January 2013

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 January 31, 2013 but because it is a paper copy, it may not have all the information contained in the electronic version.

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

**Using National Drug Codes (NDCs) on Professional/Ancillary Claims**

Currently, Blue Cross and Blue Shield of Oklahoma (BCBSOK) requires inclusion of National Drug Codes (NDCs) and related NDC data (qualifier, unit of measure, number of units, and price per unit), along with the applicable HCPCS or CPT code(s) on claim submissions for unlisted or “Not Otherwise Classified” (NOC) physician-administered/supplied drugs.

Inclusion of NDCs is already business-as-usual for many Home Infusion Therapy (HIT) and Specialty Pharmacy providers. Changes are on the horizon in 2013, and including NDC data on claims will play a significant role. We would like to encourage all providers – in addition to HIT and Specialty Pharmacy providers – to begin using NDCs and related data when physician-administered drugs are billed under the medical benefit on professional claims.

For general information to assist you with using NDCs on electronic (837P) and paper (CMS-1500) claims, please refer to the NDC Billing Guidelines (Professional/Ancillary) in the Formulary and Pharmacy section of our website at bcbsok.com/provider. Also watch the News and Updates section of our Provider website for NDC announcements, key dates and related resources.

**In the Know: Taxonomy Code Reminders for Providers with Multiple Specialties**

The health care provider taxonomy code set is a comprehensive list of unique 10-character alphanumeric codes. The code set is structured into three levels—provider type, classification, and area of specialization—to enable individual, group, or institutional providers to clearly identify their specialty category or categories in HIPAA-standard transactions. While taxonomy codes currently are not required by Blue Cross and Blue Shield of Oklahoma (BCBSOK), use of these codes on claims will assist BCBSOK in selecting the appropriate provider record during the claims adjudication process.

If you have obtained a unique Organization (Type 2) NPI number for each specialty, you should bill with the appropriate Individual (Type 1) and Organization (Type 2) NPI number combination. If you do not have a unique Organization (Type 2) NPI number for each specialty, you are strongly encouraged to include the applicable taxonomy code in your claims submission.
• **If you submit electronic claims in the ASC X12N 837P or 837I format** – Taxonomy codes should be placed in segment PRV03, Loop 2000A at the billing level, segment PRV03, Loop 2310B at the claim/rendering level, and if applicable, segment PRV03, Loop 2420A at service line level, if the rendering information is different than that given at the 2310B Level.

• **If you submit paper CMS-1500 professional claims** – The taxonomy code for the rendering provider should be placed in the shaded portion of field 24j, with the qualifier “ZZ” in the shaded portion of field 24i. The taxonomy code for the billing provider should be placed in field 33b, preceded by the “ZZ” qualifier.

• **If you submit paper UB-04 institutional claims** – The taxonomy code should be placed in Form Locator 81, along with the “B3” qualifier.

**Back To Basics...**
Taxonomy codes are not assigned; rather, they are self-reported by providers. Entry of your taxonomy code(s) was required when you completed the NPI application process with the National Plan and Provider Enumeration System (NPPES). You may conduct a search for registered taxonomy codes and assigned NPIs via the online NPI Registry at [https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do](https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do).

Additional information about taxonomy codes, along with the entire Health Care Provider taxonomy code set, can be found within the HIPAA-related Code Lists section of the Washington Publishing Company (WPC) website at wpc-edi.com without online access may contact the WPC at 425-562-2245 to find out how to purchase a printed code list.

**Keeping Your ICD-10 Conversion on Track**

The ICD-10 conversion is a significant undertaking for small and large practices alike. Without a focused and clear plan, some providers may run the risk of missing the U.S. Department of Health and Human Service’s Oct. 1, 2014, deadline, which could lead to delays in claims payments. The ability of multiple business teams, including but not limited to the Information Technology (IT) team, to manage the threat of “scope creep” is crucial to converting to ICD-10 on time and within budget.

