BLUE REVIEW℠

A Provider Publication

January 2020

Please distribute this newsletter, which contains claims, billing, Medical Policy, reimbursement, and other important information, to all health care providers, administrative staff, and billing departments/entities. This version of Blue Review is based on the electronic version that was distributed in January 2020 but because it is a summary copy, it may not have all the information contained in the electronic version. To sign up to receive the Blue Review electronically, complete the request form that can be found at bcbsok.com/provider.

You can find the *Blue Review* online at bcbsok.com/provider/news and updates

News & Updates

Coordinating Care Among Behavioral Health and Medical Providers

Coordinating care between behavioral health and medical providers helps deliver the best care for our members. Our surveys consistently show providers appreciate care coordination. Consulting and referring providers should share information such as diagnoses, medications, treatment plans and recommendations to ensure care is appropriately coordinated. We've provided a simple form to help providers request information from each other.

Be sure members sign a release to allow you to share information with other providers before using this form.

Coordination of Care Form

The form is useful for both referring and consulting providers. To request patient visit information from a consulting provider, complete the Patient Information and Referring Provider sections before sending it to the consulting provider. The consulting provider can use the form to communicate information about the visit to the referring provider. Do not send this form to us. It is for your use with other providers only.

Need help finding a Behavioral Health provider?

Call the number on the member's ID card to find outpatient providers or behavioral health facilities. You can also search for providers using Provider Finder®

Have a member with complex health needs?

More support and resources from a behavioral health or medical clinician are available. Call the number on the member's ID card to refer members to Case Management and learn about other resources.

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Pricing update for Visco-Supplements Beginning Jan. 1, 2020

The following Visco-Supplements will have a change in payment methodology effective January 1, 2020.

Code	Drug Name
J7318	DUROLANE 60MG/3ML Prefilled Syringe
J7320	GENVISC 850 10MG/ML Solution
J7322	HYMOVIS 24MG/3ML Solution Prefilled Syringe
J7326	GEL-ONE 30MG/3ML Prefilled Syringe
J7328	GELSYN-3 8.4MG/ML Solution
J7329	TRIVISC 10MG/ML Solution Prefilled Syringe

Beginning January 1, 2020, the reimbursement change for these products will be reflected in the state-wide professional NDC fee schedule.

For more information on NDC billing guidelines, visit the Pharmacy Program section on our website. If you have questions, email provider inquiries or call the Provider Contract Support Unit at 800-722-3730, Option 2.

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Reminder of Change to the Preservice Appeals process for your Medicare Patients Covered by Blue Cross and Blue Shield of Oklahoma

This is a reminder that important changes to the preservice appeals process recently occurred for your Blue Cross and Blue Shield of Oklahoma (BCBSOK) patients enrolled in BCBSOK's Medicare programs, as we communicated on July 31, 2019.

As of November 1, 2019, eviCore healthcare (eviCore), an independent medical benefits management company, is no longer administering the appeals for denied and partially denied Medicare prior authorization requests. BCBSOK has assumed responsibility for conducting the preservice appeals process, from preservice appeal intake the appeal determination. eviCore, however, will continue its role in administering the initial determination of prior authorization requests.

Note: The medical policies being used for preservice appeal reviews have not changed. Remember when submitting a preservice appeal to always follow the directions included within the denial letter.

These changes are designed to streamline workflows and lead to an improved member and provider experience.

Use Availity® or your preferred vendor to check eligibility and benefits to determine if you are in-network for your patient and if prior authorization or prenotification is required. Refer to "Eligibility and Benefits" on our website for more information on Availity. You can also refer to the Clinical Resources / Prior authorization page for assistance.

Use iExchange® for other services requiring prior authorization through BCBSOK. More information on iExchange or instructions on how to set up an iExchange account, can be found on the provider tools / iExchange webpage.

Payment may be denied if procedures are performed without authorization. If this happens, you may not bill your patients.

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if benefit preauthorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSOK's provider website.

Please note that verification of eligibility and benefits, and/or 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. If you have questions, contact the number on the member's ID card. eviCore healthcare is an independent specialty medical benefits management company that provides utilization management services for BCBSOK. eviCore is wholly responsible for its own products and services. BCBSOK makes no endorsement, representations or warranties regarding any products or services provided by eviCore.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSOK.

iExchange is a trademark of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSOK makes no endorsement, representations or warranties regarding any products or services offered by Availity, eviCore, AIM or 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.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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Oklahoma – Reminder Medicare Advantage Program 30 Day Readmission Facility

Consistent with the Centers for Medicare Medicaid Services (CMS) guidelines, beginning March 1, 2020, Blue Cross and Blue Shield of Oklahoma (BCBSOK) will review inpatient hospital claims for Medicare Advantage members, both PPO and HMO, to determine if readmissions to the same facility within 30 days of discharge are clinically related. If so, BCBSOK may deny payment to the facility for the related readmissions. These changes help support quality of care improvement efforts by linking payment to the quality of facility care for our Blue Cross Medicare Advantage members. As a provider, what should I expect?

