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Tip! Search for article of interest to your practice or facility!

P = Professional
F = Facility
P/F = Professional & Facility

Click here to learn about our new and updated products for 2015!

Is Your Office or Facility Ready for Flu Season?  

Click here to read our bulletin regarding reimbursement for influenza vaccines and an important reminder about Medicare Part D vaccine coverage.

Please note that the price for 90658, influenza split virus, is based upon the lowest priced brand/NDC (National Drug Code). Please use the most appropriate Q code for the product.

Have You Completed Your Office Manager Satisfaction Survey?  

Our 2014 Office Administration Satisfaction Survey was mailed to you recently. Your feedback and ideas are invaluable to us as we continually look for ways to improve the quality of our services to our members.

A similar survey was sent in September to the physicians in your office, and that survey should be returned to us by October 30, 2014.

The Office Administration Satisfaction Survey is a separate study that focuses on the administrative staff of physicians' offices. Please return the questionnaire at your earliest convenience, but no later than November 14, 2014, in the postage-paid envelope that was provided.

Thank you for your participation!

Learning Opportunities

Register Today!

Check out the Education section of our website for information regarding Fall Seminars and our Navigating the Blues educational series. Click here to obtain schedules and registration forms.

Notify Us of Tax ID Changes

If your tax ID changes, please notify us immediately. This is especially critical for primary care physicians, as your patients’ PCP record will need to be updated to indicate the change.

Accurate tax ID information is important as it may affect the cost share applied when you render services to the member. If there is a discrepancy between your new tax ID and the one on file for the member's PCP, the member will be required to pay a higher (specialist) copay.

Updates to your information can be made using our Practitioner Demographic Changes form, available at ExcellusBCBS.com/wps/portal/xl/prv/contactus/updateinfo/.
Affordable Care Act Update - Dental Caries Prevention Billing -
We notified you in a bulletin dated August 14, 2014, of our intention to implement U.S. Preventive Services Task Force recommendations on August 31, 2014. These recommendations include dental caries prevention for infants and children through age 5. Be aware that the preventive medicine codes for billing dental caries prevention are 99381, 99382, 99392 and 98393. The dental codes for topical application of fluoride and fluoride varnish are D1206 and D1208 and can be billed under the medical contract per the USPSTF recommendations. Do not bill using unlisted evaluation and management codes 99429 or 99499 for this service to be covered in full. Please note that new CPT codes are added quarterly. Further updates will be forthcoming. As group and product exceptions apply, please verify member eligibility by visiting our website, ExcellusBCBS.com/Provider, or by calling Customer Care prior to delivering any preventive service covered under the mandate to determine whether the service is covered in full. Contact Customer Care if you have questions.

Make Sure Your Practice Information is Accurate:

- **Review Practice Information At Least Every 90 Days!** To help ensure that our provider directories are accurate, please review your practice demographic and accepting patient status information at least every 90 days using the Find a Doctor tool on our website, ExcellusBCBS.com. To make updates to your practice information via our website, go to: ExcellusBCBS.com/wps/portal/xl/prv/contactus/updateinfo/

- **Is a Supervising Physician Leaving Your Practice?** As a reminder, when a supervising physician leaves your practice, please ensure that your providers, including nurse practitioners, physician assistants and certified registered nurse anesthetists become reassigned to another physician in your practice, and that a new registration form is completed for the mid-level provider. If you have questions, contact your Provider Relations Representative.

Member Rights & Responsibilities - The delivery of quality health care requires cooperation between patients, their providers and the health care plan. A key step to ensure quality is for patients and providers to understand their rights and responsibilities. We publish Member Rights & Responsibilities on our website, please take a moment and click here to review.

Medical Identity Theft - Medical identity theft is a growing problem. The results of this fraud can threaten us financially, and can also threaten our safety when medical records become tainted with someone else’s health conditions, blood type, etc. There is a simple process that will greatly reduce the likelihood that your practice will inadvertently facilitate an occurrence of identity theft – Check ID cards and ask for a photo ID!

Add a step to your intake process requiring that the member present his or her ID card along with a photo ID at each and every visit. Carefully check to make certain that not only the name, but also the date of birth and address (if available) match the information provided on the member’s ID card. Finally, check to be sure that the person who hands you the ID is the person in the picture.
Fraud, Waste & Abuse - Compliance Violations Must be Reported

We would like to remind you of your obligations regarding reporting suspected or actual fraud, waste, abuse and any compliance violations. Please take note of the following:

- Providers must report any actual or suspected fraud, waste or abuse, compliance violation or violation of any applicable law or regulation, or any actions that conflict with our corporate policy, practice or procedure.

- Reports can be made by contacting our Ethics and Compliance Hotline at 1-800-275-0170, or the Fraud Hotline at 1-800-378-8024.

- When a report is made, steps will be taken to protect anonymity and confidentiality, where warranted and appropriate.

- We will not tolerate any form of retaliation against a person who makes a good-faith report in accordance with the Code of Conduct.

