

CapsuleNewsSM

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS Fourth Quarter 2013

2014 Operation Updates

- [Montana Providers document](#) 
- [Click here](#) for up-to-date information and announcements about Provider Online Services.
- [2014 Dental Provider Information](#)

Notice Regarding Annual Benefit Updates

Blue Cross and Blue Shield of Montana (BCBSMT) will soon begin processing annual benefit changes for 2014. Beginning January 2014, if you are using an online Web vendor to obtain patient eligibility and benefits, you may be instructed to contact BCBSMT Provider Customer Service. Please be aware that BCBSMT expects a substantial increase of calls due to the large number of policy changes underway. To avoid lengthy hold times, providers are encouraged to defer their general eligibility and benefit calls for patients who are not scheduled for an upcoming appointment. If your patient needs immediate service, please contact the appropriate provider customer service number listed on their identification card. We appreciate your patience while we update our files.

Information about Change to BCBSMT Employee Health Insurance Plan

Beginning January 1, 2014, BCBSMT employees will become members through the HCSC employee group health insurance plan under Blue Cross and Blue Shield of Illinois (BCBSIL).

Please be aware of the following details:

- BCBSMT employees will receive new identification cards with a different alpha prefix. Claims will continue to be submitted to BCBSMT, but will now process through BlueCard.
- Separate identification cards will be issued for medical, dental, and vision.
- Only the subscriber name will be listed on the identification card. Covered dependents' names will not be listed separately.

Questions about 2014 benefits, eligibility, and claims should be directed through HCSC employee customer service avenues.

- The Customer Service contact number is (800) 409-9462 and can be found on the member ID card.
- The dental customer service number is (866) 639-2952. You will not be able to contact this number until after January 1, 2014.
- The vision customer service number is (800) 773-2847 or access the internet website www.davisvision.com 

Questions about 2013 or prior benefits, eligibility, and claims should be directed through BCBSMT customer service number at (800) 447-7828, or access the Montana online provider portal through the BCBSMT website.

If you have any other questions, email your Provider Account Consultant at HCS-X6100@bcbsmt.com or call 1-800-447-7828, Extension 6100, Option 3.

ClaimsXtenTM First Quarter 2014 Updates

BCBSMT reviews new and revised Current Procedural Terminology (CPT®) and HCPCS codes on a quarterly basis. Codes are periodically added to or deleted from the ClaimsXten software by McKesson without changing the software version. BCBSMT will now load this additional data to the BCBSMT claim processing system within 60 to 90 days after receipt from McKesson and will confirm the effective date on the BCBSMT website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) will continue to be posted on the BCBSMT website.

Beginning on or after February 10, 2014, BCBSMT will enhance the ClaimsXten code auditing tool by adding the fourth quarter 2013 and the first quarter 2014 codes and bundling logic into its claim processing system.

Additionally, on or after February 10, 2014, the following additional edits will be added: based on CPT and HCPCS code description, procedure code S2900 (Surgical techniques requiring use of robotic surgical system) will bundle to 55866 (Laparoscopy, surgical prostatectomy, retropubic readical, including nerve sparing, includes robotic assistance, when performed).

For updates on the ClaimsXten implementation and other BCBSMT news, programs and initiatives, refer to the BCBSMT Provider website at bcbsmt.com/pages/provider. Additional information also may be included in 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.

CPT copyright 2012 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Reminder: CMS-1500 Paper Claim Form (Version 02/12) Available January 2014

As reported in the Capsule News Third Quarter 2013 issue, the National Uniform Claim Committee (NUCC) recently announced that in early January 2014, the health care industry will transition to a revised version of the CMS-1500 paper claim form: OMB-0938-1197 FORM 1500 (02-12).

The tentative 2014 transition timeline, which aligns with Medicare's, includes:

- January 6, 2014 – Payer begins receiving processing paper claims on the revised CMS-1500 claim form (version 02/12).
- January 6, 2014 through March 31, 2014 – Dual-use period during which Payer continues to receive and process paper claims submitted on the old CMS-1500 claim form (version 08/05), as well as on the revised CMS-1500 claim form (version 02/12).
- April 1, 2014 – Payer receives and processes paper claims submitted only on the revised CMS-1500 claim form (version 02/12).

