BlueCross BlueShield of Oklahoma

# Blue Review

A Provider Publication

## January 2014

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 on January 13, 2014 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 at bcbsok.com/provider.**

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

## Patient Benefits Accessibility During Annual Updates

Blue Cross and Blue Shield of Oklahoma (BCBSOK) is working to incorporate the 2014 benefit changes elected by our groups and retail market policy holders. Providers performing an inquiry for eligibility or benefits for these members may be instructed to contact Customer Service to obtain the information until the systems are updated.

During this time, we anticipate an increase in our call volumes, which may result in extended hold times through February due to the large number of policy changes underway. We are requesting you postpone an "eligibility and benefits request" for patients who are not scheduled for an appointment in the future or in need of immediate treatment or service.

## Update on Confirming Eligibility for BCBSOK Members

With the new federal requirement for individuals to have insurance coverage beginning Jan. 1, along with new commercial groups with coverage starting Jan. 1, Blue Cross and Blue Shield of Oklahoma (BCBSOK) is pleased to be serving many new members.

*There are some important things to be aware of when verifying eligibility:*

**Member ID information:** Member ID information: Members should receive their member ID card within days of completing their enrollment. However, some of your patients may not have received their member ID card at the time of their appointment. If they have their member identification number and group number from another source, such as their new member welcome letter or phone confirmation, we can verify eligibility and benefits.

- For patients who do not have this information, you should direct them to contact our Member Customer Service Center at 866-520-2507 to obtain their information. Or, reschedule their appointment to a later date.
- If the member is exhibiting an urgent need for inpatient services or admission and you are unable to verify their information, please contact 855-462-1784 for preauthorization.

**Confirming coverage:** As usual, coverage cannot be used until the member's first month premium payment has been applied to activate their coverage. Also, benefits may vary depending on the coverage purchased by the member. It is important to check for eligibility and benefits each time you see a patient. We are experiencing high call volumes and increased hold times due to 2014 updates. At this time, please wait until patients have scheduled appointments before making eligibility and benefit inquires.

**Network terms:** We want to stress the importance of confirming your network status for the member's plan before services are provided. As a reminder, the terms of your network contract prevent you from refusing to provide services to a BCBSOK member, regardless of where they purchased their coverage. Care provided for emergency conditions will follow our standard authorization process.

## Health Plans Will Include More Benefits Considered Essential to Good Health

Beginning in 2014, the Affordable Care Act (ACA) requires certain health plans must cover basic health needs. The Affordable Care Act defines this coverage as “essential health benefits” (EHBs).

Certain health benefits that are deemed "essential" must be offered by non-grandfathered individual plans and non-grandfathered fully insured small group plans both on and off the exchange in 2014. No lifetime maximums or annual dollar limits are allowed on these 10 essential health benefit categories as defined by a benchmark plan selected by the government beginning in 2014:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Habilitative and rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

For more information on ACA, please visit the Standards and Requirements page of our provider website.

## Learn What’s New on iEXCHANGE® for 2014

Beginning Jan. 1, 2014, Blue Cross and Blue Shield of Oklahoma is enhancing iEXCHANGE, our Web-based preauthorization tool, to support requests for additional behavioral health, pharmacy and medical/surgical treatment services.

With the iEXCHANGE portal you can submit initial and extension requests for approval prior to services being rendered, once eligibility, benefits and preauthorization requirements have been confirmed through your current process. This flexible tool provides real-time response for direct submission of in-patient admissions, (select) outpatient medical services, and enables you to send preauthorization submissions after hours and on weekends.

We have scheduled one and a half hour webinars throughout the month of January to provide iEXCHANGE users with an overview of what’s new and improved for 2014. To register for a January webinar, visit the Training section on our provider website.

For more information about iEXCHANGE, including how to register if you are not a current user, visit the Tools section on our provider website.

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*Please note that the fact that a service has been preauthorized/pre-certified 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 and the terms of the member’s certificate of coverage applicable on the date services were rendered.*

## Closer Look: Documentation and Coding for Pulmonary Diagnoses

On Oct. 1, 2014, all HIPAA-covered entities must transition from ICD-9-CM to the ICD-10-CM/PCS code sets. At that time, claims with ICD-9-CM codes will not be accepted unless they are for service dates or discharge dates prior to Oct. 1, 2013.

As we draw closer to the 2014 ICD-10 implementation date, it is essential to take note of the key differences to coding in the ICD-10-CM code set. The goal of this article is to take a closer look at documentation and diagnosis coding for these chronic pulmonary conditions to successfully achieve accurate and compliant practices.

