PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

November 1, 2023

WHAT'S INSIDE:

L08R04 (12/13)

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes

(published in every summary of monthly bulletins)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) collaborates with providers to ensure accurate information is reflected in all provider directories. In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers.

- Accepting new patients
- Demographic address and phone changes
- Office hours or other changes that affect availability
- Tax ID changes
- Practitioner additions or terminations
- Branch additions

The appropriate form for each of these changes or updates can be located on the Blue Cross website at bluecrossmn.com/providers/provider-demographic-updates

Providers are obligated, per federal requirements, to update provider information contained in the National Plan & Provider Enumeration System (NPPES). Updating provider information in NPPES will provide organizations with access to a current database that can be used as a resource to improve provider directory reliability and accuracy. Providers with questions pertaining to NPPES may reference NPPES help at https://nppes.cms.hhs.gov/webhelp/nppeshelp/HOME%20PAGE-SIGN%20IN%20PAGE.html

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820.**

CONTRACT UPDATES

Reimbursement Changes for Behavioral Health Providers, Effective 11/1/23 | P73-23

Effective November 1, 2023, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be increasing the Blue Cross Behavioral Health Fee Schedule.

Rate Allowances
Providers may request a list of rate allowances by emailing Fee.Schedule.Allowance.Request@bluecrossmn.com. Include all provider NPI(s) and Blue Shield ID Number(s) with your request.

If you would like to receive a comprehensive copy of the July 1, 2023, renewal Agreement, please email your request to Request.Contract.Renewal@bluecrossmn.com.

Questions?
If you have any questions about the Agreement, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

2024 Renewal Changes Summary for Primary Care Clinic Providers | P83-23

The purpose of this Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus) Bulletin is to communicate changes to the 2024 Blue Plus Primary Care Clinic Provider Service Agreement (Agreement). The

Agreement is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. Material changes to the Agreement effective January 1, 2024, are detailed below.

Provider Services Agreement Changes:

Article III.C. Claims Submission. As communicated in Provider Bulletin P74-22 published on December 1, 2022, Blue Plus implemented a change to the claims timely filing limit for all lines of business from 120 to 180 days, effective February 1, 2023. Article III.C. of the Agreement now states: "In no event may Provider submit claims later than 180 days from the date of service."

No material changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be submitted once **annually** to Blue Plus, per Minnesota Department of Human Services requirements. The form is located at bluecrossmn.com/providers/forms-and-publications (enter "Disclosure of Ownership and Management Information Form" in the Search bar). Email the completed form and any questions to: DisclosureStatement@bluecrossmn.com

Questions?
If you have any questions about the Agreement, please call Provider Services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of the January 1, 2024 renewal Agreement, please email a request direct from the participating provider to: Request.Contract.Renewal@bluecrossmn.com

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2024 Renewal Changes Summary for Institutional Providers | P84-23

The purpose of this Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Bulletin is to communicate changes to the 2024 Institutional Provider Service Agreement (Agreement). The Agreement is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. Material changes to the Agreement effective January 1, 2024, are detailed below.

Provider Services Agreement Changes:

Article III.D. Claims Submission. As communicated in Provider Bulletin P74-22 published on December 1, 2022, Blue Cross implemented a change to the claims timely filing limit for all lines of business from 120 to 180 days, effective February 1, 2023. Article III.D. of the Agreement now states: "In no event may Provider submit claims later than 180 days from the date of service."

Article IV.G. Overpayments. The following provision 3 has been added to Article IV.G. of the Agreement to address recovery of identified overpayments in the case of DRG audit findings:

3. In the case of DRG audit findings, only the portion of the claim directly impacted by the audit finding will be subject to recoupment with the remainder being paid to Provider. Blue Cross will recoup only the allowed amount that was greater than the allowance for the DRG as determined by the audit rather than 100% of the claim. Due to system limitations, the paid DRG that should be provided on the provider remit will not be supported. Blue Cross will provide the DRGs for these adjusted claims on a weekly basis on a spreadsheet in lieu of the remit.

No material changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be submitted once **annually** to Blue Cross, per Minnesota Department of Human Services requirements. The form is located at bluecrossmn.com/providers/forms-and-publications (enter

"Disclosure of Ownership and Management Information Form" in the Search bar). Email the completed form and any questions to: DisclosureStatement@bluecrossmn.com.

Questions?
If you have any questions about the Agreement, please call Provider Services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of the January 1, 2024 renewal Agreement, please email a request direct from the participating provider to: Request.Contract.Renewal@bluecrossmn.com.

Change in Calculation of Allowance for Time-Based Anesthesia Codes | P87-23

Blue Cross and Blue Shield of Minnesota (Blue Cross) will update the calculation methodology of time-based anesthesia for claims submitted on and after January 19, 2024.

Currently, the methodology for calculating commercial time-based anesthesia codes is dividing the units (minutes) by 15 and rounding to the higher whole number prior to applying the conversion factor.

Blue Cross will be aligning with the Medicare methodology beginning January 19, 2024, and updating the calculation to divide the units (minutes) by 15 and rounding to the nearest tenth prior to applying the conversion factor.

Products Impacted
Commercial, including FEP.

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

eviCore Healthcare Specialty Utilization Management (UM) Program: Medical Oncology Drug Prior Authorization Updates | P75-23

The eviCore Healthcare Utilization Management Program will be making updates to the Medical Oncology Current Procedural Terminology (CPT) Prior Authorization (PA) Code List.

The following drug is awaiting regulatory approval. When approved, the drug will automatically be added to the PA list for oncologic reasons effective immediately. CPT codes will be assigned closer to the approval date.

Drug Name
camrelizumab

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of CPT codes that require prior authorizations, eviCore clinical guidelines, and other provider resources on the eviCore Implementation Resources website.

To view CPT Code lists:

- Access the 'Provider Section' of the Blue Cross website at bluecrossmn.com/providers
- Select **"See all tools and resources"** under *Tools and Resources*

- Select **"See medical policy and prior authorization info"** *under Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the "**Medical policies"** tab, then scroll down and click on the "eviCore healthcare clinical guidelines" link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
- Select **"Solution Resources"** and then click on the appropriate solution (ex. Medical Oncology)
- Select **"CPT Codes"** to view the current CPT code list that require a prior authorization

To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at bluecrossmn.com/providers
- Select **"See all tools and resources"** under *Tools and Resources*
- Select **"See medical policy and prior authorization info"** *under Medical policy and prior* **Second page template no header or footer**
- Select **"See medical policy and prior authorization info"** *under Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the "**Medical policies"** tab, then scroll down and click on the "eviCore healthcare clinical guidelines" link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
- Click on the **"Resources"** dropdown in the upper right corner
- Click **"Clinical Guidelines"**
- Select the appropriate solution: i.e., Medical Oncology
- Type **"BCBS MN"** (space is important) in 'Search by Health Plan'
- Click on the **"Current," "Future,"** or **"Archived"** tab to view guidelines most appropriate to your inquiry.

To Provide Feedback on Future Guidelines:

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to future guidelines managed by eviCore.

The future guidelines are available for physician comment for at least 45 days from the posting date found on the document. Make sure your voice is heard by providing feedback directly to us.

To submit feedback, complete the Provider feedback form for third-party clinical policies/guidelines/criteria PDF via https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies.

Products Impacted

This change only applies to:

- Individual subscribers
- Fully insured commercial subscribers
- Self-insured commercial subscribers (Select Groups)
- Medicare Advantage subscribers

Prior Authorization Look Up Tool

Providers should use the Prior Authorization Look Up Tool on Availity.com/Essentials to quickly determine if an authorization is required. By entering Member Group Number, Date of Service and Procedure Code, the tool will indicate whether an Authorization is required. If an Authorization is not required, the tool will allow the user to print the results for their records. If an Authorization is required, the user will move directly into the next field in Authorization application to complete the request.

To access the Prior Authorization Look Up Tool

1. Log in at Availity.com/Essentials
2. Select **Patient Registration**, choose **Authorization & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you will be redirected

to the Authorization Look Up Tool application.

To submit a Prior Authorization (PA) Request to eviCore
Providers submit eviCore PA requests at Availity.com/Essentials. There is no cost to the provider.

Instructions on how to utilize this portal are found at Availity.com/Essentials. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests and submit all applicable clinical documentation with the PA request. Failure to submit required information may result in review delays or denial of the request due to insufficient information.

Note: An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

If a provider does not obtain a required prior authorization before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.

Questions?
If you have questions and would like to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

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eviCore Healthcare Specialty Utilization Management (UM) Program: Laboratory Management Clinical Guideline Updates | P76-23

eviCore has released clinical guideline updates for the Laboratory Management program. Guideline updates will become **effective January 1, 2024.**

Please review all guidelines when submitting a prior authorization request.

New Guidelines:
- Infectious Disease Laboratory Testing
- Liver Fibrosis Assessment Biomarkers
- Urinary Tract Infection Molecular Testing
- Nail Disorder Infectious Disease Testing, Including Onychomycosis

Guidelines with substantive changes:
- Genitourinary Conditions Molecular Testing (NEW TITLE: Sexually Transmitted and Other Reproductive Tract Infection Testing)
- Cystic Fibrosis Testing
- Lynch Syndrome Genetic Testing
- Non-Invasive Prenatal Screening
- Somatic Mutation Testing - Solid Tumors
- Somatic Mutation Testing - Hematological Malignancies
- BRCA Analysis
- Facioscapulohumeral Muscular Dystrophy Genetic Testing
- Special Circumstances Influencing Coverage Determinations
- Noonan Spectrum Disorder Genetic Testing
- Investigational and Experimental Laboratory Testing

Retired Guidelines:
- BRCA Ashkenazi Jewish Founder Mutation Testing [Refer: BRCA Analysis]
- FibroTest/FibroSURE [Refer: Liver Fibrosis Assessment Biomarkers]
- Macula Risk [Refer: Investigational and Experimental Laboratory Testing]

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of CPT codes that require prior authorizations, eviCore clinical guidelines, and other provider resources on the eviCore Implementation Resources website.

