PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **FEBRUARY 3, 2020**

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes
(article is published in every monthly Bulletin)

In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers. Blue Cross is hereby reminding all providers to submit a form to us whenever any of the following changes occur:

- 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

Forms Location
Based on what change has occurred, submit the appropriate form located on our website at **providers.bluecrossmn.com**. Select "Administrative Updates" in the "What's Inside" section to obtain instructions on completing the various forms or access the link below:

https://www.bluecrossmn.com/healthy/public/personal/home/providers/admin-updates.

How do we submit changes?
Send the appropriate form via fax as indicated below:
Fax: 651-662-6684, **Attention: Provider Data Operations**

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective April 6, 2020 (P10-20, published on 2/3/20)

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 April 6, 2020:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-71	Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions • Brolucizumab (Beovu®)	No *(Replacing policy II-173)*	Continued	Commercial
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: • Afamelanotide (Scenesse®) • Luspatercept (Reblozyl®)	No	New	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Infliximab (Avsola™) • Afamelanotide (Scenesse®) • Luspatercept (Reblozyl®)	No	New	Medicare Advantage

Products Impacted
The information in this bulletin applies **only** to subscribers who have coverage through commercial and Medicare Advantage lines of business.

Submitting a PA Request when Applicable

- 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. 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 providers.bluecrossmn.com
  - Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
  - Select the "+" (plus) sign next to Medical and Behavioral Health Policies, then select "Blue Cross Blue Shield of Minnesota Medical Policies" to access policy criteria.
- Prior Authorization Lists are updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access Prior Authorization Lists for all lines of business:
  - Go to providers.bluecrossmn.com
  - Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
  - Select the "+" (plus) sign next to "Utilization Management" to access the Prior Authorization Lists.
- 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. The requirement applies to subscribers starting therapy and to those already being treated with a therapy noted above.
- **Providers may submit PA requests for any treatment in the above table starting March 30, 2020.**

Providers can Submit an Electronic Prior Authorization (ePA) Request

- Online via our free Availity provider portal – for Blue Cross to review.
- For Medical Drugs, PA's can also be submitted using a NCPDP standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, the Minnesota Uniform Form for PA Request and Formulary Exceptions fax form located under the Forms section on the Blue Cross website, or their own PA form (secure fax: 651.662.2810).

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 providers.bluecrossmn.com
- Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
- Select the "+" (plus) sign next to "Medical and Behavioral Health Policies" to see the Upcoming Medical Policy Notifications section

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

Updated Bulletin: Commercial Inpatient Admission Notification Process Changes

(P11-20, published on 2/3/20)

This information replaces the content previously published in Provider Bulletin P54R2-19. The information in this bulletin applies to members with **commercial coverage** from Blue Cross and Blue Shield of Minnesota or Blue Plus (Blue Cross) or from any out-of-state Blue plan. This information does not apply to Medicare plans, Federal Employee Program® (FEP®), Minnesota Health Care Programs (Families and Children, MinnesotaCare, and Minnesota Senior Care Plus) or Minnesota Senior Health Options (MSHO).

Prior to this change, inpatient admission notifications (also known as preadmission notifications or PANs) were required for all planned and unplanned acute hospital admissions. Starting April 1, 2020, concurrent review will also be required for any inpatient hospital stay longer than the number of days initially allowed with the admission notification.

Admission notifications do not require clinical records at the time of submission, but these admissions must be medically necessary and are subject to retrospective review or audit. For most acute admissions, seven days are allowed with the initial admission notification. If the member is not discharged within the allowed days, a concurrent review must be requested using the Authorizations tool in the Availity portal.

Requests for concurrent review should include:

- Relevant ER, MD and nurse notes
- History & Physical
- Relevant imaging and labs
- Transition of care/discharge plan

Requests for concurrent review for hospital stays reimbursed according to a Diagnosis-Related Group (DRG) methodology will be treated as a continued stay notification. A medical necessity review for length of stay will not be completed at the time of submission, but continued stays must be medically necessary and reasonable and are subject to retrospective review or audit. Hospital stays reimbursed under any other payment methodology, including outlier methodology, are subject to medical necessity/length of stay review when the concurrent review request is submitted.

