PROVIDER QUICK POINTS
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

September 6, 2018

Migration of Minnesota Health Care Programs Subscribers to Amerigroup

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has entered into a collaborative agreement with Amerigroup Health Solutions, a subsidiary of Anthem, to operationally support subscribers who have coverage through a Minnesota Health Care Program (MHCP) including Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+). Amerigroup has a proven Medicaid track-record in 17 other states. This change will help Blue Cross deliver an improved member experience, better health outcomes, and achieve lower medical cost goals. **Effective December 1st, 2018, Providers are required to follow the policies and procedures indicated below for Minnesota Health Care Program Subscribers.** The policies and procedures identified in this bulletin will be incorporated into the Blue Plus Manual by December 1, 2018. Blue Cross is publishing this information in advance to allow for providers to prepare for any changes affecting their operations. Medical policies will be available for review on October 1, 2018.

Provider seminars are scheduled in October to provide education on these changes as well as other Blue Cross initiatives. Seminar dates, times and locations are published in Provider Quick Points QP75-18. For providers that are unable to attend in person, a webinar will also be available.

Website Reference

Information in this Bulletin will be available by October 1 on the provider page on the Blue Cross website: https://www.bluecrossmn.com/healthy/public/personal/home/providers/

- Go to 'Tools and Resources'
- Select 'Minnesota Health Care Programs Migration'

Blue Cross will be posting weekly updates on this site.

Products Impacted

The changes will impact the following programs; Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+).

Provider Contracts, Credentialing and Demographics

Blue Cross will maintain the provider data, credentialing and contractual relationship with providers. The provider contracts in place will remain and any communications related to contracts will continue to be provided by Blue Cross. All processes regarding these functions will remain consistent with current processes.

Provider Services

For questions regarding eligibility and benefits, utilization management, or claims, please contact Provider Services at **1-866-518-8448** on or after December 1, 2018.

For questions regarding contracts, credentialing, or demographic set up, please continue to contact Provider Services at **1-800-262-0820**.

Subscriber ID

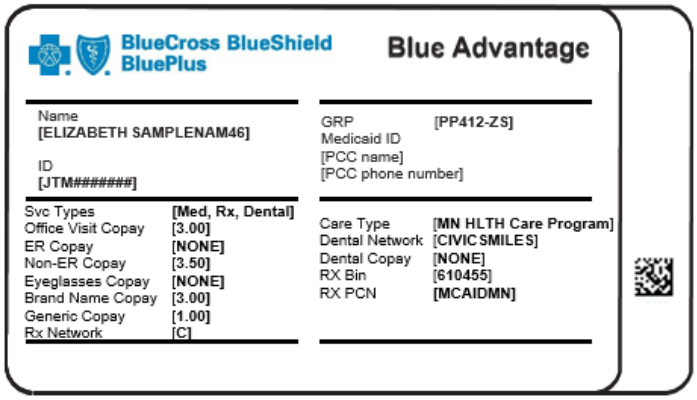
Subscribers will receive a new ID card to be used for dates of service beginning December 1, 2018. Subscriber ID cards should be verified at every visit. **Claims submitted with an incorrect subscriber ID will deny for no coverage.**

New prefixes have been assigned:

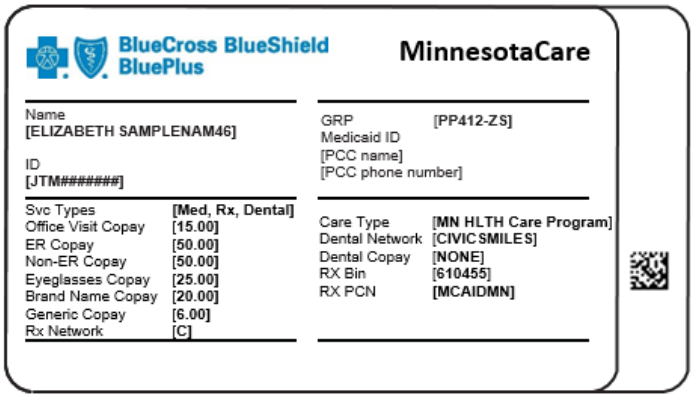
- LMN – Medicaid (PMAP, MNCare, MSC+)
- JTM – Secure Blue (MSHO)

