



BLUE REVIEWSM

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

FOURTH QUARTER 2015

Updates to the Blue Cross and Blue Shield of Montana Medicare Advantage Preauthorization List Effective January 1, 2016

On January 1, 2016, the Blue Cross and Blue Shield of Montana (BCBSMT) Medicare Advantage (PPO) plan and Medicare Advantage HMO plan will have some changes to the list of procedures requiring preauthorization. Please see the updated preauthorization list on page 2.

As a reminder, our automated preauthorization tool — Aerial™ iExchange® (iExchange) — supports direct submission and provides online approval of benefits for inpatient admissions, as well as select outpatient, pharmacy and behavioral health services 24 hours a day, seven days a week — with the exception of every third Sunday of the month when the system will be unavailable from 10 a.m. to 2 p.m. (Mountain Time). iExchange is accessible to physicians, professional providers and facilities contracted with BCBSMT. For more information or to set up a new account, complete and submit the online enrollment form located at <https://www.bcbsmt.com/provider/education-and-reference/iexchange>.

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PLEASE CONTACT YOUR PROVIDER NETWORK REPRESENTATIVE IF YOU HAVE ANY QUESTIONS AND/OR IF YOU NEED ADDITIONAL INFORMATION.

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SERVICES REQUIRING PREAUTHORIZATION

The attending physician must obtain preauthorization for the services listed below except in an emergency.

Medical/Surgical
Acute inpatient hospital stays
Ambulance (A0430, A0431, A0435, A0436)
DME greater than \$2500 (E0652, K0822, E0748, E0747, L8680, E0760, K0861)
Home health care
Inpatient rehabilitation
Long term care hospital (LTCH)
Medications (J1459, J1556, J1557, J1559, J1561, J1562, J1566, J1568, J1569, J1572, 90283, 90284, J2357, J1745, J0490, Q2043, J3262, J2323, J9035, C9257, J9310, J0585, J0587, J2505, J9228, C9027, C9453, J0881, J0882)
Organ transplants other than ocular and kidney
Plastic, reconstructive and aesthetic surgery (15775-15835)
Prosthetics/orthotics greater than \$2500
Skilled nursing facility (SNF)
Advanced radiology - including PET scans, CT Scans, MRIs require prior authorization inclusive of the following codes.
– PET Scans (78459, 78491, 78492, 78608, 78609, 78811 to 78816)
– Breast MRIs (77058 through 77059)
– CT Cardiology studies (75571 through 75574)
GI Radiology services including 91110, 91111
Behavioral Health
All inpatient stays
Partial hospitalization program (PHP)
Outpatient services:
ECT - 90870
rTMS - 90867, 90868
Psychological testing - 96101, 96102, 96103
Neuropsychological testing - 96105, 96110, 96111, 96116, 96118, 96119, 96120, 96125

REMINDER:

Please be sure to watch for new ID cards from our members at the beginning of the year.

In 2016, many of our members/your patients may be changing or purchasing new Blue Cross and Blue Shield of Montana (BCBSMT) benefit plans. Any changes in a member's benefit plan will result in a new BCBSMT insurance card being issued to that member with a new ID number and potentially a new alpha prefix.

To ensure that claims are processed in an accurate and timely way, providers should verify that our members' ID cards are current on the date of service. Claims submitted with old member ID numbers may be rejected with a message of "This policy was canceled" or "No record of coverage was found."

Provider Enrollment Requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from your local BCBS Plan regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.

Air Ambulance Services

Blue Cross and Blue Shield of Montana (BCBSMT) would like to partner with our network hospitals and providers in the state to mitigate the impact of the health care costs that continue to reach unprecedented levels for Montanans. Among those contributing factors is the use of out-of-network providers, which can create avoidable financial hardships for your patients, our members. To address that issue, BCBSMT is currently focusing on the immediate concerns with air ambulance services by creating a directory of our participating air ambulance providers to assist our members and your patients in seeking quality, affordable care.

To ensure our members receive the full air ambulance benefits of their BCBSMT health care plan, we urge you to transport our members via in-network air ambulance providers whenever possible, potentially saving your patients thousands of dollars.

Thank you for all you do to ensure the health and well-being of our members, and we appreciate your further collaboration to ensure that your patients continue to receive the best care possible without the adverse impacts of out-of-network costs.

Should you have any questions about this communication, please contact us at 1-800-447-7828, Extension 6100 or at HCS-X6100@bcbsmt.com.

