

CapsuleNewsSM

**A NEWSLETTER FOR MONTANA
HEALTH CARE PROVIDERS
Third Quarter 2015**

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Join a Webinar: Using ICD-10 in Online Benefit Preauthorization Requests

Blue Cross Blue Shield of Montana (BCBSMT) will be offering educational webinars through September 2015 to demonstrate the differences you may encounter when using ICD-10 codes in iExchange[®], our online benefit preauthorization tool. Select a date from the list below to register now for an iExchange ICD-10 Enhancements webinar.

- [Sept. 16, 2015 – 1 to 2 p.m. MT](#)

Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

ICD-10: It's Really Happening

The transition to ICD-10 is federally mandated. The compliance deadline is Oct. 1, 2015. As of the compliance deadline, claims without valid ICD-10 codes, as required, will not be accepted by Blue Cross Blue Shield of Montana (BCBSMT). Use of ICD-10 also affects eligibility and benefits requests, preauthorization, electronic health records, referrals and other processes.

Are you ready? Are you sure? Take action now. Visit the Standards and Requirements/ICD-10 section of our website at bcbsmt.com/provider for readiness tips and educational resources.

ICD-10: Quick Facts and Resource Reminders

The U.S. Department of Health and Human Services (HHS) published a final ruling in early August 2014, confirming an Oct. 1, 2015, mandated transition to ICD-10. As of this compliance deadline, all Health Insurance Portability and Accountability Act (HIPAA) covered entities **must** use ICD-10 on claims and other health care transactions.

- ICD-10-CM will replace ICD-9-CM for diagnosis coding in all health care settings. ICD-10-PCS will replace ICD-9-CM for inpatient procedure coding.
- Outpatient and professional ICD-10 coding is based on date of service; inpatient institutional ICD-10 coding is based on date of discharge.
- Outpatient and professional claims will need to be split if services dates span the compliance date.
- Use of other codes, such as Current Procedural Terminology (CPT[®]), HCPCS and Revenue Codes will not be impacted by the transition to ICD-10.

There are many industry resources available to assist providers with making the transition to ICD-10. The Centers for Medicare & Medicaid Services (CMS) offers training modules for Continuing Education Units (CEUs) and helpful resources for small and medium provider practices, such as the [Road to 10](#) site and new [Quick Start Guide](#).

Please refer to the Standards and Requirements/ICD-10/Stay Informed section of our Provider website for additional links to helpful external sites and educational resources. You'll also find links to BCBSMT resources, such as answers to [frequently asked questions](#).

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ICD-10: Approaching the Finish Line

As mandated by the U.S. Department of Health and Human Services (HHS), all Health Insurance Portability and Accountability Act (HIPAA) covered entities must use ICD-10 codes on claims and other health care transactions as of the Oct. 1, 2015, compliance deadline.

CLAIM SUBMISSION REMINDERS

ICD-10 codes must be used on all claims with dates of service on or after Oct. 1, 2015, and inpatient institutional claims with dates of discharge on or after Oct. 1, 2015. As of the Oct. 1, 2015, compliance deadline, claims without valid ICD-10 codes, as required, will not be accepted by Blue Cross Blue Shield of Montana (BCBSMT). Use of other codes, such as Current Procedural Terminology (CPT[®]), HCPCS and Revenue Codes will not be impacted by the transition to ICD-10.

TESTING END DATE: AUG. 14, 2015

We want to thank those providers who participated in our ICD-10 Testing Program. BCBSMT began conducting end-to-end testing of electronic claims submitted by selected providers in April 2015. Testing was completed as of Aug. 14, 2015.

BENEFIT PREAUTHORIZATION UPDATE

In addition to claims, ICD-10 codes must also be used on other transactions, such as benefit preauthorization requests. BCBSMT will begin accepting ICD-10 codes as of Sept. 21, 2015, for benefit preauthorization requests for services that will be rendered on or after Oct. 1, 2015. Prior to submitting a benefit preauthorization request, we encourage you to check eligibility and benefits through your preferred online vendor portal.

DID YOU RECEIVE OUR ICD-10 'SPECIAL EDITION'?

ICD-10 is really happening and we want to help increase awareness in the provider community. Earlier this month, we published a *Capsule News* Special Edition newsletter to spotlight key topics, such as the importance of training and refresher training, improving your documentation, tips for small practices and resource reminders. Please share this newsletter with your staff.

