



A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

Second Quarter 2013

Health Care Service Corporation and Blue Cross and Blue Shield of Montana Alliance Update

Health Care Service Corporation (HCSC) and Blue Cross and Blue Shield of Montana (BCBSMT) announced in September their intention for BCBSMT to join forces with the Blue Cross and Blue Shield Plans in Illinois, Texas, Oklahoma, and New Mexico in a new alliance with HCSC, which operates these Plans. The regulatory approval process for the Montana transaction is moving forward. On May 2, 2013, the hearing officer issued his recommendations that the transaction be approved by the regulators. The next step in the process is for the Insurance Commissioner and the Attorney General, who both must approve the transaction, to make their final decisions on the transaction. This alliance, once it receives regulatory approval, will bring HCSC and BCBSMT together in a business combination of dedicated people, best practices, innovative technology, and other assets to advance health care excellence in the state of Montana. BCBSMT looks forward to working with Commissioner Lindeen and Attorney General Fox as this process moves forward, because we believe this alliance is right for Montana.

For questions or concerns about this communication, please contact your Health Care Services Provider Account Consultants at 1.800.447.7828.

| Region | Representative | Phone |
|---------|----------------------------------|--------------|
| Western | Jenifer Sampson | 406.437.6121 |
| Central | Julie Sakaguchi | 406.437.6122 |
| Eastern | Christy McCauley | 406.437.6068 |

Conversion Factors Increase May 1, 2013

Effective May 1, 2013, Blue Cross and Blue Shield of Montana (BCBSMT) is increasing the resourced-based relative value system (RBRVS) conversion factor to \$55.35 and the anesthesia conversion factors to \$59.00. In the RBRVS system, services are assigned units of value, known as Relative Value Units (RVU), based on the resources (physician's work, the practice expense, and professional liability insurance) required to provide the services. BCBSMT uses the Transitioned Non-Facility RVU and Transitioned Facility RVU totals. The applicable total RVU is multiplied by the BCBSMT conversion factor to calculate the BCBSMT allowable fee for participating providers.

Payment for the administration of anesthesia is based on the American Society of Anesthesiology methodology. The compensation method for physicians and certified registered nurse anesthetists is a base and time unit calculation (base units plus time units multiplied by the conversion factor). Anesthesia time is reported in minutes, and each 15-minute increment equals one unit. More information is available in the Relative Value Unit and Anesthesia Compensation policies published at [bcbsmt.com](#) (click on Providers and then Provider Policies). For questions or concerns about this communication, please contact your Health Care Services Provider Account Consultants at 1.800.447.7828.

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How The New HIPAA Omnibus Final Rule Affects Providers

Please note that the below information is intended for general informational purposes only. The information should not be construed as legal advice or as legal opinion on any specific facts or circumstances and is not intended to replace independent legal counsel or consultant. You are urged to consult a lawyer or consultant concerning the steps you and/or your company need to take to comply with the HIPAA Rules and regulations or any specific legal questions you may have.

On January 17, 2013, the Office for Civil Rights (OCR), U.S. Department of Health and Human Services (HHS), released the highly anticipated final rule (the "Final Rule"), which modified numerous aspects of the HIPAA regulations concerning privacy, security, enforcement, and breach notification. The Final Rule is actually comprised of four rules:

1. **Final modifications to the HIPAA Privacy, Security, and Enforcement Rules** as mandated by the Health Information Technology for Economic and Clinical Health Act, P.L. 411-05 (HITECH) as well as certain other modifications to improve the rules;
2. **Final modifications to the HIPAA Enforcement Rule**, originally published on October 30, 2009, as an interim final rule, to incorporate increased and tiered monetary penalties pursuant to HITECH, among other changes;
3. **Final rule on Breach Notification for Unsecured Protected Health Information (PHI)** under HITECH, which supplants an interim final rule published on August 24, 2009; and
4. **Final rule implementing certain provisions of the Genetic Information Nondiscrimination Act of 2008 (GINA)** by revising the HIPAA Privacy Rule to provide for increased privacy protections for genetic information.