“Scope creep” may be defined quite literally – when the scope of one’s project creeps beyond its original time and budget boundaries, line item, by line item. Scope creep often goes unnoticed until deadlines and expenses are impacted.

**Make a Plan**
A comprehensive plan with a clear vision and buy-in from the necessary stakeholders is one of the best defenses against scope creep. Everyone working on the implementation should be able to use the plan to make key decisions.

**Assess Your Vendors**
Your health information technology vendors may be assisting you with hardware purchasing and installation, maintenance, support services and infrastructure needs. Communicate your ICD-10 conversion plan to your vendors so they understand your goals. Ask your vendor to commit to detailed deliverables and a defined resolution process. If you have signed a contract without precise specifications, request an addendum.
Communication is Key

Ensure your team knows the goals and the limitations of your plan. Engage stakeholders from the beginning and provide frequent updates about accomplishments and challenges. A well-communicated plan that engages your health care organization as well as your vendors can help guard against scope creep to keep your ICD-10 implementation plan on time and within budget.

For additional information on ICD-10, visit the Standards and Requirements/ICD-10 section of our website at bsbok.com/provider. We encourage you to complete our ICD-10 Provider Readiness Assessment Survey, which is available in the Standards and Requirements/ICD-10 section of our website at bcbsok.com/provider.

Providers with Multiple Specialties

If you have obtained a unique Organization (Type 2) NPI number for each specialty, you should bill with the appropriate Individual (Type 1) and Organization (Type 2) NPI number combination accordingly.

In the absence of a unique Organization (Type 2) NPI number for each specialty, you are strongly encouraged to include the applicable taxonomy code* in your claims submission. Taxonomy codes play a critical role in the claims payment process for providers practicing in more than one specialty. Electronic claims transactions accommodate the entry of taxonomy codes and will assist Blue Cross and Blue Shield of Texas (BCBSTX) in selecting the appropriate provider record during the claims adjudication process. For assistance in billing the taxonomy code in claim transactions, refer to your practice management software and/or clearinghouse guides.

*The health care provider taxonomy code set is a comprehensive listing of unique 10-character alphanumeric codes. The code set is structured into three levels—provider type, classification, and area of specialization—to enable individual, group, or institutional providers to clearly identify their specialty category or categories in HIPAA transactions. The entire code set can be found on the Washington Publishing Company (WPC) Web site, at http://www.wpc-edi.com/codes/taxonomy. The health care provider taxonomy code set levels are organized to allow for drilling down to a provider’s most specific level of specialization.

Enhancements to ClaimsXten™ Code Auditing Tool

Blue Cross and Blue Shield of Oklahoma (BCBSOK) will implement an expanded version ClaimsXten code auditing tool, with the new 2013 CPT/HCPCS codes and additional bundling logic, into our claim processing system beginning on or after Feb 25, 2013.

The ClaimsXten tool offers flexible, rules-based claims management with the capability of creating customized rules, as well as the ability to read historical claims data. ClaimsXten can automate claim review, code auditing and payment administration, which we believe results in improved performance of overall claims management.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSOK’s code-auditing software. Refer to our website at bcbsok.com/provider for additional information on gaining access to C3.
For updates on the ClaimsXten implementation and other BCBSOK news, programs and initiatives, refer to the BCBSOK Provider website at bcbsok.com/provider. Additional information also may be included in upcoming issues of the Blue Review.

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 and the terms of the member’s certificate of coverage applicable on the date services were rendered.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third party vendor that is solely responsible for its products and services.

**UPDATE: Asthma activities have positive outcomes**

Blue Cross and Blue Shield of Oklahoma (BCBSOK) recently conducted a quality assessment of selected asthma patients seen by our providers serving both our PPO and HMO members. The results of the assessment indicate positive outcomes from several key asthma awareness efforts.

