May 2013

Providerfocus

Published Monthly for Physicians, Health Care Providers, and Their Office Staff

Demystifying Health Care Benefits for Members

New payment summary helps members better understand copayments and deductibles

Employers increasingly are choosing health plans that give members the responsibility of understanding the costs of medical services. These plans may have tiered networks, limited networks, or increased cost share.

With this increased complexity, we know that members need simple tools for understanding and using their health benefits.

That's why we recently redesigned our Explanation of Benefits (EOB). We send an EOB to any member who seeks medical services and has a balance due. The document shows how a claim processed against the member's benefits and the amount the provider will bill them.

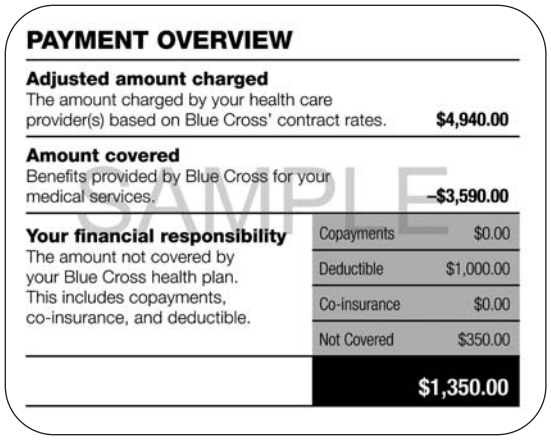
The new EOB - renamed the **Summary of Health Plan Payments** - is easier to read and designed to reduce member confusion. Blue Cross Blue Shield of Massachusetts' COO Bruce Bullen asserts that, "The new summary will better educate our members about their health care costs." He continued, "It's a milestone in our development of transparency tools."

About the new, simplified summary

We gathered valuable input from members to help develop the new summary. It now includes a simple payment overview and a glossary of commonly used health care terms, and complies with state and federal requirements.

The redesigned document will help members better understand their benefits and give them the ability to make better-informed health care decisions.

In March we began sending the new summary of payments to our PPO members who have a balance due. We will gradually begin using it for the rest of our members over time.



PAYMENT OVERVIEW

Adjusted amount charged
The amount charged by your health care provider(s) based on Blue Cross' contract rates. **$4,940.00**

Amount covered
Benefits provided by Blue Cross for your medical services. **–$3,590.00**

Your financial responsibility
The amount not covered by your Blue Cross health plan. This includes copayments, co-insurance, and deductible.

Copayments	$0.00
Deductible	$1,000.00
Co-insurance	$0.00
Not Covered	$350.00
	$1,350.00

SAMPLE

To view a sample of our new *Summary of Health Plan Payments*, log on to **bluecrossma.com/provider** and click on **Resource Center>Forms>TBD.** ❖

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In Brief

Our Member Rights and Responsibilities Statement Is Available Online

A copy of our "Member Rights and Responsibilities" statement is available in the Member Education section of your online *Blue Book* manual.

To view this information, log on to **bluecrossma.com/provider** and click **Resource Center>Admin Guidelines & Info>Blue Books.**

Under the Professional *Blue Book* listing, click on **Appendix**, then select **Member Education.** The Rights and Responsibilities section appears on pages 7-12. ❖

Physician News

Use Clear Coverage to Enter Diagnoses for Molecular Diagnostic and Genetic Tests for HMO/POS Members

Technological advances are driving the rapid growth of new genetic tests and molecular diagnostic services. Appropriately used, these tests can help confirm a diagnosis, determine the risk of developing a disease or condition, offer insight on treatment options, and monitor response to certain pharmacogenetic agents.

Starting this fall, we will ask ordering clinicians and testing laboratories to use McKesson's online Clear Coverage application to supply us with data for genetic tests and molecular diagnostic services. This data will help us develop appropriate prior authorization requirements for these services. We have developed this approach after consulting with our network clinicians and laboratories.