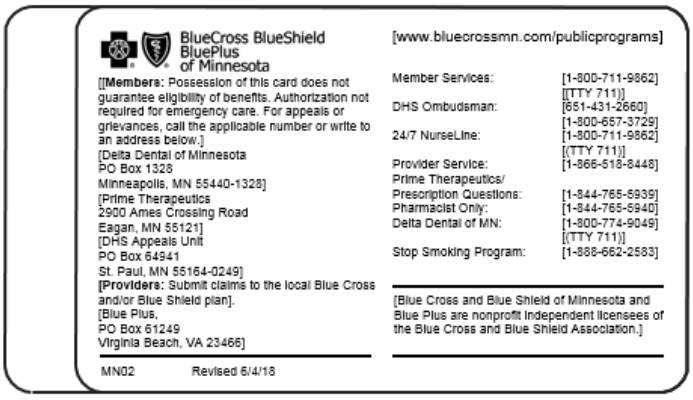
Sample cards (please note that the details may differ from what is displayed below):

PMAP

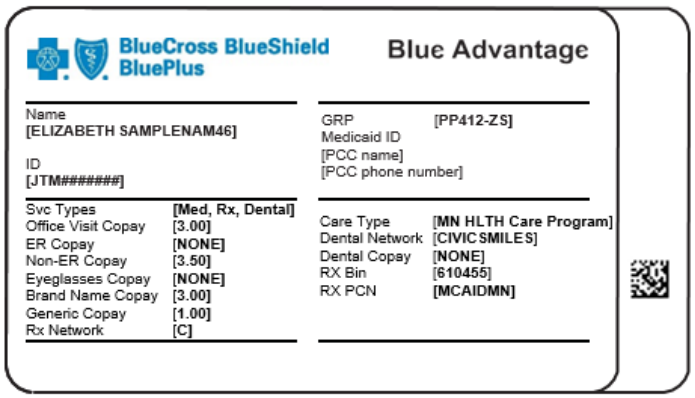


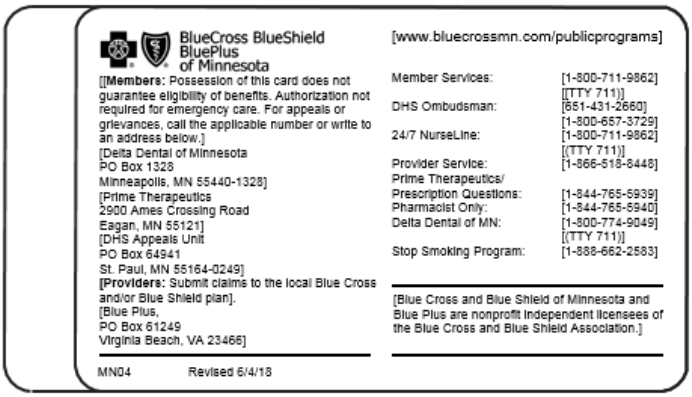
MNCare





MSC+





Eligibility and Benefits and Claim Status

When checking eligibility and benefits or claim status on Availity.com for a service date on or after December 1, 2018, select 'BCBSMN Blue Plus Medicaid' from the Payer listing. **Use the new Payer ID code 00562 when submitting a 270/271 or 276/277 Electronic Data Interchange (EDI) transaction. If an eligibility and benefits EDI transaction or a claim status EDI transaction is not submitted with the new Payer ID code, a non-covered or claim not found response will be received. Providers will need to correct the payer ID and resubmit the transaction.**

Claim Submissions

Claims for dates of service that occur on and after December 1, 2018 will be processed by Amerigroup. **Claims for dates of service beginning December 1, 2018 must be submitted with the new payer ID Code 00562. Claims submitted under the wrong Payer ID Code will reject and the claims will need to be resubmitted under the correct payer ID code.**

Claims currently processed via Bridgeview, i.e. Elderly Waiver claims, will also be processed by Amerigroup. Additional information regarding this process change will be communicated directly to the appropriate subset of providers in a separate notification.