Use of asthma drugs was found in 94 percent of the patient records. This was coupled with low rates of hospitalization and urgent care visits by the patients. This is a positive outcome for patients with asthma, indicating that drug therapy can be a highly productive tool to prevent emergency visits.

Additionally, of the patients who had an asthma action plan, none reported hospitalization or urgent care visits. Action plans help patients identify their triggers, early symptoms of asthma attacks and action steps to prevent or offset the attacks. A sample asthma action plan can be found on our website in the forms section or you can contact your provider representative.

Encouraging patients to manage their asthma through action plans and by providing them with educational updates when they are in the office for regular visits has been proven to reduce hospitalizations and urgent care visits.

**Administrative Simplification Operating Rules Update**

Administrative Simplification is a provision of the Affordable Care Act (ACA). Under ACA, new Operating Rules for HIPAA-standard transactions must be implemented to promote greater uniformity in the delivery of electronic health care data from health plans to providers. Software vendors and any other electronic business entity that provides transaction-related services, such as billing services and third party administrators, are also affected.

In December 2012, Blue Cross and Blue Shield of Oklahoma (BCBSOK) successfully deployed the mandated Operating Rules for Eligibility and Benefits (ANSI 270/271) and Claim Status (ANSI 276/277), for health information technology vendors such as Availity®, Passport/Nebo Systems and RealMed®. Online Eligibility and Benefits and Claim Status options are now available continuously Monday through Saturday, with the exception of 8 p.m. to midnight on Sunday, for providers who are conducting administrative transactions for local and BlueCard®/out-of-area members. This includes the Claim Research Tool (CRT), which providers may access on the Availity portal.

In addition to extended hours of operation for electronic administrative transactions, enhancements include:
- Capability to access past and future dates of service for eligibility and benefits
- More flexible parameters when searching by name to allow users a more comprehensive return of data meeting the search criteria
- A new notification process to help ensure that users are aware of any scheduled downtime or unscheduled outages

The Availity Eligibility and Benefits tip sheet in the Claims and Eligibility/Electronic Commerce/Online Transaction Tip Sheets section of our Provider website at bcbsok.com/provider has been enhanced to reflect functionality changes. The Eligibility and Benefits Companion Guide and Claim Status Companion Guide are available in the Claims and Eligibility/Electronic Commerce/Electronic Data Interchange (EDI) Transactions section of our Provider website. Additional updates will be included in upcoming issues of the Blue Review.

Availity is a registered trademark of Availity, L.L.C. RealMed is a registered trademark of RealMed Corporation, an Availity Company. Availity, L.L.C. and RealMed Corporation are independent third party vendors and are solely responsible for their products and services. BCBSOK makes no representations or warranties regarding any of these vendors. If you have any questions or concerns about the products or services they offer, you should contact the vendor(s) directly.

Preventive Colonoscopies: Updated FAQs and Article Clarification

On Sept. 15, 2012, we posted an article titled, “Processing Claims for Preventive Colonoscopies Now Automated.” This article included five frequently asked questions (FAQs) about colorectal cancer screening via colonoscopy. In response to additional provider inquiries, we’ve updated these Preventive Colonoscopy Claim FAQs with answers to the following new questions:

- When a colonoscopy is performed to follow up on a previously identified abnormality, is it covered as a preventive service with no patient cost-share under the health care reform law?
- How often can a patient be screened for colorectal cancer using colonoscopy without patient cost-sharing under health care reform?

Previous Article Clarification

The September article stated, “ACA requires that preventive services such as diagnostic colonoscopy be covered without member cost sharing when the member is covered by a non-grandfathered health care plan.” The article also stated, “Accurate claims billing is essential to receiving correct payment for a preventive care service like a diagnostic colonoscopy.” Please note that the term “diagnostic colonoscopy” in these sentences refers to colorectal cancer screening using colonoscopy.

