BlueCross BlueShield of Montana

BLUE REVIEW℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS — FOURTH QUARTER 2017

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Blue Cross and Blue Shield of Montana Plan President Announcement

We are pleased to announce that Dr. Monica Berner has been promoted to president of Blue Cross and Blue Shield of Montana (BCBSMT). Most recently, Dr. Berner was responsible for all Montana Plan operations, including sales and account management, government and public relations, provider network management, and medical management. Previously, Dr. Berner served as chief medical officer and medical director. This promotion will better enable her to focus on the needs of our Montana members, providers, producer partners and communities.

Dr. Berner joined BCBSMT in April 2009, after working in direct patient care for 12 years. She received her medical degree in 1994 from Baylor College of Medicine in Houston, Texas. Dr. Berner had a private medical practice in Aloha, Oregon, before joining the Lewis and Clark County Community Health Center in Helena. She then became a Veterans Affairs staff physician in the outpatient clinic at Fort Harrison, Montana's Veterans Hospital. Dr. Berner was named the Montana Medical Association's 2016 Merit Award winner for her leadership in health care innovation and her extensive work on behalf of Montana physicians.

Dr. Berner succeeds Mike Frank, who continues his role as senior vice president, overseeing the financial and operational performance of the Blue Cross and Blue Shield Plans in Montana, New Mexico and Oklahoma. In addition, Frank has responsibility for Dearborn National, the company's ancillary services provider.

Important Information about Provider Finder® and HealthCare.gov

We are aware there is a problem with clinics and medical groups appearing incorrectly as in- or out-of-network on healthcare.gov and on our Provider Finder. We are working diligently to resolve the issue.

If you search for a clinic or medical group and it is not listed as in-network, you are encouraged to search for individual physicians to determine whether they are in- or out-of-network.

If you have any questions, please reach out to our network management team by calling **1-800-447-7828**, Ext. 6100 or by emailing hcs-x6100@bcbsmt.com.

PROVIDER NETWORK REPRESENTATIVE CONTACT INFORMATION

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

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

Laura Knaff
406-437-6961
Laura_Knaff@bcbsmt.com

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

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

Our *Blue Review* 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

In-Home FOBT/FIT & HbA1c Test Kits for Federal Employee Program® (FEP) Members

Beginning in November, some Blue Cross and Blue Shield Federal Employee Program members may receive the Fecal Immunochemical Test (FOBT/FIT) for colorectal cancer screening and/or Hemoglobin A1c in-home test kits. Members were identified for possible participation if they have a diagnosis of diabetes and did not have a claim for hemoglobin A1c testing and/or had no claim history of colorectal cancer screening. Members can first expect to receive a communication about the tests, and within that communication, members will have the option to opt out of the program and decline the test kits.

The following two tests will be sent out to our members and processed by Home Access Health Corporation at no additional cost to members:

- FIT tests for colorectal cancer screenings
- A1C tests for blood sugar control for diabetes

Test results will be sent via mail to both the member and their primary care physician (PCP) on file. Our goal is to encourage members to close care gaps by making the process easier to complete the test(s) in the comfort of their own homes.

We are requesting that you do the following:

- Encourage your patients to take these test kits should they receive them and advise your patients that after taking the tests, they should return them in the prepaid postage envelope to the address listed.
- Reiterate to your patients that they should provide their PCP's name and mailing address, along with their sample, to receive the test results.
- Please be on the lookout for these test results so that you can place them into the member's records and be prepared to follow up on any alert values received.

If you have any questions or if you need additional information, please contact your BCBSMT provider network representative. Members can use the Customer Service number listed on the back of their insurance card.

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

Home Access Health Corporation, an independent company, provides laboratory services to Blue Cross and Blue Shield of Montana. Home Access Health is solely responsible for the products, services, and test results that they provide.

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

The updated 2018 Medicare Advantage Provider Manual has been published on the Provider Portal, under Network Participation, Blue Cross Medicare Advantage, Resources.

The 2018 Commercial Provider Manual and 2018 Medicare Advantage Provider Manual have been updated and are posted on the Secured Provider Portal.

Commercial Prior Authorization Requirements

Beginning January 1, 2018, providers will be required to obtain preauthorization through BCBSMT or eviCore for certain procedures as outlined below.

