CONNECTON

In this issue:

NATIONAL HEALTHCARE DECISIONS DAY
CLEAR COVERAGE™ KUDOS
PROMOTING CARE COORDINATION

A nonprofit independent licensee of the Blue Cross Blue Shield Association
What's Inside:

Click the title below to go directly to the article.

News You Can Use pg. 3
Clear Coverage Preauthorization Tool pg. 4
Retroactive Authorizations for MMC pg. 4
Coordination of Care pg. 5
Vaccines for Children Program pg. 5
National Healthcare Decisions Day pg. 6
Utilization Review Criteria pg. 7
Coding Corner pgs. 8-9
New Program to Improve Billing Accuracy pg. 9
Pharmacy News pg. 10
Medical Policy pg. 10
Did You Know? pg. 11

Don't Keep the Latest News & Updates to Yourself...

Share this newsletter with your coworkers via the "Forward this email to a Friend” option in the eAlert!

Web Self-Service Tools

We know how busy your work day can be. That’s why we remind you of the time-saving tools and information available on our website, ExcellusBCBS.com/Provider. They are quick, convenient and available 24/7.

As of April 12, 2017, use of our web self-service tools to check member eligibility and benefits is required.

Read our March 16, 2017 notice for more details.
NEWS YOU CAN USE

LUNCH AND LEARN OPPORTUNITY
If you'd like to learn more about Medicare, please join us in our Utica, NY office at 12 Rhoads Drive on May 2, 2017, from noon to 1 p.m. We will discuss Medicare eligibility, Medicare Advantage vs. Medicare Supplement plans, and much more! Lunch will be provided. To register for this free event, click here.

GO PAPERLESS!
Visit our InstaMed® page to learn about the benefits of receiving your payments and remittance advice electronically. InstaMed is a free service!

UPDATE PRACTICE INFORMATION
Please review your practice information to ensure that it is up-to-date. Visit ExcellusBCBS.com and click on the Find A Doctor tab. Select the provider network in which you participate, then select the health plan product(s) in which your office participates, enter the provider’s first and last name, then scroll down and click Search.

To update your practice information, complete our Demographic Changes form and submit it electronically or print a copy of the form and fax or mail it to us.

PREAUTHORIZATION FOR CITY OF ROME EMPLOYEES
We remind you to use the standard list of services requiring preauthorization when rendering care to employees of the City of Rome. The list is available on our website. Click here to access.

NEW ENROLLMENT REQUIREMENT
Effective May 1, 2017, our provider enrollment process will require physicians and health care practitioners to provide medical school information, internships and residencies (with start and end dates) when submitting an application for enrollment as a participating provider.

YOU CALL THE SHOTS TRAINING
You Call the Shots is web-based immunization training offered by the Centers for Disease Control and Prevention. It’s free, and you can earn continuing education credits! Review available courses, which include an updated training module related to human papillomavirus and the related vaccines.

THERAPY SERVICES REMINDER
As of March 1, 2017, use of the Clear Coverage™ online authorization tool is required when requesting authorization for physical, occupational and speech therapy services for our Safety Net members. All requests for authorization must be accompanied by the therapy evaluation and will show as pended in Clear Coverage until medical necessity review is complete. Review our December 1, 2016 bulletin for more details.
TRY IT, YOU'LL LIKE IT!

Don’t just take our word for it. Check out the comments shared by medical office staff regarding the convenience and ease of our online Clear Coverage™ preauthorization tool.

“Clear Coverage walks you through each step of entering an authorization — very user-friendly.”

“I don’t have to fax anything, which means less paperwork.”

“I love getting an instant response — no waiting around for a determination. Most of the time, I get a response right when the patient is checking out, which improves patient satisfaction.”

Clear Coverage includes an interactive question-and-answer medical review, based on Excellus BlueCross BlueShield-specific or InterQual® evidence-based criteria. We worked with McKesson to integrate Clear Coverage with our business rules so that your office or facility can receive an instant decision regarding approval or pend for medical necessity review. See how this time-saving tool can benefit you! If your practice isn’t currently using Clear Coverage, why not make your job a little easier?

