BlueCross BlueShield of Oklahoma

Blue Review[SM]

A Provider Publication

January 2017

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 on Jan. 5, 2017 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

2017 Market Place Provider Education

Blue Cross and Blue Shield of Oklahoma would like to invite you to a 2017 Market Place Provider Education audio session. This education tool will include topics such as,

- Market Place Facts & Statistics for Oklahoma
- New Provider Notifications
- 2017 Provider Network & Product Updates
- 2017 Pharmacy Changes
- Other Important Changes

This audio session is 30 minutes and prerecorded for your convenience.

Click here to listen to the 2017 Market Place Provider Education audio session

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BCBSOK Vision Plan Notifications

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Oklahoma (BCBSOK) members will transition from Davis Vision to EyeMed. This impacts pediatric members (in individual, small group and student health markets) and Medicare Advantage members. In November, we sent letters to affected members notifying them of the new vision vendor. With EyeMed, the member also receives discounts on eyewear materials in addition to the funded benefit. Should you have any questions regarding this transition, please contact your BCBSOK provider representatives.

For all other BCBSOK members, providers for vision care could vary. Contact the customer service number on the member's ID card to verify the member's vision benefits.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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Reporting On-Demand Application Now Available via AvailityTM

The new Reporting On-Demand viewer application is now available in the Blue Cross and Blue Shield of Oklahoma (BCBSOK) branded Payer Spaces section on the Availity Web portal. This new tool permits registered Availity users to readily view, download, save and/or print the Provider Claim Summary (PCS) online, along with other reports as they become available. It also offers you the opportunity to obtain claim outcome results for multiple patients dated Dec. 1, 2016 and going forward, in one central location.

Providers currently enrolled for Electronic Remittance Advice (ERA) from BCBSOK will continue receive their remittances electronically, but also have the same opportunity to view, download, and/or print the claim summary as a complimentary option. If you currently rely on paper claim summaries, Availity registration is strongly recommended to gain access to the report viewer application. As a reminder, effective March 1, 2017, claim summary information will no longer be distributed via paper mailing.

BCBSOK will be hosting one-hour educational webinars for you to learn more about the application. New and existing users are highly encouraged to attend. To register for a complimentary online training session, select a date and time below.

January 11, 2017 – 2 to 3 p.m.

January 18, 2017 – 2 to 3 p.m.

January 25, 2017 – 2 to 3 p.m.

February 01, 2017 – 2 to 3 p.m.

February 08, 2017 – 2 to 3 p.m.

February 15, 2017 – 2 to 3 p.m.

February 22, 2017 – 2 to 3 p.m.

March 01, 2017 – 2 to 3 p.m.

BCBSOK supports an array of online tools including the Reporting On-Demand report viewer to registered Availity users, at no additional cost. To register, simply go to availity.com, select "Register," and complete the online application today.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSOK. BCBSOK makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

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Secondary Code-auditing Software Scheduled for Implementation as of March 19, 2017

Blue Cross Blue Shield of Oklahoma (BCBSOK) will be implementing an additional code-auditing software system, effective **March 19, 2017.***

This software will enhance auditing of professional and outpatient facility claims for correct coding according to Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT®) and Centers for Medicare & Medicaid Services (CMS) guidelines. Upon implementation, providers may use the Claim Inquiry Resolution tool, available on the Availity™ Web portal, to research specific claim edits. For additional information, watch the *Blue Review*, as well as the News and Updates section of our Provider website.

The above notice does not apply to government programs claims.

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Changes to the Provider Claim Review Form

Effective Jan. 1, 2017, the paper Provider Claim Review Form for Blue Cross Blue Shield Oklahoma (BCBSOK) will be simplified for providers when submitting written claim inquiries.

The most efficient way to request a claim review for specific inquiries is electronically through Availity™ using the Claim Inquiry Resolution (CIR) tool. When you must submit a claim review via paper, it is submitted using one universal Claim Review Form. As a result, this form is utilized for several different reasons; such as, paper corrected claims, requested medical records, claim check denials, or even basic claim reviews.