Blue Cross and Blue Shield of Montana (BCBSMT) Air Ambulance Network			
Provider	Phone Number	Rotor	Fixed Wing
Benefis Healthcare	Mercy Flight Communication Center at 1-800-972-4000	•	•
Billings Clinic Hospital	1-800-325-1774		•
Kalispell Regional Healthcare	1-866-302-9767	•	•
MT Medical Transport	406-457-8205		•
St Vincent's Healthcare	1-800-JET-HELP (1-800-538-4357)	•	•

Disclaimer: A provider's participation status may change.
Contact Customer Service using the phone number on the back of the members health plan ID card to obtain the most up to date information.



November Training Opportunities

Please join this month's provider education series being offered by Blue Cross and Blue Shield of Montana (BCBSMT).

For the month of November, BCBSMT will be covering the 2016 Montana Provider Updates: Network and Product Changes.

The November webinars will provide important information to providers regarding the 2016 Marketplace plans and product updates, pharmacy updates, and Provider Finder.

Please register for one of these educational presentations by choosing one of the links below.

WEBINAR SCHEDULE

- Nov. 3, 2015, 10 a.m. MT
- Nov. 5, 2015, 2 p.m. MT
- Nov. 10, 2015, 2 p.m. MT
- Nov. 12, 2015, 10 a.m. MT
- Nov. 17, 2015, 10 a.m. MT
- Nov. 19, 2015, 2 p.m. MT

For additional information on the above training opportunity please contact Susan Lasich at 406-437-6223, or email susan_lasich@bcbsmt.com.

Coordinating Care for Mental Illness Makes a Difference for Patients

Mental illness is a serious problem in the United States. It's estimated that about a **fifth of U.S. adults suffer from a mental health disorder**, and about **4 percent have serious mental illnesses**, which include schizophrenia, bipolar disorders and major depressive disorders.

For those most acutely affected by serious mental illness, inpatient behavioral health care can be an important aspect of treatment. But inpatient care often isn't enough. Patients who get inadequate outpatient treatment — or no treatment at all — after they are discharged may end up in the emergency room or hospitalized again. Without appropriate follow-up care, they're also at greater risk for financial difficulties, homelessness, unemployment and suicide.

The transition to outpatient treatment for behavioral health patients can be crucial to preserving the gains achieved in inpatient care. Many patients need a plan for continued care and the support to help them stick with it.

That's the goal of Blue Cross and Blue Shield of Montana's Behavioral Health Care Coordination & Early Intervention program (CCEI). By identifying and engaging at-risk patients, the program aims to help meet their medical and behavioral health needs, promote their safety and address any barriers to adhering to treatment plans.

"The idea is if they make their initial follow-up appointment, it reinforces the need to see the psychiatrist and adhere to medications and stay in treatment," says Scott Holder, enterprise divisional vice president, Behavioral Health, Clinical Operations of our operating company's health insurance Plans in Illinois, Montana, New Mexico, Oklahoma and Texas.



It starts with encouraging members to make it to their first follow-up appointment within seven days of discharge and establish a relationship with a behavioral health professional.

The CCEI program has assisted about 15,000 members across our five Blues Plans since its inception in 2013. While still in inpatient care, members are included in the program if they meet certain criteria that can increase the likelihood of negative consequences. These "triggers" include having a diagnosis of an eating disorder, being age 12 or under, having been in inpatient care for 25 days or longer, having at least one behavioral health readmission in the past year or being identified as part of a vulnerable population. Members can also be included in CCEI at the discretion of our behavioral health clinical staff.

The program attempts to identify members for inclusion early so that post-discharge treatment planning can start before the member leaves the facility.

When members are identified, our discharge coordinators contact inpatient facility utilization review staff to provide information about CCEI, determine whether there are potential gaps

Talking with Blue Cross and Blue Shield of Montana (BCBSMT) Behavioral Health Staff

Blue Cross and Blue Shield of Montana (BCBSMT) behavioral health representatives are available to help with questions about member benefits, requests for authorization, care coordination, finding community resources for members and more.

You can reach a BCBSMT behavioral health representative Monday through Friday from 8:00 a.m. to 6:00 p.m. Central Time. For assistance, just dial the Customer Service number on the back of the member's ID card; call toll-free or collect. After normal business hours, you can leave a message in a confidential voicemail box. A representative will return your call within 24 hours and identify herself/himself by name, title and company name.

BCBSMT behavioral health representatives are available 24 hours a day, seven days a week for crisis calls and emergency preauthorization requests via the Customer Service number on the back of the member's ID card.

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in establishing discharge plans and discuss how we can help coordinate the members' care. The discharge coordinators also ask the facility staff to review information about CCEI with the members.

After members leave inpatient care, discharge coordinators try to contact them within 48 hours. The focus of the contact is to try to make sure members have a comprehensive plan to meet their medical and behavioral health treatment needs, including a behavioral health follow-up visit within seven days of discharge. Research has shown that patients who don't keep their post-discharge follow-up appointment are twice as likely as those who keep their appointments to be rehospitalized in the same year.

