# PROVIDER BULLETIN
## PROVIDER INFORMATION

BlueCross BlueShield Minnesota

October 1, 2018

## Revised: Provider Price Disclosure Requirement

*The information in this Bulletin replaces Provider Bulletin P43-18, which was published on September 4, 2018. The reason for this revision is due to the effective date incorrectly communicated as January 1, 2019. The correct effective date is July 1, 2019.*

Effective July 1, 2019, in accordance with Minnesota Statute 62.J.81, Providers must provide patients with information regarding other types of fees or charges that the patient may be required to pay in conjunction with a visit to the Provider, including but not limited to any applicable facility fees, within ten business days from the day of a completed request. In addition, Providers must maintain a list of the services over $25.00 that correspond with the Provider's 25 most frequently billed current procedural terminology (CPT) codes. This list shall be updated annually and must be posted in the Provider's reception area of the clinic or office and made available on the Provider's Web site if the Provider maintains a Website. No contract between a Provider and Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) prohibits any of these price disclosures. Price disclosure is not a guarantee of final costs for Health Services received nor a final determination of eligibility of coverage.

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

# Office of the Revisor of Statutes

## 2018 Minnesota Statutes

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### 62J.81 DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1. **Required disclosure by provider.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay.

(b) In addition to the information required to be disclosed under paragraph (a), a provider must also provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees.

(c) The information required under this subdivision must be provided to a consumer within ten business days from the day a complete request was received by the health care provider. For purposes of this section, "complete request" includes all the patient and service information the health care provider requires to provide a good faith estimate, including a completed good faith estimate form if required by the health care provider.

(d) Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this subdivision.

Subd. 1a. **Required disclosure by health plan company.** (a) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

(b) The information required under this subdivision must be provided by the health plan company to an enrollee within ten business days from the day a complete request was received by the health plan company. For purposes of this section, "complete request" includes all the patient and service information the health plan company requires to provide a good faith estimate, including a completed good faith estimate form if required by the health plan company.

Subd. 2. **Applicability.** (a) For purposes of this section, "consumer" does not include a medical assistance or MinnesotaCare enrollee, for services covered under those programs.

(b) For purposes of this section, a good faith estimate is not:

(1) a guarantee of final costs for services received from a health care provider; or

(2) a final determination of eligibility for coverage of benefits or provider network participation under a health plan.

**History:** *2004 c 288 art 7 s 3; 2006 c 255 s 24; 2007 c 147 art 15 s 9; 2011 c 108 s 36; 2016 c 158 art 2 s 20; 2018 c 168 s 1*

**NOTE:** The amendment to this section by Laws 2018, chapter 168, section 1, is effective July 1, 2019. Laws 2018, chapter 168, section 1, the effective date.

**25 Most Frequently Billed Current Procedural Terminology (CPT) Codes**

**University of Minnesota School of Dentistry**

| | |
|---|---|
| 99213 | Established Patient Office Visit; Expanded Problem Focused |
| 99204 | New Patient Visit; Comprehensive |
| 97110 | Therapeutic Exercise |
| 99203 | New Patient Visit; Detailed |
| 97140 | Manual Therapy Techniques |
| 70355 | Orthopantogram |
| 41874 | Alveoloplasty, each quadrant (specify) |
| 99214 | Established Patient Office Visit; Detailed |
| 99499 | Cleft Palate Clinic Team Consultation; Other E & M |
| 99212 | Established Patient Office Visit; Problem Focused |
| 99202 | New Patient Office Visit; Expanded Problem Focused |
| 99241 | Consultation; New or Established Patient; Problem Focused |
| 97162 | Patient Evaluation; Moderate Complexity |
| 97112 | Neuromuscular Reeducation 1 or More Areas |
| 97035 | Ultrasound (For Physical Therapy) |
| 70486 | Computed Tomography; Maxillofacial Area; Without Contrast Material |
| 21031 | Excision of Torus Mandibularis |
| 64612 | Chemodenervation of Muscle(s); Innervated by Facial Nerve, Unilateral |
| 97161 | Patient Evaluation; Low Complexity |
| 99201 | New Patient Office Visit; Problem Focused |
| 40808 | Biopsy; Vestibule of Mouth |
| 92524 | Behavioral and Qualitative Analysis of Voice and Resonance |
| 92522 | Evaluation Speech Sound Production; eg. Articulation, Phonological Process, Apraxia, Dysarthria |
| 99211 | Established Patient Office Visit; Presenting Problems Minimal |
| 40812 | Excision, Destruction |

As of July 1, 2019, in accordance with Minnesota Statute 62.J.81

July 2019