This revised paper claim form also aligns with accredited electronic claim submission requirements. For more information on the CMS-1500 claim form and technical specifications, visit the NUCC website at nucc.org. 

Please Note: If you use a practice management system or a billing service for clearinghouse, it's important to check with your vendor(s) to ensure they are aware and can accommodate any changes.

Tip: Electronic claim submission can help streamline your administrative processes, help protect your patients' information, and may result in faster claim processing and payment. To learn more about these electronic benefits visit the Claims section of the [Provider Education page](#).

Recontracting of Dental Providers

As we look to the immediate future – particularly with the implementation of the Affordable Care Act and the introduction of the Health Insurance Marketplace (Marketplace) - BCBSMT is committed to partnering with health care providers, employers, and the citizens of Montana to bring innovation to health care in Montana.

The Marketplace will provide an additional channel for individuals to shop, compare, and purchase health insurance, including dental coverage. To be designated as a Qualified Health Plan (QHP) able to sell products on the Marketplace, BCBSMT is required to secure accreditation from a nationally recognized accrediting organization. As a result of this requirement, BCBSMT has been transforming its business processes, business

structure, and focus on quality improvement to meet the standards identified by the Utilization Review Accreditation Commission (URAC).

To meet one of URAC's requirements, revisions must be made to all participating provider contracts. As a result, the entire BCBSMT provider network must be recontracted with the new URAC-compliant provider contracts. In addition to recontracting, all providers must be credentialed by BCBSMT. The recontracting effort includes all professional providers, including dentists.

The first phase of the recontracting effort began with contracts and credentialing applications being sent to all BCBSMT participating dentists. Additional phases to recontract other professional providers and institutional providers, such as hospitals, will continue in the weeks to come.

How Important is Your Documentation for ICD-10?

The countdown to the transition to ICD-10 has begun, and we are less than a year away. The U.S. Department of Health and Human Services (HHS) has required all HIPAA-covered entities to make the switch from ICD-9 to ICD-10 on October 1, 2014. In previous issues of the Capsule News, we've shared resources for planning, tips for evaluating technology vendors, training and more. All of these elements are part of one core objective that links ICD-10 to many other health care initiatives: improving documentation.

Many larger practices and hospitals have already implemented Clinical Documentation Improvement (CDI) programs as more quality initiatives and compliance requirements are implemented across the industry. Even without a formal CDI program, smaller practices should assess their documentation processes to ensure they are prepared for ICD-10, Risk Adjustment and other initiatives dependent on accurate documentation.

A patient's diagnoses and procedures performed is documented in their medical record, and this information often travels from the front desk to physicians, nurses, coding professionals, billing staff, insurance carriers, government entities and accreditation organizations. Transitioning from ICD-9 to ICD-10 requires everyone involved along the continuum of patient care to understand the greater specificity of ICD-10 and to be able to capture the relevant new information that needs to be recorded with ICD-10.

The good news is that if providers are currently documenting accurately, coders will have much of the information they need to code with ICD-10. If physicians aren't providing detailed documentation now, this is the time to make those documentation improvements to help coders accurately describe the medical record.

One of the major changes in ICD-10 is the ability to record laterality in many applicable diagnoses. Many codes also require identifying the encounter- whether it is initial, subsequent, or sequela.

Consider the following example: A patient was treated for a compound fracture of the right tibia and fibula after being struck by a car. The ICD-9 code would likely be 823.92, fracture of tibia and fibula unspecified part, open. For ICD-10 coding, the coder must know:

- Which leg and which specific bone(s) the patient injured (in this example, the right tibia and fibula)
- Whether the fracture is open or closed
- Whether the fracture is displaced
- For open fractures – need to know type of trauma to choose the appropriate character from the Gustilo-Anderson classification system
- The severity of the soft-tissue damage
- Whether the encounter sequence is initial, subsequent, or sequela

This will give the coder the necessary information to determine the ICD-10 codes of S82.201A, unspecified fracture of shaft of right tibia, initial for closed fracture; and S82.401A, unspecified fracture of shaft of right fibula, initial for closed fracture.