**Asthma**

The ICD-9-CM code structure classifies asthma into a single code category, 493. Accurate code assignment involves determination of specific fourth and fifth-digit subclassifications. The fourth-digit identifies the asthma type, while the fifth-digit identifies the presence of an acute exacerbation, status asthmaticus or an unspecified episode as follows:

| | |
|---|---|
| **Fourth-digit subclassification:** | 0 = Extrinsic Asthma 493.**0**X |
| | 1 = Intrinsic Asthma 493.**1**X |
| | 2 = Chronic Obstructive Asthma 493.**2**X |
| **Fifth-digit subclassification:** | 0 = Unspecified 493.X**0** |
| | 1 = with status asthmaticus 493.X**1** |
| | 2 = with (acute) exacerbation 493.X**2** |

When selecting the appropriate ICD-9-CM fifth-digit subclassification, an important consideration is to distinguish between an acute asthma exacerbation versus a status asthmaticus episode. The ICD-9-CM coding guidelines define status asthmaticus as a "severe, intractable episode of asthma unresponsive to normal therapeutic measures."[1]

An acute asthma exacerbation, on the other hand, is an increase in severity of asthma symptoms such as shortness of breath, wheezing, coughing and chest tightness. When a status asthmaticus episode occurs, documentation should be concise and include specific terms such as intractable asthma attack; severe, intractable wheezing; and severe prolonged asthma attack.[2] Concise documentation will allow for unambiguous interpretation and code assignment.

**Chronic Obstructive Pulmonary Disease (COPD) and Chronic Bronchitis**

Over time, asthma may develop into COPD and one diagnosis may exacerbate the other. As such, clinical documentation for these pulmonary diagnoses is key to accurate code assignment. The ICD-9-CM code structure represents a relationship between COPD and Chronic Bronchitis. When both of these conditions occur together, the two diagnoses are grouped into a single code category, 491.[1] These conditions represent instances when an individual may have a combination of pulmonary disorders that fall within the COPD category. For example, the fifth-digit assignment identifies obstructive chronic bronchitis with the presence of an acute exacerbation, acute bronchitis or obstructive chronic bronchitis with no exacerbation as follows:

| | |
|---|---|
| **Fifth-digit subclassification:** | 0 = without exacerbation 491.2**0** |
| | 1 = with (acute) exacerbation 491.2**1** |
| | 2 = with (acute) bronchitis 491.2**2** |

Code 491.20, obstructive chronic bronchitis without exacerbation, is reported for a diagnosis of COPD with bronchitis without acute bronchitis or an acute exacerbation.[1] This is commonly documented as chronic obstructive bronchitis. Conversely, code 491.21, obstructive chronic bronchitis with (acute) exacerbation is reported to capture a diagnosis of acute bronchitis with chronic obstructive bronchitis. From an ICD-9-CM coding perspective, this is considered an acute exacerbation and is often documented as COPD with acute exacerbation.[1,2,3]

Over the coming months, Blue Cross and Blue Shield of Oklahoma will be providing more information about impacts of coding and documentation that may help your practice with the transition to ICD-10, Risk Adjustment and more.

*[1] American Hospital Association (AHA). (2013). ICD-9-CM for Physicians-Volumes 1&2. Salt Lake City: Optum.*
*[2] Brown, F. (2012). Faye Brown's ICD-9-CM Coding Handbook . Chicago: Health Forum, Inc.*
*[3] AHA. (2002, Q3). AHA Coding Clinic. COPD with Exacerbation.*

## Code Correctly – Avoid ICD-10 Coding Pitfalls!

Blue Cross and Blue Shield of Oklahoma (BCBSOK) conducted preliminary ICD-10 testing with a subset of providers in 2012 and 2013. Although we are planning a larger scale testing phase in second quarter 2014, we want to share some of the common issues identified in our initial testing. Submitting claims with the following errors after Oct. 1, 2014, may delay or negatively impact reimbursement.

**Use of Invalid Diagnosis Codes**
Invalid diagnosis codes were common for three reasons (see below), all of which would cause a claim to get rejected. Providers who use billing services or practice management systems that have claims scrubbers may avoid these problems; however, they should serve as test conditions for any provider.

