Payment Categories"** means all those specific categories of Health Services described in Attachment B-Definition of Outpatient Health Service Categories, if applicable, and identified on Attachment A-Rate Table.
- **"Negotiated Payment Per Day" or "Per Diem"** means the dollar amount agreed upon by Blue Cross and the Provider as payment in full for each covered day per inpatient category, if applicable, of Health Services indicated on the Attachment A-Rate Table. The Negotiated payment per day rate includes Blue Cross' payment and amounts due from all other parties and will not exceed Provider's allowed Regular Billed Charges.
- **"Negotiated Payment Per EAPG Visit"** means the dollar amounts used to determine Blue Cross' total liability for all Outpatient Health Services as indicated in Attachment A-Rate Table, if applicable. These payments include Blue Cross payment and all amounts due from all other parties and will not exceed Provider's allowed Regular Billed Charges.
- **"Negotiated Reimbursement Adjustment"** means the aggregate reimbursement percentage change agreed upon between the Parties for the Contract Period.
- **"EAPG Pricing"** means for services and procedures not reimbursed using EAPG methodology, reimbursement will be the then current standard Blue Cross Aware reimbursement with no further decrease applied.
- **"Ratio of Cost to Charge" (RCC)** means the ratio of Provider's cost (total expenses exclusive of bad debt) to its charges (gross patient and other operating revenue) as determined by the Provider's Medicare Cost Report.

Payment Methodology
(continued)

- **“Regular Billed Charges”** means the schedule of regular billed charges of Provider for Health Services, provided that in no event shall Regular Billed Charges be higher than the charges for the same Health Services provided to a private pay patient who is not a Subscriber.
- **“Reimbursement Rates”** means the payment rates calculated during negotiations that produce the overall agreed upon Negotiated Reimbursement Adjustment.
- **“Reported Charge Description Master Adjustment”** means the expected percent change of the charge description master the Provider submits to Blue Cross and is utilized to calculate the Reimbursement Rates. Chagemaster adjustment forms must be provided separately for inpatient, outpatient and professional services.

Payment Methodology
(continued)

“Ungroupable DRG” means a DRG to which has assigned a Relative Weight of Zero (0).

“Case” Definitions:

1. **“EAPG Case Rate”** means the total amount paid for an Outpatient Case which is reimbursed using an EAPG and is either calculated by multiplying the EAPG Base Rate by the EAPG Relative Weight, or where an allowed amount has been specified for an EAPG, as specified in the Attachment A – Rate Table of the Provider Service Agreement. The EAPG Case Rate includes Blue Cross’ payment and amounts due from all other parties and will not exceed Provider’s Regular Billed Charge.
2. **“MS-DRG Case Rate”** means the total amount paid for an Inpatient Case which is reimbursed using a DRG and is either calculated by multiplying the DRG Base Rate by the DRG Relative Weight, or where an allowed amount has been specified for a DRG, as specified in the Attachment A Rate Table to the Provider Service Agreement. The DRG Case Rate includes Blue Cross’ payment and amounts due from all other parties and will not exceed Provider’s allowed Regular Billed Charges.
3. **“Outpatient Case”** (for outpatient acute care hospital) means all outpatient Health Services rendered within a single encounter or visit. If multiple outpatient Health Services are performed and submitted on a single claim, it will be considered as an Outpatient Case, and will be assigned to a single category or service, and counted as one encounter for payment purposes as defined in Attachment B: Definition of Outpatient Health Service Categories of the Provider Service Agreement.
4. **“MS-DRG Outlier Case” or “MS-DRG Outlier”** (for inpatient hospital outlier services) means a Medically Necessary Inpatient Case that meets all of the criteria as specified in the Attachment A Rate Table of the Provider Service Agreement, if applicable.
5. **“MS-DRG Inpatient Case”** (for inpatient acute care hospital) means a single inpatient admission to the Provider, as described in the applicable Schedule of Payment Plan, attached to the Provider Service Agreement
6. **“Negotiated Per Case Rate” or “Per Case”** means the dollar amounts used to determine Blue Cross’ total liability for all Health Services in an outpatient category, if applicable, of Health Services indicated in Attachment A-Rate Table. These payments include Blue Cross payment and all amounts due from all other parties.

Payment Methodology
(continued)**Fee Schedules**

Effective July 1 of each year, Blue Cross implements the most current Relative Value Units (RVUs) as published in the Federal Register and as implemented by Blue Cross. Payment for Health Services not assigned RVUs shall be calculated at the then current applicable fee schedule as set forth in the Aware Provider Service Agreement.

A list of applicable fee schedule allowances is available to the Provider upon request by the Provider, up to twice annually.

Provider must submit the request via email to

Fee.Schedule.Allowance.Request@bluecrossmn.com.

Blue Cross will not accept retroactive charge increases from the Provider. Payment amounts may be affected by Provider certification or Blue Cross credentialing criteria, as detailed in Chapter 2 of the Provider Policy & Procedure Manual.

For new programs of Health Services (e.g., pain, pulmonary rehabilitation, infant sleep apnea, the use of new technology, or services delivered at a particular site of service) the Provider agrees to give Blue Cross at least ninety (90) days advance written notice before implementing any such new program. Within ninety (90) days of receipt of such notice, Blue Cross shall notify the Provider that the service is covered, not covered, covered at a lower rate or at a different site of service. Blue Cross reserves the right to elect not to cover any new program or Health Service, require that certain services be delivered in a specific setting, or to apply a different payment arrangement for such program or Health Service. Blue Cross understands that care delivered in a higher cost setting with no improvement in outcomes does not support affordable, quality care. Blue Cross may determine that its existing networks already hold sufficient capacity for a particular Health Service.

Changes to Minnesota Health Care Programs and Medicare Payment

In the event that CMS or DHS has published rate or methodology changes, Blue Cross shall implement such changes within 90 days of the date that such change is effective or by the first day of the following calendar quarter after the changes are released, whichever is later, unless otherwise specified by the state or federal regulatory agency.

The Provider shall not request adjustments, and Blue Cross shall not adjust any claims paid prior to the effective date Blue Cross implements any such changes. Payment to the Provider for Health Services provided to Subscribers of the Minnesota Health Care Programs and Medicare Members shall be consistent with the Provider's licensure as reported to Blue Cross and as verified with the applicable licensing board.

Direct Payment

Blue Cross sends claims payments directly to participating providers. Payments are sent weekly.

Minnesota Statute 62J.536 requires all providers to accept from group purchasers the health care payment and remittance advice transaction (835). The statute further allows the use of web-based technology for complying with the requirements as long as the data content and rules of the Minnesota Uniform Companion Guides are followed.

Blue Cross does not print and mail *any* paper remittances. Provider must register through Availity to receive the electronic 835 or to view its remittance information.

A nonparticipating provider generally receives neither direct reimbursement from Blue Cross nor a copy of the statement for any Subscriber who has Blue Cross coverage. Subscribers cannot assign benefits to providers. Blue Cross pays Subscribers directly for nonparticipating Minnesota or border providers. However, the provider will be paid directly if the Subscriber has PMAP/MinnesotaCare coverage.

Electronic Funds Transfer

Blue Cross offers Electronic Funds Transfer (EFT). Instead of weekly checks with remits, Provider can now receive electronic payments directly into its facility's checking or savings account. The funds are securely transferred via the Automated Clearinghouse (ACH) process.

Electronic payment will streamline the reconciliation process, eliminate deposit delays due to check handling, and improve cash flow.

The Provider Automatic Payment application is available at **bluecrossmn.com**; click on the Provider icon and then forms.

MNCare Tax

For those Health Services that are subject to the MinnesotaCare Tax, Blue Cross shall compensate Provider for such tax amounts. For all Health Services paid based upon a "fixed fee" method (for example, fee schedule amounts, per diem amounts, per case amounts, etc.), this means that Blue Cross shall add an amount representing the tax to such fixed payments (for example, if the fee schedule amount is \$100.00 and the then-current tax percentage is 1.8 percent, Blue Cross shall pay Provider \$101.80). Examples of fee schedules that do not include the MinnesotaCare tax are those for workers' compensation, HIAA, Federal Employee Program, out-of-state providers, and some specific provider types. For all Health Services paid at Regular Billed Charge or a percentage of Regular Billed Charge, the amount billed to Blue Cross by Provider shall be deemed to include the then-current tax amount and Blue Cross shall not increase its payment by the applicable tax percentage amount for such claims (for example, if Provider is paid on a 70 percent of Regular Billed Charge basis, and Provider's Regular Billed Charge is \$100.00, Blue Cross shall reimburse the Provider \$70.00). Provider agrees to accept such payments as payment in full from Blue Cross or the Plan Sponsor. If the amount of Blue Cross' MinnesotaCare tax payments for a given Health Service exceeds the amount of tax owed for that Health Service, Provider agrees to refund the excess to Blue Cross.

Inpatient Claims Paid
at DRG Rates

Blue Cross pays inpatient claims at APR DRG (All Patients Refined Diagnosis-Related Group) rates for most hospitals.

About APR DRGs

Blue Cross reserves the right to update the APR DRG inpatient categories of care. APR DRGs are a way of categorizing inpatient hospital services by diagnosis groups that have similar patterns of hospital resource use. DRG assignment is based on the patient's diagnoses, procedure codes, age, sex, discharge status, and severity of illness. Payments are based on the assigned APR DRG weight, multiplied by a base rate (conversion factor) that Blue Cross negotiates with hospitals.

Coding Compliance

Coding compliance relates to the accuracy and completeness of the ICD-10-CM diagnosis and procedure codes that are used to assign DRGs and determine payment. Blue Cross requests that hospitals establish adequate internal procedures to ensure the accuracy of claims submissions. Blue Cross reserves the right to conduct random chart audits on a sample of records to ensure that diagnoses submitted justify the DRG and adhere to ICD-10-CM coding rules. Coding errors that are determined to represent a fraudulent claim may be subject to penalties.

Complication and Co-morbidity Defined

According to St. Anthony Publishing (Ingenix), a “complication” is a condition that arises during a hospital stay and prolongs the length of stay by at least one day in approximately 75 percent of the cases. The same source defines “co-morbidity” as a preexisting condition that, because of its presence with a specific diagnosis, will cause an increase in length of stay by at least one day in approximately 75 percent of cases. The condition must affect the patient’s hospital care by requiring one or more of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic studies or procedures
- Increased length of stay
- Increased nursing care and/or monitoring

Although there is a standard list of diagnoses that are considered complications or co-morbidities, if the diagnosis does not require one or more of the above services, it should not be listed as a diagnosis. The provider must verify and document the conditions, based on clinical findings and treatment in the record.

Serious Preventable
Medical Errors

When the negligence, omission, or error on the part of Provider results in the Subscriber incurring additional medical expenses, no payment will be made by Blue Cross for, nor shall Provider bill either Blue Cross or the Subscriber for said additional medical expenses. The National Quality Forum has defined certain events as serious preventable medical errors, and these are the situations for which no payment shall be made by Blue Cross or the subscriber.

A listing of these events can be found at www.qualityforum.org. This listing will be updated periodically by the National Quality Forum.

Examples of serious preventable errors include:

- Unintended retention of a foreign object in a patient after surgery.
- Patient death or serious disability associated with a medication error (for example, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration).
- Surgery performed on the wrong body part.
- Surgery performed on the wrong patient.
- Wrong surgical procedure performed on a patient.
- Infant discharged to the wrong person.

Replacement of
Medical Devices

No payment will be made by Blue Cross and neither Blue Cross nor the Subscriber shall be billed for the cost of a replacement device in excess of the actual cost paid by Provider for the replacement device.

Provider is obligated to submit to Blue Cross proof of the actual payment amount made by Provider to the manufacturer or reseller of the replacement device for such replacement device and is likewise obligated to advise Blue Cross of any rebate, retroactive payment, warranty program payment and/or waiver of payment received from the device manufacturer or reseller.

This applies to, but is not limited to, devices subject to warranty replacement programs and/or recalls, whether or not such warranty replacement programs and/or recalls are due to device failures design defects and/or defective materials.

If a third party such as a medical device manufacturer or reseller recalls or replaces a device and Provider is either reimbursed for the cost of the device or is not charged for the replacement device, no charge for the device will be billed to Blue Cross or the Subscriber.

Provider shall bill only for the professional services associated with the replacement procedure; provided however, that no payment will be made by Blue Cross, and Provider shall not bill Blue Cross or Subscriber for any Health Service in the event that the Subscriber is held harmless by the manufacturer and/or other third party for such Health Services rendered in the removal of a defective device and/or insertion of a replacement device.

Overpayments

1. In the event Blue Cross makes a corrective adjustment, Blue Cross may deduct any overpayments from future payments owed to Provider together with an explanation of the credit action taken. Blue Cross shall be entitled to use a statistically valid sample when determining overpayment amounts. Blue Cross shall have the right to offset against any amounts due and owing or which become due and owing to Provider under the Provider Service Agreement, any amount (a) due and owing or which become due and owing to Blue Cross and/or any Affiliate under the Provider Service Agreement and/or (b) that may have been paid by Blue Cross and/or its Affiliates to Provider in error, including without limitation, payments made to Provider for non-covered Health Services. To the extent Blue Cross exercises the foregoing right to offset against claims for Health Services otherwise properly payable, such claims to which the offset is applied shall be deemed to be paid by Blue Cross, and Provider shall not have the right to balance bill Subscriber for such claim amounts.

Settlement for
Hospitals

- A. Cases/Settlement Time Frame, if applicable. Settlements will be calculated and paid only on cases where Blue Cross has Primary Coverage Responsibility. Unless otherwise specified, a final settlement will be calculated by Blue Cross within 180 days after the applicable term ends, and will include a three-month run-out of claims data.
- B. Payment of Settlement. Blue Cross shall be under no obligation to complete any settlements if the Agreement has not been signed by Provider. Any amounts due to the Provider from Blue Cross will first be netted against any outstanding balances due to Blue Cross from the Provider. If no outstanding balance is due, Blue Cross will then pay the settlement amount to the Provider. If an outstanding balance is due Blue Cross, all such payments shall be made within ninety (90) days of when the settlement is sent by Blue Cross to Provider, or upon a mutually agreed upon payment plan. If payment is not received within the ninety (90) day period or an arrangement for payment has not been agreed upon, any unpaid amounts due Blue Cross will be collected in four (4) weekly amounts by reducing Blue Cross' future claim payments to the Provider.
- C. Non-Adjudicated Claims. In the event a claim or claim adjustment is not adjudicated prior to the three-month settlement run-out period, it will not be included in the settlement unless otherwise agreed to at Blue Cross' discretion.
- D. Settlement Amounts. Any settlement amounts (either due to or due from Provider) totaling less than one hundred dollars (\$100) in aggregate (across all Blue Cross lines of business) may be waived at Blue Cross' discretion. Provider agrees not to bill Subscriber for any such amounts which would otherwise be due from Blue Cross.

Settlement for
Hospitals
(continued)

E. Settlement Appeals.

2. The Provider is entitled to one appeal and, if need be, one secondary appeal. After that, any unresolved issues will be resolved via a meeting and, if necessary, via the dispute resolution process described in the Arbitration provision of the Agreement. Secondary appeals must be submitted with additional information over and above what was submitted with the initial appeal.
3. Provider agrees to forward final settlement appeals, if any, to Blue Cross within ninety (90) calendar days of Provider's receipt of the final settlement. In the event of an appeal, the Provider still must make payment for the full balance due Blue Cross in accordance the payment of settlement provision. If such payment is not timely received by Blue Cross, any unpaid amounts due Blue Cross will be collected in four (4) weekly amounts by reducing future claim payments to Provider.
4. Blue Cross reserves the right to review, and, if necessary, correct the settlement in its entirety, upon Provider's appeal. Blue Cross is not limited to reviewing only appealed items.
5. Secondary appeals. Provider shall have sixty (60) calendar days from the date of receipt of Blue Cross' response to the original appeal, to submit a secondary appeal for the same original appeal.
6. Failure of Provider to appeal or submit a secondary appeal within the timeframe(s) specified herein; constitute a waiver of Blue Cross' obligation to review the appeal or secondary appeal

If Provider disputes Blue Cross' response to a secondary appeal, the Parties shall meet within 60 days to attempt to reach agreement on the completion of the final settlement. Provider shall provide Blue Cross with the reasons for its dispute and any needed background documentation prior to the meeting. Both Parties shall ensure that the appropriate staff members attend the meeting. The Parties shall be subject to the dispute resolution process described in the Arbitration provision of the Agreement if disagreement remains after the first meeting

Remittance Advice

Introduction

Weekly remittance cycles are run for original and adjustment claims that are provider payable, and for original and adjustment claims that are member payable and were completed on Friday.

Providers will receive a separate remittance for each line of business (Payer Name); BLUECROSS BLUESHIELD OF MINNESOTA, BLUECROSS BLUESHIELD BLUEPLUS OF MINNESOTA, FEP, Wilson McShane, CCS/TPA.

Electronic Remittance Advice (ERA) are accessible through Availity, Blue Cross' Clearinghouse at www.availity.com. Availity solutions for providers include a free, online Provider Portal for real-time information exchange with many payers as well as a premium all-payer tool to manage revenue cycle, reduce claim denials, and capture patient payments.

Claim Adjustment Group Code (Group Code)

Blue Cross follows the Committee on Operating Rules for Information Exchange (CAQH CORE) Code Combinations defined Business Scenarios and the MN Uniform Companion Guide (MUCG) for Claim Adjustment Group Codes (CAGC), Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC).

Claims Adjustment Reason Codes (CARC) Remittance Advice Remark Code (RARC)

Claim Adjustment Group Codes assign financial responsibility for the unpaid portion of the claim balance. A Claim Adjustment Group Code must always be used in conjunction with a CARC.

CARCs provide an overall explanation for the financial adjustment and may be supplemented with the addition of more specific explanation using RARCs.

RARC's provide additional explanation for an adjustment already described by a (CARC) or to convey information about remittance processing. There are two types of RARCs, supplemental and informational. Supplemental RARCs provide additional explanation for an adjustment already described by a CARC. Informational RARCs are referred to as Alerts and are all prefaced with Alert. Alerts are used to convey general information about the remittance processing and are never related to a specific adjustment or CARC.

A copy of the Payment/Advice MUCG can be found at <https://www.health.state.mn.us/facilities/ehealth/auc/guides/index.html>.

CAQH-CORE maintains and regularly updates their code combinations on their website at: <https://www.caqh.org/core/ongoing-maintenance-core-code-combinations>.

A full list of Group, CARC and RARC Codes can be found at <https://x12.org/reference>

Questions and Answers 7. **How can I identify adjustments in the remittance?**

Adjustments can occur at the claim, service line. They will appear as claim transaction showing a reversal of the original charge, payment, and adjustment amounts, along with a Claim Status code of 22 "reversal of previous payment" in the CLP02, Claim Level 2100 Loop. The corrected claim will follow in a new claim segment.

8. **What is a Forward Balance (FB)?****Forward Balance**

When refunds from reversals and corrections exceed the claim payments resulting in a negative balance, Forward Balance (FB) processing is applied. The Provider Adjustment (PLB) Segment allows the negative balance from the current remit to be moved into a future remit.

