PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

November 1, 2023

Reimbursement Policies for Minnesota Health Care Programs (MHCP), effective January 1, 2024

As communicated in Provider Quick Point QP95-22, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be transitioning MHCP Operations back to Blue Cross as of January 1, 2024.

For many covered services, Blue Cross has been configuring the claims processing system to be consistent with MHCP guidelines. Services following MHCP guidelines effective January 1, 2024, will not have a Reimbursement Policy published. Providers are encouraged to review the Provider Policy and Procedure Manual, Provider Bulletins and Quick Points for additional information.

The following Reimbursement Policies will be published and applicable to MHCP subscribers effective January 1, 2024.

Reimbursement Policy	Status	Summary
EM-002: Same Day Same Service	No change	This policy addresses coding and reimbursement for multiple evaluation and management (E/M) services reported for the same patient on a single date of service. E/M services appended with modifier -25 will have a 20% reduction applied to the allowed amount.
EM-013: New Patient	New	This new policy addresses when a new patient E/M is eligible for reimbursement.
Facility-002: Incremental Nursing	New	This new policy addresses appropriateness of incremental nursing services billed under revenue code 023X.
Facility-003: Inpatient Hospital Readmission	No change	This policy addresses readmissions to the same hospital within 15 days of discharge.
Facility-006: Outpatient Hospital Services Prior to an Inpatient Admission	Change	This policy addresses those outpatient hospital services that are to be billed on the inpatient claim when performed on the day of or within 3 days prior to admission to the same hospital.
GC-003: Code Editing Policy	No change	This policy addresses the industry standard coding edits utilized to assist in a consistent claim review process.

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Reimbursement Policy	Status	Summary
GC-005: Unlisted Procedure Code Policy	No change	This policy addresses the appropriate use of unlisted CPT/HCPCS codes. Unlisted codes should only be used if no code exists to describe the procedure, service, or supply.
GC-009: Maximum Units Per Day	No change	This policy addresses the reimbursement of CPT/HCPCS codes submitted with multiple units on the same date of service. The maximum units per day values generally align with CMS MUE, in addition to CPT/HCPCS code descriptions, industry standards, and what is clinically appropriate for a specific service.
GC-071: Bundled Services	New	A new policy that addresses bundled services designated on the National Physician Fee Schedule (NPFS) Relative Value file with a Status B or P indicator.
GC-073: Clinical Trials	No change	This policy addresses reimbursement for routine costs related to certain clinical trials.
GC-074: Cellular and Gene Therapy	New	This policy addresses coding and reimbursement for Cellular and Gene Therapy Products. Reimbursement will be determined using the following methodology: Wholesale Acquisition Cost (WAC).
GC-079: Hair Removal for Gender Affirming Procedures	New	A new policy that addresses hair removal procedures when performed in conjunction with gender dysphoria treatment.
LP-001: Laboratory Rebundling Policy	New	This policy addresses coding and reimbursement for laboratory rebundled services. The tests listed under each organ or disease-oriented panel (80047- 80081) identify the defined components of that panel, and all tests listed must be performed to bill for that panel.
LP-008: Genetic/Molecular Test Coding	No change	Blue Cross requires that all providers billing for genetic and molecular testing services bill according to the coding recommendation in the Concert Genetics portal.
REHAB-004: Physical, Occupational and Speech Therapy (PT, OT, ST) Modalities and Evaluation	No change	This new policy addresses physical, occupational and speech therapy modalities and evaluation services. In addition, it addresses the 15% reduction in the allowed amount for services modified with the CO or CQ modifiers.
SI-002: Bilateral Procedures	No change	This policy addresses coding and reimbursement for bilateral procedures. Blue Cross determines reimbursement of bilateral procedures based on the Bilateral Indicator assigned by the Centers for Medicare and Medicaid Services (CMS).
SI-003: Co-Surgeon and Team Surgeons	Change	This policy identifies the procedures eligible for co-surgeon and team surgeon reimbursement and the associated documentation requirements. Beginning 1/1/2024, reimbursement will be 62.5 percent of the global surgery fee schedule amount for allowable team surgery (modifier 66) services.

Reimbursement Policy	Status	Summary
SI-004: Modifier 22	Change	This policy addresses reimbursement for services that are submitted with a 22 modifier. Beginning 1/1/2024, submission of a claim using the 22 modifier will require documentation to be submitted with the claim.
SI-005: Multiple Surgical Reduction	No change	This policy addresses reimbursement for multiple procedures performed by the same physician or other qualified healthcare professional (QHP) on the same date of service during the same patient encounter. Blue Cross utilizes the National Physician Fee Schedule Relative Value File to determine which procedures are eligible for multiple procedure reduction.
SI-007: Global Surgical Package	Change	This policy addresses the Global Surgical Package, as defined by the Centers for Medicare and Medicaid Services (CMS). This includes all services normally provided by the surgeon, or other physician or qualified health care professional within the same group and same specialty during the preoperative, intraoperative, and postoperative period of a procedure. Beginning 1/1/24, the modifiers listed below will be reimbursed at the following: – 54: 80% of allowed amount – 55: 15% of allowed amount – 56: 5% of allowed amount
SI-019: Once in a Lifetime Procedures	New	A new policy that addresses procedures that are generally performed only once in a patient's lifetime. For example, a patient only has one appendix; therefore, an appendectomy can be performed only once in the patient's lifetime.
SI-022: Wrong Surgical and Other Invasive Procedures	No change	This policy addresses reimbursement for services associated with a wrong surgical or other invasive procedure reported on either an institutional or professional claim. Blue Cross will not reimburse for these or related services.

Products Impacted

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

Questions?

Please email Blue Cross at MHCPProviders@BlueCrossMN.com