Effective and Compliance Dates. The Final Rule took effect on March 26, 2013. In general, covered entities, their business associates, and subcontractors have 180 days beyond the effective date—until September 23, 2013—to comply with the provisions of the Final Rule. However, the provisions of the Enforcement Rule are effective and apply on March 26, 2013, except as otherwise specified in the Enforcement Rule. Additionally, there are transition provisions allowing covered entities and their business associates up to one year beyond the Final Rule compliance date to amend existing contracts under certain conditions.

HHS OCR and WEDI Sponsored Webinars. On May 14, 2013, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) and the Workgroup for Electronic Data Interchange (WEDI) announced the launching a series of co-sponsored webinars on various aspects of the Omnibus HIPAA Rulemaking. WEDI was formed in 1991 by then Secretary of HHS Dr. Louis Sullivan and was named in the original 1996 HIPAA legislation as an advisor to HHS. The 90-minute webinars are specifically designed for small health care providers, with a focus on practical strategies for implementing the Omnibus Rule changes within a small clinical practice.

Mark Your Calendars - The virtual sessions are scheduled for June 14, June 28, July 17, and July 26, 2013 from 1:00 – 2:30 p.m. Eastern Time on the following topics:

- HITECH Omnibus Overview of the Rule - **June 14**
- Drill down on the new HITECH Privacy Rule - **June 28**
- Breach and Enforcement under the HITECH Omnibus Rule - **July 17**
- Business Associates and the HITECH Omnibus Rule - **July 28**

Registration is free of charge and available [here](#).

For additional information on a wide range of topics about the Privacy and Security Rules, please visit the [OCR Privacy website](#). You can also call the OCR Privacy toll-free phone line at 1.866.627.7748. Information about OCR's civil rights authorities and responsibilities can be found on the [OCR home page](#). To subscribe to the OCR list serv, [click here](#).

ICD-10: What Are You Waiting For?

With the ICD-10 deadline set at October 1, 2014, organizations should be ramping up their preparations for the switch. Once your organization has laid the foundation for the ICD-10 transition through planning, you will need to conduct thorough testing—both within your organization and with your business trading partners such as vendors and health plans.

ICD-10 implementation is not a quick fix; larger practices may need over a year to implement it.

Now is the time to assess or reassess and see whether you are where you want to be in your ICD 10 implementation timeline. ICD-10 implementation requires resources – time to plan, time to educate, time to execute, time to upgrade systems, etc. Productivity losses, delayed or denied claims, and frustrated staff are a few things that an unprepared office would face. You may be left scrambling: trying to find education and training, trying to get on a vendor's already full schedule, trying to get your provider's documentation ready, trying to get your policies and procedures updated, trying to get everything done in a shortened time frame. Figure out what you need, when you need it, and how you are going to get it lest you risk revenue issues by procrastinating.

More information on preparing for the transition to ICD- 10 is available at [Medicare ICD-10 Coding](#). For questions or concerns about this communication, please contact your Health -Care Services Provider Account Consultants at 1.800.447.7828.

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Prior Authorization and Inpatient Precertification Reminder

Please keep in mind that if pre-service and concurrent reviews are not completed in a timely manner your patients' claims may be denied until adequate clinical information is received to make a retro-determination for coverage.

This applies for both services that are inpatient or outpatient and prior authorization or precertification is recommended. Visit the BCBSMT website for [Prior Authorization](#). As we increase our efficiencies in timeliness and pre-service determinations, we will no longer be calling or faxing to request records for post-service review. Instead, services will be denied until a request for review and adequate clinical information is received.

Psychotherapy CPT Changes

CPT made some significant changes to the psychotherapy section for 2013. The last major update to the psychotherapy section of CPT was in 1998, so it was time. There are 11 new codes, 4 code revisions, and 27 deleted codes. There was a need to account for the dramatic changes in the practice of psychiatry and mental health including the shift from single disorders to management of multiple disorders and medical co-morbidities. There has also been a drastic reduction in inpatient psych beds causing a shift in the site of service from inpatient to outpatient with more complex and higher risk patients being seen in the outpatient setting.

