BlueCross BlueShield of Oklahoma
Blue Review℠
A Provider Publication

June 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 June 8, 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

UPDATE: Implementation for Medicare Prior Authorization Requirements through eviCore

Blue Cross and Blue Shield of Oklahoma (BCBSOK) has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to provide Utilization Management services for prior authorization requirements outlined below.

Effective June 1, 2017, Blue Cross Medicare Advantage℠ members will be subject to the prior authorization requirements set forth in this article. eviCore will manage prior authorization requests for the following specialized clinical services effective for dates of service on or after June 1, 2017:

- **Outpatient Molecular Genetics**
- **Outpatient Radiation Therapy**
- **Musculoskeletal**
  - Chiropractic
  - Physical and Occupational Therapy
  - Speech Therapy
  - Spine Surgery (Outpatient/Inpatient)
  - Spine Lumbar Fusion (Outpatient/Inpatient)
  - Interventional Pain
- **Outpatient Cardiology & Radiology**
  - Abdomen Imaging
  - Cardiac Imaging
  - Chest Imaging
  - Head Imaging
  - Musculoskeletal
  - Neck Imaging
  - Obstetrical Ultrasound Imaging
  - Oncology Imaging
  - Pelvis Imaging
  - Peripheral Nerve Disorders (Pnd) Imaging
  - Peripheral Vascular Disease (Pvd) Imaging

    - Spine Imaging
- **Outpatient Medical Oncology**
- **Outpatient Sleep Program**
- **Outpatient Specialty Drug**

The Blue Cross Medicare Advantage Preauthorization Requirements List has been updated to include the **services listed above that require preauthorization through eviCore, for dates of service on or after June 1, 2017.**

Providers can contact eviCore using one of the following methods:

- The eviCore HealthCare Web Portal will be 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.

The rendering provider must obtain prior authorization for services outlined in this notification, except for emergency care or urgent services. PCP referrals are not required if the specialty provider selected is in network.
Services performed without prior authorization and that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

iExchange® services will continue to be available for all other services that require prior authorization.

BCBSOK and eviCore will be providing additional information, including training opportunities, in the coming months. Please continue to visit the bcbsok.com/provider site and the *BCBSOK Blue Review Newsletter* for updates.

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.

* 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.
** Prior authorization determines whether the proposed service or treatment meets the definition of medical necessity under the applicable benefit plan. Prior authorization 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.

Q.I.S. or Quality Improvement Strategy

The Affordable Care Act contains a provision for health plans to develop and maintain a "quality improvement strategy" designed to improve health outcomes or reduce health disparities. Additionally, CMS requires the intervention is to be grounded in "market-based" incentives to better align with value-based reimbursement. The incentive link also allows for "in kind" incentives. This requirement is triggered after two years of participation in the retail marketplace. Therefore, Blue Cross and Blue Shield of Oklahoma (BCBSOK) submitted a Q.I.S. in the fall of 2016.

Our Q.I.S. builds upon the success of the program developed by the Health Care Service Corporation Pharmacy team called Pharmacists Adding Value and Expertise (P.A.V.E.). In the BCBSOK version, however, we are using a contract clinical pharmacist for the intervention instead of the member's retail pharmacy. The intervention is fueled by data analytics within Pharmacy calculating measures of adherence of medication use from claims. The clinical pharmacist then targets members with suboptimal adherence with communications designed to pinpoint the barriers to adherence. Non-adherence tends to fall into a handful of categories, some of which can often be easily overcome by moving to a Tier 1 medication, synchronizing refills, arranging for 90 day supplies, and/or use of mail order. P.A.V.E. was rolled out in IL, MT, and NM Albertson's stores serving Medicare Advantage members in January 2016 yielding a 46% improvement in member engagement.

The details of the BCBSOK Q.I.S. include a target population of on-exchange retail members with diabetes. The outcome of interest is a simple laboratory test of average three month diabetes control called the hemoglobin A1c (or Hgb A1c). A value less than 8% is considered "in control". We routinely collect this clinical data, when available, for HEDIS measures in all populations. We are using a convenience sample to gather and aggregate these lab results.