Claims can be submitted directly on Availity.com. Select 'BCBSMN Blue Plus Medicaid' from the Payer drop-down to appropriately route the claim.

Please note: for those subscribers that have a primary commercial Blue Cross plan and secondary PMAP or MSHO plan, Blue Cross will not automatically crossover a claim to Amerigroup. A secondary claim will need to be submitted with the appropriate secondary subscriber ID and payer code.

Professional claims should be split and submitted with the appropriate Payer ID and Subscriber ID based on the date of service. Claims submitted with an incorrect payer ID for the date of service on the claim will be rejected.

Inpatient and outpatient facility claims should be submitted using the active Payer ID and Subscriber ID based on the 'statement from date'. Claims submitted with an incorrect payer ID for the 'statement from date' will be rejected.

Claim attachments may be submitted on Availity, by mail, or via fax using the MN AUC Coversheet.

- Submit attachments via fax to 1-833-224-6929.
- To submit via Availity, select 'BCBSMN Blue Plus Medicaid' as the payer.
  - Go to 'Claims and Payments' from the Availity home page
  - Select 'Medical Attachments'
  - Click on 'Send Attachment' and enter the required fields
  - Click submit.

- Attachments can also be submitted by mail to:

  Blue Cross and Blue Cross Blue Shield of Minnesota
  Attn: Consumer Service Center
  PO Box 66776
  Virginia Beach VA 23466

Remittance

Providers will receive daily remits Monday through Friday.

Claim Appeals

Information regarding the appeal process will be available on a later date.

Restricted Recipient

Information regarding how to manage restricted recipient patients will be available on a later date.

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 December 1, 2018, Blue Cross will implement new medical policies that will apply to services provided under the medical benefit for Medicaid (PMAP, MNCare, MSC+) and MSHO subscribers. The medical policies will be available to view on October 1, 2018. Additional direction regarding location of the policies and a full list of impacted polices will be published in the October bulletin and updates will be posted to the migration site.

Please note that Federal and State Guidelines, including Minnesota Health Care Program (MCHP) policies, supersede the Amerigroup Medical Policies and Clinical Utilization Management Guidelines.

Prior Authorizations (PA) for Outpatient Services

The primary purpose of the PA process is to ensure that evidence-based care is provided to our subscribers, driving quality, safety, and affordability. Prior Authorizations will be reviewed by Amerigroup for dates of service beginning December 1, 2018. The Precertification Look Up Tool will be available on Availity beginning October 1, 2018, which will allow a search by procedure code.

Please note this is not a comprehensive list and is included here as a guide on when to call for prior authorization. If the service is listed, you are required to submit a prior authorization.

- Drugs – Drugs covered under the medical benefit (medical drugs). For information on drugs covered under the pharmacy benefit, providers should continue to refer to information on the Blue Cross website of Prime Therapeutics' website. Medical drugs typically are those that are administered by a health care provider (e.g. infused/injected drugs, intravenous chemotherapy) and are not self-administered (e.g. oral dosage formulations, self-injectables, inhalers, topicals).
- Durable Medical Equipment (DME) –Wearable cardiac monitors, walkers, commode chairs, pressure reducing devices and supports, humidifiers, respiratory assist devices, patient lifts, TENS units, nebulizer, oxygen suction machine, traction/trapeze apparatus, power and manual wheelchairs/wheelchair accessories, pediatric wheelchairs and accessories and motion exercise device for use on knee only
- Home Health Care Services – Certain home care services require prior authorization.

