BlueCross BlueShield of Montana

2014 Operational Updates
for Montana Providers

Blue Cross and Blue Shield of Montana (BCBSMT) will be implementing several operational changes beginning January 1, 2014. Following is an overview of how these changes will impact your office. If you have questions or need additional information, contact your Provider Account Consultant at 1-800-447-7828, ext. 6100, Option 3 or hcs-x6100@bcbsmt.com.

INTERNAL

	CURRENT	EFFECTIVE 01/01/2014
Care Management		
Case Management Negotiations	BCBSMT clinical nursing staff negotiates rates for alternate benefit agreements with providers in circumstances where it benefits the member and group.	***Upon conversion:*** Network Management will negotiate provider rates related to an alternate benefit arrangement.
Health Care Management	The Health Care Management team currently provides Care Coordination, Utilization Management, Healthy Wonders and Wellness Programs	***Upon conversion:*** Health Care Management standard Blue Care Connection program includes: • Case Management • UM Preauthorization • Concurrent and Medical Necessity Review • Core Behavioral Health • Special Beginnings • Condition Management • Care Coordination and Early Intervention (CCEI) • Lifestyle Management - Weight Management, Tobacco Cessation, Metabolic Syndrome (MetS), leading indicators • Screening Reminders • Wellness Programs • 24/7 Nurseline
Behavioral Health		
Chemical Dependency and Behavioral Health Coverage	The BCBSMT Behavioral Health (BH) program currently includes: • Case Management (CM) • Utilization Management (UM) for the review of level of care admissions for Inpatient, Partial Hospitalization, Residential Treatment, and Intensive Outpatient Care.	***Upon conversion:*** The BCBSMT BH program will include CM, UM and the following: • Care Coordination Early Intervention (CCEI) program for outreach to high risk members post discharge. • 24 hour access to master's prepared independently licensed BH clinicians for inpatient authorizations and assistance for member immediate needs. • Patient Safety Program for outreach to identified members who may benefit from support and encouragement to access BH services. • Specialty care programs for consultation and case review: Autism Care Team and Eating Disorder Team. • Care onTarget – online condition management program for Depression and Substance Abuse conditions (assessment, tutorials, chat with clinician, other education resources). • Electroconvulsive Therapy (ECT) review – Medical Policy effective 10/25/2013. • Prior Authorization required PER PROVIDER CONTRACT effective 1/1/14 for converted and non converted groups. If not completed, will be reviewed once claim received. • Effective 1/1/14 for converted and non converted groups, telephonic reviews will be introduced for initial requests for IP, IOP, PHP and Residential Treatment. • Beginning 7/1/14, prior authorization for psych and neuropsych testing will be introduced.
Dental Coverage		
Dental Network of America (DNoA)	NA	• DNoA will be the dental network administrator. • DNoA has over 25 years of experience as a dental network administrator. • DNoA will also become the dental network administrator for the BCBSMT dental PPO network. • The transition to DNoA will occur later in 2014. • By participating in the BCBSMT dental PPO network, providers are automatically part of the DNoA Preferred Network. • Providers will be provided more information about DNoA and the DNoA Preferred Network.
Dental Claim Processing Changes	Non-participating dental provider claims are paid to the member directly. All out-of-state dental providers are processed as non-participating.	***Upon conversion:*** All in-state dental providers will be paid by DNoA directly. Participation status is irrelevant in payment.