- Any provider who violates, enables, encourages, directs, facilitates, allows or knowingly fails to report an actual or suspected violation of the code, any applicable law or regulation, any Medicare sub-regulatory guidance or any Excellus BCBS policy, practice or procedure risks termination of his or her relationship with Excellus BCBS.

For additional information, visit ExcellusBCBS.com/wps/portal/xl/our/compinfo/fraudabuse/

Preauthorizations for New PT/OT/ST & Home Care Services Must be Requested Via Clear Coverage™ Authorization Tool

Effective November 15, 2014, we will require that all preauthorizations for new physical therapy, occupational therapy, speech therapy and home care services be requested through our Clear Coverage electronic preauthorization tool.

Clear Coverage is a Web-based, real-time software developed by McKesson, and is accessible via the Referrals & Auths section of our website, ExcellusBCBS.com/ProviderReferralsAuths. It offers greater self-service options and immediate resolution of preauthorization requests. In addition, Clear Coverage provides:

- **Faster turnaround:** 60 percent to 80 percent of requests are answered immediately.

- **Faster pending case resolution:** most clinical information is immediately accessible for clinical evaluation.

- **Evidence-based clinical decision support:** includes InterQual® criteria for standards of care, as well as regional product-specific medical policy criteria, when applicable.

- **Single point-of-access:** consolidated workflow for many types of authorizations across multiple payers; allows administration of various payment rules for coordination of benefits.

If you would like additional information, our Clear Coverage resource guide and tip sheets are available by clicking here. Your Provider Relations Representative is also available to provide training in your office.

Please direct questions related to Clear Coverage to our Customer Care Medical Intake number at 1-800-363-4658.
Radiology Billing – Modifiers 26 and TC

Knowing when to bill globally and when to segment a code into the professional component (modifier 26) or the technical component (modifier TC) is crucial in order to properly bill all radiology services rendered. When a radiology service is billed globally, the provider is reimbursed for the equipment, supplies, and technical support, as well as the interpretation of the results and the report.

However, if a facility performed the technical aspects of a service, and the provider only interpreted the results and wrote a report, modifier 26 is necessary to indicate that the provider should receive reimbursement only for the professional component.

Similarly, the technical component, modifier TC, includes billing only for the equipment, supplies, technicians, and facility, but not the interpretation of the service.

Most radiology codes, including ultrasounds, X-rays, CT scans, magnetic resonance angiography and MRIs may be billed with modifier 26 or TC, or with no modifier at all, indicating that the provider performed both the professional and technical services.

For example, an orthopedic surgeon sees a member in his or her office for a broken ankle. The surgeon requests that X-rays of the member’s ankle be taken in his office. The surgeon would bill 73600, radiologic examination, two views. Because no modifiers are appended to the code, the surgeon is indicating to the health plan that he or she performed both the technical component and the reading and interpretation of the X-rays for the member.

If the X-ray were taken elsewhere, such as in a facility, the facility would bill the code 73600-TC, indicating that the facility is billing only for the technical component. The radiologist at the facility who read the X-ray would also bill the code 73600-26, indicating that he or she read and interpreted the X-ray and wrote a report concerning his or her findings.

It is important to note that a facility cannot bill global if they are not the technical and interpreting provider as it results in retractions, and causes the member to pay two copays, when the member is only responsible for one.

If you have billing questions or inquiries on appropriate modifier use, please contact your Provider Relations Representative.

Attention Primary Care Physicians: PQM Program Update

Data Available for Review Mid-November

We are pleased to inform you that your Physician Quality Measurement (PQM) data will be available for review on or about November 14, 2014, via our website, ExcellusBCBS.com/Provider. The PQM program is a quality recognition program offered through the Blue Cross Blue Shield Association. This program provides information to our members, accessible via the National Doctor and Hospital Finder Web search tool (http://provider.bcbs.com/), about quality-of-care measures for primary care providers who meet the minimum threshold of 25 members in the measure.

Excellus BCBS participating providers will have their quality-of-care measures for breast cancer screening and HbA1c testing for diabetes displayed on the search tool. Measure assessments are as follows:

- **Women’s Health: Breast Cancer Screening** assesses the number of female patients ages 52 to 74 years old as of December 31, 2013, meeting eligibility criteria, who had a mammogram from October 1, 2011 through December 31, 2013.

- **Diabetes: HbA1c Testing** assesses the number of patients ages 18-75 with a diagnosis of diabetes (Type 1 or Type 2) meeting eligibility criteria, who had an HbA1c test during 2013.

(continued on the following page)
Attention Primary Care Physicians: PQM Program Update (con’t)

Our members are identified as your patient if, in the 18 months prior to the end of the reporting period (July 1, 2012, through December 31, 2013), they received most of their preventive care or evaluation and management visits with you.