If members don't have an appointment, discharge coordinators help set one up. The coordinators also encourage members to see medical and behavioral health providers and make use of community support resources such as Alcoholics Anonymous or Narcotics Anonymous. Discharge coordinators also confirm that members attended their follow-up appointments and contact members again if they didn't.

CCEI has improved outcomes. Members who engaged in the program showed 22 percent lower inpatient utilization in the six months following their initial post-discharge contact than members who didn't engage in the program. The engaged members also showed 74 percent fewer behavioral health readmissions, 4 percent fewer avoidable emergency department visits and 46 percent lower total claims costs on a per-member-per-month basis.

Beyond the numbers, the program has made a difference in members' lives. Paul* was a Blue Cross and Blue Shield member who was discharged from a behavioral health facility with a follow-up appointment scheduled in a month. But he started having side effects from his medication and needed to see a psychiatrist as soon as possible. After talking with him, Paul's discharge coordinator contacted his primary care physician, and Paul got a referral to see a psychiatrist within seven days. He has not visited the ER or been readmitted to the hospital since.

"The big picture" for the program, says Holder, "is to keep members from needing to go back to the hospital."

*Pseudonym used.



Behavioral Health Utilization Management Member Notifications of 2016 Prescription Drug Changes in Retail and Small Group

This information only applies to individual and group "metallic" plans offered on the Health Information Market.

Notifications were mailed to all current 2015 Retail Individual and Small Group (metallic/QHP plan) members impacted by a 2016 pharmacy benefit change so they are informed before open enrollment begins in November.

The changes are in the following areas:

- Value Pharmacy Network added to the prescription drug benefit plan.
- Drug list changes from a preferred brand (Tier 3) to a non-preferred brand (Tier 4) status. Also, some generic drugs moved from a preferred generic (Tier 1) to a non-preferred generic (Tier 2) status.
- Certain brand-name products will no longer be eligible for coverage under the prescription drug benefit.
- New Utilization Management Programs were added to the prescription drug benefit plan. These programs include prior authorization, step therapy and dispensing limits.
- Detailed (metallic/QHP) pharmacy changes can be found on our website: www.bcbsmt.com/go/rx-2016changes-qhp

More Enhancements Coming to the iExchange® Benefit Preauthorization Tool

We've made enhancements and continue to improve iExchange, our Web-based benefit preauthorization tool. iExchange supports requests for Behavioral Health, Pharmacy, and Medical/Surgical Treatment services.

iExchange allows you to submit initial and extension requests for approval prior to services being rendered. We strongly encourage you to verify your patients' eligibility and benefits to determine coverage and benefit preauthorization requirements prior to using the tool. This flexible tool provides real-time responses for direct submission of inpatient admissions and select outpatient medical services, including benefit preauthorization submissions after regular business hours and on weekends.

Recently, BCBSMT deployed what was formerly known as the Patient Clinical Summary. iExchange now offers an updated version called the Health Summary. Providers are able to receive additional data in the Health Summary, including more real-time data, which is the result of BCBSMT's efforts to give you access to more data and better analytics that can help improve the health of your patients. The Health Summary will display the following information:

- Conditions--chronic and acute
- Health status measures
- Plan and care data
- Medications
- Lab and test results/procedures
- Visits

COMING SOON TO IEXCHANGE

iExchange will soon support submission of online requests and required documentation for predetermination of benefits. Instead of faxing clinical information, attachments will be able to be submitted electronically. Watch our Provider website and Blue Review for more information.

Please note that the fact that a service has been preauthorized/precertified 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.

Update on claims processing for CPT code 99174

CPT code 99174 for Instrument-based ocular screening (eg, photo screening, automated-refraction), bilateral is considered to be a routine vision service. Effective 1/1/2016 this code will be denied as not a covered benefit per the member's medical contract as the service would be processed under a separate vision benefit.

You Get What You Pay for: a Look at Transitioning From Volume to Value

In The Huffington Post article, [You Get What You Pay for: a Look at Transitioning From Volume to Value](#), Dr. Stephen Ondra says to get more value from health care, "We need to change the rules of the game to incentivize greater quality and lower costs." Dr. Ondra, senior vice president and enterprise chief medical officer of our operating company's health insurance Plans in Illinois, Montana, New Mexico, Oklahoma and Texas, explains that it will take a fundamental shift in the economics of health care from a "fee-for-service" system to a "fee-for-value" system to achieve greater value.