To view CPT Code lists:

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- Select **"See medical policy and prior authorization info"** *under Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the "**Medical policies"** tab, then scroll down and click on the "eviCore healthcare clinical guidelines" link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
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- Click **"Clinical Guidelines"**
- Select the appropriate solution: i.e., Medical Oncology
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- Click on the **"Current," "Future,"** or **"Archived"** tab to view guidelines most appropriate to your inquiry.

To Provide Feedback on Future Guidelines:

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to future guidelines managed by eviCore.

The future guidelines are available for physician comment for at least 45 days from the posting date found on the document. Make sure your voice is heard by providing feedback directly to us.

To submit feedback, complete the Provider feedback form for third-party clinical policies/guidelines/criteria PDF via https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies.

Products Impacted

This change only applies to:

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Providers submit eviCore PA requests at Availity.com/Essentials. There is no cost to the provider.

Instructions on how to utilize this portal are found at Availity.com/Essentials. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests and submit all applicable clinical documentation with the PA request. Failure to submit required information may result in review delays or denial of the request due to insufficient information.

Note: An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

If a provider does not obtain a required prior authorization before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.

Questions?

If you have questions and would like to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

New Medical, Medical Drug and Behavioral Health Policy Management Updates | P81-23

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements, including prior authorization (PA) requirements.

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive the highest quality, evidence-based care. This is accomplished through expanded development of medical policies and through management of these policies to include the PA process. The primary purpose of the PA process is to ensure that evidence-based care is provided to our subscribers, driving quality, safety, and affordability.

The following prior authorization changes will be effective January 1, 2024:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: • Rozanolixizumab (Rystiggo®) • Efgartigimod alfa and hyaluronidase (Vyvgart Hytrulo) • Actemra biosimilars, included but not limited to: – Tocilizumab-bavi (Tofidence) – MSB11456***** – CT-P47***** – BAT1806***** – LZM008*****	No	New	Commercial

L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Actemra biosimilars, included but not limited to: – Tocilizumab-bavi (Tofidence) – MSB11456* – CT-P47* – BAT1806* – LZM008*	No	New	Medicare Advantage
InterQual	Eating Disorder Residential Services	Milliman Clinical Guidelines (MCG)	Continued	Commercial
InterQual	Mental Health Residential Admissions	Milliman Clinical Guidelines (MCG)	Continued	Commercial
InterQual	Substance Use Disorder Residential Admissions	Milliman Clinical Guidelines (MCG)	Continued	Commercial
Benefit Contract/ InterQual	Inpatient Hospice/Palliative Care	Benefit Contract/ Milliman Clinical Guidelines (MCG)	Continued	Commercial
InterQual	Inpatient Rehabilitation Admissions	Milliman Clinical Guidelines (MCG)	Continued	Commercial
InterQual	Long Term Acute Care (LTAC)	Milliman Clinical Guidelines (MCG)	Continued	Commercial
InterQual	Skilled Nursing Facility (SNF)	Milliman Clinical Guidelines (MCG)	Continued	Commercial
InterQual	Acute Medical and Acute Behavioral Health Inpatient Admissions	Milliman Clinical Guidelines (MCG)	Continued for FEP	Commercial

**PA will be required upon FDA approval.*

Products Impacted

- The information in this bulletin applies only to subscribers who have coverage through a Commercial or Medicare Advantage line of business.

Submitting a PA Request when Applicable

- **Providers may submit PA requests for any treatment in the above table starting December 25, 2023.**
- Providers must check applicable Blue Cross policy and attach all required clinical documentation with the PA request. PA requests will be reviewed when patient-specific, relevant medical documentation has been submitted supporting the medical necessity of the service. Failure to submit required information may result in review delays or a denial of the request due to insufficient information to support medical necessity. If a provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.
- PA approval will be based on the Blue Cross policy criteria. To review Blue Cross criteria:
  - Go to www.bluecrossmn.com/providers/medical-management
  - Select “See Medical and Behavioral Health Policies” then click “Search Medical and Behavioral Health Policies” to access policy criteria.

- Current and future PA requirements and related clinical coverage criteria can be found using *the Is Authorization Required* tool in the Availity Essentials® portal or at www.bluecrossmn.com/providers/medical-management prior to submitting a PA request.
- Prior authorization lists are also updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access the PDF prior authorization lists for all lines of business go to www.bluecrossmn.com/providers/medical-management

Prior Authorization Requests

- For information on how to submit a prior authorization please go to bluecrossmn.com/providers/medical-management
- Note: An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

Reminder Regarding Medical Policy Updates & Changes:
Medical Policy changes are communicated in the Upcoming Medical Policy Notifications section of the Blue Cross Medical and Behavioral Health Policy website. The Upcoming Policies section lists new, revised, or inactivated policies approved by the Blue Cross Medical and Behavioral Health Policy Committee and are effective at minimum 45 days from the date they were posted. To access the website:

- Go to https://www.bluecrossmn.com/providers/medical-management
- Select "See Medical and Behavioral Health Policies" then click "See Upcoming Medical and Behavioral Health Policy Notifications."

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

Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans Managed by Blue Cross and Blue Shield of Alabama | P82-23

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to our draft policies for Coupe Health and Self-Funded benefit plans managed by Blue Cross and Blue Shield of Alabama.

The draft policies are available for physician comment for 45 days from the posting date found on the document. At the conclusion of the 45 days, policies will go into effect. Make sure your voice is heard by providing feedback directly to us.

How to Submit Comments on Draft Medical Policies
Complete our medical policy feedback form online at https://mn-policies.exploremyplan.com/portal/web/mn-policies/feedback or send comments and supporting documentation to us by mail or fax:

Birmingham Service Center
Attn: Health Management - Medical Policy
P.O. Box 10527
Birmingham, AL 35202
Fax: 205-220-0878

Draft Medical Policies
Draft medical policies can be found at Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
MP-203	Home Non-Invasive Positive Airway Pressure Devices for the Treatment of Respiratory Insufficiency and Failure
MP-714	Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing
MP-748	Remote Electrical Neuromodulation for Migraines
MP-754	Annular Closing Device

Draft Provider-Administered Drug Policies
Draft provider-administered drug policies can be found at Policies & Guidelines (exploremyplan.com) and Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
PH-90721	Izervay (avacincaptad pegol)
PH-90727	Veopoz (pozelimab-bbfg)
PH-90026	Aflibercept: Eylea, Eylea HD
PH-90017	Benlysta_IV (belimumab)
PH-90027	Cerezyme (imiglucerase)
PH-90635	Dextenza (dexamethasone insert)
PH-90105	Elelyso (taliglucerase alfa)
PH-90133	Natalizumab (Tysabri, Tyruko)
PH-90614	Saphnelo (anifrolumab-fnia)
PH-90114	Soliris (eculizumab)
PH-90427	Ultomiris (ravulizumab-cwvz)
PH-90141	VPRIV (velaglucerase alfa)
PH-90649	Vyvgart_IV (efgartigimod alfa-fcab)
PH-90712	Vyvgart_SQ (efgartigimod alfa and hyaluronidase-qvfc)

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Blue Cross and Blue Shield of Minnesota to Automate Receipt of Acute Admission, Discharge and Transfer Data for MHCP Members | P74-23

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is partnering with vendor Audacious Inquiry, a wholly owned subsidiary of PointClickCare, to receive Admission, Discharge, Transfer (ADT) data for Minnesota Health Care Programs (MHCP) subscriber acute admissions, effective January 1, 2024.

Audacious Inquiry operates the MN Encounter Alert Service (MN EAS), an automated notification solution for the state of Minnesota with limited coverage in Wisconsin and North Dakota.

MN EAS enables providers throughout the state to transmit patient encounter alerts (ADT) for individuals who have been admitted to, or discharged or transferred from, an EAS-participating hospital, emergency department, long-term care facility, or other provider organization in real time.

The goal of these alerts is to help achieve better outcomes and care transitions for patients by facilitating the electronic exchange of clinical data between providers and Blue Cross enabling near real time care coordination.

Emergency Room visits, inpatient, observation, and some outpatient transitions of care alerts are also available with MN EAS (and each MN EAS participant can fine tune alerts for their needs). Blue Cross may outreach to providers on certain inpatient admissions to assist with discharge planning and member transitions.

Provider Impact
For Minnesota MHCP subscribers, admission and discharge notification requirements will become automated for acute inpatient admissions at facilities located in Minnesota or a bordering county that are participating in the MN EAS service for admission dates beginning January 1, 2024.

Providers will no longer need to submit admission, concurrent review, or discharge notification information in Availity Essentials.

- For providers that are not participating with MN EAS, admission and discharge notification are required and must be completed through Availity Essentials.
- For Subacute** facilities requiring prior authorization (PA), the provider must complete the PA and concurrent review processes (including medical record submission) through Availity Essentials.