Watch for more ICD-10 coding examples and information about documentation practices in upcoming issues of the Capsule News. More information about ICD-10 can be found at bcbsmt.com/pages/provider.aspx. And for transition planning resources, visit the Centers for Medicare & Medicaid website at cms.gov/icd10. 

PBM Change Alters Processing for Diabetic Supplies for HMK

Effective October 1, 2013, the pharmacy benefit manager changed for Healthy Montana Kids (HMK) (formerly the CHIP program) from BCBSMT to administration by Xerox. This change altered how diabetic supplies are processed

through the pharmacy benefit with BCBSMT. Diabetic supplies can no longer be processed through the pharmacy benefit. Diabetic supplies must now be processed through member's' medical benefits as a medical supply to BCBSMT.

If you carry diabetic supplies such as test strips, lancets, syringes, and needles, these items must be processed through the medical benefits using the CMS 1500 or UB04 claim form, whichever you typically use and submit claims on to BCBSMT. If you already submit claims to BCBSMT electronically for other durable medical equipment, you can use the same process to bill diabetic supplies. If you do not have the ability to submit claims electronically, you will need to complete a paper CMS 1500 or UB04 claim form and mail the form to BCBSMT at P. O. Box 7982, Helena, MT 59604.

If you have questions about how to submit a claim form, please contact BCBSMT at 1-855-258-3489. If you would like to become a HMK participating provider, please contact BCBSMT Healthcare Services at 1-800-447-7828, Extension 6100.

Why Checking Eligibility and Benefits is Important

Whenever a patient visits a provider's office and before services are rendered, your office staff should ask to see the member ID card and check for eligibility and benefits*. Significant changes to the health care industry are now here and, while it has always been important to check eligibility and benefits, the following are additional reasons to incorporate this procedure for every visit, even if multiple visits were approved:

- Patients may change or cancel their individual policy
- Policies and benefits may change during the course of treatment
- Copays and coinsurance may vary by product and metallic level
- Patient may be in the federally mandated grace period
- Serves to identify network status to determine whether benefits are available or significantly reduced if performed by an out-of-network provider

The best way to check for eligibility and benefits is electronically. For more information about checking for eligibility and benefits, including information on how to sign up for electronic options, visit the [Provider Education/BCBSMT Basics](#) section of our Provider website.

*Verification of 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, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

Mailing Your Claims to the Correct Address?

When mailing claims and claims correspondence to Blue Cross and Blue Shield of Montana (BCBSMT), please make sure you are using the correct address information. Unless otherwise instructed, mail all hard copy claims and claims correspondence to:

Blue Cross and Blue Shield of Montana
P.O. Box 7982
Helena, Montana 59604

Additional information about claims submissions can be found in the [BCBSMT Provider Manual](#).

BCBSMT Medical Policy to be Aligned with HCSC's

As BCBSMT integrates with HCSC, medical policies continue to be reviewed and updated to align with HCSC. As part of this process, BCBSMT's Chief Medical Officer has joined the HCSC Medical Policy team to provide a voice for Montana members and providers. In addition, all published BCBSMT Medical Policies have been vetted and approved by our local Montana Physician Advisory Committee, comprised of BCBSMT network physicians.

The transitional alignment will be completed by January 1, 2014, with the exception of radiation therapy related medical policies. BCBSMT will maintain separately identifiable radiation therapy policies that align with CareCore

National. These include the most current guidelines for the provision of radiation therapy, based on recommendations from national and international medical societies and evidence based medicine research centers. In addition, the criteria are supplemented by information published in peer-reviewed literature.

