BLUE REVIEW℠

A Provider Publication

December 2018

Please distribute this newsletter, which contains claims, billing, Medical Policy, reimbursement, and other important information, to all health care providers, administrative staff, and billing departments/entities. This version of Blue Review is based on the electronic version that was distributed in December 2018 but because it is a summary copy, **it may not have all the information contained in the electronic version. To sign up to receive the Blue Review electronically, complete the** request form **that can be found at** bcbsok.com/provider**.**

You can find the *Blue Review* online at bcbsok.com/provider/news and updates

News & Updates

New Benefit Preauthorization Requirements for Select Infusion Drugs

Effective Jan. 1, 2019, benefit preauthorization will be required for select infusion drugs for the Blue Cross and Blue Shield of Oklahoma (BCBSOK) members in the networks listed below. These are drugs that are administered by health care professionals and typically covered under the member's medical benefit.

Blue Advantage PPO℠
Blue Preferred PPO℠
Blue Choice PPO℠
BlueLincs HMO℠

Starting on Jan. 1, 2019, if you are prescribing these select infusion drugs, you will need to submit a benefit preauthorization to BCBSOK prior to administration of the drug. To request benefit preauthorization, use our online tool, iExchange®. You may also call the number on the member ID card for assistance.

Please note that the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. BCBSOK makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Medecision. If

you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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BCBSOK Expansion or Changes to Preauthorization Requirements Beginning Jan. 1, 2019

Effective Jan. 1, 2019, benefit plans managed by Blue Cross and Blue Shield of Oklahoma (BCBSOK) will be updating preauthorization requirements.

You should verify patient eligibility and benefits prior to every scheduled appointment. Eligibility and benefit information includes membership validation, coverage status and preauthorization requirements. To obtain fast, efficient, detailed information for BCBSOK members, please access the Availity® Eligibility and Benefits tool. Please note that you must be registered with Availity to gain access to this **free online tool**. Additional tip sheets are available on the BCBSOK provider website.

Below is a list of the newly impacted care categories that may need preauthorization for various networks effective Jan. 1, 2019:

- Molecular and Genetic testing
- Radiation Therapy
- Advanced Imaging
- Cardiac Imaging
- Musculoskeletal Joint and Spine Surgery
    - Pain Management
    - Joint and Spine Surgery
- Select Outpatient Procedures
- Medical Benefit Specialty Pharmacy

It is imperative that providers check member eligibility and benefits and verify preauthorization requirements through Availity or their preferred vendor.

A 2019 list of services that **may** require preauthorization or prenotification is available. Not all requirements apply to every BCBSOK plan. Watch for future detailed updates, as well as available training sessions, on bcbsok.com/provider.

Please feel free to contact your Provider Network Representative if you have any questions or if you need additional information.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits, is not a guarantee of payment. Benefit determination will occur when a claim is received and will be based other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services when rendered.

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Medicare Advantage: Preauthorization Change for Psychological and Neuropsychological Testing

Effective June 1, 2018, Blue Cross and Blue Shield of Oklahoma (BCBSOK) made updates to the Blue Cross Medicare Advantage℠ preauthorization requirements for psychological and neuropsychological testing procedures. The updates improve member access to care and decrease provider administrative responsibilities.

For in-network providers, benefit preauthorization of routine psychological and neuropsychological testing is no longer required. Prior authorization will only be enforced if BCBSOK determines a provider's pattern of testing varies significantly from their provider peer group.

Additionally, periodic auditing will be conducted by BCBSOK to evaluate that testing is consistent with the presenting clinical issue, national and local coverage determinations, medical policy and benefit plan design. If benefit preauthorization is required or testing is not consistent with the above determinants, BCBSOK will contact the provider to obtain additional information.

If you have any questions, contact your assigned Provider Network Representative. Thank you for your cooperation as we work to optimize our Care Management program to better serve our providers and members.

Please note that the fact that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

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Documentation is Crucial for a successful 'Annual Visit' Campaign

We are continuing a preventive care campaign to remind members to schedule their annual exams. This month, we are encouraging members with asthma to see their health care provider.

We know you see a lot of patients. Since this campaign may add to your patient volume, we wanted to remind you about carefully documenting patients' medical records. Careful documentation is needed for proper assignment of ICD-10-CM/PCS codes. To help make sure claims are properly billed and the right benefits are applied, your documentation must paint a complete picture of each patient's condition.

As you know, medical record data can also be used to help create provider report cards and show meaningful use in electronic health records. Potential patients may use provider profiles, with online comparison tools, to choose where to go for care.

Clinical documentation improvement tools and services are widely available. Regardless of whether you established a clinical documentation improvement (CDI) program, there are some basic CDI tips you can use to support accurate ICD-10 coding on your claims:

1. **Lay the groundwork** by outlining a complete history
2. **Go below the surface** by highlighting potential red flags and risk factors
3. **Include progress notes** to illustrate how the patient was monitored and evaluated
4. **Put the pieces together** with details on why decisions were made
5. **Focus on teamwork** between medical, coding and billing staff
6.

Thank you for your efforts to support our members' health and wellness at their annual visits and all other visits.
Careful medical record documentation will help ensure your claims accurately reflect the care and services you give to our members.

This material is for educational purposes only. Health care providers are instructed to submit claims using the most appropriate codes based upon the medical record documentation and coding guidelines and reference materials.

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FEP® Introduces Blue Focus

Starting Jan. 1, 2019**,** you may begin seeing Blue Cross and Blue Shield of Oklahoma (BCBSOK) Federal Employee Program® (FEP) members with FEP Blue Focus - a new benefit plan consistent with our commitment to expand access and make health care more affordable. We will also continue to offer FEP members our Standard Option and Basic Option products.