Find out more in Dr. Ondra's [latest article](#). Watch for future [HuffPost articles](#) from Dr. Ondra in this newsletter, and follow him on Twitter at [@StephenOndra](#) where he tweets about his work and the future of health care.

2016 New Product for BCBSMT – Blue Focus Point of Service (POS)

Blue Cross and Blue Shield of Montana (BCBSMT) is introducing a new product for individuals, families and small groups in the Billings and Missoula areas of the state in 2016 – the Blue Focus POSSM plan. This new product offering will be available on and off the Marketplace and applies to seven counties:

- Lake
- Yellowstone
- Stillwater
- Sweet Grass
- Missoula
- Carbon
- Musselshell

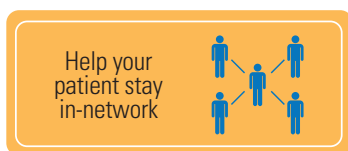
Blue Focus POS offers members a lower premium and better benefits when accessing an in-network provider. The member can access a broader provider network but those services will be subject to out-of-network benefits. Under the Blue Focus POS product, members will select a primary care physician (PCP), but referrals are not required. However, pre-authorizations are required in order to receive in-network cost-sharing benefits.

Offering the new POS product will make us more competitive in 2016. The inclusion of POS plans will provide our members with an additional plan option to fit their individual needs.

It is important to make sure doctors and hospitals are in a member's network when referring them for additional medical services. By staying in-network, members may reduce or even avoid additional out-of-pocket expenses.

If you have questions, you can call your BCBSMT provider representative. BCBSMT members can call the toll-free Customer Service number listed on the back of their ID card.

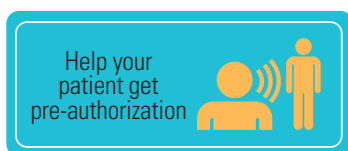
BLUE FOCUS POS (BLC)



A POS gives members access to a select group of contracted doctors and hospitals.



When a member signs up, they **must select a primary care physician (PCP)**. If you are a PCP, you are the patient's first point of contact for most of their basic health care needs.



In POS patient needs special tests or needs to see a specialist, **preauthorization may be required**.



Remind patients that hospital emergency departments are the right place to go when they have **an emergency illness or serious injury ...** but they're not designed to provide routine health care or treat minor problems.

December Training Opportunities

Please see below for December's provider education series being offered by Blue Cross and Blue Shield of Montana (BCBSMT).

For the month of December, BCBSMT will be covering the 2016 Pharmacy Changes. The December webinars will be hosted by Luke Ostby, PharmD, Director of Pharmacy, and he will discuss the 2016 updates with regard to the pharmacy benefits. This program may be of interest to your clinical and business office staff.

TOPICS WILL INCLUDE:

- Pharmacy Web Tools
- Formulary changes and alternatives
- Utilization Management (Prior Authorization & Step Therapy)
- Pharmacy Networks

Please register for one of these educational presentations by choosing one of the links below.

WEBINAR SCHEDULE

- [Tuesday, Dec. 1, 10 a.m. MT](#)
- [Thursday, Dec. 3, 2 p.m. MT](#)
- [Tuesday, Dec. 8, 2 p.m. MT](#)
- [Thursday, Dec. 10, 10 a.m. MT](#)
- [Tuesday, Dec. 15, 10 a.m. MT](#)
- [Thursday, Dec. 17, 2 p.m. MT](#)

For additional information on the above training opportunity please contact Susan Lasich at 406-437-6223, or email susan_lasich@bcbsmt.com.

Asthma Care Reminder

The National Institute of Health (NIH) National Asthma Education and Prevention Program recommends that patients with persistent asthma should be treated with an inhaled corticosteroid. According to the NIH National Heart, Lung, and Blood Institute guidelines, chronic inhaled corticosteroid use is safe in adults and children, and can be the most effective and preferred first-line control therapy for asthma¹. Inhaled corticosteroids improve asthma control more effectively than any other long-term control medications. An analysis of eight cohort and ecologic studies conducted strongly suggest that inhaled corticosteroids, when taken regularly, can decrease the number of hospitalizations for asthma by up to 80 percent². Pharmacy claims often show that asthma patients rely on albuterol rescue inhalers as the primary treatment for their asthma. A patient refilling their albuterol rescue inhaler more than once a month may be an indication that their asthma is not being appropriately treated.

If your patients are not adherent to, or are resistant to taking their inhaled corticosteroid as directed, please discuss and address their concerns. Some reasons patients may not be taking inhaled corticosteroids are:

- Concerns about taking a steroid medication (inhaled corticosteroids have fewer and less severe systemic side effects than oral steroids),
- Lack of immediate relief that albuterol inhalers can provide,
- Difficulty remembering twice daily dosing,
- Improper inhaler technique (have your patient demonstrate their technique while in the office), and
- In rare cases, thrush (prevented by rinsing mouth after use).

