PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

December 1, 2023

WHAT'S INSIDE:

L08R04 (12/13)

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes

(published in every summary of monthly bulletins)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) collaborates with providers to ensure accurate information is reflected in all provider directories. In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers.

- 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

The appropriate form for each of these changes or updates can be located on the Blue Cross website at bluecrossmn.com/providers/provider-demographic-updates

Providers are obligated, per federal requirements, to update provider information contained in the National Plan & Provider Enumeration System (NPPES). Updating provider information in NPPES will provide organizations with access to a current database that can be used as a resource to improve provider directory reliability and accuracy. Providers with questions pertaining to NPPES may reference NPPES help at https://nppes.cms.hhs.gov/webhelp/nppeshelp/HOME%20PAGE-SIGN%20IN%20PAGE.html

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820.**

Medical Record Retention Requirements Reminder | P94-23

All Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Provider Agreements contain a provision requiring providers to maintain accurate and accessible medical records.

Article III - Authority and Covenants (E) or (G), depending on which provider agreement that the provider holds, requires that providers shall, at provider's expense, maintain and promptly submit when requested medical record documentation that is complete, clear, comprehensive, concise, consistent, and legible and which conforms with reasonable documentation standards as set forth in the Provider Policy & Procedure Manual. Health Services rendered to Subscribers with no corresponding documentation in the medical record are not eligible for payment and will be the Provider's financial responsibility. The provider shall maintain all Subscriber medical records for a minimum of ten (10) years after the last date a Health Service was provided to the Subscriber under this Agreement. The provider shall ensure that all diagnoses are supported in the medical record documentation for each encounter.

Products Impacted
All

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

CONTRACT UPDATES

New Commercial Reimbursement Policy: New Patient, Effective February 5, 2024 | P88-23

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be implementing a new policy, **Commercial Evaluation and Management-013 New Patient.**

This policy is consistent with the Centers for Medicare and Medicaid Services (CMS), which states a "new patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service from the physician or physician group practice (same physician specialty) within the previous 3 years.

Products Impacted

- Commercial
- Federal Employee Program (FEP)

Questions?

Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

eviCore Healthcare Specialty Utilization Management (UM) Program: Medical Oncology Drug Prior Authorization Updates | P89-23

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

The following drugs are awaiting regulatory approval. When approved, the drugs 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
imetelstat
nogapendekin alfa
odronextamab

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 **bluecrossmn.com/providers**
- Select "**Medical and behavioral health policies**" under "**Medical Management**"
- Scroll down and click on the "**eviCore healthcare clinical guidelines**" link, located under *Other evidence-based criteria and guidelines we use and how to access them*
- 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 **bluecrossmn.com/providers**
- Select "**Medical and behavioral health policies**" under "**Medical Management**"
- Scroll down and click on the "**eviCore healthcare clinical guidelines**" link, located under *Other evidence-based criteria and guidelines we use and how to access them*
- Click on the **"Resources"** dropdown in the upper right corner

- Click **"Clinical Guidelines"**
- Select the appropriate solution: i.e., Medical Oncology (Note: read and accept disclaimer)
- 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.

To Provide Feedback on Future Guidelines:

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to future guidelines managed by eviCore.

The future guidelines are available for physician comment for at least 45 days from the posting date found on the document. Make sure your voice is heard by providing feedback directly to us.

To submit feedback, complete the Provider feedback form for third-party clinical policies/guidelines/criteria PDF via https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies.

Products Impacted

This change only applies to:

- Individual subscribers
- Fully insured commercial subscribers
- Self-insured commercial subscribers (Select Groups)
- Medicare Advantage subscribers

Prior Authorization Look Up Tool

Providers should use the Prior Authorization Look Up Tool on Availity.com/Essentials 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.

To access the Prior Authorization Look Up Tool:

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

To submit a Prior Authorization (PA) Request to eviCore

Providers submit eviCore PA requests at Availity.com/Essentials. There is no cost to the provider.

