SUMMER 2007

BlueCross BlueShield of Oklahoma

Network News

A newsletter for contracting physicians, hospitals, pharmacies and other health care network providers

NPI transition is underway

Thank you for your cooperation as Blue Cross and Blue Shield of Oklahoma continues to move toward National Provider Identifier (NPI) compliance. The following steps will facilitate the transition:

Step 1: GET IT

If you do not have your NPI yet, there are two ways to apply:

- Online: Submit an online application via the National Plan and Provider Enumeration System (NPPES) Web site at **https://nppes.cms.hhs.gov/NPPES/Welcome.do**.
- Mail: Call **1-800-465-3203**, or e-mail the NPI Enumerator to request a paper application at **customerservice@npienumerator.com**

Step 2: SHARE IT

Once you receive your NPI, you must share it with:

- Blue Cross and Blue Shield of Oklahoma
- Your electronic trading partners (billing services, clearinghouses and software vendors)
- Other health plans and payers

To share your NPI with Blue Cross and Blue Shield of Oklahoma, send us a copy of your confirmation letter or e-mail from the NPPES Enumerator for verification purposes. For details, visit the health care providers section at www.bcbsok.com.

Blue Cross and Blue Shield of Oklahoma sends confirmation postcards to providers once we have validated and loaded your NPI information into our system. Please allow three to four weeks for receipt of your confirmation postcard. Notification of participation in our NPI-only transition program will be provided to you in a separate communication.

Step 3: TEST IT

During the extended dual-identifier acceptance phase, it is very important to continue submitting *all* paper and electronic claims with the appropriate NPI *and* Blue Cross and Blue Shield of Oklahoma provider number, or only your Blue Cross and Blue Shield provider number.

NOTE: Do not submit claims with only your NPI until you have received notification from Blue Cross and Blue Shield of Oklahoma regarding your participation in our NPI-only transition program. Claims submitted with only your NPI number prior to notification may be rejected.

Electronic submitters:

Have your electronic trading partners contact our Electronic Commerce (E-Commerce) Center Hotline (formally the EDI Hotline) at **1-800-746-4614** to confirm program details and to schedule a date for your transition to NPI-only processing.

Paper submitters:

You should now be using the revised CMS-1500

Continued on page 4

Paper claim submitter alert

Please be advised that as of November 1, 2007, Blue Cross and Blue Shield of Oklahoma will no longer accept claims submitted on the CMS-1500 (version 12/90) or UB-92 claim form. CMS-1500 (12/90) or UB-92 claim forms that are received after October 31, 2007 will be returned to you with a reminder letter to resubmit your claims using the correct version of the form.

As a reminder, professional providers filing with Blue Cross and Blue Shield of Oklahoma should now be using the current version of the CMS-1500 (version 08/05). Facility providers should now be using the new UB-04 claim form.

For assistance with filling out the revised CMS -1500 (08/05) claim form, please refer to the CMS-1500 "How to Complete" document located in our health care providers section at www.bcbsok.com. For additional information on the new UB-04 billing form, visit the National Uniform Billing Committee (NUBC) Web site at **www.nubc.org**.

Hear the difference

New voice-activated phone system implemented

Blue Cross and Blue Shield of Oklahoma's provider line and medical services department have an alternative to touch-tone phone navigation. Implemented earlier this year, the new voice-activated automated system is simplifying the way health care providers submit and receive information.

This new voice automated system allows health care providers to conveniently perform self-service inquiry resolution and access key information by speaking requests. Many prompts still accommodate touch-tone entry should that be your office's preference.

Follow these tips to ensure a trouble-free call:

- Speak clearly
- Minimize background noise
- Avoid using speaker or cellular phone
- Interrupt – it's OK!
- Be prepared to document responses and confirmation number
- Speak numbers in single-digit format. For example, if your provider number is 61, this should be spoken as "six one" instead of "sixty-one"

Provider Line 1-800-722-3730

The initial prompt will ask you to speak one of the following:

- BlueLincs HMO
- Custom Group Services
- FEP (Federal Employees Program) or *call 1-800-722-3130*
- Credentialing
- Or More Choices
  - Health Industry Relations, say "HIR"
  - BlueCard or *call 1-800-496-5774*
  - HealthCheck or Plan 65, say "health"
  - Group market employer coverage, say "group"
  - For all others, say "other"

Medical Services 1-800-672-2378

- To precertify a hospital admission or initiate a new case, say "precertification" or press 1 on the phone pad.
- To provide clinical review, say "clinical review" or press 2.
- For case management or home IV infusion, say "case management" or press 3.
- For benefits, eligibility or claims status, say "benefits" or press 4.

