PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **MAY 1, 2020**

ADMINISTRATIVE UPDATES

Coronavirus (COVID-19) Information for Providers (P37-20, published 5/1/20)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) created a Coronavirus website where providers can access all Blue Cross updates related to COVID-19. The website can be accessed by going to www.bluecrossmn.com/providers and clicking 'see latest information' within the 'Coronavirus Info' box in the upper right-hand portion of the provider landing page.

The webpage includes a regularly updated Frequently Asked Questions (FAQ) document, along with all other provider communications related to COVID-19, including Provider Bulletins and Quick Points. Blue Cross encourages providers to access this website regularly for updates as additional information is published as it becomes available.

Questions?
If you have questions regarding Minnesota Health Care Programs (MHCP) or Minnesota Senior Health Options (MSHO) plans, please contact provider services at **1-866-518-8448**. For all other questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Provider Liability Appeals Temporary Extension Due to COVID-19 (P35-20, published 5/1/20)

Due to COVID-19's impact on provider offices, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is increasing the timely filing requirement for provider liability appeals. The timely filing requirement will be increased to 180 calendar days for provider liability appeals for claim remits dated March 1, 2020 and after for all lines of business. This is a temporary extension for the duration of the National Health Emergency related to COVID-19. Please note that this increase in timely filing does not extend the timeframe for submission of claims.

Questions?
If you have questions for a member enrolled in a Minnesota Health Care Programs (MHCP) or Minnesota Senior Health Options (MSHO) plan, please contact provider services at **1-866-518-8448**. For all other questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

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**

CONTRACT UPDATES

Sequestration Suspension for Medicare Lines of Business (P29-20, published 5/1/20)

The Coronavirus Aid, Relief, and Economic Security Act of 2020 (CARES Act) temporarily suspends Medicare Sequestration. In alignment with this act, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will temporarily suspend sequestration for all Medicare lines of business for dates of service beginning May 1, 2020 through December 31, 2020. For facility claims, the suspension of sequestration will apply to claims with 'statement to' dates starting May 1, 2020 through December 31, 2020.

Questions?
If you have questions for a member enrolled in a Minnesota Senior Health Options (MSHO) plan, please contact provider services at **1-866-518-8448**. For all other Medicare products, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

2020 Renewal Changes Summary for Aware Professional Providers (P30-20, published 5/1/20)

The purpose of this Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Cross) Bulletin is to communicate substantive changes to the 2020 Aware Provider Service Agreement. The complete Provider Service Agreement (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2020 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) **Article II.H. The definition of "Minnesota Health Care Programs"** has been updated to most accurately align with current DHS requirements.
2) **Article III.F. Coding Requirements** has been clarified to refer to the existing reimbursement information for unlisted codes as detailed in Reimbursement Policies, which can be found at https://www.bluecrossmn.com/providers/reimbursement-policies
3) **Article XI.F. The Provider Merger** provision has been updated to include reference to practice expansions and additional new locations.

No changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted **annually** to Blue Cross per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Questions?
If you have any questions about the changes made in 2020, please call Provider Services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of a new Agreement that reflects these changes, please email a request to the following address: Request.Contract.Renewal@bluecrossmn.com

2020 Renewal Changes Summary for Blue Plus Referral Health Professional Providers

(P31-20, published 5/1/20)

The purpose of this Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Plus) Bulletin is to communicate substantive changes to the 2020 Blue Plus Referral Health Professional Provider Service Agreement (Agreement). The complete Agreement is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2020 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) **Article II.H. The definition of "Minnesota Health Care Programs"** has been updated to most accurately align with current DHS requirements.
2) **Article III.D. Clinical Coding Requirements** has been clarified to refer to the existing reimbursement information for unlisted codes as detailed in Reimbursement Policies, which can be found at https://www.bluecrossmn.com/providers/reimbursement-policies
3) **Article XIII.N. The Provider Merger** provision has been updated to include reference to practice expansions and additional new locations.

No changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted **annually** to Blue Plus per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Reimbursement
Participating Providers may request a list of applicable rate allowances by emailing a request to Fee.Schedule.Allowance.Request@bluecrossmn.com up to twice annually. Your request must include the participating provider's NPI(s) and Blue Shield ID Number(s).

Questions?
If you have any questions about the changes made in 2020, please call Provider Services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of a new Agreement that reflects these changes, please email a request to the following address: Request.Contract.Renewal@bluecrossmn.com

2020 Renewal Changes Summary for Suppliers of Durable Medical Equipment
(P32-20, published 5/1/20)

The purpose of this Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Cross) Bulletin is to communicate substantive changes to the 2020 Provider Service Agreement with Suppliers of Durable Medical Equipment (DME). The complete Provider Service Agreement with Suppliers of Durable Medical Equipment (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2020 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) **Article III.K. The definition of "Minnesota Health Care Programs"** has been updated to most accurately align with current DHS requirements.
2) **Article III.F. Coding Requirements** has been clarified to refer to the existing reimbursement information for unlisted codes as detailed in Reimbursement Policies, which can be found at https://www.bluecrossmn.com/providers/reimbursement-policies
3) **Article XI.N. The Provider Merger** provision has been updated to include reference to practice expansions and additional new locations.

No changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted **annually** to Blue Cross per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Questions?
If you have any questions about the changes made in 2020, please call Provider Services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of a new Agreement that reflects these changes, please email a request to the following address: Request.Contract.Renewal@bluecrossmn.com

Billing Change for Board Certified Behavioral Analysts (P33-20, published 5/1/20)

Effective July 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating the billing requirement for Behavioral Health Clinics. The update requires Board Certified Behavioral Analysts (BCBAs) to submit claims using their individually assigned NPI number and discontinue submitting claims using a supervising NPI number. This change in billing will help ensure accurate claims payment. Clinical trainees should continue to use their supervisor's NPI number.

Certification will be validated for each Provider with the Behavior Analyst Certification Board national registry.

Clinics that currently perform Health Services using BCBAs should submit the Minnesota Uniform Practitioner Change form as soon as possible to ensure these individuals are appropriately added to the clinic set up and claims are paid without delay.

To obtain an individual billing number for your practitioner(s) to be affiliated to your clinic submit a Minnesota Uniform Practitioner Change Form. The form is located on our website at providers.bluecrossmn.com. Select "Administrative Updates" in the "What's Inside" section and select "Add a Practitioner to Your Group" or access the link below:
https://www.bluecrossmn.com/providers/administrative-updates

Products Impacted
This information applies to all lines of business.

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

Clinical Laboratory Improvement Amendments (CLIA) Requirements Enforcement
(P36-20, published 5/1/20)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will begin more oversight for the purpose of enforcing the requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. For dates of service beginning July 1, 2020, Blue Cross will require that all claims submitted reflect the CLIA program rules to ensure test specimens in interstate commerce consistently provide accurate procedures and services by a CLIA certified lab.

Any provider that solicits or accepts specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the Department of Health and Human Services. Payers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet the CLIA requirements.

This may impact providers who perform laboratory work and submit 837P transactions.

Providers that do not have a CLIA certification may continue to provide services to members. When drug tests or other laboratories are needed, providers can continue to perform venipuncture and collection at their office, and then send the sample to a CLIA-accredited laboratory.

Claims Processing
The CLIA number must be submitted on all 837P transactions for laboratory services billed by any provider performing tests covered by CLIA. Claims submitted by providers for clinical laboratory services covered under CLIA without a valid and current CLIA certificate will deny.

Blue Cross reserves the right to recoup and/or recover monies previously paid on a claim that falls within the guidelines submitted without a valid CLIA certificate number.