- Laboratory – Certain genetic testing and diagnostic lab testing
- Surgery – tissue cultured autografts, application of skin substitutes, rhytidectomy, nerve grafts, destruction of vascular lesions, certain biopsies, spinal surgeries, orthognathic surgery, surgery performed for potentially cosmetic reasons, sinus surgeries, bronchoscopy, pacemaker insertion, coronary artery bypass grafts, endovascular aorta repair, endovascular ablation of incompetent veins, transcatheter stent placement, tonsillectomy and adenoidectomy, esophagoscopy, radiofrequency ablation of liver tumors, prostate surgery, stereotactic radiosurgery, chemo denervation, procedures performed on the lens of the eye, intracardiac catheter ablations and certain surgical implants
- Medicine – Procedures relating to ambulatory continuous glucose monitoring of interstitial tissue fluid, electrophysiological evaluations, motor/nerve conduction studies and Air Ambulance
- Orthotic – Helmet, lumbar-sacral orthotics, knee orthotics, foot orthotics, lower extremity orthotic procedures and devices
- Prosthetic – Certain upper and lower extremity prosthetics
- Therapy – Occupational, physical, speech and respiratory therapy
- Nerve Injections - Diagnostic and therapeutic nerve injections
- Long Term Support Services—eligible long-term support services require a prior authorization
- Transplant services

A Prior Authorization Look Up Tool will be available on or before December 1, 2018

To verify if a prior authorization is required, use the Precertification Lookup Tool (PLUTO). Providers can log into Availity to search by procedure code to determine if it requires an authorization. From the Availity home page, select 'Payer Spaces' from the top navigation. Select the health plan, 'BCBSMN Blue Plus Medicaid'. From the 'Payer Spaces' home page, select the 'Applications' tab and select the 'Prior Authorization Lookup Tool' tile.

PAs reviewed by Amerigroup should be submitted in the following ways:

- **Submit Medical PAs on Availity**. From the Availity home page, select 'Patient Registration' from the top navigation. Select 'Authorizations & Referrals', then select 'Authorizations'. Select the 'Payer (BCBSMN Blue Plus Medicaid) and 'Organization' and submit. The Interactive Care Reviewer (ICR) application will open. Use ICR to submit and manage (appeal) your medical prior authorizations

- **Medical Injectable Drugs Prior Authorizations Online** from the Availity home page, select **Patient Registration** from the top navigation. Select **Authorizations & Referrals**. Select Authorizations. Select the payer and organization and select Submit. The Interactive Care Reviewer (ICR) application opens. Use ICR to submit and manage (appeal) your medical prior authorizations

  Medicaid Medical Injectables:
  Phone Number: 844-410-0752
  Fax Number: 844-480-6837
  Hours of Operations: 8 AM to 8 PM, Monday through Friday

  Medicare Medical Injectables:
  Phone Number: 866797-9884 (Option 5)
  Fax Number:
  - MSC+: 800-964-3627
  - SecureBlue/MSHO: 866-959-1537

  Hours of Operation: 8 AM to 8 PM, Monday through Friday

- **Pharmacy Benefit Prescription Drugs (self-administered drugs)**: Drugs that are self-administered (inclusive of self-injection) will continue to be managed by Prime Therapeutics. To submit a pharmacy prescription drug prior authorization, contact Prime at http://www.primetherapeutics.com or at the phone numbers below:
    - MN Medicaid – 844-765-5939
    - MN SecureBlue – 888-877-6424

  Prescribers also can submit pharmacy prescription drug prior authorization requests by either submitting a request through the CoverMyMeds (CMM) free web portal or by sending an electronic NCPDP file to Prime through an integrated Electronic Medical Record (EMR) system during the e-prescribing process.
    - To access CMM, go to www.covermymeds.com
    - The first time you use the portal to submit a PA, you will need to create a CMM account.
    - For help using the CMM site select Support (top of the web page) to view FAQs, CMM physician training webinar offerings, and support options to help you get started.