Blue Medicare Rx Medicare Part D Formulary changes 2012 to 2013

The 2013 Medicare Part D annual Open Enrollment Period (OEP) began October 15, 2012 and ends on December 7, 2012. On October 23, 2012 the 2013 Blue MedicareRx Blue Cross and Blue Shield of Oklahoma (BCBSOK) Medicare Part D formulary was granted ‘conditional approval’ by the Centers for Medicare and Medicaid Services (CMS) and as with all Medicare Part D drug plans you can expect a number of formulary and utilization management changes for 2013. Some of the changes were mandated by CMS (safety concerns, drugs that no longer meet CMS’ definition of a ‘Part D medication’, etc.) but others were a result of dynamic changes in the pharmaceutical marketplace. The Blue MedicareRx 2013 Part D formulary changes include addition of some new drug therapies as well as the
migration to some important generic equivalents (e.g. BONIVA tablets, LIPITOR, MAXALT, and TRICOR) that have and/or will become available in 2013.

A copy of 2012 to 2013 formulary changes (i.e. drug removals and new Prior Authorization and Step Therapy utilization management programs) will be included in the Annual Notice of Change (ANOC) that is sent to all current members of HISC’s Medicare Part D plans. In addition, individual member letters were mailed in mid-November 2012, alerting them of 2013 formulary changes (removals, tier changes, new utilization management programs, etc.) affecting them. Finally, a copy of the 2013 formulary is already available on the BCBSOK (bcbsok.com/provider) website in time for the start of the Medicare Part D OEP. Please refer to our list below for a handy reference to the Top 30 medications that will be impacted by a change to the 2013 formulary and therefore, have the most potential to affect current members. Coverage determinations for changes, when applicable, can be submitted by the prescribing physician after December 1, 2012 with an effective date of January 1, 2013.