- PLB (PLB03-1) Adjustment Code: FB
- PLB (PLB03-2) Adjustment Identifier: Trace number used in TRN02 of the current transaction
- PLB (PLB04) Adjustment Amount: Negative amount

835 Example: PLB^1234567890^20201231^

FB>C00000000^-86.55

Prior Balance

When overpayment recovery is initiated in a prior remittance but could not be completed because the recovery amount exceeded the paid amount for the prior remittance, the provider's overpayment balance is carried forward from the prior payment to the current payment.

- PLB (PLB03-1) Adjustment Code: FB
- PLB (PLB03-2) Adjustment Identifier: Trace number from the predecessor remit FB.
- PLB (PLB04) Adjustment Amount: Positive amount

835 Example: PLB^1234567890^20201231^

FB>C00000000^86.43

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Questions and Answers
(continued)

9. **What if there is a claim on my remittance for a subscriber that is not ours?**

Request an adjustment by contacting provider services. Please **do not** return Blue Cross' payment check or send Blue Cross a refund check unless Blue Cross requests it.

10. **Why does the check I received not match the amount listed under Net Payment Activity on the statement?**

Less Prior Credit Balances and Less Current Credit Balances will be subtracted from the Net Payment Amount. The provider's check should match the amount listed in the Payment Due field on the statement.

11. **What can I bill the subscriber and how can I identify it on the statement?**

Claim Adjustment Group Codes located on the 835 Electronic Remittance Advice (ERA) assigns financial responsibility for the unpaid portion of the claim balance e.g., PR (Patient Responsibility). This is the amount that the subscriber is responsible to pay.

12. **What do I have to write off and how can I identify it on the statement?**

The Claim Adjustment Reason Code in CAS Segment with Group Code CO (Contractual Obligation) signifies a provider's contractual obligation. Any amounts associated to the use of this Group Code should be written off.

13. **Do subscribers receive their *Explanation of Health Care Benefits (EOB)* at the same time as providers?**

No, claims that are processed during the week are bundled and only EOBs with patient's responsibility greater than a copay are printed and mailed to subscribers each Saturday. All subscriber EOBs are created and exist on Blue Cross member portal and can be printed at home or can be requested by contacting Provider Services.

All EOBs for Medicare Advantage claims and adjusted claims are printed and mailed to subscribers.

Questions and Answers
(continued)

14. **How do I request an adjustment or inquiry?**

An adjustment should be requested when the provider notices the adjudication error. Please remember that if data on the claim needs to be changed, the provider must send a complete replacement claim rather than request an adjustment.

Providers can request an adjustment by:

- Fax in the *Provider Services Inquiry fax* form to:
(651) 662-2745
- Mail in a request to:
Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560

For inquiries:

- Call BLUELINE at **(651) 662-5200** or **1-800-262-0820**
- Call provider services at **(651) 662-5200** or **1-800-262-0820**. Please wait 30 days before checking the status of a claim or adjustment.

Questions and Answers
(continued)

15. What do I do with interest payments?

Interest payments that the provider receives should be posted to a miscellaneous account. This is money that is the provider's and should not be posted to the account of the subscriber it pertains to. By posting this money to a subscriber's account they may end up with a credit.

16. Are there any limits for making adjustments?

Blue Cross may make, and providers may request, corrective claim adjustments (recoupments or additional payments) to previously processed claims for services within six (6) months from last remittance date. Blue Cross has the right to make, and Provider has the right to request, corrective adjustments to any previous payment for a claim for Health Services provided, however, that any corrective adjustments by Blue Cross, or requests for corrective adjustments by Provider that are approved by Blue Cross, shall be made within twelve (12) months from the date the claim for such Health Services was paid or denied by Blue Cross unless the adjustment is made for the following circumstances (and thus are not limited to this 12-month period):

- One or more insurer is involved, whether primary or secondary (that is, Medicare secondary payer, no-fault automobile coverage, subrogation, coordination of benefits, workers' compensation, TEFRA, etc.)
- The adjustment is required due to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse.
- The adjustment is required pursuant to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse.
or
- The adjustment is required as part of a contractual settlement obligation with the provider.
- Note that provider errors or data changes require a replacement claim or cancel claim be submitted within six months of the last adjudication date.
- Corrective adjustment requests must be received within 12 months from the date the claim was last paid or denied by Blue Cross.

Note: In the event Blue Cross requires medical records or an audit to finalize the amount of any corrective adjustment, Blue Cross shall notify the provider of the intent to pursue a corrective adjustment within 12 months of the date a claim is paid or denied and include a request for relevant

medical records or notification of an audit. Failure of the provider to timely provide such medical records shall not limit Blue Cross' ability to pursue any such corrective adjustments. The 12-month time frame allotted for BC to determine any adjustments shall be extended by the time period it takes for providers to provide requested medical records or information. For example, if Blue Cross notifies a provider on January 1, 2021 that it intends to pursue a corrective adjustment on claims from the time period January 1, 2020 through January 1, 2021 and requires medical records to confirm the amount owed, and provider fails to provide the medical records until July 1, 2021, this shall not limit Blue Cross' ability to pursue a corrective adjustment for the time period of January 1, 2020 through January 1, 2021, provided that Blue Cross shall be required to complete any audit of such medical records promptly following receipt of such medical records.

Remit Balancing Tips

The amounts reported in the 835 Electronic Remittance Advice, if present, must balance at three different levels; the service line, the claim, and the transaction.

Service Line Balancing

Although the service payment information is situational, it is required for all professional claims or anytime payment adjustments are related to specific lines from the original submitted claim. When used, the submitted service lines minus the sum of all monetary adjustments must equal the amount paid for the service line.

- $\text{Charge} - \text{Adjustment Amount} = \text{Payment Amount}$

Claim Balancing

Balancing must occur at the claim level so that the submitted charges minus the sum of all monetary adjustments equals the claim paid amount.

- $\text{Charge} - \text{Adjustment Amount} = \text{Claim Payment Amount}$

Remit Balancing

Within the transaction, the sum of all payments minus the sum of all adjustments, through use of the Claim Adjustment and Service Adjustment Segments, CAS, or Provider Level Adjustment Segments, PLB, decrease the payment when the adjustment amount is Positive, and increase the payment when the adjustment amount is negative.

- $\text{Sum of all Payments totaled} - \text{the Sum of all Adjustments} = \text{Total payment amount of this remittance}$

Chapter 10

Appeals

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Provider Appeals

Introduction

Providers are eligible to appeal:

- Post service claim appeals
- Pre authorization and Admission Notification denials
- Coding appeals

Because there are two basic types of appeals this chapter is divided into two appeal sections. The General Appeal Guideline section deals with all appeals that are not related to our coding software edits. The Coding Software Edit Appeals deals only with ClaimCheck and other coding related denials.

For information regarding settlement appeals, refer to your provider agreement.

For information regarding submission of replacement or cancel claims, refer to Chapter 8 in this manual.

Instructions for the submission of appeals are listed in this chapter.

Please read the information carefully to ensure your appeal is reaching the appropriate area within Blue Cross and Blue Shield of Minnesota (Blue Cross) as that will allow for an efficient and timely review of your request.

General Appeal Guidelines

This section does not address appeal guidelines for coding software edit appeals.

Cancel/Void and Replacement Claims

Minnesota statute 62J.536, requires providers to submit all claims electronically. This requirement includes all cancel and replacement claims as well as original submissions. Cancel claims are claims that should not have been billed or where key claim information such as the billing provider or patient name were submitted incorrectly. Replacement claims are sent when data submitted on the original claim was incorrect or incomplete.

Minnesota providers and out of state providers who participate with Blue Cross are **not** allowed to submit adjustment requests via paper or through provider web self-service. Providers are required to adhere to the State of Minnesota Uniform Companion Guide requirements and the AUC Best Practices for replacement claims. Additionally, provider services will **not** accept requests to change data elements within a claim as these should be sent electronically as replacement claims. Provider services will accept requests to adjust claims in situations where the claim processed incorrectly even though correct information was provided on the original submission.

Required supporting documentation requirements are discussed later in this section.

Exceptions

Exceptions to this electronic replacement claims enforcement are as follows:

- Dental formatted adjustment requests will still be accepted if received on paper.
- Pharmacy formatted adjustment requests will still be accepted if received on paper.
- Nonparticipating providers that are located in counties that border Minnesota are exempt from the statute, therefore paper claims will still be accepted from these providers.
- Adjustment Requests received from the Veterans Administration (VA) and Indian Health Services.

Additional Information

If Provider is unable to send electronic replacement and/or cancel claims, Blue Cross has secured the services of Availity to provide a free web-based tool for provider data entry of claims. To learn more about submitting claims using Availity's no-cost web-based tool, go to availity.com. Availity LLC is an independent company provider claims administration {services}.

Post Service Claim Appeals

A post service claim appeal is a written request for review.

The Minnesota Uniform Companion Guides, version 6.0, dated February 19, 2013, Section 3.2.3, define an appeal as “Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.”

All post service claim appeals related to provider liability amounts must be submitted on the Minnesota Administrative Uniformity Committee (AUC) Appeal Request Form along with all necessary and supporting documentation required on the form. The AUC form can be accessed at:

<https://www.health.state.mn.us/facilities/auc/forms/index.htm>

The AUC form must include a specific and comprehensive explanation of the reason for the appeal. This explanation must include patient name, patient member ID, claim number(s), dates of service (s) and a specific detail(s) about what is being appealed and why it should be overturned. All pertinent medical records should be submitted at the time of appeal.

Providers should include appeal information for only one subscriber per AUC form. If providers are appealing their liability on multiple claims for the same subscriber, all claims should be submitted using a single AUC form.

Post claim appeals require providers to include all supporting documentation of items such as chart notes, medical records, operative reports and letters of medical necessity. Both the patient’s name and date of service must be included on each page of the documentation submitted to assure the documentation is specific to the patient and corresponds to the dates of service.

Providers appealing member liability on behalf of a subscriber must include written authorization from the subscriber. Authorization requests for a Medicare and Medicare Advantage subscriber require an Appointment of Representative (AOR) form, available at:

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>.

All other lines of business require an Authorization for Disclosure of Health Information (ADHI) form, available at:

<https://www.bluecrossmn.com/providers/forms-and-publications> (under the category: *forms – member*, search: *authorization*).

A post service claim appeal must be requested within 90 days of the date claim notification is issued. There is no limit on the dollar amount for an initial appeal.

Exception:

If a provider does not obtain a required prior authorization (PA) before rendering services, Blue Cross and Blue Plus (BlueCross) will deny claims as provider liability for lack of PA. Effective for dates of service June 3, 2019 and beyond, this denial will not be eligible for a medical necessity appeal, and an appeal should not be submitted. However, an **administrative appeal may be submitted for limited situations**. These appeals must be submitted within 60 days of the claim notification issuance date and must be supported by submitted documentation:

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

A standard claim appeal submitted with a completed AUC appeal form and attached supporting documentation will be completed within 60 days of receipt. The appeal decision is final unless the charges in question exceed \$500.00. At that time, a voluntary second level review is available.

Appeals of Processed Claims

Providers may submit a post service claim appeal related to their provider liability under one of the following categories:

- Timely filing denial
- Payer allowance
- Incorrect benefit applied
- Eligibility issues
- Coding issues
- Benefit Accumulation Errors
- Medical Policy/Medical Necessity

This appeal process does not apply to settlement appeals, medical necessity and pre authorization denials occurring prior to claim submission.

Voluntary Second Appeal

Voluntary Second Appeals must be filed within 60 days of the notification upholding the decision of the initial appeal. To be eligible for a voluntary second appeal, the amount at issue must be \$500.00 or more. Calculate the amount at issue by subtracting the deductible, coinsurance, and paid amount from the billed charge.

For example:

Billed amount	\$2,000.00
(deductible)	500.00
(coinsurance)	200.00
(paid amount)	500.00
	500.00
Amount at issue	\$ 800.00

If the amount in question is \$500.00 or more then this appeal review may be conducted by the Appeals & Grievances Team as well as Integrated Health Management.

Claims for the same patient or multiple patients relating to the same category can be aggregated at this level (you may combine two or more claims to meet the \$500.00 amount-in-controversy requirement).

Voluntary second appeals must be submitted with additional information over and above what was submitted with the initial appeal. These requests must also be submitted on an AUC Appeal form and should note “**Secondary Appeal**” on the form.

Submitting Requests
for Post Service Claim
Appeals

Post service claim appeals may be mailed or faxed.

Mailing address:

Blue Cross and Blue Cross Blue Shield of Minnesota
Attn: Appeals & Grievances Team
PO Box 982800
El Paso, TX 79998-2800

Fax: **(651) 662-2745**

Pre authorization and
Admission Notification
Appeal Process

You may appeal a pre authorization request or admission notification request denied as medically unnecessary. Your request may be initiated by letter or telephone. Written requests should be addressed to the Appeals & Grievances Team using the address or fax number provided in the denial letter. An appeal reviewer will review the case and make a final determination.

You may appeal a pre authorization request or an admission notification request denied for benefit administration within 30 days of notification. Your request must be in writing and should be addressed to:

Blue Cross and Blue Shield of Minnesota
Attn: Appeals & Grievances Team
PO Box 982800
El Paso, TX 79998-2800

You may also fax your denied pre authorization appeals to **(651) 662-9517**.

When coverage is denied for Pre authorization or admission Notification based on medical necessity, Blue Cross notifies the provider by telephone and/or sends letters to the member, hospital and physician. The physician, member or facility may appeal the denial. The appeal may be initiated either by letter or by telephone.

Blue Cross' review is only a medical necessity review and is subject to all other limitations in the member's contract. Services may be denied because of exclusions, limitations on preexisting conditions, and medical necessity requirements contained in the member's contract. These contract provisions will prevail over a medical necessity decision. The decision to continue an inpatient stay or services ultimately rests with the patient and the physician.

During the appeal process, all available information is provided to a physician reviewer who is board certified in the same or similar general specialty as typically manages the medical condition or treatment and was not involved in the original determination.

Urgent/Expedited Appeals

An urgent appeal is done when an initial or continued treatment is dependent on a quick determination. Urgent is defined as medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, although it may not rise to the level of being a life-threatening circumstance, or
2. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals are completed within 72 hours of receipt of the appeal request, or sooner, based on the medical exigencies of the case. Providers should contact the Blue Cross clinician who signed the denial letter to initiate an urgent appeal.

BlueCard® Appeals

Appeals for BlueCard claims are handled through Blue Cross.

Generally, you will not find the appeal process any different. If coordination is required with the member's Plan, we will coordinate it. Appeals for timely filing of BlueCard claims must be submitted to the patient's Blue Plan.

BlueCard Appeal vs. Adjustments

BlueCard requires that for the following circumstances, new claims must be submitted. Adjustments /appeals cannot be reviewed in these instances:

- Change an incorrect Individual Provider Number or NPI
- Change an incorrect member ID number, including alpha prefix
- Claim was sent in for a patient that is not yours
- Claims that are returned to you with either a yellow or green form attached

Appealing Claims
Processed by the
Member's Plan

Appeals for claims processed by the member's plan are also handled by them. However, you should send a completed AUC Appeal Form and the applicable attachments to Blue Cross and we will work with the member's plan to facilitate your request.

Supporting Documentation

Both the patient’s name and date of service should be included on **each page** of the documentation submitted to assure the documentation is specific to the patient and corresponds to the dates of service at issue.

When the provider submits the appealed claim, the responsibility for gathering and submitting documentation that supports the service rests with the provider.

The list below includes common types of claim denials that may be submitted for appeal and the sources of documentation suggested for each type. This information is presented as a guide to assist you and is not a complete listing.

Type of Denial or Reduction	Documentation
Surgical Complications	Operative report, chart notes, letter stating rationale for complication
Medical Necessity	Medical records and rationale for service performed
Investigative	Medical records and rationale for service performed
Cosmetic	Medical records and rationale for services
DRG/Category Code	Rationale for questioning of payment
Private Room	Notes, doctor’s order and letter of medical necessity
Allowed Amount for unlisted codes	Chart notes or invoice, NDC number and a letter to review allowance for an unlisted code. This is independent from medical necessity review process. Note: An invoice is required for DME or supply allowance appeals.
Allowed Amount – for modified CPT/HCPCS codes.	Chart notes, letter and operative report when applicable to review allowance.
Allowed Amount – excluding unlisted codes.	Copy of fee schedule or provider agreement.

Supporting
Documentation
(continued)

Type of Denial or Reduction	Documentation
Incompatible Diagnosis	Letter requesting review of codes that are denying as incompatible and related notes
Timely Filing	<p>Timely filing is addressed in Chapter 8.</p> <p>Documentation supporting submission of a claim after timely filing, such as secondary coverage, patient expired during timely filing period, or DME rental charges that span the timely filing period.</p>

Utilization Review
Decision Appeal

Under current external review provisions, Provider or any other authorized representative may initiate an external review appeal on behalf of a Subscriber, with the express written authorization of said Subscriber. Provider and Blue Cross agree that this appeal process is binding, unless the Subscriber initiates an external appeal related to Utilization Review decisions. If a Subscriber, a duly authorized representative of the Subscriber, or a Provider initiates an appeal related to Utilization Review decisions, Blue Cross shall abide by all applicable external review requirements of Minnesota Statutes, Section 62Q.73.

Coding Software Edit Appeals

Coding Software Edit Appeals

This section addresses appeal guidelines for coding software edit appeals. Refer to Chapter 10 for details and types of coding denials.

Post Service Claim Appeals

A post service claim appeal is a written request for review.

The Minnesota Uniform Companion Guides, version 6.0, dated February 19, 2013, Section 3.2.3, define an appeal as “Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.”

Post service claim appeals require the provider to include with the request documentation of items such as chart notes, medical records, operative reports and letters of medical necessity. Appeals present detailed information in an attempt to change a previous decision made by Blue Cross.

All post service claim appeals must be submitted on the AUC Appeal Request Form available on the AUC web site, <https://www.health.state.mn.us/facilities/auc/index.html>, along with the supporting documentation.

A post service claim appeal must be requested within 90 days of the process date of the claim. There is no limit on the dollar amount for an initial appeal.

The appeal decision is final unless the denied charge(s) in question exceeds \$500.00. If the charges exceed \$500.00, and are within 60 days of the denial determination, a second level review is available.

Claims for the same patient or multiple patients relating to the same code can be aggregated at this level (you may combine two or more claims to meet the \$500.00 amount-in-controversy requirement).

Second appeals must be submitted with additional information over and above what was submitted with the initial appeal. These requests must also be submitted on an AUC Appeal form and must note “**Secondary Appeal**” on the form.

Coding Appeals

Blue Cross' coding edits are updated at minimum annually to incorporate new codes, code definition changes and edit rule changes. All claims submitted after the implementation date of this update, regardless of service date, will be processed according to the updated version. Where Medicare's CCI (Correct Coding Initiative) edits are identical to our coding software edits, we will consider the appeal with additional documentation; however, the denial may still be upheld. Adjustments, and/or request refunds will not be made when processing changes are a result of new code editing rules due to a software version update. Notice of this update will be published in the Provider Press and/or a Provider Bulletin.

Blue Cross has adopted a standard process to review coding edit appeals and providers have the right to appeal with additional information. Appeals received without additional information will not be reviewed. The denial will be upheld.