It is highly recommended that you work with your patient to create an asthma action plan. An asthma action plan can be a written, individualized worksheet showing your patient the steps to take in order to prevent their asthma symptoms worsening. Also, for patients with persistent asthma, assess their symptoms and determine if an inhaled corticosteroid is appropriate.

Blue Cross and Blue Shield of Montana uses the GuidedHealth® clinical rules platform to review claims data that it receives to help identify members who have had a claim for an asthma rescue inhaler but have not received an inhaled corticosteroid. The prescribing physicians of these identified members are sent informational letters on a quarterly basis to help increase awareness and promote patient safety.

BCBSMT is also committed to working with communities to help improve pediatric asthma care. Through collaboration with the American Lung Association of the Upper Midwest (ALAUM), BCBSMT is supporting the Enhancing Care for Children with Asthma Project, a program that implements community-based interventions to improve the health outcomes of children with asthma. For more information about the Enhancing Care for Children with Asthma Project, visit the ALAUM at lung.org.

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- Certain brand-name products will no longer be eligible for coverage under the prescription drug benefit.
- New Utilization Management Programs were added to the prescription drug benefit plan. These programs include prior authorization, step therapy and dispensing limits.
- Detailed (metallic/QHP) pharmacy changes can be found on our website: www.bcsmt.com/go/rx-2016changes-qhp

¹Global Strategy for Asthma Management and Prevention. Global Initiative for Asthma (GINA) 2012.

²Suisa, Samy et al. Inhaled corticosteroids: Impact on asthma morbidity and mortality. *J Allergy Clin Immunol*. 2001. Jun;107(6):937-44.

GuidedHealth is a registered trademark of Prime Therapeutics LLC (Prime), a pharmacy benefit management company. BCBSMT contracts with Prime to provide pharmacy benefit management and other related services. BCBSMT, as well as several other Blue Cross and Blue Shield Plans, has an ownership interest in Prime. BCBSMT makes no endorsement, representations or warranties regarding GuidedHealth. If you have any questions about this product or services, you should contact Prime Therapeutics directly.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed 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. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Medicare Marketing Guidelines for Providers

The 2016 Centers for Medicare & Medicaid Services (CMS) Annual Election Period for beneficiaries is fast approaching. For those providers who have contracted with Blue Cross and Blue Shield of Montana (BCBSMT) to provide services to our Blue Cross Medicare Advantage (HMO)SM or Blue Cross Medicare Advantage (PPO)SM members, it's important to keep in mind the rules established by CMS when marketing to potential new members.

You may not be planning specific marketing activities, but what if a patient asks for information or advice? Remaining neutral when assisting with enrollment decisions is essential. Below, you'll find a partial listing of additional "Dos" and "Don'ts" for providers, as specified within the CMS Medicare Marketing Guidelines (MMG) for contract year 2016 (section on Provider-Based Activities).

- ## DO:
- Provide the names of Plans/Part D Sponsors with which [you] contract and/or participate (see MMG section 70.11.2 for additional information on provider affiliation)
 - Provide information and assistance in applying for the LIS*
 - Make available and/or distribute plan marketing materials in common areas
 - Refer [your] patients to other sources of information, such as SHIPs** plan marketing representatives, [the] State Medicaid Office, local Social Security Office, CMS' website at <http://www.medicare.gov/> or 800-MEDICARE
 - Share information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from <http://www.medicare.gov/>), or other documents that were written by or previously approved by CMS.

- ## DON'T:
- Accept Medicare enrollment applications
 - Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
 - Mail marketing materials on behalf of Plans/Part D Sponsors
 - Offer inducements (e.g., free health screenings, cash, etc.) to persuade beneficiaries to enroll in a particular plan or organization.
 - Accept compensation directly or indirectly from the plan for enrollment activities
 - Distribute materials/applications within an exam room setting.

The above lists provide just a sampling of important points for your convenience. For a more in-depth review of the guidelines that are applicable to providers, please refer to the Provider Medicare Marketing Guidelines located in the "Education & Reference /Important Links" section of our website at bcbsmt.com/provider.

If you have questions about these guidelines or are planning marketing activities, please refer to the Managed Care Marketing page located under Health Plans, in the Medicare section of the CMS website, at cms.gov.

*LIS refers to low income subsidy

**SHIPs are Senior Health Insurance Assistance Programs

This material is provided for informational purposes only and is not the provision of legal advice.

If you have any legal questions with respect to CMS rules or regulations, you should seek the advice of legal counsel.