Blue Cross and Blue Shield of Oklahoma launches performance-based recognition program for network health care providers

In the second half of 2007, Blue Cross and Blue Shield of Oklahoma will begin analyzing claims data for a new performance-based recognition program for network health care providers.

"Performance-based recognition is our response to an industry-wide push to improve the quality and cost-effectiveness of health care by focusing on outcomes," said Dr. Joe Nicholson, medical director, Blue Cross and Blue Shield of Oklahoma. "We want to recognize those physicians whose patients consistently experience positive outcomes in order to emphasize quality of care and minimize any complications."

Blue Cross and Blue Shield first announced the program to physicians this spring in a series of small group presentations, seeking physicians' feedback on what indicators should first be studied. As a result of that feedback, the Oklahoma insurer recently announced the following four measures will be evaluated in 2007:

- Hemoglobin A1c testing for diabetics
- Lipid panel for diabetics
- Hepatic enzyme monitoring for statin use
- Lipid panel for coronary artery disease

Nicholson said additional indicators will be studied in 2008, as the performance based recognition program continues its phased implementation. Watch for additional details about the program in future issues of *Network News*.

Use correct code for billing spinal decompression services

Blue Cross and Blue Shield of Oklahoma's current medical policy under the title "Non-Surgical Spinal Decompression Traction Devices" states that "Non-surgical spinal decompression traction devices are considered experimental, investigational and unproven" and as such are not covered services in our benefit plans.

As a general reminder and to avoid a claim audit, payment delays or rejections, health care providers billing for vertebral axial decompression should only bill this procedure under the following Health care Common Procedure Coding System (HCPCS) code:

- S9090 Vertebral Axial Decompression, per session

This includes services using devices such as DRX-9000™, DRX-9000C™, the DRS System™, the Spina System™, the Lordex® Decompression Unit, the SpineMED™ Decompression Table as well as any other comparable devices that might be developed or are not named previously.

Vertebral axial decompression service should not be billed under the following HCPCS codes:

- 64722 Decompression, unspecified nerve(s)
- 97012 Traction mechanical
- 97110 Therapeutic exercise
- 97112 Neuromuscular re-education
- 97140 Manual therapy techniques
- 97530 Therapeutic activities
- 97039 Unlisted modality

Billing of this service under these or any code other than S9090 is inappropriate.

New forms for preauthorizations

To streamline the preauthorization process, Blue Cross and Blue Shield of Oklahoma's pharmacy department has developed new, drug-specific, preauthorization forms.

These new forms eliminate the need for health care providers to supply medical records in most instances. The forms contain questions related to diagnosis and other criteria that help to establish medical necessity. Blue Cross and Blue Shield customer service will fax the appropriate form to the provider. To initiate this process, the provider can call the customer service number on the back of the member's ID card.

Prescription drug formulary changes

The prescription drug formulary is updated quarterly for Blue Cross and Blue Shield of Oklahoma and BlueLincs HMO members with a three-tier drug plan. To view the most current formulary, visit www.bcbsok.com and click on "Health Care Providers" then click "Pharmacy Information."

The following changes have been made to the formulary:

Drugs listed/moved to Tier II

Procainamide Tab CR 750 mg, 1000 mg
Baraclude
Epivir HBV
Lialda Tab

Drugs listed/moved to Tier III

Ethmozine

Program aids expecting mothers

An innovative prenatal program launched July 1 for eligible Blue Cross and Blue Shield of Oklahoma members. Healthy Expectations® is a comprehensive program that helps expectant members better understand and manage their pregnancies.

Working in partnership with the expectant member's health care provider, Healthy Expectations focuses on providing the member with educational resources and tools she needs to help her take better care of herself and her baby.

The program includes:

- 24-hour, toll-free access to a BabyLine staffed by maternity nurses
- Educational materials
- An e-mail newsletter every two weeks beginning at the 13th week of pregnancy with information on a baby's development at specific stages
- Access to an online health information library
- Case management services if the member is considered high risk

The Healthy Expectations prenatal program is available to most Blue Cross and Blue Shield of Oklahoma members. Patients can verify eligibility and register for Healthy Expectations by calling **1-877-904-BABY (2229).**

NPI transition is underway (Continued from page 1)

(version 08/05) or the new UB-04 claim forms, which have been revised to support inclusion of both your NPI and your Blue Cross and Blue Shield of Oklahoma provider number, or only your Blue Cross and Blue Shield provider number, throughout the extended dual-identifier acceptance phase.