Some of the features of Blue Focus include:

- The first ten office visits of the year to in-network doctors for only $10
- No more than a $5 copay for preferred generic drugs
- No copay for the first two telehealth visits, $10 copay for each additional visit
- No copay or coinsurance for ER visits for accidental injuries if the visits are within 72 hours of the injury
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We are proud of our long history of serving federal employees, retirees and their families with products that deliver high-quality, comprehensive coverage. We appreciate your continued partnership in serving our FEP members.

Additional information is available at fepblue.org. If you have any questions regarding this benefit, please call FEP Customer Service at 800-972-8382.

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Check Procedure Code-specific Benefit Preauthorization Requirements Online

As you know, it's important to check eligibility and benefits first to determine if benefit preauthorization is required. Requesting benefit preauthorization is not a substitute for checking eligibility and benefits. Obtaining benefit preauthorization, if required, may help alleviate claim and process denials.

To help ensure you have quick access to benefit preauthorization requirements for specific Current Procedural Terminology (CPT®)/ Healthcare Common Procedure Coding System (HCPCS) codes, Blue Cross and Blue Shield of Oklahoma (BCBSOK) will soon be implementing an electronic alternative. With this change when you conduct electronic eligibility and benefits inquiries/responses (270/271 transactions) through the Availity® Provider Portal or your preferred web vendor, you will have the option to verify if specific Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) codes require benefit preauthorization.

CPT/HCPCS code inquiry verification is for benefit preauthorization determination only and is not a code-specific quote of benefits. To verify if a CPT/HCPCS code is a covered benefit for a specific patient, you may need to speak with a Customer Advocate. Refer to the Eligibility and Benefits Caller Guide for more information.

How to check benefit preauthorization requirements online for CPT/HCPCS codes:

- Enter the optional CPT/HCPCS code(s) and the associated place of service on the Eligibility and Benefit Inquiry entry screen (270), through the Availity portal or your preferred web vendor.
- The Pre-Authorization Info tab on the Eligibility and Benefit Inquiry response (271) will display specific benefit preauthorization requirements based on the CPT/HCPCS codes entered.
- The Pre-Authorization Info tab will also indicate contact information for completing the benefit preauthorization request, and other important details.

Note: To receive an online quote of benefits, make sure you select a Benefit/Service Type when completing the Eligibility and Benefit Inquiry (270). If a Benefit/Service Type is not selected, you will only receive benefit preauthorization requirements for the CPT/HCPCS code entered.

Exceptions

At this time, online CPT/HCPCS code inquiry verification for benefit preauthorization is **not available** for the following BCBSOK members:

- Federal Employee Program®
- Blue Cross Medicare Advantage (HMO)℠ and Blue Cross Medicare Advantage (PPO)℠

For More Information

Watch the BCBSOK provider website News and Updates for more information and training.

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Feature Tip

Group C-PCM Exception Products List Can Now Be Found Online

Group C-PCM Exception Products are now available on the bcbsok.com/provider website under the Pharmacy Program tab/Related Resources. Providers have the option of obtaining Group C Exception Products by contacting the Specialty Pharmacy listed with the product.

We appreciate your network participation.

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Provider Data and Directory Updates

Maintaining accurate provider data and directories are an important part of providing Blue Cross and Blue Shield of Oklahoma (BCBSOK) members with the information they need to manage their health. Our online provider directory, Provider Finder® helps members find in-network doctors and hospitals. The directory is also a helpful tool for you to refer your BCBSOK patients to other participating providers.

Please review your information in Provider Finder to ensure it's correct. To update your directory information or other information such as tax identification numbers, supervising physician information, hospital privileges, etc., please visit the Information Change Request section on the BCBSOK provider website.

All changes should be submitted at least 30 days in advance of the effective date of the change. For more information, please contact your BCBSOK Provider Network Representative.

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Web Changes

- Posted November Blue Review to Education and Reference Center/News and Updates/Blue Review page
- Posted 2019 Preauthorization Requirement List to Clinical Resources /Prior Authorization
- Updated Clinical Practice Guidelines under Clinical Resources/Clinical Practice Guidelines

Stay informed!

Watch the News and Updates on our Provider website for important announcements.

Provider Training

For dates, times and online registration, visit the Provider Training page.

Making the Health Care System Work. Better. Together.

We have an insider's view of how health insurers, doctors, hospitals, employers and governments depend on one another to provide access to affordable, high-quality care and help people live healthy, productive lives. We put together a team of writers and multimedia creators to work with business and thought leaders, inside and outside of our organization, to explore ways we can all work together to make the health care system work better for everyone. Learn more about the online magazine we created to tell these stories.

BCBSOK Online Provider Orientation

The Online Provider Orientation is a convenient and helpful way for providers to learn about the online resources available to them.

Medical Policy Reminder

Approved new or revised BCBSOK medical policies and their effective dates are posted on the BCBSOK website the first day of each month. These policies may impact your reimbursement and your patients' benefits. You may view all active and pending policies, or view draft Medical Policies and provide comments. These can be accessed on the Standards and Requirements page of our provider website.

While some information on new or revised medical policies may occasionally be published for your convenience, please visit bcbsok.com/provider for access to the most complete and up-to-date information.

On-demand Training

An eRM tutorial is available to show you how to navigate the features of the eRM tool. Log in at your convenience to complete the tutorial and use it as a reference when needed.

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