If you have a question or appeal about our policy regarding a particular coding combination, provide a written statement of the concern, along with the following and/or documentation normally required for a medical review.

- Written explanation supporting the procedures submitted, that is, specific references, specialty specific criteria
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted

Once received, the inquiry or appeal will be reviewed and if necessary, forwarded to the Integrated Health Management department for determination. The review may result in approval or denial of the claim, based on review of the information submitted.

Note: Requests to add modifiers or any coding changes (addition, removal or change) to a denied service must be submitted as replacement claims. Modifiers 24, 25, 57, 59, 78, or 79 only require supporting documentation be attached to the replacement claim.

Appeal requests may be faxed or mailed.

Send your appeal request to the following address:

Blue Cross and Blue Shield of Minnesota
Attn: Provider Coding Appeals
PO Box 982800
El Paso, TX 79998-2800

Fax appeal requests to: **(651) 662-2745**

Supporting Documentation

Both the patient’s name and date of service should be included on **each page** of the documentation submitted to assure the documentation is specific to the patient and corresponds with the dates of service at issue.

When the provider submits the appealed claim, the responsibility for gathering and submitting documentation that supports the service rests with the provider.

The list below includes common types of claim denials that may be submitted for appeal and the sources of documentation suggested for each type. This information is presented as a guide to assist you and is not a complete listing.

Type of Denial or Reduction	Documentation
Timely Filing	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.
<ul style="list-style-type: none"> • Coding Edits: • Procedure Code Unbundling/Replacement • Mutually Exclusive Procedures • Incidental Procedures • Medical Visits on the Same Day as Surgery • Global Surgical Package – Pre- and Postoperative Services • Units of Service Validation and Restriction 	All supporting documentation for corresponding date of service.

Signature requirements

Complete and appropriate provider signatures are required. Your appeal may be denied if the following are not found on the documentation:

- Practitioner legible* handwritten signature or a unique electronic identifier (“e.g., electronically signed by”)
*Illegible handwritten signatures will be rejected unless there is a signature log sent with the appeal or is on file
- Provider credentials
- Date and time signed

Stamped signatures are not allowed.

Arbitration

<p>Timeline to Commence Arbitration</p>	<p>The Parties agree that any disputes or controversies relating to payment for Health Services shall be commenced no later than two years from the date of the provision of said Health Services by Provider (provided that such time limit shall not apply to those circumstances where claims adjustments are not limited to 12 months, as set forth in the Provider Policy & Procedure Manual). If the source of a dispute or controversy does not in any respect involve a payment for a Health Service, then such action must be commenced within two years of the date on which Provider’s claim arose. Any action not brought within the time limits set forth above shall be barred, without regard to any other limitations period set forth by law or statute.</p>
<p>Venue/Applicable Law</p>	<p>All arbitrations between the Parties shall be venued in Minneapolis, Minnesota and shall be conducted in accordance with Minnesota law and, except to the extent inconsistent with Minnesota law, the Commercial Arbitration Rules of the American Arbitration Association. If any of the Parties are defendants to a claim which is not subject to mandatory arbitration, including, without limitation, claims involving medical malpractice, then that Party may assert indemnity or contribution claims against any other Party within the non-arbitrable action.</p>

<p>Process to Invoke Arbitration</p>	<p>A Party may invoke arbitration by serving written notice on the other Party. The notice will include a list of arbitrator candidates. If the Parties agree on one of the arbitrator candidates in the notice, then the arbitrator will serve as the sole arbitrator of the dispute. If the Parties do not agree on an arbitrator within fifteen (15) calendar days after receipt of the notice, the recipient of the notice will select one arbitrator and the Party providing notice will select one arbitrator within ten (10) calendar days thereafter and the two arbitrators so selected will select a third arbitrator within ten (10) calendar days thereafter. The third arbitrator so selected will be the sole arbitrator and will conduct the arbitration.</p> <p>All disputes between the Parties will be separately arbitrated and will not be joined or combined with the arbitration or other resolution of disputes between Blue Cross and any other person(s) or class of persons, unless expressly agreed to by the Parties in writing. Notwithstanding the above, and except for medical necessity reviews as detailed in Minnesota statute 62M, the Parties further agree that any appeals decision involving Medical Necessity or provider credentialing for which arbitration is pursued will be overturned or modified only if the arbitrator determines that the decision of the appeals panel or reviewer was arbitrary and capricious. Nothing in this mandatory arbitration provision shall provide a right of arbitration where such rights have been waived or another review process has been agreed to.</p>
<p>Arbitration Expenses/Award</p>	<p>Each Party will be responsible for payment of its own attorneys or other advisors and for its appointed arbitrator. The expenses and fees of the sole arbitrator and of the arbitration proceeding will be shared equally by each of the Parties. The Parties will abide by and perform any award rendered by the arbitrators and a judgment of the court having jurisdiction in accordance with this Agreement may be entered on the award.</p>

Chapter 11

Coding Policies and Guidelines

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Introduction

Purpose

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential, if appropriate, and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

Overview

Blue Cross and Blue Shield of Minnesota (Blue Cross) requires submission of valid codes to report medical services and supplies on both professional and institutional claims. This includes Healthcare Common Procedural Coding System (HCPCS) codes, International Classification of Diseases, 9th and 10th Revision, Clinical Modification (ICD-9-CM, ICD-10-CM) diagnosis and procedure codes and Revenue codes.

The Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set regulation stipulates submission and acceptance of approved medical code sets. HCPCS and ICD-9-CM or ICD-10-CM and ICD-10-PCS codes are among the approved HIPAA medical code sets and must be valid for the actual date of the service. If a HCPCS or ICD-9-CM or ICD-10-CM and ICD-10-PCS code is not valid for the date of service, the claim will be returned or denied.

Revenue codes are a data element of the institutional claim (837I or UB-04) and must be valid for the date of submission. If a Revenue code is not valid on the date submitted, the claim will be returned or denied.

HCPCS Codes

The HCPCS coding system was developed by CMS (Centers for Medicare and Medicaid Services) to standardize coding systems used to process claims for all payers, including Medicare and Medicaid. HCPCS is a two level coding system- Level I, a.k.a., CPT, and Level II, alpha-numeric codes.

All nationally developed codes are accepted; however, coverage is not guaranteed and other restrictions may apply. Services may deny for various reasons including a subscriber contract exclusion or service limitation, Blue Cross corporate or medical policy, or subject to standardized coding edits.

HCPCS codes are updated several times throughout the year. The primary update is January of each year. CMS provides updates to Level II codes on a quarterly basis. In addition to January, code updates are done in April, July and October. CPT codes are generally updated only in January; however, the AMA can release codes early and make codes slated for the next year's publication available in the prior July.

You will be notified of coding updates by Bulletin or the *Provider Press* newsletter as to effective date of acceptance by Blue Cross.

Reimbursement of new HCPCS/CPT codes billed on professional claims (CMS HICF/837P) will be based on of the then current standard Blue Cross fee schedule allowed amount unless explicitly stated otherwise.

CPT/Level I

Level I or CPT (Current Procedural Terminology) codes are developed and maintained by the American Medical Association. Each procedure is identified with a five-digit numeric or numeric-alpha code. CPT is a set of codes, descriptions and guidelines intended to describe procedures and services performed by physicians and other health care providers. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

There are eight main sections to the CPT manual, including subsections with anatomic, procedural, conditions or descriptor subheadings. All listings are in numeric order except for Evaluation and Management (E/M) codes. E/M codes are the most frequently used and are listed first in the CPT manual

Section Numbers and Sequences:

E/M	99201 to 99499
Anesthesiology	00100 to 01999 and 99100 to 99140
Surgery.....	10021 to 69990
Radiology	70010 to 79999
Pathology and Laboratory	80047 to 89398
Medicine (except Anesthesiology)	90281 to 99199 and 99500 to 99607
Category II Codes.....	0001F to 9007F
Category III Codes.....	0019T to 0380T

Modifiers

A modifier is used to indicate that the service or procedure that has been performed has been altered by some specific circumstance but has not changed the definition or code. A complete listing of modifiers is found in Appendix A of CPT. Level I codes are not limited to CPT modifiers. HCPCS Level II modifiers may also be used with Level I codes and/or in combination with CPT modifiers.

CPT/Level I
(continued)

CPT Format

CPT codes are five characters in length (either all numeric or numeric-alpha) and designed as stand-alone descriptions of medical procedures. Some procedures in CPT are not printed in their entirety but refer back to a common portion of the procedure listed in the preceding entry. These are sometimes referred to as indented procedures.

For example:

97010.....Application of a modality to one or more areas; hot or cold packs

97012.....Traction, mechanical

The common part of the code 97010 is before the semicolon and is also considered part of the code 97012. The full narrative for 97012 is “Application of a modality to one or more areas; traction, mechanical.”

Guidelines

Guidelines are presented at the beginning of each of the main eight sections. Some section subheadings may contain instructions or information specific to those codes.

Code Symbols

Certain symbols may precede a code to indicate additional information:

- New CPT codes will be preceded by a bullet (●) symbol.
- Revised CPT codes will be preceded by a triangle (▲) symbol.
- Add-on CPT code will be preceded by a plus (⊕) symbol.
- Codes that include moderate sedation will be preceded by a target (⊙) symbol.

Level II HCPCS Level II HCPCS are developed and maintained by CMS. Level II consists of codes for supplies, materials, injections and services. Each Level II code is identified with a five-character (alphanumeric) code.

Level II codes are generally referred to simply as HCPCS codes to differentiate them from the Level I (CPT) codes. HCPCS codes are generally used because CPT has a limited code selection for these areas. All listings are in alpha category order except for modifiers.

Format

HCPCS codes are five characters in length, consisting of one alpha and four numeric characters. Level II codes start with alpha characters A through V and relate to these nationally defined categories:

- A0000-A0999.....Transportation Services Including Ambulance
- A4000-A8999.....Medical and Surgical Supplies
- A9000-A9999.....Administrative, Miscellaneous and Investigational
- B4000-B9999Enteral and Parenteral Therapy
- C1000-C9999Outpatient PPS
- D0000-D9999.....Dental Procedures
- E0100-E9999.....Durable Medical Equipment
- G0000-G9999.....Procedures/Professional Services (Temporary) (including Injections, Laboratory, Medical Services, Supplies)
- H0001-H2037.....Alcohol and Drug Abuse Treatment Services (includes prenatal care codes)
- J0000-J9999.....Drugs Administered Other than Oral Method (J0000-J8499 – Other than Chemotherapy, J8500- J8999 – Oral Chemotherapy Drugs, J9000-J9999-Chemotherapy Drugs)
- K0000-K9999.....Temporary Codes (for DMERCS including Durable Medical Equipment, Orthotics & Prosthetics, Supplies)
- L0000-L4999.....Orthotics Procedures and Devices
- L5000-L9999.....Prosthetic Procedures

Level II HCPCS
(continued)

M0000-M0999.....Medical Services
P0000-P9999Pathology and Laboratory (including Blood Products)
Q0000-Q9999Q Codes (Temporary) (including Injections, Laboratory,
Occupational Therapy, Physical Therapy)
R0000-R5999Diagnostic Radiology Services (including Portable X-ray)
S0000-S9999Temporary National Codes (Non-Medicare)
T1000-T9999.....National T Codes Established for State Medicaid Agencies
V0000- V2799Vision Services
V5000- V5399Hearing Services

Modifiers

A modifier is used to indicate that the service or supply has been altered by some specific circumstance but has not changed the definition or code. A complete listing of modifiers is found as an appendix to the HCPCS manual. Level II codes are not limited to HCPCS modifiers. CPT modifiers may also be used with Level II codes and/or in combination with HCPCS modifiers.

Code Changes

- New HCPCS codes will be preceded by bullet (●) symbol.
- Revised HCPCS codes will be preceded by a triangle (▲) symbol.
- Reinstated HCPCS codes will be preceded by a circle (○) symbol.

Reinstated codes were previously deleted codes that have been reactivated.

ICD-9-CM/ICD-10-CM

ICD-9-CM and ICD-10-CM are a statistical classification system that arranges diseases, injuries and procedures into groups.

Most ICD-9-CM are numeric and consist of three-, four- or five-digit numbers and a description.

ICD-10-CM codes are:

- Up to seven characters in length
- Always starts with an alpha character
- Second character is always numeric (0-9)
- Characters 3-7 can be either numeric or alpha
- Placeholder of “X” is used when the 7th character is required and there is no 5th or 6th character

The coding structure is revised approximately every 10 years by the World Health Organization. Annual updates, effective October 1, are published by NCVHS and CMS.

Code Changes (not all publishers will include this information)

- New ICD-9-CM or ICD-10-CM codes will be preceded by a bullet (●) symbol.
- Revised ICD-9-CM or ICD-10-CM codes will be preceded by a triangle (▲) symbol.

Format for ICD-9-CM

ICD-9-CM consists of three volumes:

Volume I - The Tabular List

Volume I is a numeric listing of diagnosis codes and descriptions consisting of seventeen chapters that classify diseases and injuries. In addition, two sections of supplementary codes (V and E codes) are included.

Most diagnosis codes are four- or five-digit codes. The base ICD-9-CM diagnosis code consists of three digits, which may be further defined or classified by a fourth or fifth digit following a dot (this divides and identifies the base diagnosis).

Volume 2 - The Alphabetical Index

Consists of an alphabetic list of terms and codes.

ICD-9-CM/ICD-10-CM
(continued)

Volume 3 - Procedures: Tabular List and Alphabetic Index

Volume 3 is a numeric listing of procedure codes and descriptions consisting of 17 chapters containing codes and descriptions for surgical procedures and miscellaneous diagnostic and therapeutic procedures. Codes from Volume 3 are intended only for use by hospitals for inpatient services.

ICD-9-CM procedure codes are two-, three- or four-digit codes. The base ICD-9-CM procedure code consists of two digits that may be further defined or classified by a third or fourth digit following a dot (this divides and identifies the base procedure).

ICD-10-PCS

Format for ICD-10-CM

ICD-10-CM contains an Alphabetic Index and a Tabular Index.

The alphabetical is a list of terms and their corresponding codes.

- Alphabetic Index lists main terms in alphabetical order with indented sub terms under main terms
- Index is divided into 2 parts: Index to Diseases and Injuries and Index to External Causes

The tabular List is a chronological list of codes divided into chapters based on body system or condition. There are 21 chapters in ICD-10-CM.

- Tabular List is presented in code number order

Linking/Pointing or Sequencing for Diagnoses

In the professional claim record, there are two diagnosis elements - one is at the header level of the claim and the other is at the line level and points to the values populated at the claim level. In the 837P electronic transaction record the Diagnosis Code Pointer is found in the 2400 loop - SV107-1, SV107-2, SV107-3, SV107-4.

The primary diagnosis for the service performed must be appropriately linked to that service, especially if more than one diagnosis relates to a line item. Up to eight diagnoses can be submitted per professional claim and up to four of those can be linked to a detail service line; however, adjudication is based on the first linked diagnosis.

Only valid diagnoses submitted to their full specificity, are accepted.

ICD-10-PCS

ICD-10-PCS (Procedure Coding System) is a replacement for ICD-9 procedures (ICD-9-CM, Volume 3). Like ICD-9 volume 3 codes, they are intended only for use by hospitals for inpatient services.

ICD-10-PCS structure:

- ICD-10-PCS has 7 digits
- Each can be either alpha (not case sensitive) or numeric
- Numbers 0 – 9 are used
- Letters O and I are not used to avoid confusion with numbers 0 and 1
- Build-a-code concept – a code is chosen from each category below to define a specific procedure
 1. Section
 2. Body system
 3. Root operation
 4. Body part
 5. Approach
 6. Device
 7. Qualifier

Only valid procedures submitted to their full specificity, are accepted.

Revenue Codes Revenue codes are developed by the National Uniform Billing Committee (NUBC) and are used to identify specific accommodation charges, ancillary service charges, or a type of billing calculation. They are only to be submitted on the institutional electronic claim format (837I).

Format

Revenue codes are four digits in length. The first three digits define the category and the fourth digit defines the subcategory. It is important for the subcategory to be properly defined for appropriate payment. For example: 012X is the category for “Room & Board-Semi-Private (Two Bed).” While 012X indicates the type of accommodations it does not identify the department or area in the hospital where the patient is staying. However, the code **0122** Obstetrics (OB) would properly indicate a semiprivate room in the OB.

The list of revenue code is extensive and can be found in the NUBC UB 04 manual under FORM LOCATOR SPECIFICATIONS, form locator 42.

HIPAA transaction standards require submission of HCPCS/CPT codes on outpatient facility claims. Guidelines for submission of HCPCS/CPT codes including modifiers can be found in the UB-04 manual under FORM LOCATOR SPECIFICATIONS, form locator 44.

Compatibility

HCPCS and ICD-9-CM and ICD-10-CM Codes

Blue Cross requires that diagnosis codes and procedures performed be compatible. These conditions are identified separately not only to assure correct coding, but also appropriately apply benefits. For example, maternity related procedures should be linked to maternity related diagnoses.

Revenue Codes

Revenue codes must also be compatible with the type of facility, place of service and type of claim. On the 837 institutional claim, this is the claim facility type code and claim frequency code. Some revenue codes are very specific to the place where the service was rendered.

For example, the TOB 0111 indicates an original claim for a hospital inpatient admission through discharge.

Preventive Care
Coding Tips
Brochure

Blue Cross recognizes the importance of preventive care for our subscribers. The preventive care you provide helps people stay healthy, avoids the onset of disease, and reduces healthcare costs.

Because there is often confusion about appropriate coding for preventive care, Blue Cross put together a brochure with tips to help providers navigate this area. The preventive care coding tips brochure is available on our website at providers.bluecrossmn.com under tools and resources.

Preventive Care
Services

Administration of Blue Cross' preventive care policy includes a list of defined preventive care services according to evidence-based guidelines. Payment for listed services would be subject to the subscriber's coverage options for preventive care and cancer screening. Variations in preventive payment and coverage may occur based upon contracts, benefits and funding type (fully insured employer group versus self-insured employer group). Benefits should be verified through use of the electronic eligibility transaction, our provider web self service site at www.availity.com or through BLUELINE.