**Frequently Asked Questions & Important Steps to Take!**

**How is the data obtained?** Data is derived from the current year Healthcare Effectiveness Data and Information Set (HEDIS) reporting. For each measure, a rate is calculated based on the number of your patients who received the recommended treatment (numerator) divided by the number of patients who should have received the recommended treatment (denominator). Your rate is compared to the average score for providers in our network – the local comparison. A star rating is also noted, utilizing Quality Compass quartile rankings that are weighted based on health plan membership by each measure. If your rate meets or exceeds the 75th percentile, you receive a three-star ranking (exceeds performance expectations); a rate at or above the 50th, but less than the 75th percentile earns a two-star ranking (meets performance expectations); and a rate below the 50th percentile earns a one-star ranking (below performance expectations).

**What do I need to do?** **IMPORTANT** – If you are a primary care provider who has met the 25 member minimum threshold in either measure, you will receive a letter from us in the next several weeks notifying you that you have PQM information to review in the Excellus BCBS provider website. You will have 45 days from the date on the letter to log-in to our website, ExcellusBCBS.com/Provider, and review your data. Once you log-in, select **Patient Care** (menu at the top of the page). From this screen, select the “Physician Quality Measurement (PQM)” link to progress to the Practitioner Performance Screen. On this page you will see a "Review and Approve Your Data Now" link that will advance you to a secure provider authentication log-in window before taking you to the links with your patient-level detail and score information. Patient-level detail is provided for every member who is included in the denominator, along with a numeric value for the numerator, denominator, rate, local comparison score and star rating. After reviewing your information, you need to take action by checking one of the following reporting options in the select display status link:

- **“Yes, I approve the display of my score with star rating and local comparison score for this measure.”** If you select this option, your rate, numerator, denominator, star rating and local comparison score will be viewable on the National Doctor and Hospital Finder search tool for that specific measure.

- **“No, I do not approve the display of my score with star rating and local comparison score for this measure.”** If you select this option, the search tool will display "Physician chooses not to display information” for that measure.

- **If you do not select one of the two reporting options by December 29, 2014**, your information will automatically be displayed on the National Doctor and Hospital Finder search tool.

If you do not have Internet access, please contact Customer Care to obtain a paper copy of your data.

**What if the data is not correct?** For 2014, if you dispute any data, you have the right to opt out of reporting by selecting the "No, I do not approve the display of my score with star rating for this measure” option. Although claims data is fairly timely and accurate for breast cancer screening and HbA1c testing for diabetes, we recognize that you may have more current and/or complete information to supplement our data. **Beginning in 2015**, an online process will be available for you to report corrections.

**When will scores be available online to members?** Our members will be able to view quality scores via the National Doctor and Hospital Finder search tool in the spring of 2015.

**Where can I call if I have any questions?** If you have any questions, please contact Customer Care. You must call us by **December 29, 2014**, if you have concerns about the ratings or wish to provide feedback.
Confidentiality for Victims of Domestic Violence

New York State Insurance Law §2612 provides that an insurer, such as Excellus BCBS, shall keep confidential and not disclose the address and telephone number of the victim of domestic violence, or any child residing with the victim, and the name, address, and telephone number of a person providing covered services to the victim, to a policyholder or another insured covered under the policy against whom the victim has a valid order of protection, if the victim, the victim's legal representative, or if the victim is a child, the child's parent or guardian, delivers to the insurer at its home office a valid order of protection.

Excellus BCBS will accommodate a reasonable request made by a requester for a covered individual to receive claim-related information from us by alternative means of communication or at alternative locations. Except with the express consent of the requester, Excellus BCBS will not disclose to the policyholder or another insured covered under the policy:

- The address, phone number or any other personally identifying information of the covered individual or any child residing with the covered individual;
- The nature of the services provided to the covered individual;
- The name, address and phone number of the provider of the covered health care services; or
- Any other information from which there is a reasonable basis to believe the foregoing information could be obtained.

We have adopted these procedures to maintain the confidentiality of, and to refrain from disclosing, the information protected by Insurance Law § 2612. To submit a request, members should call the Customer Care number listed on the back of their ID card.

For further information, call the New York State Domestic and Sexual Violence Hotline at 1-800-942-6906, or visit www.opdv.ny.gov/help/dvhotlines.html.

Medicaid Managed Care — Made Easy

Are You Confused About Our Medicaid Managed Care Product Names?

In the past, there has been confusion regarding the Medicaid managed care products that Excellus BCBS offers its members, as the product names differs based on the county in which the member resides.

We offer our Blue Choice Option Medicaid managed care product to members residing in Monroe, Wayne, Livingston, Seneca, Yates and Ontario counties. In addition, we offer our HMOBlue Option Medicaid managed care product to members residing in Broome, Herkimer, Oneida and Otsego counties. Please be aware that while these product names are different, the benefits are the same.

Why is it important to know the correct product names?

Periodically, your office may receive a call from a person who identifies themselves as an "Excellus BCBS Medicaid managed care member." This call could be part of a secret shopper audit conducted by the New York State Department of Health, and therefore, it is important that the staff member answering the call provides the appropriate product information for your office location.