BCBSOK is streamlining the paper claim review process which will allow more accurate processing. As of Jan. 1, 2017, written claim inquiries must be submitted on one of the specific provider Claim Review Forms listed below. Each Claim Review Form must include the BCBSOK claim number (Document Control Number), along with the key data elements specified on the forms.

New Provider Claim Review Forms:

- Additional Information Form
- Claim Review Form
- Corrected Claim Form

Verification of online claim status is strongly encouraged prior to submitting claim reviews. The most effective way to determine claim status is electronically through your preferred web vendor; such as Availity Claim Research Tool Making use of electronic options allows retrieval of needed information in real-time.

As indicated above, Availity users have access to the Claim Inquiry Resolution tool, which delivers a method of online assistance for specific inquiries on finalized claims. This tool is designed to help save you time by reducing the amount of calls and written inquiries submitted.

To learn more about these online options, view the Provider Tools section in our Education and Reference Center at *bcbsok.com/provider*. For personalized online training regarding electronic tools, contact our Provider Education Consultants at PECS@bcbsok.com.

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New Preferred Statewide Lab Services Effective Jan. 1, 2017

Effective Jan. 1, 2017, LabCorp and Regional Medical Laboratories (RML) are the **preferred statewide** providers for outpatient clinical laboratory services for Blue Cross and Blue Shield of Oklahoma (BCBSOK). Both laboratories have multiple locations statewide, full-time pathologists on staff and convenient technology that provides access to prompt lab results.

While LabCorp and RML are not the only network laboratories available to BCBSOK members, these two preferred laboratories allow members to maximize benefits and lower their out of pocket costs.

NOTE: This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free standing ambulatory surgery centers).

For more information visit the BCBSOK provider website under network participation – Preferred Laboratories.

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UPDATE: New Requirements through EviCore

Blue Cross and Blue Shield of Oklahoma (BCBSOK) has contracted with eviCore healthcare (eviCore)* to provide certain utilization management services for outpatient molecular and genomic testing and outpatient radiation therapy. eviCore is an independent company that provides specialty medical benefits management for BCBSOK.

Preauthorization Requirements
BCBSOK requires preauthorization (for medical necessity) ** through eviCore for outpatient molecular and genomic testing and outpatient radiation therapy. Refer to the eviCore implementation site and select the BCBSOK health plan for the applicable CPT/HCPCS code list and radiation therapy physician worksheets.

Contact Information
eviCore preauthorization's for outpatient molecular and genomic testing and outpatient radiation therapy can be obtained using one of the following methods:

- The eviCore Healthcare Web Portal is available 24x7. After a one-time registration, you are able to initiate a case, check status, review guidelines, view authorizations/eligibility and more. The Web Portal is the quickest, most efficient way to obtain information.
- Providers can call toll-free at **855-252-1117** between 7 a.m. to 7 p.m. (local time) Monday through Friday.
- More specific program-related information can be found on the eviCore implementation site.
- Refer to the eviCore implementation site and select the BCBSOK health plan for provider training orientation presentations.

* eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSOK.
** Preauthorization determines whether the proposed service or treatment meets the definition of medical necessity under the applicable benefit plan. Preauthorization of a service is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

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New Preauthorization Requirement for Applied Behavioral Analysis

Effective **Jan. 1, 2017,** there will be a requirement for a preauthorization for Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder for **eligible** Blue Cross and Blue Shield of Oklahoma (BCBSOK) members**.** Preauthorization for these services is processed through Behavioral Health Medical Management Review, by calling the number on the member's ID card.

Continue to watch the Provider website at **bcbsok.com/provider** and the ***Blue Review*** provider newsletter for additional information regarding the following preauthorization forms:

- Diagnostic Physician/Specialist Evaluation
- Provider Credentials Verification
- Assessment Info and Initial Treatment Plan

Reminders:

- The member must have an Autism Spectrum Disorder diagnosis from a qualified diagnostician.