Fully insured and Retail business:
New prior authorization requirements effective 1/1/18;

Prior Authorization completed by Utilization Management at BCBSMT and online through iExchange (www.bcbsmt.com/provider/education-and-reference/iexchange or **800-447-7828** or FAX 866-900-2634):

- **Musculoskeletal (MSK)**
  - Interventional Pain Management
    - Percutaneous and Implanted Nerve Stimulation and Neuromodulation
    - Spinal Cord Stimulation
- **Orthopedic**
  - Functional Neuromuscular Electrical Stimulations (FNMES)
  - Artificial Intervertebral Disc
  - Lumbar Spinal Fusion
- **Sleep studies**
  - Adult and Pediatric Facility-Based Polysomnography
  - Adult and Pediatric Facility-Based PAP Titration

  Note:
    - Sleep Study service providers must have the credentials necessary to conduct Sleep Study services.
    - Sleep Studies performed in the home do not require prior approval.
    - Clinical information submitted should include why a home sleep study is contraindicated.
- **Non-emergent Air Ambulance** (refer to Medical Policy for definition, Policy # ADM1001.005 located at link www.bcbsmt.com/provider/standards-and-requirements/medical-policies)

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Influenza Virus Vaccine Code Update

The American Medical Association (AMA) has released a new Current Procedural Terminology (CPT®) code 90756 which is effective January 1, 2018, for claims processed with dates of service (DOS) on or after January 1, 2018.

CPT code 90756-Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use may be used to best describe preservative containing Flucelvax Quadrivalent vials which received FDA approval July 07, 2017, for the 2017-2018 flu season.

For claims prior to January 1, 2018, doses using preservative containing Flucelvax Quadrivalent 2017-2018 NDCs may be submitted with 90749-Unlisted vaccine/toxoid or Q2039-Influenza virus vaccine, not otherwise specified.

90674-Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use-may continue to be used to best describe ***preservative and antibiotic free*** Flucelvax Quadrivalent pre-filled syringes.

NOTE: When billing flu vaccines code descriptions may be specific to dosage, formulations such as trivalent vs quadrivalent, preservative vs preservative free, or other distinctive features (i.e. split virus, recombinant DNA, cell cultures, intradermal, or intramuscular).

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Effective 3/1/18 new prior authorization requirements for Fully Insured and Retail:

- With eviCore (www.evicore.com or calling **855-252-1117**)
  - Advanced Radiology Imaging (PET/CT scans, MRIs, CT, CTA, MRA, Nuclear Medicine)

Blue Cross and Blue Shield of Illinois Employer Group (which covers BCBSMT employees) and National Accounts will be using health advocacy solutions (HAS):

- HAS is being offered to Self-funded groups, National Accounts, and BCBSMT covered employees (BCBSMT employees)
- HAS offers three different options – Primary, Advanced, and Premier

New prior authorization requirements **effective 1/1/18**:

- **Primary package;**
  - With eviCore (www.evicore.com or calling **855-252-1117**)
    - Molecular and Genomic Testing (eviCore)
    - Radiation Therapy (eviCore)
    - Advanced Radiology Imaging (Notification Only – eviCore)
- **Advanced package;**
  - With eviCore (www.evicore.com or calling **855-252-1117**)
    - Molecular and Genomic Testing (eviCore)
    - Radiation Therapy (eviCore)
    - Sleep Studies and Sleep DME (eviCore)
    - Advanced Radiology Imaging (eviCore)
- **Premier package;**
  - With eviCore (www.evicore.com or calling **855-252-1117**)
    - Molecular and Genomic Testing (eviCore)
    - Radiation Therapy (eviCore)
    - Sleep Studies and Sleep DME (eviCore)
    - Advanced Radiology Imaging (eviCore)
  - Completed by Utilization Management at BCBSMT online through iExchange
    - Cardiology
    - Ear Nose and Throat
    - Gastroenterology
    - Musculoskeletal
    - Neurology
    - Non-Emergent Air Ambulance
    - Outpatient Surgery
    - Orthognathic Surgery
    - Mastopexy
    - Reduction Mammaplasty
    - Bunionectomy
    - Carpal Tunnel Repair
    - Cardiac Catherization

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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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- Inguinal Hernia Repair
- Lithotripsy
- Specialty Pharmacy
- Wound Care

For additional information about the Preauthorization requirements effective 1/1/18 for Fully insured and Retail:

www.bcbsmt.com/static/mt/provider/pdf/news/new-2018-additional-benefit-preauthorization-requirements.pdf

For additional information about the Preauthorization requirements effective 1/1/18 for BCBSMT & National Accounts through HAS:

www.bcbsmt.com/static/mt/provider/pdf/news/HAS-Disclosure-MT-100617.pdf

Services performed without benefit preauthorization may be denied for payment and in whole or in part, you may not seek reimbursement from members. Please note a member penalty may also apply based on the benefit plan.