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

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 Healthcare Specialty Utilization Management (UM) Program: Cardiology and Radiology Clinical Guideline Updates | P90-23

eviCore has released clinical guideline updates for the Cardiology & Radiology program. Guideline updates will become **effective February 1, 2024.**

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

- Preface to the Imaging Guidelines
- Abdominal Imaging Guidelines
- Breast Imaging Guidelines
- Cardiac Imaging Guidelines
- Chest Imaging Guidelines
- Head Imaging Guidelines
- Neck Imaging Guidelines
- Musculoskeletal Imaging Guidelines
- Oncology Imaging Guidelines
- Pelvis Imaging Guidelines
- Peripheral Nerve Disorders (PND) Imaging Guidelines
- Peripheral Vascular Disease (PVD) Imaging Guidelines
- Spine Imaging Guidelines
- Pediatric Abdominal Imaging Guidelines
- Pediatric Cardiac Imaging Guidelines
- Pediatric Chest Imaging Guidelines
- Pediatric Head Imaging Guidelines
- Pediatric Neck Imaging Guidelines
- Pediatric Musculoskeletal Imaging Guidelines
- Pediatric Oncology Imaging Guidelines
- Pediatric Pelvis Imaging Guidelines
- Pediatric Peripheral Nerve Disorders (PND) Imaging Guidelines
- Pediatric Peripheral Vascular Disease (PVD) Imaging Guidelines
- Pediatric Spine Imaging Guidelines

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- Access the 'Provider Section' of the Blue Cross website at **bluecrossmn.com/providers**
- Select "**Medical and behavioral health policies**" under "**Medical Management**"
- Scroll down and click on the "**eviCore healthcare clinical guidelines**" link, located under *Other evidence-based criteria and guidelines we use and how to access them*
- Select **"Solution Resources"** and then click on the appropriate solution (ex. Radiology or Cardiovascular)
- 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 **bluecrossmn.com/providers**
- Select "**Medical and behavioral health policies**" under "**Medical Management**"
- Scroll down and click on the "**eviCore healthcare clinical guidelines**" link, located under *Other evidence-based criteria and guidelines we use and how to access them*
- Click on the **"Resources"** dropdown in the upper right corner
- Click **"Clinical Guidelines"**

- Select the appropriate solution: i.e., Cardiology & Radiology (Note: read and accept disclaimer)
- 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.

To Provide Feedback on Future Guidelines:

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to future guidelines managed by eviCore.

The future guidelines are available for physician comment for at least 45 days from the posting date found on the document. Make sure your voice is heard by providing feedback directly to us.

To submit feedback, complete the Provider feedback form for third-party clinical policies/guidelines/criteria PDF via https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies.

Products Impacted

This change only applies to:

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

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Providers should use the Prior Authorization Look Up Tool on Availity.com/Essentials 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.

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

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.

New Medical, Medical Drug and Behavioral Health Policy Management Updates, Effective February 5, 2024 | P91-23

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 February 5, 2024:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: • Avacincaptad pegol (Izervay™)	No	New	Commercial
II-287	Rozanolixizumab (Rystiggo®)	Yes *(Moving from Policy II-173)*	Continued	Commercial
II-181	Tocilizumab (Tofidence™)	Yes *(Moving from Policy II-173)*	Continued	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Avacincaptad pegol (Izervay™)	No	New	Medicare Advantage
II-181	Tocilizumab (Tofidence™)	Yes *(Moving from LCD L33394)*	Continued	Medicare Advantage
II-181	Tocilizumab (Tofidence™)	Yes	New	Medicaid

Products Impacted
The information in this bulletin applies only to subscribers who have coverage through Commercial, Medicare Advantage, or Minnesota Health Care Programs products including Families & Children, MinnesotaCare, MSC+ and MSHO.

Submitting a PA Request when Applicable

- **Providers may submit PA requests for any treatment in the above table starting January 29, 2024.**
- 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 www.bluecrossmn.com/providers/medical-management
  - Select “See Medical and Behavioral Health Policies” then click “Search Medical and Behavioral Health Policies” to access policy criteria.