The rapid growth in the number of genetic tests and molecular diagnostic services available can make it difficult for physicians to know which test is most appropriate for a patient. Health plans are also faced with the following additional challenges in making coverage decisions—namely inadequate:

- Publication of evidence-based guidelines.
- Specific billing codes that result in use of CPT codes that do not provide information about the types of tests being performed and why.

Your participation in our genetic testing notification initiative will provide important information about which tests are being ordered and why, and will help reduce the number of tests ultimately requiring utilization review.

Phased approach starts in fall of 2013

Clinician Input Phase: Beginning this fall for HMO and POS members only, we will ask clinicians to enter only the test name and diagnosis into McKesson's Clear Coverage web-based tool.

Medical Policy/Prior Authorization Phase: After we have analyzed the data, anticipated in 2014, we'll work with clinical experts to determine which molecular diagnostic and genetic tests will require utilization review and prior authorization. You will receive advance notice about these requirements.

Instructions for ordering clinicians

During the Clinician Input phase, we will ask the **ordering clinician** to:

- Access Clear Coverage by logging on to **bluecrossma.com/provider**.
- **Determine if your patient is included.** We are asking you to enter information only for commercial HMO/POS members who live in and have a PCP based in Massachusetts. If your patient's name does not appear in the Clear Coverage tool (PPO, Medicare HMO Blue® and Federal Employee Program members will not appear), you do not need to submit data.
- **Use Clear Coverage** to select the diagnosis, test, and your identifying information. You may choose to also review the test-specific, evidence-based support tools offered by Clear Coverage as well as BCBSMA policy information, and then print a laboratory notification for your patient.

Instructions for servicing laboratories

We will ask **servicing laboratories** to check whether the ordering clinician has entered the diagnosis, test ordered, and ordering clinician information into Clear Coverage for HMO/POS members who live in and have a PCP based in Massachusetts. If you:

- See the member's information but the ordering clinician has not entered the diagnosis and procedure code, we ask that you either **enter** it or call the clinician's office to ask them to enter it.
- Do not see the member's information in Clear Coverage, no further action is required.

We will hold training later this year

To help you and your staff learn to use the Clear Coverage tools and develop efficient workflows, we will hold trainings later this year. We will send you more details about these opportunities and the program launch date as they become available.❖

Physician News

Reminder: Sleep Management Program Kicks off July 1, 2013

Our Sleep Management Program will go into effect on July 1 and will be administered by AIM Specialty Health.

Ordering clinicians

All clinicians who will request prior authorizations for sleep studies or sleep DME and supplies must register with AIM before **July 1** in order to request authorizations.

- If you are currently using AIM's website to request radiology authorizations, you **do not** need to re-register.
- If you are not currently using AIM's website, please register at **aimspecialtyhealth.com/gowebsleep**. You can start requesting authorizations for sleep studies or sleep DME and supplies beginning June 16 for services on or after July 1.
- AIM can assist large group practices with the registration process.

June 1 deadline for facilities, sleep laboratories, and DME providers

Also as part of this program, facilities, sleep laboratories, and DME providers are required to complete an online assessment survey by **June 1**. Sleep providers that complete this assessment survey will be included in an online directory for referring providers. This requirement is not part of credentialing and does not affect network participation.

- To complete the assessment survey, go to **aimspecialtyhealth.com/gowebsleep**.
- If you have not registered previously with AIM, you will need to do so. After registering, complete the online survey assessment by selecting **BCBSMA** from the drop-down menu.
- You do not need to complete the assessment survey if you only read sleep testing results and do not perform the technical and/or global component of these services.❖

Medicare News

Talking to Your Patients About Urinary Incontinence

Urinary incontinence affects 15-30% of people 65 and older who live in the community according to the HMO Workgroup on Care Management, a group representing insurance plans and group practices. Urinary incontinence becomes more common with age, but it is not an inevitable consequence of aging.