Please refer to the [Medical Policy](#) link, policies with significant changes are listed under the link New Medical Policies and provide a 90-day advanced notification of the changes. Watch for communications related to the future update of the Medical Policy site.

Risk Adjustment

Risk Adjustment is a provision of the Affordable Care Act (ACA) and is intended to promote the success of the law's new Health Insurance Marketplace. Risk Adjustment levels the playing field by discouraging adverse selection of members and is accomplished via a two-step process: 1) risk assessment, which evaluates the health risk status of an individual to create a clinical profile; and 2) rate adjustment, which determines the resource utilization needed to provide medical care to an individual. The Risk Adjustment methodology serves as a mechanism to convey the illness burden a provider is managing within their patient population, thus allowing for fair comparison of quality outcomes and cost performance.

Comprehensive documentation and accurate diagnosis coding is critical for accurate risk assessment, which is the basis of Risk Adjustment. Accurate coding enables:

- Identification of patients that may benefit from disease and medical management programs
- Appropriation of health care needs based on accurate health status representation
- Ability to convey a complete picture of a patient's conditions to facilitate assignment of diagnosis codes to the highest level of specificity
- An accurate picture of the patient's health status
- Clinical documentation programs to provide guidance with regard to documentation standards

Another consideration is the October 1, 2014, transition from ICD-9-CM to ICD-10-CM. As we draw closer to the January 1, 2014, implementation date for the Risk Adjustment provision of ACA, we will take a deeper dive into compliant ICD-9-CM and ICD-10-CM diagnosis coding and documentation for four of the most common chronic conditions.

Over the next several months, the *Capsule News* will feature documentation and coding information for behavioral/mental health disorders, chronic kidney disease, diabetes mellitus, and pulmonary disorders. The goal of the series is to provide a review of accurate and compliant documentation to support best coding practices. The series will:

- Provide an overview of each chronic condition
- Identify common examinations/tests that aid in diagnosing each chronic condition
- Feature common signs and symptoms associated with each chronic condition
- Take a closer look at risk factors, comorbidities and complications of each chronic condition
- Identify common medications associated with each chronic condition
- Provide differences and similarities of ICD-9-CM and ICD-10-CM diagnosis code structure

Please watch upcoming issues of the *Capsule News* as well as the Announcements section of the Provider website for additional information and updates on documentation and coding information.

Transplant Services only with Blue Distinction Centers for Transplant Network

Beginning January 1, 2014, only Blue Distinction Centers for Transplant Network (BDCT) will be offered to BCBSMT members for transplant services. As you discuss transplant facility options with your patients in need of a transplant, it is important to refer them to the BDCT website to locate a BDCT transplant facility. This will provide your patients with access to the highest level of benefit. This information is available at: <http://www.bcbs.com/innovations/bluedistinction/center-list/>. In the **Specialty** drop-down box, choose **Transplant**. Click **Change/Add transplant type**. Click **Apply Search**.

Please note that some BCBSMT member plans require the use of a BDCT facility. To verify your patient's transplant benefit, contact a BCBSMT Customer Advocate at 800-447-7828.

The BDCT Network is a nationwide program, offered to Blue Cross and/or Blue Shield Plans, that facilitates the provision of quality outcomes and cost-effective care from leading institutions for seven types of transplants:

- Heart
- Single or bilateral lung
- Combined heart/bilateral lung
- Liver
- Simultaneous pancreas-kidney
- Bone marrow/stem cell (autologous/allogeneic)
- Pancreas

Blue Distinction Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT). Each facility is also subject to periodic reevaluation as criteria continue to evolve.

More than 100,000 people in the United States were registered for organ donations from one of the nation's 800+ transplant programs.* The Blue Distinction Centers for Transplants® program can help you find the transplant program that meets the needs of your patients who are BCBSMT members.

* Source: The Organ Procurement and Transplantation Network (OPTN), the unified transplant network established by the United States Congress under the National Organ Transplant Act (NOTA) of 1984. Visit www.optn.org to learn more.

** These organizations have provided information and input, but do not formally endorse the Blue Distinction Centers® program.