BlueCross BlueShield of Montana

BLUE REVIEW℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

FOURTH QUARTER 2016

Enroll Now for ERA and EFT

You can enroll for Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) through HeW™. Also, providers can make necessary changes to their current ERA and EFT enrollments, all within this functionality. In turn, Blue Cross and Blue Shield of Montana (BCBSMT) coordinates with HeW to ensure a seamless transition to going paperless.

SOME BENEFITS OF ENROLLING FOR ERA:

- Faster remittance delivery
- Automatically post to patient accounting system
- Designated delivery to a specific clearinghouse or vendor

SOME BENEFITS OF ENROLLING FOR EFT:

- Quicker receipt of funds
- No more waiting on mailed paper checks
- Direct deposit into bank account of choice

Online ERA and EFT enrollment is available on the BCBSMT provider website in the Electronic Commerce area under Claims & Eligibility section at bcbsmt.com/provider. Taking advantage of this opportunity can help streamline your account reconciliation and payment processes.

— CONTINUED ON PAGE 2

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

Western Region:

Christy McCauley, 406-437-6068,
Christy_McCauley@bcbsmt.com

Leah Martin, 406-437-6162,
Leah_Martin@bcbsmt.com

Central Region:

Floyd Khumalo, 406-437-5248,
Thamsanqa_F_Khumalo@bcbsmt.com

Eastern Region:

Susan Lasich, 406-437-6223,
Susan_Lasich@bcbsmt.com

INSIDE THIS ISSUE

353125.1116

Provider Claim Summary Paper-to-Electronic Conversion Coming March 1, 2017

BCBSMT recognizes immediate access to the Provider Claim Summary (PCS) is vital for posting patient accounts and reconciling financials. Oftentimes, providers who receive this information via postal mail are waiting on delivery, which delays administrative processes.

The BCBSMT Secure Provider Portal® (SPP) gives providers access to a PCS report viewer application, allowing you to readily view, download, save and/or print the PCS online, as often as needed. Through this report viewer, you have the opportunity to obtain claim outcome results for multiple patients, in one central location.

Effective Mar. 1, 2017, claim summary information will be delivered through this online report viewer, rather than distribution via paper mailing. This online alternative is an additional offering to our other electronic tools through the BCBSMT SPP and HeW®. If you currently rely on paper claim summaries, BCBSMT SPP registration is strongly recommended to gain access to the report viewer application.

Providers who are already enrolled for the Electronic Remittance Advice (ERA) from BCBSMT will continue receiving their remittances electronically, but will have an additional opportunity to view, download, and/or print the claim summary using the report viewer as a complimentary option.

Exceptions to continue receiving paper mailing may be considered for providers lacking an Internet Service Provider (ISP) in their area. To submit an exception or request training for online applications, contact *PECS@bcbsil.com*. If a request cannot be submitted by email, contact your local BCBSMT network representative, who will forward to the appropriate area on your behalf. Otherwise, beginning Mar 1, 2017, claim summary information will be accessible exclusively through the report view application. Providers will be directed to make use of the report viewer if an exception request is not received by Feb. 17, 2017. The exception review process may require up to 5 business days before a response is returned.

BCBSMT supports an array of online tools to registered Secure Provider Portal users, including the report viewer, at no additional cost. To register, simply go to bcbsmt.com/provider, select Log In Secure Provider portal and complete the online application today.

Additional communication regarding the above-referenced change may be published in upcoming News & Updates articles, as well as on our Provider website.

— CONTINUED FROM PAGE 1

Once your organization is enrolled for ERA, providers and billing services gain the ability to use the HeW Remit Reader. This tool permits you to search, view, save and print remittance information, even if the ERA is delivered to a different receiver. To learn more about the Remit Reader, visit HeW or call 877-565-5457. If you are not registered with HeW, sign up today at hewedi.com.

For additional assistance with ERA and EFT registration email a Provider Education Consultant at *ECommerceHotline@bcbsil.com* or call 800-746-4614.

HeW is a separate company that operates a health information network to provide electronic information exchange services to medical professionals. HeW provides administrative services to BCBSMT. BCBSMT makes no endorsement, representations or warranties regarding any products or services offered by third party vendors. If you have any questions or concerns about the products or services the vendor offers, you should contact the vendor directly.