**1. Confusion between letters and numbers.**
We saw several examples where numbers were used in place of letters or vice versa. This confusion happened most frequently with the following commonly used numbers and letters in ICD-10:

| Number | Letter |
|---|---|
| 3 | S |
| 0 | O |
| 1 | I |
| 2 | Z |

**Examples:**

- A pediatrician used diagnosis code 301.80XA – Unspecified open wound of other part of head, initial encounter, and should have used diagnosis code S01.80XA. The "S" was incorrectly sent as a "3."

- A hospital trying to send a procedure code for a C-section – Extraction of products of conception, low cervical, open approach conception, low cervical, open approach, sent a procedure code of I0DOO21 when they were trying to send 10D00Z1. The letter "I" was used in place of the number "1," the letter "O" was used twice rather than the number "0," and the number "2" was used in place of the letter "Z."

**2. Transposed digits and typographical errors.**

- For example, a hospital used diagnosis code K45.909 when they should have used diagnosis code J45.909 for unspecified asthma, uncomplicated. The letter "K" was used in place of a "J" in error.

**3. Truncated and incomplete diagnosis codes**.
These types of errors are primarily received from physicians' offices. They are not as common with submissions from hospitals.

- For example, a physician's office used diagnosis code R50 – Fever, when only diagnosis codes R50.2, R50.81-R50.84 and R50.9 are valid for that use.

**Inappropriate Use of ICD-10 Diagnosis Codes**
Many providers struggled with the combination diagnosis codes available in ICD-10 and continued to bill conditions separately in error. In some cases, they used two diagnosis codes that are mutually exclusive, as in this example:

- A hospital sent a claim with diagnosis code I25.10 - Atherosclerotic heart disease of native coronary artery without angina pectoris, along with a second diagnosis of I20.9 - Angina pectoris, unspecified. However, they should have used a single diagnosis code of I25.119- Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris.

**Lack of Trimester or Encounter Sequence When Needed**
Some ICD-10 diagnosis codes require identification of the encounter or trimester sequence. There were numerous claims received that did not specify or provided incorrect trimester /encounter information. Consider the following two examples:

- **Trimesters**: A hospital sent a series of obstetrical claims that involved the treatment of a patient who had low weight gain during pregnancy. The diagnosis codes for the trimesters were submitted out of sequence. The hospital used a diagnosis code of O26.12 - Low weight gain in pregnancy, second trimester, then on a later date of service used a diagnosis code of O26.11 - Low weight gain in pregnancy, first trimester.

- **Encounters**: The injuries section (S00.00XA-S99.929S) in ICD-10-CM and poisonings/external causes section (T07-T88.9XXS) is full of diagnosis codes that contain encounter sequence information. We saw many of these miscoded, such as billing the subsequent encounter diagnosis code T23.161D - Burn of first degree of back of right hand, subsequent encounter without billing the initial encounter with diagnosis code T23.161A - Burn of first degree of back of right hand, initial encounter.

**Use of "Unspecified" Diagnosis Codes**
Some providers were using unspecified diagnosis codes when a more specific diagnosis was available.

- For example, a general practitioner billed diagnosis code J20.9 - Acute bronchitis, when a more specific diagnosis code J21.0 - Acute bronchiolitis due to respiratory syncytial virus was available. The practitioner coded the same claim in ICD-9 with the additional diagnosis of respiratory syncytial virus, so the underlying virus was most likely documented in the patient's chart. Coding guidelines dictate that diagnosis code assignment should fully identify the diagnostic condition, including specificity in describing causal conditions, secondary processes, manifestations and complications.

Whether you are conducting testing with BCBSOK or other payers/clearinghouses, the ICD-10 coding issues identified above are essential. Good documentation practices and accurately coding with ICD-10 upon the Oct. 1, 2014, transition date will help avoid delayed, rejected and incorrect claims.

## GuidedHealth® Helps Identify Drug Therapy Opportunities

At Blue Cross and Blue Shield of Oklahoma (BCBSOK), we understand that medication therapy can be an essential part of a member's overall treatment plan. That's why we use the GuidedHealth clinical rules platform to conduct periodic reviews to help identify opportunities that can positively impact members' medication therapy.

This platform drives our Retrospective Drug Utilization Review (RDUR) program, which integrates medical and pharmacy claims data for generating evidence-based, medication-related recommendations for physicians and members.

The GuidedHealth program targets drug therapy issues in modules such as overutilization, safety and cost. The table below lists the programs that were implemented during the fourth quarter of 2013. If your patient is identified via one or more of these categories, you may receive a letter from BCBSOK that references GuidedHealth.