INTERNAL -- *continued*		
	CURRENT	EFFECTIVE 01/01/2014
Dental Coverage -- *continued*		
Dental ID Card	BCBSMT members receive a single medical/dental/pharmacy ID card with Dependent names on the card	***Upon renewal:*** Members will receive a separate Dental ID card with dental customer service phone numbers and dental claims submission information. Dependents' names will not be listed on the Dental ID card. Dependents can be verified using the BCBSMT portal **(bcbsmt.com)**.
Dental Customer Service	Dental providers currently use the standard BCBSMT Customer Service number	***Upon renewal:*** A new dental only Customer Service number will be provided: **1-866-739-4090**.
Dental Claims Information	Dental providers currently use the standard BCBSMT claims address to submit claims information	***Upon renewal:*** • New Dental claims address is: **Blue Cross and Blue Shield of Montana PO Box 6227 Helena, MT 59604**
DNoA Preferred Network Identifier and Phone Number	BCBSMT currently does not list a network	***Upon renewal:*** • The DNoA Preferred Network name and phone number will be listed on the Dental ID cards. • The DNoA Preferred Network includes all of the BCBSMT Dental participating providers.
Dental EOB and Check Changes	Dental providers receive one cumulative EOB and check for all members serviced.	***Beginning 1/1/2014:*** • Providers will get a separate EOB with a separate check for every claim submitted. Members will receive checks for claims submitted by out-of-state dentists only and should forward to the Provider if applicable. • When BCBSMT discounts are applied, the following EOB message will appear: **"Dental Network of America PPO fee schedule used to process this claim. Thank you for participating in the DNoA Preferred Network."**
Pre-Service Estimate	BCBSMT does not provide pre-service estimates.	• A pre-service estimate will be automatically sent to dental providers when a claim is submitted without service dates.
Miscellaneous / Other		
Transplant Network	BCBSMT uses Blue Distinction Centers® for Transplant (BDCT) and Interlink Transplant Network which offer Centers of Excellence for heart, heart/lung, single lung, double lung, liver, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell and small bowel transplants. BCBSMT nurses manually re-price claims from Interlink with the discount agreement pricing for preservice, transplant, post service claims for one year post service. BDCT claims are processed manually based on a global transplant case allowance.	The Human Organ Transplant Program will only include the Blue Distinction Centers for Transplant (BDCT). Case Management will continue to educate members about available BDCT facilities and the advantages of using them. Transplant claims are handled by claims examiners in the Full Service Units (FSUs).
Provider Precertification Change from Recommended to Required	BCBSMT strongly recommends obtaining approval for non-emergency inpatient admissions and Prior Authorization (predeterminations).	***Upon conversion:*** BCBSMT will **require** participating providers to notify the Plan for inpatient admissions and recommending preauthorization. The change will be reflected in new provider contracts and the provider manual. There will not be a penalty if precertification is not done prospectively.