- The ABA service provider must have the credentials necessary to conduct ABA services.
- An initial functional assessment, including a treatment plan that identifies any deficient skills and the appropriate interventions, must be completed.
- After the first authorization for ABA services, additional authorizations may require concurrent review to ensure the member continues to meet the medical necessity guidelines.
- iExchange® is not available for ABA preauthorization or behavioral health at this time, therefore please call the number on the back of the member's ID card for ABA preauthorization requests.

Please be aware that not all benefit plans within a particular network provide coverage for ABA for the treatment of Autism Spectrum Disorder. Member eligibility and benefits should be checked before every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

Keep in mind that BCBSOK will deny claims for ABA services that do not meet medical necessity criteria and that you perform without preauthorization.

If you have any questions, please contact your BCBSOK Provider Network Representative Lore Holtsberg at 405-316-7199 or Lore_Holtsberg@bcbsok.com.

Please note: The fact that a service or treatment has been preauthorized or predetermined for benefits 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. "Coverage" means the determination of whether or not the particular service or treatment is a covered benefit under the terms of the particular member's benefit plan. A coverage determination is based upon plan documents and (when applicable) a review of clinical information to determine whether clinical guidelines/criteria for coverage are met. Regardless of any benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

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Announcing a New Change for Rehabilitative and Habilitative Services for Members Enrolled in Qualified Health Plans under the Affordable Care Act

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Oklahoma (BCBSOK) will implement a change for rehabilitative and habilitative services that are essential health benefits (EHB) and billed by Physical Therapy, Speech Therapy, and Occupational Therapy providers as well as any other providers that may bill for these services. This new change will apply to Blue Advantage PPO℠ and Blue Preferred PPO℠ members enrolled in qualified health plans under the Affordable Care Act. This does not apply to other BCBSOK plans.

The change impacts visit limits for rehabilitative and habilitative services and devices. Each rendered service should be billed separately since these plans provide coverage for 30 visits per calendar year for inpatient habilitative and rehabilitative services and 25 visits per calendar year for outpatient habilitative and rehabilitative services. As a result of this change, only claims for habilitative services should be submitted with a CPT modifier of SZ. This modifier will be used to identify applicable procedures as habilitative for claims adjudication. This requirement does not impact how rehabilitative services are currently billed.

Reminder:

- Habilitative services are health care services and devices that help a person keep, learn, or improve skills and assist with functioning for daily living. These services could include devices that are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- Rehabilitative services which could include devices are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or a disabling condition.
- When submitting claims for habilitative services, please submit procedure codes with a **CPT** modifier of **SZ**. Refer to your applicable billing policies and procedures for more information regarding applicable rehabilitative and habilitative procedure codes.

Member benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It's strongly recommended that providers **ask to see the member's ID card for current information** and photo ID to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

If you have any questions or if you need additional information, please contact your BCBSOK Network Representative.

Please Note: The fact that a service or treatment has been preauthorized or predetermined for benefits 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. Regardless of any benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

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Flucelvax Quadrivalent Billing Update

Effective Jan. 1, 2017, BCBSOK directs providers to use CPT® Code 90674 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage) when billing for Flucelvax Quadrivalent. Until the CPT code 90674 becomes effective, Flucelvax Quadrivalent should be billed with CPT code 90749 (Unlisted vaccine/toxoid).

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Avoiding Administrative Claim Denials

Blue Cross Medicare Advantage wants to help you avoid administrative claim denials. To prevent denials from occurring, a list of administrative claim denials that providers may receive has been created, along with tips on how to avoid them.

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New Payer ID for Blue Cross Medicare Advantage

Effective **Jan. 1, 2017,** changes affecting claims submissions for Blue Cross Medicare Advantage Plans will assist in streamlining claims processing and improve efficiencies of claims routing to our primary claims adjudicator. The changes are as follows:

New Payer ID

- The Payer ID for the Blue Cross Medicare Advantage plans will change to 66006 for claims submitted on and after **Jan. 1, 2017**. Providers that are not registered with Availity and Experian Health (ecare online) should contact their clearinghouse to confirm the new Payer ID for this plan - as other clearinghouses may assign their own unique number.