• **Level of IP**	**Provider Participating in MN EAS**	**Provider Not Participating in MN EAS**
Acute IP Admission: notification and discharge date update	Automated	Provider to submit Admission Notification and Discharge date through Availity Essentials
Subacute**: PA is required	Provider to submit PA/concurrent review with clinical records through Availity Essentials	Provider to submit PA/concurrent review with clinical records through Availity Essentials

***Subacute Levels that require PA: Acute Rehabilitation Admissions, Long Term Acute Care (LTAC) Skilled Nursing Facility; Eating Disorder Residential Services (MN Providers); Psychiatric Residential Care; Substance-Related Disorders Residential Care*

If your provider organization has not enrolled in MN EAS and is interested in finding out additional information, please contact Nick.Regier@pointclickcare.com

Products Impacted
- Families and Children
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)

Questions?
Please email Blue Cross at MHCPProviders@BlueCrossMN.com

Minnesota Health Care Programs (MHCP) Operations Transitioning back to Blue Cross, effective 1/1/24 | P77-23 |

As communicated in Provider QuickPoint QP95-22, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be transitioning Minnesota Health Care Programs (MHCP) Operations back to Blue Cross as of January 1, 2024.

Blue Cross has established a landing page on the website for all documents related to the transition: https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs-mhcp.

All claims, adjustments and appeals should continue to be submitted to Amerigroup through December 31, 2023. Amerigroup will complete the processing of all claims, adjustments or appeals that were received prior to January 1, 2024.

Beginning on January 1, 2024, all claims (including replacement and void submissions), appeals and provider inquiries should be directed to Blue Cross. Claims for dates of service prior to January 1, 2024, that have not yet been submitted to Amerigroup should be sent to Blue Cross for processing, regardless of date of service. Blue Cross will be establishing a crosswalk for the subscriber ID numbers from the AGP ID to the new Blue Cross ID. Providers should use the subscriber ID effective on the date of service when submitting an electronic transaction.

Blue Cross will be loading the historical claims data into the new operating system for processing. This will allow Blue Cross to process adjustments and appeals on previously processed claims for dates of service prior to January 1, 2024.

Blue Cross anticipates that applicable Medical Policies, Reimbursement Policies and Prior Authorization lists will be published on the website by January 1, 2024, along with the updated Provider Policy and Procedure Manual and the Blue Plus Manual.

Provider Services
For all questions including eligibility and benefits, utilization management, or claims, contact Provider Services at **651-662-9962** or toll free at **1-866-518-8448** beginning on January 1, 2024. Although these numbers are currently routed to Amerigroup, they will be transferred back to Blue Cross effective January 1, 2024.

Subscriber ID
Subscribers will receive a new ID card and subscriber ID number to be used for dates of service beginning January 1, 2024.

Eligibility should be verified at every visit. Claims submitted with an incorrect subscriber ID will be denied for no coverage.

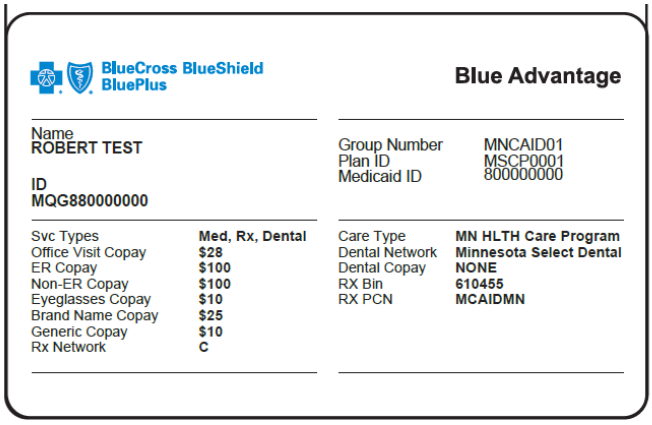
New alpha prefixes will be effective January 1, 2024:

- **MQG** for Families and Children, MNCare and MSC+
- **MQS** for Secure Blue MSHO

Subscriber ID Format (following the prefix) will be '**8**' followed by the subscriber's PMI effective January 1, 2024.

Sample ID cards are shown below. Please note that providers may see a slight variation after final testing and approvals are complete.

Blue Advantage


BlueCross BlueShield BluePlus

Blue Advantage

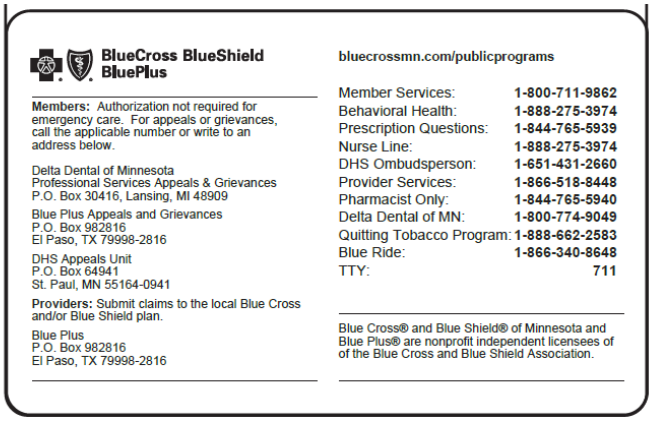
Name
ROBERT TEST

ID
MQG880000000

Svc Types	Med, Rx, Dental
Office Visit Copay	$28
ER Copay	$100
Non-ER Copay	$100
Eyeglasses Copay	$10
Brand Name Copay	$25
Generic Copay	$10
Rx Network	C

Group Number	MNCAID01
Plan ID	MSCP0001
Medicaid ID	800000000

Care Type	MN HLTH Care Program
Dental Network	Minnesota Select Dental
Dental Copay	NONE
RX Bin	610455
RX PCN	MCAIDMN


BlueCross BlueShield BluePlus

bluecrossmn.com/publicprograms

Members: Authorization not required for emergency care. For appeals or grievances, call the applicable number or write to an address below.

Delta Dental of Minnesota
Professional Services Appeals & Grievances
P.O. Box 30416, Lansing, MI 48909

Blue Plus Appeals and Grievances
P.O. Box 982816
El Paso, TX 79998-2816

DHS Appeals Unit
P.O. Box 64941
St. Paul, MN 55164-0941

Providers: Submit claims to the local Blue Cross and/or Blue Shield plan.

Blue Plus
P.O. Box 982816
El Paso, TX 79998-2816

Member Services:	1-800-711-9862
Behavioral Health:	1-888-275-3974
Prescription Questions:	1-844-765-5939
Nurse Line:	1-888-275-3974
DHS Ombudsperson:	1-651-431-2660
Provider Services:	1-866-518-8448
Pharmacist Only:	1-844-765-5940
Delta Dental of MN:	1-800-774-9049
Quitting Tobacco Program:	1-888-662-2583
Blue Ride:	1-866-340-8648
TTY:	711

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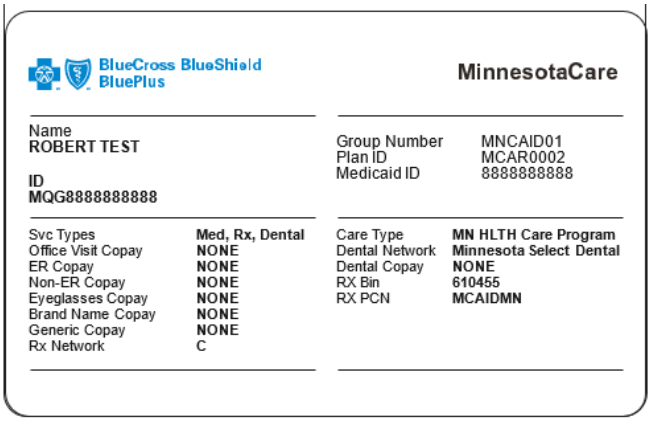
MinnesotaCare


BlueCross BlueShield BluePlus

MinnesotaCare

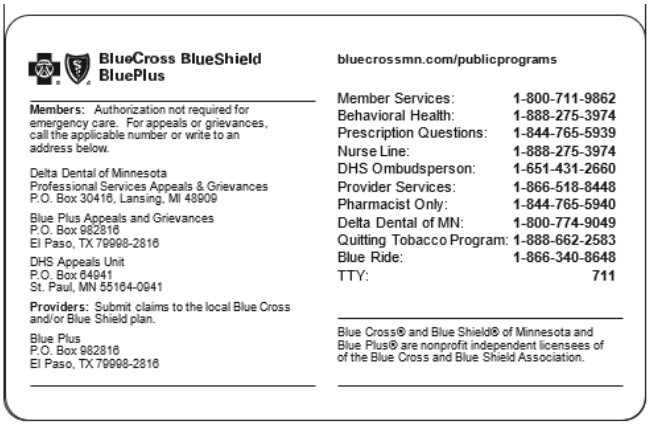
Name
ROBERT TEST

ID
MQG8888888888

Group Number MNCAID01
Plan ID MCAR0002
Medicaid ID 8888888888

Svc Types	Med, Rx, Dental
Office Visit Copay	NONE
ER Copay	NONE
Non-ER Copay	NONE
Eyeglasses Copay	NONE
Brand Name Copay	NONE
Generic Copay	NONE
Rx Network	C

Care Type	MN HLTH Care Program
Dental Network	Minnesota Select Dental
Dental Copay	NONE
RX Bin	610455
RX PCN	MCAIDMN


BlueCross BlueShield BluePlus

bluecrossmn.com/publicprograms

Members: Authorization not required for emergency care. For appeals or grievances, call the applicable number or write to an address below.