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.

To obtain benefit preauthorization through BCBSMT for the care categories noted above, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSMT. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Provider Network Representative.

HELP Plan Update

Effective January 1, 2018, BCBSMT will no longer administer the Montana HELP Plan. Members will transition to Montana Medicaid. These members will continue to present with a BCBSMT card through December 31, 2017. Customer Service inquiries, eligibility inquiries, claims submission, and claims processing for dates of service in 2016 and 2017 will continue to be handled by BCBSMT through December 31, 2018.

Beginning January 1, 2018, these members will present with a Montana Medicaid card and will be eligible for the Standard Medicaid benefit package.

If you are already enrolled as a Montana Medicaid provider, you will not need to make any changes except that you will no longer submit claims to BCBSMT and you will no longer use the YDM portion of the member ID This change will be reflected on each member's Access to Health ID Card. You should continue to verify eligibility at http://medicaidprovider.mt.gov/, before providing services to the member.

If you are not enrolled, you can become a Montana Medicaid provider by going to http://medicaidprovider.mt.gov/providerenrollment. If you have questions about the application or enrolling process, please call Montana Provider Relations at **1-800-624-3958**.

For HELP Plan claims inquires with dates of service in 2016 and 2017, please call Provider Services at **1-877-296-8206**.

For claims inquires with dates of service beginning January 1, 2018, please call Montana Provider Relations at **1-800-624-3958**.

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 2. Radiology 3. Medical Oncology 4. Molecular Genetics 5. Musculoskeletal - (PT/OT/ST;Spine/Joint/Pain/Chiro) 6. Radiation Therapy 7. Sleep 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 Call toll-free at **855-252-1117** between 7 am -7 pm local timeMonday through Friday except holidays. 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 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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MT TeenVax Challenge Winners

Dear Immunization Providers,

Thank you for displaying and sharing information about the 2017 MT TeenVax Challenge! The Montana Immunization Program and our partners are very pleased with the response to this year's challenge. We received 470 entries and randomly selected winners in 48 counties. There were 160 more entries than last year. Entrants reported hearing about the MT TeenVax Challenge from: healthcare provider (237); materials posted at healthcare provider office (101); health department (161); Facebook (18); school (10) and other (25).

We contacted the parents/guardians of the winners over the past week. Thirty seven health departments will be presenting the gift card to the winner, while the others were directly mailed. You may see a photo and/or article in your local paper. Information on which counties have winners can be found on our webpage at http://dphhs.mt.gov/publichealth/Immunization/AdolescentVaccines.

We appreciate all the vaccines you provide to teens and the work in catching up those who missed vaccination. We hope you will continue to join us with our campaign to increase adolescent coverage rates in Montana. If you have any questions, please contact the Montana Immunization Program at **406-444-5580** or hhsiz@mt.gov.

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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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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 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 *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.	

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.

Important Information on ABA Authorizations and Payment

Starting October 1, 2017, BCBS will align our ABA authorizations and payments of T codes with Centers for Medicare and Medicaid Services (CMS) recommended edits. These edits limit per day how many units of the ABA T code can be billed per day. If you want more information on these CMS edits, please go to cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, then locate the link toward the bottom of the page for 'Practitioner Services MUE Table-Effective 10/1/17'. The T codes are listed there with the units per day that can be billed.

Operational Effectiveness: Better and Faster Ways to Do Business Together

How can we help providers so that they can effectively drive operational and clinical efficiencies while continuing to deliver quality care? BCBSMT is committed to making system and process improvements and innovations to better support and collaborate with the providers. Now more than ever, collaboration is essential to help control rising health care costs, avoid redundant or unnecessary care, identify opportunities for members to get the right care at the right time and place, and streamline administrative work. Ultimately, we want to make it easier for providers to do business with us and we want to continue to earn their satisfaction.

In the months ahead, we are rolling out new ways to work together, which have been created with efficiency and effectiveness in mind. As we systematically deploy new processes and programs, we are helping providers realize the ability to integrate these new efficiencies into existing workflows with relative ease.

We are introducing more ways to transact provider-payer business electronically, with an increased emphasis on online forms, tools and other resources. The increased focus on electronic tools will help improve data accuracy, which in turn helps ensure claims process accurately and provider directories are up-to-date.