If you have questions regarding our Medicaid managed care products, please call your Provider Relations Representative.

Remember...

Blue Choice Option is available to members residing in Monroe, Wayne, Livingston, Seneca, Yates and Ontario counties.

HMOBlue Option is available to members residing in Broome, Herkimer, Oneida and Otsego counties.

Looking to Contact Your Provider Relations Representative?

Click here to access the most current Provider Relations Contact & Territory List.
Coding Updates

Diagnosis Coding for Evaluation & Management

We remind you of the importance of diagnosis coding for evaluation and management (E&M). Please reference the information below to help ensure that your office or facility is engaging in accurate and complete coding.

ICD-9-CM diagnosis tips:

Diagnosis codes for each visit/encounter must:
- Support the reason for the visit (chief complaint, etc.).
- Support all services performed during the visit.
- Support all ICD-9-CM/ICD-10-CM diagnosis codes reported on the claim form or billing statement.
- Support the E/M level of service billed.

ICD-9-CM diagnosis coding questions to ask yourself:
- Are all reported diagnoses relevant to the member’s visit?
- What is the reason for this member’s visit/encounter?
- Is there an ICD-9-CM coding rule that takes precedence over the reason for the visit/encounter? Was it applied?

CMS E&M coding guidelines:


Care Coordination - It’s All about Positive Touch Points

Touch points are the points at which prospective customers experience a company’s culture, products or services. The more positive a prospect’s touch point experiences, the easier it is to turn the prospect into a satisfied customer.

In health care, we have touch points. Patients come into contact with a vast array of health care professionals and service providers, with each contact being a touch point in the process and an important part of the patient experience.

While it is up to all of us to make each of these touch points positive, a large portion of the responsibility falls on the primary care provider, whose effectiveness at interpreting and explaining the various aspects of the process to the patient and his or her family often determines the outcome.

Each year, patient satisfaction data is collected in the form of the Consumer Assessment of Healthcare Providers and Systems, or CAHPS. This survey asks patients to rate the effectiveness of the care they have received, including such items as the PCP’s access to patient records, quality of follow-up, efficiency of providing test results, communication about prescription medicines, care management and coordination with specialists.

This survey determines how effectively the health care system has taken advantage of its touch point opportunities. And it is our opportunity to take the system’s pulse about how well we are serving our members (your patients), who are also either satisfied or dissatisfied customers. To learn more about the survey, visit https://www.cahps.ahrq.gov/.

Roles & Responsibilities of Local Plans, Home Plans & Providers

BlueCard is a national program that enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan’s service area. There is often confusion about roles and responsibilities of the Local Plan, Home Plan and the provider. Please review the following FAQs for clarification.

What are the roles and responsibilities of the Local Blue Cross and/or Blue Shield Plans to their providers?

Your local Blue Cross and/or Blue Shield Plan’s responsibilities include all provider-related functions, such as:

- Being the single contact for all claims payment, customer service issues, provider education, adjustments and appeals.
- Pricing claims and applying pricing and reimbursement rules consistent with provider contractual agreements.
- Forwarding all clean claims received to the member’s Blue Cross and Blue Shield Plan to adjudicate based on eligibility and contractual benefits.
- Conducting appropriate provider reviews and/or audits.
- Confirming that providers are performing services and filing claims appropriately within their scope of practice and according to their local Blue Cross and/or Blue Shield Plan.
- Conducting HIPAA standard transactions.
- Training for providers on BlueCard.

What are the roles and responsibilities of the member’s Home Plan to the provider?

- Adjudicating claims based on member eligibility and contractual benefits.
- Responding to prior authorization and precertification requests/inquiries.
- Requesting medical records through the Local Plan when review for medical necessity, determination of a preexisting condition, or high-cost/utilization is required.
- Answering questions regarding benefits and eligibility.

What are the roles and responsibilities for the provider?

- Obtaining benefits and eligibility information, including covered services, copays and deductible requirements.
- Filing claims with the correct Local Plan and including, at minimum, the required elements to ensure that timely and correct processing, such as:
  - Current member ID card number
  - All other party liability information
  - All member payments, such as copay, coinsurance or deductibles
- Submitting medical records in a timely manner when requested by the local or member Home Plan.

Should a member’s Blue Plan ever directly contact an out-of-area provider?

The member’s Blue Plan should only contact an out-of-area provider to solicit, clarify, or confirm clinical information for the purpose of performing case management or disease management activities.
Medical Record Documentation Standards: Medical Record Review Process

In keeping with the National Committee for Quality Assurance recommendations, in addition to compliance with all state and federal regulatory bodies, we have established medical record documentation standards. These standards promote efficient and effective assessment, treatment and health promotion and are designed to facilitate confidential coordination and continuity of care. In addition to adherence to these standards, medical records should be kept in a manner that is confidential, current, comprehensive and organized and allows for easy retrieval.