- Beginning March 1, 2020, BCBSOK will perform a clinical review of acute care facility readmissions that occur within 30 days of discharge from the same facility.

- If BCBSOK determines that a provider has submitted one or more claims for inpatient admissions occurring within 30 days after a patient has been discharged from an initial acute inpatient stay, BCBSOK may request medical records from the provider.

As a provider, what should I do?

- Upon request of medical records, the facility must forward related medical records and any documents involving the admissions.
- If it is determined that the acute stays were clinically related, BCBSOK may deny payment to the facility for the readmission(s).
- Providers may dispute determinations through existing processes.

Learn More

- Visit the CMS Medicare Claims Processing Manual, section 40.2.5 for Repeat Admissions.
- If you have questions, contact your Provider Network Representative.

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Reminder: Out-of-Network Medicare Providers Can Treat Group Medicare Advantage Open Access (PPO) Members

As a Medicare provider, you do not need to have a contract with Blue Cross and Blue Shield of Oklahoma (BCBSOK) to treat Blue Cross Group Medicare Advantage Open Access (PPO)℠ members.

As we announced in November, Blue Cross Group Medicare Advantage Open Access (PPO) is the new name of Blue Cross Medicare Advantage (PPO) Employer Group℠. This plan offers members access to care from any providers nationwide ¬who accept Medicare assignment and are willing to bill BCBSOK. Members' coverage levels are the same in and out of network, and you will be paid the Medicare allowed amount

What you need to know

- Referrals are not required for office visits.
- Prior authorization may be required for certain Medicare-covered services.
- Out-of-network providers will be paid the Medicare allowed amount for covered services as defined by Medicare, less any member cost-sharing. In-network providers will be paid their contracted rate.
- For eligibility, prior authorization or claims inquiries, call 877-299-1008.

Member ID card

Group Medicare Advantage Open Access (PPO) members will have this ID card. Look for "Open Access" on the front.

Learn more about Group Medicare Advantage Open Access (PPO).

Questions? Email BCBSOK Provider Network Representatives.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations.
It is important to check eligibility and benefits for each patient before every scheduled appointment. Eligibility and benefit quotes include membership confirmation, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information on applicable benefit prior authorization/pre-notification requirements. Ask to see the member's BCBSOK ID card and a driver's license or other photo ID to help guard against medical identity theft.

Checking eligibility and benefits and/or obtaining benefit prior authorization/pre-notification or predetermination of benefits is not a guarantee that benefits will be paid. Payment 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 your patient's policy certificate and/or benefits booklet and/or summary plan description. Regardless of any benefit determination, the final decision regarding any treatment or service is between you and your patient. If you have any questions, please call the number on the member's ID card.

PPO plans provided by Blue Cross and Blue Shield of Oklahoma, which refers to HCSC Insurance Services Company (HISC). PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC and HISC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and HISC are Medicare Advantage organizations with a Medicare contract. Enrollment in these plans depends on contract renewal.

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BCBS National Coordination of Care℠ Program to Serve Group Medicare Advantage PPO Members

Beginning Jan. 1, 2020, we will participate in a new Blue Cross and Blue Shield Association (BCBSA) National Coordination of Care program to help improve care and services for Blue Cross Group Medicare Advantage (PPO)℠ (MA PPO) members nationwide. This program also will help streamline administrative processes for providers.

As we announced in November, Blue Cross Group Medicare Advantage (PPO) is the new name of Blue Cross Medicare Advantage (PPO)℠ for Blue Cross and Blue Shield of Oklahoma (BCBSOK) members who purchase MA PPO coverage through their employers or other groups. While the name has changed, the program retains its traditional PPO network that allows members to seek care in-network and out-of-network, typically providing cost savings for in-network care.

Through the BCBS National Coordination of Care program, BCBSOK will collaborate with you to identify gaps in care and retrieve medical records for claims you submit to BCBSOK for Group MA PPO members living in Oklahoma. This includes BCBSOK members with Group MA PPO coverage, as well as Group MA PPO members enrolled in other BCBS Plans who are living in Oklahoma.