Medicaid Claims Handling for Medicaid Members

Blue Cross and Blue Shield Plans currently administer Medicaid programs in multiple states, providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each BCBS Plan. Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out-of-state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires prior authorization.

Identifying Medicaid Members to Determine Eligibility and Benefits

BCBS Plan ID cards do not always indicate that a member has a Medicaid product. BCBS Plan ID cards for Medicaid members do not include the suitcase logo that you may have seen on most BCBS ID cards, but they do include a disclaimer on the back of the ID card providing information on benefit limitations. For members with such ID cards, you should obtain eligibility and benefit information and prior authorization for services using the same tools as you would for other BCBS members.

- Submit an eligibility inquiry by calling the BlueCard® Eligibility Line at 800.676.BLUE.
- Submit an eligibility inquiry using BlueExchange.
- Obtain preservice review using the Electronic Provider Access (EPA) tool.

Medicaid Billing Data Requirements

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims. These data elements and other data elements that are important to submit, when applicable, on Medicaid claims are included below.

Effective March 2016, applicable Medicaid claims submitted without these data elements will be denied. Prior to March 2016, applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- National Drug Code
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- Billing Provider (Second) Address Line
- Billing Provider Middle Name or Initial
- (Billing) Provider Taxonomy Code
- (Rendering) Provider Taxonomy Code
- (Service) Laboratory or Facility Postal Zone or Zip Code
- (Ambulance) Transport Distance
- (Service) Laboratory Facility Name
- (Service) Laboratory or Facility State or Province Code
- Value Code Amount
- Value Code
- Condition Code
- Occurrence Codes and Date
- Occurrence Span Codes and Dates
- Referring Provider Identifier and Identification Code Qualifier
- Ordering Provider Identifier and Identification Code Qualifier
- Attending Provider NPI
- Operating Physician NPI
- Claim or Line Note Text
- Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT))
- Service Facility Name and Location Information
- Ambulance Transport Information
- Patient Weight
- Ambulance Transport Reason Code
- Round Trip Purpose Description
- Stretcher Purpose Description

Medicaid Reimbursement and Billing

Claims for all BCBS Medicaid members should be submitted to your local BCBS Plan. If you are contracted with your local BCBS Plan for Medicaid, your local Medicaid rates will only apply for BCBSMT members; they do not apply to out-of-state Medicaid members. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state. Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations ([42 CFR 447.15](#)).

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member's plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.

Medicaid Encounter Data Reporting

The data elements mentioned above need to be included on Medicaid claims, so that BCBS MCOs are able to comply with encounter data reporting requirements applicable in their respective state.

Commonly Asked Questions

HOW DO I SUBMIT MEDICAID CLAIMS?

Medicaid claims should be submitted to your local BCBS Plan in the same manner as you submit claims for other BCBS members. You will also receive your payment in the same manner, although the payment amount will likely be different from your contracted rate, or different from the Medicaid rate in the state in which you practice.

HOW DO I KNOW THAT I AM SEEING A MEDICAID MEMBER?

Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. BCBS Plan ID cards for Medicaid members:

- Will not include a suitcase logo.
- Will contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness, for example, "This member has limited benefits outside of BCBSMT. Providers should request eligibility/benefit information.

Providers should always submit an eligibility inquiry if the Plan ID card has no suitcase logo and includes a disclaimer with benefit limitations, using the same tools available for BlueCard:

- BlueCard Eligibility Line
- BlueExchange

Because Plan member ID cards will not always indicate that the member is enrolled in a Medicaid product, you should always obtain eligibility and benefit information. With an eligibility response, you should receive information on Medicaid coverage.

WHAT AMOUNT SHOULD I EXPECT TO RECEIVE FOR MEMBERS THAT RESIDE OUTSIDE OF BCBSMT'S SERVICE AREA?

When billing for services rendered to an out-of-state Medicaid member, you will be reimbursed according to the member's home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

MY STATE DOES NOT REQUIRE ME TO INCLUDE AN NPI OR NDC CODE AND MANY OF THE OTHER DATA ELEMENTS LISTED ABOVE ON A MEDICAID CLAIM. WHY DO I HAVE TO INCLUDE THESE CODES?

Most state Medicaid programs require NPI and NDC codes and the additional data elements (when applicable) to be populated on claims submitted for Medicaid members for encounter data reporting purposes. To ensure compliance with state Medicaid requirements, providers who bill for Medicaid members should include these data elements on applicable BCBS Medicaid claims or the claims may be pended or denied.

I do not often see Medicaid members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members in other states?

Many state Medicaid programs require providers to enroll before reimbursement may be provided by the Plan. If you do not enroll with the state where required, the claim could be denied.