Health Information Exchange (HIE) Update

By Dr. Jonathan Griffin, Medical Director

Increasingly, both payers and providers are being held to higher regulatory requirements and standards of performance. Provider reimbursement and payer sustainability are progressively being linked to clinical quality scores as well as healthcare cost and utilization trends. Employer groups and individual consumers are demanding cost controls and transparency of healthcare outcomes. Demands in the healthcare market are great and the stakes are high. BCBSMT believes that success in today's healthcare market requires strengthened provider payer partnerships and new methods of exchanging actionable information that can improve the health of Montanans, optimize the way that healthcare is delivered and ultimately lead better cost containment.

Transparency is a buzzword you might hear in the market. Most groups talking about transparency now are focused on pricing of healthcare services and products alone. This is important, but does not allow for focus on all indicators. To move the dial on cost containment and quality outcomes, BCBSMT's idea of transparency is much broader and stems from our goal to be the best provider partner and leader in value based care. An example of our innovation and commitment to transforming the healthcare market through valued based care is the Billings Health Information Exchange pilot project.

Information exchange with providers is becoming more and more important in order to gauge the value of healthcare that BCBSMT is purchasing on behalf of members. Claims information provides a great deal of insight about members' utilization of healthcare services. Clinical information from provider electronic health record (EHR) systems describe the results of that care – the outcomes. Putting the two sources of information together helps paint the picture of total value: quality outcomes, member experience, and cost. Transparency is much more than just a price alone, but is a suite of information allowing consumers, providers, and payers to make informed decisions and to adequately and responsibly manage care.

Health information has always been fragmented. Provider EHR systems don't talk to each other. Payer claims systems don't talk to each other. And rarely will you find clinical and claims data together, in one system. What is more, most provider organizations have difficulty manipulating data within their own systems to generate meaningful, actionable information that can help better coordinate high quality care services for their patients-our members.

The HIE pilot is setup as a demonstration of success in the Billings community, using shared information to enhance care systems, quality improvement efforts, and to decrease the cost of care. Connecting data across organizations and the ability to translate larger pools of information to actionable reports is essential for success either as a provider organization or a payer.

The Billings HIE pilot is associated with a statewide effort to transition the project to a neutral, not-for-profit, third party health information exchange organization for the State of Montana. Developing a commanding sophistication with the aggregation and processing of data into action may be the single most important success factor in the emerging healthcare market. The value of healthcare requires transparency of both clinical and claims information to be successful. The HIE creates this possibility.

Modeling the great achievements Oklahoma has seen with its HIE and working together with the Billings Clinic, RiverStone Health, and St. Vincent Healthcare, BCBSMT continues to lead the way with our partners in building a public-private statewide health information exchange that will create transparency, enabling consumers' to see that their healthcare dollars are purchasing the highest value, highest impact services possible.

Upcoming Changes to the Provider Claim Review Form

Effective January 1, 2017, the paper Provider Claim Review Form for BCBSMT will be simplified for providers when submitting written claim inquiries.

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

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

NEW PROVIDER CLAIM REVIEW FORMS:

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

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

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

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

BlueCard Program Manual Reminders

To assist you when you are providing care and services to out-of-area Blue Plan members, a BlueCard Program Manual is available in the Standards and Requirements section of our website at bcbsmt.com/provider.

This manual includes information on how the BlueCard program works, how to identify BlueCard members, claim filing guidelines, key contacts, answers to frequently asked questions, a glossary of BlueCard terms and other important details.

EXAMPLES OF SPECIFIC SECTIONS INCLUDED IN THE BLUECARD PROGRAM MANUAL ARE:

- BlueCard Program Advantages for Providers
- Coverage and Eligibility Verification
- Electronic Provider Access
- Ancillary Claims
- Contiguous Counties/ Overlapping Service Areas

We encourage you to become familiar with the procedures and guidelines in this helpful resource.

