PROVIDER QUICK POINTS
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

December 12, 2018

Migration of Minnesota Health Care Programs Frequently Asked Questions (FAQ)

Below is information Providers may find helpful regarding the migration of Minnesota Health Care Programs Subscribers to Amerigroup. As previously communicated the migration is taking place on January 1, 2019.

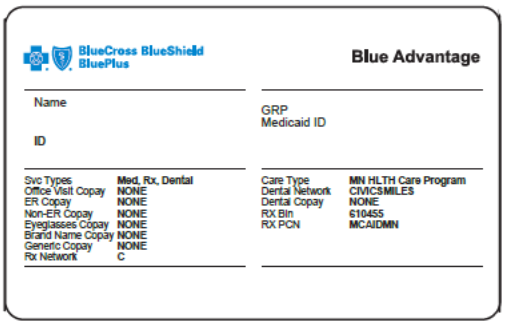
Eligibility and Benefits

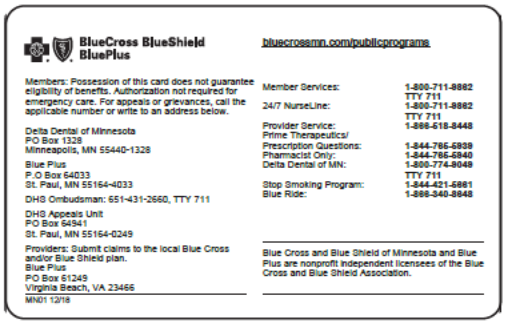
Q. Can providers use the PMI number to research benefits/eligibility after January 1, 2019? Will the subscriber's PMI number be on their ID card?

A. No, providers will use the subscriber's new ID number to research benefits and eligibility. The PMI number will be on the subscriber's ID card.

Q. Will subscriber cards have Amerigroup or Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross), and will they identify the product?

A. Blue Cross and Blue Shield of Minnesota and Blue Plus will be on the card as well as the product information (see sample ID cards below).





Q. What is the turnaround time for eligibility files to be loaded into Amerigroup from the time they are released from the Minnesota Department of Human Services (DHS)?

A. It is a 48-hour turnaround time from when the download is received to when it is loaded into the claim system.

Q. Does Availity show the benefit level for in-and out-of-network coverage?

A. Availity will display the *Eligibility & Benefits* returned by the payer, which will include benefits for in- and out-of-network coverage.

Continued

Q. With the transition of Medicaid, will out-of-state subscribers be able to use the Blue Cross network?

A. No, out of state Medicaid networks are specific to the state in which they are contracted.

Q. When were subscribers notified of the Amerigroup migration and what were they told? When will they get new cards?

A. Subscribers will begin receiving welcome letters and new ID cards via mailings beginning December 7, 2018.

Q. Are providers required to issue an *Advanced Beneficiary Notice* (*ABN*)?

A. An *ABN* is required for non-Medicare covered services provided to Minnesota Senior Health Options subscribers.

Q. Is the 276/277 Claims Status Inquiry transaction real time? Will I get a response right back?

A. Yes, the 276/277 transaction for claims status is real time. A response will be received immediately upon submission.

Demographics

Q. If providers have demographic changes, how quickly will they be sent through to Amerigroup?

A. Depending on the type of change, provider demographic data will be updated by Blue Cross within 30-90 days of receipt. Once these changes are made by Blue Cross, provider demographic file changes will be processed three times per week. Changes should appear in the electronic directory two to three days after the changes are made internally.

Q. How will the provider directory be managed, and how long will it take for provider demographics to be loaded?

A. Depending on the type of change, provider demographic data will be updated by Blue Cross within 30-90 days of receipt. Once these changes are made by Blue Cross, provider demographic file changes will be processed three times per week. Changes should appear in the electronic directory two to three days after the changes are made internally.

Medical Policies

Q. Can you define clinical edit?

A. Claim system edits on a code may include but are not limited to coding errors and errors conflicting with a *Medical Policy* or Reimbursement Policy and may impact codes submitted on the same or different claims.

Q. If the Blue Cross medical policy will be applied, does the claim get submitted to the Blue Cross current payer ID or through the new payer ID?

A. All claims submitted for dates of service January 1, 2019, and after should be submitted to Amerigroup.

Q. Can you add the Medical Policy Grid to the migration website?

A. The Medical Policy Grid is posted on the Medicaid migration website.

Prior Authorizations

Q. What system is used for submission of authorizations?

A. Interactive Care Reviewer (ICR) is used for prior authorization, notifications, precertification and prior approval.

Q. Will Amerigroup allow a retro authorization or a retro certification if medically necessary?

A. No retro authorizations or retro certifications will be processed. Providers may submit the claim and submit an appeal if the claim is denied for no prior authorization or certification obtained.

