February 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 February 6, 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 bcbson.com/provider.

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

News & Updates

Claims System Enhancement for CRNA and Supervision/Direction Services
Beginning on or after Feb. 1, 2014, Blue Cross and Blue Shield of Oklahoma (BCBSOK) will enhance our system to automate claims processing for Certified Registered Nurse Anesthetists (CRNA) and Supervising/Direction of CRNA services. This enhancement will improve claims processing by decreasing overall claim cycle times and improving the accuracy of claims payments. As a reminder, BCBSOK reimburses 100 percent of the allowable amount for covered anesthesia services rendered by a CRNA. Supervision/Direction of CRNA services is not eligible for separate reimbursement and will process as provider responsibility.

Update on the Affordable Care Act: Grace Periods
The Affordable Care Act (ACA) includes a provision that allows health insurance Marketplace enrollees who receive the advance premium tax credit (APTC), a three-month grace period to pay their premium — provided they have already paid at least one month’s premium in full. It is important to note that not all members who purchase coverage on the health insurance Marketplace will receive the APTC.

The provision requires all payers to complete claims (for covered services rendered) in the first month of the grace period. For covered services rendered during months two and three, payers must either pay or pend claims.

During the three-month grace period, members are eligible for covered services under their plan.

Eligibility
You will be notified through electronic and phone eligibility, and benefits verification when a member has entered into a grace period during the last two months of the grace period. All preauthorization letters will encourage providers to confirm whether the member is in a grace period.

Claims Processing
All allowable services provided during the first month of the grace period will be the responsibility of Blue Cross and Blue Shield of Oklahoma (BCBSOK), subject to member cost sharing.

During the second and third months of the grace period, BCBSOK will pend the claims the member incurs during this period. If the member pays all outstanding premium payment(s) in full, claims incurred during this period will process according to the member’s benefits.
If the member has not paid premiums in full by the end of the grace period, BCBSOK will terminate the member’s policy retroactive to the first day of month two of the grace period. BCBSOK will deny any claims pended in months two and three of the grace period.

**Pharmacy Claims**
A member’s pharmacy claims will be denied during months two and three. If the member retroactively pays the premium in full, they may submit claims for prescriptions dispensed during this time to BCBSOK.

If a member elects to receive a 90-day supply of a prescription during month one of the grace period, the member will receive the full 90-day prescription and BCBSOK will pay this claim.

**Provider Contract Requirement**
Your contract with BCBSOK requires the provision of services to members and prohibits advance payment for such covered services except for member’s required cost sharing, if any. You may notify your patients that they will be responsible for payment for the full cost of provided services, up to billed charges, if their health care coverage terminates at the end of the grace period. You can encourage your patients to make their premium payments to avoid termination of their health insurance policies.

**Note:** provider implications of the ACA grace period will not begin until March 2014.

**Member Engagement**
Over the next few months, BCBSOK will implement an educational campaign directed at new members. This campaign will help them fully understand the benefits and responsibilities of health care coverage, including a timely premium payment.

As a reminder, the terms of your network contract prevent you from refusing to provide services to a BCBSOK member, irrespective of where they purchased their coverage.

Look for more information about the grace period in future editions of *Blue Review*.

**ClaimsXten™ Second Quarter 2013 Updates**
BCBSOK reviews new and revised Current Procedural Terminology (CPT®) and HCPCS codes on a quarterly basis. Codes are periodically added to or deleted from the ClaimsXten software by McKesson and are not considered changes to the software version. BCBSOK will normally load this additional data to the BCBSOK claim processing system within 60 to 90 days after receipt from McKesson and will confirm the effective date on the BCBSOK website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) will continue to be posted on the BCBSOK provider website.

Beginning on or after May 19, 2014, BCBSOK will enhance the ClaimsXten code auditing tool by adding the second quarter codes and bundling logic into our claim processing system.

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 ClaimsXten, watch the News and Updates on our provider website, as well as upcoming issues of *Blue Review*.
Checks of eligibility and/or benefit information are 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.

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Behavioral Health Program to Utilize ASAM Criteria
The Blue Cross and Blue Shield of Oklahoma (BCBSOK) Behavioral Health Program has adopted the American Society of Addiction Medicine Criteria — The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions — as the behavioral health clinical screening criteria for patients with addiction disorders for all levels of care. This change will apply to all commercial, retail and Medicare Advantage plans effective April 1, 2014. The most recent version of The ASAM Criteria was released in October 2013, following a review by a team of adult and adolescent addiction treatment specialists and an extensive field review process.

