October/November 2013

Providerfocus

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

FINAL ISSUE—See details below

Our New Provider Website—Provider Central—is Live

Log in With Your BlueLinks Username and Password

Provider Central, our new provider website that replaces *BlueLinks for Providers*, is now live. This website is your central source for news, information and access to self-service tools.

This first release of our newly branded site helps lay the foundation for enhancements in the future.

What's new?

Provider Central features:

- Simplified navigation and better organization of content
- A robust news center, where you can easily search and print current and archived articles and notices
- Electronic delivery of news and information to streamline our communications to you and eliminate the use of paper—reducing our environmental impact
- Patient engagement tools to help you educate and support your patients
- Quality improvement and efficiency tools and resources
- For AQC providers who use the AQC Resource Center, we've integrated content from that site onto Provider Central for a more seamless and integrated experience.

What you can still rely on

- You can still find us at the same URL: bluecrossma.com/provider.
- If you are already a registered user of BlueLinks for Providers, you do not have to re-register to use Provider Central—just log on with your BlueLinks username and password.

We simply ask that you update your contact information and agree to new terms of use when you sign in. You will also continue to have the ability to:

-Verify member eligibility
-Submit referral and authorization requests
-Review the status of your claims
-Request claims adjustments.

providercentral

bluecrossma.com/provider

Our newsletters are going paperless

To improve the delivery of news and information, we're transitioning from paper to electronic communications, starting with the elimination of our paper newsletters.

This is the final issue of *Provider Focus*. You will still receive all of the news that used to appear in Provider Focus—just in an online format in the News Center.

Once a month we will e-mail you a "News Recap" that contains a summary of the previous months' headlines with links to the full articles.

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In This Issue

Thank you!

For Helping Us Earn High NCQA Rankings

Thanks to your efforts to provide quality health care to our members, NCQA's Health Insurance Plan Rankings 2013–2014 has ranked Blue Cross Blue Shield of Massachusetts:

- As the #3 ranked private HMO/POS health plan in America[1]
- As the top-ranked Medicare Advantage PPO health plan in the country[2]
- Among the highest-rated PPO private health plans[1] and Medicare HMO plans[2] in the nation.

Our partnership with our network doctors and hospitals plays an important role in producing these results—both through data and actionable information we provide about our members, as well as through our payment models, such as the AQC. The AQC rewards quality efficiency, and effectiveness rather than quantity of care.

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Physician News

Thank You For Helping Us Earn NCQA's Annual #3 Ranking for Private Health Plans and the Top-Ranked Medicare PPO in the U.S., *continued*

continued from page 1

We could not have achieved these results without the outstanding care that our providers give to our members throughout the year, ensuring that they receive the evidence-based preventive services that their age and/or gender indicates are appropriate, and for our chronically ill members, ensuring that their condition is carefully monitored and managed.

"Our success is due in part to our strong provider relationships," said Blue Cross Blue Shield President and CEO Andrew Dreyfus. "Our approach to ensuring quality health care for our members involves our extensive network of doctors and hospitals. Through innovation and collaboration, we are improving the health of our members and advancing transformation of the health system to provide effective, affordable care."

The 2013-14 NCQA Health Insurance Plan Rankings measure the quality of care and member satisfaction among 557of the nation's Medicare health insurance plans and 577 private plans. Health plans throughout the country were evaluated on a wide variety of areas, such as member's overall satisfaction with their health plan, access to high-quality primary and specialty care, and effectiveness of wellness and prevention efforts, such as child immunizations, cancer screenings and treatment of diseases.❖

[1] NCQA's Health Insurance Plan Rankings 2013–2014–Private
[2] NCQA's Health Insurance Plan Rankings 2013-2014 –Medicare

ICD-10 Readiness—Please Take Survey by Oct. 31, 2013

To help providers meet the ICD-10 compliance deadline of October 1, 2014, Massachusetts health plans and MassHealth are conducting tan ICD-10 provider progress survey. The results will assess statewide compliance efforts underway and will be used to develop education strategies, training materials, and resources to aide providers with ICD-10 preparations.