- **Medical Drug PAs should be submitted electronically**:
    - Online via Availity.com
    - Using an 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.

Pre-Certification for Inpatient Admissions

All medical inpatient admissions, both elective and emergent, will require pre-certification beginning December 1, 2018. All behavioral health inpatient admissions, both elective and emergent, will require notification beginning December 1, 2018. Failure to comply with notification rules may result in an administrative denial.

Pre-Certification/Authorization with supporting documentation is required for:

- Emergent Inpatient admissions
- Planned/Elective admissions
    - Inpatient Surgery
    - Skilled Nursing Facilities (SNF)
    - Long-Term Acute Care (LTAC)
    - Acute Rehabilitation

Authorization is also required for the following services; however, for these services, clinical information is not needed since a medical necessity review is not required:

- Observation – clinical information only needed for non-par facilities.
- Obstetric Deliveries – a medical necessity review will be required for anything over a 48 hour stay for vaginal delivery and anything over a 72 hour stay for a cesarean section delivery.

Emergent inpatient admissions require notification to Amerigroup within one business day following the admission.

- Authorizations can be submitted via phone, fax or web portal.
    - Phone: 866-518-8448
    - Fax: PMAP, MSC+, MNCare (Medicaid) Fax: 1-844-480-6840. MSHO (Medicare) 844-480-6842
    - Web: Process will be communicated in a separate Provider Bulletin.
- Failure to comply with notification rules result in an administrative denial.
- All medical emergent inpatient hospital admissions will be reviewed within one business day of the facility notification to Amerigroup.
- Clinical information for the initial (admission) review will be requested by Amerigroup at the time of the admission notification.

- For medical admissions, the facilities are required to provide the requested clinical information within 24 hours of the request.
- If the information is not received within 24 hours, a lack of information adverse determination (i.e., a denial) may be issued.
- If the clinical information is received, a medical necessity review will be conducted using applicable nationally recognized clinical criteria.
- Decisions are communicated verbally or via fax within 24 hours of the determination

Planned/Elective admissions must receive prior approval at least 72 hours prior to the medical admission or scheduled procedure to ensure the proposed care is a covered benefit, medically necessary, and performed at the appropriate level of care.

- Authorizations can be submitted via phone, fax or web portal.
  - Phone: 866-518-8448
  - Fax: PMAP, MSC+, MNCare (Medicaid) 844-480-6839. MSHO (Medicare) 866-959-1537
  - Web: Process will be communicated in a separate Provider Bulletin
- Failure to comply with notification rules may result in an administrative denial.
- A medical necessity review will be conducted using applicable nationally recognized clinical criteria
  - If needed, additional supporting documentation may be requested to determine if the request is medically necessary.
- Determinations will be communicated to the facility.
  - For standard requests, a decision will be communicated as expeditiously as required by the enrollee's/member's condition, not to exceed ten (10) calendar days**.**
  - For expedited/urgent requests, decisions will be communicated as expeditiously as required by the enrollee's/member's condition, not to exceed 72 hours.

Inpatient Concurrent Review is the process of obtaining clinical information to establish medical necessity for a continued inpatient stay, including review for extending a previously approved admission.

- Facilities are required to supply the requested clinical information within 24 hours of the request to support continued stay.
- During each concurrent review interval, the clinician will assess member progress and needs to help coordinate such needs prior to discharge. This is done to help facilitate a smooth transition for the member between levels of care or home, and to avoid delays in discharge due to unanticipated care needs.
- In addition, the attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

MCG care guidelines for inpatient level of care will be used beginning December 1, 2018. Amerigroup licenses and utilizes MCG care guidelines to guide utilization management decisions. The four (4) 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.
- **Recovery Facility Care (RFC)**: Coordinate an effective plan for transitioning people to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).
- **Chronic Care (CC)**: Evaluate needs, identify goals, develop personalized care plans, and support effective self-care. The modular design supports quick and efficient assessments and enables you to manage multiple comorbidities and behavioral health conditions.