You will receive requests only from BCBSOK or our vendor when medical records are needed, or when potential gaps in care or risk adjustment gaps are identified related to claims submitted to BCBSOK for these members. You will no longer receive these requests from multiple BCBS plans or their vendors.

This program is part of our ongoing initiative to support our members in receiving the right care at the right time and place. As a result of concerns about gaps in care, this program may help encourage members to come into your practice more frequently, allowing for greater continuity of care. For out-of-area members with Group MA PPO coverage, this program will help BCBSOK give these members' BCBS Plans a fuller understanding of their members' health status.

Questions? Call the Customer Service number on the member's ID card.

Important Reminders

- As outlined in your contract with us, you are required to respond to requests in support of risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®) and other government-required activities within the requested timeframe. This includes requests related to this program.
- It is important that you use Availity® or your preferred vendor to check eligibility and benefits for all BCBSOK patients before every scheduled appointment, including for Group MA PPO members in this program. Eligibility and benefit quotes include membership confirmation, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information on applicable benefit prior authorization requirements. Ask to see the member's BCBSOK ID card and a driver's license or other photo ID to help guard against medical identity theft. See our Eligibility and Benefits page for more details.
- Consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any other applicable laws and regulations, BCBSOK or BCBSOK's vendor is contractually bound to preserve the confidentiality of members' protected health information (PHI) obtained from medical records and provider engagement on Stars and/or risk adjustment gaps. You will only receive requests from BCBSOK or BCBSOK's vendor that are permissible under applicable law. Consistent with your current practices, patient-authorized information releases are not required in order for you to fulfill medical records requests and support closure of Stars and/or risk adjustment gaps received through this care coordination program.

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Reminder: Medicare Providers May Not Bill Participants in the Qualified Medicare Beneficiary Program

As a Medicare provider, you may not bill individuals enrolled in the Qualified Medicare Beneficiary Program (QMB), a federal Medicare Savings Program.

Individuals enrolled in QMB are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a State Medicaid benefit, QMB covers the Medicare premiums, deductibles, coinsurance and copayments of QMB beneficiaries. QMB beneficiaries are not responsible for Medicare cost-sharing, or out-of-pocket costs.

Your Responsibility

Providers participating in Blue Cross Medicare Advantage℠ plans may not bill their QMB patients for services provided to them, regardless of whether the state reimburses the full Medicare cost-sharing

amounts. You must bill both Medicare and Medicaid and accept Medicare payments and any Medicaid payments as payment in full.

Federal Law

Please ensure that you and your staff are aware of the federal billing law and policies governing QMB. It is against federal law for any Medicare provider to bill QMB patients, whether or not the provider accepts Medicaid. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB patients for Medicare cost-sharing.

Helpful Tips

To avoid billing QMB patients, please take these precautions:

- Understand the Medicare cost-sharing billing process
- Be sure your billing software and staff remove QMB patients from Medicare cost-sharing billing and related collections efforts

More Information

Call Customer Service at 877-774-8592 to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.

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Reminder that Laboratory Benefit Level Changes for Some Members this Month

As we shared in the October *Blue Review*, beginning Jan. 1, 2020, or upon a member's renewal date, non-preventive labs are no longer covered at the no member cost-share level for some Blue Cross and Blue Shield of Oklahoma (BCBSOK) PPO and HMO members. Non-preventive labs will be treated as a standard medical benefit regardless of diagnosis code. Any applicable cost sharing (copay, coinsurance and deductible) may apply, based on the member's health plan.

What does this mean for you?

- You may have to seek payment from both BCBSOK and the member.
- You may want to alert members that they could have to pay any applicable cost share (copayment, coinsurance, deductible) for laboratory services.

Please refer to the Preventive Services Clinical Payment and Coding policy, which contains the list of lab procedures that are considered preventive and will continue to process at the no cost share benefit level when billed with a preventive diagnosis.

As a reminder, it is important to check member eligibility and benefits through Availity® Provider Portal or your preferred vendor web portal 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. Checking eligibility and benefits also helps providers

confirm benefit preauthorization requirements. Providers must also ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly. Obtaining benefit preauthorization is not a substitute for checking member eligibility and benefits.

To confirm how a lab will process if it's not identified on the Preventive Clinical Payment and Coding Policy, please call the number on the member's ID card.

Note: This information does not apply to members who have Medicaid or Medicare plans.