Contact your Provider Relations Representative to set up training, or use our training request form.

RETRO AUTHORIZATIONS FOR MEDICAID MANAGED CARE

We remind you that retroactive authorizations for our Medicaid Managed Care members follow the same rules as those in place for our commercial lines of business. Any requests for retroactive authorizations must be submitted within 14 calendar days from the date of service. Exceptions will be considered when:

- A member has been discharged from an inpatient admission (including non-routine obstetrical admissions) prior to notification of the discharge, where timely notification was provided
- The exception is specified in provider or state contracts

Note: For preauthorization of genetic testing or outpatient testing for substance use, a five business day grace period from the date of lab receipt of the specimen will be allowed. Any specimens already processed by the lab will be treated as a retrospective request. Retrospective authorization requests that do not meet these exception criteria will be denied, and an appeal may be submitted through the normal process.
Recent gaps in care have been identified for Excellus BlueCross BlueShield members seeking mental health and/or substance use (MH/SU) services. Members have experienced difficulties in being scheduled for an urgent MH/SU visit within 48 hours from when the appointment was requested. Gaps have also been seen regarding MH/SU follow-up visits within seven days of discharge from a psychiatric admission. Open communication and exchange of medical record information are vital to providing standard quality of care to your patients.

Coordination of care between PCPs and MH/SU providers when co-managing the care for patients with MH/SU conditions is critical. Please review office practices to ensure that information is shared between specialties in a timely and accurate manner. Please educate patients on the importance of sharing of information when co-managing illnesses by asking each patient during each visit if he or she would like to sign a consent form for release of information specific to mental health and/or substance abuse, and enter all pertinent information into the patient’s medical record.

**VFC PROGRAM**

**VACCINES FOR CHILDREN**

We remind you that the New York State Department of Health (NYSDOH) requires providers administering vaccines to children (younger than 19 years of age) with Child Health Plus, HMOBlue Option or Blue Choice Option coverage to participate in the New York Vaccines for Children (VFC) program. VFC is federally-funded and provides vaccines at no cost. Our Health Plan covers the vaccine administration fee only. Although VFC provides vaccines at no cost, we ask that you submit vaccine codes to our Health Plan to help us track codes for childhood immunization quality reporting. Please bill $0.00 as the charge when submitting codes for VFC supply vaccines to help ensure that the claim is not rejected. Only vaccines listed on the New York state immunization schedule are included in the VFC program.

**VFC Program Benefits**

- reduces vaccine cost as a barrier to vaccinating at the right time with the right vaccine
- eliminates the need to refer patients to public clinics
- increases immunization rates

**Not Currently Participating in VFC?** If you are not currently participating, you will not be eligible for free vaccines, and will not be reimbursed for the cost of vaccines. If you need additional information or would like to enroll in the VFC program, please contact the NYSDOH Immunization Program via email at nyvfc@health.ny.gov or call 1-800-543-7468.
April 16, 2017, marks the 10th annual National Healthcare Decisions Day (NHDD), a day set aside to encourage everyone age 18 and older to have family discussions about personal values and beliefs, to choose a spokesperson and to complete a health care proxy (known in some states as a durable power of attorney for health care). This year’s NHDD theme is “It always seems too early, until it’s too late.”

CONVERSATIONS CAN CHANGE LIVES!

Encourage your patients to start their conversation. Review the advance care planning resources on CompassionAndSupport.org. Check out ReachMD’s podcast series on the 2014 Dying in America report, and review Conversation Resources that align with the report. Share resources with colleagues, family and friends.

Integrate advance care planning into your daily work flow. Don’t hesitate to contact me at Patricia.Bomba@lifethc.com if I can help you to get started.

