February 2021

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 February 2021 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 on the BCBSOK provider website.**

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

News & Updates

Telemedicine

In response to the COVID-19 pandemic, Blue Cross and Blue Shield of Oklahoma (BCBSOK) expanded access to telemedicine services to give our members greater access to care. The experience confirmed the importance of telemedicine in health care delivery. Members can access their medically necessary, covered benefits through providers who deliver services through telemedicine.

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Utilization Management

Utilization Management review helps determine the medical necessity and appropriateness of treatment for certain services. Utilization Management includes:

- Prior Authorization
- Predeterminations

- Post-service reviews

Learn More

Atrial Fibrillation

High quality documentation and complete, accurate coding can help capture our members' health status and promote continuity of care. Below are resources for documenting and coding atrial fibrillation (AF). This information is from the ICD-10-CM Official Guidelines for Coding and Reporting and the sources listed below*.

ICD-10-CM AF Codes	
Paroxysmal Atrial Fibrillation	I48.0
Persistent Atrial Fibrillation	I48.1x
Chronic Atrial Fibrillation	I48.2x
Typical Atrial Flutter	I48.3
Atypical Atrial Flutter	I48.4
Unspecified Atrial Fibrillation	I48.91
Unspecified Atrial Flutter	I48.92

Codes for AF Types

According to ICD-10-CM guidelines, these four unique codes describe the types of AF:

- **Persistent AF (I48.11)** describes AF that does not terminate within seven days, or that requires repeat pharmacological or electrical cardioversion.
- **Permanent AF (I48.21)** is persistent or longstanding persistent AF where cardioversion cannot or will not be performed, or is not indicated.
- **Chronic AF, unspecified (I48.20)** may refer to any persistent, longstanding persistent or permanent AF.

- **Chronic persistent AF** has no widely accepted clinical definition or meaning. Code **I48.19, Other persistent atrial fibrillation**, should be assigned.

Active AF vs. "History of" AF

- In coding, "history of" indicates a condition is no longer active.
- Document in the note any current associated physical exam findings (such as irregular heart rhythm or increased heart rate) and related diagnostic testing results.
- Only one code may be assigned for a specific type of AF. The type of AF (paroxysmal, persistent, permanent or history of) should be documented consistently throughout the note to avoid unspecified codes that don't fully define the member's condition.

Best Practices

- Include patient demographics, such as name and date of birth, and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure documents are signed and dated by a credentialed provider.
- Document each diagnosis as having been monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Take advantage of the Annual Health Assessment (AHA) or other yearly preventative exam as an opportunity to capture all conditions impacting member care.

***For more details, see:**

- 2021 ICD-10-CM (Chapter 9: Diseases of the Circulatory System)
- AHA Coding Clinic, Q2, Q4 2019
- Centers for Medicare & Medicaid Services Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance
- BCBSOK Medicare Advantage Annual Wellness Visit Guide

Questions? Email provider inquiries or call the Provider Contract Support Unit at **800-722-3730**, Option 2. Your inquiry will be routed to a professional provider representative.

not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly.

Diabetes Mellitus

High quality documentation and complete, accurate coding can help capture our members' health status and promote continuity of care. Below are resources for documenting and coding diabetes mellitus (DM). This information is from the ICD-10-CM Official Guidelines for Coding and Reporting and the sources listed below*.

Sample ICD-10-CM DM Codes	
Type 1 DM without complications	E10.9
Type 2 DM without complications	E11.9
Type 1 DM with diabetic chronic kidney disease (CKD) Use additional code to identify CKD stage (N18.1–N18.6)	E10.22
Type 2 DM with CKD Use additional code to identify CKD stage (N18.1–N18.6)	E11.22

Codes for DM Types

DM types are divided into five categories:

- **E08** DM due to underlying condition
- **E09** Drug or chemical induced DM
- **E10** Type 1 DM
- **E11** Type 2 DM
- **E13** Other specified DM

ICD-10-CM requires **documentation to specify DM with hyper- or hypoglycemia**, instead of controlled or uncontrolled. Without this documentation, **DM unspecified** will be coded.

Specificity Matters

These categories are further divided into subcategories of four, five or six characters. They include the DM type, the body system affected and the complications affecting that body system.

Best Practices

- Include patient demographics, such as name and date of birth, and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure documents are signed and dated by a credentialed provider.
- Document each diagnosis as having been monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Assign as many codes as needed to describe all disease complications. This includes combination codes (such as E11.621 Type 2 DM with foot ulcer) and additional codes (such as CKD stage and ulcer site).
- Assign codes appropriate for the patient's condition.
- Take advantage of the Annual Health Assessment (AHA) or other yearly preventative exam to capture all conditions impacting member care.

***For more details, see:**

- 2020 ICD-10-CM Official Guidelines for Coding and Reporting, Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E08–E13)
- Centers for Medicare & Medicaid Services Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance
- BCBSOK Medicare Advantage Annual Wellness Visit Guide

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Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Jan. 1, 2021 — Part 2

This article is a continuation of the previously published Quarterly Pharmacy Changes Part 1 article. While that part 1 article included the drug list revisions/exclusions, dispensing limits, utilization management changes and general information on pharmacy benefit program updates, this part 2 version contains the more recent coverage additions, utilization management updates and any other updates to the pharmacy program.

Read More

Provider Data and Directory Updates

Blue Cross and Blue Shield of Oklahoma (BCBSOK) is required by the Center for Medicare and Medicaid Services to contact our providers on a quarterly basis requesting verification of information, such as: provider name, organization name, accepting new patients, street address, phone number, hospital affiliations and other changes that affect availability to patients.

Maintaining accurate provider data and directories are an important part of providing 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 please visit our Information Change Request section on our website. **If your information is correct as listed on our website, no further action or response is needed.**

Please submit your changes at least 30 days ahead of the effective date. If you have any questions or if you need additional information, please Email provider inquiries or call the Provider Contract Support Unit at **800-722-3730, Option 2**.

Web Changes

- Posted: *January Blue Review* to Education and Reference Center/News and Updates/Blue Review webpage.

- Updated: Behavioral Health Quality Improvement Program to the Clinical Resources/ Behavioral Health Program
- Posted: Behavioral Health Quality Improvement Program 2020 Executive Summary and 2021 Goals/Clinical Resources/Behavioral Health Program
- Updated: Clinical Payment and Coding Policies to Standards and Requirements

Stay Informed!

Watch News and Updates 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 be evaluated during the claim adjudication process, you can 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 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 to learn about the online resources available to you.

Medical Policy Reminder

Approved new or revised BCBSOK medical policies and their effective dates are posted on the BCBSOK website the first and fifteenth day of each month. These policies impact your reimbursement and your patients' benefits. You 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 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.