Delta Dental of Minnesota
Professional Services Appeals & Grievances
P.O. Box 30416, Lansing, MI 48909

Blue Plus Appeals and Grievances
P.O. Box 982816
El Paso, TX 79998-2816

DHS Appeals Unit
P.O. Box 64941
St. Paul, MN 55164-0941

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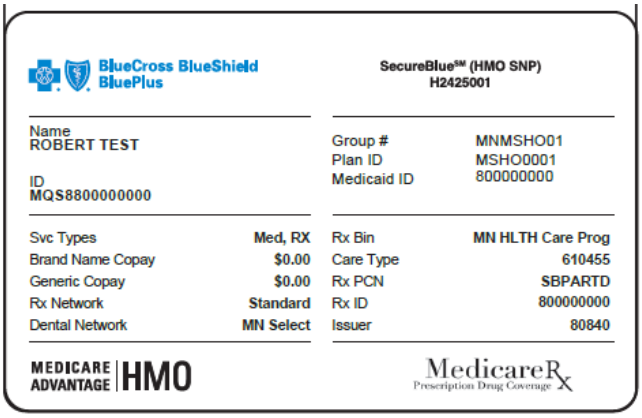
MSHO (note that the Rx Bin and Care Type must be switched)


BlueCross BlueShield BluePlus

SecureBlue℠ (HMO SNP)
H2425001

Name
ROBERT TEST

ID
MQS8800000000

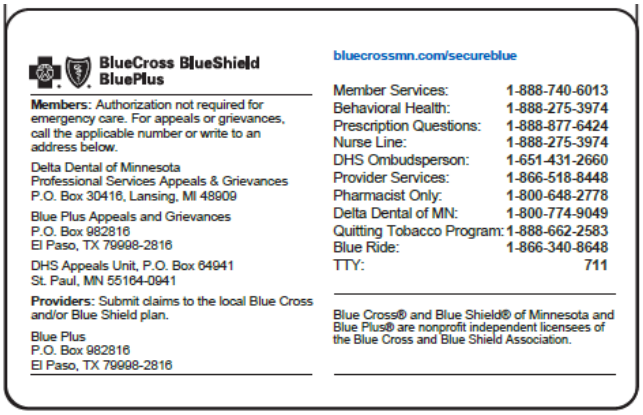
Group # MNMSHO01
Plan ID MSHO0001
Medicaid ID 800000000

Svc Types	Med, RX
Brand Name Copay	$0.00
Generic Copay	$0.00
Rx Network	Standard
Dental Network	MN Select

Rx Bin	MN HLTH Care Prog
Care Type	610455
Rx PCN	SBPARTD
Rx ID	800000000
Issuer	80840

MEDICARE ADVANTAGE | HMO

MedicareRx Prescription Drug Coverage


BlueCross BlueShield BluePlus

bluecrossmn.com/secureblue

Members: Authorization not required for emergency care. For appeals or grievances, call the applicable number or write to an address below.

Delta Dental of Minnesota
Professional Services Appeals & Grievances
P.O. Box 30416, Lansing, MI 48909

Blue Plus Appeals and Grievances
P.O. Box 982816
El Paso, TX 79998-2816

DHS Appeals Unit, P.O. Box 64941
St. Paul, MN 55164-0941

Providers: Submit claims to the local Blue Cross and/or Blue Shield plan.

Blue Plus
P.O. Box 982816
El Paso, TX 79998-2816

Member Services:	1-888-740-6013
Behavioral Health:	1-888-275-3974
Prescription Questions:	1-888-877-6424
Nurse Line:	1-888-275-3974
DHS Ombudsperson:	1-651-431-2660
Provider Services:	1-866-518-8448
Pharmacist Only:	1-800-648-2778
Delta Dental of MN:	1-800-774-9049
Quitting Tobacco Program:	1-888-662-2583
Blue Ride:	1-866-340-8648
TTY:	711

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Eligibility & Benefits and Claim Status

When checking Eligibility & Benefits or Claim Status on Availity.com/essentials, select 'BCBSMN BLUE PLUS MEDICAID (00726)' from the Payer dropdown list. Use the new Payer ID code 00726 when submitting a 270/271 or 276/277 Electronic Data Interchange (EDI) transaction. If an Eligibility & Benefits EDI transaction or a Claim Status EDI transaction is not submitted with the new Payer Name or ID code, a non-covered or claim not found response may be received. Providers will need to correct the Payer Name or ID and resubmit the transaction.

Please note that eligibility files will not be loaded until mid to late December 2023.

Availity Essentials Messaging

Availity Essentials Messaging will be available January 1, 2024, for MHCP membership. Messages will be able to be sent after receiving a valid Eligibility & Benefits or Claim Status response on Availity Essentials.

Claim Submissions

Claims for dates of service performed on or after January 1, 2024, will be processed by Blue Cross. Claims for dates of service beginning January 1, 2024, must be submitted with the new payer ID Code 00726. Providers are encouraged to verify their system will have the necessary changes made to accommodate the new payer ID. This may involve contacting an external vendor or clearinghouse to ensure their software has been updated.

Claims submitted under the wrong Payer ID Code will be rejected, and the claims will need to be resubmitted under the correct payer ID code. For efficiency, Blue Cross will be increasing front end edits including HIPAA Compliance and Payer Specific Edits to allow providers the opportunity to correct claims with the goal of receiving clean claims to reduce claim rejections returned on the 835 Remittance.

Claims for dates of service prior to January 1, 2024, that have not yet been submitted to Amerigroup should be sent to Blue Cross for processing, regardless of date of service. These claims must be submitted with the new payer ID code 00726. This includes all replacement and void submissions. Timely filing limits will continue to be enforced.

Claims currently processed via Bridgeview, i.e., Elderly Waiver claims, will continue to be processed by Bridgeview. The Payer ID for Bridgeview claims is FS802 on Availity Essentials.

For Subscribers that have a primary commercial Blue Cross plan and secondary MHCP plan, Blue Cross will not have the ability to automatically crossover the claim to coordinate benefits. A secondary claim must be submitted with the appropriate secondary subscriber ID and payer code, along with the primary payment information.

Claim Attachments
Claim attachments must be submitted via fax using the MN AUC Claims Attachment Cover Sheet or by mail:

- Fax to 1-800-793-6928
- Mail to:
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  Attention: Claims Processing
  PO Box 982816
  El Paso, TX 79998-2816

Remittance
Weekly Remittance EDI file will be delivered and viewable on the Remittance Viewer application within Availity Essentials by the end of the day on Thursdays.

Appeals
Post-Service claims appeals submitted beginning on January 1, 2024, will be reviewed by Blue Cross regardless of the original payer. Upon migration to Blue Cross, providers will not have the capability to submit appeals through the Availity Essentials platform. Blue Cross anticipates this capability will be available soon and will communicate this information when applicable.

Post-service claim appeals must be submitted within 90 days of the remittance date.

If a claim is denied due to a required Prior Authorization not being obtained, an appeal for medical necessity will not be accepted. An administrative appeal may be submitted for limited situations. These exceptions are listed below, 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 Availity outage).
- Emergency and urgent care services that are performed in the emergency room do not require prior authorization and will be considered at the in-network benefit level.

Provider Appeals must be submitted using one of the following processes:

- Submit the AUC Claims Appeal Request form with appropriate documentation via fax to 651-662-6288
- Submit the AUC Claims Appeal Request form with appropriate documentation via USPS:
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  Attention: Provider Appeals
  PO Box 982816
  El Paso, TX 79998-2816

Pre-Service Appeals

- Submit appeal with appropriate documentation via fax to 651-662-6287
- Submit the appeal with appropriate documentation via USPS:
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  Attention: Appeals & Grievances
  PO Box 982816
  El Paso, TX 79998-2816

Restricted Recipient Program (RRP)
RRP is a State Mandated program that Blue Plus is required to implement and manage per contractual requirements from the MN Department of Human Services (DHS). RRP is a program for Medicaid recipients who meet certain criteria.

Potential Program Recipients:

- Frequent Emergency Department (ED) Utilizers
- Subscribers who struggle with substance abuse (multiple prescriptions for controlled RX, duplication of prescribers/pharmacies, receiving controlled RX while enrolled in Medication Assisted Therapy)
- Subscribers or claims that indicate potential Fraud, Waste and Abuse (of clinics/ED/transportation services)
- High dollar claims

Providers will submit Restricted Recipient referrals through the current Blue Cross processes. No change in submission process for MHCP member requests is required. The Managed Care Referral Form and Minnesota Restricted Recipient Program Member Referral Request Form can be found on the Blue Cross website under the “forms – clinical operations” category. Direct links to the forms are below.

https://www.bluecrossmn.com/sites/default/files/DAM/2023-09/managed-care-referral-form.pdf

https://www.bluecrossmn.com/sites/default/files/DAM/2023-09/RRP-program-referral.pdf

Restricted Recipient information will not be returned on the 271 eligibility and benefits transaction. Blue Cross anticipates this capability will be available soon and will communicate this information when applicable. Providers should verify Restricted Recipient status using MN-ITS. Questions can be directed to the RRP Team at **651-662-5062** (telephone) **or 651-662-6286** (fax).

Medical Policy
As stewards of healthcare expenditures on behalf of the state, Blue Cross is charged with ensuring the highest quality, evidence-based care is delivered to our subscribers. Effective January 1, 2024, Blue Cross will implement new medical policies that will apply to services provided under the medical benefit for Medicaid (Families & Children, MNCare, MSC+) and MSHO subscribers.

Please note that Federal and State Guidelines, including Minnesota Health Care Program (MHCP) policies, may supersede the Medical Policies, if applicable.

Applicable Medical Policies were published in a separate bulletin, see Provider Bulletin P78-23.

Prior Authorizations (PA) for Outpatient Services as of January 1, 2024

Providers will follow current PA processes through December 31, 2023, regardless of the date of service. Any PA approvals obtained through Amerigroup will be forwarded to Blue Cross for use in claims adjudication where applicable.

Beginning January 1, 2024, Providers should reference to Provider Bulletin P79-23 for information regarding services requiring prior authorization.