Use our educational resources. There is a free educational resources order form to order materials for your practice. The website offers informational videos, practical issues to consider and family discussion tips, guidelines for choosing a spokesperson, a downloadable health care proxy and MOLST forms, and a free advance care planning booklet.

Consider joining the NHDD New York State Coalition. While NHDD is on April 16, the coalition works year-round to promote the value of advance care planning, health care proxies and MOLST. If you are interested in sharing your skills and expertise while growing professionally and creating sustainable community education on advance care planning, please join the NHDD NYS Coalition by contacting Meg.Greco@Excellus.com today.

Raise awareness through social media. Follow @PatBombaMD, @KatieGOrem and @MOLSTMeg on Twitter. Use #NHDD and #NHDDNY in your messages. Like CompassionAndSupport on Facebook and encourage friends to do so.

Thank you for your support of National Heathcare Decisions Day!

Patricia A. Bomba, MD, FACP

Dr. Bomba is Vice President and Medical Director for Geriatrics at Excellus BlueCross BlueShield. She chairs the MOLST Statewide Implementation Team and serves as eMOLST Program Director. Dr. Bomba also chairs the National Healthcare Decisions Day NYS Coalition.
To help ensure that our members have access to appropriate medical and behavioral health services, we use nationally recognized criteria to determine appropriateness of care for members. These criteria provide us with objective clinical indicators for assessing a patient’s condition and determining the appropriate level of care. Determinations of medical necessity are based on factors such as specific clinical information, comorbidities, type of care needed, treatment setting, and assessment of the patient’s clinical stability.

These nationally recognized criteria (e.g. InterQual®, Medicare) are used by health plans, medical insurers, hospitals, physician groups, ancillary providers, and public agencies to assist in the review of the health care services. In addition to national criteria, we use state and/or community-developed utilization management criteria and corporate medical policies for both medical and behavioral health inpatient and outpatient care. These criteria are used to ensure that we meet the minimum contractual requirement that all services rendered must be medically necessary. We evaluate the criteria on an annual basis, incorporating any enhancements. These criteria may be further modified by locally adopted industry or community standards to evaluate the level of care decisions for provided health care services.

If there are substantial changes when the criteria undergo annual review, we will notify you separately with the details and implementation date. Recently, we transitioned from using InterQual® 2015 criteria to using InterQual® 2016 criteria for review of applicable medical services and InterQual® 2016.2 criteria for review of applicable behavioral health services. Our team of Medical Directors reviewed these revisions and determined that they include additional criteria points to enhance the ability to conduct reviews but that they are not significant in terms of process change or impact on reviews. We began using the new criteria sets as of March 6, 2017. Also, New York state has mandated the use of LOCADTR 3.0 criteria for substance use disorder medical necessity reviews for Medicaid and Health and Recovery Plan (HARP) products. For consistency purposes, we have chosen to use LOCADTR 3.0 for all lines of business for all substance use disorder medical necessity reviews.

Our corporate medical policies are also available on our website. We encourage you to provide feedback on the draft policies. In this way, we solicit and incorporate local practitioner input. To access InterQual® criteria or our corporate medical policies from our website, ExcellusBCBS.com/Provider, select Patient Care > View Our Policies.

We have also developed preauthorization guidelines for specific services, and you must notify us prior to rendering these services. The guidelines are reviewed and updated at least annually. The current preauthorization guidelines were effective on January 1, 2017. They can be found on our website, ExcellusBCBS.com/Provider. Select Referrals and Auths > Preauthorization.

If we make an adverse determination (i.e., a denial) regarding requested or provided services for one of your patients, you may request a copy of the review criteria upon which we based our decision. In addition, the treating physician may discuss the decision with our medical director. We include reference to the specific criteria used in making the decision on all adverse determination notifications, along with instructions on how to request these criteria, speak to the medical director or file an appeal. Our decision-making is based solely upon the application of nationally recognized clinical criteria, transparent corporate medical policies, and the existence of coverage. We do not, in any way, encourage decisions that result in underutilization or reward utilization review decision-makers for denials of coverage or limits on access to care. If you would like to review specific utilization management medical criteria, ask any questions on how it is used, or request paper copies of any of the documents referenced in this article, contact our Customer Care team at 1-800-920-8889.
This month, we will review how to improve documentation specificity for obesity and morbid obesity.