Q. Where can providers find additional information on the restricted recipients (RR) process?

A. The RR process remains the same and is documented in the RR section on the Minnesota Health Care Program (MHCP) migration website.

Q. Will authorization requests sent prior to January 1, 2019, have the same authorization number in the new system?

A. Authorizations created in the Blue Cross system will have a different number when they are cross-walked to the Amerigroup system. To look up a crossed-over authorization, use the new subscriber ID number.

Q. If patients are scheduled for after January 1, 2019, and the procedure requires PA under the new policies, how will the PA be handled?

A. There will be a grace period for providers during the transition period. Please see *Provider Bulletin P77-18* published December 3, 2018.

Q. How will Newborn & NICU admissions be handled for pre-certification for Amerigroup?

A. For babies delivered via vaginal delivery or cesarean, the baby is covered under the mother's inpatient precertification process. Babies transferred to NICU do require authorization. Providers are required to send notification and follow the emergent/acute inpatient authorization process. Amerigroup will request additional information if required to complete the authorization.

Q. If a patient is an observation patient on December 31, 2018, and is then admitted inpatient on January 1, 2019, where should the PA request be submitted?

A. If a patient presents for observation on December 31, 2018, and becomes an emergent admission on January 1, 2019, the admission and statement from date would be December 31, 2018. Claims and PA requests for dates of service prior to January 1, 2019, should be submitted to the current Blue Cross payer ID.

Q. What is the turnaround time to authorize a patient for a skilled nursing facility?

A. Post-acute discharge need requests (skilled nursing, acute rehab, etc.) should be faxed and or called into the health plan. ICR will not provide an immediate decision for these request types. The health plan has 10 days to render a determination.

Q. What are the inpatient notification requirements for holidays and weekends?
A. Emergent inpatient admissions require notification within one business day following the admission.

Q. How long does an approved authorization last once it is obtained?
A. The authorization will identify an initial approved time period. If additional days are clinically warranted, the provider is responsible for obtaining an authorization for the additional days.

Precertification

Q. Is there a peer-to-peer process for approval if admission/authorization is declined?
A. When a request is denied after reviewing for medical necessity, the requesting provider will be notified of the decision along with the process to appeal or reach out to the reviewing physician for peer-to-peer discussion of the case. Providers may call the peer-to-peer line at **1-844-815-4712** to discuss a specific case.

Q. If a patient is inpatient and surgery is determined necessary during the stay, does the surgery require authorization?
A. For elective or nonemergent inpatient stays, surgical procedures that are associated with the admitting diagnosis are included in the pre-certification review. If a subscriber's condition changes and additional procedures are required, the facility must submit updated clinical records for further review.

Q. What is the timing for concurrent review? What is the frequency?
A. Concurrent review and additional documentation will be required for any inpatient days of stay that exceed what was approved in the original precertification. As additional inpatient days of stay are required for the patient and requested by the facility, additional concurrent reviews will be reviewed. Example: Original approved stay three days, concurrent review requested to add an additional three days.

Q. When a patient starts as observation and requires a precertification, when does the clock start?
A. A preauthorization should be initiated when the decision to admit the patient is made. If the admission is emergent in nature, the emergency admission notification rule applies. Notification should be made within 24 hours.

Claims

Q. Can attachments be added under the new payer ID in Availity after the claim has been submitted?
A. If a claim is filed through Availity, attachments can be added.

Q. Is there a way to limit the clinical data that is returned on Patient360?
A. The practice administrator can assign a PHI Access or a No PHI Access role to each person. The PHI cannot be restricted further.

Q. Where will the Amerigroup teams be located?
A. There will be a local team in Minnesota to support the Minnesota business. The majority of the Claims team and National Call Center will be located in Virginia. Support from claims personnel in other states might be used as needed.

Q. How is the claim processed if the GW modifier is submitted?
A. There are no front-end edits for the GW modifier.

Q. Does a secondary benefit claim for a Minnesota Senior Care Plus (MSC+) subscriber crossover automatically?
A. If Medicare is the primary benefit, no claim crossover will occur for MSC+ coverage. The provider is responsible for submitting the claim for secondary Medicaid benefit processing to Amerigroup.