For additional information, visit the [Standards and Requirements/ICD-10 section](#) of our website. If you have ICD-10 questions, email us at icd@bcbsmt.com and we will be happy to assist. Or, contact your assigned Provider Network Representative.

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BCBSMT Announces Training for New Tools

Blue Cross Blue Shield of Montana (BCBSMT) will be offering educational webinars through September 2015 on how the refund process works and a new offering called Electronic Refund Management and Claim Inquiry Resolution. Select a date from the list below to register now for a webinar.

Refund Process and Electronic Remittance Advice (ERA/835)

- Provider Claims Summary Review
- Recoupment Identification
- 835 PLB Segments and Code Description
- Identify adjustments vs actual recoupments

Electronic Refund Management (ERM) and Claim Inquiry Resolution (CIR)

- Electronic Refund Notifications
- Inquire, Suspend & Dispute Refunds
- Multiple Payment Options
- Unsolicited Refund Capability
- Upload or Fax Supporting Documentation
 - Medical Records
 - Primary Carrier EOB
- Claim Denial/Pricing/Processing Inquiries

Webinar Dates/Times:

- Tuesday, September 8, 2015 10:00 am
- Thursday, September 10, 2015 2:00 pm
- Tuesday, September 13, 2015 2:00 pm
- Thursday, September 15, 2015 10:00 am

Register for a free webinar at www.bcbsmt.com/provider or for more information contact Susan Lasich at 406-437-6223 or email susan_lasich@bcbsmt.com.

New Guide Outlines Member ID Card Basics

As an independently contracted BCBSMT provider, you may render services to BCBSMT members, as well as other Blue Plan members who travel or live in Montana. With the growing number of available products, plans and corresponding networks, it is increasingly important to ask for each member's current ID card at every visit, along with a photo ID, prior to checking eligibility and benefits. For an overview of key elements to watch for, along with guidance on how to interpret and use this information, please refer to our new Quick Guide to Blue Cross and Blue Shield Member ID Cards. This handy reference is available in the [Standards and Requirements/BlueCard® Program/Related Resources section](#) of our website.

Member ID cards are for identification purposes only and do not guarantee eligibility, benefits or payment of claims. Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

ClaimsXten™ Adds Three New Outpatient Facility Rules, Effective Oct. 12, 2015

Beginning on or after Oct.12, 2015, BCBSMT will enhance the ClaimsXten code auditing tool by adding three new Outpatient Facility Rules into our claim processing system. The new facility rules will apply for any claims with dates of service on or after Oct.12, 2015. The new rules are summarized below:

Medically Unlikely Edits (MUE) Multiple Lines Facility Rule

This new facility rule identifies claim lines where the MUE has been exceeded for a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code, reported by the same provider, for the same member, on the same date of service.

An MUE is an edit that reviews claims for unit of service for a HCPCS or CPT code for services rendered by a single provider/supplier to a single beneficiary on the same date of service.

The ideal MUE is the maximum unit of service that would be reported for a HCPCS or CPT code on the vast majority of appropriately reported claims. The maximum allowed is the total number of times per date of service that a given procedure code may be appropriately submitted by the same provider.

Outpatient Code Editor (OCE) CMS CCI Bundling Rule

This new facility rule identifies claims containing code pairs found to be unbundled according to Centers for Medicare & Medicaid Services (CMS) Integrated Outpatient Code Editor (I/OCE). One of the

functions of the I/OCE is to edit claims data to help identify inappropriate coding due to the following reasons: The procedure is a mutually exclusive procedure that is not allowed by the Correct Coding Initiative (CCI) and/or the procedure is a component of a comprehensive procedure that is not allowed by the CCI.

Unbundled Pairs Outpatient Rule

This new facility rule identifies the unbundling of multiple surgical codes when submitted on facility claims. This rule detects surgical code pairs that may be inappropriate for one of the following reasons: one code is a component of the other code, or these codes would not reasonably be performed together on the same date of service.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the [ClaimsXten page](#) on our website. Information also may be published in the Recent News section of our website, as well as upcoming issues of the *Capsule News*.