Exhibit 1 – Medicaid Billing Data Elements

Required Data Elements for Medicaid Claims

837 Reference	837 Professional1 Data Element Reference	837 Institutional2 Data Element Reference	Professional Paper Claim Item Reference (CMS1500)3	Institutional Paper Claim Form Locator (UB04)4
National Drug Code	Loop 2410 LIN03	Loop 2410 LIN03	Item Number 24 Shaded Portion	Form Locator 43
Rendering Provider Identifier (NPI)	Loop 2310B NM109 unless overridden when reported in Loop 2420A NM109 ONLY when Rendering is different from Loop 2010AA Billing Provider	Loop 2310D NM109 unless overridden when reported in Loop 2420C NM109 ONLY when Rendering is different from Loop 2310A Attending Provider	Item Number 33A NPI# or Item Number 24J (Unshaded) Rendering Provider ID#	Form Locators 78-79 Form Locator 43 Line Level
Billing Provider NPI	Loop 2010AA NM109	Loop 2010AA NM109	Item Number 33A NPI#	Form Locator 56

Other Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.

837 Reference	837 Professional1 Data Element Reference	837 Institutional2 Data Element Reference	Professional Paper Claim Item Reference (CMS1500)3	Institutional Paper Claim Form Locator (UB04)4
Billing Provider (Second) Address Line	Loop 2010AA N302	Loop 2010AA N302	Item Number 33 Billing Provider Info & Ph # Line 2	Form Locator 1 Line 2
Billing Provider Middle Name or Initial	Loop 2010AA NM105	Loop 2010AA NM105	Item Number 33 Billing Provider Info & Ph # Line 1	Form Locator 1 Line 1
(Billing) Provider Taxonomy Code	Loop 2000A PRV03	Loop 2000A PRV03	Item Number 33B Other ID #	Form Locator 81
(Rendering) Provider Taxonomy Code	Loop 2310B PRV03 unless overridden when reported in Loop 2420A PRV03	Not applicable for institutional claim	Item Number 24I ID Qualifier #	Not applicable for institutional claim
(Service) Laboratory or Facility Postal Zone or Zip Code	Loop 2310C N403 unless overridden when reported in Loop 2420C N403	Loop 2310E N403	Item Number 32 Service Facility Location Information Line 3	Form Locator 1 Line 3
(Ambulance) Transport Distance	Loop 2300 CR106 unless overridden when reported in Loop 2400 CR106	Loop 2400 SV205 with applicable revenue code	Not reportable on 1500 form	Form Locator 42 with applicable revenue code
(Service) Laboratory Facility Name	Loop 2310C NM103 unless overridden when reported in Loop 2420C NM103	Loop 2310E NM103	Item Number 32 Service Facility Location Information Line 1	Form Locator 1 Line 1
(Service) Laboratory or Facility State or Province Code	Loop 2310C N402 unless overridden when reported in Loop 2420C N402	Loop 2310E N402	Item Number 32 Service Facility Location Information Line 3	Form Locator 1 Line 3
Value Code Amount	Not applicable for professional claim	Loop 2300 HI in 5th position within the composite data element (Value Information HI) Up to 24 value codes may be reported with a corresponding amount	Not applicable for professional claim	Form Locators 39-41 Up to 12 value codes may be reported with a corresponding amount Form Locator 81 after above are exhausted
Value Code	Not applicable for professional claim	Loop 2300 HI in 2nd position within the composite data element (Value Information HI) Up to 24 value codes may be reported	Not applicable for professional claim	Form Locators 39-41 Up to 12 value codes may be reported Form Locator 81 after above are exhausted
Condition Code	Loop 2300 HI in 2nd position within the composite data element (Condition Information HI) Up to 24 condition codes may be reported	Loop 2300 HI in 2nd position within the composite data element (Condition Information HI) Up to 24 condition codes may be reported	Item Number 10d	Form Locators 18-28 Up to 11 condition codes may be reported Form Locator 81 after above are exhausted

Other Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.