To avoid duplicate survey requests from various health plans, HealthCare Administrative Solutions (HCAS) developed this survey on behalf of the following organizations:

- Blue Cross Blue Shield of Massachusetts
- Boston Medical Center HealthNet Plan
- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- MassHealth
- Neighborhood Health Plan
- Network Health
- Tufts Health Plan

In addition, the Massachusetts Health Data Consortium (MHDC), Massachusetts Association of Health Plans (MAHP), Massachusetts Medical Society (MMS) and the Massachusetts Hospital Association (MHA) support this effort.

Please complete this brief survey, located at: surveymonkey.com/s/HCASICD10Survey by October 31, 2013.

An ICD-10 summary of statewide results report will be available on the HCAS website in November at hcasma.org/NewsAndInformation.htm.

To avoid duplicate responses, we request that each organization required to comply with the ICD-10 mandate provide a single unified survey response on behalf of that organization.❖

For information on our ICD-10 plan, visit bluecrossma.com/provider, and click on Office Resources > ICD-10.

Physician News

Updated Disease Guidelines Are Available on Provider Central

Several updated disease guidelines have been reviewed and approved and are now available on our website. Our care managers reference these guidelines when helping to facilitate care for our members.

To access these evidence-based guidelines to manage your own patients, log on to bluecrossma.com/provider and click on Clinical Resource> Treatment Resources, then choose the appropriate condition on the left.❖

Condition:	Guidelines:	Status:
Asthma	Diagnosis and management of asthma. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Jul.	Reviewed and endorsed
Pediatric Asthma	Age 0-4: Management of asthma in children 0 to 4 years. Southfield (MI): Michigan Quality Improvement Consortium. Age 5-11: Diagnosis and management of asthma. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Jul. 86 p. [81 references]	Reviewed and endorsed
Congestive Heart Failure	Institute for Clinical Systems Improvement. Heart Failure in Adults. Updated July 2013.	The changes to the guidelines are summarized within the guideline. There is no significant clinical practice changes noted.
COPD	Institute for Clinical Systems Improvement. Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD). Updated March 2013.	Reviewed and endorsed
Coronary Artery Disease	National Guideline Clearinghouse: Coronary heart disease.	Reviewed and endorsed
Depression	American Psychiatric Association (APA) Practice Guidelines for the Treatment of Major Depressive Disorder, Third Edition.	Reviewed and endorsed
	Care Guide for Major Depression in Adults in Primary Care and Pharmacy Guidelines for Major Depression.	Updated to reflect our current formulary
Diabetes	Standards of medical care in diabetes. I. Classification and diagnosis.	The changes to the guidelines are summarized within the guideline. There is no significant clinical practice changes noted.

Physician News

Ending Reimbursement for Relay Health's webVisit® Service

We have supported the use of telehealth technologies since 2003, primarily through Relay Health e-visits. With more robust telehealth technologies now available, we are developing new strategies on how to best support telemedicine to meet the evolving health care market and regulatory demands. For this reason, we will end reimbursement for Relay Health e-visits effective December 31, 2013.

We believe that the full value of telehealth will be realized when incentives are well aligned between providers, patients, and payers. That is why we have chosen to support telehealth as a practice tool in global payment initiatives like our Alternative Quality Contract (AQC). Payment models like the AQC, which allow greater flexibility and innovation in the delivery of care, will facilitate the adoption and integration of alternate care delivery channels like telehealth solutions.

To better understand the value of telehealth, we are piloting an online care initiative with select AQC provider groups using physician-deployed technology. Patients will use the technology to receive care from their own PCP and affiliated providers, thereby maintaining care efficiency and continuity.❖

Our New Provider Website is Live, *continued*

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Provider Central is the way that we will communicate with you

When you log on to Provider Central for the first time—whether you are a new user or have been a registered BlueLinks for Providers user—you'll need to agree to receive electronic communications from us.

Please let others in your office and organization know about the site and ask them to register to get news and updates in their inbox.

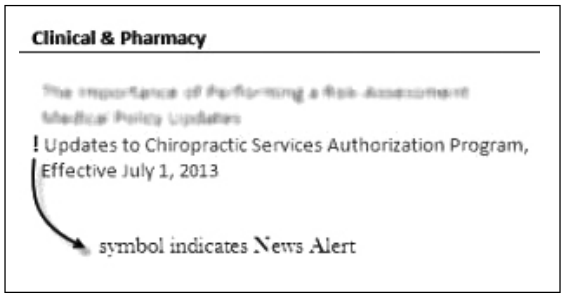
About News Alerts

As we mentioned in our September issue of *Provider Focus, F.Y.I.* notices that we previously mailed and posted online will now be called *News Alerts*.