ClaimsXten is a trademark of McKesson Information Solutions, Inc., an independent third party vendor that is solely responsible for its products and services.

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Air Ambulance Services

Blue Cross 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. To assist with this, we have enclosed a laminated directory of BCBSMT's participating air ambulance providers that can be placed by your Emergency Department's phone for easy reference.

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 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)	*	*
**NE Stat Air	STAT Air Dispatch Line: 1-800-992-7828 (Montana toll-free) ; 406-228-3500 (Out of State)		*
<p>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.</p> <p>**In negotiations – currently non-participating</p>			

Important Notice Regarding Billing for Point of Use Convenience Kits

Blue Cross Blue Shield of Montana (BCBSMT) periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our member's benefit plan and meet BCBSMT's guidelines. Some providers are submitting claims for point of use convenience kits that are used in the administration of injectable medicines. These prepackaged kits contain not only the injectable medicine, but also non-drug components including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

Typically, the cost of convenience kits exceeds the cost of its components when purchased individually. Non-drug components included in the kits are inclusive of the practice expense for the procedure performed for which no additional compensation is warranted. Effective Oct. 1, 2015, reimbursement for these point of use convenience kits will be reduced. Services should be provided in the most cost effective manner and in the least costly setting required for the appropriate treatment of the member.

Modifier 25 Reminders

The Current Procedural Terminology (CPT[®]) codebook defines Modifier 25 as a "significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service."

When you submit a Blue Cross Blue Shield of Montana (BCBSMT) Provider Review Form requesting review of a previously submitted claim that contained Modifier 25, we will perform a retroactive audit to

determine if the services rendered warrant use of this modifier. If we receive a request to add Modifier 25 to a previously submitted claim, medical records are required to complete our review. If appropriate documentation is not included, the Provider Review Form will be returned to you along with a request to include medical information explaining the reason for adding the modifier to a claim that was originally sent without one.

Remember these tips when using Modifier 25:

- Documentation must support significant and separately identifiable preoperative and/or postoperative work, above and beyond the usual care associated with the performed procedure.
- Documentation must support that the patient's symptom, problem or condition required a separately identifiable E/M service.
- The reported E/M service must meet the key components (history, examination and complexity of medical decision making) of the selected E/M service.
- The E/M service must be distinct from the service performed.
- Modifier 25 should only be appended to E/M services and not procedures.
- Modifier 25 is not used to report an E/M that resulted in the decision to perform surgery. Refer to Modifier 57 guidelines for an E/M service which results in a decision for surgery.
- Procedures include preoperative evaluation services necessary prior to performing a procedure or other service. This may include, but is not limited to assessing the site/condition, explaining the procedure, and obtaining informed consent.

Please refer to the CPT codebook for additional details.

As a reminder, BCBSMT actively participates in inquiries and investigations to accurately identify and appropriately address potential fraudulent activities through our Special Investigations Department (SID). The SID is committed to reducing health care costs and helping to protect the integrity of the BCBSMT independently contracted provider network. Contact the BCBSMT Fraud Hotline at 800-621-0992 to learn more about SID or to report fraudulent concerns. Reports may be made anonymously.

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Tips to Help Your Patients Improve Medication Adherence

Using the GuidedHealth[®] clinical rules platform to review Blue Cross Blue Shield of Montana (BCBSMT) claims data, patients with BCBSMT pharmacy benefits, are identified as potentially non-adherent to an antiviral, cholesterol, diabetes, depression, hypertension and/or respiratory prescription drug. Informational letters are sent on a quarterly basis to prescribing providers of these identified members to help increase awareness and promote patient safety.

According to *Script Your Future*, a national campaign to raise awareness about medication adherence, nearly three out of four Americans do not take their medications as directed.* For patients with a chronic condition, non-adherence with prescriber instructions may lead to adverse events that may not be immediate but could be harmful over time. There are many reasons people do not take their medications, such as inconvenience, cost or side effects.