- Current and future PA requirements and related clinical coverage criteria can be found using *the Is Authorization Required* tool at www.availity.com/essentials or at www.bluecrossmn.com/providers/medical-management 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 include applicable codes. To access the PDF prior authorization lists for all lines of business go to www.bluecrossmn.com/providers/medical-management

Prior Authorization Requests

- For information on how to submit a prior authorization please go to bluecrossmn.com/providers/medical-management
- 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 https://www.bluecrossmn.com/providers/medical-management
- Select "See Medical and Behavioral Health Policies" then click "See Upcoming Medical and Behavioral Health Policy Notifications."

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans Managed by Blue Cross and Blue Shield of Alabama | P92-23

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to our draft policies for Coupe Health and Self-Funded benefit plans managed by Blue Cross and Blue Shield of Alabama.

The draft policies are available for physician comment for 45 days from the posting date found on the document. At the conclusion of the 45 days, policies will go into effect. Make sure your voice is heard by providing feedback directly to us.

How to Submit Comments on Draft Medical Policies
Complete our medical policy feedback form online at https://mn-policies.exploremyplan.com/portal/web/mn-policies/feedback or send comments and supporting documentation to us by mail or fax:

Birmingham Service Center
Attn: Health Management - Medical Policy
P.O. Box 10527
Birmingham, AL 35202
Fax: 205-220-0878

Draft Medical Policies
Draft medical policies can be found at Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
MP-038	Continuous Glucose Monitoring Systems

Policy #	Policy Title
MP-537	Peroral Endoscopic Myotomy (POEM) for Treatment of Esophageal Achalasia and Refractory Gastroparesis
MP-548	Identification of Microorganisms Using Nucleic Acid Probes
MP-748	Remote Electrical Neuromodulation for Migraines
MP-754	Annular Closing Device

Draft Provider-Administered Drug Policies

Draft provider-administered drug policies can be found at Policies & Guidelines (exploremyplan.com) and Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
PH-90002	Actemra IV
PH-90670	Amvuttra (vutrisiran)
PH-90497	Beovu (brolucizumab-dbll)
PH-90018	Berinert (C1 Esterase inhibitor, Human)
PH-90693	Briumvi (ublituximab-xiiy)
PH-90028	Cimzia (certolizumab pegol)
PH-90273	Cinqair (reslizumab)
PH-90168	Cinryze C1 Esterase inhibitor, Human)
PH-90098	Denosumab
PH-90660	Enjaymo (sutimlimab-jome)
PH-90202	Entyvio (vedolizumab)
PH-90347	Fasenra (benralizumab)
PH-90061	Hyaluronic Acid Derivatives
PH-90177	Ilaris (canakinumab)
PH-90104	Infliximab
PH-90167	Kalbitor (ecallantide)
PH-90158	Krystexxa (pegloticase)
PH-90223	Lemtrada (alemtuzumab)
PH-90133	Natalizumab
PH-90260	Nucala (mepolizumab)
PH-90298	Ocrevus (ocrelizumab)
PH-90379	Onpattro (patisiran lipid complex)
PH-90078	Ranibizumab
PH-90503	Reblozyl (luspatercept-aamt)
PH-90207	Ruconest (C1 Esterase inhibitor, recombinant)
PH-90176	Simponi_ARIA (golimumab)
PH-90674	Spevigo (spesolimab)
PH-90117	Stelara (ustekinumab)
PH-90634	Susvimo (ranibizumab)

PH-90697	Syfovre (pegcetacoplan)
PH-90549	Uplizna (inebilizumab-cdon)
PH-90659	Vabysmo (faricimab-svoa)
PH-90146	Xolair (omalizumab)
PH-9400	Botulinum Toxin
PH-9402	Eptinezumab (Vyepti)
PH-9403	Immunoglobulin Therapy
PH-9406	Rituximab

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Moving Expenses Benefit added to Minnesota Health Care Programs (MHCP); New Effective Date April 1, 2024 | P85R1-23

Revision: Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be implementing a benefit for Moving Expenses for eligible MHCP subscribers. The original effective date was to be January 1, 2024, but per DHS the benefit will now be effective on April 1, 2024.

Below is the information that was previously published on November 1, 2023:

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be implementing a benefit for Moving Expenses for eligible MHCP subscribers.