Amerigroup has the right to customize MCG care guidelines based on determinations by its Medical Policy & Technology Assessment Committee (MPTAC).

Reimbursement Policies

Effective December 1, 2018, the following reimbursement policies will be in place. The Reimbursement Policies can be found on providers.bluecrossmn.com. Within the 'Tools and Resources' section, select 'Medicaid and MSHO Reimbursement Policies' to view the policies. The table below provides high level information regarding how the policy compares to the reimbursement policies in place prior to December 1, 2018.

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Professional Anesthesia Services Category: Anesthesia		**X**		Blue Cross allows reimbursement for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery for up to 150 minutes by either the delivering physician or a qualified provider other than the delivering physician based on the time the provider is physically present with the member.
Assistant at Surgery (modifiers 80/81/82/AS) Category: Coding		**X**		Assistant Surgeon services reported with Modifier AS will be eligible for reimbursement according to CMS reimbursement guidelines, currently 13.6 percent.
DME Modifier for New, Rented and Used Equipment Category: Coding		**X**		Blue Cross allows reimbursement for new, rented, or used equipment appended with the appropriate modifier. The listed modifiers are considered reimbursement modifiers and must be billed in the primary or first modifier field to determine appropriate reimbursement: • Modifier NU: new equipment • Modifier RR: rented equipment Modifier UE is not a recognized modifier. Reimbursement will be based on the applicable fee schedule or contracted/negotiated rate for claims submitted for the equipment with the valid modifier identifying new or rented equipment.

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Diagnoses Used in All Patients Refined Diagnosis Related Groups Computation Category: Coding		**X**		Blue Cross ensures the diagnosis and procedure codes that generate the All Patients Refined Diagnosis Related Groups (APR DRGs) are accurate, valid and sequenced. Blue Cross performs APR DRG audits to determine the diagnostic and procedural information that led to the APR DRG assignment is substantiated by the medical record.
Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU) Category: Coding			**X**	
Modifier 22: Increased Procedural Service Category: Coding		**X**		Reimbursement for appropriate use of Modifier 22 will be based on 125 percent of the fee schedule or contracted/negotiated rate.
Modifier 24: Unrelated Evaluation and Management Service by the Same Physician during the Postoperative Period Category: Coding			**X**	
Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service Category: Coding			**X**	
Modifier 26 and TC: Professional and Technical Component Category: Coding			**X**	
Modifier 57: Decision for Surgery Category: Coding			**X**	
Modifier 62: Co-Surgeons Category: Coding			**X**	

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Modifier 63: Procedure on Infants less than 4kg Category: Coding	**X**			Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for the procedure code when the modifier is valid for services performed. The neonate weight should be documented clearly in the report for the service.
Modifier 66: Surgical Teams Category: Coding		**X**		Blue Cross allows reimbursement of procedures eligible for surgical teams when billed with Modifier 66. Each physician participating in the surgical team must bill the applicable procedure code(s) for their individual services with Modifier 66. Multiple procedure rules and fee reductions apply if the surgical team performs multiple procedures unless surgeons of different specialties are each performing a different procedure. A prepayment review will be performed to support the use of Modifier 66.
Modifier 76: Repeat Procedure by Same Physician Category: Coding		**X**		Professional services will be subject to clinical review for consideration of reimbursement. Providers must submit supporting documentation for the use of Modifier 76 with the claim.
Modifier 77: Repeat Procedure by Another Physician Category: Coding		**X**		Professional services will be subject to clinical review for consideration of reimbursement. Providers must submit supporting documentation for the use of Modifier 77 with the claim.

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018

Modifier 78: Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure during the Postoperative Period
Category: Coding
		X		Blue Cross allows reimbursement for claims billed with Modifier 78 when the following criteria are met:
				• The return to the operating or procedure room is unplanned.
				• The procedure appended with Modifier 78 is:
				• The appropriate surgical code for the procedure performed
				  ○ Performed by the same physician who provided the initial procedure
				• Related to the initial procedure
				  ○ Performed during the postoperative period of the initial procedure
				
				Reimbursement is based on 70 percent of the fee schedule or contracted/ negotiated rate of the surgical procedure code when the modifier is valid for the service performed. Reimbursement is based on the surgical procedure **only**, not including preoperative or postoperative care.