The ASAM criteria are designed to support multi-dimensional assessments and treatments, attending to the multiple needs of each person and not just his or her alcohol or drug use. There is also a greater emphasis on the need for integrated care, addressing both the mental and physical health disorders present in patients with addictions.

This version of the criteria also includes:

- An updated definition of addiction
- Strength-based, recovery-oriented language
- Criteria consistent with the changes in the DSM-5
- Consolidation of adolescent and adult criteria
- Increased focus on outcomes
- Population-specific sections to address the special treatment issues and needs for:
  - Older adults
  - Persons in safety-sensitive professions
  - Pregnant women and parents with children
  - Persons in the criminal justice system

Clinical review criteria are available to physicians and other health care professionals upon request relative to a specific care review decision. Please contact BCBSOK Behavioral Health at 800-672-2378 to initiate this request.

iEXCHANGE® Adds Behavioral Health Requests for Intensive Outpatient Program
As we announced in the January Blue Review, iEXCHANGE, our Web-based preauthorization tool, has been enhanced to support behavioral health preauthorization requests that fall under the intensive outpatient program.

iEXCHANGE allows providers to submit both behavioral health and medical/surgical preauthorization requests electronically 24 hours a day, 7 days a week.*

The expanded iEXCHANGE capabilities offer an alternative to the manual fax process that is currently in place for these preauthorization requests and drastically reduces the need to initiate calls to providers regarding missing information and/or request status.
The added behavioral health requests will be supported by the real-time capabilities currently provided for medical/surgical transactions, including:

- Select outpatient services
- Extension requests
- Treatment searches
- Treatment update searches

After submitting a request using iEXCHANGE, you will receive an immediate confirmation with details on the request. Once processed, you will either receive a determination that the authorization pended for review or is approved. Users also will receive a request ID number as reference for each preauthorization request.

**Registration Options**

If you are already a registered iEXCHANGE user, no further action is needed. But if you are interested in registering for iEXCHANGE, you can do so by either:

- Completing the online enrollment form (once registration is completed, you will receive a User ID, iEXCHANGE ID and password), or
- Accessing the BCBS Behavioral Health Pre-auth Registration link via the Availity portal for Single Sign-On (SSO) access. The SSO feature allows Availity-registered users to access iEXCHANGE without a User ID and password.

**Learn More**

Webinars have been scheduled during the month of February to introduce the new system enhancements. To register for an iEXCHANGE webinar, visit the Provider Training page and select your preferred training session.

*With the exception of every third Sunday of the month from 11 a.m. to 2 p.m.*

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**ICD-10 Testing at BCBSOK**

The U.S. Department of Health and Human Services has mandated that as of Oct. 1, 2014, all HIPAA transactions must use ICD-10 codes where ICD-9 codes are currently used. In anticipation of this transition date, Blue Cross and Blue Shield of Oklahoma (BCBSOK) has published regular articles in the Blue Review and provided information on the provider website. In 2014, we will continue to publish information that may help providers with their transition to ICD-10.

We will be conducting end-to-end testing with a select number of providers this year. Our testing will cover a wide range of provider types and specialties, as well as a broad scope of claims scenarios. This approach will enable us to share testing results and information with our entire provider community over the coming months that will address many potential transition risks.

For more information about the transition to ICD-10, continue to read future issues of Blue Review, and visit the Standards and Requirements/ICD-10 section of our provider website.

**A Closer Look: Documentation and Coding for Diabetes Diagnoses**

In last month’s Blue Review, we took a closer look at documentation and coding for pulmonary diagnoses as part of our effort to provide more information that may help with the transition to ICD-10, Risk
Adjustment and more. This month, we look at diabetes, a group of metabolic diseases that includes chronic and short-term conditions such as diabetes mellitus, gestational diabetes and impaired glucose tolerance. The conditions that fall under this category can sometimes be asystematic and other times can develop complications. It is imperative that documentation is specific and accurate to facilitate accurate, complete and compliant diagnosis code assignment.

On Oct. 1, 2014, the health care industry will transition from ICD-9-CM to ICD-10-CM/PCS for diagnoses and inpatient procedure coding. It is essential to take note of the key differences in coding in ICD-9-CM versus the ICD-10-CM/PCS code sets. The goal of this article is to review documentation and diagnosis coding for conditions that fall under the diabetes umbrella to achieve accurate and compliant practices.

**Diabetes Mellitus**

Diabetes mellitus (DM) is a disease in which the body fails to properly produce or use insulin. Diabetes mellitus is divided into two categories: Type 1, "insulin-dependent DM (IDDM), previously referred to as "juvenile diabetes," and Type 2, non-insulin-dependent DM (NIDDM) previously referred to as “adult-onset diabetes.”