Products Impacted
This program applies to fully-insured and self-insured commercial lines of business, Medicare lines of business and Minnesota Health Care Programs (MHCP) including Blue Advantage Families and Children (F&C), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+).

Questions?
If you have questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820** for fully-insured/self-insured commercial and Medicare lines of business or **1-866-518-8448** for Minnesota Health Care Programs.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective July 6, 2020 (P27-20, published 5/1/20)

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 July 6, 2020:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-239	Teprotumumab (Tepezza™)	Yes *(Replacing policy II-174)*	New	Commercial
II-29	Intra-Articular Hyaluronan Injections for Osteoarthritis • No PA required for preferred drugs, Synvisc and Synvisc-One • PA required for non-preferred drugs (exception requests only)	No	New *(Exception requests for non-preferred drugs)*	Commercial
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: • Inebilizumab*	No	New	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Inebilizumab* • Valoctocogene roxaparvovec (Valrox®)*	No	New	Medicare Advantage

* PA will be required upon FDA approval.

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 may submit PA requests for any treatment in the above table starting June 29, 2020.
- 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 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.
- Current and future PA requirements can be found using the *Is Authorization Required* tool in the Availity® portal 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 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.

Prior Authorization Requests

- Participating providers must submit PA requests online via our free Availity® provider portal
- 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 fax form located under the Forms & Publications section on the Blue Cross website, or their own PA form.

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**.

Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Utilization Management Program (P28-20, published 5/1/20)

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

The following medications are awaiting regulatory approval. When approved, the medications 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	Brand Name(s)
nivolumab / ipilimumab	Opdivo / Yervoy
lurbinectedin, PM1183	Zepsyre
pertuzumab / trastuzmab	Perjeta / Herceptin SQ FDC

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 **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:

- Individual subscribers
- Fully insured commercial subscribers
- Medicare Advantage subscribers

Prior Authorization Look Up Tool

Providers should use the Prior Authorization Look Up Tool on the Availity Provider Portal 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.

This feature is accessible for lines of business managed by Blue Cross and will advise providers if Blue Cross or eviCore will review the request.

To access the Prior Authorization Look Up Tool:

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorizations & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you'll be redirected to the Authorization Look Up Tool application

To submit a Prior Authorization (PA) Request to eviCore

Providers submit eviCore PA requests via the **Availity** provider portal. There is no cost to the provider for using the portal.

Instructions on how to utilize this portal are found on the Availity website. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests 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

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.

eviCore Removal of Prior Authorizations for Echocardiogram Procedure Codes for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program (P39-20, published 5/1/20)

In an effort to help reduce administrative burden for providers, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is removing the Prior Authorization requirement for Echocardiogram procedures for the following CPT codes:

Product Level	Codes
Not Listed	0331T, 0332T, 93356
Transesophageal ECHO	0399T, 93312, 93313, 93314, 93315, 93316, 93317, 93318
Transthoracic ECHO	93303, 93304, 93306, 93307, 93308, C8921, C8922, C8923, C8924, C8925, C8926, C8929

The above codes will no longer require Prior Authorization submissions effective **June 15, 2020**.

Note: Claim Edits may still apply.

Products Impacted
This change only applies to fully insured commercial and Medicare Advantage subscribers.

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.

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements (P34-20, published 5/1/20)

Effective July 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, MinnesotaCare, and Minnesota Senior Care Plus) and MSHO products.

As stewards of health care expenditures for our members, 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.