**Blue MedicareRx - Top 30 Formulary Changes from 2012 into 2013**

<table>
<thead>
<tr>
<th>Affected Drug(s)</th>
<th>Description of Change</th>
<th>Formulary Alternative, if Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>amphetamine/ dextroamphetamine tabs</td>
<td>Is not covered on our 2013 formulary</td>
<td>amphetamine/ dextroamphetamine ER capsule or Adderall XR capsule</td>
</tr>
<tr>
<td>ANDROGEL</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may newly apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>ATRIPLA</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>AVONEX kit, AVONEX PEN</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>BONIVA tabs</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>ibandronate</td>
</tr>
<tr>
<td>BRILINTA</td>
<td>Is not covered on our 2013 formulary</td>
<td>clopidogrel or Effient</td>
</tr>
<tr>
<td>CARBATROL</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>carbamazepine SR</td>
</tr>
<tr>
<td>carbinoxamine liquid, tabs, Arbinoxia</td>
<td>Is not covered on our 2013 formulary</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>COPAXONE</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>ciproheptadine syrup, tabs</td>
<td>Is not covered on our 2013 formulary</td>
<td>levocetirizine tabs</td>
</tr>
<tr>
<td>DERMOTIC</td>
<td>Is not covered on our 2013 formulary as there are generic equivalents and/or generic alternatives available. When you choose generic drugs, you get prescription medications that are: FDA approved and regulated, Equal to brand-name drugs in terms of safety and effectiveness, and Less expensive.</td>
<td>fluocinolone acetonide (otic) oil 0.01%</td>
</tr>
<tr>
<td>diphenoxylate/atropine tabs, Lonox, Lofene</td>
<td>Is not covered on our 2013 formulary</td>
<td>loperamide capsule</td>
</tr>
<tr>
<td>FEMARA</td>
<td>Is not covered on our 2013 formulary as there are generic</td>
<td>letrozole</td>
</tr>
<tr>
<td>Drug</td>
<td>Status</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>flunisolide nasal spray</td>
<td>Is not covered on our 2013 formulary</td>
<td>fluticasone, triamcinolone acetonide, or Nasonex nasal spray</td>
</tr>
<tr>
<td>guanfacine</td>
<td>Is not covered on our 2013 formulary</td>
<td>clonidine or Intuniv</td>
</tr>
<tr>
<td>haloperidol concentrate, tabs</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>hydroxyzine pamoate caps</td>
<td>Is not covered on our 2013 formulary</td>
<td>levocetirizine tabs</td>
</tr>
<tr>
<td>ISENTRESS</td>
<td>Is not covered on our 2013 formulary</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>LIPITOR</td>
<td>Is not covered on our 2013 formulary</td>
<td>atorvastatin</td>
</tr>
<tr>
<td>LODOSYN</td>
<td>Is not covered on our 2013 formulary</td>
<td>carbidopa/levodopa, amantadine, Apokyn, bromocriptine, Comtan, pramipexole, ropinirole, or selegiline</td>
</tr>
<tr>
<td>MAXALT, MAXALT-MLT</td>
<td>Is not covered on our 2013 formulary</td>
<td>naratriptan or sumatriptan tablets</td>
</tr>
<tr>
<td>meprobamate</td>
<td>Is not covered on our 2013 formulary</td>
<td>buspirone</td>
</tr>
<tr>
<td>MESTINON TIMESSPAN</td>
<td>Is not covered on our 2013 formulary</td>
<td>pyridostigmine regular release tablet</td>
</tr>
<tr>
<td>NORVIR caps, solution, tabs</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>olanzapine</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>PERPHENAZINE/AMITRIPTYLINE</td>
<td>Is not covered on our 2013 formulary</td>
<td>quetiapine, risperidone, ziprasidone</td>
</tr>
<tr>
<td>quetiapine</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>REVATIO tabs</td>
<td>Is not covered on our 2013 formulary</td>
<td>Adcirca, Letairis, or Tracleer</td>
</tr>
<tr>
<td>SEROQUEL</td>
<td>Is on our formulary and newly requires prior authorization before we will pay for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>SUBOXONE</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>TESTIM</td>
<td>Is not covered on our 2013 formulary</td>
<td>Androderm, Androgel or Fortesta</td>
</tr>
<tr>
<td>testosterone cypionate</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>TRACLEER</td>
<td>Is on our formulary and newly requires prior authorization before we will continue payment for this drug. Quantity limits may apply.</td>
<td>Check with your doctor</td>
</tr>
<tr>
<td>TRICOR</td>
<td>Is not covered on our 2013 formulary</td>
<td>fenofibrate, Lipofen, or TriLipix</td>
</tr>
<tr>
<td>TRUVADA</td>
<td>Is on our formulary; however quantity limits may newly apply</td>
<td>On formulary, quantity limits may apply</td>
</tr>
<tr>
<td>VALTURNA</td>
<td>Has been discontinued by the manufacturer</td>
<td>eprosartan, irbesartan, or losartan</td>
</tr>
</tbody>
</table>
Medicare Part D News Update: Ranbaxy Pharmaceuticals atorvastatin recall

On November 9, 2012, Ranbaxy Pharmaceuticals announced that it was initiating a voluntary recall of its popular cholesterol lowering medication atorvastatin, which is the generic version of Pfizer’s Lipitor. The reason for Ranbaxy’s recall was due to the possibility of small (less than 1 mm) glass particles in its product. It also reported that the probability of an adverse event is low, but that it could not be ruled out. Presently, Ranbaxy has not received any reports of adverse events.1

Interestingly enough, the recall only affects the 10, 20, and 40 mg strengths of atorvastatin calcium (i.e. it does NOT include the 80 mg strength).2 In addition, Ranbaxy reported that the recall includes 41 specific lots of atorvastatin. A list of the recalled lot numbers can be found at: http://www.ranbaxyusa.com/newsdisp281112.aspx. Ranbaxy has notified its distributors and retailers of the recall and affected lots are no longer being distributed.2

Patients that are experiencing adverse effects from taking the affected medication should contact their health care provider immediately. Patients with atorvastatin prescriptions from Ranbaxy should contact their pharmacist or Ranbaxy’s Customer Coordinator at 1-866-266-7623 to find out if their prescription is affected.