Step 4: USE IT

If you submit claims electronically, Blue Cross and Blue Shield of Oklahoma will work with you or your electronic trading partner to transition you to an NPI-only environment. Please contact our E-Commerce Hotline for additional details.

If you submit paper claims, Blue Cross and Blue Shield of Oklahoma will notify you when you should begin submitting claims with only your NPI.

NPI
National Provider Identifier

Medicare Advantage PFFS members

"Medicare Advantage" is the program alternative to standard Medicare Part A and Part B fee-for-service coverage, generally referred to as "traditional Medicare." Medicare Advantage Private Fee-For-Service (PFFS) is one of the product offerings under the Medicare Advantage program that pays health care providers on a fee-for-service basis. Medicare Advantage PFFS allows members to use any doctor, specialist or hospital that accepts the Blue Plans' PFFS terms and conditions of Plan payment, as long as the health care provider is lawfully authorized to provide services under traditional Medicare.

ID card

Blue Cross and Blue Shield Medicare Advantage members are easy to recognize since they carry ID cards with the PFFS, PPO, HMO or POS logo, indicating in which plan the member is enrolled.

Becoming a Medicare Advantage PFFS provider

PFFS plans offered by Blue Plans generally use the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage "deemed provider" concept, rather than direct contracts. A health care provider is considered a deemed provider if each of the following three criteria are met per episode of care:

- Provider is aware in advance of furnishing services to a person enrolled in a PFFS plan.
- Provider can access or have reasonable access to information about the PFFS Plan's terms and conditions of payment.
- Provider renders services to that member

If a health care provider chooses not to render services to Medicare Advantage PFFS members, the provider should not treat the member, unless in an emergency or urgent situation.

Providing services to Blue out-of-area Medicare Advantage members

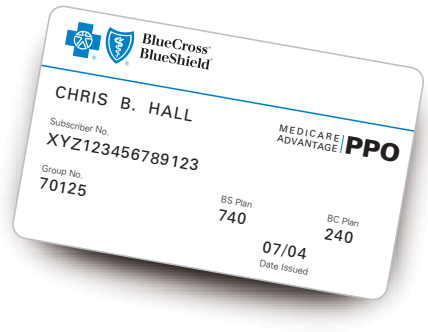
If a health care provider is aware in advance of providing services to a person enrolled in a Medicare Advantage product, and possesses or has access to the Plan's terms and conditions of payment, then that provider will be reimbursed at the Medicare-allowed amount for all covered services.

Other than the applicable member cost-sharing amounts, reimbursement is made directly by a Blue plan. In general, a health care provider may collect only the applicable cost-sharing (i.e. copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member. Special rules apply, however, in the PFFS context where balanced billing may be permitted under some plans.

See the member's ID card for the location of terms and conditions of payment.

Urgent/Emergency Care

When a health care provider that furnishes services to a PFFS member in an urgent or emergency care situation informs the PFFS Plan that it does not wish to be treated as a deemed provider, the health care provider will generally receive payment equal to what they would have received under traditional Medicare. In this context, the health care provider may only collect the applicable copayments or coinsurance under the PFFS plan from the member.



Collecting member cost sharing amount at time of service

Health care providers can collect any applicable cost sharing amount (i.e. copay, deductible). Balance billing may be permitted under some PFFS plans.

Eligibility verification

To obtain the most accurate information about a Blue Medicare Advantage member's eligibility and benefits, call **1-800-676-BLUE** (2583) and provide the alpha prefix. If a health care provider experiences difficulty obtaining eligibility information, please record the alpha prefix and call Blue Cross and Blue Shield of Oklahoma at **1-800-496-5774** to report the incident.

Claims submission

Submit claims to Blue Cross and Blue Shield of Oklahoma. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by the member's home plan.

Claims Appeal

If you think a payment amount for a service, including the member cost sharing collected, is less than what you would have received under traditional Medicare for the service, you can appeal the payment amount. Call Blue Cross and Blue Shield of Oklahoma's Provider Inquiry Unit at **1-800-496-5774** for claims appeal information or review the claims appeal process in the terms and conditions of payment, which is located on the member's ID card.

For more information, contact your provider relations representative at **1-800-722-3730**.

WHAT'S INSIDE

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Network News is a quarterly newsletter for institutional and professional providers contracting with Blue Cross and Blue Shield of Oklahoma. We encourage you to share the content of this newsletter with your staff.

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