Prior Authorization Look Up Tool
Providers can quickly determine if a service or item requires prior authorization from the health plan before care is provided by entering the member group number, date of service and procedure code. The PA Look Up tool response also includes details related to the medical policy or evidence-based criteria that may apply and any special instructions related to the prior authorization process. There are two options for providers to use:

- The Prior Authorization Lookup tool is available on the Blue Cross website under Medical Management: https://www.bluecrossmn.com/providers/medical-management/prior-authorization-lookup-tool
- On Availity Essentials, follow the Authorization Request process. The first step in this process allows the provider to determine if a PA is required using the "Is Authorization Required" tool. If an authorization is required, the provider can simply proceed to the next step to complete the process.

If an authorization is required, it is highly recommended for the provider to utilize the online process through Availity Essentials.

If providers are unable to verify prior authorization requirements through Availity Essentials or the Blue Cross website, providers may call Provider Services for assistance at **866-518-8448**.

If providers are unable to complete the prior authorization process through Availity Essentials or the Blue Cross website, providers may fax the Prior Authorization (PA) Request form, and include the Availity error, to fax **651-662-6284**.

Submit Medical and Medical Injectable Drugs Prior Authorizations using the Availity Essentials Portal

- Submit an online PA request using the Availity.com/Essentials web portal. First-time users of the portal will need to create an account.
- Transmit an electronic PA request via NCPDP file using an integrated Electronic Medical Record (EMR) system. If unsure how, providers should contact their EMR vendor for assistance.
- If unable to submit a request electronically, request authorization via fax using the MN Uniform Form.
- PA approval will be based on the applicable MHCP, CMS, or Blue Cross policy criteria. To view criteria:
  - Go to bluecrossmn.com/providers and select "*medical and behavioral health policies*" in the "*medical management*" box.
  - An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

Self-Administered Prescription Drugs
Drugs that can be self-administered by a member or caregiver (inclusive of self-injection) will continue to be managed by Prime Therapeutics.

To submit a PA request to Prime, providers can:

- Submit online requests via CoverMyMed's free web portal. First-time users of the portal will need to create an account. (For help using the portal, select Support (top of the web page) to view FAQs, physician training webinar offerings, and support options how to get started.)
- Transmit an electronic PA request via NCPDP file using an integrated Electronic Medical Record (EMR) system, to learn how providers should contact their EMR vendor for assistance.
- Request authorization by fax if unable to submit a request electronically through CoverMyMed's free web portal, using the MN Uniform Form.

- Call Prime's 24-hour contact center for assistance
  - Medicaid subscribers: **1-844-765-5939**
  - Secure Blue subscribers: **1-888-877-6424**

Inpatient Admissions as of January 1, 2024
Blue Cross will be requiring notification at the time of acute inpatient admission. Refer to Provider Bulletin P79-23 for Precertification and Prior Authorization requirements.

Blue Cross is partnering with vendor Audacious Inquiry (AI), a wholly owned subsidiary of PointClickCare, for Admission, Discharge, Transfer (ADT) data for implementation on January 1, 2024, for Minnesota Health Care Programs (MHCP). Admission and discharge notification requirements will become automated for acute inpatient admissions at facilities located in Minnesota or a bordering county that are participating in the MN EAS service for admission dates beginning January 1, 2024. Providers participating with MN EAS will no longer need to submit admission and discharge notification information. Complete information on the use of MN EAS can be found in Provider Bulletin P74-23.

MCG care guidelines, 27th edition, will be used to guide utilization management decisions. The five (5) products licensed include the following:

- **Inpatient & Surgical Care (ISC):** Manage, review, and assess people facing hospitalization or surgery proactively with nearly 400 condition-specific guidelines, goals, optimal care pathways, and other decision support tools.
- **General Recovery Care (GRG)**: Effectively manage complex cases where a single Inpatient & Surgical Care guideline or set of guidelines is insufficient, including the treatment of people with diagnostic uncertainty or multiple diagnoses.
- **Home Care (HC)**: Provides evidence-based comprehensive guidelines to enable case managers and others to maintain quality and efficiency in the patient's home environment.
- **Recovery Facility Care (RFC):** Coordinate an effective plan for transitioning people to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).
- **Behavioral Health Care (BHC):** Provides evidence-based guidelines to help healthcare professionals guide the effective treatment of patients with psychiatric disorders.

Admission to a subacute facility will require prior authorization based on the criteria published in the Prior Authorizations and Notifications document posted on the Blue Cross website.

Pursuant to information published in the Provider Policy and Procedure Manual; Compliance Audit, providers may be subject to medical necessity audits to determine if the MCG criteria has been met for inpatient stays; including short stay audits, commonly identified as 0-2 days.

Newborn Processes
Effective January 1, 2024, providers will not be required to notify Blue Cross when an enrolled subscriber gives birth. Eligible newborns of mothers enrolled in Blue Advantage Families and Children (F&C) or Blue Plus MinnesotaCare are automatically enrolled in Blue Cross for the calendar month of the birth only if they meet MHCP eligibility criteria. It is important that the mother notify her local agency of the birth of her child as soon as possible following the birth for the enrollment process to begin. Providers are encouraged to develop a process to assist MHCP subscribers in enrolling eligible newborns.

Reimbursement Policies
Reimbursement policies that will be applicable to MHCP products effective January 1, 2024, have been published in Provider Bulletin P80-23.

The Reimbursement Policies can be accessed at https://www.bluecrossmn.com/providers. Within the 'Tools and Resources' section, select 'Reimbursement Policies' to view the policies. Each Reimbursement Policy title identifies the product that the policy applies to. The Reimbursement Policies will be available at the link above by January 1, 2024.

Please note that reimbursement for many services will follow MHCP guidelines effective January 1, 2024, and therefore no Reimbursement Policy will be published.

Provider Webinars
Blue Cross will be hosting MHCP Provider Webinars in December. The webinars will be available through the Availity platform. Providers are encouraged to register for one of the sessions.

MHCP Provider Information Session
December 5, 2023, from 9-10:30 am CST
https://availity.zoom.us/webinar/register/WN_qpBB6ubsT0K6wkGyyGM-Aw

MHCP Provider Information Session
December 14, 2023, from 1-2:30 pm CST
https://availity.zoom.us/webinar/register/WN_SBTPdTasRc6Diuxgxo1g1Q

CERiS Audits for MHCP Subscribers
Blue Cross will not be establishing criteria for CERiS audits effective January 1, 2024. Additional information regarding inpatient audits will be communicated in a future bulletin.

BlueRide Non-Emergency Transportation (NEMT)
BlueRide handles Common Carrier and Special Transportation requests for rides to and from medical and dental appointments with in-network providers if the subscriber has no other means of transportation.
Subscribers who need to schedule a ride to a medical or dental appointment should be directed to call BlueRide at **1-866-340-8648** or **(651)-662- 8648**. No changes are being made to the scheduling of rides or the claim submission process for NEMT providers. Claims should continue to be submitted under Payer ID BLRDE for processing.

Questions?
Please email Blue Cross at MHCPProviders@BlueCrossMN.com

Medical Policies for Minnesota Health Care Programs (MHCP), effective 1/1/24 | P78-23

As communicated in Provider Quick Point QP95-22, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be transitioning MHCP Operations back to Blue Cross as of January 1, 2024.

Effective **January 1, 2024**, Blue Cross will be updating Medical Policy, Prior Authorization and Notification Requirements for MHCP subscribers. The lists clarify Medical Policy, prior authorization, and notification requirements for MHCP (Families and Children, MinnesotaCare, and Minnesota Senior Care Plus) and Minnesota Senior Health Options (SecureBlue) products.

As stewards of healthcare expenditures for our subscribers, Blue Cross is charged with ensuring they receive appropriate, quality care while also maintaining overall costs. The prior authorization process ensures that the health service or drug being proposed is medically necessary, and reflective of evidence-based medicine and industry standards, prior to treatment. This process helps us manage the cost and quality of care appropriately for our subscribers.

The following Medical Policies will be applicable to services provided on or after January 1, 2024. **The procedure codes associated with this set of policies will not require prior authorization.**

Policy #	Policy Title
IV-130	Ablation of Peripheral Nerves to Treat Pain
IV-170	Ablation Procedures for Treatment of Chronic Rhinitis

Policy #	Policy Title
IV-165	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse
II-127	Actigraphy
VI-61	Adjunctive Techniques for Screening and Surveillance of Barrett's Esophagus and Esophageal Dysplasia
II-107	Advanced Pharmacologic Therapies for Pulmonary Arterial Hypertension
IV-145	Amniotic Membrane and Amniotic Fluid
IV-48	Angioplasty and/or Stenting for Intracranial Aneurysms and Atherosclerosis
IV-146	Aqueous Shunts and Stents for Glaucoma
IV-154	Artificial Retinal Devices
VII-12	Automated Point-of-Care Nerve Conduction Tests
II-86	Autonomic Nervous System Function Testing
IV-162	Balloon Dilation of the Eustachian Tube
IV-01	Balloon Ostial Dilation
IV-19	Bariatric Surgery
IV-139	Baroreflex Stimulation Devices
IV-137	Bioengineered Skin and Soft Tissue Substitutes
II-70	Biofeedback
II-148	Bioimpedance Spectroscopy Devices for Detection and Management of Lymphedema
II-16	Botulinum Toxin
IV-108	Breast Ductal Lavage and Fiberoptic Ductoscopy
IV-14	Breast Implant, Removal or Replacement
IV-117	Bronchial Thermoplasty
IV-171	Bunionectomy
II-43	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
VI-24	Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Non-Traditional Lipid and Nonlipid Biomarkers
IV-176	Carpal Tunnel Decompression
IV-143	Closure Devices for Atrial Septal Defects and Patent Foramen Ovale
IV-151	Composite Tissue Allotransplantation of the Hand
II-108	Computerized Dynamic Posturography
II-191	Confocal Laser Endomicroscopy
VII-05	Continuous Glucose Monitoring Systems
II-207	Corneal Collagen Cross-Linking
XI-04	Cosmetic Criteria for Services Which Are Not Addressed by a Specific Medical Policy