The stigma and inconvenience of incontinence often lead to adverse events that may result in functional dependence and reduced quality of life.

Although urinary incontinence is treatable, more than half of patients with this condition have not talked about it with their health care practitioner.

Risk factors

- Childbirth
- Obesity
- Loss of estrogen associated with menopause
- Enlarged prostate or having had prostate surgery
- Medications including diuretics, sedatives, decongestants and anticholinergic agents
- Neurologic disruption of the bladder from stoke and other conditions.

Initiating an assessment of urinary incontinence

Because patients are often reluctant to discuss urinary incontinence with their physicians, experts suggest that clinicians proactively ask their patients about it. The goal of the assessment is to determine the impact of incontinence on the member's function and quality of life. This can be accomplished by asking questions such as "have you restricted activities or your lifestyle because of this problem?"

Because engaging patients on this topic is so important, the CMS Physician Quality Reporting System (PGRS) includes a measure related to assessment for urinary incontinence. Monitoring bladder control is also a CMS 5-Star measure of quality.

Treating patients

Seek to identify older members with urinary incontinence and initiate effective treatment. Treatment options will vary depending on the cause and severity of the incontinence.

For information on treatment options go to **nlm.nih.gov/medlineplus** and search **urinary incontinence**.

For more resources and treatments go to **cms.gov** and search **urinary incontinence**.❖

Pharmacy Update

Adults Can Now Get Vaccinated at a Pharmacy

Our members with pharmacy benefits can now go to any Express Scripts, Inc. participating pharmacy* to receive 10 different vaccinations from a registered, licensed pharmacist without cost share or a prescription.

Previously, our members could get only the flu vaccine at the pharmacy.

This change expands members' access to these preventive services. You can direct your patients to the pharmacy for these vaccines if your office doesn't have the ability to stock and administer them. Of course, members can also continue to get their immunizations from their doctor or at an outpatient clinic.

Members who have these benefits

To get immunizations at a pharmacy, members must:

- Be 18 years of age or older
- Have one of these plans with pharmacy benefits:
  - Commercial HMO, POS, PPO, Access Blue
  - Medex®
  - Managed Blue for Seniors❖

Vaccines that can be administered to members at a pharmacy:

- Chicken pox
- Diptheria, tetanus, whooping cough
- Hepatitis A
- Hepatitis B
- HPV
- Measles, mumps, rubella
- Meningitis
- Pneumonia
- Polio
- Shingles (ages 60 and older only)

**There are Express Scripts participating pharmacies nationwide. Requirements for pharmacists administering immunizations in other states vary; members should check with the pharmacy.*

Case Management to Assist With Appropriate Opioid Use for Medicare Advantage Members

Inadequate pain management and prescription opioid addiction and abuse are growing public health issues. As we noted in a previous issue of *Provider Focus*, CMS has asked us to review opioid use among our Medicare Advantage members to help facilitate safe, appropriate use of these medications.

This spring, we will begin implementing case management review for Medicare Advantage members identified as potential over-utilizers (as outlined through the CMS targeted criteria of 90 consecutive days of greater than 120 mg Morphine Equivalent Dose and four or more pharmacies or prescribers).

Our notification process

We will send the member's prescriber a letter outlining the opportunity to discuss the case with us via phone or fax. We will not contact prescribers about members whom we identify via claim data as having a diagnosis that warrants high-dosage opioid use, such as cancer or a terminal illness.❖

ESI Physician Report Cards Mail This Month

At the end of this month, Express Scripts Inc. (ESI) will send reports to Medicare Advantage physicians that will include a prescriber's report card. The report provides information about prescribing patterns for high-risk medications and diabetes treatments for this important population.