ICD-9-CM code structure classifies diabetes into a single code category, 250. Accurate code assignment required determination of specific fourth- and fifth-digit sub-classifications. The fourth digit provides details regarding the presence of manifestations or complications due to diabetes, while the fifth digit indicates whether the diabetes is controlled or uncontrolled, type 1 or type 2. The fourth-digit sub-classifications are:

- 250.0, diabetes mellitus without mention of complication
- 250.1, diabetes with ketoacidosis
- 250.2, diabetes with hyperosmolarity
- 250.3, diabetes with other coma
- 250.4, diabetes with renal manifestations
- 250.5, diabetes with ophthalmic manifestations
- 250.6, diabetes with neurological manifestations
- 250.7, diabetes with peripheral circulatory disorders
- 250.8, diabetes with other specified manifestations
- 250.9, diabetes with unspecified complication

The fifth-digit sub-classifications are:

- 0 for Type 2 or unspecified type, not stated as uncontrolled
- 1 for Type 1, [juvenile type], not stated as uncontrolled
- 2 for Type 2 or unspecified type, uncontrolled
- 3 for Type 1, [juvenile type], uncontrolled

Note that codes 250.4, 250.5, 250.6, 250.7 and 250.8 all include instructions to use an additional code to identify manifestations as diabetic.

ICD-10-CM requires an additional layer of specificity which requires providers to document additional information, such as any underlying condition that caused the diabetes or whether the diabetes is drug induced. In ICD-10-CM, the categories of diabetes mellitus will help identify the type of diabetes. Those categories are:

- E08, diabetes mellitus due to underlying condition
- E09, drug or chemical induced diabetes mellitus
- E10, Type 1 diabetes mellitus
- E11, Type 2 diabetes mellitus
- E13, other specified diabetes mellitus
ICD-10-CM does not require specification of whether the condition is controlled versus uncontrolled. ICD-10-CM classifies inadequately controlled, out-of-control and poorly controlled diabetes mellitus by type with hyperglycemia. ICD-10-CM codes for diabetes are combination codes that include the etiology and the manifestations. Assignment of codes should include as many codes needed to describe all the associated complications that the patient has. Due to the code structure, there is no instructional note found under diabetes codes in ICD-10-CM requiring an additional code to identify the manifestation since it is already part of the code description. Specific diabetes codes require additional codes in order to identify the manifestation further, such as diabetes with foot ulcer to identify the site of the ulcer, or diabetes with chronic kidney disease to identify the stage of chronic kidney disease. In ICD-10-CM it is important to review the coding guidelines and notes in each category. In particular there is one note available in each category except for Type 1 diabetes. This note states "Use additional code to identify insulin use (Z79.4)." This code would not be assigned with Type 1 cases because insulin is required to sustain life.

Secondary Diabetes
If the diabetes is secondary, choose from codes in the 249 series in ICD-9-CM.

In ICD-10-CM secondary diabetes is coded as diabetes due to an underlying condition (E08), drug or chemical induced diabetes (E09) or other types of secondary diabetes not otherwise classified (E13), which includes diabetes due to genetic defects of beta-cell function or insulin action, and postsurgical cases of diabetes. With this depth of detail, providers must document the cause of secondary diabetes in order to correctly select a diagnosis code. The cause of the secondary diabetes is sequenced first, followed by the code for the diabetes.

Gestational Diabetes
Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. It puts the woman at greater risk of developing diabetes after the pregnancy. In ICD-9-CM report 648.0, diabetes mellitus complicating pregnancy, childbirth, and the puerperium. ICD-10-CM codes for gestational diabetes are in subcategory 024.4, gestational diabetes. No other code from category O24 should be used with a code from 024.4. The codes under subcategory 024.4 include diet controlled and insulin controlled. If a patient with gestational DM is treated with both diet and insulin, use only the code for insulin controlled. Code Z79.4, long-term (current) use of insulin, should not be assigned with codes from subcategory 024. An abnormal glucose tolerance in pregnancy is assigned a code from subcategory 099.81, abnormal glucose complicating pregnancy, childbirth and the pueperium.

There are many new codes for diabetes as well as the complications from diabetes. Providers will be required to identify a causal link between the type of diabetes and the complications. Clear, concise, complete documentation will be critical to ensure accurate and compliant coding.

Administrative Simplification Updates, Reminders and Resources
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. 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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**Are You Submitting Professional Paper Claims? You May Need to Take Action!**
As a reminder, payers are accepting the revised version of the CMS-1500 paper claim form (version 02/12). Payers will accept claims submitted on either the revised form (02/12) or the previous version (08/05) through March 31, 2014. After this date, the dual-use period will end and payers will process only those claims that are submitted on the revised CMS-1500 claim form (version 02/12).