The psychotherapy section has a new structure for 2013 as outlined below:

1. Psychiatric Diagnostic Evaluation (90791, 90792)
 - o Interactive Complexity (90785)
2. Psychotherapy w/pat or family (90832-90838)
 - o Interactive Complexity (90785)
 - o Add-on for E/M service when applicable
3. Crisis Psychotherapy (90839, 90840)

Rational outlined below:

1. Psychiatric diagnostic evaluation

- **90801** (diagnostic interview exam) was replaced with 2 codes to differentiate between diagnostic evaluation with medical services (**90792**) and without medical services (**90791**)
 - 90791 & 90792 components:
 1. History
 2. Mental Status
 3. Review and order of diagnostic studies as needed
 4. Recommendations – including communication with family or other sources
 - 90792 includes all of the above PLUS:
 1. Examination (CMS psychiatric specialty exam)
 2. Prescription of Medications when appropriate
 3. Ordering of lab tests as needed
 - Additional items of consideration when billing 90791 or 90792:
 1. Use for reassessment(s) if required (e.g. patient condition changes)
 2. Report more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants (parent, significant others)
 3. Do NOT report on the same day as psychotherapy or crisis psychotherapy
 4. Do NOT report on the same day as the E/M service performed by the same individual for the same patient
 - **90802** (Interactive diagnostic interview exam) was replaced with the new add-on concept of "Interactive Complexity" (**90785**)
 - 90785 replaces all interactive codes (90802, 90810-90815, and 90823-90829)
 - Rationale for 90785: Need existed to expand "interactive" concept to include specific and recognized effort required for communication difficulties for various types of patients and situations that represent significant complicating factors that *increase the intensity of the primary psychiatric procedure* (**NOT FOR TIME**)
 - When to use 90785; the below must occur in the session:
 1. Maladaptive communication (e.g. high anxiety, high reactivity to the point it interferes with the delivery of service)
 2. Emotional or behavioral conditions inhibiting implementation of treatment plan
 3. Mandated reporting of a sentinel event exists (e.g. abuse/neglect)
 4. Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional.
 - If used with E/M, 90785
 - 1. Interactive complexity relates to the psychotherapy service only
 - 2. Interactive complexity is NOT factored into E/M
 - The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an E/--M service (+90833, +90836, +90838); this is NOT increase in intensity.

2. Psychotherapy with Patient or Family

- Site of service is no longer a criterion for code selection
- Time specifications are changed to be consistent with CPT convention
- "Individual" is not in the code titles and psychotherapy time may include face-to-face time with family members as long as the patient is present for part of the session
- Family psychotherapy focuses on the family dynamics; how the family functioning is helping/hurting patient
- Codes for psychotherapy with medical E/M services have been replaced with psychotherapy add-on codes (+90833, +90836, +90838) to be reported in conjunction with codes for E/M services.
- Use E/M code then add a psychotherapy service; thus can address the complexity of the work
- Intra-service work has not changed
- Coding Tips:
 - In order to report both an E/M code and a psychotherapy add-on code the two services must be significant and separately identifiable
 - The type and level of E/M service is selected first based upon the key components of history, exam, and medical decision making
 - Psychotherapy must be 16 minutes or more face-to-face with patient and/or family

- Time associated with activities used to meet criteria for the E/M service is NOT included in the time used for reporting the psychotherapy service
 - Time (counseling and coordination of care) may not be used as the basis of E/M code selection
 - The E/M service and the psychotherapy service may be for the same diagnosis
 - Could have 3 codes (E/M, psychotherapy, interactive complexity)
- Family Psychotherapy (90846, 90847, 90849) is unchanged from 2012
 - Use 90846 to report a service when the patient is not physically present.
 - Use 90847 to report a service that includes the patient some or all of the time. Couples therapy is reported with code 90847