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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

Availity™ 101 4Q Schedule:
December 19, 2017 11:00 am

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Another way we are building efficiencies into the provider-payer relationship is through various data solutions that will offer providers greater insight into our members' health status and the quality and cost of care they deliver. New Clinical Data Exchange (CDE) tool capabilities will streamline and speed the online exchange of member clinical data between providers and BCBSMT in a scalable and secure platform. This technology will enable connected providers to access a member's medical record and the health summary at the site of service. We anticipate this will help providers identify unmet care needs and avoid unnecessary or redundant services. We also anticipate that clinical data exchange will help reduce claims processing and payment time as a likely result of fewer pended, denied and appealed claims.

Care quality and cost analytics and reporting augment our clinical data exchange efforts. We are striving to make the health care system work better through the controlled deployment of a single, online platform for a suite of quality and efficiency analytics and reporting. Our new Provider Performance Analytics and Reporting tool is accessible in the BCBSMT-branded Payer Spaces section to registered Availity™ Web portal administrators and assigned users. This tool offers a robust suite of data dashboards that display valuable information about providers' overall BCBSMT member population and allows users to filter quality data in a variety of ways such as age range, diagnosis type, and contract type. Providers can view emergency room and pharmacy risk adjustment and incentive data, among other details. Our reporting tools can help illuminate the services that may help providers maximize reimbursement access.

In addition, provider performance efficiency analytics offer insight into the cost of care by type of care episode and how it compares to care delivered by peer providers in the same market, specialty or network for similar BCBSMT members. This new platform will allow us to deliver reports faster, and with dynamic reporting capability.

As Executive Director of Quality and Accreditation, Terri Kitchen shares, "With so many different types of performance management metrics available through the dashboards, depending on what the end user needs, there's probably a dashboard for that." We believe that the quality and efficiency data will help providers identify and prioritize practice enhancement opportunities.

To prepare for the use of these new data solutions, we encourage you to become a registered Availity user – visit availity.com today to register online at no charge. Becoming a registered Availity user will give you immediate access to many tools and resources that are available now, while also ensuring you will be first in line to begin using new data solutions when they launch.

Should health care be a packaged deal?

The health care industry is moving toward viewing and paying for all the care associated with a single condition or procedure — such as knee replacement surgery and rehabilitation — as one product. This emerging model has all parties focused on cost and quality, something not happening enough in the current fee-for-service model.

New on our online magazine, *Making the Health Care System Work*℠, we explore the **episodes of care** payment model that we are working to implement, starting with hip and knee replacements.

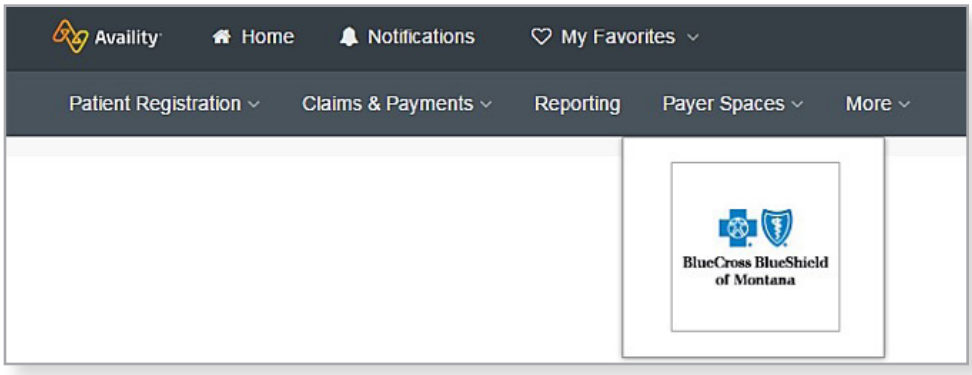
www.makingthehealthcaresystemwork.com/2017/09/20/should-health-care-be-a-package-deal/

How to Find BCBSMT Resources in Availity Payer Spaces

Have you recently been searching in the Availity Web Portal to locate a specific BCBSMT tool or enrollment option? Some of our electronic resources offered through Availity have moved to the BCBSMT-branded Payer Spaces section in Availity.

The BCBSMT-branded Payer Spaces section contains payer-specific in-house applications, resources, and links to the BCBSMT provider website for quick access to pertinent information. You can also view the latest Availity News and Announcements for various payer-specific articles, newsletters and reference documents.

Providers may access BCBSMT-branded Payer Spaces by selecting the Payer Spaces drop-down option from the Availity navigation menu.