As part of the transition, you may need to:

- **Order new paper claim forms** – Refer to the NUCC website for details.
- **Talk with your vendor(s)** – Is your software vendor, billing service or clearinghouse prepared to accommodate changes?
- **Consider switching to electronic claim submission** – Visit the Claims and Eligibility/Submitting Claims section of our website to learn more.

**Be In The Know!**
Did you get the Blue Review in your email inbox? BCBSOK regularly communicates with providers via email. Please complete our quick and easy online form to ensure you are receiving critical communications.

In addition to the monthly provider newsletter, we also send important information on topics such as:

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• Claims and billing
• Government mandates
• Medical policies
• Educational webinars
• Clinical Practice Guidelines
• Pharmacy program updates
• HEDIS results
• Provider satisfaction survey results
• Quality improvement updates
• Disease management
• How to obtain clinical criteria
• How to access Utilization Management staff
• System enhancements and availability

Please complete our quick and easy online form to ensure you are receiving critical communications.

**Health & Wellness**

**“Medical Director’s Minute” by Dr. Greg Marino, MD**

Colorectal cancer is the second leading cause of cancer deaths in Oklahoma according to data published by the American Cancer Society. Since most cases of this type cancer are diagnosed late in the disease process the survival rates are quite low.

However, colon cancer is one of two cancers that can be prevented by early screening, and unfortunately, Oklahoma is dead last in the United States in the rates of recommended preventive colorectal cancer (CRC) screenings. By proper education of both provider and members in the Blue Cross network we hope to move that statistic in a positive direction.

Early detection and removal of precancerous polyps can potentially prevent most cases of CRC. The national task forces recommend three types of tests for CRC screening:

1. Colonoscopy
2. Stool tests (Guaiac Fecal Occult Blood Test – FOBT, or Fecal Immunochemical Test – FIT)
3. Flexible Sigmoidoscopy

Preventive screening tests are now covered by all BCBSOK plans, so effective CRC screenings can be performed with no out of pocket expenses at all. For more information see: cancer.org, cdc.gov/screenforlife, bcbsok.com

**In Every Issue**

**Featured Tip: 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:**

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 effectuate 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 inquiries.

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, irrespective of where they purchased their coverage. Care provided for emergency conditions will follow our standard authorization process.

Web Changes

- Updated **Claim Research Tool (CRT)** under Claims and Eligibility/Electronic Claims Tab.
- Updated **Electronic Funds Transfer Agreement** under Education and Reference Center/Forms Tab.
- Updated **Electronic Remittance Advice Enrollment Form** under Education and Reference Center/Forms Tab.
- Added **Treating patients for osteoarthritis knee pain? Check our Select Medication List** under Education and Reference Center/News and Updates.
- Added **Learn What's New for iExchange 2014** under Education and Reference Center/News and Updates page.
- Added **Patient Benefits Accessibility During Annual Updates** under Education and Reference Center/News and Updates page.
- Added and Updated **Update on Confirming Eligibility for BCBSOK Members** under Education and Reference Center/News and Updates page.
- Added **Quick Tip: Check Your Records for Outdated Drug Codes** under Education and Reference Center/News and Updates page.
- Added **Children's Wellness Guidelines** under Clinical Resources Tab/Wellness Guidelines. These guidelines are available in English and Spanish.
- Added **Adult Wellness Guidelines** under Clinical Resources Tab/Wellness Guidelines. These guidelines are available in English and Spanish.
- Added **Medicare Crossover Non-par Electronic Funds Transfer Enrollment Form** under Claims and Eligibility/Electronic Submission/Related Resources.
- Updated **2014 Holiday Schedule Reminders** under Claims and Eligibility/Related Resources/Alerts.
- Added **Be Familiar with Member Rights and Responsibilities** on the BCBSOK Provider Home Page/Important Information.
- Added **Blue Advantage PPO Map** under Network Participation/Network Representatives.
- Added **Electronic Funds Transfer Companion Guide (835 EFT)** under Claims and Eligibility/EDI Transactions/Related Resources.
- Added **Electronic Remittance Advice Companion Guide (835 ERA)** under Claims and Eligibility/EDI Transactions/Related Resources.
- Added **Behavioral Health to add The ASAM Criteria** under Education and Reference Center/News and Updates page.
- Added **January 2014 Blue Review** under Education and Reference Center/News and Updates.
- Added **NDC February 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](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](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](http://bcbsok.com).