PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

May 1, 2014

Update: Chiropractic Services – Coding for Active/Corrective Treatment, Prior Authorization Changes and Contract Renewals

The information in this bulletin replaces Provider Bulletin P4-14 entitled "Chiropractic Services - Coding for Active/Corrective Treatment and Prior Authorization Changes" that was published on March 4, 2014. The purpose of this bulletin is to provide clarification on prior authorization requirements for Minnesota Health Care Programs subscribers and notification of changes to the chiropractic network structure to be effective July 1, 2014.

Effective July 1, 2014, Blue Cross and Blue Shield of Minnesota (Blue Cross) will be implementing the following changes across the chiropractic network.

Prior Authorization

In accordance with a notification from the Minnesota Department of Human Services (DHS) to Minnesota health plans on April 7, 2014, Blue Cross will allow 24 visits annually, before requiring prior authorization for Minnesota Health Care Programs subscribers. Providers are required to obtain prior authorization for any visits in excess of 24 annually. We are delaying the implementation of the prior authorization requirements for fully insured subscribers as described in Provider Bulletin P4-14 until further notice. We will provide at least 45 days' notice of any future implementation of prior authorization for fully insured subscribers. For subscribers of self-insured groups, prior authorization requirements vary based on the subscribers' contract.

Benefits are allowable only for services that are medically necessary. Providers are encouraged to use **availity.com** or call BLUELINE at **(651) 662-5200** or **1-800-262-0820** to obtain subscriber benefits prior to beginning services.

To obtain prior authorization, providers should complete the Chiropractic Treatment Pre-Authorization/Prior Approval Request Form. This form is available on our website at **providers.bluecrossmn.com**.

Chiropractic network structure changes

In an effort to better meet the needs of patients, subscribers and our network of providers, Blue Cross will streamline the structure of our chiropractic network. This change is the result of many recent conversations between Blue Cross and providers. We listened as chiropractors told us about their desire for Blue Cross to hold all chiropractors to the same standards, eliminate payment withholds and allow new entrants into the network. Based on this feedback, Blue Cross will begin to transition and move all chiropractors from the Select Chiropractic network to the larger Aware network. This singular chiropractic network will have consistent performance targets aligned with reimbursement, no withholds and ample opportunities to reward high performers with the best reimbursements. Additionally, as low performers exit the network, new providers will have an opportunity to join. This change will occur as groups renew and any benefits associated with the Select network will sunset on or after January 1, 2015. Contract renewals will be mailed early May, 2014. In order to continue participation status without interruption, contracts must be signed and returned to Blue Cross within 45 days to become effective July 1, 2014.

Active/corrective treatment versus maintenance therapy

Rehabilitation services that would not result in measurable progress relative to established goals are non-covered services. The "AT" modifier distinguishes active/corrective treatment from maintenance therapy. The AT modifier should be appended to the chiropractic manipulation (98940-98943) when services are considered active/corrective treatment. The absence of the AT

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modifier would indicate maintenance or palliative care. Although we request that providers assure they are using the AT modifier accurately effective immediately, Blue Cross will not begin denying claims without the AT modifier until October 1, 2014. Claims will be benefit denied to the appropriate party – provider or subscriber liability, depending on contract requirements. For Public Programs, Prepaid Medical Assistance Programs (PMAP), MinnesotaCare and SecureBlue℠ (HMO SNP), the subscriber must also sign a waiver that includes the date of service, specific service, charge, etc., indicating they acknowledge the services will not be covered and they will be responsible for paying for the services. A GA modifier is required indicating the waiver has been signed and is on file.

Coding requirements reminder

All coding and reimbursements are subject to changes, updates or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (for example, HCPCS, CPT, ICD-9-CM), only valid codes for the date of service may be submitted or accepted.

Questions?

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