The following online tools and resources are now available via the Resource tab within the BCBSMT-branded Payer Spaces section:

- Electronic Fund Transfer (EFT) online enrollment
- Electronic Remittance Advice (ERA) online enrollment
- iExchange® online benefit preauthorization registration
- National Drug Code (NDC) Units Calculator
- Electronic Refund Management (eRM) tool
- and more…

Note: The Claim Research Tool (BCBS) remains available in the Claims & Payments tab on the Availity navigation menu.

To learn more about BCBSMT's electronic offerings, visit the Provider Tools page in the Education and Reference Center of our website at bcbsmt.com/provider. For assistance or customized training, contact a Provider Education Consultant at PECS@bcbsmt.com.

New Online Magazine Spotlights Emerging Episodes of Care Payment Model

Visit our new online magazine *Making the Health Care System Work* that explores major health care topics in the national news and how we can all work together to improve the health care system. A recent article looks into moving away from the traditional fee-for-service model and toward viewing and paying for all the care associated with a single procedure or condition as one product.

Health insurers are often portrayed as part of the problem in health care. At BCBSMT, we believe that having access to affordable, quality coverage can make a positive and often profound difference in our members' lives.

This is one of the reasons we've launched *Making the Health Care System Work*, our new online magazine, to help tell our story and explore ways we can all work together to make the health care system work better for everyone. Insurers, providers, employers and members all have a vital role to play in finding bold solutions for the future.

In our recent online article – Should health care be a package deal? – we explore how the health care industry is moving toward viewing and paying for all of the care associated with a single condition or procedure, such as knee replacement surgery and rehabilitation, as one product. This new episode of care payment model has all parties focused on cost and quality, something that is not happening enough in the current fee-for-service model.

Join the Conversation

Subscribe to get updates from *Making the Health Care System Work* delivered right to your inbox. We will let you know when new stories are published and share featured stories that explore how we can help expand access to quality coverage and care, reduce costs and improve health.

Reminder: Improper Documentation of Laboratory Services Could Result in Denial of Payment for Services

The Special Investigations Department (SID) would like to remind independently contracted providers that in order to assist in prompt payment of claims and to help ensure payment integrity, BCBSMT requires laboratory services to be properly documented. Incomplete or illegible medical records may result in a reduction in or no payment for services. In order for BCBSMT to process a claim and for BCBSMT benefits to be applied, there must be sufficient documentation in the provider's or hospital's records to verify the services performed were medically necessary and required the level of care billed. Request for payment for the services may be denied if there is insufficient documentation. Additionally, if there is insufficient documentation for the claims that have already been adjudicated by BCBSMT, reimbursement may be considered an overpayment and the funds may be recovered.

Laboratory claims for BCBSMT members should be submitted through the Blue Plan where any samples were obtained, usually where the testing facility is situated. Each laboratory claim should have valid laboratory medical records documenting the services ordered and the results of the services performed. Laboratory medical records consist of a signed valid requisition and complete results of the tests performed. A valid requisition is one received from the patient's treating physician or qualified health care provider (i.e., the provider treating the patient and who will use the test results in the management of the patient's specific medical problem). Records should be complete, legible and include the following:

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Update from Centers for Medicare and Medicaid Services (CMS)

CMS NOTIFICATIONS FOR BLUE CROSS AND BLUE SHIELD OF MONTANA MEDICARE PLANS

Centers for Medicare & Medicaid Services (CMS) publishes notifications that provide CMS guidance to all Medicare physicians, providers, and suppliers, including those serving beneficiaries enrolled in Original Medicare and/or the Blue Cross and Blue Shield of Montana medicare plans. Please make sure that your staff is aware of these notifications.

These CMS notifications are also located in the Medicare Learning Network (MLN Matters) notifications on CMS.gov as well as on our BCBSMT provider website. These notices from CMS can be informational regulatory updates, informational regulatory reminders, or require actions or changes by the provider rendering services. Please review the CMS notifications regarding the Jimmo Settlement.

Continue to review the *Blue Review* for changes as well as our website.