Policy #	Policy Title
II-19	Coverage of Routine Care Related to Clinical Trials
IV-05	Cryoablation of Solid Tumors
II-155	Diagnosis and Treatment of Chronic Cerebrospinal Venus Insufficiency (CCSVI) in Multiple Sclerosis
VII-67	Dry Needling
V-17	Dynamic Spinal Visualization and Vertebral Motion Analysis
IV-52	Dynamic Spine Stabilization
X-46	Electroconvulsive Therapy (ECT)
II-132	Electromagnetic Navigational Bronchoscopy
II-94	Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus
IV-150	Endothelial Keratoplasty
IV-156	Endovascular/Endoluminal Stent Grafts for Abdominal Aortic Aneurysms
IV-157	Endovascular/Endoluminal Stent Grafts for Disorders of the Thoracic Aorta
IV-141	Endovascular Therapies for Extracranial Vertebral Artery Disease
VII-64	Esophageal pH Monitoring
VI-51	Expanded Cardiovascular Risk Panels
VI-59	Expanded Gastrointestinal Biomarker Panels
II-194	Extracorporeal Photopheresis
II-11	Extracorporeal Shock Wave Treatment for Musculoskeletal Conditions and Soft Tissue Repair
IX-05	Eyelid Thermal Pulsation
II-198	Fecal Microbiota
IV-175	Fetal Surgery for Prenatally Diagnosed Malformations
IV-174	Functional Endoscopic Sinus Surgery (FESS)
IV-28	Gastric Electrical Stimulation
IV-123	Gender Affirming Procedures
VI-16	Genetic Testing for Hereditary Breast and/or Ovarian Cancer
VI-06	Hair Analysis
II-109	Helicobacter Pylori (H. Pylori) Serology Testing
VII-03	Hippotherapy
II-04	Hyperbaric Oxygen Therapy
III-02	Hypnotherapy
II-51	Immunoglobulin Therapy
II-224	Implantable Ambulatory Cardiac Event Monitors and Ischemia Detection Systems

Policy #	Policy Title
IV-37	Implantable Middle Ear Hearing Aids (Semi-Implantable and Fully Implantable) for Moderate to Severe Sensorineural Hearing Loss
IV-80	Implanted Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea
VI-30	In Vitro Chemoresistance and Chemosensitivity Assays
II-163	Infusion or Injection of Vitamins and/or Minerals
IV-133	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence
II-145	Injectable Clostridial Collagenase (Xiaflex®) for Fibroproliferative Disorders
VII-66	Interferential Current Stimulation
II-189	Intermittent Intravenous Insulin Therapy
II-29	Intra-Articular Hyaluronan Injections for Osteoarthritis
IV-111	Intraosseous Nerve Ablation for Chronic Low Back Pain
II-271	Intravenous Anesthetics for Treatment of Chronic Pain and Psychiatric Disorders
II-71	Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions
XI-01	Investigative Indications for Medical Technologies which are Not Addressed by a Specific Medical Policy
II-153	Laser and Photodynamic Therapy for Onychomycosis
IV-82	Liposuction
II-09	Low-Level Laser Therapy and Deep Tissue Laser Therapy
II-165	Lyme Disease: Diagnostic Testing and Intravenous Antibiotic Therapy
IV-124	Magnetic Esophageal Ring for Treatment of Gastroesophageal Reflux Disease (GERD)
IV-33	Mastopexy
VI-55	Measurement of Serum Antibodies to Selected Biologic Agents
VII-62	Mechanical Stretching Devices
II-221	Medical Marijuana (Cannabis)
XI-02	Medical Necessity Criteria for Medical Technologies which are Not Addressed by a Specific Medical Policy
IV-04	Microwave Ablation of Solid Tumors
II-20	Mobile Cardiac Outpatient Telemetry
II-261	Monitored Anesthesia Care with Selected Injections for Pain
IV-119	MRI-Guided High-Intensity Focused Ultrasound Ablation and MRI-Guided High-Intensity Directional Ultrasound Ablation
VII-60	Myoelectric Prosthesis for the Upper Limb
II-223	Naltrexone Implants
IV-172	Nasal Tissue Reduction
II-177	Nerve Fiber Density Measurement
IV-147	Nerve Graft with Prostatectomy

Policy #	Policy Title
X-29	Neurofeedback
II-33	Nonpharmacologic Treatment of Acne
II-08	Nonpharmacologic Treatment of Rosacea
IV-167	Occipital Nerve Decompression for the Treatment of Chronic Headache
II-140	Occipital Nerve Stimulation
II-79	Optical Coherence Tomography of the Anterior Eye Segment
IV-16	Orthognathic Surgery
V-26	Ovarian and Internal Iliac Vein Embolization as a Treatment for Pelvic Congestion Syndrome
IV-24	Panniculectomy/Excision of Redundant Skin or Tissue
II-277	Pegcetacoplan (Syfovre)
IV-166	Penile Prosthesis Implantation
II-81	Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuormodulation Therapy (PNT)
IV-169	Percutaneous Left Atrial Appendage Occluder Devices
IV-135	Percutaneous Tibial Nerve Stimulation (PTNS)
IV-160	Percutaneous Ultrasonic Ablation of Soft Tissue
II-149	Peripheral Nerve Stimulation of the Trunk or Limbs for Treatment of Pain
IV-159	Peroral Endoscopic Myotomy (POEM)
II-205	Photodynamic Therapy for Ocular Indications (Visudyne®)
II-46	Photodynamic Therapy for Skin Conditions
II-39	Phototherapy in the Treatment of Psoriasis
II-192	Plasma Exchange
II-76	Platelet-Rich Plasma
VII-63	Powered Exoskeleton
IV-177	Prostatic Artery Embolization for Benign Prostatic Hyperplasia (BPH)
IV-148	Prostatic Urethral Lift
II-54	Quantitative Sensory Testing
IV-138	Removal of Benign Skin Lesions
IV-161	Responsive Neurostimulation for the Treatment of Refractory Focal (Partial) Epilepsy
IV-73	Rhinoplasty and Septorhinoplasty
IV-27	Risk-Reducing Mastectomy
II-47	Rituximab
IV-83	Sacral Nerve Neuromodulation/Stimulation for Selected Conditions

Policy #	Policy Title
IV-126	Sacroiliac Joint Fusion
VI-08	Saliva Hormone Tests
IV-142	Saturation Biopsy of the Prostate
II-23	Secretin Infusion Therapy for Autism
II-55	Selected Treatments for Hyperhidrosis
II-42	Selected Treatments for Tinnitus
IV-129	Selected Treatments for Varicose Veins of the Lower Extremities
XI-03	Site of Service for Selected Outpatient Procedures: Outpatient Hospital and Ambulatory Surgery Center
II-195	Sphenopalatine Ganglion Nerve Block
VII-59	Spinal Unloading Devices: Patient-Operated
II-142	Stem Cell Therapy for Orthopedic Applications
II-151	Stem Cell Therapy for Peripheral Arterial Disease
II-242	Step Therapy Bypass Supplement
IV-140	Steroid-Eluting Devices for Maintaining Sinus Ostial Patency
II-169	Sublingual Immunotherapy Drops for Allergy Treatment
IV-26	Subtalar Arthroereisis
VII-10	Surface Electromyography (SEMG)
IV-173	Surgery for Groin Pain
IV-158	Surgical Treatments of Lymphedema
IV-153	Synthetic Cartilage Implants for Metatarsophalangeal Joint Disorders
II-07	Temporomandibular Disorder (TMD): Diagnosis and Selected Treatments
II-272	Teplizumab (Tzield)
VII-18	Traction Decompression of the Spine
IV-149	Transcatheter Aortic Valve Implantation/Replacement (TAVI/TAVR) for Aortic Stenosis
II-190	Transcatheter Arterial Chemoembolization to Treat Primary or Metastatic Liver Malignancies
IV-152	Transcatheter Mitral Valve Repair (TMVR)
IV-155	Transcatheter Pulmonary Valve Implantation
V-10	Transcatheter Uterine Artery Embolization
X-14	Transcranial Magnetic Stimulation
II-31	Transesophageal Endoscopic Therapies for Gastroesophageal Reflex Disease (GERD)
IV-07	Treatment of Obstructive Sleep Apnea and Snoring in Adults
II-164	Tumor Treating Fields Therapy

Policy #	Policy Title
IV-118	Ultrasound-Guided High-Intensity Focused Ultrasound Ablation
II-98	Uterine Fibroid Ablation: Laparoscopic, Percutaneous or Transcervical Techniques
IV-131	Vagus Nerve Stimulation
II-167	Vestibular Evoked Myogenic Potential (VEMP) Testing
IX-06	Virtual Reality
IV-144	Viscocanalostomy and Canaloplasty for the Treatment of Glaucoma
VI-60	Vitamin D Screening
IV-163	Water Vapor Energy Ablation and Waterjet Tissue Ablation for Benign Prostatic Hyperplasia
V-28	Whole Body Dual X-Ray Absorptiometry (DXA) to Determine Body Composition
V-12	Wireless Capsule Endoscopy
II-134	Wireless Gastric Motility Monitoring

The following Medical Policies will be applicable to services provided on or after January 1, 2024. **The procedure codes associated with this set of policies may require prior authorization.**