Generic Lipitor is currently manufactured by five pharmaceutical companies: Apotex Inc., Dr. Reddys Labs, Mylan Pharmaceuticals, Sandoz Inc., and Teva Pharmaceuticals.3 There is no anticipated drug shortage for the 10, 20, 40 mg strengths of atorvastatin. Patients taking affected Ranbaxy atorvastatin should have their medication substituted seamlessly by their pharmacist. The substituted medication may look different. Patients with questions about product identification should contact their pharmacist for clarification.

The FDA recall process

Drugs may be recalled from the market by three methods; (a) the manufacturer can perform a voluntary recall, (b) the FDA can request the manufacturer to perform a recall, or (c) the FDA can mandate a recall.4 Each recalled drug has an individual classification of Class I-III, which are explained below:1

- **Class I recall:** a situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.
- **Class II recall:** a situation in which use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
- **Class III recall:** a situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.

As an example, the recall of Ranbaxy’s atorvastatin 10, 20, and 40 mg is a voluntary recall with a classification of Class II.5 The recalled medication should be sequestered by the pharmacy and the distributor and sent back to the manufacturer for destruction. The FDA may monitor and audit any step of the process. Recalls protect public health by removing potentially harmful products from the market.
References


Be Smart. Be Well.* Encourages Sexual Health

Be Smart. Be Well. is the Blue Cross and Blue Shield of Oklahoma (BCBSOK) website that features a variety of health and wellness topics and is available to members and the general public at BeSmartBeWell.com. The current spotlight topic is sexual health, which features a new video, produced as part of a public/private collaboration between Be Smart. Be Well. and the Centers for Disease Control and Prevention (CDC).

While many are comfortable talking with their physicians about their aches and pains, talking to them about sexual health may be a different matter. The Be Smart. Be Well. sexual health series is a great way to introduce this subject to patients and encourage:

- Frank discussions about sexual health
- Testing for sexually transmitted diseases

Be Smart. Be Well. is a valuable tool for anyone interested in learning about making healthy lifestyle choices. Past topics have included food safety, traumatic brain injuries, teen driving, caregiving, childhood asthma, drug safety, and domestic violence. Please encourage your patients to take advantage of the information and resources on BeSmartBeWell.com.

These programs are for informational purposes only, and are not a substitute for the sound medical judgment of a health care professional. Members are encouraged to talk to their doctor if they have any questions or concerns regarding their health.

Featured Tip

Keep up-to-date with the latest news and updates. Along with all the valuable information included in our Blue Review newsletter, the News and Updates section of our website gives the latest updates in webinar schedules, current programs, and policies.
Web Changes (Nov. and Dec.)

- Added BlueCard® FAQ to BlueCard® Claims Processing section.
- Replaced OK Claim Form (Claim Appeal/Reconsideration Review Request with updated document.
- Added NDC Billing Guidelines in the right navigational box of our Pharmacy pages.
- Added new Caller Guide to titled “Eligibility and Benefits” to IVR section.
- Added Colonoscopy FAQ to Claims and Eligibility Related Resources.
- Added Provider Claim Summary Form update to Related Resources.
- Replaced the Availity Eligibility and Benefits document.
- Added the “2013 Holiday Schedule Reminders.”
- Added Eligibility and Benefits Companion Guide (270/271) and Claim Status Companion Guide (276/277) to Related Resources navigation box on the EDI Transactions page.
- Added new language about the online transaction schedule in the Electronics Commerce section.
- Updated the Clinical Update Request and Outpatient Treatment Request forms in the Behavioral Health section.
- Updated language describing iEXCHANGE in the Education and Reference Section.
- Added the Blue Review-November 2012 issue to the 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. You may view all active and pending Policies or view draft Medical Policies and provide comments. These can be accessed on the Standards and Requirements page of our Provider website.

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

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