Moving Expenses is a component of the Housing Stabilization-Transition benefit and is available to subscribers receiving Housing Stabilization-Transition services that are transitioning out of Medicaid funded institutions or other provider-operated living arrangements to a less restrictive living arrangement in a private residence where the person is directly responsible for his or her own living expenses (own home). Moving Expenses are non-reoccurring and are limited to a maximum of $3,000 annually.

Covered services may include:

- Applications, security deposits and securing documentation required to obtain a lease.
- Essential household furnishings; including furniture, window coverings, food preparation items, bed/bath linens.
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating, water.
- Services necessary for the individual’s health and safety such as pest eradication and one-time cleaning prior to occupancy.
- Necessary home accessibility adaptations.

The Minnesota Department of Human Services (DHS) will review all requests for Moving Expenses. DHS currently reviews and authorizes Transitioning/Sustaining services per established criteria. The review may be performed at initial authorization or renewal. Providers should submit a plan change including Moving Expenses if a person is moving mid-eligibility period and meets criteria for Moving Expenses. DHS will communicate authorizations to Blue Cross.

Providers are required to maintain documentation of all purchases and spending, including receipts and invoices related to the subscriber’s eligible Moving Expenses. Providers are required to track costs separately from other services provided under Housing Stabilization - Transition Services.

Eligible Moving Expenses should be submitted by the authorized Housing Transition provider using HCPCS code T2038-U8. All claims for Moving Expenses must include a claims attachment with a receipt or invoice clearly identifying the service or item. Claims submitted without the attachment will not be reimbursed. All claims attachments will be reviewed to determine eligibility for the service or item.

Moving Expense providers and/or their family members cannot sell goods and services to recipients that are reimbursed through the Moving Expense benefits and Moving Expenses cannot be used to purchase goods and services from a subscriber's family member.

Products Impacted

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

Questions?
Please email Blue Cross at MHCPProviders@BlueCrossMN.com

Additional Information for Minnesota Health Care Programs (MHCP) Operations Transitioning back to Blue Cross, effective January 1, 2024 | P93-23

As communicated in **Provider QuickPoint QP95-22 Minnesota Health Care Programs Operations Transition**, and **Provider Bulletin P77-23 Minnesota Health Care Programs Operations Transitioning back to Blue Cross, effective January 1, 2024**, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be transitioning Minnesota Health Care Programs (MHCP) Operations back to Blue Cross as of January 1, 2024.

Blue Cross has established a landing page on the website for all documents and information related to the transition: https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs-mhcp

Prior Authorizations (PA)
The list of services, procedure codes and associated policies or criteria requiring PA beginning on January 1, 2024, has been published on the MHCP migration landing page. Providers will find the Families & Children, MinnesotaCare (MNCare), and Minnesota Senior Care Plus (MSC+) along with the Minnesota Senior Health Options (MSHO) PA list under the heading titled "Prior Authorizations and Notifications". Please note that there is a separate PA list for MSHO subscribers.

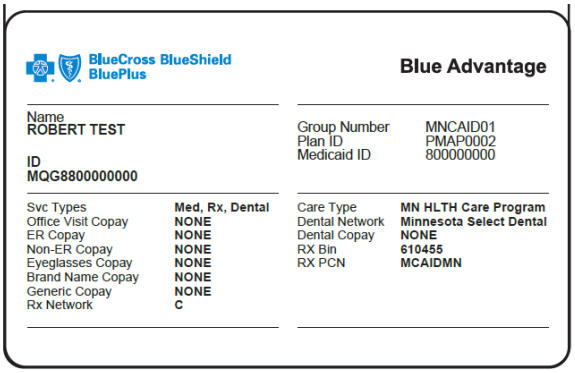
Provider Webinars
Blue Cross will be hosting MHCP Provider Webinars in December. The webinars will be available through the Availity platform. Providers are encouraged to register for one of the sessions.