Policy #	Policy Title
VI-16	Genetic Testing for Hereditary Breast and/or Ovarian Cancer
II-144	Cellular Immunotherapy for Prostate Cancer
IV-01	Balloon Ostial Dilation
IV-19	Bariatric Surgery
IV-17	Blepharoplasty and Brow Ptosis Repair
IV-14	Breast Implant, Removal or Replacement
IV-143	Closure Devices for Atrial Septal Defects and Patent Foramen Ovale
IV-123	Gender Affirming Procedures
IV-80	Implanted Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea
IV-71	Gynecomastia Surgery
IV-86	Ventricular Assist Devices and Total Artificial Hearts
IV-16	Orthognathic Surgery
IV-24	Panniculectomy/Excision of Redundant Skin or Tissue
IV-164	Perirectal Spacer for Use During Radiotherapy for Prostate Cancer
IV-32	Reduction Mammoplasty
IV-73	Rhinoplasty, Septorhinoplasty, and Septoplasty
IV-126	Sacroiliac Joint Fusion
V-10	Transcatheter Uterine Artery Embolization

Policy #	Policy Title
II-252	Idecabtagene vicleucel
II-181	Tocilizumab
II-274	Nadofaragene Firadenovec
II-186	Alglucosidase Alfa
II-256	Avalglucosidase Alfa
II-216	Laronidase
II-264	Vutrisiran
II-206	Alpha-1 Proteinase Inhibitors
II-251	Casimersen
II-152	Belimumab
II-16	Botulinum Toxin
II-249	Lisocabtagene Maraleucel
II-275	Ublituximab
II-262	Ciltacabtagene Autoleucel
II-03	Chelation Therapy
II-179	Certolizumab Pegol
II-202	Reslizumab
II-215	Idursulfase
II- 173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy
II-281	Pegunigalsidase alfa
II-263	Sutimlimab
II-182	Vedolizumab
II-214	Intravenous Enzyme Replacement Therapy for Gaucher Disease
II-250	Evinacumab
II-173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy
II-26	Agalsidase Beta
II-203	Benralizumab
II-204	Emapalumab
II-273	Etranacogene dezaparvovec
II-268	Elivaldogene autotemcel
II-222	Tildrakizumab
II-51	Immunoglobulin Therapy
II-97	Infliximab

Policy #	Policy Title
II-29	Intra-Articular Hyaluronan Injections for Osteoarthritis
II-100	Intravitreal Corticosteroid Implants
II-243	Intravenous Iron Replacement Therapy
II-147	Pegloticase
II-183	Tisagenlecleucel
II-278	Velmanase alfa
II-184	Alemtuzumab
II-173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy
II-258	Inclisiran
II-173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy
II-217	Galsulfase
II-223	Naltrexone Implants
II-211	Romiplostim
II-201	Mepolizumab
II-210	Fosdenopterin
II-185	Ocrelizumab
II-161	Abatacept
II-248	Lumasiran
II-107	Advanced Pharmacologic Therapies for Pulmonary Arterial Hypertension
II-173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy
II-47	Rituximab
II-255	Anifrolumab
II-238	Afamelanotide
II-71	Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions
II-180	Golimumab (Simponi Aria)
II-265	Risankizumab
II-168	Ustekinumab
II-159	Subcutaneous Hormone Pellets
II-277	Pegcetacoplan
II-245	Brexucabtagene Autoleucel
II-259	Tezepelumab
II-49	Natalizumab
II-272	Teplizumab

Policy #	Policy Title
II-244	Inebilizumab
II-16	Botulinum Toxin
II-145	Injectable Clostridial Collagenase for Fibroproliferative Disorders
II-257	Triamcinolone Acetonide Suprachoroidal Injection
II-34	Omalizumab
II-187	Axicabtagene Ciloleucel
II-230	Onasemnogene Abeparvovec
II-231	Brexanolone
II-267	Betibeglogene autotemcel
IV-145	Amniotic Membrane and Amniotic Fluid
IV-137	Bioengineered Skin and Soft Tissue Substitutes
IV-82	Liposuction
IV-166	Penile Prosthesis Implantation
II-192	Plasma Exchange
IV-158	Surgical Treatments of Lymphedema
II-227	Enzyme Replacement Therapy for the Treatment of Adenosine Deaminase Severe Combined Immune Deficiency (ADA-SCID)
Il-235	Crizanlizumab
II-102	Pharmacologic Therapies for Hereditary Angioedema
Il-176	Cerliponase Alfa
II-212	Burosumab
II-236	Romosozumab
II-234	Givosiran
Il-200	Sebelipase Alfa
Il-219	Vestronidase Alfa
II-211	Romiplostim
II-178	Edaravone
II-237	Luspatercept
II-171	Nusinersen
II-226	Esketamine
II-239	Teprotumumab
II-229	Ravulizumab
II-218	Elosulfase Alfa

Policy #	Policy Title
II-240	Eptinezumab
II-199	Bezlotoxumab

Products Impacted

- Families and Children
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)

Questions?
Please email Blue Cross at MHCPProviders@BlueCrossMN.com

Prior Authorization Process for Minnesota Health Care Programs (MHCP), effective 1/1/24 | P79-23

As communicated in Provider Quick Point QP95-22, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be transitioning MHCP Operations back to Blue Cross as of January 1, 2024.

For MHCP subscribers, Blue Cross has a prior authorization process for various services, procedures, prescription drugs, and medical devices.

The full list of services, procedures, prescription drugs, and medical devices that require prior authorization (PA) will be published by December 15, 2023 at https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs-mhcp. The precertification process determines whether medical necessity exists based on Clinical Criteria and is not a reflection of a member's benefits or eligibility. Benefits and eligibility must be verified each time a member seeks services.

Submitting Notification
Pre-Admission notification is required for all medical and behavioral health admissions. Discharge details must be provided for every admission. Most elective services provided by or arranged at a nonparticipating provider or facility require precertification.

Effective January 1, 2024, the acute medical and behavioral health acute admission notification and discharge requirements will become automated for Minnesota providers (including bordering counties) that are participating in the MN Encounter Alert Service (MN EAS); see Provider Bulletin P74-23.

- For **providers that are not participating with MN EAS**, admission and discharge notification is required and can be completed through the Availity Essentials portal at availity.com/essentials
- For **post-acute facilities that require precertification**, the provider can complete the precertification and concurrent review processes (including medical record submission) through the Availity Essentials portal at availity.com/essentials
- **All admissions to a non-participating facility require prior authorization.**

Submitting Prior Authorizations
Providers can quickly determine if a service or item requires prior authorization from the health plan before care is provided by entering the member group number, date of service and procedure code. The PA Look Up tool response also includes details related to the medical policy or evidence-based criteria that may apply and any special instructions related to the prior authorization process. There are two options for providers to use:

- The Prior Authorization Lookup tool is available on the Blue Cross website under Medical Management: https://www.bluecrossmn.com/providers/medical-management/prior-authorization-lookup-tool
- On Availity Essentials, follow the Authorization Request process. The first step in this process allows the provider to do determine if a PA is required using the "Is Authorization Required" tool. If an authorization is required, the provider can simply proceed to the next step to complete the process.

If an authorization is required, it is highly recommended for the provider to utilize the online process through Availity Essentials.

MCG Care Guidelines, effective January 1, 2024
Blue Cross licenses and utilizes MCG Care Guidelines, 27th edition, for inpatient and residential level of care to guide utilization management decisions. The five products licensed include the following:

- **Inpatient & Surgical Care (ISC)**: Manage, review, and assess subscribers facing hospitalization or surgery proactively with nearly 400 condition-specific guidelines, goals, optimal care pathways, and other decision-support tools.
- **General Recovery Care (GRC)**: Effectively manage complex cases where a single Inpatient Surgical Care guideline or set of guidelines is insufficient, including the treatment of subscribers with diagnostic uncertainty or multiple diagnoses.
- **Home Care (HC)**: Provides evidence-based comprehensive guidelines to enable case managers and others to maintain quality and efficiency in the subscriber's home environment.
- **Recovery Facility Care (RFC):** Coordinate an effective plan for transitioning people to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).
- **Behavioral Health Care (BHC)**: Provides evidence-based guidelines to help healthcare professionals guide the effective treatment of subscribers with psychiatric disorders.

Blue Cross utilizes the following resources to guide the prior authorization decisions:

- **Minnesota Department of Human Services — Minnesota Health Care Program (MHCP) Provider Manual**
- Substance Use Disorder (SUD) Services, American Society of Addiction Medicine (ASAM)
- **Blue Cross prior authorization**
  - **Medical Policies** (enter a specific medical policy name or part of a policy, word, or phrase into the search bar)
  - **Clinical Criteria pharmacy policies**

Prior Authorization and Notification list
Separate PA lists for Medicaid (Families & Children, MNCare and MSC+) and MSHO will be published by December 15, 2023, for an effective date of January 1, 2024 at https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs-mhcp

Retrospective PA requests
Retrospective clinical review will be considered by Blue Cross prior to the claim being submitted in consideration of scenarios that make obtaining an approval prior to rendering the service difficult, such as after-hours or urgent situations.

Products Impacted

- Families and Children
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)

- Minnesota Senior Health Options (MSHO)

Questions?
Please email Blue Cross at MHCPProviders@BlueCrossMN.com

Reimbursement Policies for Minnesota Health Care Programs (MHCP), effective 1/1/24 | P80-23

As communicated in Provider Quick Point QP95-22, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be transitioning MHCP Operations back to Blue Cross as of January 1, 2024.

For many covered services, Blue Cross has been configuring the claims processing system to be consistent with MHCP guidelines. Services following MHCP guidelines effective January 1, 2024, will not have a Reimbursement Policy published. Providers are encouraged to review the Provider Policy and Procedure Manual, Provider Bulletins and Quick Points for additional information.