3. Crisis Psychotherapy

- Rationale:
 - New concept and additional to the psychotherapy section
 - When psychotherapy services are provided to a patient who presents in high distress with complex or life threatening circumstances that require urgent and immediate attention.
 - Do NOT report 90839, +90840 with diagnostic evaluation (90791, 90792, psychotherapy (90832, 90834, 90837), or with add-on psychotherapy (+90833, +90836, +90838)
 - Do NOT report 90839, +90840 with interactive complexity (90785) or any of the procedures included in the Other Psychotherapy or Other Psychiatric Services or Procedures sections.
- 90839 is a stand-alone code not to be reported with psychotherapy or psychiatric diagnostic evaluation codes, the interactive complexity code, or any other psychiatry section code.
 - Use this code for the first 30-74 minutes of psychotherapy for crisis on a given date
 - Psychotherapy for crisis of less than 30 minutes total should be reported with 90832 or 90833
 - Report 90839 only once per date even if time spent by the physician/QHCP is not continuous on that date
- (+)90840 is an add-on code that should be reported for each additional 30 minutes of service (beyond the first 74 minutes).
- 90857 (Interactive Group Psychotherapy) was deleted and cross-walked to 90785 & 90853
 - 90853 is to be used in conjunction with 90785 for the specific patient when group psychotherapy includes interactive complexity.
- 90862 (Pharmacological Management) was deleted and cross-walked to the E/M codes with +90863 being added as an add-on to the psychotherapy code for those who cannot bill an E/M.
 - Rationale:
 0. QHCP who are not authorized to report E/M codes may report the new add-on pharmacologic management code in conjunction with the psychotherapy codes. For pharmacologic management services provided by physicians and selected QHCP, +90863 should NOT be reported since pharmacologic management services are included in the E/M.
 1. Psychotherapy services do not include pharmacologic management
 2. Do NOT count time spent on providing pharmacologic management services in the time used for the selection of the psychotherapy service.

Total Health Management Program Expansion

Blue Cross and Blue Shield of Montana (BCBSMT) is pleased to announce the expansion of our Total Health Management (THM) program into Missoula, Butte, Billings, Stevensville, and Libby. The THM program is an innovative, state-of-the-art wellness program that is based on positive health outcomes and beneficiary member engagement.

We believe the THM program will help our groups and members improve their overall health status and allow for better control of the costs of their health and wellness benefits plan by:

- Increasing Employee Productivity
- Reducing Employee Absenteeism
- Improving Employee Morale
- Reducing Health Care Costs
- Lowering Stress Levels
- Increasing Stamina

- Improving Physical Fitness
- Facilitating Weight Reduction

THM provides an incentive for BCBSMT's groups and members to collaborate with their primary care providers in the development and maintenance of healthy lifestyle choices. Cancer screenings, tobacco use, height, weight, immunizations, blood pressure, and cholesterol are the health screening measures that we ask you to monitor and communicate with our members. In exchange for this effort, BCBSMT will provide additional compensation to you.

How the Total Health Management Program Works

The BCBSMT Beneficiary Member will be responsible for [obtaining the form](#), completing Sections I and II, and submitting the form to BCBSMT.

The BCBSMT Participating Primary Care Provider will be responsible for completing Sections III and IV as follows:

- **Section III** – Health Measures and Screenings - Complete all fields.
- **Section IV** – Signature – You and your patient must sign this form, even if you have determined an office visit is not required.

Alternative Standard/Waiver – *If it is unreasonably difficult due to a medical condition for the member to achieve the standards under this program, or if it is medically inadvisable for the member to attempt to achieve the standards under this program, please develop a reasonable alternative standard or if appropriate, waive that particular standard.*

Submit your claim as you normally would with services rendered including CPT® Code 99420. The claim will be paid according to your provider arrangement with BCBSMT.

At BCBSMT, our corporate mission is to partner with Montanans to help them lead healthier lives. Our investment and promotion of the Total Health Management Program is an important part of our effort to accomplish this mission. We are grateful to you for joining us in this endeavor. We look forward to making this partnership a great success for you, for your patients, and for the groups and members served by BCBSMT.

Should you or your staff have questions or concerns or if you require additional information, please contact your Health Care Services Provider Account Consultants at 1.800.447.7828.