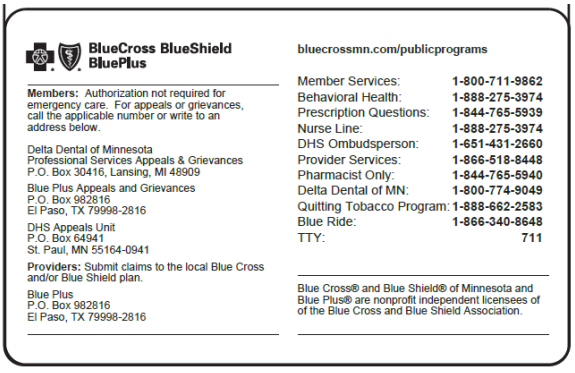
> **MHCP Provider Information Session |** December 5, 2023, from 9-10:30 am CST
> https://availity.zoom.us/webinar/register/WN_qpBB6ubsT0K6wkGyyGM-Aw
>
> **MHCP Provider Information Session |** December 14, 2023, from 1-2:30 pm CST
> https://availity.zoom.us/webinar/register/WN_SBTPdTasRc6Diuxgxo1g1Q

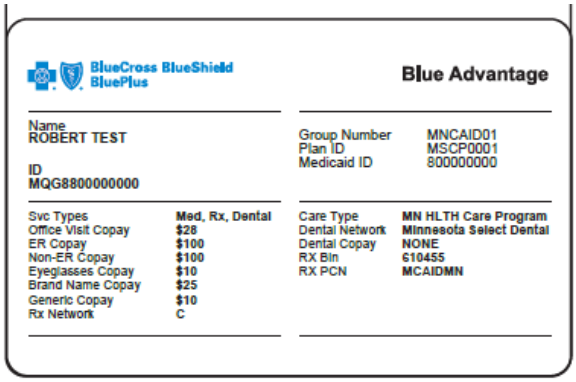
Updated Sample ID Cards

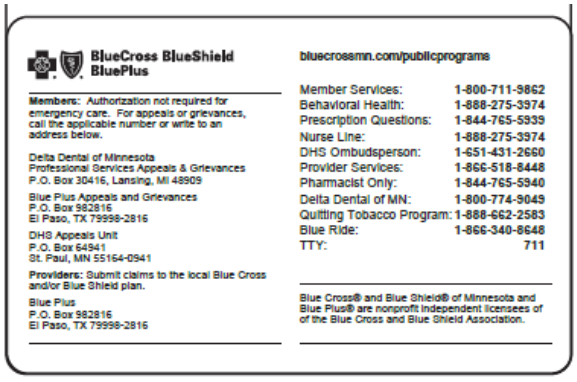
Please note that providers may see a slight variation after final testing and approvals are complete.