Government Programs Claims Handling and Post-adjudication Process Changes, Effective Jan. 1, 2017

A number of changes will be implemented as of January 1, 2017, to help improve efficiencies in routing, handling and post-adjudication processes for government programs claims. A preview of the changes and related reminders is included below. Additional information will be published in the coming months. Please watch the Blue Review and News and Updates section of our website at bcbsmt.com/provider.

BLUE CROSS MEDICARE ADVANTAGE℠

The following changes will apply to claims submitted for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ members (alpha prefixes YDJ, YDL):

- **New Payer ID (66006) –** Beginning Jan. 1, 2017, Payer ID 66006 must be included on electronic claims received for Blue Cross Medicare Advantage PPO and Blue Cross Medicare Advantage HMO members. Blue Cross Medicare Advantage claims received with the commercial Payer ID (BCBS) will not be accepted.*

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

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

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

- **Website Updates**
  Government specific webpages will be updated with the relevant information.

- **Provider Guides**
  Information will be updated in the Provider Manuals for each state as well as the 835 Companion Guide

- **Electronic Remittance Advice (835 ERA)**
  835 ERA files will be distributed to the address associated with the billing provider's Tax ID and NPI, rather than being distributed to multiple locations.

  EPS (Electronic Payment Summary) will not be available for MAPD (all states) and IL Medicaid providers post 1/1/17; however, for ERA and non-ERA receivers the Provider Claim Summary's (PCS) will be sent by mail.

  If the provider is a current ERA receiver for MAPD (all states), they will not need to re-enroll under the new Payer ID for MAPD (all states).

  The Payer ID on the 835 ERA will now match the Payer ID that is submitted on the claim, (if submitting MAPD claims using 66006 then the ERA Payer ID will also reflect 66006).

— CONTINUED ON PAGE 6

— CONTINUED FROM PAGE 5

- **Paper Claim Mailing Address and Fax**
  Effective Jan. 1, 2017, the mailing address and fax number for paper claims for non-delegated providers will be:
  Blue Cross Medicare Advantage
  c/o Claims Administration
  P.O. Box 3686
  Scranton, PA 18505

  Fax: (855) 674-9192

  Effective 2/1/17, claims received at the old BCBSMT mailbox will be rejected with a letter informing providers to resubmit to the above correct mailbox.

- **New EFT Payment Cycle**
  Effective Jan. 1, 2017, Blue Cross Medicare Advantage claim payments will be sent on a weekly basis (currently MT is on a bi-weekly payment cycle).

- **New processes**
  New format for payments:
  - EFT trace number: MAPD will start with a source code of "M" instead of "C"

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

- BCBSMT will have a new lockbox address for provider overpayments:
  BCBSMT Claims Overpayment
  29068 Network Place
  Chicago, IL 60673-1290

*If you utilize a practice management/hospital information system or billing service, and/or a clearinghouse other than Availity™ or HeW for electronic claim submission, please contact your vendor to confirm they are using the new Payer ID for the alpha prefixes referenced above, rather than assigning their own unique number.

Avoiding Administrative Claim Denials

Blue Cross Medicare Advantage[SM] (MAPD) Health Plan wants to help you avoid administrative claim denials. To prevent denials from occurring, a list of administrative claim denials that providers may receive has been created, along with tips on how to avoid them. The table below has been created as a tool to help you avoid administrative claim denials.