Annually, a random sample of physician medical records is reviewed. Our Quality Management Committee (QMC) has established a performance goal of 80 percent, designed to assess compliance with the Medical Record Documentation Standards. Physicians scoring 80 to 89 percent will be notified by letter, that while meeting the threshold, opportunities for improvement exist. Those scoring 90 percent or higher will not receive a results letter.

A corrective action plan (CAP) is required for any physician not meeting the established threshold. We will conduct subsequent reviews within six to twelve months after approval of the CAP, and will review annually until the physician meets the established goal for two consecutive years. Each year, an aggregate report of compliance with these standards is presented to the QMC to identify opportunities for improvement.

The Medical Record Documentation Standards Include the Following Categories:

- **Biographical/Personal Data:** patient identification; date of birth, current address; work/home telephone numbers; if employed, name of employer; marital status, as applicable; OB/GYN name as applicable; advance directives
- **General Chart Organization:** signed entries; dated entries; organized in sequential order; legible records (illegible records are an automatic failure and considered a quality issue)
- **Personal History:** problem list; medication list; allergies and/or adverse reactions; past medical history; family medical history; social living environment
- **Social Habits:** tobacco use; alcohol use; substance use; HIV/STD risk
- **Office Visit/Follow Up:** pertinent subjective and objective information; labs, studies, treatment plan ordered; diagnosis/impression consistent with findings; time frame for return visit; referrals/consultants; chronic medical conditions monitored as applicable; no shows documented; evidence of specialist visit/emergency room/inpatient stay as applicable; test, labs, consultations. Follow-up; care rendered must be medically indicated.
- **Preventive Services:** diet/nutrition discussion and/or counseling; patient safety; age/gender preventive health; immunization record*

Opportunities for Improvement Were Identified for the Following Criteria:

- Advance directives
- Substance use
- HIV/STD risk
- Patient safety

*We recently released “The Facts About Vaccine-Preventable Diseases in Upstate New York,” which highlights low upstate New York vaccination rates for influenza, pertussis and pneumonia and provides facts regarding common vaccine misconceptions. Please engage your patients in a conversation regarding their immunization status, as clinical research clearly shows that vaccinations for diseases such as influenza, pertussis and pneumonia save lives. To access the full report, visit ExcellusBCBS.com/wps/portal/xl/our/hpr/factsurveyreport.

Medical record documentation auditing and reporting are part of Health Care Operations and as defined by Health Insurance Portability and Accountability Act do not require patient authorization for release of protected health information. Visit our website to further review our Medical Record Documentation Standards at ExcellusBCBS.com/wps/portal/xl/prv/pc/qp/qi.

If you have questions, please call our Quality Measurement Department at 1-585-453-6310.
2015 Product Updates

We are committed to creating products that comply with health care reform, offer contemporary and innovative plan designs and simplify plan selection. In addition to our current product offerings, effective **January 1, 2015**, the following updated and new plan options will be available for our individual, small and large group markets:

### Individual

- **Updated! Bassett Preferred Gold** (previously named Bassett Gold Select):
  - Prefix: On exchange: YNB, Off exchange: YNL
  - Tier 1: Preferred Network, Bassett doctors/facilities
  - Tier 2: Excellus BCBS 31-county
  - Service area: Delaware, Herkimer, Oneida and Otsego counties
  - Cost share for Tier 1 (Preferred Network):
    - $25 PCP copay/$40 specialist copay
    - $400 single deductible/$4,000 out-of-pocket maximum
    - Rx $5/$35/$70
  - Cost share for Tier 2 (Non-Preferred Network):
    - Deductible then 20% coinsurance for PCP or specialist visit
    - $1,500 single deductible
    - Rx $5/$35/$70
  - Combined Tier 1 and 2 out-of-pocket maximum of $4,000

- **New! Bassett Preferred Silver**:
  - Prefix: On exchange: YNB, Off exchange: YNL
  - Tier 1: Preferred Network, Bassett doctors/facilities
  - Tier 2: Excellus BCBS 31-county
  - Service area: Delaware, Herkimer, Oneida and Otsego counties
  - Cost share for Tier 1 (Preferred Network):
    - $30 PCP copay/$50 specialist copay
    - $1,250 single deductible
    - Rx $10/$35/$70
  - Cost share for Tier 2 (Non-Preferred Network):
    - Deductible then 30% coinsurance for PCP or specialist visit
    - $3,750 single deductible
    - Rx $10/$35/$70
  - Combined Tier 1 and 2 out-of-pocket maximum of $6,350

- **New! CNY Preferred Gold**:
  - Prefix: On exchange: YNG, Off exchange: YNJ
  - Tier 1 (Preferred Network): St. Joseph's / Crouse doctors & facilities
  - Tier 2 (Non-Preferred Network): Excellus BCBS 31-county
  - Service area: Onondaga county
  - Cost share for Tier 1 (Preferred Network):
    - $25 PCP copay/$40 specialist copay
    - $400 single deductible/$4,000 out-of-pocket maximum
    - Rx $5/$35/$70
  - Cost share for Tier 2 (Non-Preferred Network):
    - Deductible then 20% coinsurance for PCP or specialist visit
    - $1,500 single deductible
    - Rx $5/$35/$70
  - Combined Tier 1 and 2 out-of-pocket maximum of $4,000