The aim of the intervention is to improve adherence with anti-hyperglycemic medications in order to achieve better diabetes control. If successful, this intervention should result in improved Hgb A1c measures across the board for this population. Our baseline measure in 2015 was only about 35% of the population having a Hgb A1c <8%. Our preliminary 2016 data reveals the proportion increased into the over 40% range, most likely as a result of increased attention to this specific outcome of diabetes care in CPC and Medicare Advantage. Our end goal for 2017 is to achieve a proportion of at least 55% of on-exchange members with diabetes having a Hgb A1c of <8% for the last measure of the calendar year.

Quality Improvement Strategy
The ACA* requires health insurance plans participating on the marketplaces to maintain a "quality improvement strategy" designed to prevent hospital readmissions, improve health outcomes, reduce health disparities and meet other quality improvement goals. In their recent proposed Notice of Benefit and Payment Parameters, the Centers for Medicare and Medicaid Services (CMS) implement this requirement with a focus on quality improvement strategies that are grounded in "market-based" incentives that use value-based purchasing concepts. The proposed rule also emphasizes the importance of aligning insurers' provider payment and quality improvement strategies with those efforts already underway in the Medicare program and other public and private sector payment reform initiatives. In explanation, CMS says: "We believe that aligning…standards for quality improvement strategies in Exchanges with existing initiatives will reinforce national health care quality priorities while reducing the burden on health plans and stakeholders…."

CMS is proposing that insurers that have been participating in the marketplaces for at least two years be required to implement the quality improvement strategy. Beginning in the fall of 2016, insurers that participated in one or more marketplaces in 2014 and 2015 will have to submit a quality improvement plan to CMS, followed by annual progress updates.

***Source for A.C.A. information**: http://chirblog.org/whats-happening-with-affordable-care-act-requirements-for-quality-improvement/

Insurers Required by CMS to Conduct ACA Risk Adjustment Program Audit

In 2017, the Centers for Medicare and Medicaid Services (CMS) will conduct another Initial Validation Audit (IVA) to validate the data used when assessing the payment transfers for the Affordable Care Act's (ACA) Risk Adjustment (RA) program. The provider's role is essential to the success of the IVA. Therefore, if any of your patients are selected to be included in the IVA, Blue Cross and Blue Shield of

Oklahoma (BCBSOK) is asking for your cooperation and commitment to fulfilling the requirements of the IVA.

The IVA is expected to begin in June of 2017 BCBSOK will be working with Tactical Management Incorporated (TMI) to retrieve the requested medical records that we have to submit to our IVA auditor. Our IVA auditor requires medical records in order to validate the sampled member's risk score calculation which is based on the diagnosis codes submitted on a member's claims, as well as through supplemental diagnosis submissions based on medical record review. As BCBSOK providers, you may be asked to provide medical records directly to TMI in order to validate all of the diagnosis codes used in the ACA RA risk score calculation. Please respond to these requests in a timely manner. It is important to have a successful audit to improve the healthcare delivery system.

The IVA will be performed on a sample of members enrolled in ACA-compliant individual and small group plans, both on and off-exchange. Our IVA auditor will validate medical claims of the sampled members from the previous calendar year. For example, this IVA will be conducted in 2017, but will review claims with dates of service in 2016. Please be aware some of these claims may have been paid in 2017 and are likely to be included in the IVA sample.

We understand that this is a very busy time; however, in an effort to comply with CMS' requirements, we appreciate your full support and cooperation as you receive requests from TMI and deliver the requested medical record(s) in a timely manner.

If you have any questions, please contact your Network Representative.

Medicare Advantage Overpayment Recovery

A new process was implemented for overpayment recovery on claims processed after January 1, 2017.

- The Electronic Refund Management and Claim Inquiry Resolution tools on Availity are no longer available for government programs claims.
- Request for refund letters will be sent **by mail** for all providers.
- Please review your refund letter closely and remit your refund to the address indicated on the letter.
- If you identify an overpayment and wish to send a **voluntary** refund, please use the following grid to determine the appropriate address:

Product	Original Claim Check Date	Send to Address
MA	**Pre 1/1/17**	Health Care Service Corporation 25718 Network Place Chicago, IL 60673-1257
MA	**Post 1/1/17**	Health Care Service Corporation Claims Overpayment 29068 Network Place Chicago, IL 60673-1290

In the event that you are unsure about the original payment date, please send payments to:

Health Care Service Corporation 25718 Network Place Chicago, IL 60673-1257

Oklahoma Diabetic Eye Health Alliance

On November 14, 2015 the Board of Directors of the Oklahoma Association of Optometric Physicians (OAOP) made a commitment to provide expedient, comprehensive eye care to diabetic patients. The resolution called for the association to "develop and implement a statewide program to ensure the provision of timely optometric care to diabetic patients and to communicate findings to the other members of the diabetic patient's health care team." A task force was immediately assembled, and the "Oklahoma Diabetic Eye Health Alliance" began to take shape. OAOP learned a great deal from the experience of the Pennsylvania optometrists who have operated a similar program for more than eight years.

The Oklahoma Diabetes Eye Health Alliance is a voluntary program in which Oklahoma optometrists are asked to formalize their commitment to the interventions by signing a letter of agreement. Knowing that Oklahoma optometrists are already providing excellent care to diabetic patients, it is our hope that all members will embrace the additional components of this program that solidify optometry's role as primary eye care providers. Participating optometrists commit to a certain standard of care that includes dilated fundus exams, seeing diabetic patients expediently, and communicating exam results to the patient's primary care provider and other members of the health care team as appropriate.

Our members and the primary care clinician network can expect to see the following outcomes when engaging with this program:

1. The results of all examinations will be communicated to the health care professionals involved in the care of every diabetic patient, with emphasis on the diabetic patient's primary care physician. Other reports may be generated for referring ophthalmologists, internists, diabetologists, endocrinologists, etcetera as appropriate.

2. The optometrist will provide expedient scheduling to every diabetic patient, with every effort made to schedule the patient within 1 week, or at the time interval of the physician requesting the consult.

3. The participating optometrist will provide consistent reporting to third party payers for every diabetic patient and ensure proper billing and coding for all diabetic patients, including billing the patient's medical insurance for medical exams when available.

The end result will lead to improved access and communication. The HEDIS scores for diabetes care: eye exam improved from 30-40% to 70-80% within a few years of beginning the intervention in that state.

For more information about the Pennsylvania program visit the Pennsylvania Optometric Association website. The OAOP website may be found at oaop.org

Real Time Notification of Preauthorizations and Predeterminations

Beginning April 1, 2017, we implemented electronic facsimile (fax) notification of benefit preauthorization and predeterminations to the requesting provider. This enhancement provides real time information and eliminates the need for providers to check the status of preauthorization or predetermination requests while waiting on the mailed notification letters. The faxed notification will be in addition to the notification letter delivered via mail, to the mailing address we have on file for you.

Notifications will be faxed to the number on file for you, or the number listed on the utilization management or clinical request or clinical we received from you. You can also check the status of your submitted request via iExchange.

As a reminder, because we are sending confidential protected health information (PHI) to your fax machine, it should be in a secure location that is not accessible to those who do not have the authority to review member/patient PHI.

If you do not wish to receive faxed notifications, please contact your BCBSOK network representative.

Please note that information regarding 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. 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. If you have questions, contact the number on the member's ID card.

Feature Tip

FEP® Self-Measured Blood Pressure Monitoring

The Blue Cross and Blue Shield Federal Employee Program® (FEP) and the American Medical Association (AMA) are working together to provide physicians with resources designed to help improve health outcomes for patients with hypertension or suspected hypertension. This effort supports the goals of the Million Hearts® initiative.

Information covering self-measured blood pressure monitoring, a component of the Improving Health Outcomes: Blood Pressure Program developed by the AMA, is designed to help you and your office staff engage your patients in the self-measurement of their own blood pressure.[1] According to a 15-member task force appointed by the Centers for Disease Control and Prevention (CDC), when physicians and their office staff engage their patients in the self-measurement of their own blood pressure combined with additional support (i.e., patient counseling, education or web-based support), self-measured blood pressure monitoring becomes very effective and cost efficient.[2]

In support of this effort, FEP initiated a program to provide free blood pressure monitors* to FEP enrollees over age 18 who have a diagnosis of hypertension or have high blood pressure without a diagnosis of hypertension. If your patient completes the Blue Health Assessment (BHA) and reports they have high blood pressure and you and your patient discuss home monitoring, your patient is eligible to receive a free blood pressure monitor. The BHA is a health-risk assessment and the first step in the FEP Wellness Incentive Program. In addition to the free blood pressure monitor, members can earn financial incentives for completing the BHA and for achieving goals related to a healthy lifestyle. FEP members can go to www.fepblue.org for more information.

Please do not hesitate to contact FEP Customer Service at 800-722-3130 for more details regarding this program.

[1] American Medical Association Practice Improvement Strategies, Steps Forward Program, https://www.stepsforward.org/

[2]Cardiovascular Disease: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control – When Used Alone, June 2015, http://www.thecommunityguide.org/cvd/RRSMBP.html

*The blood pressure monitors were selected by BCBS. The AMA does not endorse any particular brand or model of blood pressure monitor.

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

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In the Community

Members Receive a Discount on Route 66 Marathon Events

Blue Cross and Blue Shield of Oklahoma (BCBSOK) is proud to be the presenting sponsor of the 2017 Williams Route 66 Marathon events, scheduled for Nov. 18-19 in downtown Tulsa. BCBSOK members can receive a 10 percent discount by using the code **BCBSOK17** when registering online. The discount applies to BCBSOK members only, and we respectfully ask that this code not be shared with nonmembers.

The race events include a 5K and one mile fun run on Saturday, Nov. 18 and a marathon, half marathon and marathon relay on Sunday, Nov. 19. The race weekend also includes the Health and Fitness Expo at the Cox Business Center in downtown Tulsa. The expo will be held on Friday, Nov. 17 from 11 a.m. to 8 p.m. and Saturday, Nov. 18 from 9 a.m. to 6 p.m. The two-day expo is free, open to the public and includes more than 50 exhibitors featuring running gear and shoes, as well as sports and fitness related items. The expo is also the location of the packet pick-up for all participants and volunteers.

Race registration prices increase periodically, so sign up today for the lowest registration rate. Visit route66marathon.com to learn more.

"Be Smart-Don't Start" Celebrates 14th Successful Year

On Friday, May 12, Blue Cross and Blue Shield of Oklahoma (BCBSOK) sponsored "Be Smart-Don't Start Anti-Tobacco Day" at Science Museum Oklahoma (SMO). More than 2,300 guests received free admission to SMO, courtesy of BCBSOK. Approximately 2,700 guests including 1,700 students represented 20 schools from across the state.

To help educate school-aged children about the dangers of tobacco use, BCBSOK initiated the Be Smart-Don't Start program in 2004, teaching thousands of Oklahoma youth how to live a healthy lifestyle and make smart choices.

The program includes an anti-tobacco curriculum that is distributed to over 900 teachers in 620 schools through Newspapers in Education and published in The Oklahoman, impacting almost 200,000 students and over half a million Oklahoma citizens.

According to the Oklahoma State Department of Health, approximately 3,300 children under the age of 18 will become new smokers each year, setting them up for serious health risks throughout their lives. The Be Smart-Don't start program uses fun hands-on, educational activities as a prevention tool to help address the rising issue.

Additional Be Smart-Don't Start program partners included American Cancer Society, American Lung Association, Oklahoma City Energy FC, Oklahoma City-County Health Department, Oklahoma State University, and University of Oklahoma.

BCBSOK's Mobile Assistance Center was on-site with healthy trivia and giveaways for students, along with BCBSOK mascot Blaze, the Braggin' Blue Dragon®. The official "Be Smart-Don't Start" music video, which premiered at the 2016 event, was also distributed electronically to more than 600 schools in Oklahoma.

Reporting On-Demand

The Reporting On-Demand application is available in the BCBSOK branded Payer Spaces section on the Availity Web portal. This tool permits registered Availity users to readily view, download, save and/or print the Provider Claim Summary (PCS) online, and other reports as they become available.

For more details on viewing the PCS online, refer to the Reporting On-Demand: Online Provider Claim Summaries Tip Sheet. To register with Availity and gain access to the application, visit availity.com.

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.

Web Changes

- Posted *May Blue Review* to Education and Reference Center/News and Updates/Blue Review page

- Posted Government Programs: 835 ERA Files Displaying '0' in the Check Number Field Education and Reference Center/News and Updates
- Posted One Way BCBSOK is Taking on Asthma in May 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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