Administrative Claim Denials and Tips to Avoid Them	
Denials	**Tips**
No Referral A referral to an out-of-plan or out-of-network provider which is necessary due to network inadequacy or continuity of care must be reviewed by the MAPD Utilization Management Department prior to a MAPD patient receiving care. The Blue Cross Medicare Advantage HMO referring physician or professional provider must call the number at the back of the member's ID card to request an out-of-plan or out-of-network referral authorization. For requests that are approved, the Utilization Management Department will forward an approval letter to the out-of-plan or out-of-network physician or professional provider.	Referral requests can be submitted via: • Phone call to the Customer Service number at the back of the member's ID card • Fax to the Utilization Management Department at 855.874.4711 Refer to the MAPD Health Plan Provider manual on the website to determine referral information.
No Inpatient Notification for Post Stabilization Care following an Emergency Room (ER) admission MAPD Health Plan requires an inpatient notification within one (1) business day for all members who are admitted for inpatient care, following an ER admission, regardless of whether MAPD Health Plan is the primary or secondary insurer. Admitting physicians and professional providers are responsible for contacting the Utilization Management Department to request preauthorization for additional days if an extension of the approved length of stay is required. Blue Cross Medicare Advantage UM personnel will assist with coordinating all services identified as necessary in the discharge planning process. Plan providers and hospital admitting departments are responsible for notifying MAPD Health Plan within the following time period: All Inpatient admissions for post stabilization care following an ER admission must be reported **within one business day**. ***Note: Notification of admission for all elective inpatient stays is requested for care coordination and discharge planning.***	Use one of the following options to obtain an inpatient notification for Post Stabilization Care following an ER admission via: • iExchange (provider portal) • Phone call to the UM Preauthorization Department using the number on the back of the member's ID card • Fax to the Utilization Management Department at number on the back of the member's ID card Refer to the MAPD Health Plan Provider manual on the website to determine inpatient notification requirements following and ER admission and the process for review.
No Authorization MAPD Health Plan requires plan providers to obtain prior authorization for certain services, drugs, devices and equipment in order to be covered.	Use one of the following options to obtain a prior authorization via: • iExchange (provider portal) • Phone call to the Customer Service number at the back of the member's ID card • Fax to the Utilization Management Department at 855.874.4711 Refer to the MAPD Health Plan Provider manual on the website to determine which services require prior authorization and the process for review.

Updates to the BCBSMT Medicare Advantage Preauthorization List Effective January 1, 2017

On January 1, 2017 BCBSMT's 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 here.

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.

NOTIFICATION FOR POST STABILIZATION CARE FOLLOWING AN EMERGENCY ADMISSION

Post-stabilization notification of inpatient admissions allows BCBSMT to evaluate the appropriateness of the setting of care and other criteria for coverage purposes. It aids in early identification of members who may benefit from specialty programs available from BCBSMT, such as Case Management, Care Coordination and Early Intervention (CCEI®), or Longitudinal Care Management (LCM). Notification also allows BCBSMT to assist the member with discharge planning. Thus, for stabilized members, BCBSMT requires notification of admission for post stabilization care services within one business day following treatment of an emergency medical condition. Failure to timely notify BCBSMT and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post-stabilization care services, charges for which cannot be billed to the member pursuant to your provider agreement with BCBSMT. In the event of a claim denial that includes emergency care services, the provider is instructed to rebill the claim for the emergency services (including stabilization services), as well as post-stabilization care services for which BCBSMT may be financially responsible pursuant to 42 CFR section 422.113(c), if any, for adjudication by BCBSMT. You can submit a notification for post stabilization care services through our secure provider portal via iExchange, or by phone, using the number on the member's ID card. Timely post stabilization notification of inpatient admission does not guarantee payment.

The attending physician must obtain preauthorization for the services listed below. The attending physician or facility must also notify of inpatient admissions within one business day.

Services Requiring Preauthorization
Service
All Network Exceptions
All Organ Transplants (excludes cornea)
Inpatient facilities – Medical (approve/pend based on IRL) • Acute Care Facility/Hospital
Inpatient Rehab Facility
Home Health Care and Hospice: G0151, G0152, G0153, G0299, G0300, G0157, G0158, G0159, G0160, G0161, G0162, G0163, G0164
LTAC (long term acute care)
Skilled Nursing Facilities (SNF)