837 Reference	837 Professional1 Data Element Reference	837 Institutional2 Data Element Reference	Professional Paper Claim Item Reference (CMS1500)3	Institutional Paper Claim Form Locator (UB04)4
Occurrence Codes and Dates	Not applicable for professional claim	Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Information HI) Up to 24 occurrence codes and associated dates may be reported	Not applicable for professional claim	Form Locators 31-34 Up to 8 occurrence codes and associated dates may be reported Form Locators 35-36 (FROM field) may be used when available Form Locator 81 after above are exhausted
Occurrence Span Codes and Dates	Not applicable for professional claim	Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Span Information HI) Up to 24 occurrence codes and associated dates may be reported	Not applicable for professional claim	Form Locators 35-36 Up to 4 occurrence span codes and associated dates may be reported Form Locator 81 after above are exhausted
Referring Provider Identifier and Identification Code Qualifier	Loop 2310A NM108/09 or REF01/02 unless overridden when reported in Loop 2420F NM108/09 or REF01/02	Loop 2310F NM108/09 or REF01/02 unless overridden when reported in Loop 2420D NM108/09 or REF01/02	Item Number 17a Other ID# or 17b NPI #	Form Locators 78-79
Ordering Provider Identifier and Identification Code Qualifier	Loop 2420E NM108/09 or REF01/02 when a different from the service line Rendering Provider	Not applicable for institutional claim	Item Number 17a Other ID# or 17b NPI #	Not applicable for institutional claim
Attending Provider NPI	Not applicable for professional claim	Loop 2310A NM109	Not applicable for professional claim	Form Locator 76 Line 1
Operating Physician NPI	Not applicable for professional claim	Loop 2310B NM109 unless overridden when reported in Loop 2420A NM108/09	Not applicable for professional claim	Form Locator 77 Line 1
Claim or Line Note Text	Loop 2300 NTE02 unless overridden when reported in Loop 2400 NTE02 (Line Note NTE)	Loop 2300 NTE02	Item Number 19 Additional Claim Information	Form Locator 80
Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT))	Loop 2300 CRC02, CRC03 (EPSDT Referral CRC) Loop 2300 CRC04 and CRC05 are used when additional conditions apply	Loop 2300 CRC02, CRC03 (EPSDT Referral CRC) Loop 2300 CRC04 and CRC05 are used when additional conditions apply	Item Number 24H EPSDT/ Family Plan	Form Locators 18-28
Service Facility Name and Location Information	Not applicable for professional claim	Loop 2310E	Not applicable for professional claim	Form Locator 1
Ambulance Transport Information Patient Weight Ambulance Transport Reason Code Round Trip Purpose Description Stretcher Purpose Description	Loop 2300 CR102 CR104 CR109 CR110	Not applicable for institutional claim	Not reportable on 1500 form	Not applicable for institutional claim

Endnotes

¹ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222, Type 1 Errata to Health Care Claim: Professional (837), June 2010, ASC X12N/005010X222A1 and Errata to Health Care Claim: Professional (837), January 2009, ASC X12N/005010X222E1.

²ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, Type 1 Errata to Health Care Claim: Institutional (837), October 2007, ASC X12N/005010X223A1, Type 1 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12N/005010X223A2 and Errata to Health Care Claim: Institutional (837), January 2009, ASC X12N/005010X223E1.

³National Uniform Claim Committee (NUCC). 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12. Version 2.0. July 2014.

⁴National Uniform Billing Committee (NUBC). Official UB-04 Data Specifications Manual 2015. Version 9.00. July 2014.

See Public Health Differently!

Public health enhances quality of life in Montana by supporting healthy living in your community. As a healthcare provider, you want to connect your patients to all the health resources in their community but you don't always have time to keep up with what's available. Current information on local diabetes prevention programs, exercise programs designed to help manage arthritis, asthma self-management education, and much more is available in one easy location.

Visit our website at ChronicDiseasePrevention/CommunityBasedPrograms.mt.gov to access our Community Health Program Guide and interactive map and see what programs we offer in your community. For more information call 1-844-MTHLT4U (1-844-684-5848).

Montana Tobacco Quit Line

The Montana Tobacco Quit Line (1-800-QUITNOW) is a free service available to all Montanans. Did you know the Quit Line has culturally appropriate services for American Indians and pregnancy and postpartum programs? Visit Montana.quitlogix.org for more information and to enroll for free.

Montana Tobacco Quit Line services include:

- A FREE personalized quit plan
- 5 FREE proactive cessation coaching sessions
- 8 weeks of FREE nicotine replacement therapy (gum, patches or lozenges). Callers who enroll in Quit Line services may be eligible for up to 8 weeks of free NRT. The Quit Line will explain to the caller how and when these medications will be mailed out.
- Chantix at a reduced cost (\$25 co-pay per month for three months)
- Bupropion at reduced cost (\$5 co-pay per month for three months)
- FREE educational materials for health care providers as well as friends and families of tobacco users
- A fax referral system for health care providers who have patients that want to quit using tobacco (see provider link)
- Trained staff that offers culturally appropriate services for American Indians. Direct line, call **1-855-372-0037**
- Pregnancy and Postpartum Program offers special services to women who enroll while they are pregnant. The Pregnancy program includes all of the above as well as:
 - Additional coaching with a dedicated female coach
 - An additional 6 weeks of NRT following the birth of the child
 - A monetary reward for each coaching call completed (up to 9 calls)

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The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

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