BCBSMT is increasingly looking at medication adherence as a quality measure. Listed below are some suggestions that may help your patients improve their medication adherence:

- Simplify the drug regimen by adjusting the timing, frequency, amount and/or dosage of the medications prescribed.
- Encourage honesty when screening your patients for medication adherence. Open communication and trust can lead to uncovering perceived barriers your patients may be facing that you can then help address.
- Explain the consequences of not taking the medication and provide clear, written instructions for taking their medications.
- Offer to prescribe a 90-day supply for home delivery pharmacy services or consider prescribing generics or other less expensive alternatives, if cost is an issue.
- Recommend that your patients set a routine/daily alert by using a pillbox or some other reminder system.
- Collaborate with all of your patient's health care providers to deliver patient-centered complete care. Reach out to the patient's caregiver as well, if appropriate.

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.

**Script Your Future*, <http://scriptyourfuture.org>, National Community Pharmacists Association and Pharmacists for the Protection of Patient Care Adherence Survey, 2006.

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. 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.

Health Care News and Commentary Site Launches

The operator of Blue Cross and Blue Shield of MT is launching a new [news and commentary website](#) to convene a discussion on the major issues that face the health care industry today.

CareCore

CareCore National MedSolutions announced on June 4th the launch of a new name and brand to eviCore.

Please follow this link <https://www.carecorenational.com/news/carecore-medsolutions-rebrands-as-evicore.aspx> to read more.

There are no changes to the preauthorization process.

Post Service Claim Review Guidelines related to Radiation Therapy Services

Guidelines for BCBSMT Participating Radiation Therapy Providers to request the review of denied services on radiation therapy claims related to the Required Prior Authorization through eviCore (formerly CareCore National MedSolutions).

Retrospective authorization review

To request a retrospective review when your office has claims that have denied for no prior authorization for radiation therapy;

- Submit the request for retrospective authorization review to BCBSMT in writing. Use form “Corrected Claim or Claim Review Request Form” located on the bcbsmt.com website under Provider/Education and Reference/Forms and Documents
- Include a completed eviCore Radiation Oncology Worksheet (The worksheets are available at [CareCoreNational .com/ Radiation Tools and Criteria/Physician Worksheets](http://CareCoreNational.com/RadiationToolsandCriteria/PhysicianWorksheets))

Mail the request to:

Blue Cross Blue Shield of Montana
P. O. Box 4309
Helena, MT 59604
Or
Fax request to Claims Review
866-589-8256

Upon receipt of the needed information, BCBSMT will work with eviCore to coordinate the retrospective authorization review.

Upon completion of the review, BCBSMT will initiate an adjustment for claims within the authorized service dates, for the provider submitting the request. The claims will then process according to the authorization and a new EOB/PCR will be sent.

Re-review/Reconsideration

To request a re-review for the denial of a service on a claim when there is an approved Prior Authorization;

Review the eviCore prior authorization letter to identify the approved services and treatment dates. A reference sheet to assist your office in knowing what documentation is needed can be found at [CareCoreNational.com/Radiation Tools and Criteria/Documentation Required for Payment Appeals](http://CareCoreNational.com/RadiationToolsandCriteria/DocumentationRequiredforPaymentAppeals). Submit request for re-review/reconsideration of the denied service(s) to BCBSMT in writing using the form, “Corrected Claim or Claim Review Request Form”, located on the bcbsmt.com website under Provider/Education and Reference/Forms and Documents

Mail the request to:

Blue Cross Blue Shield of Montana
P. O. Box 4309
Helena, MT 59604
Or
Fax request to Claims Review
866-589-8256

Be specific in your questions. This will help the reviewer handle your request more expediently.

Examples:

- Received authorization from eviCore for 10 fractions of radiation treatment. The 10th service was denied. Please review the processing of this claim.
- Received authorization from eviCore for radiation treatment. The approved authorization dates were 01/01/14 to 03/01/14. The actual services started on 12/15/13. Please review for change in authorization dates.
- Received authorization from eviCore for radiation treatment. The treatment plan changed and a special radiation device was used. Please review attached medical records for review of the special radiation treatment device reported with code 77470.

Upon receipt of the necessary information, BCBSMT Medical Review will work with eviCore to coordinate the post service review of denied services. If the post service review results in an approval, the associated claim(s) will be adjusted. If the denial is upheld, a response will be provided.