— CONTINUED ON PAGE 9

— CONTINUED FROM PAGE 8

Outpatient Diagnostic Tests
• Advanced Radiology including: PET scans (78459, 78491, 78492, 78608, 78609, 78811 through 78816) Breast MRIs (77058 to 77059) CT Cardiology studies (75571 through 75574)
• GI Radiology services including 91110, 91111
Blepharoplasty: 15775, 15776, 15777, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835
Botox Injections: 64650, 64653, 64615
Air Ambulance Services: A0430, A0431, A0435, A0436
DME, Medical Supplies, Orthotics and Prosthetics > $2500 and including the following:
E0652, K0822, E0748, E0747, L8680, E0760, K0861, E0935
• Diabetic Shoes
• Power Wheelchairs
• Specialty Beds
• Hearing Aids V5298 and Cochlear Implant Devices
Specialty Drugs: J1459, J1556, J1557, J1559, J1561, J1562, J1566, J1568, J1569, J1572, 90283, 90284, J2357, J1745, J0490, Q2043, J3262, J2323, J9035, C9257, J9310, J9306, J0585, J0587, J9228, J0598, J1575, J3490 , J3590, J9271, J9299, 90378
Behavioral Health
All Network Exceptions
All inpatient Stays Facilities/Hospitals
Outpatient Mental Health Services ECT-90870 rTMS-90867, 90868 Psychological Testing – 96101, 96102, 96103 Neuropsychological Testing – 96105, 96111, 96116, 96118, 96119, 96120, 96125
Partial Hospitalization Program
Surgical Outpatient: 69930, 33282, 67904, 64561, 22614, 43644, 22840, 43774, 43775, 22851, 77338, 33225, 36476
Surgical Inpatient: 63685, 22633, 22612, 22630, 64561, 22840, 22842, 22585, 22845, 33225
Medical Outpatient: 77373, 36514, E0676, 77435
Laboratory Genetic Outpatient: 81404, 81321, 81226, 81213

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 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.

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.

— CONTINUED ON PAGE 10

Coordination of Care Between Medical and Behavioral Health Providers

BCBSMT continually strives to promote coordination of member care between medical and behavioral health providers. We understand that communication between providers regarding the treatment and coordination of a patient's care can pose difficult challenges.

Here are few resources available to you through BCBSMT:

1) The Coordination of Care Form Available Online:

To provide assistance when coordinating care, BCBSMT has created a Coordination of Care form that is available on the BCBSMT provider website.

This new form may help in communicating patient information:
- To provide member treatment information to another treating provider
- To request member treatment information from another treating provider

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

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

The Coordination of Care form is available on the BCBSMT website: https://www.bcbsmt.com/static/mt/provider/pdf/behavioral-health-coordination-of-care-form-mt.pdf

2) If you need help finding a Behavioral Health Provider for your patient:

Call the number on the back of the member's BCBSMT card to receive assistance in finding an outpatient provider or behavioral health facility.

3) Behavioral Health or Medical Case Management Services:

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

— CONTINUED FROM PAGE 9

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
- 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.

New Preauthorization Requirement for Applied Behavioral Analysis

BCBSMT uses preauthorization requirements to help ensure that the service or drug being proposed is medically necessary and appropriate, follows up-to-date medical recommendations, and is [the most/an] effective option for the member for whom it is proposed.

Effective January 1, 2017, preauthorization must be obtained prior to receiving Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder. Members enrolled in the networks listed below must obtain preauthorization;

- Traditional/Par Network
- Managed Care Network POS
- Blue Focus POS℠
- Blue Preferred PPO℠
- Blue Options℠

To initiate the preauthorization process, please complete the following three forms for review. These forms can be found in the provider section of our website at bcbsmt.com/provider. Please fax the completed forms to 855-649-9681.

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

REMINDERS:

- The member must have an Autism Spectrum Disorder diagnosis from a qualified diagnostician.
- The ABA service provider must have the credentials necessary to conduct ABA services.
- An initial functional assessment, including a treatment plan identifying any deficient skills and the appropriate interventions, must be completed.
- After the first authorization for ABA services, additional services may require concurrent review to ensure the services continue to meet the medical necessity guidelines.
- iExchange® is not available for ABA preauthorization or behavioral health at this time. Please call the number on the back of the members' ID card for ABA preauthorization requests.

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

We are focused on improving health care delivery and finding solutions that help enable our members to receive the best possible health outcomes with resources committed to their care.

Please note: The fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. Regardless of any benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

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. (MT). iExchange is accessible to physicians, professional providers and facilities contracted with BCBSMT.

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 Medecision. The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

eviCore Preauthorization Program

BCBSMT has contracted with eviCore healthcare (eviCore)* to provide certain utilization management services for outpatient molecular and genomic testing, this in addition to the current Outpatient Radiation Therapy preauthorization managed by eviCore. eviCore is an independent company that provides specialty medical benefits management for BCBSMT.