Services Considered Preventive

If a patient presents to have these services performed for preventive purposes, claims will be adjudicated as preventive care provided the reason for the visit on the claim is listed as preventive, regardless of outcome. Blue Cross' administrative guidelines are as follows:

Service	Frequency (does not apply to Blue Plus)	Clinical Practice/ Guidelines
Abdominal Aortic Aneurysm (AAA) screening	1 per lifetime	Blue Cross / USPSTF
Vision Screening: Glaucoma, Acuity, Refraction	1 per year	ICSI / Blue Cross
Hearing	1 per year	ICSI / Blue Cross
Immunizations	Per schedules determined by clinical guidelines	CDC / ACIP / Federal Mandate
Radiology: Osteoporosis Screening	1 per year	ICSI / USPSTF
Laboratory Services: Lipid Screening	As recommended by physician	ICSI / Blue Cross
Diabetes Screening	As recommended by physician	Blue Cross / ICSI / USPSTF
STD Screening: HIV, Chlamydia, Gonorrhea, Syphilis	As recommended by physician	ICSI / State of MN Mandate

	Service	Frequency (does not apply to Blue Plus)	Clinical Practice/ Guidelines
Preventive Care Services (continued)	Preventive Medical Examination for Adults including: <ul style="list-style-type: none"> • Skin Exam (including looking for melanomas, sores, lesions) • Skin Cancer Counseling to Reduce UV Ray Exposure • Testicular Exam • Prostate-Digital Rectal Exam • Breast Exam • Breast Cancer Medications Counseling • Hypertension Screening • Aspirin Use Counseling for People with Elevated CVD Risk • Height, Weight, BMI Measurements 	As recommended by physician	Blue Cross / ICSI / State of MN Mandate/U SPSTF

Cancer screening paid at the highest level

Service	Frequency	Clinical Practice/ Guidelines
Colorectal Cancer Screening: Occult Blood	1 per year	ICSI/ACS
Colorectal Cancer Screening: Barium Enema, Sigmoidoscopy, Proctosigmoidoscopy	As recommended by physician	ICSI/ACS

Preventive Care
Services
(continued)

Service	Frequency (does not apply to Blue Plus)	Clinical Practice/ Guidelines
Stool DNA, CT Colonography		
Colorectal Cancer Screening: Colonoscopy (includes selected bowel preparations, by prescription, under pharmacy benefit)	As recommended by physician	ICSI/ACS
Cervical Cancer Screening: Pap Smear	1 per year	ICSI.ACS
Breast Cancer Screening: Conventional Film Screen Mammography	1 per year	ICSI.ACS
Prostate Cancer: Prostate Specific Antigen (PSA)	1 per year	Blue Cross / State of MN Mandate
Ovarian Cancer: CA125, Trans-vaginal Ultrasound	1 per year	Blue Cross / State of MN Mandate

Preventive Care
Services
(continued)

Services for consideration under the illness/medical level of benefit

- Any/all services that have an increased frequency due to an effort to control or prevent abnormal condition from recurring
- Procedures not considered preventive according to evidence-based guidelines developed as clinical and industry standards; for example, chest X-rays, urinalysis, complex lab and diagnostic imaging procedures
- Contraceptive management that is not part of Patient Protection and Affordable Care Act (PPACA) women’s preventive “contraceptive methods and counseling”
- Eyewear including lenses, frames and contact lenses

Using the current version of the ICD-9-CM or ICD-10-CM, report the patient’s condition at the highest level of certainty that are related to the services provided. Both the findings (if any exist) and the reason for the visit should be reported.

Clinical practice guideline abbreviations include:

- CDC/ACIP – Centers for Disease Control/Advisory Committee on Immunization Practices
- ICSI – Institute for Clinical Systems Improvement
- ACS – American Cancer Society
- State of MN Mandate – Mandated by Minnesota statute
- Blue Cross – Blue Cross and Blue Shield of Minnesota and Blue Plus
- USPSTF – United States Prevention Services Task Force

Preventive
Services
Required Under
the PPACA

The Patient Protection and Affordable Care Act (PPACA) otherwise known as health care reform (HCR), includes a provision for preventive services at no cost to eligible subscribers. Blue Cross has always considered preventive services an essential part of a subscriber's ongoing care and will continue to administer preventive services in conjunction and in accordance with the administrative and recommended guidelines under HCR:

- United States Preventive Services Task Force (USPSTF) ratings of A or B
- Advisory Committee of Immunization Practices (ACIP), under the Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA) Guidelines for Preventive Care and Screenings for Women, Infants, Children and Adolescents (Children and Adolescents is called "Bright Futures")

Blue Cross' Preventive Care Services and Administrative Guidelines already incorporated a majority of these recommendations. Recommendations we already cover as preventive prior to PPACA are not listed below. As a result of PPACA, additional guidelines have been included under Blue Cross' preventive care services to ensure compliance with the law. Please see the chart below for more information on the additional services, recommendations and suggested coding.

Note: dx = diagnosis

	Preventive Service	Health Care Reform Recommendation	Suggested Codes
Preventive services required under the PPACA (continued)	<p>Counseling related to BRCA screening and BRCA Screening</p>	<p>The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</p> <p>Additional Federal guidance received in 2013 indicated BRCA screening covered under PPACA Benefit effective upon commercial plans/policies in scope of PPACA upon their plan year beginning on or after 01/01/2014. Eligibility for BRCA screening at preventive benefit levels is subject to medical necessity criteria in medical policy “Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1 and BRCA2 Genes) (VI-16). Pre authorization is required for this service. Medical policies are available at providers.bluecrossmn.com</p>	<p>Counseling: 96040, 99401-99404 and S0265 as preventive with ICD-9-CM dx V10.3, V10.43, V16.3, V16.41, V16.8 or V26.33 or ICD-10-CM dx Z31.5, Z80.3, Z80.41, Z80.8, Z85.43</p> <p>Screening: 81211 – 81217 with ICD-9-CM dx V10.3, V10.43, V16.3, V16.41, V26.33 or ICD-10-CM dx Z31.5, Z80.3, Z85.41, Z85.43</p>
	<p>Interventions to support breastfeeding</p>	<p>The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.</p>	<p>S9443 as preventive with ICD-9-CM dx V24.1 or ICD-10-CM dx Z39.1</p>

Preventive services required under the PPACA (continued)

Preventive Service	Health Care Reform Recommendation	Suggested Codes
Dental caries prevention	<p>The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF strongly recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.</p> <p>Additional Federal guidance received in 2013 indicated fluoride supplements (OTC and Prescription), with a prescription, covered under PPACA for children ages 6 months – 6 years. Benefit effective upon commercial plans/policies in scope of PPACA upon their plan year beginning on or after 1/1/2014. Groups with pharmacy benefit managers (PBMs) other than Prime Therapeutics may have a different benefit. Member must have a prescription (even for the OTC) and purchase the items at a pharmacy or pharmacy counter with their benefit ID card.</p>	<p>D1206, 99188 (age 00-06)</p> <p>Note: Benefit for fluoride OTC or prescription obtained thru a pharmacy is for ages 6 months – 6 years</p>
Screening for depression: adolescents and adults	<p>The USPSTF recommends screening adolescents and adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow-up.</p>	<p>G0444 as preventive with ICD-9-CM dx V79.0, V82.89 or ICD-10-CM dx Z13.89</p>

Preventive Service	Health Care Reform Recommendation	Suggested Codes
Preventive services required under the PPACA (continued)	<p>Recommendation for counseling for a healthy diet with hyperlipidemia and other risk factors</p>	<p>99401-99404, 99411-99412, 99078, 97802-97804, S9452, S9470 as preventive with ICD-9-CM dx V65.3 or ICD-10-CM dx Z71.3</p>
	<p>Over-the-counter (OTC) and prescription supplements – effective upon plan or policy years beginning on or after 1/1/2014 (Note: different effective date for aspirin for pregnant women who are high – risk of pre-eclampsia)</p>	<p>No medical coding – pharmacy only. Member must have a prescription (even for OTC) and purchase at the pharmacy or pharmacy counter with their benefit ID card</p>

Preventive Service	Health Care Reform Recommendation	Suggested Codes
Preventive services required under the PPACA (continued)	<p>Recommendation for counseling for tobacco use</p> <p>The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</p> <p>Additional Federal guidance received in 2013 indicated tobacco cessation products (OTC and Prescription), with a prescription, covered under PPACA. Benefit effective upon commercial plans/policies in scope of PPACA upon their plan year beginning on or after 1/1/2014. Groups with pharmacy benefit managers (PBMs) other than Prime Therapeutics may have a different benefit. Member must have a prescription (even for the OTC) and purchase the items at a pharmacy or pharmacy counter with their benefit ID card</p>	<p>Counseling: 99401-99404, 99411-99412, as preventive with ICD-9-CM dx 305.1 or V15.82 or ICD-10-CM dx F17.200 F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291 or Z87.891</p> <p>99406-99407, S9453 as preventive with ICD-9-CM dx 305.1, 649.00, 649.03 or V15.82 or ICD-10-CM dx F17.200, O99.330, or Z87.891</p> <p>Products:</p> <p>The following codes will deny with a remark code indicating claim must process thru the PBM (pharmacy benefit manager):</p> <p>S4990, S4991, S4995</p>

Preventive Service	Health Care Reform Recommendation	Suggested Codes
Preventive services required under the PPACA (continued)	<p>Recommendation for counseling for tobacco use in pregnant women</p> <p>The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.</p>	<p>S9453, 99406-99407 as preventive with ICD-9-CM dx V22.0 - V22.2, V23.0 - V23.3, V23.41, V23.42, V23.49, V23.5, V23.7, V23.81 - V23.87, V23.89, V23.9, 649.00, 649.03 or ICD-10-CM dx O09.00, O09.10, O09.219, O09.299, O09.30, O09.40, O09.519, O09.529, O09.619, O09.629, O09.819, O09.829, O09.899, O09.90, O36.80X0, O99.330, O99.331, O99.332, O99.333, Z33.1, Z34.00, Z34.80</p>

Preventive services required under the PPACA (continued)

Preventive Service	Health Care Reform Recommendation	Suggested Codes
Assess for alcohol and drug use in adolescents	HRSA recommends alcohol and drug use assessments for adolescents	G0442, G0443, H0001, 99408-99409 as preventive with ICD-9-CM dx V65.42 or ICD-10-CM dx Z71.41, Z71.42, Z71.52, Z71.6
Screening and counseling for alcohol misuse in adults	USPSTF recommends that clinicians screen adults age 18 or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse	G0442, G0443, H0001, 99408-99409 as preventive with ICD-9-CM dx V65.42 or ICD-10-CM dx Z71.41, Z71.42, Z71.52, Z71.6
Behavioral assessments for children	HRSA recommends behavioral assessments for children of all ages	99420, 99160, 99161 as preventive with ICD-9-CM dx V79.0, V79.1, V79.2, V79.3, V79.8, V79.9 (age 00-20) or ICD-10-CM dx Z13.4
Testing for tuberculosis in children	HRSA recommends tuberculin testing for children at higher risk of tuberculosis	86580 as preventive with ICD-9-CM dx V74.1 (age 00-20) or ICD-10-CM dx Z11.1
Hepatitis B Virus Screening for Adults and Adolescents – effective ON 6/1/2015	USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection	86704, 86705 86706, 87340 87341
Screening and counseling for obesity: children	The USPSTF recommends that clinicians screen all children and adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.	97802-97804, 99078, 99401-99404, 99411-99412, G0447, S9470 as preventive with ICD-9-CM dx 278.00 or 278.01 or ICD-10-CM dx E66.09, E66.1, E66.8, E66.01, E66.9

Preventive Service	Health Care Reform Recommendation	Suggested Codes
Preventive services required under the PPACA (continued)	<p>Breast cancer preventive medications – effective upon plan or policy years beginning on or after 10/1/2014</p> <p>The USPSTF recommends that clinicians engage in shared, informed decision-making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.</p> <p>Coverage of generic tamoxifen and raloxifene for women AND men ages 35 and older when prescribed for prevention of breast cancer for those at elevated risk. Effective upon plan or policy years beginning on or after 10/1/14. Brand version of tamoxifen and raloxifene are eligible as a preventive benefit when a prescription drug exception has been initiated and approved thru Prime Therapeutics. Groups with pharmacy benefit managers (PBMs) other than Prime Therapeutics may have a different benefit.</p>	No medical coding - pharmacy only

Preventive services required under the PPACA (continued)

Preventive Service	Health Care Reform Recommendation	Suggested Codes
<p>Lung Cancer Screening – effective upon policy or plan years beginning on or after 1/1/2015</p>	<p>The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.</p>	<p>71250, 71260, 71270, G0296, G0297 as preventive with ICD-9-CM dx 305.1 or V15.82 or ICD-10-CM dx F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291, Z87.891</p>
<p>Hepatitis C virus infection screening – effective upon plan or policy years beginning on or after 1/1/2014</p>	<p>USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. Also recommends offering on – time screening for HCV infection to adults born between 1945 and 1965</p>	<p>86803, G0472</p>
<p>Screening Tests for Abnormal Blood Glucose and Type 2 Diabetes Mellitus – effective upon plan or policy years beginning on or after 1/1/16</p>	<p>USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.</p>	<p>82947-82951, 83036 as preventive with ICD-9-CM dx 278.00, 278.01 or ICD-10-CM E66.01, E66.09, E66.1, E66.3, E66.8, E66.9</p>

	Preventive Service	Health Care Reform Recommendation	Suggested Codes
Preventive services required under the PPACA (continued)	Screening for High Blood Pressure in Adults- effective upon plan or policy years beginning on or after 1/1/16	USPSTF recommends screening for high blood pressure in adults aged 18 years or older	93784, 93786, 93788, 93790 as preventive with ICD-9-CM dx 401.0, 401.1, 401.9, 405.01, 405.09, 405.11, 405.19, 405.91, 405.99, 416.0, 642.33, 642.90, 642.91, 642.92, 642.93, 642.94 or ICD-10-CM dx I10, I15.0, I15.1, I15.2, I15.8, I15.9, I27.0, N26.2, O13.1, O13.2, O13.3, O16.1, O16.2, O16.3, O16.9
	Tuberculosis Screening in Adults – effective for claims processed on or after 8/1/17	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk	85555-87557, 86480, 86481, 86580, as preventive with ICD-9-CM dx V74.1 or ICD-10-CM dx Z11.1

Preventive services required under the PPACA (continued)

- Effective for plan years beginning on or after August 1, 2012, PPACA requires certain items and services covered without cost-sharing for women as recommended by the:
- United States Preventive Services Task Force (USPSTF) ratings of A or B
- Advisory Committee of Immunization Practices (ACIP), under the Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA) Guidelines for Preventive Care and Screenings for Women, Infants, Children and Adolescents

To the extent not described in the USPSTF recommendations, HRSA was charged with developing comprehensive guidelines for preventive care and screenings for women. As part of this process, HRSA commissioned an Institute of Medicine (IOM) report entitled: “Clinical Preventive Services for Women: Closing the Gaps”

- Well-woman visit
- Screening for gestational diabetes mellitus (GDM)
- Counseling for sexually transmitted infection (STI)
- Counseling and screening for human immunodeficiency virus (HIV)
- Counseling and screening for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Human papillomavirus (HPV) testing
- Contraceptive methods and counseling

Certain religious employers and eligible organizations may be, respectively, exempt or eligible for accommodation from the requirement to cover these contraceptive benefits. Women enrolled through eligible organizations may have a separate ID card for preventive contraceptive benefits. Individual policy holders may not claim exemption.

Non-preventive care received during a preventive care visit is subject to normal plan cost sharing.

Please see the chart below for more information on the additional services, recommendations and suggested coding.

Women's preventive service	Blue Cross coverage	Frequency	Suggested Coding
Well-woman visit	Well-woman preventive care visit annually for adult women (ages 12 to 64) to obtain the recommended preventive services that are age and developmentally appropriate, which may include preconception and prenatal care as well as the list of services in Table 5 – 6 “Clinical Preventive Services for Women: Closing the Gaps” July 2011 report by the Institute of Medicine – http://iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx	Annual	99384-99386, 99394-99396 as preventive with ICD-9-CM dx V70.0 or V72.31 or ICD-10-CM dx Z00.00, Z00.01, Z01.411, Z01.419
Screening for gestational diabetes mellitus (GDM)	Based upon ICSI (Institute for Clinical Systems Improvement) GDM guideline below: <ul style="list-style-type: none"> • 50 mg oral glucose load followed one hour later by the blood draw • If the one-hour (above) glucose challenge test is positive, a 100 g load followed by a 3-hour glucose tolerance test should be performed <p>Note: Confirmation tests in the 2nd bullet (above) will be treated as preventive (\$0 member liability)</p>	Gestational diabetes screening for pregnant women at any stage (week of gestation) in the pregnancy – regardless of presence of high-risk factors such as: ethnicity, BMI, family history, previous GDM, patient has DM	82947, 82948, 82950, 82951, 83036 as preventive with any of the following ICD-9-CM dx V22.0-V22.2, V23.0-V23.3, V23.41, V23.42, V23.49, V23.5, V23.7, V23.81-V23.87, V23.89 or V23.9 or ICD-10-CM dx O09.00, O09.10, O09.219, O09.299, O09.30, O09.40, O09.519, O09.529, O09.619, O09.629, O09.819, O09.829, O09.899, O09.90, O36.80X0, Z33.1, Z34.00, Z34.80

Women's preventive service	Blue Cross coverage	Frequency	Suggested Coding
Counseling for sexually transmitted infections (STI)	<p>Counseling on STIs, group or individual sessions, once per year, 30-minute maximum per session for women regardless of sexual activity</p> <p>Counseling may be similar to the 5Ps of the CDC: partners, prevention of pregnancy, protection from STIs, practices and past STIs</p>	Annual	99401, 99402, 99411, G0445 as preventive with ICD-9-CM dx V65.45 or V69.2 or ICD-10-CM dx Z71.89, Z72.51-Z72.53
Counseling and screening for human immunodeficiency virus (HIV)	<p>Counseling on HIV, group or individual sessions, once per year, 30-minute maximum per session for women regardless of sexual activity</p> <p>Counseling up to individual practitioner but may be similar to the counseling for STI</p> <p>Screening for HIV (already paid as preventive by Blue Cross prior to PPACA): lab tests to screen for HIV-1 or HIV-2 antibodies</p> <p>Testing for HIV – effective upon plan or policy years beginning on or after January 1, 2014</p>	<p>Counseling: annual</p> <p>Screening for STI: as recommended by a physician</p> <p>Testing for HIV: as recommended by a physician</p>	<p>Counseling: G0445, 99401, 99402, 99411 as preventive with-ICD-9-CM dx V65.44, V65.45 or V69.2 or ICD-10-CM dx Z71.7, Z71.89, Z72.51-Z72.53</p> <p>Screening: 86701, 86703, 86689, G0432, G0433, G0435, 87390, 87534, 87535, as preventive</p> <p>Testing: S3645, 87210, 87536, 87538,87539</p>
Counseling and screening for interpersonal and domestic violence	<p>Screening up to each individual practitioner: may be survey or checklist, usually part of standard intake/triage for office visit</p> <p>Counseling – definition of counseling up to each individual practitioner, group or individual sessions, no time limit per session, but only one session per year covered as preventive (even if multiple sessions needed)</p>	Annual	<p>Screening: No suggested coding. No coding available for screening.</p> <p>Counseling: 99401-99404, or 99411 or 99412 as preventive with ICD-9-CM dx V70.0 or V72.31 or ICD-10-CM dx Z00.00, Z00.01, Z01.411, Z01.419</p>