Appeals

To submit an **appeal** for the denial of a service on a claim;

- Submit a request for **an appeal** of the denied service to BCBSMT in writing.
- Include Medical records for the radiation treatment service you would like to have reviewed.
- A reference sheet to assist your office in knowing what documentation is needed can be found at CareCoreNational.com/Radiation Tools and Criteria/Documentation Required for Payment Appeals
- Be specific in your questions on the appeal form. This will help the reviewer handle your request more expediently.
- If the appeal results in an approval, the associated claim(s) will be adjusted. If the denial is upheld, a response will be provided.

Tomosynthesis Medical Policy update

Based on continual evidence based reviews, Blue Cross Blue Shield of Montana (BCBSMT) has made the decision to update the Digital Breast Tomosynthesis Medical Policy, **Number:** RAD601.055, effective August 15, 2015.

Following the recent HCSC Medical Policy Review Committee meeting and a face-to-face presentation by the Hologic company's subject matter experts, the HCSC Medical Directors have approved a change to the medical policy to now consider Digital Breast Tomosynthesis for screening and diagnosis as a covered, medically necessary service.

Updates to the relevant published medical literature over the past months have shown a preponderance of evidence that DBT can improve diagnostic accuracy and reduce subsequent, additional testing for women with previously indeterminate mammography findings. Improving the effectiveness of screening mammography and decreasing the emotional burden of subsequent testing for our members and your patients is a welcome development in this very challenging field of cancer detection and prevention.

DBT services that were performed prior to this literature publication and Medical Policy update will still be considered Investigational/Experimental and/or Unproven under the previous policy iteration. This is

consistent with BCBSMT company policy to address improvements in medical services once the medical literature is mature and positive results are verifiable.

New Medical Policy Identifies Intranasal Application of Topical Anesthetic for Headaches as a Non-covered Service

Blue Cross Blue Shield of Montana (BCBSMT) Medical Policy MED205.039, or Topical Application Device for Anesthetic Treatment to the Sphenopalatine Ganglion for Headaches (treatment of headache or facial pain) will become effective for dates of service on or after Nov. 1, 2015.

The medical policy states that topical application of anesthetic (including, but not limited to Marcaine or Naropin), with or without steroid(s), to the sphenopalatine ganglion as a nerve block for headaches or facial pain using an applicator for nasal spray or any other similar device, is considered experimental, investigational and, as such, is not a covered benefit.

There is no Current Procedural Terminology (CPT[®]) code that specifically describes intranasal application of a topical anesthetic for the treatment of headache or facial pain. Per the American Medical Association (AMA), providers are instructed to use CPT code 64999 (unlisted procedure, nervous system) to identify this type of treatment, which, as noted above, is not a covered benefit for BCBSMT members.

To view the BCBSMT Pending Medical Policy for Topical Application Device for Anesthetic Treatment to the Sphenopalatine Ganglion for Headaches, refer to the Standards and Requirements/Medical Policy section and select the [Active and Pending Medical Policies link](#). Pending policies are listed alphabetically – select the title of the policy you wish to view to open the document.

Third party brand names are the property of their respective owners.

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The BCBSMT Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are 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. Members should refer to their certificate of coverage or summary plan description for more complete details regarding what services are covered including, benefits, limitations and exclusions. Some benefit plans administered by BCBSMT, such as some self-funded employer plans or governmental plans, may not utilize BCBSMT Medical Policy. Members should contact the customer service number listed on the back of their identification card for more specific benefit information.

Reminder: National Drug Code (NDC) Pricing in Effect

As of May 1, 2015, professional/ancillary claims for drugs billed under the medical benefit must include NDC data, along with the appropriate HCPCS and/or Current Procedural Terminology (CPT[®]) information, in order to be processed by BCBSMT. If the NDC data and related information is not included, BCBSMT will deny any service line(s) associated with this missing information. A corrected claim would need to be submitted in order to avoid duplicate returns.

Using NDCs and related information helps facilitate more accurate payment and better management of drug costs based on what was administered and billed.

For quick tips to assist you with billing for drugs on medical claims, view the [NDC Billing Guidelines](#) and answers to [Frequently Asked Questions](#). An NDC Billing Tutorial, NDC Units Calculator Tool and the NDC reimbursement fee schedule are also available to registered users on our [secure provider portal](#) under the NDC Billing Resources page.

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The listing of any particular drug or classification of drugs is not a guarantee of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, terms, conditions, limitations and exclusions set forth in the member's policy or benefits document. 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.

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