PREAUTHORIZATION REQUIREMENTS

BCBSMT requires preauthorization (for medical necessity)
** through eviCore for outpatient molecular and genomic testing and outpatient radiation therapy for the following benefit plans:

- All individual plans
- All fully insured commercial groups
- All self-insured groups

Refer to the eviCore implementation site and select the BCBSMT health plan for the applicable CPT/HCPCS code list and radiation therapy physician worksheets.

CONTACT INFORMATION

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

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

* eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSMT.

** 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.

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

iExchange Training: 2016 System Enhancement
- December 6, 2016

iExchange Training: Predetermination Requests
- December 1, 2016

2017 Montana Provider Updates for Network and Product Changes
- December 6, 2016
- December 8, 2016
- December 14, 2016

Effort to modernize laws related to Montana's Immunization Information System this session are underway

By Bekki Kirsch-Wehner, Immunization Program Manager,
Department of Public Health and Human Services

Montana's Immunization Information system (IIS), imMTrax, securely stores immunization records accessed by health care providers and schools to quickly determine what vaccines may be needed during a medical visit or to meet school attendance requirements. An estimated 85% of the state's children have at least two shots recorded in imMTrax and additional sources of immunization information are being added to improve the completeness of the IIS.

At the current time, healthcare providers must obtain patient consent to share information with imMTrax. This approach is referred to as an "opt-in" consent model. For the many healthcare providers submitting immunization information to imMTrax daily, as well as public health agencies and school administrations who utilize the information, the current process is time consuming and inefficient. Additionally, providers using their electronic health records (EHR) to send immunization information electronically are presented with unique challenges as most EHRs are not set up to accommodate the opt-in consent module.

Montana is one of only three states that use an opt-in rather than an opt-out consent model to gather immunization information. Legislation to be proposed by the Montana Medical Association, and other partners, will propose moving to an opt-out model during the 2017 legislative session. Similar models have demonstrated cost and time savings for healthcare providers, public health agencies, and school administrations while still allowing for personal or parental choice regarding participation in imMTrax. In the opt-out model, administrative burdens are reduced by requiring documentation for only those who choose not to participate in imMTrax, which studies show is less than 4%. The opt-out model also benefits patients, by simplifying the consent process.

Most importantly, adopting the opt-out consent model will increase the overall effectiveness of imMTrax and continue to help patients, parents, healthcare providers, public health agencies, and school administrations prevent disease and disease outbreaks through improved immunization coverage.

2017 Montana Provider Updates for Network and Product Changes

For the month of December, BCBSMT will provide training on the 2017 Montana Provider Updates for Network and Product Changes. This webinar would be appropriate for any clinic or facility staff who submits authorizations for inpatient or outpatient services as well as staff members who submit claims on behalf of our members; your patients.

TOPICS WILL INCLUDE:

- Marketplace Facts and Statistics
- 2017 BCBSMT Network and Product Updates
- Medicare Advantage
- 2017 Pharmacy Changes
- Provider Finder
- Q&A

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

- Tuesday, December 6, 2016 – 10:00 a.m. MT
- Thursday, December 8, 2016 – 12:00 p.m. MT
- Wednesday, December 14, 2016 – 2:00 p.m. MT

ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and HCPCS codes are periodically added to or deleted from the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version. BCBSMT will normally load this additional data to the BCBSMT claim processing system within 60 to 90 days after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSMT Provider website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) also will be posted on the BCBSMT Provider website.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSMT's code-auditing software. Refer to our website at bcbsmt.com/provider for additional information on gaining access to C3.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the Clear Claim Connection™ page. Additional information also may be included in upcoming issues of the Blue Review.

Blue Review is a quarterly newsletter published for institutional and professional providers contracting with Blue Cross and Blue Shield of Montana. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our website at *bcbsmt.com/provider.*

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

BLUE REVIEW
Blue Cross and Blue Shield of Montana
Attn: Julie Sakaguchi
P.O. Box 4309
Helena, MT 59604
Email: *Julie_Sakaguchi@bcbsmt.com*
Website: *bcbsmt.com*