Women's preventive service	Blue Cross coverage	Frequency	Suggested Coding
Breastfeeding support, supplies and counseling	<p>Support: Per Institute of Medicine (IOM) report: "Clinical Preventive Services for Women: Closing the Gaps" employer support of breastfeeding such as allowing time for mother to express milk at the office and providing quiet and private place to express and/or store milk (mother's room)</p> <p>Supplies: Purchase, up to 100 percent of allowed charges, of manual breast pump from in-network supplier or provider</p> <p>Counseling: Trained provider to ensure the successful initiation and duration of breastfeeding. May be provided as part of the hospital or birthing center delivery stay.</p>	<p>Counseling: in conjunction with each pregnancy</p> <p>Manual breast pump: purchase</p>	<p>Support: No suggested coding. No coding available for support.</p> <p>Supplies: E0602</p> <p>Counseling: S9443 as preventive with the following ICD-9-CM dx V24.1, V22.0-V22.2, V23.0-V23.3, V23.41, V23.42, V23.49, V23.5, V23.7, V23.81-V23.87, V23.89 or V23.9 or ICD-10-CM dx O09.10, O09.219, O09.299, O09.30, O09.511, O09.529, O09.619, O09.629, O09.819, O09.829, O09.899, O09.90, O36.80X0, Z34.00-Z34.03, Z39.1,</p>
Human papillomavirus (HPV) testing	Human papillomavirus DNA testing in women with normal cytology results, regardless of risk factors or sexual activity	Screening should begin at 30 years of age and should occur no more frequently than every three years	87623, 87624, G0476 as preventive

Women's preventive service	Blue Cross coverage	Frequency	Suggested Coding
<p>Contraceptive methods and counseling *</p> <p>* Certain religious employers and eligible organizations may be, respectively, exempt or eligible for accommodation from the requirement to cover these contraceptive benefits. Women enrolled through eligible organizations may have a separate ID card for preventive contraceptive benefits. Individual policy holders may not claim exemption.</p>	<p>Counseling: Counseling for women ages 12 to 64 by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning, and the distribution of family planning products, such as: charts, thermometers, drugs, medical preparations, and contraceptive devices. Does not include the performance, or referrals for encouragement of voluntary termination of pregnancy.</p> <p>Inform any woman requesting counseling on family planning methods or procedures of:</p> <ol style="list-style-type: none"> 1. Any methods or procedures that may be followed (which may include continuous abstinence, natural family planning/rhythm method), including identification of any that are experimental or may pose a health hazard to the woman, 2. A description of any attendant discomforts or risks that might reasonably be expected, 3. A fair explanation of likely results, should a method fail, 4. A description of any benefits that might reasonably be expected of any method, 5. A disclosure of appropriate alternative methods or procedures, 6. An offer to answer any inquiries concerning 	<p>Counseling: once/year</p> <p>Methods: Select oral contraceptives, supplies and procedures will be covered</p>	<p>Counseling: 99201-99205, 99211-99215</p> <p>99384-99386</p> <p>99394-99396,</p> <p>S0610, S0612 or</p> <p>S0613 as preventive with ICD-9-CM dx V25.01-V25.04, V25.09, V25.11 – V25.13, V25.41, V25.42, V25.43, V25.49, V25.5 ICD-10-CM dx Z30.011, Z30.013-Z30.014, Z30.018-Z30.019, Z30.012, Z30.02, Z30.09, Z30.11, Z30.12, Z30.18, Z30.41, Z30.430, Z30.431, Z30.432, Z30.433, Z30.49</p> <p>Methods: Varies depending upon covered drug, supply or procedure</p>

Women's preventive service	Blue Cross coverage	Frequency	Suggested Coding
<p>Contraceptive methods and counseling * (continued)</p>	<p>An instruction that the person is free either to decline commencement of any method or procedure or to withdraw consent to a method or procedure at any reasonable time Methods: For women ages 12 to 64; specific oral contraceptives on formulary, supplies and procedures. Coverage may vary by group and pharmacy benefit manager (PBM) and is subject to change if covered formulary changes. Members should contact customer service at the number on the back of their member ID card for the specific methods covered by their group or policy.</p>		

Preventive Services Required Under the PPACA (continued)

Not all health plans, policies or employer groups will define or administer the women's preventive coverage in the same way. PPACA requires coverage of the women's preventive items for non-grandfathered status plans. Blue Cross made a business decision to apply the women's preventive benefits to plans that accepted the prior PPACA preventive care package. Some of those groups may be grandfathered status. Also, self-insured groups may offer a different, or richer, benefit. Groups may have different drugs covered for "contraceptive methods and counseling" depending upon the pharmacy benefit manager (PBM) they use. Members should verify their preventive coverage before receiving benefits by calling the customer service phone number on the back of their member identification (ID) card.

General Guides

- Submit the code that most accurately identifies the service(s) performed. Documentation in the patient's medical record must support the codes submitted.
- Do not use multiple codes when services can be represented by a single code, unless otherwise instructed. Fragmented services (reporting several codes when one adequately defines the service) will be subject to our coding software edits and may be denied.
- Unlisted codes should only be used if no code exists to describe the service or supply. HCPCS codes for unlisted services require a complete narrative description.
- Submit all services for the same date of service on the same claim.
- "C" HCPCS codes.
 - Codes **C1000-C9999** are for items classified in new-technology ambulatory payment classifications (APCs) under the outpatient prospective payment systems. These codes are exclusively for use in billing for institutional transitional pass-through payments. Blue Cross does not use an APC methodology for adjudication or payment of claims, thus C codes will not be used in adjudication. Processing and payment will be determined by other factors on the claim, such as a revenue code.
 - It is the intention of CMS to allow the use of the codes by all payers regardless of payment methodology, so C HCPCS codes will be accepted on institutional (UB-04 or 837I) claims only. However, C codes submitted on a professional claim (CMS HICF/837P), other than freestanding ambulatory surgical centers (ASC), will deny as provider liability.
 - Free-standing ASC services are submitted on a professional claim format. C codes may be submitted, as appropriate, on freestanding ASC claims.

Zero-billing

Blue Cross will allow zero-billing or no-charge claim lines.

Coding Edits

Overview

Blue Cross uses an automated procedure editing tool. This tool has been adopted and modified by Blue Cross to assist in a consistent and fair claim review process. The procedure code edits may also reflect Blue Cross' Medical Coverage Guidelines, benefit plans and other Blue Cross policies. Unbundling, fragmentation, mutually exclusive procedures, duplicate, obsolete or invalid codes are all identified through the use of this coding edit application. The procedure code edits are based on CPT guidelines, a review of the Center for Medicare and Medicaid Services (CMS) Correct Coding Initiative policies and guidelines, specialty society guidelines, agreed upon industry practices and analysis by an extensive clinical consultant network. This automated review process is designed to apply the same industry criteria consistently across all professional claims.

Edit Descriptions

Procedure Code Unbundling/Replacement

Procedure code unbundling is the submission of multiple procedure codes for a group of specific procedures that are components of a single comprehensive code. Procedure unbundling may occur in one of two ways:

A professional claim could be submitted that has procedure codes for both the individual components, and the procedure code for the comprehensive procedure. Blue Cross would rebundle the individual component codes into the comprehensive procedure code for payment.

Procedure unbundling could also occur when a professional claim is submitted with only the individual components of the comprehensive code. In this situation, the software will recognize the relationship between the comprehensive code and its individual components. Then, it will automatically add the comprehensive code to the claim and rebundle the individual components into that comprehensive code for payment.

Edit Descriptions
(continued)

An example would be billing the following procedure codes together:

33207.....Insertion of heart pacemaker, ventricular

33208.....Insertion of heart pacemaker, atrial and ventricular

Procedure 33208 is identified as the primary procedure code. CPT 33207 would be rebundled because it is an integral part of procedure 33208. Rather than a line item denial, the procedure and related charge will be summed together and a new allowance for the surviving code will be established based on your contracted fee schedule.

Another example would be billing the following procedure codes together:

82374.....Carbon dioxide

82435.....Chloride

84132.....Potassium

84295.....Sodium

In combination, the four codes above would be rebundled and replaced with the more appropriate procedure **80051**-electrolyte panel. Related charges will be summed together and the allowance based on the comprehensive code **80051**.

When this edit is applicable, the following message will appear on your current remittance advice:

- *This service is a component of a procedure that has already been processed on this or another claim.*

Mutually
Exclusive
Procedures

Mutually exclusive procedures exist when a claim is submitted for two or more procedures that are not usually performed on the same patient, on the same date of service. In mutually exclusive relationships, the most clinically intense code is recognized for payment. Clinical intensity is generally based on the total RVU for the procedures submitted.

An example would be billing the following procedure codes together:

58260..... Vaginal Hysterectomy

58150..... Total Abdominal Hysterectomy

Since a hysterectomy would not be performed using two different approaches, the vaginal hysterectomy would be denied as mutually exclusive to the abdominal hysterectomy. This edit would result in the line item denial of procedure **58260** and would be the participating network provider's liability.

Another example would be billing the following procedures together:

27550..... Closed treatment of a knee dislocation

27556..... Open treatment of a knee dislocation

The knee would not be reduced by doing both procedures. The open procedure would survive as the one that was more clinically intense. This would result in the line item denial of procedure **27550** and would be the participating network provider's liability.

When this edit is applicable, the following message(s) will appear on your current remittance advice:

- *Payment is included in the allowance of the other procedure. Service is not payable with other service rendered on the same date.*
- *These charges are not covered. Less complex procedures with the same outcome and date of service as another procedure are not eligible.*

Incidental
Procedures

Incidental is defined as a procedure carried out at the same time as a primary procedure, but is clinically integral to the performance of the primary procedure, and therefore, should not be reimbursed separately.

An example would be billing the following procedure codes together:

59300.....Episiotomy

59409..... Vaginal delivery

An episiotomy performed as part of the overall management of a delivery does not warrant a separate identification. This would result in the line item denial of procedure 59300 and would be the participating network provider's responsibility.

Another example would be billing the following procedure codes together:

44005.....Enterolysis (lysis of adhesions, separate procedure)

44140..... Partial colectomy with anastomosis

Services that are identified by CPT with the term "separate procedure" are commonly carried out as an integral component of a total service. Separate procedures are not reported in addition to the total procedure or service of which it is considered an integral component. This would result in the line item denial of procedure **44005** and would be the participating network provider's liability.

When this edit is applicable, the following message(s) will appear on your current remittance advice:

- *This procedure is incidental to another procedure processed on this or another claim.*
- *This procedure is incidental to the primary procedure. Reimbursement is included in the allowance for that primary procedure.*

Medical Visits on the Same Day as Surgery

In keeping with the CPT surgical “package,” related E/M services are not reimbursed separately when submitted with a procedure performed on the same day. Modifiers may be used with E/M services that are not considered part of the same day surgical package. Please refer to the current year’s CPT manual for E/M services and surgery guidelines.

Some of the related CPT modifiers would include:

- **-24** unrelated E/M service by the same physician during a postoperative period
- **-25** significant, separately identifiable E/M service by the same physician on the day of a procedure or other service

The provider should add these modifiers when a patient’s condition requires a significant, separately identifiable service above and beyond the usual care associated with the procedure.

Modifier **-25** submitted with codes 99214 or 99215 will not automatically override the coding edit/denial. The submission of supporting documentation using the appeal process will be required in order for additional payment to be considered.

Documentation in your files **must** support the use of modifier **-25** with E/M codes as defined in CPT. Use modifier **-25** with new-patient and established-patient E/M codes to prevent denial of significant, separately identifiable E/M services performed on the same day as a procedure or other service. Some of these other services are allergy injections, joint injections, chemotherapy administration, brachytherapy services and dialysis. Modifier **-25** is not required by Blue Cross with consultation and emergency room codes.

One of the following messages will appear on your current remittance advice:

- *Payment is included in the allowance for another service/procedure*
- *Based on the other services submitted for this service date, reimbursement is not considered for this medical visit.*

Note: Requests to add a modifier **-24** or **-25** to a denied service must follow the appeal process. An adjustment request will not be allowed.

Global Surgical Package – Pre- and Postoperative Services

As defined by CPT, the surgical “package” includes the surgical operation, local infiltration, metacarpal/digital block or topical anesthesia when used, and the normal, uncomplicated follow-up care visits. These services, when billed in addition to surgery, are denied as included in the surgical allowance. The surgical package includes all normal and uncomplicated care including pre- and postoperative visits as part of the reimbursement for the surgical procedure. Preoperative visits are defined as visits by the surgeon or another practitioner in the same practice on the day of a surgery for minor procedures and the day before or day of major surgical procedures.

We do not consider new patient codes exceptions to the package. The fact that the patient is new is not reason alone to exclude the visits from the global package. Blue Cross follows the same postoperative time frames associated with surgical procedures as Medicare of 10 or 90 days. These can be found in the Federal Register. Routine postoperative medical visits rendered with this time frame and related to the surgery will not be recognized for separate reimbursement as an unbundled component of the total surgical package.

One of the following messages will appear on your current remittance advice:

- *This procedure is within the postoperative range for a surgery found on this or another claim.*
- *This procedure is within the preoperative range for a surgery found on this or another claim.*
- *Pre- and postoperative care is a covered benefit and these services are included in the allowance*

Modifiers -55 and -56

For Blue Cross, modifiers –**55** and –**56** for pre- and postoperative care are used with surgery codes.

Modifier –57

Modifier –**57** is used to indicate that the E/M service resulted in the initial decision to perform surgery either the day before a major surgery (90 day global) or the day of a major procedure.

Units of Service
Validation and
Restriction

Blue Cross edits procedure code units on professional claims (837P/1500 HICF).

While each service must be submitted with a unit of measurement, multiple units of service per code, per date of service are only applicable if the code definition supports submission of more than one unit. This is usually indicated by words such as each or per. Additionally, the number of units for codes that qualify for submission of multiple units may be subject to limits. Although Blue Cross is not following Medicare's Medically Unlikely Edits (MUE), the editing logic is similar to MUEs.

This edit will occur in the pre-adjudication phase of processing. If the claim submission does not pass (or fails for greater than one unit per day) it will stop and be rejected back to the provider.

This rejection occurs before the submission is accepted as a claim, therefore a claim number is not assigned and the provider must correct the data and resubmit all charges. There will not be any duplicate editing or adjustments because a "claim" was not created in the payer adjudication system.

The error denial message will be:

- 2045 -- Unit(s) billed is inconsistent with procedure code. Please correct the claim and resubmit.

General Claims
Processing
Information**Scope Procedures**

Our coding software makes the following assumptions when determining payment for multiple scope procedures billed on the same date of service:

- A diagnostic scope is always incidental to a surgical scope.
- A diagnostic scope with biopsy is always incidental to a surgical scope.
- A diagnostic scope with or without biopsy is always incidental to an open surgical procedure in the same area.
- A diagnostic scope rebundles to a diagnostic scope with biopsy unless the code description makes the distinction with biopsy vs. without biopsy.
- CPT descriptions such as: complete vs. partial, with vs. without, complex vs. simple, etc. means there are two mutually exclusive codes for the procedures.

Medical and
Surgical Supplies

Medical and surgical supplies during an outpatient or physician office visit are included as incidental to the E/M service or procedure performed, and will not be separately reimbursed.

Multiple Surgery
Guidelines

Multiple surgical procedures performed during the same operative session are processed in accordance with Blue Cross multiple surgical guidelines. These guidelines state the primary procedure is determined as the highest billed charge and is reimbursed at 100 percent of the fee schedule or billed amount, whichever is less. Secondary, tertiary procedures, etc., again determined in order of billed charge, are reimbursed at 50 percent of the fee schedule or billed amount, whichever is less, regardless of separate site or incision.

In addition, procedures noted in CPT as "modifier **-51** exempt" are not subject to multiple surgery reductions.

Patient Billing Impact The patient is not responsible and must not be balance billed for any procedures for which payment has been denied or reduced by Blue Cross as the result of a coding edit. Edit denials are designed to ensure appropriate coding and to assist in processing claims accurately and consistently.

Coding Appeals Blue Cross' coding edits are updated at minimum annually, to incorporate new codes, code definition changes and edit rule changes. All claims submitted after the implementation date of this update, regardless of service date, will be processed according to the updated version. Where Medicare's CCI (Correct Coding Initiative) edits are identical, we will consider the appeal with additional documentation, but the issue may be upheld. No retrospective payment changes, adjustments, and/or request refunds will be made when processing changes are a result of new code editing rules due to a software version update. Notice of this update will be published in the Provider Press or Provider Bulletin, with a 'Summary of Change' summarizing new edits.

Blue Cross has adopted a standard process to review edit appeals and providers have the right to appeal with additional information. If you have a question or appeal about our policy regarding a particular coding combination, provide a written statement of the concern, along with the following information and/or documentation normally required for a medical review.

- Written explanation supporting the procedures submitted, for example, specific references, specialty specific criteria
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted

Once received, the inquiry or appeal will be reviewed and if necessary, forwarded to the medical review department for determination. The review may result in approval or denial of the claim, based on review of the information submitted.

Note: Requests to add modifier **-24, -25 or -59** to a denied service must follow the appeal process. An adjustment request will not allowed.

Refer to *Chapter 10* for additional information regarding submission of appeals.

Helpful Coding Tips We recognize the challenges you have in staying up-to-date with coding changes. Below are some helpful tips to assist with accurate and effective coding to support correct claim processing and reimbursement.

Code using current coding books. Order new CPT and HCPCS manuals every year, as codes are added, deleted and revised annually. Submitting invalid or deleted codes will result in claim rejection or denials.

Coding
Immunizations
and Injections

It is appropriate when administering an immunization or injection to bill administration codes (**90460-90461, 90471-90474, 96372-96379, G0008-G0010**). Reimbursement for vaccines/toxoids and immunization administration is currently allowed in addition to preventive medicine services (**99381-99387, 99391-99397, 99401-99404**) and newborn care services (**99460-99463**).

Immunizations

If only an immunization is administered, bill the CPT code for the vaccine/toxoid administered and the applicable CPT administration code (**90460-90474**).

Example: A 65-year old patient comes to your office just for a flu vaccine. Bill the appropriate vaccine code and vaccine administration code, such as 90658 and 90471.

Immunizations and E/M Visits

E/M codes **99201-99205** and **99212-99215** are eligible for separate reimbursement when billed on the same date of service as vaccine/toxoid codes **90476-90749** and the immunization administration codes **90460-90461**.

Example:

- *A one-year-old established patient has a preventive visit and a polio vaccine. Bill the appropriate preventive visit CPT code (that is, 99392), the polio vaccine (that is, 90712) and in this case, the oral administration code (90473).*

Modifiers

Overview

All modifier guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Anesthesia

Overview

All anesthesia guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Behavioral Health

Overview

All behavioral health guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Chiropractic

Overview

All chiropractic guides have been moved to a Reimbursement Policy on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Dental Services

Overview

All dental guides have been moved to a Reimbursement Policy on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Durable Medical Equipment

Overview

All durable medical equipment (DME) and supply guides have been moved to a Reimbursement Policy on the Blue Cross website.