INTERNAL -- *continued*		
	CURRENT	**EFFECTIVE 01/01/2014**
Miscellaneous / Other -- *continued*		
Medical/Surgical Utilization Management Length of Stay (LOS) and Concurrent Review	BCBSMT's current Medical/Surgical initial precertification(s) and concurrent review UM process: • Provider faxes BCBSMT UM to inform of elective or unplanned hospital admission. • UM nurse reviewer determines if level of care is appropriate. – If yes, UM nurse telephonically advises the hospital of the number of approved days. – If no, UM nurse telephonically advises the hospital the days that were partially approved or denied. Letters are only sent to provider and member if there are denied days. Includes information on appeal rights. • UM nurse keeps track of those admissions that require a concurrent review. • The Clinical Support team contacts the facility for Members with an open admission to determine if they have been discharged. If the patient remains hospitalized, they inform the hospital UM that a concurrent review is due.	***Upon conversion:*** • Provider calls or sends fax to the Enterprise Intake Unit (EIU) for elective and unplanned hospital admission. • EIU Customer Advocate (CA) determines if the needed precertification requires clinical review by UM. • If case meets non-clinical review guidelines and provider requests a length of stay (LOS) for two or fewer days, the CA will advise of approved days and send approval letter. • If case does not meet non-clinical review guidelines and provider requests a LOS greater than two days, the CA will refer the case to UM for clinical review. • If level of care is determined appropriate, UM nurse sends letter informing of approved days. • If days are not approved by Medical Director, the nurse reviewer will offer peer to peer review. • If days are still not approved by the Medical Director, the nurse will notify the provider of the denied days and inform of appeal rights. • Letters are sent for denied days with an explanation of appeal rights. • Provider required to notify BCBSMT UM if member is not discharged on last covered day (LCD) and to request concurrent review. BCBSMT UM reviewers will no longer contact the UM departments to request concurrent review.
Pay and Pursue Model	BCBSMT pursues information before making payment on any claims. This means that letters of inquiry are sent to the member to determine if another party is liable. Claims are denied until a response from the member is received.	***Upon conversion:*** BCBSMT will begin changing processes for reviewing information about potential Third Party Payers. A Pay and Pursue model will be followed while investigating potential coordination of benefits with liable entities. The Pay and Pursue model allows for payment of claims up-front followed by review for potential Third Party Payers. This process will be effective as members transition into the new claims processing system.
Code Auditing	BCBSMT claims system uses Optum Insight iCES code auditing software.	***Upon conversion:*** BCBSMT will begin using McKesson ClaimsXten™ code auditing software to process individual and group business claims. For business that hasn't transitioned to Enterprise systems, claims will continue to process on BCBSMT claims system with iCES code auditing software.
Handling Overpayments and Refunds	NA	***Upon conversion:*** Overpayments identified by BCBSMT: Providers will receive a letter to explain the overpayment. Providers have the opportunity to return the overpaid funds via check or request that overpaid amounts be withheld from future payments. If no response is received within 30 days, the overpayment will be subject to auto-recoupment by withholding from future payments. **Overpayments identified by a provider by phone call or paper correspondence:** providers will receive a letter to explain the overpayment. You will be offered the opportunity to return the overpaid funds via check or by requesting that we withhold from future payments. If no response is received within 30 days, the overpayment will be subject to auto-recoupment by withholding from future payments. **Overpayments identified by a provider and accompanied by a check:** potential overpayments will be reviewed and claim adjustments will be performed per the provider's request.
DXL Billing Changes	Some providers submit DXL claims with a separate provider ID to ensure that they are processed under the DXL provisions.	***Upon conversion:*** As members transition into the new system, providers will use their normal provider ID to submit DXL claims. They will be priced appropriately in the new system.
Crossover Benefits (COB) Pay and Pursue	BCBSMT pursues information before making payment on any claims by sending a letter of inquiry to the member to find out if another party is liable. Claims are denied until the member responds.	***Upon conversion:*** • BCBSMT will implement a Pay and Pursue model while investigating potential coordination of benefits with other insurance. The Pay and Pursue model allows for up-front payment of claims while conducting a review for potential COB. This process will go into effect as members transition into the new claims processing system. • If overpayments are identified, providers/members will receive letters detailing the overpayment and subrogation process.
Provider Portal	Providers access Provider Claim Remits (PCRs), and patient information such as eligibility, claim, benefit and deductible/out of pocket on **bcbsmt.com**.	• Providers will continue to access all patient information via **bcbsmt.com**. **In addition to accessing PCRs, providers will be able to view the Provider Claims Summary (PCS).**

INTERNAL -- *continued*

	CURRENT	EFFECTIVE 01/01/2014
Miscellaneous / Other -- *continued*		
ID Card	Members have one ID card for all coverage.	***Upon conversion:*** • New ID cards will be issued upon conversion. Members will have to give their providers a copy of their new card for billing so that claims are processed correctly. • As members transition into the new system, they will be issued new ID prefixes that will help direct their claims. • Members will also receive a separate ID card for vision and dental coverage if enrolled.
Medicare Secondary Payer Claims Submission	BCBSMT processes claims where Medicare is primary as they are submitted.	***Upon conversion:*** Providers will be required to wait 30 days before submitting claims for processing to accommodate the Medicare Crossover process. Claims will be rejected if submitted prior to the 30th day.