The following Reimbursement Policies will be published and applicable to MHCP subscribers effective January 1, 2024.

Reimbursement Policy	Status	Summary
EM-002: Same Day Same Service	No change	This policy addresses coding and reimbursement for multiple evaluation and management (E/M) services reported for the same patient on a single date of service. E/M services appended with modifier -25 will have a 20% reduction applied to the allowed amount.
EM-013: New Patient	New	This new policy addresses when a new patient E/M is eligible for reimbursement.
Facility-002: Incremental Nursing	New	This new policy addresses appropriateness of incremental nursing services billed under revenue code 023X.
Facility-003: Inpatient Hospital Readmission	No change	This policy addresses readmissions to the same hospital within 15 days of discharge.
Facility-006: Outpatient Hospital Services Prior to an Inpatient Admission	Change	This policy addresses those outpatient hospital services that are to be billed on the inpatient claim when performed on the day of or within 3 days prior to admission to the same hospital.
GC-003: Code Editing Policy	No change	This policy addresses the industry standard coding edits utilized to assist in a consistent claim review process.
GC-005: Unlisted Procedure Code Policy	No change	This policy addresses the appropriate use of unlisted CPT/HCPCS codes. Unlisted codes should only be used if no code exists to describe the procedure, service, or supply.
GC-009: Maximum Units Per Day	No change	This policy addresses the reimbursement of CPT/HCPCS codes submitted with multiple units on the same date of service. The maximum units per day values generally align with CMS MUE, in addition to CPT/HCPCS code descriptions, industry standards, and what is clinically appropriate for a specific service.

GC-071: Bundled Services	New	A new policy that addresses bundled services designated on the National Physician Fee Schedule (NPFS) Relative Value file with a Status B or P indicator.
GC-073: Clinical Trials	No change	This policy addresses reimbursement for routine costs related to certain clinical trials.
GC-074: Cellular and Gene Therapy	New	This policy addresses coding and reimbursement for Cellular and Gene Therapy Products. Reimbursement will be determined using the following methodology: Wholesale Acquisition Cost (WAC).
GC-079: Hair Removal for Gender Affirming Procedures	New	A new policy that addresses hair removal procedures when performed in conjunction with gender dysphoria treatment.
LP-001: Laboratory Rebundling Policy	New	This policy addresses coding and reimbursement for laboratory rebundled services. The tests listed under each organ or disease-oriented panel (80047- 80081) identify the defined components of that panel, and all tests listed must be performed to bill for that panel.
LP-008: Genetic/Molecular Test Coding	No change	Blue Cross requires that all providers billing for genetic and molecular testing services bill according to the coding recommendation in the Concert Genetics portal.
REHAB-004: Physical, Occupational and Speech Therapy (PT, OT, ST) Modalities and Evaluation	No change	This new policy addresses physical, occupational and speech therapy modalities and evaluation services. In addition, it addresses the 15% reduction in the allowed amount for services modified with the CO or CQ modifiers.
SI-002: Bilateral Procedures	No change	This policy addresses coding and reimbursement for bilateral procedures. Blue Cross determines reimbursement of bilateral procedures based on the Bilateral Indicator assigned by the Centers for Medicare and Medicaid Services (CMS).
SI-003: Co-Surgeon and Team Surgeons	Change	This policy identifies the procedures eligible for co-surgeon and team surgeon reimbursement and the associated documentation requirements. Beginning 1/1/2024, reimbursement will be 62.5 percent of the global surgery fee schedule amount for allowable team surgery (modifier 66) services.
SI-004: Modifier 22	Change	This policy addresses reimbursement for services that are submitted with a 22 modifier. Beginning 1/1/2024, submission of a claim using the 22 modifier will require documentation to be submitted with the claim.
SI-005: Multiple Surgical Reduction	No change	This policy addresses reimbursement for multiple procedures performed by the same physician or other qualified healthcare professional (QHP) on the same date of service during the same patient encounter. Blue Cross utilizes the National Physician Fee Schedule Relative Value File to determine which procedures are eligible for multiple procedure reduction.

SI-007: Global Surgical Package	Change	This policy addresses the Global Surgical Package, as defined by the Centers for Medicare and Medicaid Services (CMS). This includes all services normally provided by the surgeon, or other physician or qualified health care professional within the same group and same specialty during the preoperative, intraoperative, and postoperative period of a procedure. Beginning 1/1/24, the modifiers listed below will be reimbursed at the following: – 54: 80% of allowed amount – 55: 15% of allowed amount – 56: 5% of allowed amount
SI-019: Once in a Lifetime Procedures	New	A new policy that addresses procedures that are generally performed only once in a patient's lifetime. For example, a patient only has one appendix; therefore, an appendectomy can be performed only once in the patient's lifetime.
SI-022: Wrong Surgical and Other Invasive Procedures	No change	This policy addresses reimbursement for services associated with a wrong surgical or other invasive procedure reported on either an institutional or professional claim. Blue Cross will not reimburse for these or related services.

Products Impacted

- Families and Children
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)

Questions?
Please email Blue Cross at MHCPProviders@BlueCrossMN.com

Moving Expenses Benefit added to Minnesota Health Care Programs (MHCP) | P85-23

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be implementing a benefit for Moving Expenses for eligible MHCP subscribers effective January 1, 2024.

Moving Expenses is a component of the Housing Stabilization-Transition benefit and is available to subscribers receiving Housing Stabilization-Transition services that are transitioning out of Medicaid funded institutions or other provider-operated living arrangements to a less restrictive living arrangement in a private residence where the person is directly responsible for his or her own living expenses (own home). Moving Expenses are non-reoccurring and are limited to a maximum of $3,000 annually.

Covered services may include:

- Applications, security deposits and securing documentation required to obtain a lease.
- Essential household furnishings; including furniture, window coverings, food preparation items, bed/bath linens.
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating, water.
- Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.
- Necessary home accessibility adaptations.

The Minnesota Department of Human Services (DHS) will review all requests for Moving Expenses. DHS currently reviews and authorizes Transitioning/Sustaining services per established criteria. The review may be performed at initial authorization or renewal. Providers should submit a plan change including Moving Expenses if a person is moving mid-eligibility period and meets criteria for Moving Expenses. DHS will communicate authorizations to Blue Cross.

Providers are required to maintain documentation of all purchases and spending, including receipts and invoices related to the subscriber's eligible Moving Expenses. Providers are required to track costs separately from other services provided under Housing Stabilization - Transition Services.

Eligible Moving Expenses should be submitted by the authorized Housing Transition provider using HCPCS code T2038-U8. All claims for Moving Expenses must include a claims attachment with a receipt or invoice clearly identifying the service or item. Claims submitted without the attachment will not be reimbursed. All claims attachments will be reviewed to determine eligibility for the service or item.

Moving Expense providers and/or their family members cannot sell goods and services to recipients that are reimbursed through the Moving Expense benefits and Moving Expenses cannot be used to purchase goods and services from a subscriber's family member.

Products Impacted

- Families and Children
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)

Questions?
Please email Blue Cross at MHCPProviders@BlueCrossMN.com

Electronic Visit Verification Requirements for Home Health Services | P86-23

Blue Cross and Blue Shield of Minnesota and Blue Plus including Bridgeview (Blue Cross) are using an Electronic Visit Verification (EVV) for personal care services and home health services as required by the federal 21st Century Cures Act. The law defines applicable services as those that require an in-home visit. Home Health providers should have received either a letter in the mail or an email with the information contained in this bulletin.

Information about EVV, including the specific services affected, is available on the DHS website at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/evv/

The law requires providers to use an electronic verification method to record member information, individual provider information, location of the services, beginning and ending times of the services, along with the date and type of service performed.

Blue Cross is using a hybrid EVV model. With the hybrid model, providers may select either the Blue Cross provided system or an EVV system that works best for their business. Blue Cross is using the state-selected system, HHAeXchange, as our EVV vendor. If providers choose another EVV system, the system must be able to submit data to HHAeXchange's system. Blue Cross will not charge providers to access HHAeXchange's system. It is understood that providers might need to spend time and resources to make this change and comply with the law in cooperation with Blue Cross.

Blue Cross requires all home health care providers to connect to the HHAeXchange system by the Provider Go-Live date. The Provider Go-Live date was October 16, 2023, which was communicated by the Minnesota Department of Health Services (DHS) in a letter dated September 22, 2023. On that date, providers were to be connected to the HHAeXchange system, using their selected EVV system for services specified in the law. Blue Cross understands it will take time for EVV use to become routine for direct support workers and people who use services and for providers to comply fully.

HHAX platform options
HHAeXchange offers a free EVV solution and free data-integration options for providers who already have an EVV solution. Provider agencies play a vital role in the success of the EVV project. All Blue Cross home health and personal care service providers must choose one of these two options:

- Providers without an EVV solution may set up and use the free EVV tools from HHAeXchange provided by Blue Cross.
- Providers who use a different EVV system may use their existing EVV system and send visit data to the HHAeXchange system using electronic data interchange.

HHAeXchange Enrollment Form
Providers must complete the HHAeXchange enrollment survey. The enrollment form link is located at: https://www.cognitoforms.com/HHAeXchange1/MinnesotaMCOHHAeXchangeProviderEnrollmentForm

Providers must complete the enrollment form if new to HHAeXchange in Minnesota. Providers currently enrolled with HHAeXchange must update their enrollment form to indicate all managed care organizations (MCO) with whom you work.

Products Impacted
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)

Questions?
Email MHCPProviders@BlueCrossMN.com

For questions or help with the HHAeXchange system, email Support@HHAeXchange.com or visit the project website at https://hhaexchange.com/mn/