If the member has already discharged and additional days are not needed, discharge information is required. Cases can be updated using the Authorizations tool in the Availity portal to add:

- Discharge date (required)
- Discharge destination (required)
- Discharge instructions (optional text box)
- Discharge diagnosis (optional)

Discharge summaries can also be added to a case in Availity by selecting "Attachments" in the Choose Update screen (optional).

Why does Blue Cross require admission and continued stay notifications?
Blue Cross utilizes admission, continued stay and discharge data to identify members who may benefit from additional support or specialty services, such as case management, disease management and behavioral health support programs. The Blue Cross Case Management team also offers support to members as they transition back home or to a post-acute care facility. Case Managers review the discharge summary details and work with members to avoid preventable readmissions by ensuring they understand medication changes, signs and symptoms that would require immediate attention, attend scheduled follow up appointments and follow through with discharge instructions after they return home.

For longer stays, Blue Cross may also work with the hospital Case Manager prior to discharge to help with discharge planning and coordinating post-acute care if needed.

Frequently Asked Questions – Inpatient Admission Notifications

How do I submit an inpatient admission notification for a Blue Cross and Blue Shield of Minnesota member?	Admission notifications should be submitted to Blue Cross using the Authorizations tool within the Availity portal. Admission notifications can be submitted 24 hours a day using the Availity portal and are accepted up to two business days after the date of admission to accommodate admissions over the weekend and on holidays. Admission notifications for newborns can be submitted as soon as the baby is added to the subscriber's plan. We cannot process any requests for newborns until they are an active member. These admissions can be submitted in the Availity portal for up to one year after birth. Note: Observation stays do not require prior authorization or notification.

How do I submit an inpatient admission notification for a member from an out-of-state Blue Cross Blue Shield plan?	Admission notifications should be submitted to the member's home plan. Home plan contact information can be found: • On the back of the member's ID card • Using the Medical Policy and Prior Authorization Router at mktg.bluecrossmn.com/router/ (Enter the first three characters of the member's ID number) Admission notifications submitted via the Authorization tool in the Availity portal will also be routed using the first three characters of the member's ID number. If applicable, the member's home plan information will be displayed.
Do admissions for labor and delivery require notification?	Yes. Labor and delivery admissions (vaginal and c-section) require admission notification and are automatically approved. When adding the notifications in the Availity portal, use the Labor and Delivery service types. Admission and discharge data for labor and delivery admissions is used to identify members who may need support for themselves or for their newborn.
If a surgical procedure requires prior authorization, is an admission notification still required for the inpatient hospital admission?	Yes. If the surgical procedure requires prior authorization, this should be done first. The surgery itself must be medically necessary and covered by the subscriber's plan for the admission and other related charges to be covered. Once the surgery is approved, the inpatient notification can be submitted. Note: While a surgical procedure may require prior authorization, observation stays associated to the surgery do not require prior authorization or notification.
If the date of admission changes, how can I update the inpatient admission notification?	If the admission date changes for a planned inpatient stay, call Blue Cross at 1-800-528-0934.
If the member does not actually admit or their planned stay changes to an observation stay, do I need to withdraw or cancel the notification?	The inpatient notification can be withdrawn if it is in one of the following statuses in the Availity portal: • Incomplete • Pending Review • Pending Action If a notification case is in "approved" status it does not need to be cancelled or withdrawn. It will not count against the subscriber's benefits. It will simply be maintained as a record of the originally requested admission.
If I didn't submit an inpatient admission notification within two business days and the member is still inpatient, should I still notify Blue Cross of the admission?	Yes. If an admission notification was not submitted within the allowed timeframes using the Availity portal and the member is still inpatient, please call 1-800-528-0934 to notify Blue Cross of the admission. (Phone notifications are only accepted when the notification cannot be submitted through the Availity portal.)
How is claim payment impacted by the admission notification requirements?	Blue Cross will monitor adherence and provide reporting and education to providers throughout 2020 to help maximize compliance with admission, continued stay and discharge notification requirements. All admissions must be medically necessary and are subject to retrospective review or audit. Payment will not be allowed for any admissions or continued stays found to be not medically necessary.

Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Utilization Management (UM) Program (P13-20, published 2/3/20)

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

The following oncologic drugs already require PA through eviCore's Medical Oncology program, but will have the following code changes **effective March 1, 2020:**

Drug	Deleted/Discontinued code(s)	Newly added code(s)
Bevacizumab-bvzr (Zirabev)		Q5118
Calaspargase pegol-mknl (Asparlas)	J3490, J3590	J9118
Cemiplimab-rwlc (Libtayo)	C9399, J9999	J9119
Levoleucovorin (Khapzory™)	J3490, J3590	J0642
Mogamulizumab-kpkc (Poteligeo)	C9038, C9399, J9999	J9204
Moxetumomab pasudotox-tdfk (Lumoxiti)	C9399, J9999	J9313
Tagraxofusp-erzs (Elzonris)	J3490, J3590	J9269
Trastuzumab-anns (Kanjinti)		Q5117
Trastuzumab-qyyp (Trazimera)		Q5116

The following drugs have been added to the Medical Oncology program and will require prior authorization **for oncologic reasons beginning April 1, 2020:**

Drug	Code(s)
Polatuzumab vedotin-piiq (Polivy)	C9399, J9309, J9999
Pegfilgrastim-bmez (Ziextenzo)	J3490, J3590
Rituximab-pvvr (Ruxience)	C9399, J3490, J3590, J9999
Gemcitabine NaCL (Infugem)	J9199

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of CPT codes that require prior authorization, 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 **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources,* read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- 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 **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources,* read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Click on the "**Resources**" dropdown in 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

Products Impacted
This change only applies to **fully insured commercial** and **Medicare Advantage** subscribers.
The changes do not impact:

- Blue Cross Commercial Self-Insured Subscribers
- Blue Cross Platinum Blue and Senior Gold Subscribers
- Blue Cross Government Programs [Families and Children (F&C), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) health plans]
- Blue Cross Federal Employee Program (FEP) Subscribers

To submit a Prior Authorization (PA) Request to eviCore
Providers submit eviCore PA requests via our free Availity provider portal. Instructions on how to utilize this portal are found on the Availity website.

Providers need to reference the eviCore clinical guideline criteria, submit prior authorization request via Availity, 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.
- Some of the Medical Oncology Drugs listed above may be approved by the Food and Drug Administration (FDA) for use treating non-oncology indications. To identify if a prior authorization for a drug for non-oncology use, please refer to the Prior Authorization Lists posted on the Blue Cross website. To access the Pre-Authorization Lists:
  - Go to providers.bluecrossmn.com
  - Select "Medical Policy" under Tools and Resources, read and accept the Blue Cross Medical Policy Statement
  - Review the lists under the "Utilization Management" section

Questions?
If you have questions, please contact eviCore provider service at **844-224-0494**.

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

MHCP Prenatal Service Third Party Liability Change (P9-20, published 2/3/20)

Background

The Bipartisan Budget Act of 2018 makes changes to the coordination of benefits process for prenatal services, which formerly received special treatment under the Medicaid third party liability requirements. This law directs Medicaid to apply standard coordination of benefits rules when processing claims for prenatal services. Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement these changes effective **April 1, 2020**.

Products Impacted
This information applies to the following Minnesota Health Care Programs:

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

What is the impact of this change?
Blue Cross will no longer "pay and chase" claims for prenatal services. In accordance with the Bipartisan Budget Act of 2018, prenatal services are now subject to standard coordination of benefits procedures. Additional information on this legislation can be found here:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib060118.pdf

In situations where third party liability is likely, Blue Cross will return a claim to the provider noting the party which Blue Cross believes is responsible for payment. If the provider bills the liable third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to Blue Cross for payment of the balance, up to the maximum Medicaid payment amount established for the service.

Questions?
If you have questions, please contact Provider Services at **1-866-518-8448.**

Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements (P12-20, published 2/3/20)

Effective April 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government programs medical policy and pre-authorization/pre-certification/notification lists. The lists clarify medical policy, prior authorization, and notification requirements for the Minnesota Health Care Programs (Families and Children, MNCare, and MSC+) and Minnesota Senior Health Options (MSHO) products.

As stewards of healthcare expenditures for our subscribers, we are 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 members.

The following **new** policies and/or prior authorization requirements **will be applicable** to subscriber claims on or after **April 1, 2020**.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0152	Vyondys 53 (golodirsen)	Yes	Yes	Yes

The following policies have transitioned to new policy numbers, with changes in clinical criteria, and **will be applicable** to subscriber claims on or after **April 1, 2020**.