- Obesity is defined as having a body mass index (BMI) of 30 - 39.9.
- Morbid obesity is defined as having a BMI of 40 or over; or a person who is greater than 100 pounds over his or her ideal body weight; or a BMI of 35 or more and experience obesity-related health conditions. Morbid may also be referred to as “extreme” or “severe” obesity.

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E66.01</td>
<td>Morbid (severe) obesity due to excess calories</td>
</tr>
<tr>
<td>E66.09</td>
<td>Other obesity due to excess calories</td>
</tr>
<tr>
<td>E66.1</td>
<td>Drug-induced obesity</td>
</tr>
<tr>
<td>E66.2</td>
<td>Morbid (severe) obesity with alveolar hypoventilation (Pickwickian syndrome)</td>
</tr>
<tr>
<td>E66.3</td>
<td>Overweight</td>
</tr>
<tr>
<td>E66.8</td>
<td>Other obesity</td>
</tr>
<tr>
<td>E66.9</td>
<td>Obesity, unspecified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BMI</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z68.3-</td>
<td>Obesity BMI 30.0 – 39.9</td>
</tr>
<tr>
<td>Z68.4-</td>
<td>Morbid obesity BMI 40 and over</td>
</tr>
</tbody>
</table>

**Other types of obesity important to specify in your documentation:**

- Drug-induced obesity, which is caused to certain drugs that can cause rapid weight gain. Examples include antipsychotic drugs, tricyclic antidepressants, lithium, valproate, and glucocorticoids.
- Morbid obesity with alveolar hypoventilation, also known as Pickwickian syndrome or obesity hypoventilation syndrome, is a condition in which severely overweight people do not breathe rapidly enough or deeply enough, which results in low blood oxygen and high blood carbon dioxide levels.

**Documenting for obesity and morbid obesity:**

- To report a diagnosis of morbid obesity with a BMI of 35.0 - 39.9, an obesity-related chronic medical condition or comorbidity, including but not limited to diabetes, hypertension, or obstructive sleep apnea, should be linked to support the morbid obesity diagnosis.
- To report a BMI of 40 or more without a corresponding diagnosis of morbid obesity, the provider must document clinical significance of the BMI. Clinical significance can be demonstrated through a discussion of weight loss, diet, and/or exercise specific to the BMI.
- Obesity and morbid obesity may not be coded based solely upon a documented BMI; the condition itself must be stated by the provider legally accountable for establishing the patient’s diagnosis.
- When documenting morbid obesity, watch for verbiage that negates a definitive confirmation of the diagnosis such as “appears morbidly obese.”


**Important Documentation Reminders**

Be sure to include treatments specific to weight loss, such as:

- Dietary changes
- Exercise and activity
- Behavior changes/lifestyle modifications
- Surgery - gastric bypass/gastric banding/gastric sleeve
- Prescription drugs/anorexants

Remember **M.E.A.T.** - All diagnoses submitted on a claim should be supported by **M**onitoring, **E**valuation, **A**ssessment, and/or **T**reatment in the medical record documentation.

---

**BILLING ACCURACY**

**NEW PROGRAM TO IMPROVE CLAIM SUBMISSION BILLING ACCURACY**

We are collaborating on a new program that will be administered by OrthoNet™, an independent company that provides orthopaedic specialty benefit management and other services. We will be implementing a Focused Claim Review program to ensure billing accuracy in claims submissions. Through this program, select claims for complex surgical procedures will be reviewed prior to payment. These claims will be selected using OrthoNet’s algorithms and will be reviewed by same/similar specialist physicians. If a claim is selected for audit, your office will receive a letter requesting documentation, typically the detailed chart notes for a particular procedure or date of service. Once you send the requested documentation to the vendor, the documentation will be reviewed and compared to each CPT claim line to ensure proper coding. This is not a review for the medical necessity of the services billed.