**We Invite Your Comments**
In support of your treatment plan for our member, a drug therapy opportunity summary will be included with your letter for your consideration, along with a medication claims profile for the identified member. We hope you find this information helpful and we want to thank you in advance for taking the time to review all medication-related recommendations. If you receive a letter, we would appreciate your taking the time to fill out the enclosed feedback survey so we can continue to improve the service we provide.

**Fourth Quarter 2013 Programs**

| Module | Objective | Program Examples |
|---|---|---|
| Overutilization | Identify potential misuse and/or abuse, as well as drug conflict and off-label use | • Off-label Use (requires medical claim)<br>• Trinity<br>• Stimulant Polypharmacy |
| Safety | Identify and recommend discontinuation of potentially unsafe medication use | • High-dose Acetaminophen |
| Cost Savings | Promote the awareness of generic drug alternatives in place of non-formulary brand products. | • Generic Opportunity<br>• Proton Pump Inhibitors<br>• Statins |

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

*GuidedHealth is a registered trademark of Prime Therapeutics LLC (Prime), a pharmacy benefit management company. BCBSOK contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSOK, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. BCBSOK makes no endorsement, representations or warranties regarding GuidedHealth. If you have any questions about this product or services, you should contact Prime Therapeutics LLC directly.*

## Administrative Simplification Updates, Reminders and Resources

Blue Cross and Blue Shield of Oklahoma (BCBSOK) has updated its systems and business processes for the Administrative Simplification Phase III Operating Rules for 835 Electronic Funds Transfer (EFT) and 835 Electronic Remittance Advice (ERA), as mandated under the Affordable Care Act (ACA). The 835 EFT/ERA operating rules were authored by the Committee on Operating Rules for Information Exchange (CORE), which is part of the Council for Affordable Quality Healthcare (CAQH) initiative. By increasing uniformity when exchanging health care data, the operating rules are intended to help promote greater adoption and utilization of electronic transactions.

**Online Enrollment Available Now**

Participation in EFT and ERA is strongly encouraged for all BCBSOK contracted providers. As we have outlined in many previous communications, EFT, ERA and other electronic transactions have many advantages, including greater security of your patients' health care data, decreases paper waste and may reduce the amount of time your staff may spend on manually processing the paper version of these transactions.

If you are already enrolled for electronic payment and remittance transactions, you will not need to enroll again. However, if you have not signed up for EFT and ERA, now is the time, as the enrollment process is easier than ever. BCBSOK contracted providers who are registered with Availity® may complete the EFT and ERA electronic enrollment process online via the secure Availity provider portal. Please note that you must be a registered Availity user to complete the online enrollment process. Visit availity.com for more information.

**Reassociation Reminder: Contact Your Bank**

New and current EFT and ERA users should contact their financial institutions to request that the necessary data for reassociation is sent with each payment. Reassociation is a process that supports matching of payments with claim data for posting to your patient accounts. A sample letter you can customize and send to your bank is available in the CORE section of the CAQH website. (Go to Mandated Operating Rules then select EFT and ERA. Scroll down to Implementation Resources section and look for the Sample Provider EFT Reassociation Data Request Letter link.) This document includes instructions to assist you with requesting delivery of the reassociation data, as well as a glossary of key terms.

**For More Information**

For general information about Administrative Simplification, along with BCBSOK-specific resources, please visit the Administrative Simplification page, as well as the News and Updates section of our Provider website. Articles also may be included in upcoming issues of the *Blue Review.*

For clarification regarding the Administrative Simplification operating rules, you should refer to the CAQH CORE website. As indicated on the site, any questions not addressed by CAQH CORE online resources may be directed to CORE@caqh.org.

CAQH CORE is a multi-stakeholder collaboration of more than 130 organizations representing providers, health plans, vendors, government agencies and standard-setting bodies developing operating rules to help simplify health care administrative transactions. For additional information, refer to the CORE section of the CAQH website.

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## Self-administered Specialty Drug Claim Processing Reminder

As a reminder, beginning Jan. 1, 2014, Blue Cross and Blue Shield of Oklahoma (BCBSOK) expanded its claims processing system edit to redirect professional electronic (837P) and paper (CMS-1500) claims for fertility, oral oncology and various other select self-administered specialty drugs.* Specialty drugs approved by the U.S. Food and Drug Administration (FDA) for self-administration must be billed under the member's pharmacy benefit for members to receive coverage consideration.

Members impacted by the recent claim system edit expansion were advised through letters sent in late October. These member letters included a sample list of self-administered specialty medications, along with instructions on how to obtain these specialty medications and whom to call for assistance, if needed.