Modifier 91: Repeat Clinical Diagnostic Laboratory Test Category: Coding			**X**	
Modifier LT and RT: Left Side/ Right Side Procedures Category: Coding			**X**	

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Modifier Usage Category: Coding	**X**			Blue Cross allows reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers. Reimbursement is based on the code-set combinations submitted with the correct modifiers. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. Refer to the specific modifier policies for guidance on documentation submission. The use of correct modifiers does not guarantee reimbursement.
Multiple and Bilateral Surgery: Professional Reimbursement Category: Coding			**X**	
Split-Care Surgical Modifiers Category: Coding		**X**		Blue Cross reimbursement for split-care surgical modifiers applies the following percentages of the fee schedule or contracted/negotiated rate for the surgical procedure: • Modifier 54 (surgical care only): 70 percent • Modifier 55 (postoperative management only): 20 percent • Modifier 56 (preoperative management only): 10 percent The global surgical package consists of preoperative services, surgical procedures, and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.
Reimbursement for Reduced and Discontinued Services Category: Coding			**X**	

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Reimbursement of Services with Obsolete Codes Category: Coding	**X**			Blue Cross does not allow reimbursement for services billed with obsolete codes, in compliance with industry standard coding practices according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Unlisted, Unspecified or Miscellaneous Codes Category: Coding			**X**	
Durable Medical Equipment (Rent to Purchase) Category: DME and Supplies		**X**		Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased when the purchase price has been met. The reimbursement limit for rented DME is 10 months. A break in continuous use is defined as a period of two months or more.
Drugs and Injectable Limits Category: Drugs		**X**		Reimbursement will be considered up to the Clinical Unit Limits (CUL) allowed for the prescribed/administered drug. When there is no MUE assigned by CMS, identified codes will have a CUL assigned or calculated based on the prescribing information, The Food and Drug Administration, and established reference compendia. Claims that exceed the CUL will be reviewed for documentation to support the additional units. If the documentation does not support the additional units billed, the additional units will be denied.
Preventive Medicine and Sick Visits on the Same Day Category: Evaluation and Management		**X**		Blue Cross allows limited reimbursement for preventive medicine and sick visits on the same day. Modifier 25 must be billed with the applicable Evaluation and Management code for the allowed sick visit.
APR DRG Inpatient Facility Transfers Category: Facilities			**X**	

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
APR DRG Newborn Inpatient Stays Category: Facilities		**X**		Reimbursement is allowed for newborn inpatient stays with the appropriate normal newborn or sick baby All Patients Refined Diagnosis-Related Group (APR DRG) code. Reimbursement for newborn inpatient stays grouped to calculate sick baby APR DRG codes will be subject to clinical review. Providers must provide authorization or medical records to support the admission for the higher level of care associated with the sick baby APR DRG. Failure to provide appropriate documentation will result in the claim being processed based at the normal newborn APR DRG rate.
Inpatient Readmissions Category: Facilities			**X**	
Preadmission Services for Inpatient Stays Category: Facilities			**X**	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Category: Prevention			**X**	
Vaccines for Children (VFC) Program Category: Prevention			**X**	
Prosthetic and Orthotic Devices Category: Prosthetics and Orthotics			**X**	
Claims Timely Filing Category: Administration	**X**			Blue Cross follows the following standard: • By contract for participating providers and facilities • 12 months for nonparticipating providers and facilities
Code and Clinical Editing Guidelines Category: Administration			**X**	
Documentation Standards for Episodes of Care Category: Administration			**X**	