News Alerts include notices that could impact your reimbursement, office operations, or technology and systems, and notices that will ensure compliance with state and federal regulatory requirements. These notices will continue to be delivered within agreed-upon timeframes.

You'll receive *News Alerts* online via the news center. They will have a distinct format that sets them apart from other news items, as well as a red exclamation point near the headline (see image). We will send you an e-mail each time a *News Alert* is posted, so please keep your e-mail address and profile up to date in our system.

We will continue to send certain communications—such as letters about authorization decisions, medical record requests, and claims-related issues—via mail. But the majority of your news will be delivered electronically.



Questions?

Please contact Network Management and Credentialing Services at 1-800-316-BLUE (2583).❖

Coding Corner

This section offers tips on how to code services for complex cases and how to complete your CMS-1500 claims accurately to help ensure prompt payment.

Malnutrition: Documentation and Coding Overview

Malnutrition is a clinical problem for many adults in the U.S. The Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) has recommend that a standardized set of diagnostic characteristics to identify and document adult malnutrition. Diagnosing and treating malnutrition promotes positive patient outcomes and reduces health care costs.

Guidelines for coding malnutrition

Documenting and correctly assigning ICD-9-CM codes for malnutrition can be challenging for providers and coders, but is easier if you keep in mind the guidelines below:

- For patients diagnosed with malnutrition, the medical note should include the clinical evaluation and management plan by the treating physician or health care professional. Remember to document the specific type of malnutrition and the degree of severity.

- A code assignment for malnutrition based solely on a nutritionist's note *is not appropriate*. When the nutritionist's assessment indicates malnutrition, the treating physician or health care professional should be queried to confirm the diagnosis and its significance to patient-care management.

Diagnostic Coding for Malnutrition

ICD-9-CM Codes	ICD-10-CM Codes
260 Kwashiorkor	E40 Kwashiorkor
261 Nutritional marasmus	E41 Nutritional marasmus
262 Other severe protein-calorie malnutrition	E42 Marasmic kwashiorkor
263.0 Moderate degree protein-calorie malnutrition	E43 Unspecified severe protein-calorie malnutrition
263.1 Mild degree protein-calorie malnutrition	E44.0 Moderate degree protein-calorie malnutrition
263.2 Arrested development following protein-calorie malnutrition	E44.1 Mild degree protein-calorie malnutrition
263.8 Other protein-calorie malnutrition	E45 Retarded development following protein-calorie malnutrition
263.9 Unspecified protein-calorie malnutrition	E46 Unspecified protein-calorie malnutrition

Note: The ICD9-CM index instructs coders to report code ICD-9-CM 260, Kwashiorkor for malnutrition (protein only). However *Coding Clinic*, Third Quarter 2009, p. 6, states that for code assignment 260, kwashiorkor *must be specifically* documented by the provider. ICD-10-CM will correct this issue by indexing malnutrition (protein only) to E46, unspecified protein-calorie malnutrition.❖

MEDICARE ADVANTAGE QUALITY CARE NEWS

Changes to 2014 Medicare Product and Prescription Benefits

We are committed to offering our members high-quality, affordable health care products. To meet this commitment, we are making several benefit enhancements to our Medicare products, including pharmacy benefits, that will be effective January 1, 2014. We are pleased to offer more affordable options for our members, including rate reductions for all direct-pay products.

New Zero-Dollar Premium Medicare PPO Blue SaverRx plan

Starting January 1, 2014, we will offer a new Medicare Advantage Prescription Drug PPO Plan with a zero-dollar ($0) premium. With this plan, members will have comprehensive coverage that includes Part D prescription drug coverage. Members can be seen by both in-and out-of-network physicians with the same cost-share.