Appeals

Q. What address should be used in different appeal situations? Can providers continue to use the *AUC Cover Sheet* and fax?
A. Blue Cross recommends using the online appeal process through Availity. Additional documentation may be attached along with the appeal request.

Providers may still fax the *AUC Appeal Form* to **1-833-224-6929**.

Adjustments have been made to the mailing information to avoid confusion for providers.

When submitting by mail, send the *AUC Appeal Form* with documentation via mail to:
Blue Cross and Blue Shield of Minnesota and Blue Plus
ATTN: Consumer Service Center
PO Box 64033
St. Paul, MN 55164-4033

Availity

Q. Are claims attachments used in order to attach to new claims or claims that you are requesting additional information for? Or can they be attached to established requests?
A. Any claim filed through Availity may have attachments added at the time the claim is filed, upon submission of a PA or to support a claims appeal.

Specific Scenarios

Q. Skilled nursing facility payments: Is precertification still required if DHS is paying?
A. Amerigroup requires clinical reviews on all subscribers admitted as inpatient to skilled nursing facilities in which payment will be rendered by Amerigroup.

Q. Can you provide more specifics regarding the process for concurrent review and how it will be requested?

A. The provider is responsible for reaching out to request additional dates of stay outside of the original precertification based upon changes in the subscriber's medical needs. The plan will also reach out to the provider to assess discharge plans for the subscriber. If a concurrent review is required, based upon the subscriber's medical needs, additional documentation will be requested to review and determine additional days of stay needed.

Q. Does Amerigroup take a 278? If so, how will records be submitted for them?

A. 278 Transactions are a *HIPAA*-mandated transaction and are supported by Amerigroup through Availity. When submitting a 278 transaction, a response will be sent to the provider stating that the transaction has been received and that the final decision will be communicated once review is completed.

Other

Q. How do other care systems interact with the Provider Online Reporting Tool? What is the purpose?

A. The Availity Provider Online Reporting Tool offers access to meaningful information and reports that create the opportunity to effectively manage the health and wellness of subscribers. The reports and information available through the Provider Online Reporting Tool can be accessed via the Availity Portal. Visit **https//www.availity.com** to register or log in.

Q. Is Patient360 assigned at the PCP or entity level?

A. Patient360 is at the subscriber level. The subscriber information will contain information generated from PCP, specialty and ancillary providers.

Q. What role security is available for the Patient360 tool?

A. Each person can be assigned a PHI Access role or a no PHI Access Role.

Q. How does a provider enroll for electronic funds transfer (EFT) and remits?

A. Blue Cross will continue to manage the EFT process. Availity will handle *Electronic Remittance Advice* registrations. Providers will still need to register on Availity for remittance viewer/835 capabilities.

Q. Are there case managers working within the Disease Management department (chronic conditions, smoking cessation, etc.)?

A. Yes, the team consists of dedicated case managers working on the special programs.

Q. What is the escalation process for claim issues as of January 1, 2019?

A. Providers should contact Provider Services at **1-866-518-8448** for any questions regarding eligibility and benefits, claims or utilization management. If escalation is required, the Provider Services team will work with Provider Relations team.

Q. How will a provider bill for babies born prior to the migration? For instance, a baby born on 12/30 that goes to the NICU – will they have a Blue Cross ID number and an Amerigroup ID number?

A. For all inpatient stays, benefit determination and claim submissions are based upon the statement from date on the subscribers claim. Any claim with a statement from date on or after January 1, 2019 will be submitted to Amerigroup.

Examples:

Infant is born on December 30, 2018, and transfers to a NICU within the same facility:

- *Providers would use the current Blue Cross ID card and submit claims through the current Blue Cross process.*

Infant is born on December 30, 2018, transfers to a NICU within the same facility and an interim billing is necessary:

- *Providers would use the current Blue Cross ID card and submit claims through the current Blue Cross process for the interim claim.*
- *Additional interim billing or final billing by providers submitted on or after January 1, 2019 would have follow the statement from date and be submitted to Amerigroup.*

Infant was born on December 30th, 2018 and transfers from that facility to a separate facility NICU on or after January 1, 2019:

- *For the initial claim providers would use the current Blue Cross ID card and submit claims through the current Blue Cross process.*
- *The second facility NICU claim for on or after January 1, 2019 would require the new Amerigroup ID and submission to Amerigroup for claim payment.*

Contracts

Q. How many Medicaid networks are available?

A. Blue Cross will continue to have responsibility for provider contracting, provider demographics and credentialing. The current provider network will remain in place for the MHCP population.