(continued on the following page)
2015 Product Updates (con’t)

**Individual (con’t)**

- **Updated! Silver Standard (subsidy plan):**
  - Prefix: YNE
  - Cost share change:
    - Decreased deductible from $1,750 to $1,200
    - Increased the out-of-pocket maximum from $4,000 to $5,200

- **Updated! Base (catastrophic plan):**
  - Prefix: YNE
  - Cost share change:
    - Increased both the deductible and out-of-pocket maximum from $6,350 to $6,600

**Small Group**

- **New! SimplyBlue Plus 14 (Silver):**
  - Prefix: YND
  - Cost share:
    - First three PCP visits covered-in-full, not applied to deductible
    - $2,600 single deductible/$4,500 out-of-pocket maximum
    - 20% coinsurance after deductible
    - Rx $10/$35/$70, subject to deductible

- **New! SimplyBlue Plus 5 (Bronze):**
  - Prefix: YND
  - Cost share:
    - First three PCP visits covered-in-full, not applied to deductible
    - $30 PCP copay/$50 specialist copay
    - $4,000 single deductible/$6,600 out-of-pocket maximum
    - Rx $10/$35/$70, subject to the deductible

**Large Group**

It is important to note that we are offering new PPO product options for 2015 – see below. For our current Blue PPO, HealthyBlue and SimplyBlue plans, additional eyewear allowances of $150 to $200 will be available in addition to existing allowances of $60 and $100.

- **New! SimplyBlue Hybrid Plan Options:**
  - Note: Our hybrid plan has an in-network deductible and prescription drug is not integrated in the deductible or out of pocket maximum. This plan does not follow rules for IRS HSA eligibility.
    - Cost share:
      - $3,000/$9,000 in network deductible option
      - 10% in network coinsurance option
      - Option with all non-preventative services subject to the deductible
      - Option that removes $0 PCP copay for member to age 19

- **New! HealthyBlue and SimplyBlue High Deductible Health Plan Option 12:**
  - Cost share:
    - $4,000 single/$8000 family deductible
    - 30% in network coinsurance; 50% out of network coinsurance

(continued on the following page)
2015 Product Updates (cont)

Large Group (cont)

- **New!** HealthyBlue and SimplyBlue High Deductible Health Plan Option 13:
  - Cost share:
    - $3,500 single/$7,000 family deductible
    - 50% in network coinsurance; 50% out of network coinsurance

How Our Tiered Preferred/Non-Preferred Networks Work

**Tier 1 (Preferred Network):** Our members who are enrolled in preferred network plans pay less out of pocket when they go to a “Preferred Network” provider or facility. In order for the lower cost share to apply, they must see a provider in this preferred network. The value to the member is lowest out-of-pocket costs when the preferred network is used. There is no coverage for care at a non-par (out-of-network) provider or facility for any services except for emergency care and dialysis.

**Tier 2 (Non-Preferred Network):** Our members who are enrolled in non-preferred network plans have access to the larger network. Members may also use the Excellus BCBS EPO/PPO network in our 31-county service area. However, if they go to a provider outside of the preferred network, they will pay more out-of-pocket. The value to the member is access to larger network, but the member will pay more to use the non-preferred network. There is no coverage for care at a non-par (out-of-network) provider or facility for any services except for emergency care and dialysis.

**IMPORTANT — Check ID Cards, Verify Benefits & Eligibility!**

As we gear up for the new year, it’s important to remember that there are many changes that affect our member’s coverage, such as new plans and product offerings and cost share variations. Make it a rule to ask for and make a copy (front and back) of your patient’s ID card at every visit. Also, prior to rendering services, be sure to verify benefits and eligibility via our website, ExcellusBCBS.com/ProviderCoverageClaims, or by calling Customer Care.

Consumer-Driven Health Plans: Patient-to-Provider Payment

Consumer-driven health plans continue to grow in popularity, and along with these types of plans comes a new type of patient — one who is encouraged to improve his or her own health and take control of personal health care decisions and expenses in collaboration with his or her provider.

Your office or facility has likely seen and will continue to see an increase in patients with this type of coverage; therefore, it is important to know how these plans work and how to best manage patient-to-provider payment.

Consumer-driven health plans consist of three main components: 1) affordable high-deductible health plans 2) a funding account such as a health savings account, health reimbursement account, or a flexible spending account 3) access to online health information, tools and resources.

Patients pay out-of-pocket for services until their deductible is met. This excludes preventive services, which are covered in full. The patient is responsible for paying a deductible up to a certain amount. The amount the patient will have to pay for his or her deductible depends on his or her plan. Providers may bill the patient at the time of service, if the deductible is not met. After the deductible is reached, the patient will pay a percentage of cost, called coinsurance.