The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Home Health, Home Infusion, Hospice)

Overview

All home health, home infusion and hospice guides have been moved to a Reimbursement Policy on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is: 2

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Hospital/SNF Care

Overview

All hospital and skilled nursing facility service guides have been moved to a Reimbursement Policy on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Laboratory

Overview

All laboratory and pathology guides have been moved to a Reimbursement Policy on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Maternity

Overview

All maternity guides have been moved to a Reimbursement Policy on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Medical Emergency

Overview

All medical emergency guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Medical Services

Evaluation and Management (E/M)

All Evaluation and Management Services have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Anticoagulation Clinic-S9401

All anticoagulation clinic guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Chemotherapy Administration

All chemotherapy administration guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

E-Care Visits

All E-care visit guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Immunizations

All immunizations guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is: <https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Injections

All injections guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Interpreter Services	<p>All interpreter service guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:</p>
	<p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Locum Tenens	<p>All locum tenens guides have been moved to Reimbursement Policies on the Blue Cross website.</p>
	<p>The link to the Reimbursement Policy section on the Blue Cross website is:</p> <p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Natural Family Planning	<p>All natural family planning guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:</p>
	<p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Nicotine Dependence	<p>Blue Cross covers services for the treatment of tobacco dependence. However, coverage for these services depends on the type of provider submitting the claim, the procedure/service and diagnosis codes submitted, and the patient's contract with Blue Cross. Due to these many variables, exact payment cannot be determined until we receive the claims for processing.</p>
	<p>Diagnosis Codes</p>
	<p>If the <i>primary</i> reason for the outpatient visit to the clinician is tobacco use, claims should be submitted with one of the following diagnosis codes:</p>
	<ul style="list-style-type: none"> • 305.1 (ICD-9-CM) or F17.200 (ICD-10-CM) • V15.82 (ICD-9-CM) or Z87.891 (ICD-10-CM)
	<p>Procedure/Service Codes</p>
	<p>Clinicians should submit the HCPCS code that reflects the service furnished. Claims may process differently depending on the code submitted. The difference reflects the application of the member's contract benefits.</p>
	<ul style="list-style-type: none"> • E/M codes 99201-99215: Claims submitted using these problem-related visit codes will process according to the illness portion of the patient's contract.

Nicotine
Dependence
(continued)

- E/M codes **99241-99245**: Claims submitted using these consultation codes will process according to the illness portion of the patient's contract when submitted with a tobacco diagnosis.
- E/M codes **99401-99404**: Claims submitted using these preventive counseling codes will process according to the preventive portion of the patient's contract. These codes may also be covered under the Patient Protection and Affordable Care Act (PPACA) otherwise known as health care reform (HCR) and as such, will be processed according the preventive portion of the patient's contract.
- Codes **99406** and **99407**: Claims submitted using these counseling visit codes will process according to the illness portion of the patient's contract. These codes may also be covered under the Patient Protection and Affordable Care Act (PPACA) otherwise known as health care reform (HCR) and as such, will be processed according the preventive portion of the patient's contract.
- Code **S9453** for stop-smoking classes is generally not an eligible service under the patient's contract; however, may be covered under the Patient Protection and Affordable Care Act (PPACA) otherwise known as health care reform (HCR) and as such, will be processed according the preventive portion of the patient's contract.
- E/M codes **99384-99387** and **99394-99397**: These comprehensive preventive medicine services include counseling/anticipatory guidance/risk factor reduction interventions. Tobacco cessation counseling is part of a comprehensive preventative medicine evaluation. Therefore it is not separately reportable under these codes.
- Psychiatric codes 90832, 90833, 90834, 90836, 90837, 90838: Claims submitted using these codes will process according to the substance abuse portion of the patient's contract.

Nicotine
Dependence
(continued)

- Group counseling codes **99411-99412** will process according to the illness portion of the patient's contract when submitted with a tobacco diagnosis; however, may be covered under the Patient Protection and Affordable Care Act (PPACA) otherwise known as health care reform (HCR) and as such, will be processed according the preventive portion of the patient's contract.
- For questions regarding "incident to" services please refer to Chapter 8 of this manual.
- Codes for reporting patient documentation or supplemental tracking for performance measurement (**4000F-4001F**) may be submitted. These are zero-billed and zero-allowed codes.

Revenue Codes
Used by Facilities
0944, 0945 or
0953

Facilities such as hospitals, skilled nursing facilities and residential treatment centers, must bill for tobacco use under revenue codes **0944** (drug rehabilitation), **0945** (alcohol rehabilitation) or **0953** (Chemical Dependency (Drug and Alcohol)). Outpatient claims must be submitted with the appropriate HCPCS code. Claims submitted using these codes will process according to the substance abuse portion of the patient's contract.

Eligibility to Bill
for Specific
Procedures/Servi
ces

Standard guidelines regarding provider eligibility apply to procedures/services submitted with a tobacco diagnosis. Provider eligibility depends on the provider's scope of practice and the type of procedure/service being billed. Some procedure/service codes specific to mental health and chemical dependency may only be performed by a qualified mental health provider.

Coverage for
Tobacco
Treatment
Medications

All fully insured Blue Cross plans with drug coverage cover stop-smoking medications. The same copayments and deductibles apply. With a physician's prescription these patients are eligible for Zyban and/or any FDA-approved nicotine replacement therapy drug (patch, gum, lozenge, inhaler and nasal spray).

Note #1: In order to trigger this benefit, the patient does need a physician's prescription even if the medication is available over the counter (except as described below in Note #2).

Note #2: Blue Cross wants to encourage people to use both counseling and medications. Fully insured members who choose to enroll in the Stop-Smoking Program can trigger their benefit for either patch, gum or lozenge without a physician's prescription if:

- they enroll in our **free** Stop-Smoking Program (phone-based counseling),
- they have pharmacy benefits that cover FDA-approved OTC NRT and these benefits are administered through Prime Therapeutics, Blue Cross' pharmacy benefit manager, and
- the Quit Coach at the Stop-Smoking Program determines that the member can safely take the medications.

Each self-insured group account chooses whether or not if will cover prescription and/or over-the-counter stop-smoking aids. Thus coverage varies greatly among self-insured groups. Your patients who have Blue Cross coverage through a self-insured group should call the customer service number on the back of their member ID card to determine if they have coverage for tobacco treatment medications and what restrictions might apply. If you have questions you may contact Blue Cross provider services.

Medication
Therapy
Management
(MTM)

All medication therapy management (MTM) guides have been moved to Reimbursement Policies on the Blue Cross website.

The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Oral Medication	<p>All oral medication guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:</p> <p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Non-Physician Health Care Practitioners	<p>If the service is rendered by a non-physician health care practitioner that we credential, and/or verify licensure and are issued individual provider numbers, that practitioner must submit the services under the individual provider number that Blue Cross has issued to him or her or NPI.</p> <p>Some practitioners who are not credentialed or issued individual provider numbers or NPIs (such as LPN, RN, dietitian), work under the supervision of a physician. The services must be submitted under the supervising physician's provider number/NPI. The -U7 modifier must be submitted with the procedure/service to indicate these services. This includes those clinics with a pharmacist on staff. Services would be billed under the supervising MD with the -U7 modifier.</p>
Practitioners That ARE Credentialed by Blue Cross and Issued Individual Provider Number/NPIs	<ul style="list-style-type: none"> • Acupuncturists (LAc) • Certified Ind. Clinical Social Worker (CICSW) • Certified Marriage and Family Therapist (CMFT) • Certified Nurse Midwife (CNM) • Certified Professional Counselor (CPC) • Chiropractor (DC) • Dentist (DDS, DMD) • Psychologist (PhD., MA, PsyD., MS, EDD) • Licensed Certified Social Worker (LCSW) • Licensed Ind. Clinical Social Worker (LICSW) • Licensed Ind. Social Worker (LISW) • Licensed Marriage & Family Therapist (LMFT) • Licensed Prof. Clinical Counselor (LPCC) • Optometrist (OD) • Physician Assistant (PA) • Physician (MD, DO) • Podiatrist (DPM) • Psychiatric Mental Health Nurse Practitioner (PMHNP) • Registered Nurse Clinical Specialist (CNS) • Registered Nurse Practitioner (NP)

Practitioners that are NOT Credentialed by Blue Cross But Are Issued Individual Provider Number/NPIs

Although the following practitioner types do not go through the credentialing process, they do require an individual provider number or NPI for claims submission.

- Audiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Licensed Assoc. Counselor (LAC)
- Lic. Assoc. Marriage & Family Therapist (LAMFT)
- Licensed Psychological Practitioner (LPP)
- Occupational Therapist (OT)
- Physician Therapist (PT)
- Registered Nurse First Assist (RNFA)
- Resident
- Social Worker (Levels: LISW, LGSW, LSW, LMSW, CSW, LSW, LMSW, CISW, CASW)
- Speech and Language Therapist

Counseling and/or Risk Factor Reduction

Individual preventive medicine counseling (codes **99401-99404**) are reimbursed per contract benefits. Group preventive medicine counseling (codes **99411-99412**) may be covered under the Patient Protection and Affordable Care Act (PPACA) otherwise known as health care reform (HCR).

Room or Machine Set-Up Charges

Room or machine set-up charges are considered to be an integral part of the procedure/service being done. Do not submit separately for these services.

Supplies in the Office

All office supplies in the office guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Adjunct CPT Codes

Adjunct CPT codes **99024-99091** are designed for the provider to report special circumstances under which a basic procedure/service is performed.

Blue Cross does **not** consider these or provider inconvenience fees as reimbursable services and they are denied as a provider liability.

Care Plan Oversight Services

Care plan oversight services codes **99374-99380** are not reimbursed by Blue Cross as a separate service from the E/M codes and will deny as provider liability.

Prolonged Physician Services	<p>All prolonged physician services guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:</p> <p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Telephone Calls	<p>All telephone calls guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:</p> <p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Medical Team Conferences	<p>Medical conferences without face-to-face patient contact, codes 99367-99368, are not reimbursed, and will deny as provider liability.</p>
Televideo Consultants / Telehealth / Telemedicine Services	<p>All televideo consultations guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:</p> <p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Unusual Travel	<p>Unusual travel charges (99082) are non-covered services and will deny as provider liability</p>
Urgent Care	<p>All urgent care guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:</p> <p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>
Weight Management Care	<p>All weight management care, nutritional counseling and medical nutrition therapy guides have been moved to Reimbursement Policies on the Blue Cross website:</p> <p>https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies</p>

Assessment
Management
Program for Fully
Insured

The Integrated Health Management division of Blue Cross utilizes a management program called Access Management. The program only applies to fully insured members with commercial Managed care (Blue Plus) and preferred provider (Aware[®]) coverage who are using services at a higher frequency than their known medical conditions would normally warrant.

Program Details

Members that meet the Access Management program criteria will be assigned to a specific physician for their primary care needs who, in turn, will coordinate all their care and medication needs. The member will also be assigned to a single pharmacy and a single hospital. Access to specialty care may be discussed with the Blue Cross access manager assigned to the member. Assignment to the Access Management program is for 24 months.

Member identification

To see if a member is enrolled in the Access Management Program check the 270/271 Eligibility transaction as noted below.

Members enrolled in the program will have the letters AMP on their member ID card. Members currently enrolled will receive new member ID cards with AMP on them. As individuals are enrolled in the program a new member ID card will be issued with AMP on the card. When members exit the program a new member ID card will be issued without AMP.

Eligibility

If you are not the assigned physician, pharmacy or hospital for a member in this program, it may affect claims payment should you provide services to a member enrolled in this program. If we have received claims from you within 12 months prior to the member being placed in this program, you will be notified by telephone and/or letter of the member's placement.

Assessment
Management
Program for Fully
Insured
(continued)

Eligible services provided to a member in the Access Management program will only be reimbursed when one of the following criteria is met:

- The service is provided by the member's assigned provider
- The service is of a provider type or type of service that is not listed as needing Access Management. This includes Durable Medical Equipment (DME), home care, ambulance services, mental health or chemical health services.

Eligibility Transaction

The following Loops and Segments will be populated in the 271 eligibility response when the above Eligibility criteria are met.

- HIPAA Version 5010
 - 2110C/D – EB (Subscriber/Dependent Eligibility or Benefit Information)
 - EB01 = MC (Managed Care Coordinator)
 - 2110C/D – DTP (Subscriber/Dependent Eligibility/Benefit Date)
 - DTP01 = "193" (Period Start)
 - DTP02 = "D8" (Date Expressed in Format CCYYMMDD)
 - DTP03 = CCYYMMDD (Period Start Date)
 - 2110C/D – MSG (Message Text)
 - MSG01 = Access Management Program

Additional Information

If one of your patients is enrolled in this program, you will be notified by letter by the access manager. As the primary provider, you will be coordinating the identified member's care with the Blue Cross access manager.

If you have a patient covered by fully insured commercial coverage who you believe would benefit from the Access Management program, contact Ariel Cohen, manager, at **(651) 662-9005** or Louise Clyde, director, at **(651) 662-6193**.

Health Care
Home (HCH)

All health care home guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Optometric/Optical Services

Overview

All optometric and optical service guides have been moved to a Reimbursement Policy on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Pharmacy Services

Claims Submission

Pharmacy Claims for Blue Cross Subscribers without a Pharmacy Benefit Manager	<p>All pharmacies that are contracted with Blue Cross and Blue Shield of Minnesota (Blue Cross) are required to submit prescription charges on behalf of any Blue Cross subscriber, when a subscriber's contract does not use a pharmacy benefit manager. The pharmacy should not request that the subscriber pay for any services before claim adjudication other than the copayment amount stated on the subscriber's Subscriber ID card. At this time the pharmacy claims should be submitted in a paper format. Once the claim is received at Blue Cross, the appropriate benefits and reimbursement will be applied according to the provider and subscriber contracts.</p>
Claims Filing Requirements	<p>Most of our Subscriber 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 Subscriber's ID card. If the Subscriber has drug processing through Prime Therapeutics, the medical identification (ID) card will indicate RxPCN (the carrier code) "PGIGN" or "HMSH" for migrated subscribers. A Prime Therapeutics provider must be used. You must include the two-digit numeric dependent code, which is indicated before the name on the Subscriber ID card. For an example of a Subscriber ID card, refer to bluecrossmn.com. Type in the search field "sample id card."</p>
Drug Claims Submission	<p>Providers within the Prime Therapeutic network must submit claims electronically.</p> <p>If the Subscriber has Prime Therapeutics coverage, but the Prime Therapeutics information is not printed on the Subscriber ID card, the Subscriber should pay the prescription in full and submit the claim to Prime Therapeutics for direct reimbursement.</p> <p>Submit Prime Therapeutics Subscriber drug claims to:</p> <p>Prime Therapeutics Mail Route BCBSMN P.O. Box 25136 Lehigh Valley, PA 18002-5136</p>
Prescribing Physician's NPI	<p>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 Subscribers. Leaving this data element out or use of a dummy NPI number constitutes an incomplete pharmacy claim.</p>

Prior
Authorization

Expansion of Drug-related Prior Authorization Categories and Services

Blue Cross added prior authorization (PA) categories for drugs and an online PA request portal/service that is enabled with eligibility checking and electronic fax submission capability. Prior authorization requests may continue to be faxed to their review destination external to the portal. Complete a [Minnesota Uniform Form for Prescription Drug Prior Authorization \(PA\) Requests and Formulary Exceptions](#)

Prior authorization categories

PA categories and criteria can be accessed using the Blue Cross and Blue Shield of Minnesota provider link.

Access: [Resources for Health Care Providers](#)

- Under Tools and Resources, select Medical policy, then acknowledge the Acceptance statement.
- Select “+” next to “Utilization Management” scroll down the page to “Pharmacy Utilization Management” and Select.

Prior
Authorization
(continued)

CoverMyMeds prior authorization request service

CoverMyMeds (CMM) is a free service to providers, which allows quick and easy submission of PA requests for various drug plans. Experience with CMM by other plans has demonstrated marked reductions in physician office call-backs regarding PA requests, after CMM is implemented.

You may access CMM 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). You 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:

- **Find the right PA form** – Enter the state, drug, and Blue Cross drug plan and click Start request. The appropriate PA forms will display.
- **Share the PA form (optional step)** – Begin to populate the PA form then use the system to fax or email the form to another health care provider for completion.
- **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.

Injectable Drugs

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

Pharmacies
Submitting
Claims for DME

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

The Aware Agreement, Article III, Section A, "Scope of Services" states: "Provider shall provide Health Services to Subscribers for eligible Prescription Drugs which are authorized by a valid prescription." This section also includes the dispensing of durable medical equipment (DME) to Blue Cross subscribers.

It is the responsibility of the participating pharmacy to submit the claims for all such eligible services to Blue Cross on behalf of the subscriber. After the claim is processed by Blue Cross, you will be notified of the proper amount to bill the subscriber, if any balance remains due from the subscriber.

It is also the responsibility of all participating providers to abide by all other terms and provisions of the agreement including, but not limited to, the administration of the coordination of benefits provisions. This process is detailed in Article III, Section M, Coordination of Benefits.

Claim Processing

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 subscriber. Rely on “claim response” to correctly identify the amount to collect from the Subscriber. If a Subscriber’s contract contains the formulary amendment, a dual copay may be in effect. Again, rely on “claim response” to determine the correct amount to collect from the Subscriber.
Vacation Prescription Requests	Requests for additional drug quantities may be made by the Subscriber, physician, or pharmacist. The Subscriber would contact the customer service 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 drugs 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 Subscriber’s copay, the Subscriber should pay the lesser of the allowed amount as shown on the claims response.
Discounting or Waiving Copays	In order to maintain the level of subscriber responsibility specified in Blue Cross contracts, it is essential that Subscribers pay the agreed-upon copay for preferred and non-preferred drugs. Both Subscriber and provider agreements specifically state that the copay must be collected in full. Noncompliance of this provision, through discount or waiver, could result in termination of the provider agreement.
Pharmacy Audits	Blue Cross performs comprehensive pharmacy program integrity audits to ensure compliance with its programs.

Drugs

Drug Formulary

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

- **BCBSMN FlexRx:** This is the formulary for Blue Cross' PPO and other commercial business. This formulary provides Subscribers broad access to medications at a reasonable cost that utilizes both brand and generic drugs.
- **BCBSMN GenRx:** This is a formulary for some commercial business. This formulary consists mostly of generic drugs. Brand drugs are on the formulary only when a generic drug is not available to treat a specific medical condition or when the brand drug offers a significant advantage over generic drugs.
- **BCBSMN BasicRx Individual (Non-Grandfathered):** This is a formulary with an effective drug list that is designed to lower the cost of care with drug and category level exclusions. This formulary is compliant with the benchmark formulary requirements of the Affordable Care Act and is used in business lines where such compliance is required.
- **BSBSMN KeyRx:** This is a formulary for the commercial business. It is a formulary with an effective drug list that is designed to lower the cost of care with drug and category level exclusions.
- **BCBSMN GenRx Small Group (HSA-Blue Print-Blue Connect):** This is a formulary certified compliant with the benchmark formulary requirements of the Affordable Care Act and it is used in business lines where such compliance is required.
- **BSBSMN 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.

Drug Formulary
(continued)**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 non-preferred drug to a preferred status by sending a letter to Blue Cross. 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

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-Preferred
Status

Physicians may request coverage of a non-preferred drug for a Subscriber by completing the [Minnesota Uniform Form for Prescription Drug Prior Authorization \(PA\) Requests and Formulary Exceptions](#). Subscriber liability for non-preferred drugs is subject to the Subscriber specific benefit design.

Quantity Limits,
Prior
Authorization,
and Step Therapy

Blue Cross has implemented programs to help subscribers to use drugs safely and to make sure drugs prescribed by a provider are used correctly. The following programs are currently utilized by Blue Cross.