Additional plan changes

In addition to our new product, our Medicare product changes include:

- Premium decreases for all non-group products
- The addition of a dental plan to Medicare PPO ValueRx; now all Medicare Advantage plans include dental coverage.
- Removal of the following annual deductibles from two plans: the $1,000 annual deductible from the Medicare HMO Blue ValueRx℠ plan and the $500 out-of-network annual deductible from the Medicare PPO Blue PlusRx℠ plan—providing even more benefit to our members.
- For all Medicare Advantage plans, except the new Medicare PPO Blue SaverRx℠ plan, we decreased our Tier 1 and 2 generic drug copayments from $6/$12 to $4/$8.

Prescription benefit plan updates

We are making the following changes to our Blue MedicareRx Value Plus℠ (PDP) product starting January 1, 2014:

- We are pleased to offer a new Preferred Pharmacy Network to help members save money on prescription copayments.
- Most generic and brand name drugs will be available at lower copayments if filled at a preferred pharmacy. Members can get a 30-day supply of Tier 1 preferred generic drugs for as low as $1.
- Mail order copayments will also decrease. Members can get up to a 90-day supply of Tier 1 preferred generic drugs for $1.
- Generic drugs may be placed on any of the five tiers, depending on drug cost, rather than being covered only on Tiers 1 and 2.

Medex®'–Direct-pay Medicare supplemental plan updates

Effective January 1, 2014, Blue Cross Blue Shield will decrease premiums for our most popular plans, Medex Core and Medex Bronze. Members will continue to receive the same comprehensive coverage of benefits.❖

Medicare Advantage Health Risk Assessments

As part of our ongoing quality and medical management initiatives, we conduct voluntary in-home health risk assessments (HRA) for our Medicare Advantage HMO Blue℠ and PPO Blue℠ members.

We contract with Matrix Medical Network (Matrix) to conduct these HRAs to determine which patients may benefit from our medical management programs. Licensed and credentialed nurse practitioners and physician assistants conduct the assessments to help our members better understand and manage their health needs.

Copies of the HRAs are sent to members' PCPs. If you receive a copy of your patient's HRA, please include it in the patient's medical record for review during their next visit.

Questions? Please call Network Management and Credentialing Services at 1-800-316-BLUE (2583).❖

Office Staff Notes

Upcoming Changes to Member ID Cards

This fall, we will make a minor change to our member ID cards to comply with Blue Cross Blue Shield Association requirements and lay the foundation for future advances in technology.

Beginning in November, the magnetic strip on the back of the cards will be replaced with a bar code.

The transition to bar code will allow online and mobile applications to be used in the future. For now, there is no need to change your procedures.

Please see below for a side-by-side comparison of the old magnetic strip and new bar code.

If you have questions about these changes, please contact Network Management and Credentialing Services at 1-800-316-BLUE (2583).❖

Old magnetic strip

New bar code

You Do Not Need to Participate in Medicare Advantage PPO Blue℠ to Care for Medicare Advantage PPO Members

Medicare PPO Blue, a Medicare Advantage plan, offers members the flexibility to see providers in and out-of-network.

Even if you are not participating in the Medicare PPO Blue network but you participate in Medicare, you can be reimbursed for care provided to any of our Medicare PPO Blue members.

We will reimburse you for covered services based on non-contracted provider reimbursement rates.

Medicare Open Enrollment: October 15 - December 7

Medicare beneficiaries can make changes to their Medicare health plan and prescription drug coverage for 2014 between October 15 and December 7, 2013. During this time, patients may ask question about your participation in Medicare Advantage plans. Keep in mind you do not need to participate in Medicare Advantage PPO Blue to care for Medicare Advantage PPO members.

For more information, contact Network Management and Credentialing Services at 1-800-316-BLUE (2583).❖

Office Staff Notes

Expanded Access to Breast Pumps for Members through Ameda Direct

We cover breast pumps with a prescription at no out-of-pocket cost to members. This fall, to make it even easier for our Massachusetts members to get breast pumps, we are pleased to announce that we have contracted with Ameda Direct, one of the nation's leading breast pump manufacturers.

Members living in Massachusetts with a breast pump prescription from their physician, certified nurse midwife, or nurse practitioner can contact Ameda at 1-877-749-7867 to request a breast pump and order accessories at exclusive discounts. Online ordering will be available later this fall.