To help providers determine the correct path for medication fulfillment and ensure that the correct benefit is applied, a Specialty Pharmacy Program Drug List is available on our provider website.

- This list identifies medications that require administration by a health care professional, and are often covered under a member's medical benefit.
- This list also identifies specialty drugs that are approved by the U.S. FDA for self-administration, and are usually covered under the member's pharmacy benefit. For these self-administered drugs, the member's physician must write or call in the prescription to a pharmacy provider that is contracted to provide specialty services.

A specialty pharmacy program drug list is also available as a reference for your patients on our website, at bcbsok.com/member. In accordance with their benefits, members may be required to use a preferred specialty pharmacy. Providers and members may call the number on the member's ID card to verify coverage or obtain clarification on the member's benefits.

*The various other select specialty drugs of this system edit expansion include: Actimmune, Apokyn, Firazyr, Fuzeon, Leuprolide Acetate, Octreotide Acetate and Stelara.

*Third-party brand names are the property of their respective owners. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set for the above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions.*

## BCBSOK Claim Letters Get a New Look

Blue Cross and Blue Shield of Oklahoma (BCBSOK) is continually working to improve the customer experience, including correspondence related to the claim process. We know that you and your patients appreciate information that is easy to understand. That's why we recently updated the format, tone and readability of many of our standard claim letters.

In addition to redesigning the letter format, the content was updated to provide a friendly, but professional and concise message. The letters are written in plain language. New sections explain the next steps in the claim process, to help the reader take action, if needed. For contracted providers, the new letters will specify if we need additional information from you, helping to ensure that you get paid as quickly as possible.

Your patients can view their letters electronically on our secure member website, Blue Access for Members℠. See a sample of a revised provider letter.

# Featured Tip

## Quick Tip: Check Your Records for Outdated Drug Codes

When billing with National Drug Codes (NDCs) on medical professional/ancillary electronic (837P) or paper (CMS-1500) claims, it is important to ensure that the NDC used is valid for the date of service. This is because NDCs can expire or change. An NDC's inactive status is determined based on a drug's market availability in nationally recognized drug information databases. Additionally, an NDC is considered to be obsolete two years after its inactive date.

It is a good idea to conduct a periodic check of records or automated systems where NDCs may be stored in your office for billing purposes. To help ensure that correct reimbursement is applied, the NDC on your claim should match the active NDC on the medication's current label or packaging. Inactive products will continue to be reimbursed until they become obsolete.

For more quick tips to assist you with billing for drugs on medical claims, view the NDC Billing Guidelines and answers to Frequently Asked Questions in the Submitting Claims section of our provider website.

# Web Changes

- Updated eRM Webinar Schedule under Education and Reference Center/Training tab
- Updated the Psychological/Neuropsychological Testing Request Form under Clinical Resources/Behavioral Health Program/Forms
- Updated the Intensive Outpatient Program Form under Clinical Resources/Behavioral Health Program/Forms
- Updated the Electroconvulsive Therapy Request Form under Clinical Resources/Behavioral Health Program/Forms
- Update Clinical Update Form -- Focused Outpatient Management Program under Clinical Resources/Behavioral Health Care Program/Forms
- Updated Medical Necessity Criteria under Clinical Resources/Behavioral Health Program
- Updated Behavioral Health FAQ's under Clinical Resources/Behavioral Health Program/Additional Information
- Added December 2013 - Blue Review to Education and Reference Center/News and Updates
- Updated ClaimsXten Rule Descriptions under Claims and Eligiblity/Submitting Claims
- Updated PAVET.2 form under Education and Reference Center/Forms
- Updated Quality Improvement Web page under Clinical Resources tab. Changes were made to Patient Access to Care, Provider Standards of Care and Physical Setting and Safety standards. The Quality Program Review heading was also added to this Web page.
- Added NDC January 2014 Fee Schedule to the secure provider portal on the home page of the BCBSOK provider website.

# Medical Policy Reminder

Approved new or revised HCSC Medical Policies and their effective dates are posted on the BCBSOK website the first day of each month. These policies may impact your reimbursement and your patients' benefits. Active and pending Policies or views of draft Medical Policies can be accessed at the BCBSOK Provider website http://www.bcbsok.com/provider/standards/index.html.

While some information on new or revised Medical Policies may occasionally be published for your convenience, for access to the most and complete up-to-date information, please visit our website http://www.bcbsok.com/provider/standards/index.html.

# Training Schedules

For lists of training schedules, visit the Training Page in our Education and Reference Center tab at bcbsok.com.