Please review the report and determine if any evidence-based care decisions should be implemented. ESI's Academic Detailing Team will be available to answer questions regarding the report.❖

Office Staff Notes

Next Generation Find a Doctor Tool Has Launched

As reported previously in *Provider Focus*, we've upgraded our most-used self-service tool for members and providers. Along with a new look and easier interface, our Find a Doctor tool now integrates primary care physician and hospital provider quality data and delivers new features, such as online mapping. And when a member logs on to Member Central, the tool pre-populates their plan's provider network.

The provider version of the tool includes the provider's referral circle information and NPI to aid you in making referrals. If you are looking for a professional, such as a physician, nurse practitioner, behavioral health/substance abuse professional, or specialist, search by name or location under Health Care Professionals. If you are looking for a facility such as a hospital, DME provider, imaging center, or lab, search by Medical Facilities. To access our Find a Doctor tool, log on to **bluecrossma.com/provider**, select **Manage Your Business>Find a Doctor**❖

Credentialing Requirements Reminders

Below we provide some reminders on requirements that help to expedite the credentialing process:

- Practitioners with a hospital affiliation may start the initial credentialing process 60 days prior to their hospital affiliation effective date. Please note that we may return credentialing files opened earlier than 60 days prior to the hospital effective date due to missing or incomplete information.
- Reference letters are no longer required during initial credentialing for any ancillary provider except for Nurse Practitioner Primary Care Providers (NP-PCP) without a hospital affiliation. NPPCPs without a hospital affiliation must submit two letters of reference—one from their BCBSMA credentialed collaborating physician and one from another BCBSMA-credentialed provider.
- Physician and behavioral health practices must provide notice of 24-hour coverage. Please be sure to include the name, specialty, and phone number of each practitioner covering in your absence on the *Integrated Massachusetts Application Form* found on the Council for Affordable Quality Healthcare's (CAQH) website: **www.caqh.org**
- Advanced Practice Nurses (NP, NPPCP, CRNA, CNM, PNP, RNCS), must include their collaborating physician on credentialing documentation.
- Surgical podiatrists must have an affiliation and admitting arrangements with a BCBSMA participating hospital or a BCBSMA free-standing ambulatory surgery center. Non-surgical podiatrists do not need a hospital affiliation, admitting arrangements or reference letters.
- Remember to keep your CAQH application up-to-date with current information, including any certifications and expiration dates that may have passed since your last attestation.❖

Office Staff Notes

Use the Correct Identification Number on FEP Claims to Avoid Rejections

Federal Employee Program (FEP) members have IDs that begin with the letter R followed by eight digits (e.g., R99999999).

Starting on September 20, 2013, if you submit a claim for an FEP member using any number other than the correctly formatted ID number, the claim will deny with message code E672:

Either this claim has been submitted under the wrong identification number, or the patient is not a member of Blue Cross and Blue Shield of Massachusetts. Please resubmit the claim with the identification number as it appears on his or her ID card.

Please always ask our members for their current ID card. Use our technologies to check benefits and eligibility and update your records with their most current insurance information and ID number.❖

If you submit an FEP member claim using a format other than the one shown above, your claims will reject.

InfoDial® Claim Submissions to End

InfoDial® will no longer accept claim submissions effective October 1, 2013.

For a convenient way to submit claims, please consider using our Direct Data Entry (DDE) tool. This free tool is ideal for small and mid-size practices and is available through Online Services.

There are a number of advantages to using this tool including:

- No claim forms to fill out and mail; you can submit all primary professional claims via DDE, including BlueCard℠ claims.
- No tedious telephone entry.
- Save time and money; no billing agency is needed.
- It's simple to create, edit and submit claims electronically—all for free.❖

To:	Please:
Learn more about DDE, view our online tutorial, and download our *Quick Tips* for registering and submitting claims	Log on to **bluecrossma.com/provider** and select the link in the Direct Data Entry for Professional Claims box on the right-hand side of the page.
Register for BlueLinks for Providers	Go to **bluecrossma.com/provider** and click on the blue box labeled **Register Now**.
Contact us with questions	Call **1-800-771-4097** option 4, M-F 8am-4pm EST or email us at **provider.self.service@bcbsma.com**

Join Us for Help with Online Claim Entry

If you are a solo practitioner who submits claims using InfoDial® or paper, we can help you with your transition to Online Services Direct Data Entry (DDE). Join us at our offices in Quincy for an informal walk-through of how to submit a claim. Parking is free.