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Duplicate or Subsequent Services on the Same Date of Service Category: Administration		**X**		Blue Cross allows reimbursement of a duplicate or subsequent service provided on the same date of service if billed with an appropriate modifier or with additional units, as applicable within benefit limits. Reimbursement of duplicate or subsequent services is based on the correct usage of certain modifiers which indicate the service was appropriately repeated or additionally billed for the same member.
Emergency Services: Nonparticipating Providers and Facilities Category: Administration	**X**			Out-of-state professional and facility reimbursement will be based on the amount that would have been reimbursed to the provider according to Minnesota's state Fee-for-Service (FFS) Medicaid program.
Locum Tenens Physicians/Fee-for-Time Compensation Category: Administration		**X**		Locum tenens reimbursement is allowed for physicians and advanced practice registered nurses.
Medical Recalls Category: Administration	**X**			Blue Cross does not allow reimbursement for repair or replacement of items due to a medical recall but will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. In circumstances where we have reimbursed the provider for repair or replacement of items or procedures related to items due to a medical recall, we are entitled to recoup or recover fees from the manufacturer and/or distributor, as applicable. In circumstances where we have reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, we are entitled to recoup or recover fees from the provider.
Multiple Delivery Services Category: Surgery		**X**		Blue Cross allows reimbursement for multiple births during the same delivery or combined delivery method.

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Other Provider Preventable Conditions (OPPC) Category: Administration		**X**		Other Provider Preventable Conditions (OPPC) are not eligible for reimbursement. Erroneous surgical events occurring during an inpatient stay should be reflected on Type of Bill 0110 (no-pay claim) along with all services or procedures related to the surgery using the appropriate modifier (PA, PB, or PC).
Present on Admission Indicator for Health Care-Acquired Conditions Category: Administration	**X**			Blue Cross require the identification of hospital-acquired conditions and health care-acquired conditions (both referred to as Health Care Acquired Conditions HCAC) through the submission of a Present on Admission (POA) indicator for all diagnoses on facility claims. If the POA indicator identifies an HCAC, the reimbursement for that episode of care may be reduced or denied.
Reimbursement for Eligible Billed Charges Category: Administration	**X**			Eligible Charges means charges billed by the provider subject to conditions and requirements which make the service eligible for reimbursement. Blue Cross allows reimbursement of Eligible Charges. The allowed amount reimbursed for the Eligible Charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, copayments, deductibles, and coordination of benefits.
Reimbursement for Items under Warranty Category: Administration	**X**			Blue Cross does not allow reimbursement for repair or replacement of rented or purchased items during the warranty period designated by the applicable manufacturer.
Reimbursement of Sanctioned and Opt-Out Providers Category: Administration	**X**			Blue Cross does not allow reimbursement to providers who are excluded or debarred from participation in state and federal health care programs. Claims received for services submitted by sanctioned or opt-out providers as provided herein will be denied.

Reimbursement policy name and category	New	Change	No change	As of December 1, 2018
Abortion (Termination of Pregnancy) Category: Surgery	**X**			Blue Cross does not allow reimbursement for induced abortions.
Global Surgical Package for Professional Providers Category: Surgery		**X**		Blue Cross allows separate reimbursement for preoperative physicals occurring during the global period. Additionally, Split-Care Surgical Modifiers, Modifier 24, Modifier 25, and Modifier 57 have become related policies and are not addressed within this reimbursement policy.
Maternity Services Category: Surgery		**X**		Blue Cross requires that providers use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims. Blue Cross also outlines when various obstetric services are included in the global reimbursement for obstetric services or when these services are eligible for separate reimbursement, pre-term prevention and newborn care.
Hysterectomy Category: Surgery			**X**	
Robotic Assisted Surgery Category: Surgery	**X**			Blue Cross does not allow separate or additional reimbursement for the use of robotic surgical systems. Surgical techniques requiring use of robotic surgical systems will be considered integral to the surgical services and not a separate service. Reimbursement will be based on the payment for the primary surgical service(s).
Sterilization Category: Surgery			**X**	

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