(continued on the following page)
Consumer-Driven Health Plans: Patient-to-Provider Payment  (cont)

To best manage patient-to-provider payment, be sure to:

- Inform the patient of your policy regarding collection of payment at the time of service.
- Confirm the status of the deductible by visiting the Excellus BCBS website ExcellusBCBS.com/ProviderCoverageClaims > Deductible & Cost Sharing, or by calling Customer Care.
- Keep a list of our allowances, and if the patient has not met his or her deductible, collect the allowed amount at the time of service based upon CPT code.
  - Physicians may obtain our schedule of allowances via the secure section of our website. Login and password required.
  - For other health care professionals, each December, we mail you an annual fee schedule notice that contains a schedule of allowance for the most commonly billed codes for your specialty.
  - If you have questions or need additional information about our schedule of allowances, please contact your Provider Relations Representative.
- Always submit a claim, regardless of the patient’s status in meeting his or her deductible.
- If your office or facility requires payment at the time of service, and it’s determined on the remittance invoice that too much was collected, you are required by law to promptly refund the difference to the patient.

If you would like education and training for your office on consumer-driven health plans, please contact your Provider Relations Representative. You can also visit our website, ExcellusBCBS.com/Member/CDHC, for additional information about these plans. See below for a tool that you can use in your office to help with payment collection at time of service.

**CDHP Office Notepad**

To assist your office with payment collection, we offer a Consumer-driven Health Care Provider Office Notepad (sample to right), which explains to the member that cost-sharing may be required at time of service if his or her deductible is not yet met. We recommend placing these pads in your waiting room and at your reception area.

If you would like a supply, order online at ExcellusBCBS.com/Provider > Print Forms > Brochures > Order Free Preprinted Patient Brochures and Supplies

Complete the form and mail or fax it to the address/fax number indicated.
Attention Dental & Medical Providers

We would like you to be aware of information regarding our subsidiary, Lifetime Benefit Solutions Inc. (LBS), which provides comprehensive employee benefits administration and innovative risk management solutions to employee benefit programs, and its Web-based technology and business process enhancement that impacts dental and medical plans.

Starting in May 2014, LBS began issuing new dental ID cards to its members enrolled in its dental plans and will issue the remainder of new ID cards to its dental members in mid-December. For members enrolled in its medical plans, ID cards will be issued in December 2014.

ID Cards

The new ID cards for both dental and medical plans are easy to identify as they contain the LBS company name and logo. In addition, they contain a 12-character ID number and the new LBS Provider Service phone numbers: 1-315-448-9028 and toll-free 1-866-616-7216. There is also a change to claim submission information on the back of the ID card — the electronic payer ID is “EBSRM” and the claim mailing address:

Lifetime Benefit Solutions, Inc.
P.O. Box 780
Liverpool, New York 13088-0780

Note: ID cards containing the old company name “EBS-RMSCO” and ID number are still valid and will be replaced throughout 2015.

Web Portal

A convenient feature of LBS’s technology enhancement is that coverage and claims information is available online through a secure Web portal, MyEBSRMSCO. The Web portal is easy to use and can save your office time! Features include access to:

- Claim details and payment status
- Provider remittance statements
- Member and dependent coverage information
- Interactive capabilities such as online forms

To register, visit www.ebsrmsco.com. Using the “Access my Account” down arrow, select MyEBSRMSCO and review the prompts on the login page. As part of this improvement, all LBS members will be fully transitioned to the new Web-based technology. Therefore, it is imperative that you check member ID cards at each visit to verify that you have the current information with a 12-character ID number on file.

If you currently use LBS’s rSolutionz Web portal, please be aware that access will only be available until March 31, 2015. As part of the technology enhancement, on January 8, 2015, rSolutionz will display members with a termination date of January 1, 2015. This does not mean coverage has terminated.

LBS remains committed to providing you with outstanding service as it continues to enhance its business and technology capabilities.

This is important information for your practice, so please share it with your office manager, front-end staff and any other practice locations you may have. In addition, verify with your billing vendor that your billing software accommodates 12-character ID numbers.

If you have questions, contact Lifetime Benefit Solutions Customer Service Center at 1-315-448-9029 or 1-877-300-9969. Note: If you reside within the “315” area code, please call 1-315-448-9029.
CLIA Waivers & Urine Drug Screening Billing Guidelines for all Lines of Business

Attention Physicians, Reference Labs & Hospitals

Our billing guidelines for drug screening tests mirror those established by the Centers for Medicare & Medicaid Services for safety, accuracy and quality of diagnostic testing. We have communicated previously on this topic, and this article is meant to clarify additional questions we have received from our participating providers.

Facilities, and private providers that perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Therefore, any provider who performs laboratory testing must obtain a CLIA certificate.