Blue Advantage – no copay and copay

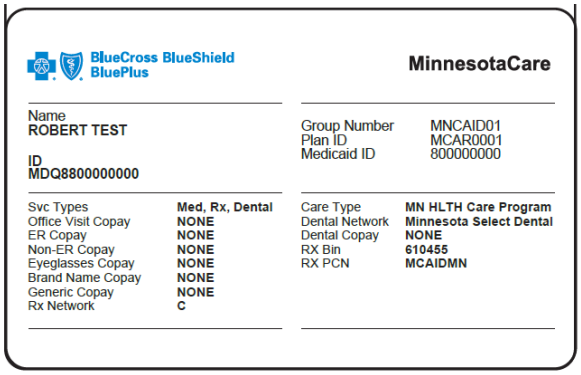


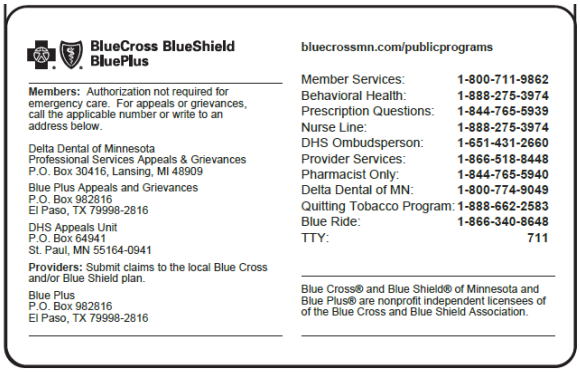


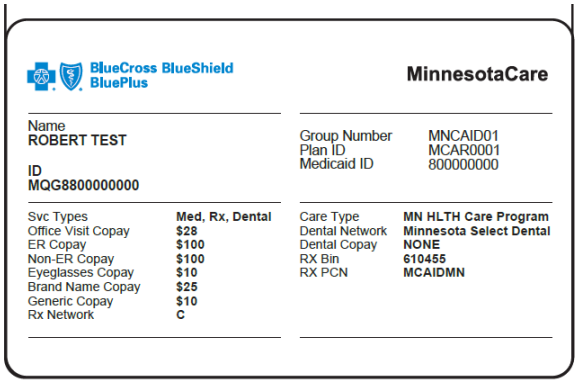


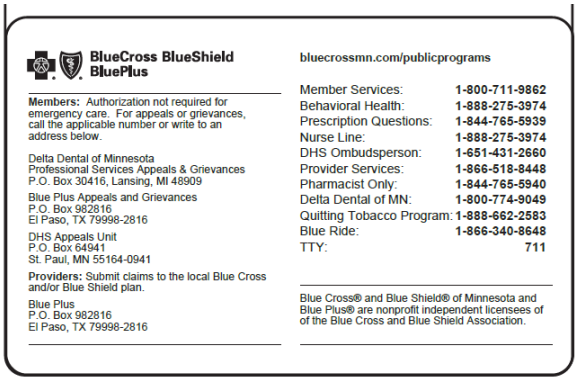


MinnesotaCare – no copay and copay

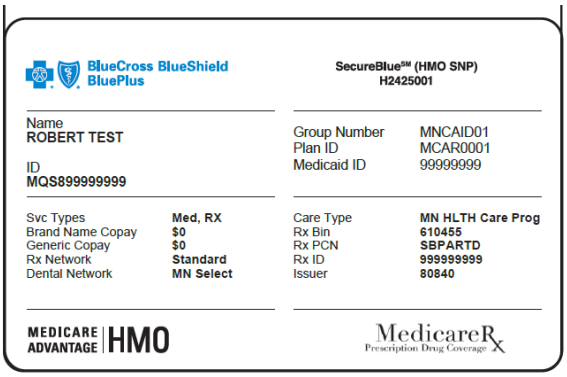


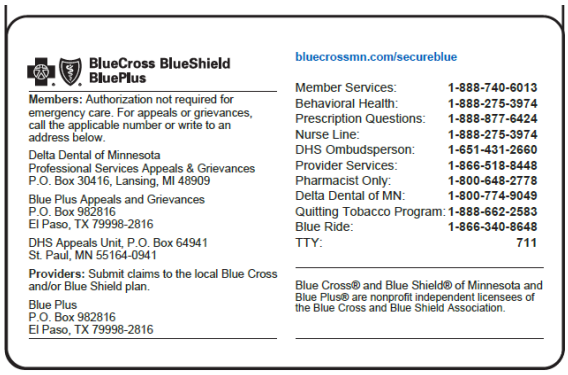






Minnesota Senior Health Options (MSHO)





Reimbursement Policy Changes
Reimbursement Policy changes effective on January 1, 2024, were communicated in Provider Bulletin P80-23. For many covered services, Blue Cross has configured 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. Blue Cross will be following the MHCP guidelines for Anesthesia Services and therefore, a separate Reimbursement Policy will not be published.

Claim Submission
Blue Cross follows the requirements published in the AUC Best Practices titled Claim Service Dates Restricted to Same Calendar Months which can be located at: Best Practice - Claim Service Dates Restricted to Same Calendar Month (state.mn.us)

On a professional claim, service date spans should only be within the same calendar month. Multiple claims may be submitted for different dates within the same calendar month based on the provider's billing practices.

On an institutional outpatient claim, statement and service date spans should only be within the same calendar month. Observation, extended recovery, and emergency department services beginning before and completing after midnight are exceptions to this Best Practice if performed during the same visit. Procedures beginning on one day and ending on another should be billed together.

This best practice does not apply to an institutional inpatient claim.

Replacement and Cancel/Void Claims
Blue Cross follows the requirements as published in the AUC Best Practices titled Replacement/Void Claims which can be located at: Best Practice - Replacement Void Claim (state.mn.us)

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