Due to the current peacetime emergency, the following prior authorization requirements will be removed and **will not be applicable** to member claims retroactive to dates of service on or after **February 4, 2020**. However, the policy will remain in effect.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
CG-LAB-14	Respiratory Viral Panel Testing in the Outpatient Setting	No	Yes	Yes

Where do I find the current government programs Pre-Certification/Pre-Authorization/Notification list?
Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization**

Where do I find the current government programs Medical Policy Grid?
Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/provider-manuals-and-guides**

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://provider.publicprograms.bluecrossmn.com/minnesota-provider/medical-policies-and-clinical-guidelines

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

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

Children's Therapeutic Services and Supports (CTSS) Prior Authorization Requirement

(P25-20, published 5/1/20)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will require prior authorization when a Minnesota Health Care Programs (MHCP) member has exceeded 200 hours of combined Children's Therapeutic Services and Supports (CTSS) individual, family, or group treatment, or 150 hours of CTSS Day Treatment. Once a member's treatment has exceeded these thresholds, claims will deny unless an authorization request is sent prior to submitting the 201st hour or 151st hour claims respectively. This requirement is effective July 1, 2020, and any member that has exceeded those thresholds ongoing will need to request authorization.

Required Documentation:
The following documentation must be sent by the CTSS provider prior to submitting the 201st hour of CTSS skills treatment or 151st hour of CTSS day treatment, either by fax to **1-800-505-1193** or via the ICR tool on the **Availity Portal**:

- Clinical documentation to support request, including but not limited:
    - Child and Adolescent Service Intensity Instrument (CASII)
    - Strengths and Difficulties Questionnaires (SDQ)
    - Individual Treatment Plan (ITP)
- *Behavioral Health Outpatient Treatment Report Form* (found in the *Forms* section of **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/home**)
- Failure to submit this authorization request will result in denial of claims for lack of prior authorization (PA) for treatment that exceeds the thresholds.
- For appeals information, see the *Claim Appeals* section of the website (found at **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/home**)

Medical Necessity Criteria:
Requests for prior authorization will be reviewed for medical necessity per MCG 23rd Edition Mental Health Support Services (B-809-T), in addition to a review for service eligibility per statutory requirements (256B.0943). If the member is eligible for the service and the request meets medical necessity per the MCG criteria, further hours would be approved dependent on the individual characteristics of the case.

CTSS Codes Impacted:

- CTSS Skills Training – 200-hour threshold:
    - H2014 UA: Skills Training & Development — Individual
    - H2014 UA HQ: Skills Training & Development — Group
    - H2014 UA HR: Skills Training & Development — Family
- CTSS Day Treatment – 150-hour threshold
    - H2012 UA HK: Behavioral Health Day Treatment
    - H2012 UA HK U6: Behavioral Health Day Treatment (Interactive)

Products Impacted
This information applies to the following products:

- Minnesota Health Care Programs including:
    - Families and Children (formerly Prepaid Medical Assistance Program)
    - MinnesotaCare

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

Minnesota Senior Health Options (MSHO) Model of Care Training Requirements
(P26-20, published 5/1/20)

What is the Special Needs Plan-Model of Care (SNP-MOC)?
The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans to have a Model of Care (MOC). SecureBlue[sm] is Blue Plus' Minnesota Senior Health Options (MSHO) plan, a Fully Integrated Dual Eligible Special Needs Plan (SNP) in which Medicare and Medicaid benefits and services are integrated into one benefit package. The SecureBlue Model of Care (SNP-MOC) is the Blue Plus plan for delivering coordinated care to SecureBlue members. The SNP-MOC documents the staff, systems, procedures, and improvement activities Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members.

The SNP-MOC ensures that Blue Plus, in partnership with its contracted providers and care coordination delegates, meets the unique needs of the frail and vulnerable SecureBlue population.

Who is required to complete SNP-MOC training?
CMS requires all providers and appropriate staff to complete Model of Care training **upon initial employment and annually thereafter**. Providers and appropriate staff required to complete the training include anyone who may participate in a SecureBlue member's Interdisciplinary Care Team, be responsible for implementation of the member's Collaborative Care Plan or manage planned or unplanned transitions of care.