Please note: Federal Employee Program Members have benefits for breast pumps only when ordered through CVS Caremark at 1-800-262-7890❖

Email Your Application Status Questions

You can email us at providerapplicationstatus@BlueCrossBlueShield.com to check the status of credentialing applications, contracts, and other provider updates. We will respond to inquiries by the next business day.

Please include the following information in your email:

- Provider name and NPI
- Practice name and NPI
- What are you checking on?
- When and where did you submit your information?

Please refrain from calling us about the status of an application which you've already emailed us about.❖

Attention Paper Claim Submitters: Transition Plan for New 1500 Claim Form Approved

The National Uniform Claim Committee (NUCC) recently approved a transition timeline for version 02/12 of the paper 1500 Health Insurance Claim Form.

In June, NUCC approved the updated 1500 Claim Form that accommodates ICD-10 reporting needs and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

Blue Cross Blue Shield will follow NUCC's implementation timeline, which aligns with Medicare's transition timeline. We will communicate more details about the transition as we near the implementation dates.

We recommend electronic claim submission for the most efficient processing. If you continue to submit paper claims, please make note of the April 1 deadline below.❖

Effective:	Payers, including Blue Cross Blue Shield will:
January 6, 2014:	Begin receiving and processing paper claims submitted on the revised 1500 Claim Form (version 02/12).
January 6 - March 31, 2014	Continue to receive and process paper claims submitted on the old format (version 08/05 and the new format (02/12) during this dual-use period.
April 1, 2014	Receive and process paper claims submitted only on the revised 1500 Claim Form (version 02/12). We will return any old 1500 forms that we receive after this date.

Office Staff Notes

Corrections to Articles in September *Provider Focus*

Credentialing Guidelines

An article in September's *Provider Focus* (Updated Credentialing Guidelines to Reflect Provider Requests for Change) included inaccurate information about credentialing requirements for Oral and Maxillofacial Surgeons.

The article stated that Oral and Maxillofacial Surgeons who provide care under the medical benefit plan(s) must be board-certified by the American Board of Oral and Maxillofacial Surgery (ABOMS). This is incorrect.

The following is the correct guideline for board certification:

A physician (MD, DO), or oral surgeon (DDS/DMD, MD/DDS, or DMD) who is applying for initial participation in a Blue Cross credentialed provider medical network must be currently board-certified by a recognized board or agency (see below) OR must meet the current training requirements for board certification.

Recognized Boards and Agencies:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA)
- American Board of Oral and Maxillofacial Surgery (ABOMS)

FEP Medical Policies

An article in the Medical Policy Updates section of the September *Provider Focus* (Medical Policy Updates) included an incorrect reference to the website for Federal Employee Program Medical Policies. To view FEP Medical Policies, visit **fepblue.org** and search for Medical.❖

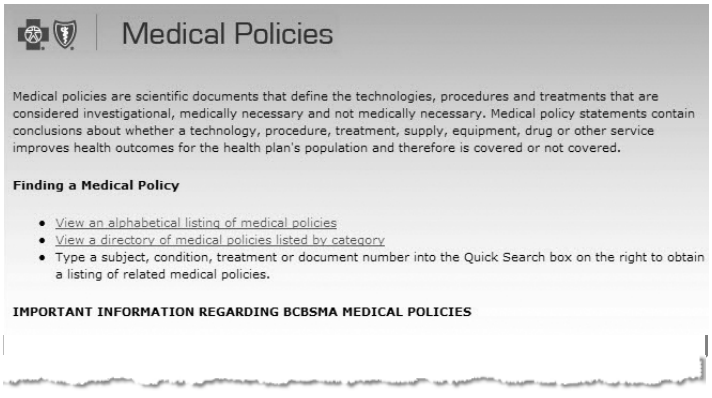
Medical Policy Update

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

Log on to bluecrossma.com/provider and select Office Resources> Policies & Guidelines> 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.❖



Ancillary News

All Psychiatrists and Behavioral Health Clinicians May Apply to Managed Care Network

We currently maintain two behavioral health provider networks for our managed care members: the Personal Help Connection (PHC) network and the Managed Care Behavioral Health (MCBH) network.

To increase efficiency, we will have moved all accounts to our MCBH network by January 1, 2014.

To improve access to care, we invite providers who do not currently participate in the MCBH network to apply.