Prior Authorization: Blue Cross requires prior authorization for selected drugs (the list of drugs requiring prior authorization is available on the Blue Cross member/subscriber website and provider links). Providers or subscribers may initiate a prior authorization request from the Blue Cross website, by phone, fax, electronically or in writing.

Step Therapy: In some cases, Blue Cross requires a subscriber to first try certain drugs as a prerequisite to using a brand name drug in the same category.

Quantity Limits: For certain drugs, Blue Cross limits the amount of the drug that will be paid by Blue Cross at one time.

Substitutions/Interchanges: Blue Cross' formularies are designed to promote generic prescribing and utilization of generic drugs by subscribers, such that generic substitution or therapeutic interchange programs are seldom, if ever implemented. Minnesota State Laws determine how generic substitution and therapeutic interchange may be delivered at the point of sale. In general, a generic version of a brand name drug may be dispensed if in a pharmacist's professional judgment, the less expensive generically available drug is safely interchangeable with the prescribed brand.

Drug list and request form

FlexRx Standard Prior Authorization, Quantity Limit and Step Therapy Drug List (PDF) – The list is subject to change without notice.

1. Access [Blue Cross Health, Dental and Vision Plans](#)
2. To locate the document hit “See prescription drugs information”
3. Hit “search a drug list”
4. Select BCBS Minnesota and on the dropdown menu select “not a Medicare Part D Member”
5. Select BCBS MN FlexRx Drug List and find document titled “Utilization Management Summary”.

Quantity Limits,
Prior
Authorization,
and Step Therapy
(continued)

GenRx Standard Prior Authorization, Quantity Limit and Step Therapy Drug List t (PDF) – The list is subject to change without notice.

1. Access [Blue Cross Health, Dental and Vision Plans](#)
2. To locate the document hit “See prescription drugs information”
3. Hit “search a drug list”
4. Select BCBS Minnesota and on the dropdown menu select “not a Medicare Part D Member”
5. Select BCBS MN GenRx Drug List and find document titled “Utilization Management Summary”

Coverage Exception form can be found at www.myprime.com.

The prescriber can also get this form by calling provider services at **(651) 662-5200** or **1-800-262-0820**.

The prescriber must complete and submit a coverage exception form to request a quantity limit exception, prior authorization, or step therapy exception.

Compounded
Prescriptions

Use of the compound indicator for compounded prescriptions is reserved for prescriptions requiring the pharmacist to combine two or more ingredients.

Dispense As
Written (DAW)

Blue Cross provides for the payment of claims coded “dispense as written” (DAW). Consistent with state law, DAW must be in the physician’s handwriting or when an oral prescription is given, specifically stated. Physicians may use DAW to prevent generic substitution. Only a physician may indicate DAW on a prescription. Neither Subscriber nor pharmacist may change this status for any reason. A DAW may not always result in a lower copay. This will be dependent on the subscriber’s benefit plan.

Investigative
Drug Use

Drugs used investigatively are not eligible for reimbursement.

Drug Programs

Specialty Drugs

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

Other prescription drugs

Only select injectable and oral 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 in regard to the specialty drug network.

Specialty Drugs
(continued)**Specialty Network Suppliers**

The specialty drug benefit program offers you 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)
<https://www.alliancerxwp.com/>
- **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.

Minnesota Health Care Programs

Child and Teen Checkups

- Child and Teen Checkups (C&TC) are comprehensive preventive care services provided to children under the age of 21 enrolled in a Minnesota Health Care Program. These services are usually performed at the primary care clinic (PCC). They may also be performed by a public health nurse clinic.
- C&TC's can be identified by the billing of procedure code S0302 on the claim. Since these checkups involve additional time spent with the patient, this code allows the provider to charge a "bump-up" amount for performing the C&TC.

Covered Services

- Anticipatory guidance and health education
- Assessment of physical growth and measurements
- Health history including mental health, nutrition, and chemical use
- Developmental/behavioral assessments
- Physical examination including sexual development, oral exam
- Immunizations/review
- Laboratory tests including blood lead, hemoglobin/hematocrit and other tests as indicated
- Vision screening
- Hearing screening
- Dental checkups - verbal referral for preventive dental care
- Diagnosis and treatment of health conditions listed in the Minnesota Health Care Programs (MHCP) benefit plan and others determined to be medically necessary, are also covered services.

Child and Teen
Checkups
(continued)

The visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to:

- **Contraindication (medical reasons, service recently performed elsewhere):** Service may still be reported with \$0.00 or \$0.01 charge
- **Parent Refusal:** Service may still be reported with \$0.00 or \$0.01 charge
- **Unsuccessful Attempt (child uncooperative):** Service may be reported with modifier – 52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible.

Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed.

- Use most appropriate diagnosis code based on patient age.

C&TC Component	Commonly Billed Code(s)	Notes
Anticipatory Guidance and health education	Not billed separately, part of the E&M	
Measurement – height, weight, head circumference, blood pressure	Not billed separately, part of the E&M	
Health History	Not billed separately, part of the E&M	
Developmental/Autism Spectrum Disorder (ASD) in Toddlers	96110	<p>This code may be billed if a measurable tool is used to assess the developmental level of the child, or screening for Autism Spectrum Disorder (ASD) in Toddlers</p> <ul style="list-style-type: none"> • 96110 for an objective, standardized developmental screening instrument • 96110-U1 for an ASD-specific screening
Social-Emotional / Behavioral	96127	<p>This code may be billed if a measurable tool is used to assess the behavioral level of the child.</p> <ul style="list-style-type: none"> • 96127 for a social-emotional or mental health screening with a standardized instrument
Physical – including sexual development and oral exam	99381-99385 or 99391-99395	This code is billed according to whether the child is a new or established patient and the age of the child.

C&TC Component	Commonly Billed Code(s)	Notes
Immunizations / Vaccines	90460, 90461, 90471, 90472, 90473, 90474 Appropriate vaccine/toxoid code with an – SL modifier (if the immunization is available through the Minnesota Vaccines for Children program).	<p>Administration is billed with the appropriate administration code(s).</p> <p>Immunizations are billed with the appropriate vaccine code appended with an – SL modifier to indicate the vaccine was obtained free through the Minnesota Vaccines for Children program.</p> <p>All providers must use the available free vaccines for MHCP covered children.</p> <p>Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components.</p> <p>Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.</p>
Laboratory Tests	Billed as appropriate	
Blood Lead	83655	Blood lead screening is a required component at 12 and 24 months of age; but can occur at other times within these ranges if necessary. Lead testing is a federally required component of C&TC.
Vision	99173	This code may be billed for children three years of age and older to indicate that an objective screening was performed.
Hearing	V5008 or 92551, 92552, 92582 or 92583	This code may be billed for children three years of age and older to indicate that an objective screening was performed.
Dental Checkups- verbal referral	Not billed separately, part of the E/M	Dental services processed through Delta Dental of Minnesota.

C&TC Component	Commonly Billed Code(s)	Notes
Fluoride Varnish Application	99188	Billed by PCC or Public Health Nursing Clinic and paid as part of the C&TC. Eligible providers include: <ul style="list-style-type: none"> • Nurse practitioners • Nurses • Physicians • Physician Assistants • Staff under the supervision of the treating physician
Maternal depression screening	96161	Administration and interpretation of health risk assessment instrument for the mother. This service is billed on the child's claim.

S0302

If HCPCS code S0302 is submitted on a claim for any subscriber other than an MHCP subscriber, it will be denied as provider liability. Code S0302, completed early periodic screening diagnosis and treatment service (EPSDT) (list in addition to code for appropriate evaluation and management service), should be submitted only when a complete C&TC is performed for an MHCP subscriber (for example, Families and Children or MNCare).

C&TC Referral Codes

- The C&TC referral codes must be submitted on C&TC claims to inform state and county C&TC staff that a referral was made. Follow-up assistance is provided by the state and county to help assure follow-up care is received. The C&TC referral codes also fulfill Minnesota's reporting requirements to the Centers for Medicare and Medicaid Services (CMS) for the number of referrals made as a result of C&TC screenings.
- The C&TC referral code pertains to the entire claim and must be entered as value '01' in loop 2300, CLM12 on the 837P claim. It documents that a complete C&TC screening was performed for enhanced/appropriate reimbursement purposes.

Public Health
Nursing Services

The following services may be billed by Public Health on a professional claim (837P). Public Health may bill for Enhanced Services for “At-Risk” Pregnancies, as well as patient education services found in Chapter 10 of the MHCP manual.

Codes	Description
H1001	“At-risk” Antepartum Management
H1002	Care coordination
H1003	Prenatal health education I Prenatal health education II Prenatal nutrition education services
H1004	Postpartum follow-up home visit
S9442	Birth classes, non-physician provider, per session
S9443	Lactation classes, non-physician provider, per session
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session
S9446	Patient education, not otherwise classified, non-physician provider, group, per session

Interpretive Services

Blue Plus contracts with several interpreter agencies to provide sign and spoken interpreter services for subscribers of Blue Plus MHCP plans only.

These subscribers can be identified by their identification numbers, which begin with Alpha Prefix LMN or JTM. Effective October 1, 2018, Blue Plus implemented a change to require all ancillary service providers to perform their own direct billing for interpreter services (with some exceptions, noted below).

Ancillary Providers (see definition below) are welcome to utilize any agency that they wish, in-house or contracted agency or the services of any qualified interpreter at the clinic. Any interpreter services provided to Blue Plus MHCP subscribers must be rendered by an interpreter registered and rostered on the Minnesota Department of Health (MDH) website with proper certification.

Providers may use individual interpreters or may also establish a relationship with an interpreter agency. Providers must submit the claim for the interpreter services. Blue Plus will reimburse the Provider for the interpreter services provided at their site. The Provider pays the interpreter or agency directly. The arrangement between the Provider and the interpreter or agency is independent of Blue Plus.

Ancillary Services are defined as:

- Chiropractic
- Acupuncturist
- Vision Retail
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Eye Clinics
- Pharmacy
- Durable Medical Equipment (DME)
- Adult Rehabilitative Mental Health Services (ARMHS)
- Assertive Community Treatment (ACT)
- These listed providers must now perform their own direct billing.
- agency meet these requirements.

Services provided by interpreters who do not meet the qualifications outlined in the statute are ineligible for payment and should not be billed to Blue Plus. Interpreters who are not properly qualified cannot bill either Blue Plus or the subscriber.

Claims that do not have a medical claim associated with the interpreter claim are subject to recoupment.

Hospitals are responsible for arranging and reimbursing for interpreter services for hospital inpatient services.

Interpreter services are not separately reimbursable in a facility place of service, whether inpatient or outpatient, as the interpreter services are included in the facility's reimbursement.

Clinic based interpreter – If a primary care clinic or other health care provider has interpreter services available the subscriber must use the facility's interpreter services.

Interpretive
Services
(continued)

If a subscriber's Personal Care Assistance (PCA) speaks the same language as the subscriber a separate interpreter is not eligible. This is considered a duplication of service.

Exemptions to the Interpreter Policy:

The following provider specialties are exemptions from this policy:

- County Public Health and Social Service Agencies
- Care Coordinators and delegates
- Home Health Agencies

The only exception for direct billing to Blue Plus is:

- Dental
- Contracted County Social Service and Public Health
- Blue Plus Care Coordination Delegates
- Home Health Agencies (Non-Behavioral Health)

All others must direct bill.

Interpretive
Services
(continued)

Billing Guides

The following guides for reporting interpreter services have been approved by the MN Administrative Uniform Committee and are listed in the MINNESOTA UNIFORM COMPANION GUIDE FOR IMPLEMENTATION OF THE ASC X12/005010X222. HEALTH CARE CLAIM: PROFESSIONAL (837).

Note: Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report one unit.

- T1013 -- Face-to-face oral language interpreter services per 15 minutes
- T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes
- T1013-GT -- Telemedicine interpreter services per 15 minutes
- T1013-U4 -- Telephone interpreter services per 15 minutes
- T1013-UN, UP, UQ, UR, US Interpreter services provided to multiple patients in a group setting
 - Report T1013 for each patient in the group setting
 - Append the modifier indicating how many patients in the group
 - Report one unit per 15 minutes per patient
- Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line.
- Include appropriate “place of service” on the claim.
- No shows or cancellations will not be reimbursed
- Additional services that are not reimbursed are: interpreter’s mileage, parking fees, meals, wait time, travel time, transportation, voicemail services, and weekend or after-hours premium fees.

Ineligible Interpreter Services:

- Translating documents (paper to paper)
- Community health workers (CHW) – included in CHW service rates
- Day treatment & habilitation (DT&H) providers – included in the DT&H rate
- ICF/DDs (Intermediate Care Facility/Developmental Disability) – included in the facility rate
- Indian Health Service (IHS) for federally funded encounter rate recipients – included in the encounter rate
- Inpatient hospitals – included in the inpatient hospital DRG payment
- Nursing facilities – included in the per diem rate
- Transportation providers – the service of transporting a patient does not include interpreter service reimbursements

Blue Plus Contracted Interpreter Agencies

Provider		Geographic Coverage (By County)
<p>ARCH Language Network</p> <p>Phone: (651) 789-7897 or toll free at 1-877-789-7818 Monday – Friday: 7:00 am - 6:00 pm</p> <p>Fax: (651) 789-7898</p>		Metro, Southern MN, Western MN
<p>The Bridge</p> <p>Phone: (320) 259-9239 Monday – Friday: 8:00 am - 5:00 pm</p> <p>After hours and weekends: (320) 656-8119</p> <p>Fax: (320) 654-1698</p>		North Metro, St. Cloud, and surrounding counties
<p>Intercultural Mutual Assistance Association (IMAA)</p> <p>Phone: (507) 289-5960</p> <p>Fax: (507) 289-6199</p>		Southeast MN
<p>Itasca Interpretation Services</p> <p>Phone: 651-457-7400</p> <p>Fax: 651-457-7700</p> <p>24 hours, 7 days a week</p>		Metro
<p>The Language Banc</p> <p>Phone: (612) 558-9410</p>		Metro, Stearns and surrounding Counties
<p>Project FINE</p> <p>Phone: (507) 452-4100</p>		Winona County Only

Community
Health Workers

Blue Plus may reimburse for certain educational services provided by Community Health Workers (CHWs).

Practitioner Enrollment Process

- A CHW must meet Minnesota Department of Human Services (DHS) eligibility requirements and be enrolled through DHS before requesting enrollment with Blue Plus. DHS requirements are outlined in the MHCP Manual, which can be found at www.dhs.state.mn.us.
- Upon receiving a Unique Minnesota Provider Identifier (UMPI) number from DHS, a CHW may then request to be registered with Blue Plus. This process may be initiated by completing the Individual Practitioner Addition and Termination Form, which can be accessed at bluecrossmn.com. The CHW must be registered with Blue Plus before services can be billed.

Subscriber and Service Eligibility

Subscribers enrolled in the following Blue Plus plans will have benefits for services rendered by a CHW:

Blue Plus Plan	Alpha Prefix
Blue Advantage (Families and Children)	LMN
MinnesotaCare	LMN
Minnesota Senior Care +	LMN
SecureBlueSM (HMO SNP)	JTM

Community
Health Workers
(continued)

- In order to be considered eligible for reimbursement, educational services provided by a CHW must be rendered face to face in a clinic, outpatient or home setting and be related to a medical diagnosis. In addition, the services must be supervised by a Blue Cross and Blue Shield of Minnesota (Blue Cross) or Blue Plus eligible physician, dentist, public health nurse, mental health professional, or advanced practice registered nurse (APRN).
- Reference the MHCP Provider Manual for additional information regarding requirements for physician orders/care plans, medical record documentation, record keeping and curriculum as they relate to CHWs. This communication can be found at www.dhs.state.mn.us.

Billing

CHW services should be billed to Blue Plus as follows:

- Claims format: Professional (837P)
- Codes: 98960, 98961, 98962, D1206 or 99188
- Provider Number: Enter the Blue Plus individual provider number or UMPI number of the CHW on each service line
- Diagnosis: Enter a valid ICD-9-CM or ICD-10-CM diagnosis(es) on the claim and link to the appropriate service line

Reimbursement

Blue Plus will utilize our standard Minnesota Health Care Programs pricing methodology for reimbursement of CHW services.

Newborn
Circumcision

For subscribers of MCHP, claims payment for newborn circumcision is the responsibility of Blue Plus. Circumcision coverage is limited to only those procedures that are medically necessary (a pathologic condition exists that requires circumcision). This limitation applies to circumcision for all ages. The newborn circumcision exception for religious practice was eliminated.

A pre-authorization will be required for all circumcisions for determination of medical necessity.

Subscriber Eligibility

This legislative change in circumcision benefits and claims processing applies to subscribers in all MHCP products:

MHCP Product Name		Subscribers ID Alpha Prefix
Blue Plus: Blue Advantage (Families and Children)		LMN
Blue Plus: MinnesotaCare		LMN
Minnesota Senior Care Plus (MSC+)		LMN
Blue Plus: SecureBlue		JTM

Hearing Aid Fee
Schedule Update

Blue Plus uses the MHCP Hearing Aid Volume Purchase Contract (which contains the MHCP Hearing Aid Contract) as the base Medical Assistance Fee Schedule. Blue Plus will follow the non-covered code list contained in the MHCP Hearing Aid Contract and the DHS supply limits.

Products Affected

The following MHCP products are affected:

- Blue Advantage (Families and Children & MSC+)
- MinnesotaCare
- SecureBlue

MHCP Hearing Aid Volume Purchase Contract

The hearing aid service provider must dispense the hearing aid according to the hearing aid exam, selection and prescription of the otolaryngologist and audiologist.

For accurate claims processing, the provider will need to submit an attachment that includes the manufacturers' specifications. Providers should utilize the information contained in the current MHCP contracts, including manufacturer, model name and model number. This information will need to be included in the attachment when the claim for reimbursement is submitted. Blue Plus will verify that the hearing aid billed is a covered benefit for the subscriber and will apply the current MHCP Hearing Aid Volume Purchase Contract pricing for reimbursement. Items not included in this pricing will defer to the DHS Medical Assistance standard fee schedule or the Blue Plus standard fee schedule, as applicable.

Website

The current MHCP Contract Pricing can be found at:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_010724

Hearing Aid Fee
Schedule Update
(continued)

Pre authorization

If the subscriber requires a hearing aid that is not listed on the DHS Volume Hearing Aid Purchase Contract or the subscriber needs a replacement prior to the five-year expected usage of their current hearing aid, a pre authorization may be submitted for review of coverage to the Pre authorization fax line as follows:

- Blue Advantage Families and Children/MSD+/MNCare: 844-480-6839
- MSHO/SecureBlue: 866-959-1537

Please include the following information in the request:

Audiologic recommendations, including:

- Written recommendations for hearing aid(s), including the manufacturer specifications
- Follow-up plan for determining the effectiveness of the hearing aid
- Audiogram or reason why this was not obtained
- History of previous hearing aid use
- Pure tone average
- Reason why a standard hearing aid on the Volume Hearing Aid Purchase Contract is not appropriate for this subscriber

GenRx Formulary

The drug formulary GenRx will apply for subscribers covered under MHCP.