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
MHCP	ING-CC-0143	Polivy (polatuzumab vedotin-piiq)	Yes	Yes
MHCP	ING-CC-0031	Intravitreal Corticosteroid Implants [Yutiq (fluocinolone acetonide intravitreal implant) only]	Yes	Yes
MHCP	Blue Cross II-230	Zolgensma (onasemnogene abeparvovec)	Yes	Yes

Where do I find the current government programs Pre-Certification/Pre-Authorization/Notification list?

Go to **providers.bluecrossmn.com**

- Under Tools & Resources, select "Medical Policy," and read/accept the Blue Cross Medical Policy and UM Statement
- Under Utilization Management, then 'Precertification Lists' select the 'MN Government Programs Pre-Certification/Pre-Authorization/Notification List'

OR

Go to **providers.bluecrossmn.com**

- Under Tools & Resources, select "Minnesota Health Care Programs site"
- Under Resources, select "Prior Authorization Requirements" then select "Prior Authorization List"

Where do I find the current government programs Medical Policy Grid?

Go to **providers.bluecrossmn.com**

- Under Tools & Resources, select "Minnesota Health Care Programs site"
- Under Resources, select "Manuals and Guides"
- Under Medical Policies and Clinical UM Guidelines, select "Medical Policy Grid"

Where can I access medical policies?

- **MN DHS (MHCP) Policies:** http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_157386
- **Blue Cross Policies:** https://www.bluecrossmn.com/providers/medical-policy-and-utilization-management
- **Amerigroup Policies:** https://medicalpolicies.amerigroup.com/am_search.html

  AND
  https://www.anthem.com/pharmacyinformation/clinicalcriteria

Please note that the Precertification Look Up Tool (PLUTO) will not be available for prior authorization look up.

Questions?

If you have questions, please contact Blue Cross Provider Services at **1-866-518-8448**.

Change in Requirements for Newborn Precertification Process for Minnesota Health Care Programs (P15-20, published 2/3/20)

Effective April 1, 2020, we request that providers submit the *Newborn Notification of Delivery Form* when submitting the mother's inpatient precertification request.

This information allows additional resources to be provided as quickly as possible after delivery, such as care coordination for mothers with sick babies who may need extra support.

The information on the *Newborn Notification of Delivery Form* is already included in the online (Interactive Care Reviewer) submission of the mother's precertification request, so the additional form is not required when submitting online.

When faxing in a precertification request for the mother's inpatient admission, fax the request to **1-844-480-6839**. Precertification requests faxed in will not be denied if missing the form; however, if not available at the time the precertification is submitted, providers may add it when submitting discharge documentation.

Providers can access both forms (the *Newborn Notification of Delivery Form* and the *Prior Authorization/ Precertification Request*) on the website at https://provider.publicprograms.bluecrossmn.com/minnesota-provider/home in the 'Forms' section.

Well baby services will continue to be covered under the submission of the mother's inpatient precertification request with no separate authorization required.

Effective April 1, 2020, facilities are required to submit the request via fax or by phone to ensure timely determination for the authorization of a sick newborn, circumcision or other urgent newborn services requiring medical review. When submitting the request, providers should note that the Minnesota Medicaid ID number (PMI) is not yet available from the Minnesota Department of Human Services (DHS).

Completed forms should be faxed to **1-800-964-3627**. Any necessary clinical reviews of services will be processed even though DHS may not have determined ongoing coverage.

Newborn claims will not be processed until Blue Plus receives the newborn's enrollment information from DHS and the baby is active in our system.

Newborns born to mothers enrolled in Blue Advantage Families and Children (F&C) or MinnesotaCare are automatically enrolled in Blue Plus for the calendar month of the birth only. It is important that the mother notify her local agency of the birth of her child for the enrollment process to begin (if enrolled in F&C or MinnesotaCare).

Products Impacted
This information applies to the following Minnesota Health Care Programs:

- Families and Children (F&C)
- MinnesotaCare (MNCare)

Questions? If you have questions, please contact Provider Services at **1-866-518-8448**.

BlueRide Transportation – Claims Payment Transition Back to Blue Plus Platform – April 1, 2020 (P14-20, published 2/3/20)

Overview:
Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus) works closely with participating transportation Providers to schedule member rides and process claims for BlueRide. **Blue Plus has made the decision to transition the administration of BlueRide back to Blue Plus from LogistiCare, effective for service dates April 1, 2020 for claims processing and effective June 1, 2020 for ride scheduling.**

Blue Plus will be holding two Q&A sessions regarding this change. There will be in person and conference call access to both sessions. You need only attend one of the sessions.