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Feature Tip

Notification of Annual Benefit Updates

Blue Cross and Blue Shield of Oklahoma (BCBSOK) will be updating member files with annual benefit changes over the next several weeks. As always, we encourage you to verify your patients' coverage first, using Availity® or your preferred vendor portal.

If a call to BCBSOK is needed, hold times may be longer than normal. Customer Advocates will be available for eligibility and benefit inquiries from 7:30 a.m. to 6 p.m. CT Jan. 2 to 24, 2020, Monday through Friday. Claims Customer Advocates hours will remain the same from 8:30 a.m. to 4:30 p.m. CT. As a reminder, you can get routine eligibility and benefit information as well as claims status in seconds using Availity or the web vendor of your choice.

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In the Community

Partners in Healing the Uninsured

Since 2005, the Health Alliance for the Uninsured (HAU) has worked to facilitate the provision of specialty health care services to uninsured persons who receive their primary care from 15 free clinics and two community health centers in Oklahoma County. The provision of these needed services is possibly solely through the generous support of volunteer physician and hospital partners. Via a second program, the HAU

secures over $3.5 million in free medication such as insulin, inhalers, Hep C medications and more. Through HAU's Care Connection and Prescription Assistance Programs, suffering is relieved, health is renewed and lives are restored.

Not surprisingly, the need for general practice and specialty services far exceeds the number of patient openings willing to be seen by all our current volunteer specialists. Specific needs exist in the areas of Rheumatology, Endocrinology, Vascular Surgery, Otolaryngology, Cardiology, Podiatry, Neurology and Neurosurgery. We need the support of more physicians who are willing to donate their services to a set number of patients each month.

It's Easy and Rewarding to Sign Up for the HAU Referral Network
For more information or if you are an interested physician, please contact Beverly Caviness at Beverly.Caviness@hauonline.org or 405-286-3343 or HAU Medical Director Dr. Jan Miller at jan.miller@hauonline.org.

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Provider Data and Directory Updates

Maintaining accurate provider data and directories are an important part of providing Blue Cross and Blue Shield of Oklahoma (BCBSOK) members with the information they need to manage their health. Our online provider directory, Provider Finder® helps members find in-network doctors and hospitals. The directory is also a helpful tool for you to refer your BCBSOK patients to other participating providers.

Please review your information in Provider Finder to ensure it's correct. To update your directory information or other information such as tax identification numbers, supervising physician information, hospital privileges, etc., please visit the Information Change Request section on the BCBSOK provider website.

All changes should be submitted at least 30 days in advance of the effective date of the change. For more information, please contact your BCBSOK Provider Network Representative.

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Web Changes

- Posted December Blue Review to Education and Reference Center/News and Updates/Blue Review page.
- Posted Reminder Medicare Advantage Program 30 Day Readmission Facility to Education and Reference Center/News and Updates

Stay informed!

Watch the News and Updates on our Provider website for important announcements.

Provider Training

For dates, times and online registration, visit the Provider Training page.

ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (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. Blue Cross and Blue Shield of Oklahoma (BCBSOK) will normally load this additional data to the BCBSOK claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSOK Provider website. Advance notification of updates to the ClaimsXten software version also will be posted on the BCBSOK Provider website.

To help determine how some coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to use Clear Claim Connection™(C3). C3 is a free, online reference tool. Refer to the Clear Claim Connection page on our website for more information on gaining access to C3, as well as answers to frequently asked questions about ClaimsXten. Updates may be included in future issues of the Blue Review. Note: C3 does not contain all of the claim edits and processes used by BCBSOK in adjudicating claims, and the results from use of the C3 tool are not a guarantee of the final claim determination.

BCBSOK Online Provider Orientation

The Online Provider Orientation is a convenient and helpful way for providers to learn about the online resources available to them.

Medical Policy Reminder

Approved new or revised BCBSOK medical policies and their effective dates are posted on the BCBSOK website the first day of each month. These policies may impact your reimbursement and your patients' benefits. You may view all active and pending policies, or view draft Medical Policies and provide comments. These can be accessed on the Standards and Requirements page of our provider website.

While some information on new or revised medical policies may occasionally be published for your convenience, please visit bcbsok.com/provider for access to the most complete and up-to-date information.

On-demand Training

An eRM tutorial is available to show you how to navigate the features of the eRM tool. Log in at your convenience to complete the tutorial and use it as a reference when needed.

We Want Your Feedback

Do you have a helpful suggestion or feedback about our website? Fill out our Feedback Survey.

 Like us on Facebook  Follow us on Twitter  Watch us on Youtube