Please note that the Blue Cross Medicare Advantage member ID cards will contain the following applicable state alpha prefix:

State	**PPO**	**HMO**
Oklahoma	**YUX**	**YUB**
Illinois	XOD	XOJ
Texas	ZGD	ZGJ
New Mexico	YID	YIJ
Montana	YDJ	YDL

- The above state alpha prefix must be submitted using the new Payer ID 66006, even for members who seek services from you when out of state. **You will no longer use the commercial payer IDs for out of state members with these prefixes.** Claims with these prefixes will be rejected if submitted to the commercial payer ID.

Electronic Inquiry Submission Updates

- Effective for services rendered on and after Jan 1, 2017 –Blue Cross Medicare Advantage eligibility and benefit and claim status inquiry transactions will have a new drop down with payer options available within the Availity Web portal.
  - Blue Cross Medicare Advantage

- Blue Cross Medicare Advantage providers will no longer have access to the Claim Research Tool on Availity. Claim status can be obtained through Availity or your current web vendor via the electronic 276 claim status inquiry process.

Payment Cycle

Payment cycles continue to be weekly. Blue Cross Medicare Advantage will make payments each Monday.

- The paper claim mailbox address and fax number will change to:

Blue Cross Medicare Advantage
P.O. Box 3686
Scranton, Pa. 18505
Fax Number: (855) 674-9192

- Effective Feb. 1, 2017, claims received at the old BCBSOK P.O. Box will be rejected with a letter informing providers to resubmit to the above P.O. Box.

New processes

- New format for payments:
  - EFT trace number:
    - Blue Cross Medicare Advantage will start with a source code of “M” instead of “C”

- A new process will be implemented for claims overpayment recovery:
  - ERM (Electronic Refund Management) claims refund and inquiry process post 1/1/17 will not be available through ERM.
    - Request for refund letters will be sent by mail for all providers
    - Providers may submit requested and voluntary refunds to the new lockbox listed below

  - HCSC will have a new lockbox address for provider overpayments
Health Care Service Claims Overpayment
29068 Network Place
Chicago, IL 60673-1290

Electronic Remittance Advice (835 ERA)

- 835 ERA files will be distributed to the address associated with the billing provider’s Tax ID and NPI, rather than being distributed to multiple locations.

- EPS (Electronic Payment Summary) will not be available for Blue Cross Medicare Advantage (however for ERA and non-ERA receivers the Provider Claim Summary’s (PCS) will be sent by mail.

- If the provider is a current ERA receiver for Blue Cross Medicare Advantage, they will not need to re-enroll under the new Payer ID for Blue Cross Medicare Advantage.

- The Payer ID on the 835 ERA will now match the Payer ID that is submitted on the claim. When submitting Blue Cross Medicare Advantage claims using 66006 the ERA Payer ID will also reflect 66006.

We appreciate your patience during this transition. BCBSOK will be providing additional information and educational webinars on these changes in the coming months. Please watch for further information on the BCBSOK website at bcbsok.com/provider and in the ***Blue Review*** provider newsletter.

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Blue Cross Medicare Advantage Prior Authorization List Effective Jan. 01, 2017

The Blue Cross Medicare Advantage 2017 Prior Authorization List is now available online at bcbsok.com/provider under the Network Participation - Medicare section.

Attending physicians must obtain prior authorization for the services outlined in the Blue Cross Medicare Advantage Prior Authorization List, except in an urgent situation.

For additional prior authorization information for members in the Tulsa area HMO, please contact Customer Service at 1-866-796- 5709.

For additional prior authorization information for members in the Oklahoma City area HMO and all PPO members, please contact Customer Service at 1-877-774-8592.

Plans provided by Blue Cross and Blue Shield of Oklahoma, which refers to a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC) (PPO plans),and also to GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs) (HMO and HMO-POS plans) and GHS Managed Health Care Plans (GHS-MHC) (HMO and HMO-POS plans). HCSC, GHS-MHC, and BlueLincs are Independent Licensees of the BlueCross and Blue Shield Association. HCSC, GHS-MHC and BlueLincs are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's, GHS-MHC's and BlueLincs' plans depends on contract renewal.
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Coordination of Care Between Medical and Behavioral Health Providers

Blue Cross and Blue Shield of Oklahoma (BCBSOK) continually strives to promote coordination of member care between medical and behavioral health providers. We understand that communication between providers regarding the treatment and coordination of a patient's care can pose difficult challenges.

Here are few resources available to you through BCBSOK:

1. **The Coordination of Care Form Available Online:**
   To provide assistance when coordinating care, BCBSOK has created a Coordination of Care form that is available on the BCBSOK provider website.

This new form may help in communicating patient information:

- To provide member treatment information **to** another treating provider
- To request member treatment information **from** another treating provider

It is important to note that a written release to share clinical information with the member's medical provider(s) must be obtained prior to the use of this form. BCBSOK recommends obtaining a written release prior to the onset of treatment.

If you are requesting member treatment information from another provider, it is recommended that the Patient Information and Referring Provider sections of the form be completed in order to expedite the care coordination process for the receiving provider.

The Coordination of Care form is available on the BCBSOK website:

http://www.bcbsok.com/pdf/coordination_care.pdf

1. **If you need help finding a Behavioral Health Provider for your patient:**
   Call the number on the back of the member's BCBSOK card to receive assistance in finding an outpatient provider or behavioral health facility.

2. **Behavioral Health or Medical Case Management Services:**
   If you believe your patient has complex health needs and could benefit from additional support and resources from a clinician, you can make a referral to one of the BCBSOK Case Management Programs by calling the number on the back of the member's BCBSOK card. The Case Management programs can also provide you and the member with information about additional resources provided by their insurance plan.

Prime Pharmacy Network Change Effective Jan. 1, 2017

Effective Jan. 1, 2017 (regardless of renewal policy date), CVS pharmacies and CVS pharmacies in Target stores will no longer be a part of BCBSOK's standard pharmacy network with Prime.

This network change will not impact Medicaid or Medicare member plans at this time.

BCBSOK has made a decision to not include pharmacies within the pharmacy network where a premium reimbursement on generic drugs is requested. In order for BCBSOK to maintain affordable benefits for our members and customers, it is vital to obtain competitive reimbursement rates from participating pharmacies within Prime's network.

Members will continue to have a large selection of retail pharmacy options to fill prescriptions. In every county where BCBSOK has a presence, we exceed network adequacy standards set by the state with the remaining pharmacies in network.

BCBSOK is committed to helping our members find the most convenient alternative for their pharmacy coverage needs. Members can visit https://www.myprime.com/en/find-pharmacy.html to locate a large selection of in-network retail pharmacy locations and resources to ensure a smooth transition of their prescriptions.

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. Please review our online provider directory at Provider Finder. The directory is a helpful tool for providers to refer their BCBSOK patients to other participating providers.

To update your directory information or other provider information such as tax identification numbers, supervising physician information, hospital privileges, etc., please submit the BCBSOK Provider Notification Form via fax to
918-549-2141 or email the form to oknetworkmanagement@bcbsok.com.

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

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Web Changes

- Posted *December Blue Review* to Education and Reference Center/News and Updates/Blue Review page
- Posted Provider Claim Summary report Viewer Application Webinars to the Education and Reference Center/News and Updates
- Posted Availity Claim Research Tool: Enriched Status Results to the Education and Reference Center/News and Updates
- Posted Availity Provider Claim Summary Report Viewer Application Webinars to the Education and Reference Center/News and Updates
- Posted Secondary Code-auditing Software Scheduled for Implementation to the Education and Reference Center/News and Updates

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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