February 6, 2020 10:00 am – noon
Blue Cross Blue Shield of MN – Blue Cross University
3311 Terminal Drive
Eagan, MN 55121
Dial 651-662-4100 or 1-855-563-2583 Code 258250

Or

February 11, 2020 2:00 pm – 4:00 pm
Blue Cross Blue Shield of MN – Blue Cross University
3311 Terminal Drive
Eagan, MN 55121
Dial 651-662-4100 or 1-855-563-2583 Code 113580018

Additional details on this new process will be communicated to transportation providers over the coming days.

Blue Plus is committed to reconciling all claims payments submitted to LogistiCare through April 1, 2020 as quickly as possible. To meet this goal, Blue Plus will work with participating transportation Providers and LogistiCare to get all claims submitted and processed.

Availity Changes for Non-Emergent Transportation (NEMT) Providers:

Claims for dates of service that occur on and before March 31, 2020 will be processed by LogistiCare using payer ID code A5143.

Claims for dates of service beginning April 1, 2020 must be submitted with the new payer ID code BLRDE and will be processed by Blue Plus. You or your vendor or clearinghouse will have to register at Availity to submit claims and receive your remittances for services after April 1, 2020 using this new payer ID code.

Claims submitted under the wrong payer ID code with dates of service before or after April 1, 2020 will be properly routed at Availity to the correct payer for processing. See examples below:

- Claims with earliest date of service on or before March 31, 2020 submitted with payer ID code BLRDE will be corrected to payer ID code A5143.
- Claims with earliest date of service on or after April 1, 2020 submitted with payer ID code A5143 will be corrected to payer ID code BLRDE.

Claims can also be submitted directly on Availity.com. Select Professional claims under Claims & Payments and then select 'BLUERIDE NON-EMERG TRANSPORTATION' from the Payer drop-down to appropriately route the claim for services April 1, 2020 and after.

We sincerely appreciate your patience and understanding throughout this process. If you have any questions, please contact Transportation.Liaison@bluecrossmn.com.

Questions & Answers:

Q: How does that affect me as a provider for the April 1, 2020 claims transition?
A: Claims for dates of service that occur on and before March 31, 2020 will continue to be processed by LogistiCare using payer ID code A5143. Claims for dates of service beginning April 1, 2020 must be submitted with the new payer ID code BLRDE and will be processed by Blue Plus.

Q: What Payer ID number should I be using in the Availity portal?
A: Claims for dates of service that occur on and before March 31, 2020 will continue to be processed by LogistiCare using payer ID code A5143. Claims for dates of service beginning April 1, 2020 must be submitted with the new payer ID code BLRDE and will be processed by Blue Plus.

Q: What member identification number should I put on my new claim?
A: You will continue to use the Member ID that you have used in 2019 (Starts with a 7) and is on the current member ID cards.

Q: Who can I contact if I have questions about this?
A: Contact Transportation.Liaison@bluecrossmn.com with any questions.

Q: How will payment processing work?
A: Claims with dates of service prior to April 1, 2020 will be paid by LogistiCare using their standard schedule If there are any claim corrections on those claims from January 1, 2019 through March 31, 2020 that would be needed, you must contact LogistiCare provider help line at 855-933-6989 or blueridеadmin@logistiCare.com. Claims with dates of service April 1, 2020 and after will be paid by Blue Plus.

Q: Where will I see my remittance advice?
A: Remittance advices are located on the Availity portal under “Remittance Viewer”. If you need assistance locating your remittance advices, please contact Availity at 1-800-282-4548. Remittance advices for services after April 1, 2020 will have to be viewed through the new payer ID code on Availity. When you register for claims submission under the new payer ID code, please also remember to register to receive your remittances under that new payer ID code.

Q: Will the BlueRide member phone number remain the same?
A: Yes, members will continue to call 1-866-340-8648 or 651-662-8648 (TTY/TDD 711). Hours of operations are: 8:00 am to 5:00 pm Monday through Friday.

Q: Will members be notified about this transition to LogistiCare?
A: Yes, members will be notified but not until the ride scheduling is moved back to Blue Plus. They will not be notified prior to the April 1, 2020 claims change.