At a minimum, the Interdisciplinary Care Team includes the member and/or their authorized caregiver, the Care Coordinator, and the Primary Care Physician. Based on the member's clinical and social needs, the Interdisciplinary Care Team may also include specialists, physician assistants, a psychiatrist or other behavioral health specialists, physical therapists, community health workers, nurses, local or social service case managers, and Blue Plus Health Coaches. CMS does not provide a definition for "routine basis." **Providers should ensure that all providers and staff who are delivering care that is part of the patient's treatment plan are completing this training**. The Collaborative Care Plan addresses the member's medical, functional, cognitive, psychosocial, and mental health needs identified in the Minnesota Long Term Care Consultation health risk assessment tool.

How to Complete SNP-MOC Training
Blue Plus has made this training available in a brief and easy to understand presentation in order to help providers meet this requirement in the most efficient manner possible. The SecureBlue SNP-MOC training is available online through the BCBSMN Learning and Development website supported by Availity.

- *Providers using Availity*, log in to the Availity portal. Click Payer Spaces | BlueCross BlueShield of Minnesota. Click Resources | Access BCBSMN Learning and Development. Providers will be directed to the Catalog. Search **Blue Plus SecureBlue Special Needs Plan Model of Care** – On-Demand, then click Enroll OR select "Minnesota Health Care Programs" under the Category dropdown to find the training.
- *Providers not using Availity*, use the link https://bcbsmn.availitylearningcenter.com to create an account. To create a new account, select Sign Up Now and follow the prompts. Use your email address as the username. Providers will be directed to the Dashboard. Click "Get Started" on the rotating banner titled Learn with Blue Cross and Blue Shield of Minnesota | then click on Access the Training Catalog | select Blue Plus SecureBlue Special Needs Plan Model of Care– On-Demand, then click Enroll.

As described in the Blue Plus Manual, providers should document and maintain MOC training completion records and provide such records to Blue Plus upon request to validate that the training has been completed. (A certificate can be printed after completion of the training). At a minimum, the training completion record must include the provider's or staff person's name, their department or title, and the date the training was completed. The Availity website will also track completion of your training.

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

Questions?
Blue Plus is able to assist providers in overcoming any barriers to training completion. Questions can be sent in an email to medicare.compliance.training@bluecrossmn.com.

Non-Emergency Medical Transportation Fee Schedule Update (P28-20, published 5/1/20)

Effective April 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is updating the Blue Cross medical assistance fee schedule for services provided by all contracted Non-Emergency Transportation providers to eligible Minnesota Health Care Programs (MHCP) Subscribers. Blue Cross is temporarily adjusting the rates to be in alignment with anticipated changes expected to be made to Minnesota law to support essential needed care during the COVID-19 pandemic emergency.

The Reimbursement Rates detailed below apply to the following transportation services for eligible MHCP Subscribers, as detailed in the Provider Service Agreement with transportation providers, and are effective from April 1, 2020 through 60 days after the COVID-19 emergency declared by the governor is terminated. In the event that these Reimbursement Rate increases will be extended beyond the initial time period detailed above, Blue Cross will issue subsequent communications to providers to assure a comprehensive understanding of the most current and accurate details.

Claims that have already processed for dates of service beginning April 1, 2020 that may allow additional reimbursement will be identified and reprocessed. Adjustments are anticipated to be completed by May 15, 2020.

Providers are encouraged to adjust their charges accordingly and issue replacement claims with the updated charges. Replacement claims may be submitted beginning May 18, 2020.

Type of Transportation	Base Rate	Mileage Rate	Additional Details
Unassisted Transport Metro	$16.50	$1.95	
Unassisted Transport Greater MN	$16.50	$1.95	
Assisted Transportation	$19.50	$1.95	
Lift-equipment/ramp transport	$27.00	$2.33	
Protected Transportation	$112.50	$3.60	
Stretcher Transportation	$90.00	$3.60	Attendant if Medically Necessary $13.50

Rates not listed above remain the same as detailed in the Provider Service Agreement with transportation providers. Future contract addenda will be updated to reflect this information upon renewal.

Questions?
If you have questions, please contact Provider Claims at **1-800-531-6680**.