This formulary offers drugs that have been shown to be safe and effective, while being cost conscious. The GenRx formulary consists of almost all generics, with the exception of a few generics that were not included on the new formulary due to safety or efficacy concerns. A limited number of brand-name drugs will be on formulary to provide appropriate coverage of most disease states.

What does this mean for you?

You may need to prescribe a different drug that treats the same symptoms or condition to an MHCP subscriber. Please be aware that most of our SecureBlue subscribers have a Medicare Part D formulary and will not be affected.

What steps should you take?

Determine which of your patients' current prescription drugs will not be on the GenRx drug list. To determine which drugs are on the new GenRx formulary, visit bluecrossmn.com to view the list of drugs available to MHCP subscribers. Under the orange "Resources" tab, choose "prescription drugs." Then click on "Search the drug lists." When the pop-up window appears, choose the GenRx drug list.

What if a subscriber tries to fill a prescription for a drug not listed in the new formulary?

The prescription will not be filled by the pharmacy. The subscriber will be referred back to the prescribing physician for a new prescription.

Formulary
Exception
Process

Dispense as Written (DAW) will not process at point of sale until a formulary exception has been received.

Anti-psychotic drugs

For anti-psychotic drugs prescribed to treat a diagnosed mental illness or emotional disturbance that are not on the 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 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 non-formulary drug.

DAW for non-formulary drugs

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

Formulary
Exception
Process
(continued)

What does this mean for you?

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

What steps should you take?

Determine which of your patients' current prescription drugs written as DAW are not on the GenRx drug list. To determine which drugs are on the GenRx formulary, visit providers.bluecrossmn.com to view the list of drugs available to MHCP subscribers. Under the "Tools & Resources" tab, choose "formulary and special program drug lists." Then click on "see the lists" under "Blue Cross formularies" and select "GenRx."

What if a subscriber tries to fill a DAW prescription for a drug not listed in GenRx?

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

Glucose Testing
Meters

The new GenRx drug formulary for MHCP subscribers will include only the Bayer CONTOUR and BREEZE 2 glucose testing meters and strips. All other meters and test strips will be removed from the drug list.

We are committed to helping you make this change and serving these subscribers' health care needs. If the patient and doctor can show that a glucose meter other than the Bayer CONTOUR or BREEZE is the best option for a subscriber's treatment, the provider can ask Blue Plus for a formulary exception. For assistance with this, a subscriber can call the subscriber services number on the back of the subscriber ID card.

PCA Billing

Effective January 1, 2019, claims for Personal Care Assistant (PCA) services for members under age 65, must be submitted to the Department of Human Services (DHS).

Claims for Personal Care Assistant (PCA) services for members age 65 and older, must be submitted to Blue Plus using one date of service per claim line. PCA services may not be billed with a span of dates; each date of service must be billed separately. Any claim lines that are submitted with more than one date of service will be denied for improper format. All claim lines should have an individual PCA associated with the service.

All PCA claim lines, except for QP supervision, must include at least one of the relationship modifiers on each line. All other HCPCS code and modifier combinations still apply to PCA claims. Multiple modifiers can be submitted on one line to further identify services provided. Claims that do not include an appropriate modifier will be denied. These claims may be reconsidered when the appropriate modifier is provided to Blue Cross, however, in order to be as efficient as possible, please make every effort to submit the claims accurately and completely during the initial submission.

Report PCA services as follows:

PCA code/modifier combination	Code narrative	Modifier instructions
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of care treatment (code may not be used to identify services provided by home health aide or certified nursing assistant)	1:1 ratio (one assistant to one patient)
T1019-UA	Personal care services, ; PCA supervision	The – UA modifier is submitted to indicate PCA services are supervised
T1019-TT	Personal care services, ; Individualized service provided to more than one patient in same setting	The – TT modifier is submitted to indicate personal care assistant PCPO services at a 1:2 ratio (one assistant to two patients)
T1019-HQ	Personal care services, ; Group setting	The – HQ modifier is submitted to indicate personal care assistant PCPO services at a 1:3 ratio (one assistant to three patients)

PCA Billing
(continued)

PCA code/modifier combination	Code narrative	Modifier instructions
T1019-U6	Personal care services, Temporary service increase	The – U6 modifier is submitted to indicate the service is for a PCA temporary 45 day increase
T1019-U5	Personal care services, Services units available through the notice of termination, reduction or denial of services	The – U5 modifier is submitted to indicate the service is for a PCA notice of reduction
S5130	Homemaker service, NOS; per 15 minutes	
S5131	Homemaker service, NOS; per diem	

Individual PCA Enrollment

Individual PCA enrollment forms submitted with incomplete information will be sent back to the provider unprocessed along with a letter requesting the missing information. Upon receipt of a complete form, the form will be processed and, if appropriate, the individual will be affiliated with the agency. Blue Cross will require individuals to submit their assigned UMPI number on the enrollment form. Blue Cross will not enroll an individual PCA that submits a copy of the completed background study in lieu of an UMPI number.

Minnesota Health Care Programs

ID numbers for subscribers that have coverage with MHCP are as follows:

Product Name Group	Subscriber ID Numbers
Blue Advantage (Families and Children)	ID numbers that begin with Alpha Prefix LMN Age under 65 – Submit to DHS
MinnesotaCare Expanded (Children)	ID numbers that begin with Alpha Prefix LMN Age under 65 – Submit to DHS
Minnesota Senior Care Plus (MSC+)	ID numbers that begin with Alpha Prefix LMN Age 65+)
SecureBlue	All ID numbers that begin with Alpha Prefix JTM

Chiropractic,
Physical,
Occupational,
and Speech
Therapy
Authorization

All of the following services provided to MHCP subscribers will require pre-authorization by Blue Plus:

- Chiropractic services beyond 12 visits per calendar year
- Physical therapy visits beyond 40 visits per calendar year
- Occupational therapy visits beyond 40 per calendar year
- Speech therapy visits beyond 50 per calendar year

These changes are consistent with changes in Minnesota statute regarding chiropractic and therapy services for MHCP subscribers. Commercial lines of business are not impacted by this change.

Minnesota Health Care Programs

ID numbers for the affected products are as follows:

Product Name Group	Product ID Numbers
Blue Advantage (Families and Children)	All ID numbers that begin with Alpha Prefix LMN
MinnesotaCare	All ID numbers that begin with Alpha Prefix LMN
Minnesota Senior Care Plus (MSC+)	All numbers that begin with Alpha Prefix LMN
SecureBlue	All ID numbers that begin with Alpha Prefix JTM

Chiropractic,
Physical,
Occupational,
and Speech
Therapy
Authorization
(continued)

Outpatient physical, occupational and speech therapy services:

- Initial evaluation
- Any additional evaluations
- Plan of Care including the following:
 - Subscriber's diagnosis
 - Description of subscriber's functional status / limitations
 - Treatment plan
 - Treatment goals (functional, measurable and time-specific)
 - Requested frequency and expected duration of treatment
 - Discharge plan
 - Subscriber's progress toward goals

Ordering practitioner

Documentation Required

Pre authorization requests should be submitted two weeks in advance of reaching the visit threshold as listed above as follows:

- Phone number: 866-518-8448
- Fax PMAP/MSM+/MNCare: 844-480-6839
- Fax MSHO/SecureBlue: 866-959-1537

Submit the following documentation when requesting an authorization:

Chiropractic services:

Evaluation and diagnosis: Indicate how the subluxation diagnosis was determined.

Chief complaint: List subscriber's current symptoms.

Assessment and treatment plan: Provide your physical assessment and treatment plan including when the subscriber will be discharged, number of visits planned and frequency of visits planned.

Rationale for continued treatment: Provide evidence of subscriber's improvement with chiropractic services and goals for further care.

Chiropractic,
Physical,
Occupational,
and Speech
Therapy
Authorization
(continued)

Outpatient physical, occupational and speech therapy services:

- Initial evaluation
- Any additional evaluations
- Plan of Care including the following:
 - Subscriber's diagnosis
 - Description of subscriber's functional status / limitations
 - Treatment plan
 - Treatment goals (functional, measurable and time-specific)
 - Requested frequency and expected duration of treatment
 - Discharge plan
 - Subscriber's progress toward goals
 - Ordering practitioner

Pre authorization Process

The timeline for decisions is up to ten business days. Decisions will be communicated via telephone or fax, and letter. Approvals are communicated via telephone with a letter as follow-up. Denials are communicated with a fax copy of the denial letter and a follow-up letter sent by mail.

MHCP coverage guidelines are followed for MHCP subscribers. All services must be medically necessary for continued coverage.

Specialized Maintenance Therapy is only covered for children under 21 years of age.

Services to Restricted Recipients

Under the Minnesota Restricted Recipient Program, either DHS or Blue Plus identifies subscribers of Blue Plus 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 care 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. Although other subscribers of Blue Plus MHCP require a referral only to nonparticipating providers, all services to a restricted recipient from other than the designated primary care physician require a referral.

Restricted Recipient Program

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 care 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 care service from a designated provider, including services from a Blue Plus participating Personal Care Provider Organization (PCPO).

Services to
Restricted
Recipients
(continued)

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

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

If you are a designated primary care provider, you can verify this and the restricted recipient status of a subscriber through Blue Plus provider service or through MN-ITS, the Minnesota Department of Human Services (DHS) billing system, at www.mn-its.dhs.state.mn.us/login.html. Typically, a recipient is restricted to one primary care physician, pharmacy and hospital. A recipient may also be restricted to other designated providers or be referred by the primary care physician to other providers, if appropriate. When a subscriber is restricted only for certain types of services, no referral is required to restriction.

Claims Reimbursement

Eligible services provided to a restricted recipient will only be reimbursed when one of the following criteria is met:

- 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
- The service is of a provider type or type of service that is not listed as restricted on the recipient's file

Additional Information

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

www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922#mrrp.

MHCP Pre
authorization

MHCP coverage guidelines are followed for MHCP subscribers. All services must be medically necessary for coverage.

To obtain preauthorization, providers should complete the Pre-Service Request Form located on the Blue Cross website at:

<https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs>

To assure timeliness of the review, please submit your request form at least 14 days in advance of the procedure whenever possible.

Medical Necessity Criteria

To view the medical necessity review criteria for these services go to www.bluecrossmn.com/providers/migration-minnesota-health-care-programs and select “Medical Policy”

Coding Requirements Reminder

All coding and reimbursement is subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (for example, HCPCS, CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS), only valid codes for the date of service may be submitted or accepted.

Transportation
Services**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 rules in order to remain participating providers. 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.

BlueRide Common Carrier and Volunteer

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

Transportation
Services
(continued)

BlueRide handles Common Carrier Transportation requests for rides to and from medical and dental appointments with in-network providers, if the subscriber has no other means of transportation. A BlueRide representative will talk to our subscribers to make sure they are eligible for their transportation requests. Providers of common carrier 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 only available to Blue Advantage (Families and Children, MSC+), SecureBlue and MN Care (particular subset groups) Subscribers.

Subscribers who need to schedule a ride to a medical or dental appointment must be directed to call BlueRide, toll free number at 1-866-340-8648 or (651)-662-8648.

BlueRide phones are answered between the hours of Monday through Friday, 8:00 a.m. - 5:00 p.m. For scheduling purposes, Common Carrier transportation requests need to be received at least two business days prior to the day the ride is needed. Some other restrictions may apply. Subscribers do have 1 Short Notice Ride (SNR) ride exception per month for urgent or emergency medical situations. The BlueRide team will handle these issues and schedule these rides.

Rides must be scheduled by the subscriber or legally authorized representative (such as a guardian with proper paperwork). The subscriber 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 subscriber or other appropriate legal paperwork such as guardianship papers that allows the individual to act on the subscriber's behalf.

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

Transportation
Services
(continued)

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 staff. 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 should be approved ahead of the ride. If wait time could not be foreseen, requests must be submitted the next business day. It is expected that wait time request 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
- 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.

Units of Service

Code	Description	Amount	Unit of Service
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments	30 Minutes	1 per 30 minutes
A0080	Non-emergency transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest	1 Mile	1 per mile
A0100	Non-emergency transportation, taxi	1 Base Rate	1 per leg
A0110	Non-emergency transportation and bus, intra or inter-state carrier	1 Base Rate	1 per leg
A0120	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	1 Base Rate	1 per leg

Transportation
Services
(continued)

Modifiers-use proper codes with the following modifiers

For DeadHead, 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

Transportation
Services
(continued)

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):

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

Transportation
Services
(continued)

RUCA (Rural Urban Communiting 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.

Prior Approval of all scheduled rides through BlueRide

The trip confirmation number should be put in the authorization line in the loop 2300 on the 837P. This is required for all Transportation claims to be paid. BlueRide does all Prior Approval for scheduled rides.

No Shows

Blue Plus requires transportation providers to report all no shows to BlueRide by submitting to the Minnesotatransbcbs@logisticare.com. No Shows must be reported to Blue Plus by the following business day. No Shows are not covered under Blue Plus. No Shows should never be billed to Blue Plus or the member.

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 Minnesota Health Care Programs subscribers. The trip sheet must be complete, comprehensive and contain all required elements in the document. Trip sheet must have all required fields completed on the Department of Human Services Trip Log or Blue Plus Trip Log.

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)

Transportation
Services
(continued)

Per Contract:

Verification of Eligibility:

All provisions of your Provider Service Agreement continue to apply to transportation services including, but not limited to, 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#

Authorization Requirements for Common Carrier Services

Types of Transports	Description
<p>Transports exceeding 30 and 60 mile limits</p>	<p>Local county human services or tribal agencies are responsible for authorization of access transportation services to MHCP-covered medical services received more than 30 miles from the recipient's home or residence for primary care and more than 60 miles from the recipient's home or residence for specialty care.</p> <p>FFS authorization is based on medical necessity and no provider within those 30 and 60 mile distances is capable of providing the level of care needed. Documentation of the authorization by the local agency is maintained at the agency in the client's file and is not entered into the MHCP claims processing system.</p>
<p>See MHCP Provider Manual – Non-Emergency Medical Transportation Services for more information:</p> <p>http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141021#</p> <p>Non-Emergency Medical Transportation Procedure Codes, Modifiers and Payment Rates:</p> <p>http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_016391#</p> <p>These provisions, along with all Provider Service Agreement requirements are subject to audit at any time by Blue Plus.</p>	

Special
Transportation
Services

Special 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, as required by the Minnesota Department of Human Services (DHS). Blue Plus Providers must follow all documentation and billing rules in order to remain participating providers. 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.

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 will be imperative that STS providers keep all administrative information up to date at Blue Plus.

BlueRide can be reached at (651) 662-8648 or toll-free at 1-866-340-8648. BlueRide phones are answered between the hours of Monday through Friday, 8:00 a.m. - 5:00 p.m. 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. Subscribers do have 1 Short Notice Ride (SNR) ride exception per month for urgent or emergency medical situations. The BlueRide team will handle these issues and schedule these rides.

STS providers will be notified of scheduled rides via fax/email from the BlueRide staff.

Rides must be scheduled by the subscriber or legally authorized representative (such as a guardian with proper paperwork). The subscriber 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 subscriber or other appropriate legal paperwork such as guardianship papers that allows the individual to act on the subscriber's behalf.

Special Transportation Level of Need (LON)

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

State law prohibits reimbursement of special transportation for Minnesota Health Care Program recipients without a current and approved Level of Need 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. Minnesota Health Care Programs (MHCP) subscribers who need to schedule a ride to an eligible medical or dental appointment should call BlueRide at (651) 662-8648 or toll free at 1-866-340-8648.

Special
Transportation
Services
(continued)

Additional information

Signed forms will be valid for one year from date of the medical provider's signature. Any LON's that are incomplete or unreadable will be considered invalid, rejected, and returned to the provider. LON's must be faxed to the Medical Provider Fax at: 1-855-933-6992 at LogistiCare 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 subscriber requires special transportation and indicates 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 subscribers. 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 completed on 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 subscriber. 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 subscriber is defined as a subscriber who is physically or mentally impaired in a manner that keeps him/her from safely accessing and using common carrier transportation. If an eligible MHCP subscriber does not meet this definition and is in need of transportation, please refer them to BlueRide at 1-866-340-8648 so they may talk to a representative.

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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. Wait time should be approved ahead of the 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
- T2007 - Transportation waiting time, air ambulance and non-emergency vehicle, one half (1/2) hour increments
- T2049 - Non-emergency transportation; non-ambulatory stretcher van mileage
- A0170 - Parking Tolls and Fees
- Each procedure code must be billed by units

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Units of Service

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

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Modifiers-use proper codes with the following modifiers

For DeadHead, 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):

Code	Description
D -	Diagnostic or therapeutic site other than 'P' or 'H' when these are used as origin codes
E -	Residential, domiciliary, custodial facility (other than an 1819 facility)
G -	Hospital based ESRD facility
H -	Hospital
I -	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J -	Freestanding ESRD facility
N -	Skilled nursing facility (SNF)
P -	Physician's office
QM -	Ambulance service provided under arrangement by a provider of services. 1. 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. 2. Note: Institutional-based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly
R -	Residence
S -	Scene of accident or acute event
X -	Intermediate stop at physician's office on way to the hospital (destination code only)

Special
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RUCA (Rural Urban Commuting 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.

Prior Approval of all scheduled rides through BlueRide

The trip confirmation number should be put in the authorization line in the loop 2300 on the 837P. This is required for all Transportation claims to be paid. BlueRide does all Prior Approval for scheduled rides.

Multiple Riders

Each Blue Plus subscriber must have an approved ride authorization for the schedule ride. This includes all family members who may be riding in the same vehicle for medical appointments. This excludes escorts, who may be family members. Multiple Riders should be applicable to the highest degree possible.

No Shows

Blue Plus requires transportation providers to report all no shows to BlueRide by submitting to Minnesotatransbcbs@logisticare.com. No Shows must be reported to Blue Plus by the following business day. No Shows are not covered under Blue Plus. No Shows should never be billed to Blue Plus or the member.

Per Contract:

Verification of Eligibility:

All provisions of your Provider Service Agreement continue to apply to transportation services including, but not limited to, 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#

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Authorization Requirements for Special Transportation Services

Types of Transports	Description
<p>Transports exceeding 30 and 60 mile limits</p>	<p>Local county human services or tribal agencies are responsible for authorization of access transportation services to MHCP-covered medical services received more than 30 miles from the recipient's home or residence for primary care and more than 60 miles from the recipient's home or residence for specialty care.</p> <p>FFS authorization is based on medical necessity and no provider within those 30 and 60 mile distances is capable of providing the level of care needed. Documentation of the authorization by the local agency is maintained at the agency in the client's file and is not entered into the MHCP claims processing system.</p>
<p>See MHCP Provider Manual – Non-Emergency Medical Transportation Services for more information:</p> <p>http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141021#</p> <p>Non-Emergency Medical Transportation Procedure Codes, Modifiers and Payment Rates:</p> <p>http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_016391#</p> <p>These provisions, along with all Provider Service Agreement requirements are subject to audit at any time by Blue Plus.</p>	

Radiology Services

Overview

All radiology guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Rehabilitative Services

Overview

All rehabilitative service guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>

Surgical Services

Overview

All surgical service guides have been moved to Reimbursement Policies on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies>