BlueCross BlueShield of Montana

# BLUE REVIEW℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS — THIRD QUARTER 2017

## INSIDE THIS ISSUE

# Looking at Variability in Pricing Solutions through Shared Data

How often someone uses health care services, where they go for care, and how much they pay for care are foundational issues in the ongoing struggle to control the nation's rising health care costs.

A comprehensive, independent study published by Health Care Cost Institute shows that employers and insurers that provide private health coverage can pay for services that vary widely in price, depending on the state where people live. Further, they found that prices can even vary across a broad range within the same cities and metropolitan areas, based on site of service and contracting rates. Those price differences exist for even the most routine diagnostic procedures.

Wide differences in prices for the most common medical services is one potential cost driver that Blue Cross and Blue Shield of Montana (BCBSMT) works to impact. Variability of pricing is a leading cause of unnecessary health care spend for our members.

Broad ranges in pricing across the state are found in common as well as high-cost procedures. Moreover, there is no consistent correlation between cost and quality (i.e., higher cost does not necessarily equate to higher quality).

While most health care consumers have yet to establish a habit of researching how much a procedure will cost them in advance, BCBSMT is working to change that behavior. We've implemented a new program, Benefit Value Advisor, that helps members get cost estimates, schedules appointments, assists with pre-certification, and provides educational resources for procedures like CAT scans, MRIs, endoscopy and colonoscopy procedures, and surgeries like joint replacement and bariatric surgery.

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## PROVIDER NETWORK REPRESENTATIVE CONTACT INFORMATION

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Our *Blue Review* provider newsletter is produced quarterly for participating professional and institutional providers across all lines of business (commercial and government programs). The newsletter serves as a vehicle to communicate timely, consistent and relevant messaging related to:

- New products, programs and services available at BCBSMT
- Notification of changes as required by contract or other mandates
- Member initiatives and patient resources

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Cost and quality transparency and actionable data will enable payers and providers to better collaborate on ways to make health care more affordable. BCBSMT is rolling out new data solutions this year and next that will help inform providers' clinical decisions and give them deeper insights into their care costs and quality.

Providers will have increased electronic access to members' health summaries before or at the time of service. They also may see unmet health care needs or avoid the cost and inconvenience of a member receiving redundant or unnecessary treatment with access to the health summaries.

Additionally, new performance and quality reporting will help providers pinpoint and prioritize opportunities for cost and quality improvements. These tools make transparent information that can help identify factors that explain the cost impact caused by variability in pricing.

These are a few examples of how BCBSMT is helping to make the health care system work better, together with providers, for the benefit of health care consumers.

Amy Barbour, a customer service specialist in the Benefit Value Advisor program, says the typical member's mindset about health care is at odds with how Americans generally approach other choices. "While people would never dream of not knowing the price of a part for a car repair," she says, "in the medical world, not knowing the costs doesn't seem to throw them for a loop."

But Barbour believes things are slowly changing. "Ten years from now, I think it will be unheard of to not know health care costs in advance."

Sources:

http://www.modernhealthcare.com/article/20160427/NEWS/160429918

https://www.theatlantic.com/health/archive/2012/09/how-transparency-can-empower-patients-and-fix-health-care/262531/

https://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html?_r=1

http://healthaffairs.org/blog/2015/12/30/making-sense-of-price-and-quantity-variations-in-u-s-health-care/

http://www.healthcarepricingproject.org/

http://www.medscape.com/viewarticle/776951

## Healthy Montana Kids (HMK)

HMK has implemented a dedicated phone and fax line for preauthorization requests. Please use the following information:

- For pre-authorization, **855-699-9907**
- HMK Intake Fax line, **855-610-5684**

## Provider Manuals

On an annual basis BCBSMT reviews and updates the following Provider Manuals:

- HELP Plan Provider Manual
- Medicare Advantage (MA) Provider Manual
- Commercial Provider Manual

# BlueCard Program Reminder Checklist

The BlueCard program is designed to help our members take their benefit coverage with them when they travel. It also offers providers access to an electronic network for claim submission and reimbursement.

As a result, while you may see multiple patients from out-of-area Blues Plans, you still have one source for claim filing in most instances – your local Blue Plan. For Montana providers, that's BCBSMT.

Here's a quick checklist of important reminders:

- Ask members for their current ID card. BlueCard members have a suitcase logo on their ID card. Also ask for a photo ID to confirm the member's identity.
- Verify the member's eligibility, benefits and copayments. For faster processing, verify coverage electronically through Availity™, or your preferred vendor portal.
- When recording the member ID number, be sure to include the three-digit alpha prefix. This indicates the member's group.
- Submit BlueCard claims to BCBSMT electronically. Do not submit duplicate claims.
- Check claim status online. Check the status of the original claim online by submitting an electronic claim status request to BCBSMT provider portal. Or, use the Availity Claim Research Tool for enhanced claim status.

For additional information on our BlueCard program, refer to the BlueCard Program Provider Manual in the Standards and Requirements/BlueCard Program section of our website at bcbsmt.com/provider.

Verification of eligibility and/or benefit information 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, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered, including benefit limitations and exclusions.

## Medicare Advantage Overpayment Recovery

As a reminder, 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 are sent **by mail** when overpayments are identified on government programs claims.
- Please review your refund letter closely and remit your refund to the address indicated on the letter. Please include a copy of your refund request letter along with your refund.
- 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 Date | Send to Address |
|---|---|---|
| MA | **Pre 1/1/17** | BCBSMT<br>P.O. Box 5089<br>Helena, MT 59604-9954 |
| MA | **Post 1/1/17** | Claims Overpayment Department<br>29068 Network Place<br>Chicago, IL 60673-1290 |

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

  Claims Overpayment Department
  P.O. Box 731431
  Dallas, TX 75373-1431

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 BCBSMT. BCBSMT makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendors directly.

# Has your information changed? Let us know!

When seeking health care services, our members often rely upon the information in our online Provider Finder®. In particular, potential patients may use this online tool to confirm if you or your practice is a contracted in-network provider for their health care benefit plan. Other providers may use the Provider Finder when referring their patients to your practice.

We encourage you to check your own information in the Provider Finder – look for the link on our Provider website Home page at bcbsmt.com/provider. Is your online information accurate? If changes are needed, it's important that you inform BCBSMT as soon as possible.

### USE OUR ONLINE CHANGE REQUEST FORMS

For ease of use, we have placed the Update Office Information form in three different locations to help you update your information:

- Visit the **Network Participation/Update Your Provider Network/Information** (printed and faxed/mailed)
- Visit the **Education and Reference/Forms and Documents** (printed and faxed/mailed)
- Log into the Secured Provider Portal, and access the **Update Office Information** link (automatic submission).

You can request most changes online by using one of our electronic change request forms and the instructions are included on each form.

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## Medical Policy Updates

Medical policies, both new and revised, are used as guidelines for benefit determinations in health care benefit programs for most BCBSMT members, unless otherwise indicated. These policies may impact your reimbursement and your patients' benefits. You may view active, new and revised policies, along with policies pending implementation, by visiting the **Standards and Requirements/Medical Policy** section of our Provider website. Select "View all Active and Pending Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the **Medical Policies** Home page.

You may also view draft medical policies that are under development, or are in the process of being revised, by selecting "View and comment on Draft Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the **Draft Medical Policies** page. Just click on the title of the draft policy you wish to review, and then select "Comments" to submit your feedback to us.

Please visit the **Standards and Requirements/Medical Policy** section of our Provider website for access to the most complete and up-to-date medical policy information.

The BCBSMT Medical Policies are for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own clinical judgment based on each individual patient's health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Some benefit plans administered by BCBSMT, such as some self-funded employer plans or governmental plans, may not utilize BCBSMT Medical Policies. Members should contact the customer service number on their member ID card for more specific coverage information.

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You can request various different changes using the forms which guide you in organizing your information, as follows:

1. **Request Demographic Information Changes**
   Use this form to request changes to your practice information currently on file with BCBSMT (such as address, email or NPI). You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) NPI. As a participating provider, your NPI(s) should already be on file with BCBSMT. You may use this online form to request changes, such as deactivation of an existing NPI.

2. **Request an Additional Location**
   Use this form to notify BCBSMT that a new location needs to be added to your Provider practice. Please remember to include an effective date and the appropriate payment address information.

3. **Request Removal of Provider from Group**
   Use this form to notify BCBSMT when an individual provider is leaving any or all of your practice locations.

Please note that changes are not immediate upon submission of an online change request form. Processing can take a minimum of 30 business days. If you would prefer to mail or fax your changes to BCBSMT, there is a downloadable Provider Information Change Request Form in the Education and Reference/Forms section of our Provider website. If you have any questions or need assistance, contact Network Management at HCS-X6100@bcbsmt.com.

### EXCEPTIONS TO THE ONLINE REQUEST PROCESS

The following types of changes are more complex and require special handling:

- **Multiple changes, especially changes involving more than one billing NPI –** This type of change or request should be submitted via email to HCS-X6100@bcbsmt.com, or by calling **800-447-7828** extension **6100**.
- **Tax ID changes that involve Legal Business Name changes –** This type of change often requires a new contract. To request a contract application, visit the Network Participation/Contracting section of our Provider website.
- **Ancillary provider changes –** Skilled nursing facilities, home health agencies, hospice, home infusion therapy, durable medical equipment (DME) suppliers, orthotics and prosthetics, dialysis centers, and other ancillary providers may request changes by sending details to HCS-X6100@bcbsmt.com, or by calling **800-447-7828** extension **6100**.

## Clinical Payment and Coding Policy Posted

BCBSMT is implementing clinical payment and coding policies based on criteria developed by specialized professional societies, national guidelines (e.g. Milliman Care Guidelines (MCG)) and the CMS Provider Reimbursement Manual. Additional sources are used and can be provided upon request. The clinical payment and coding guidelines are not intended to provide billing or coding advice but to serve as a reference for facilities and providers.

The following policies are getting implemented:

- Preventive Services Policy - effective 08/09/17
- Psychological and Neuropsychological Testing - effective 09/04/17

Refer to Clinical Payment and Coding Policies under Standards and Requirements on the bcbsmt.com/provider for details on the policies being implemented and additional information on when they apply.

# Blue Cross Medicare Advantage 2018 Prior Authorization Guidelines

On January 1, 2018 BCBSMT's Medicare Advantage PPO plan and Medicare Advantage HMO plan will have some changes to the list of procedures requiring preauthorization. The grid below includes services that are Prior Authorized internally and services that are Prior Authorized through eviCore. For the complete grid by procedure code, please refer to the following webpage - bcbsmt.com/provider/network-participation/blue-cross-medicare-advantage.

| Prior Authorization rules - Medicare Medical / Surgical/Behavioral Health | |
|---|---|
| **PREAUTHORIZATION REQUIREMENTS* through eviCore - Effective 01/01/2018** | |
| 1. Cardiology<br>2. Radiology<br>3. Medical Oncology<br>4. Molecular Genetics<br>5. Musculoskeletal - (PT/OT/ST;Spine/Joint/Pain/Chiro)<br>6. Radiation Therapy<br>7. Sleep<br>8. Specialty Drug | Utilizing the eviCore Healthcare Web Portal is the most efficient way to initiate a case, check status, review guidelines, view authorizations / eligibility and more url: https://www.evicore.com/healthplan/bcbs OR<br>Call toll-free at **855-252-1117** between 7 am -7 pm local timeMonday through Friday except holidays.<br>TX ONLY between 6 am to 6 pm central time Monday through Friday and between 9 am-noon central time on Saturdays, Sundays, and legal holidays. |
| *including Network Exceptions including Out of Plan or Out of Network (due to Network Adequacy) for managed programs | |
| Note: For specific codes that apply, please access url: https://www.evicore.com/healthplan/bcbs<br>For a full list of services, visit the BCBS eviCore webpage at BCBS.com/provider under Clinical Resources. | |
| Prior Authorization rules - Medicare Medical / Surgical/Behavioral Health through Blue Cross Blue Shield call toll free 877-774-8592 between 8 a.m. to 8 p.m. (CST) Monday through Friday except holidays. | |
| **Network Participation** | |
| Out of network providers must seek prior authorization for all services. The exceptions are for emergency services and services provided by I.H.S. | |
| **Notification Requirements** | |
| In cases of an emergency, notification is required within one business day of admission. | |

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## Blue Cross Medicare Advantage Electronic Claim Submission Edits

Beginning Sept. 16, 2017, BCBSMT will implement new electronic claim submission validation edits for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ Professional and Institutional claims (837P and 837I transactions). These claim edits will be applied to claims during the pre-adjudication process to help increase efficiencies and to comply with Medicare data reporting requirements.

Currently, these validation edits impact Blue Cross Medicare Advantage claims throughout the claim adjudication process, as well as in post-adjudication encounter data reporting, which can result in claim rejects or denials for missing data elements. Providers submitting these claims electronically on or after Sept. 16, 2017, may see new edit messages on the response files from their practice management system or clearinghouse vendor(s) before the claim is adjudicated. These responses will specify if additional data elements are necessary. If you receive claim rejections, the affected claims must be corrected and resubmitted with the needed information as specified in the rejection message.

As a reminder, Blue Cross Medicare Advantage electronic claims that are submitted through Availity™ or Experian Health must be submitted using Payer ID 66006. If these claims are submitted via direct data entry through the Availity Web portal, providers should select the drop-down payer option of "Blue Cross Medicare Advantage." Providers who are not registered with Availity or Experian Health should contact their clearinghouses to confirm the appropriate Payer IDs to be used when submitting Blue Cross Medicare Advantage claims, as other clearinghouses may assign their own unique numbers.

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| **Medical Necessity** | |
|---|---|
| Medical necessity must be met for all services regardless if prior authorization is required. All services are subject to retrospective review and recoupment in accordance with State and Federal rules and regulations. | |
| **Inpatient Facility Admission Summary** | |
| All planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse). Elective admissions must have prior authorization before the admission occurs. | |
| All unplanned inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse). Notification must be made within one business day of admission to the facility. | |
| Admission to a skilled nursing facility, a long term acute care hospital (LTACH) or a rehabilitation facility. | |
| All residential treatment program admissions. | |
| **Limitations Of Covered Benefits by Member Contract** | |
| This list is not exhaustive. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Consult the member benefit booklet, or contact a customer service representative to determine coverage for a specific medical service or supply. | |
| **Covered Service** | **Prior Authorization** |
| Allergy care, including tests and serum | Please refer to the procedure code list for Authorization Requirements |
| Bariatric surgery | Yes |
| Blepharoplasty | Yes |
| Botox Injections | Yes |
| Chemotherapy and Radiation Therapy | Yes |
| DME - Medical supplies, Orthotics and Prosthesis (Any single durable medical equipment prosthetic and orthopedic device greater than $1500) | Please refer to the procedure code list for Authorization Requirements and Accumulated Annual limits without authorization |
| Emergency dental care | Yes |
| Ground and air ambulance | Ground - No |
| | Air - Yes |
| Hearing services and devices | Yes |
| Home health care and intravenous services | Please refer to the procedure code list for Authorization Requirements |
| Hospital services (inpatient, outpatient) | Please refer to the procedure code list for Authorization Requirements, Skilled nursing facilities in IL are reviewed through eviCore. Inpatient stays with services that are managed by eviCore will be reviewed through eviCore. |
| Hyperbaric Oxygen | Yes |
| Injections | Please refer to the procedure code list for Authorization Requirements |
| Implantable Devices | Yes |
| Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests | Please refer to the procedure code list for Authorization Requirements |
| Long Term Acute Care (LTAC) | Yes, (LTAC facilities in IL only are reviewed through eviCore) |
| Minor surgeries | Please refer to the procedure code list for Authorization Requirements |
| Network Exceptions including Out of Plan or Out of Network (due to Network Adequacy) | Please refer to the procedure code list for Authorization Requirements |
| Nutritional counseling services | Please refer to the procedure code list for Authorization Requirements |
| Nutritional products and special medical foods | Yes |

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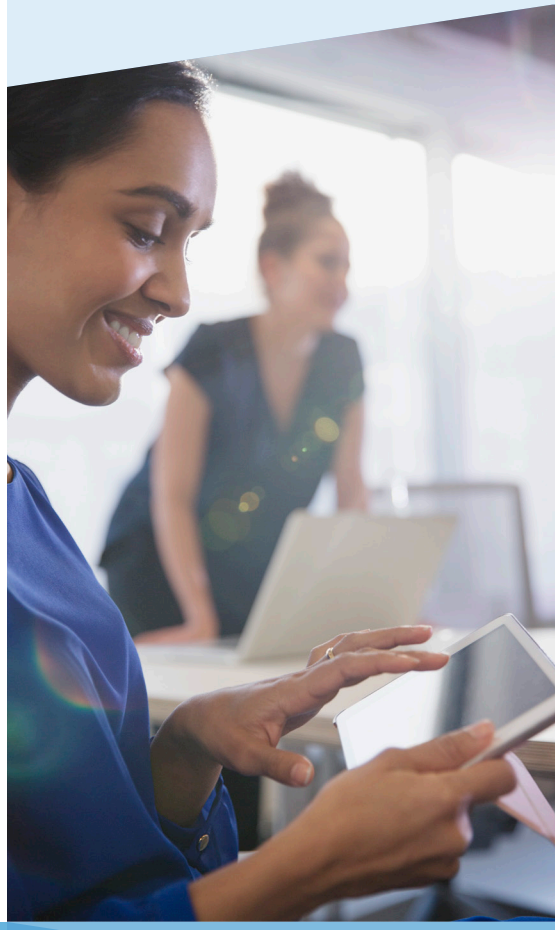
If you have questions regarding an electronic claim rejection message, contact your practice management/ hospital information system software vendor, billing service or clearinghouse for assistance. For additional information on electronic options, refer to the **Claims and Eligibility/ Electronic Commerce section** of our Provider website.



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| Covered Service | Prior Authorization |
|---|---|
| Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants | No |
| Podiatry (foot and ankle) services | Yes |
| Personal care services and private duty nursing (home- or school-based) for children under age 21, who qualify under the EPSDT program | Yes<br>If your child is disabled, he or she may qualify for more services. Please call Customer Service and ask to speak with a Care Coordinator/Case Manager for more information. |
| PET, MRA, MRI, and CT scans | Please refer to the procedure code list for Authorization Requirements |
| Routine physicals | No |
| Second opinions (in network) | No |
| Skilled Nursing Facilities | Yes, (SNF facilities in IL only are reviewed through eviCore) |
| Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation | Yes, Please refer to the procedure code list for Authorization Requirements |
| **Covered Service** | **Prior Authorization** |
| Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants | Please refer to the procedure code list for Authorization Requirements; all transplants and pre-transplant evaluation require prior authorization |
| Intersex Reassignment Surgery 55970, 55980 | Yes |
| **Summary of Services and Behavioral Health UM requirements**<br>*Providers requesting services for Texas Medicare Advantage HMO Plans should contact Magellan for authorization requirements | |
| **Covered Service** | **Prior Authorization** |
| All Inpatient Stays Facilities/Hospitals | Yes |
| All Network Exceptions | Yes |
| Partial Hospitalization | Yes |
| Psychological/Neuropsychological Testing | Please refer to the procedure code list for Authorization Requirements |
| Electroconvulsive Therapy | Yes |
| Transcranial Magnetic Stimulation | Yes |
| Outpatient Services | Please refer to the procedure code list for Authorization Requirements |
| Please view the comprehensive preauthorization grid for a list of procedure codes that require review. The PDF document allows for bookmarking and searching for the code. | |

Blue Cross and Blue Shield of Montana (BCBSMT) has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to provide preauthorization for expanded outpatient and specialty utilization management.

** 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.

## CNI Advantage, LLC to Begin Perm Medical Review Process

CNI Advantage, LLC will begin the Payment Error Rate Measurement (PERM) medical record review process in August 2017. PERM participation is required under the Federal Improper Payments Elimination and Recovery Act (IPERA) of 2010. CNI will begin contacting providers for CHIP, HELP, and Medicaid claims that have been sampled for review. Providers are encouraged to respond to CNI within the given timeframe, submit all requested documentation, and return the documentation with the claim-specific cover letter for each claim pulled for review.

Please contact **Krista Cronholm** with DPHHS Program Compliance Bureau for any PERM questions at **406-444-9365**, KCronholm@mt.gov.

Providers may also visit the CMS provider web page at any time to become familiar with the entire PERM Process.

# Integration of Prime Therapeutics® and Walgreens® Specialty Pharmacy and Mail Order Services

BCBSMT's pharmacy benefit manager (PBM), Prime Therapeutics LLC (Prime), and Walgreens announced a strategic alliance in August 2016 to create a first-of-a-kind model for pharmacy benefit management that aligns a national pharmacy chain, a leading PBM and health plans, including a long-term retail pharmacy agreement. As part of this alliance, Prime and Walgreens have formed a combined company for specialty pharmacy and mail order services, headquartered in Orlando, FL.

Teams have been working to unite each organization's mail service and specialty pharmacy operations. As of mid-August 2017, all BCBSMT members whose pharmacy benefits are administrated through Prime will have been integrated into the new combined company's pharmacy systems.[1] A summary of the changes you might experience from this integration is included below for your reference.

### SPECIALTY PHARMACY SERVICES

As of July 15, 2017, BCBSMT members were integrated into the new specialty pharmacy system. The new company is nationally accredited by ACHC and URAC. Any additional accreditation and licenses will be pursued as needed. Additionally, a vast selection of previously labeled limited distribution products will be available through Prime Therapeutics Specialty Pharmacy.

There are no changes to the way you submit a prescription. The following remains the same:

- The name used when e-prescribing: Prime Therapeutics Specialty (as of 4/5/2017)
- The fax number used to send prescriptions
- The Prior Authorization process; patient prior authorization approvals on file were transferred and will follow the BCBSMT process for renewals
- The number you call to reach Prime Specialty Pharmacy: **877-627-MEDS**(6337)
- The hours of operation: Monday-Friday, 8:00 a.m. – 8:00 p.m., ET

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## New ClaimsXten™ Rules to be Implemented

Beginning on or after September 18, 2017, BCBSMT will implement 4 new rules to the ClaimsXten software database. These new rules are defined as:

**Add On Without Base Code** – This rule will identify claim lines containing a CPT/HCPCS add-on- code billed without the presence of one or more related primary service/base procedure codes. According to American Medical Association (AMA), "add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code."

**Global Component Billing –** This rule will identify procedure codes which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule will also identify when duplicate submissions occur for the total global procedure or its components across different providers

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For prescriptions coming to your location, you may notice changes in Prime Therapeutics' communications and packaging, including:

- The use of the Prime Specialty Pharmacy and Walgreens names/logos may both appear on the packing receipt, enclosed information sheets, stickers on the box, etc.
- Cooler/cooler packaging and the box holding the medicine may look different
- The label affixed to the front of the box may show a dispensing location other than Orlando, FL

## MAIL ORDER SERVICES

Covered 90-day supply mail order prescriptions are being filled by the PrimeMail by Walgreens Mail Service home delivery program as of August 18, 2017.

There is a new way to submit a prescription electronically:

- For patients with expired/no remaining refill prescriptions, you will need to provide a new prescription. If submitting this prescription electronically after August 18, you will need to send it to Walgreens Mail Service in Tempe, AZ, or you can fax the prescription to **800-332-9581**.

**Please Note:** Existing PrimeMail ePrescribing or fax methods you may be using currently can continue to be used for the immediate future but will be returned as 'unable to fill' at some point later this year. Please take this opportunity to update any pharmacy information that may be stored in your patients' records.

Also, if your patient had a current prior authorization approval on file, it was transferred over to the new mail order system and will follow the standard BCBSMT process for renewals.

Members with prescription history within the last 12-18 months were notified of the specialty pharmacy and/or mail order service changes. Full integration of all mail service and specialty pharmacy services is expected to be completed by the first quarter of 2018. More information about the new combined company, including the official name, will be shared in future *Blue Review* issues and/or in the News and Updates section of our Provider website.

If your patients have questions about their pharmacy benefits, please advise them to contact the Pharmacy Program number on their member ID card. Members may also visit bcbsmt.com and log in to Blue Access for Members℠ (BAM℠) for a variety of online resources.

[1] Members with Medicare Part D or Medicaid coverage transitioned to the new mail order services as of earlier this year.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSMT contracts with Prime Therapeutics to provide pharmacy benefit management and other related services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSMT and contracting pharmacies is that of independent contractors. BCBSMT, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Prime has entered an agreement with Walgreens, an independently contracted pharmacy, to form a combined specialty pharmacy and mail order services company, owned by Prime and Walgreens.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. This is only a brief summary of some plan benefits. For more complete details, including benefits, limitations and exclusions, members should refer to their certificate of coverage. Regardless of benefits, the final decision about any medication and pharmacy choice is between the member and their health care provider.



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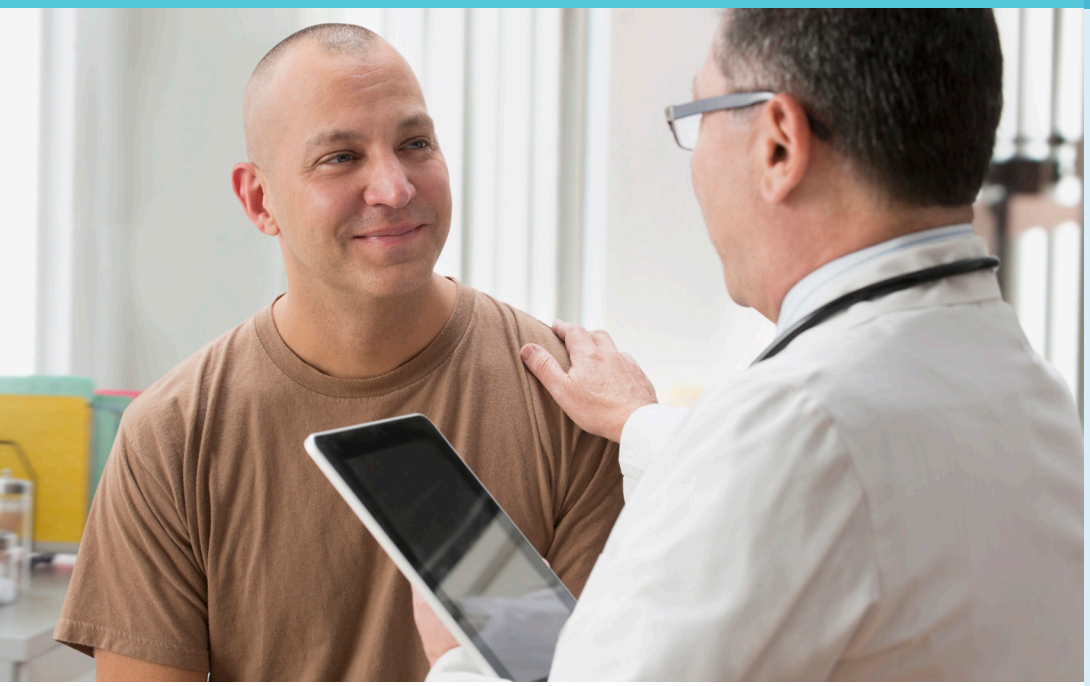
**Duplicate Component Billing –** This rule identifies when a professional or technical component of a procedure is submitted and the same global procedure was previously submitted by the same provider ID for the same member for the same date of service.

**New Patient Code for Established Patient –** Identifies claim lines containing new patient procedure codes that are submitted for established patients. According to AMA, "A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last 3 years." As well, similar guidance is provided by Centers for Medicare Medicaid Services (CMS): According to Pub 100-04, Medicare Claims Processing Manual Ch. 12, Physicians/Non-Physicians Practitioners, Section 30.6.7, Subsection A, "Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years."

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the Education & Reference/Provider Tools/ Clear Claim Connection page on our Provider website at bcbsmt.com/provider. Information also may be published in upcoming issues of the *Blue Review*.

Checks of eligibility and/or benefit information are 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.



# Colon Cancer Screenings Goal: 80% Participation by 2018 – Will You Commit?

In collaboration with the American Cancer Society and the National Colorectal Cancer Roundtable, BCBSMT and Dr. Monica Berner, Chief Medical Officer, has signed a pledge to have 80 percent of our members ages 50-75, screened for colon cancer by 2018.

Dr. Berner said, "Overall health is important to us at Blue Cross and Blue Shield of Montana. We strongly encourage all our members age 50 and older to get screened for colon cancer. Members younger than 50 with risk factors for colon cancer may need screening starting at an earlier age. We are reaching out to you, as their providers, to help get the word out and to make colorectal cancer screening a priority."

In 2017, the American Cancer Society estimated there would be 135,430 new cases of colorectal cancer and 50,260 deaths nationwide. For Montana, it was estimated that there would be 500 new cases of colorectal cancer with an estimated 170 deaths. The incidence of colorectal cancer from 2009-2013 was 45.7 Males and 34.5 females per 100,000, age adjusted to 2000 US standard population. The good news is that the rates of new colorectal cancer cases and deaths among adults aged 50 and older is decreasing in this country due to an increase in screening and changes in some risk factors (eg., a decline in smoking)

**How far away are we from reaching this goal?** In 2016, the national Healthcare Effectiveness Data and Information Set (HEDIS®) PPO average was 57.1 percent compared to BCBSMT's Commercial PPO HEDIS result of 48.57 percent.

**We need your help to reach this goal!** This Article outlines the types of screening available, barriers to colorectal cancer (CRC) screening and how you can help us reach our goal of 80% by 18 for Montana.

**Who Should Get Screened?** Adults aged 50-75 who are a average risk for CRC and are asymptomatic.

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## Overcoming Barriers to Colorectal Cancer Screenings

CRC screenings can be a highly effective preventive measure that offers your patients the best possible outcomes. The U.S. Preventive Services Task Force (USPSTF) has found convincing evidence that screening for colorectal cancer with several different methods can accurately detect early-stage colorectal cancer and adenomatous polyps.[1]

### Patient Concerns

Some of the reasons for not completing screening:

- I did not know the test would be covered by insurance
- I am afraid of the test/discomfort
- I do not have symptoms; some people equate no symptoms as being cancer free.
- Embarrassment/awkwardness regarding bowel functions and /or test that involves stool collection.
- Concerns regarding cost and/or interruption of daily life responsibilities.

### Patient Education

- Inform patients that there are several screening options available, including simple take home tests that can be completed in the privacy of their own home.
- Sensitivity to personal and cultural fears surrounding cancer itself is important. Let patients know that many people diagnosed with colon cancer do not have any symptoms or a family history, which is why screening is so important even when they feel healthy. It can take 10 years for a polyp to become cancer.
- Discuss the variety of CRC screening options, as well as individual considerations that may impact CRC screening test selection. Offer a questionnaire at check in to expedite CRC screening selection and to allow the patient to formulate questions about CRC screenings.

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**Some people need screening at a younger age due to risk factors:**

- Family History of colon cancer and/or polyps
- Older age
- Personal history of colon cancer, polyps, or Inflammatory Bowel disease.
- Males or Black adults

The American College of Gastroenterology recommends colonoscopy as the preferred cancer prevention screening method and Fecal Immunochemical Testing (FIT) as the preferred cancer detention option.

| CRC Screening Options | |
|---|---|
| **Screening** | **Interval** |
| Colonoscopy-screening and diagnostic follow up of positive results can be done at the same time. | Every 10 years[1] |
| Flexible Sigmoidoscopy-May still need colonoscopy for positive results. | Every 5 years |
| CT Colonography-extra colonic findings are common | Every 5 years[1] |
| Stool-based Test (including) | |
| FIT or immunologic Fecal Occult Blood Test (iFOBT). FIT tests may be one or two sample tests. (No dietary restrctions) | Every year[1] |
| Guaiac based stool tests or gFOBT (less sensitive than FIT any typically requires more samples and dietary restrictions) | Every year[1] |
| Stool DNA with FIT testing, also known as Cologuard- Exact Sciences (FDA Approved) | Every 3 years[1] |

**Advantages of FIT include:**

- PCPs may stock FIT tests in the office and dispense as appropriate following a brief discussion with their patients.
- Patients complete the test in the privacy of their own home.
- Depending on the FIT test brand, testing may be accomplished with a single specimen

According to the American Cancer Society, a stool specimen from a digital rectal exam tested for blood with a gFOBT or FIT is not an acceptable way to screen for colorectal cancer. Research has shown that a stool specimen obtained by digital rectal exam will miss more than 90% of colon abnormalities, including most cancers.

## Start the Conversation!

Your recommendation that your patients get screened for colorectal cancer carries the greatest impact for colorectal cancer screening compliance.

Thank you for your continued support and interest in colorectal cancer screenings for our members.

The Centers for Disease Control and Prevention provides free continuing education for PCPs, nurses, nurse practitioners and clinicians who perform colonoscopies. Access Screening for Colorectal Cancer: Optimizing Quality (CME), to download, print or watch the presentations on YouTube.

With your influence, we can raise the CRC screening rate, and meet the 80 percent by 2018 goal.

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- Once a screening option is agreed upon, explain the expectations and process. Assure that medication for discomfort will be provided for CRC screening procedures. Patient brochures and information are available through the local ACS.
- Stocking Fecal Immunochemical Testing (FIT) kits in the office, to dispense during visits, can be effective. **When patients agree to FIT testing, allow them to open the kit, handle the materials and complete the paperwork.** The mystery will be removed if they can visualize the test and ask questions. They will also be more likely to complete the CRC screening if they feel confident in the process.

## Provider Concerns

- Visit Constraints- Addressing acute and chronic conditions may take precedence over preventative care during a visit.
- Train your staff to Identify patients with gaps in preventative care to allow for focused and efficient use of your time. Office systems that flags patients needing CRC screenings are advantageous. Have printed materials available in the waiting room and encourage conversations.
- Become familiar recommended careening options since various factors determine which option is best for each patient.
- Identify a CRC screening campion in your office to train staff in identifying patients who are due for screenings.
- Standing orders will allow key staff to assess, implement and follow up with patients regarding their selected CRC screening option.
- Have patients call the number on the back of their insurance card for any questions regarding coverage.

# Antidepressant Medication Management Initiative

BCBSMT is committed to improving the rate at which members remain on antidepressant medications after newly diagnosed and treated depression.

### Did you know?

- According to the American Psychological Association (APA), major depressive disorder is a chronic condition that requires patients to participate actively in and adhere to treatment plans for long periods, despite the fact that side effects or requirements of treatment may be burdensome.
- APA guidelines recommend antidepressants as the initial treatment for mild to moderate depression.
- Our goal and who is eligible?
- Our goal is to increase antidepressant medication adherence. The program is targeting members age 18 and older with at least one of the following:
  - At least one principal diagnosis of major depression in an outpatient, ED, intensive outpatient, or partial hospitalization setting
  - At least two visits in an outpatient, emergency department, intensive outpatient, or partial hospitalization setting on different dates of service with any diagnosis of major depression
  - At least one inpatient (acute or non-acute) claim
- We measure adherence for both the acute and continuation phases as outlined in HEDIS® 2017 specifications.
- Effective Acute Phase: Percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks)
- Effective Continuation Phase: Percentage of newly diagnosed and treated members who remained on an antidepressant for at least 180 days (6 months)

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## Provider Learning Opportunities

A snapshot of complimentary upcoming training sessions offered by BCBSMT is included below. To register, visit the Training page in the Education and Reference Center on our website at bcbsmt.com/provider.

### BCBSMT WEBINARS

**BCBSMT: Availity™ Provider Training**

Oct. 10, 2017, 11 a.m.

Oct. 17, 2017, 11 a.m.

Special training for Availity Professional Claim Entry

Oct. 24, 2017, 11 a.m.

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Comprehensive analysis of the results will be conducted quarterly and annually by BCBSMT.

### What you can do

- The physician should assess and acknowledge potential barriers to treatment adherence, including lack of motivation, side effects of treatment, and logistical, economic or cultural barriers to treatment.
- The physician should collaborate with the patient (and if possible the family) to minimize the impact of these potential barriers.
- Patients should be given realistic expectations during the different phases of treatment, including the time course of symptom response and the importance of adherence for successful treatment.
- Misperceptions, fears and concerns about antidepressants should be addressed with the patient.
- Education should be provided about major depression, the risk of relapse and the early recognition of recurrent symptoms, and the efficacy of Cognitive Behavioral Therapy in combination with medication.
- Patients should be informed about the need to taper antidepressants rather than discontinuing them prematurely.
- Common side effects of antidepressants should be discussed with the patient. The physician should encourage the patient to identify side effects they would consider reasonable and those they would consider unbearable.
- Physicians should offer to explain when and how to take the medication, reminder systems, information about continuing the medication after symptoms of depression improve, strategies to incorporate medication into the daily routine, and minimizing the cost of antidepressant regimens to improve adherence.

"Practice Guideline for the Treatment of Patients with Major Depressive Disorder 3rd Edition" (2010) American Psychiatric Association
"HEDIS® 2017 Volume 2 Technical Specifications for Health Plans (the Healthcare Effectiveness Data and Information Set)

## Referrals for Cost-Sharing for American Indians and Alaska Natives on Limited Cost-Sharing (LCS) Plans

American Indians and Alaska Natives (AI/AN) can get treatment from Indian health care providers at Indian Health Services, Tribal and Urban Indian (I/T/Us) facilities.

Under the LCS plans, AI's who need services they cannot obtain through an Indian health care provider can get the services at a different provider without paying anything out of pocket, if they have a referral from the IHS provider.*

Indian health care providers should use the following process to submit referrals for members to waive cost sharing for medical care that is not available at I/T/U facilities:

If an AI/AN arrives at your facility or clinic with the referral from an IHS provider, please send the referral to the following so BCBSMT can ensure the claims are reviewed and processed correctly;

**Referral is faxed to 972-385-8210 and received in our Payment Services Claims Processing area.**

**Referrals can also be mailed to:**

**7777 East 42nd Place**
**Tulsa Oklahoma 74145**
**Attn: I/T/U Referral**

*Members who receive services from an out-of-network provider may incur additional charges.

# Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

## WHAT YOU NEED TO KNOW

### STOP – Impact to You

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. QMB is a Medicare Savings Program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

### CAUTION – What You Need to Know

The QMB program is a State Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance, and copayments under certain circumstances.) Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full

Medicare cost-sharing amounts. Further, all original Medicare and MA providers—not only those that accept Medicaid—must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately bill QMB individuals are subject to sanctions.

### GO – What You Need to Do

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staff are aware of the Federal billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a MA provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

**Background:** This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.

## BILLING OF QMBS IS PROHIBITED BY FEDERAL LAW

Federal law bars Medicare providers from billing a QMB beneficiary under any circumstances. See Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by Section 4714 of the Balanced Budget Act of 1997. QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, States can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

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## Update from Centers for Medicare and Medicaid Services (CMS)

### PROHIBITION ON BILLING DUALLY ELIGIBLE INDIVIDUALS ENROLLED IN THE QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

Plan Payment Group, Center for Medicare
Sharon Donovan, Director,
Program Alignment Group, Medicare-Medicaid Coordination Office (MMCO)

SUBJECT: Qualified Medicare Beneficiary Program Enrollee Status Resources This memorandum provides information regarding existing Centers for Medicare & Medicaid Services (CMS) resources for plans to identify the status of Qualified Medicare Beneficiary (QMB) Program enrollees. In 2017, CMS reminded plans of their obligations to educate network providers about QMB billing rules and to maintain procedures that ensure network providers do not discriminate against enrollees based on their payment status, e.g., QMB.[1]

In response we received several questions about how to identify QMB status and promote compliance. This memorandum addresses these questions and offers resources and potential strategies for plans.

The QMB Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans.

[1] See Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter; Medicare Managed Care Manual, Ch. 4, Section 10.5.2.

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## Inappropriate Billing of QMB Individuals Persists

Despite Federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015.

## Important Clarifications Concerning the QMB Billing Law

Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

1. All original Medicare and MA providers--not only those that accept Medicaid—must abide by the billing prohibitions.
2. QMB individuals retain their protection from billing when they cross State lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different State than the State in which care is rendered.
3. Note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

## Ways to Improve Processes Related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and MA plans if applicable), can promote compliance with QMB billing prohibitions.

Determine effective means to identify QMB individuals among your patients, such as finding out the cards that are issued to QMB individuals, so you can in turn ask all your patients if they have them. Learn if you can query State systems to verify QMB enrollment among your patients. MA providers should contact the plan to determine how to identify the plan's QMB enrollees. Beginning October 1, 2017, you will be able to readily identify the QMB status of your patients with new Medicare Fee-For-Services improvements. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.

1. Determine the billing processes that apply to seeking reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to QMB beneficiaries. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.
   - Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.
2. Ensure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

**QMB Eligibility and Benefits**

| Program | Income Criteria* | Resources Criteria* | Medicare Part A and Part B Enrollment | Other Criteria | Benefits |
|---|---|---|---|---|---|
| QMB Only | ≤100% of Federal Poverty Line (FPL) | ≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index | Part A*** | Not Applicable | Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them) |
| QMB Plus | ≤100% of FPL | Determined by State | Part A*** | Meets financial and other criteria for full Medicaid benefits | Full Medicaid coverage Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them) |

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis").
For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System.

## Additional Information

For more information about dual eligibles under Medicare and Medicaid, please visit https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html and https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html and refer to Dual Eligible Beneficiaries Under Medicare and Medicaid. For general Medicaid information, please visit http://www.medicaid.gov/index.html.

# Requesting Predetermination of Benefits

As a reminder, predetermination of benefits requests may be submitted electronically through iExchange®, which is accessible through the Availity™ Web portal. Providers also may verify status and/or obtain online approvals for submitted predetermination requests via iExchange. This tool is designed to help save you time by reducing the amount of calls and written inquiries submitted. For providers who need to submit paper predetermination requests should send the patient's medical documentation using the Predetermination Request Form.

BCBSMTis streamlining the predetermination of benefits review process to help facilitate more accurate processing of incoming requests. Beginning December 1, 2017, written predetermination requests must be submitted using the Predetermination Request Form. If these written requests are sent to BCBSMT without the Predetermination Request Form starting Jan. 1, 2018, the inquiry will be returned to the submitting provider requesting that the predetermination be sent with the appropriate form. This form is available on our Provider website in the **Education and Reference Center/Forms and Documents** section at bcbsmt.com/provider.

Online verification of the patient's eligibility and benefits is strongly encouraged prior to submitting predetermination requests. Real-time coverage status and benefit details may be obtained electronically through Availity, or your preferred web vendor.

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

Checking eligibility and/or benefit information and/or 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. If you have any questions, please call the number on the back of the member's ID card.

iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSMT makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Medecision. 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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The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

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