Participating in the MCBH network benefits you by:

- Allowing you to offer your services to all of our managed care members
- Providing continuity of care for any patients you saw through the PHC network.

Next Steps for You

To check whether you currently participate with the MCBH network, review your contract's signature page or call Network Management Services at 1-800-316-BLUE (2583).

No further action is required if you already participate in the MCBH network.

If you currently participate in the PHC network and would like to apply for participation in the MCBH network, log on to bluecrossma.com/provider and select Office Resources > Enrollment > Maintaining & Changing Status > Network & Product Participation and complete a *Contract Update* form.❖

Pharmacy Update

Announcing Pharmacy Program Changes for 2014

In 2014, we are making several changes to our pharmacy programs and benefits. Clinical changes are made in consultation with our Pharmacy & Therapeutics (P&T) Committee, which is comprised of independently practicing physicians and pharmacists who are not employed by Blue Cross Blue Shield.

On January 1, 2014, we will:

- Complete the phasing out of the BlueValue Rx formulary.
- Update our standard, Blue MedicareRx, and Medicare Advantage formularies.
- Transition medications previously available through both medical and pharmacy benefits to a member's Blue Cross Blue Shield pharmacy benefits only. This means you won't be able buy and bill us for the medications on this list; however, you can order the medication through a specialty pharmacy and submit the claim for administration. These medications will only be available through a retail specialty pharmacy in our retail specialty pharmacy network with the exception of the joint fluid replacement medications. For joint fluid replacement medications only, a member can obtain the medication through a retail pharmacy.
- Update benefits for Blue MedicareRx Value Plus:
  - Generic and brand drugs will be available with lower co-pays at preferred pharmacies.
  - Generic drugs will appear on any of the five tiers based on drug cost, rather than being placed only in Tiers 1 and 2.

Next year, we also plan to offer some employer accounts a four-tier, commercial pharmacy benefit instead of our traditional three-tier pharmacy benefit.

You can learn more about these changes by reading the *F.Y.I.* on our secure website. Log on to bluecrossma.com/provider and go to our news page.❖

Billing Notes

Reimbursement for PA Assists at Surgery

After consulting with members of the physician and physician assistant (PA) community regarding the next phase of our PA-contracting project, we have decided the following: To allow physician and physician group practices to bill and be reimbursed for a PA who is not contracted or credentialed to assist at surgery, effective for dates of service on and after November 1, 2013.

This payment policy applies only to claims submitted using a CMS-1500 claim form and is an interim solution until we have a network of contracted PAs.

In 2014, we will notify you of our plans for PA credentialing and contracting.

To bill for the PA assist at surgery from November 1, 2013 until the PA network is in place, please use the physician NPI with the AS modifier. Reimbursement will be at 85 percent of the assistant surgery fee schedule amount. You should only bill for PA assist at surgery services that fall under the scope of the PA's license and the supervising physician's scope of practice.❖

Clarification of Compression Stocking Coverage

In the May issue of *Provider Focus*, we announced changes in the coverage of compression stockings effective July 1. 2013, including a quantity limit of *two pairs of compression stockings every six months*[1]. Please note that our claims system considers historical claims that paid within the last six months when determining the two-pair limit.

For example, if a claim for compression stockings was paid on June 1, 2013, the next available date of service for a claim for compression stockings is December 1, 2013.

If you have questions about this, please contact Network Management and Credentialing Services at 1-800-316-BLUE (2583).❖

[1] This limit does not apply to Federal Employee Program Members

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

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Boston, MA 02215

Providerfocus

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

At Your Service

- Provider Central
  bluecrossma.com/provider
  Our website has the resources to help you care for our members, and offers you the ability to check claim status, and eligibility and benefit information. Available 24 hours a day, 7 days a week.
- Claims-related issues:
  Provider Services: 1-800-882-2060
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
  Ancillary Provider Services: 1-800-451-8124
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
- Fraud Hotline: 1-800-992-4100
  Please call our confidential hotline if you suspect fraudulent billing or health care activities.
- Non-claims-related issues:
  Network Management & Credentialing Services:
  Reach your Network Manager or inquire about contracting and credentialing issues (all provider types):
  1-800-316-BLUE (2583)
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.

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