After you have registered for the tool, we'll show you how to enter claims and access your reports. You can begin submitting claims with DDE the next day.

To register, log on to **bluecrossma.com/provider**, select **Resource Center>Training & Registration>Course List**, and choose **Getting Started with Online Claim Entry**❖

Location:	Dates and times:	Register by:	Information to bring:
BCBSMA One Enterprise Drive Quincy	Thursday, May 23 10 – 11 a.m.	Thursday, May 16	Your BlueLinks for Providers username and password Information for one claim, one subscriber, and one dependent
	Tuesday, June 11 1 – 2 p.m.	Tuesday, June 4	

Office Staff Notes

Changes in Coverage of Compression Stockings

Effective July 1, 2013, we are updating our members' coverage for compression stockings and adding quantity limits for these supplies. These changes apply to members who belong to all of our health plans.

As always, please check the member's benefits and eligibility before supplying these services.

Durable Medical Equipment fee schedule will be updated

As a result of these changes, we are updating your fee schedule with the changes listed below.

List of codes updated for podiatrists, NPs, NP-PCPs, urgent care centers

We've updated the list of durable medical equipment codes that can be billed by physicians, podiatrists, nurse practitioners, nurse practitioner-PCPs, and urgent care centers to reflect the coverage changes for compression stockings (see the chart below for details). Please remember you can only bill DME codes on this list if it is within the scope of your specialty.

The updated list will be available on July 1 by logging on to **bluecrossma.com/provider** and clicking on **Resource Center> Admin Guidelines & Info> Billing Resources.**❖

Coverage change:	Update to the DME fee schedule:	Update to the list of DME codes billed by physicians, podiatrists, NPs, NP-PCPs, urgent care centers:
Compression stockings with a gradient pressure of 30 mm Hg or greater only are covered.	These procedure codes will be deleted from your fee schedule: A6530, A6533, A6536, A6539, and A6544	These codes will be deleted from the list: A6530, A6533, A6536, and A6539
A quantity limit of 2 pairs of compression stockings every 6 months has been added. This includes below-the-knee or thigh-length sizes in any combination. For example, one pair of below-knee (A6532) and one pair of thigh length (A6534) or two pairs of A6532.	These codes will have quantity limits of every 6 months: A6531, A6532, A6534, A6535, A6537, A6538, A6540, A6541, A6545 and A6549 One pair equals 2 units.	These codes will have quantity limits of every 6 months: A6531, A6532, A6534, A6535, A6537, A6538, A6540, A6541, and A6549 One pair equals 2 units.

Medical Policy Update

Lists of New, Revised, and Clarified Medical Policies are Now Available Online

Log on to **bluecrossma.com/provider**, select **Manage Your Business>Review Medical Policies>View Medical Policies**. In the middle of the page, you will find summaries of Medical and Pharmacy Policy Updates, grouped by the month in which the policy or update is effective. Each month's list is organized alphabetically by policy title. Click on the policy title to view a summary of the update.❖

MASSACHUSETTS
Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Landmark Center
401 Park Drive
Boston, MA 02215

Providerfocus

ROUTING BOX
Date received:_____
Please route to:
- ☐ **Office manager**
- ☐ **Physician**
- ☐ **Nurse**
- ☐ **Billing manager**
- ☐ **Billing agency**
- ☐ **Receptionist**
- ☐ **Other:** _____

At Your Service

Providerfocus is published monthly for BCBSMA physicians, health care providers, and their office staff. Please submit letters and suggestions for future articles to:

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E-mail: **focus@bcbsma.com**

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