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

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Requisition

- Complete patient identification
- Complete ordering provider identification [at a minimum, full name and National Provider Identifier (NPI)]
- Signature of ordering physician (must be legible; "Signature on File," signature stamp or photocopies of signature are not acceptable)
- Facility and location where sample was collected is relevant [e.g., office, home, hospital, Residential Treatment Center (RTC); also include state (such as Illinois)]
- Type of sample (e.g., blood, serum, urine, oral swab)
- Date and time collected
- Date and time received in the lab
- Identity of individual who collected sample
- For urine testing, a temperature at time of collection may be relevant and aid in validity
- ICD-10-CM diagnosis codes received from ordering provider (specificity required)
- Identify specific tests ordered (avoid "Custom" panels)
- For drug testing, a current medication list may be relevant and aid in supporting medical necessity
- For drug testing Point of Care (POC) test results may be relevant and aid in supporting medical necessity

Providers are reminded to refer to BCBSMT's Urine Drug Testing Policy MED207.154. In addition, it is useful to recall that Medicare will only pay for tests that are medically reasonable and necessary based on the clinical condition of each individual patient. Confirmation of drug screening is only indicated when the result of the drug screen is different than suggested by the patient's medical history, clinical presentation, or the patient's own statement. Medicare makes this statement to reinforce that the ordering provider is cautioned that the justification for the need for testing is required.

Laboratory Results Documentation

- Complete identification of performing entity (name, address, Clinical Laboratory Improvement Amendments (CLIA) number)
- Identity of patient (full name, date of birth)
- Identity of ordering provider (name, NPI number)
- Identity of facility, if applicable
- Date sample was collected
- Date sample was received in lab
- Date test results were reported
- Complete test results including validity testing if performed

Although BCBSMT does not require a laboratory provider to recover and submit medical records from an ordering provider, it should be noted that it is the billing provider's responsibility to be able to substantiate the medical necessity of the laboratory services billed. If necessary, BCBSMT will request records from an ordering provider to substantiate and provide supporting information during a laboratory claim audit/review. Insufficient or a lack of supporting information may result in denial of the laboratory claim. For more information, see the BCBSMT's Urine Drug Testing Policy MED207.154 by visiting the

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MAO COVERAGE OF SUPERVISED EXERCISE THERAPY (SET) FOR SYMPTOMATIC PERIPHERAL ARTERY DISEASE (PAD)

Effective immediately:
CMS has determined that the cost and reimbursement for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) will be covered, for calendar years 2017 and 2018 only, by original fee-for-service Medicare. Providers should bill necessary SET items and services obtained by beneficiaries enrolled in MA plans to original fee-for-service Medicare. For 2019 and subsequent years, providers should plan to bill SET items and services to the beneficiaries' MA plan unless notified otherwise.

Consistent with §1862(a)(1)(A) of the Act, Medicare Administrative Contractors will consider whether SET for PAD services are reasonable and necessary and reimbursable by original Medicare for Medicare beneficiaries enrolled in MA plans in calendar years 2017 and 2018.

For additional information, please refer to the link below:

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10236.pdf

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Standards and Requirements/Medical Policy section of our website at bcbsmt.com/provider for the most up-to-date medical policy information.

Medicare auditors similarly require a billing provider to assume responsibility for obtaining supporting documentation as needed from a referring physician's office. For more information, see the Medicare Program Integrity Manual on the Centers for Medicare & Medicaid Services (CMS) website.

It is the responsibility of the ordering provider to document in a patient's medical record the support required to determine the medical necessity for each service ordered so as to allow BCBSMT to determine if the services are eligible for coverage. The record must be specific to an individual patient and not consist of "standing," "routine" or "orders per protocol." Such "one size fits all" ordering will not support the necessity for testing and may result in a payment denial for the laboratory service.

Familiarity with health care plan medical policies regarding laboratory testing may help prevent unexpected claim denials. Orders alone do not ensure reimbursement. Medical policies, benefits, eligibility, and medical record documentation are the determining factors for reimbursement.

Laboratories also should be mindful of requests for testing received from inpatient and intensive outpatient behavioral health facilities as laboratory services are included in per diem rates paid to the entities and should not be "unbundled" and submitted for separate claim reimbursement. In those instances, separate reimbursement for laboratory services may be denied or disallowed as payment is included in the ordering provider's per diem payment.

BCBSMT's Medical Policies may be found by visiting the Standards and Requirements/ Medical Policy section of our website at bcbsmt.com/provider. Medicare Local and National coverage documents may be found online by searching Medicare's public website. Individual benefit/coverage information may be found by calling the Customer Service number on the member's insurance ID card.

NEWS FROM DPHHS

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: Susan Lasich
P.O. Box 4309
Helena, MT 59604
Email: Susan_Lasich@bcbsmt.com
Website: bcbsmt.com