CLIA regulatory requirements vary according to the type of test performed. Please follow the billing instructions below when submitting claims for drug screening tests. These billing guidelines pertain to all Excellus BCBS lines of business. Billing CLIA waivered tests without the CLIA waiver leaves a provider vulnerable for regulatory intervention.

Practices that have a CLIA Certificate of Waiver, and are performing point-of-care tests, should use HCPCS code G0434

G0434 – The description for the billing point of care code: drug screen, other than chromatographic; any number of drug classes, by CLIA-waived test or moderate complexity test, per patient encounter

Practices using automated instrumentation to perform high-complexity qualitative or quantitative testing should use HCPCS code G0431

G0431– The description for the billing code for qualitative testing with automated instrumentation: drug screen, qualitative, multiple drug classes by high complexity test method (e.g., immunoassay, EIA) per patient encounter

Providers performing urine screens or similar testing in their office must apply for a CLIA Waiver or utilize a compliant laboratory for testing

For additional information related to drug screening tests, please refer to the CMS website, www.cms.hhs.gov/clia.
Medical Policy Updates

Excellus BCBS works to ensure that the development of corporate medical policies occurs through an open, collaborative process. We encourage participating providers to become actively involved in medical policy development. Each month, draft policies are available on our website for review and comment. To access, click here. Providers now have the capability of attaching supporting documentation related to their comments.

There are no new or updated policies to report for the month of November.

When policy criteria change, our requirements related to medical records may also change. Please refer to our website, or call Customer Care, for the most current information. Medical records requirements can also be found on our website. Failure to submit required records with claim submission may delay processing and payment.

Although medical policies may be effective on the date they are approved by the Medical Policy Committee, updates to the claims processing systems may not occur for up to 90 days. Questions regarding medical policies should be directed to Customer Care.

News from FLRx

Medical Specialty Drug Reminder: Coverage Under the Medical Benefit
(Applies to All Lines of Business)

Select medical specialty drugs require preauthorization under the medical benefit; as such, claims will deny or suspend for review across all lines of business if preauthorization is not obtained. Reference our website frequently for updates to the medication list, as new drugs are added when they receive FDA approval. To avoid disruption in therapy for new members on office/home care-administered specialty drugs, fill out a medical specialty preauthorization form in a timely manner.

For a complete list of medications that require preauthorization under the medical benefit, visit our website, ExcellusBCBS.com/Provider, and in the Manage Medications box (lower right side of page) click on the Medical Specialty Drugs link. When calling for a benefit quote for an office-administered/homecare medication, including chemotherapy, the drug name and/or J-code (or both) should be given to the representative.

You can now use our electronic preauthorization system Clear Coverage for Medical Specialty Drugs. To learn more, access our Clear Coverage Provider Resource Guide and Tip Sheets at ExcellusBCBS.com/ProviderEducation. If you have questions, contact Customer Care.

Ask the Pharmacist

Our clinical pharmacists are available to answer your questions on a broad range of topics, including:

- New Clinical Data
- Optimal Drug Selection
- Drug Interactions
- Adverse Reactions
- Drugs in the News
- Monitoring Parameters
- Therapeutic Uses

To learn more or to ask questions via our secure online form, visit ExcellusBCBS.com/wps/portal/xl/prv/drg/dil/.

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Stay Current on Important Dates!

Post this calendar at your desk!

November

- Fall seminars start for the month of November
- Office Manager satisfaction surveys should be returned
- PQM program data available for review via website, ExcellusBCBS.com/Provider
- Preauthorizations for new physical therapy, occupational therapy, speech therapy and home care services must be requested through Clear Coverage electronic preauthorization tool
- Office closed for Thanksgiving

December

- Fall seminars start for the month of December
- Navigating the Blues starts for the month of December
- Office closed for winter holiday

Help In Managing Your Patients Who Have Diabetes

November is American Diabetes Month. According to the American Diabetes Association, 8.3% of the U.S. population—nearly 26 million people—suffer from diabetes. Although diabetes is one of the leading causes of death in the U.S., it can be treated effectively to limit its effects and maintain a high quality of life.

Our Member Care Management team offers a specialized program to assist you in managing the health of your patients with diabetes. We can provide educational materials, important screening reminders and personal contact via phone to help your patients comply with your treatment plan. You can refer your patients to our diabetes management program by calling 1-800-434-9110.

*Dates subject to change.
Pass Us Along...forward this newsletter, via the “Forward this email to a Friend” option, in your Connection eAlert to the following staff in your office or facility:

- Office Manager
- Business Staff
- Front Desk Staff
- Medical Records/Medical Assistants
- Primary Care Physicians
- Specialists
- Physician Assistants/Clinical Nurse Specialists
- Nurses
- Referral and Precertification Staff

Visit us online at ExcellusBCBS.com/Provider.

Tried online, but still need help?
Contact Customer Care at 1-800-920-8889

Customer Care Hours of Operation
Monday through Thursday, 8 a.m. to 5:30 p.m.,
Friday 9 a.m. to 5:30 p.m.