To ensure a high quality implementation of this program, we will be engaging OrthoNet to review paid claims (retrospective claim review) for the same types of scenarios they will be reviewing as part of the prepayment program. Over the next few months, OrthoNet will select paid claims to review. If your claim is selected for audit, we will review our internal records to see if we already have the necessary claims documentation on hand. If we do have the documentation, we will share it with OrthoNet. If we do not already have the documentation, OrthoNet will send a letter to your office requesting it.

If OrthoNet recommends any changes to reimbursement, we will send a letter advising you of the findings and give you information on how to dispute the findings. During this process, our implementation team will monitor the program to see if there are any ways that the prepayment program can be modified to mitigate impacts to your office.

Additional information about the prepayment program, including the expected implementation date, will be shared as the details become available.
PHARMACY NEWS

BILLING REQUIREMENT FOR STELARA, PROLASTIN C, ARALAST AND ZEMAIRA

To ensure that your claims are submitted accurately and to allow for timely processing and correct reimbursement, we would like to advise you of billing requirements effective **May 15, 2017**, for J-code claims J3357 (Stelara) and J0256 (Prolastin C, Aralast and Zemaira). Prior to submitting claims for these medications, please confirm that they are submitted with a drug code that includes:

- Appropriate national drug code (NDC) and
- Number of NDC units administered

This requirement applies for all lines of business. As you may know, New York state requires that the NDC and number of units be included for all J-code drug claims for HMOBlue Option, Blue Choice Option and Child Health Plus claims.

To read our bulletin on this topic, click [here](#). To access helpful NDC billing tips, click [here](#).

MEDICAL POLICY

MEDICAL POLICY UPDATES

We work 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 the draft policies, click [here](#).

Providers now have the capability of attaching supporting documentation related to their comments.

**CURRENT POLICIES recently updated with changes**

**Artificial Cervical Intervertebral Discs** have been proposed as an alternative to anterior cervical discectomy and fusion as it is felt that a more functional device, such as prosthetic disc, would better restore not only the anatomy but also normal mechanical function in the cervical neck region. This year’s policy revision has expanded coverage criteria and now allows coverage for both a single level disc implantation, and for two-level disc placement (simultaneous implantation and for subsequent implantation of an artificial cervical disc) when specific criteria are met, as outlined in the medical policy.

**External Prosthetic Devices**, which are worn as an anatomic supplement, are used to replace non-functioning or absent body parts. External prosthetic devices that replace the function of a permanently inoperative or malfunctioning organ/body part are considered medically appropriate. Custom prosthetic devices with enhanced features are not medically necessary if activities of daily living can be met with standard prosthetic devices. Precise clinical information is required for consideration of coverage when non-standard prosthetic devices (e.g., microprocessor-controlled lower limbs, Otto Bock C-leg®, Intelligent Prosthesis, Ossur Rheo) are requested. With this year’s update, we have added a new statement to the guidelines section stating the following: Polishing and resurfacing of an eye prosthesis (V2624) may be performed up to two times per year.
A BILLION-DOLLAR MYTH:

THAT OUR NONPROFIT HEALTH PLAN DOESN’T PAY TAXES

Over the past two years, Excellus BlueCross BlueShield and our parent company have paid $988 million in federal and state taxes. In 2016 alone, we paid $506 million, including about $105 million in federal taxes for the national Affordable Care Act.

We’re nonprofit—in the sense that we have no shareholders and deliberately do not seek large margins. Our mission is to help people in our communities live healthier and more secure lives through access to high quality, affordable health care.

But we’re not a charity. We’re a business that needs to generate a margin to stay in business, but we keep our margin low to keep coverage more affordable. In upstate New York, we’re a good part of the reason why coverage here costs less than the national average.