HealthCare News
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BCBSND.com

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Medical policy

Medical policies available online

Blue Cross Blue Shield of North Dakota (BCBSND) regularly develops and revises medical policies in response to rapidly changing medical technology. BCBSND is committed to updating the provider community as medical policies are adopted and/or revised. Benefit determinations are made based on the medical policy in effect at the time of service.

The following medical policies were reviewed by BCBSND's Internal Medical Policy Committee on Nov. 17, 2015. Medical policies are available online at www.bcbsnd.com/web/providers/policies.

Revised medical policies. See policy for changes.

- CT Perfusion Imaging
- Carrier Testing for Genetic Diseases
- Molecular Analysis for Targeted Therapy for Non Small Cell Lung Cancer
- Autologous Chondrocyte Implantation
- Breast Pump
- Pulse Oximetry
- Bariatric Surgery
- Microprocessor controlled Prosthesis
- Wireless Capsule Endoscopy
- Adjustable Banding for Plagiocephaly
- Insulin Pump

Revised pharmacy policies. See policy for changes.

- Botulinum Toxin
- Caprelsa
- Cerdelga
- Glucose Test Strips Prior Approval
- Hereditary Angioedema
- HPV vaccination
- Nexavar
- Supprelin LA
- Sutent
- Synagis
- Tasigna
- Thalomid
- Votrient
- Xalkori
- Zelboraf
- Zydelig
- PCSK9 Inhibitors

New policies

- Artificial Pancreas Device
- Orthopedic Application of Platelet Rich Plasma
- Autografts and Allografts in Treatment of Focal Articular Cartilage Lesions

New pharmacy policies

- Lonsurf
- Odomzo
- Iressa
- Orkambi
- Cotellic

Draft policies available

- Charged Particle Proton or Helium Ion Radiotherapy
- Cryosurgical Ablation of Miscellaneous solid Tumors
- Radiofrequency Ablation of Miscellaneous Tumors

The above draft policies were reviewed at the BCBSND Internal Medical Policy Committee meeting in November 2015. Providers have the opportunity to give feedback on the draft policy until Feb. 29.

Claims and coding

Claim adjustment requests

Based on an increase in the number of claim adjustment requests that are being submitted with "billed in error" as the reason, Blue Cross Blue Shield of North Dakota (BCBSND) is providing the following clarification to providers on when it is appropriate to use the "billed in error" request and when the claim adjustment request should be used.

Billed in error request

The billed in error request should only be used when charges were billed erroneously. Examples include:

- services not performed
- wrong patient/member billed
- charges removed from patient's account

Claim adjustments

The claim adjustment request should be used if a correction is being submitted to the original claim. Claim adjustments may include, but are not limited to, additions, deletions or changes to the following information:

- Benefit plan number (a new claim must be submitted for BlueCard claims)
- Patient name
- HME item returned
- Date of service
- Dollar amount
- Place of service
- Coordination of benefits (must include all pertinent information, including remittances from the other insurance)

Claim adjustments should be submitted as soon as a processing issue is discovered. Requests for claim adjustments submitted 180 days or more after the payment listing date will not be accepted.

The claim adjustment request should include a detailed explanation of changes. If BCBSND is unable to determine what action is necessary, BCBSND will return the request for clarification.

Professional claim adjustments are for services submitted on a CMS-1500 claim form.

Institutional claim adjustments are for services submitted on a UB-04 claim form.

Claim adjustment requests are not required for new claims or medical record requests from BCBSND.

UPDATED: Supporting medical documentation is required for the following claim adjustment requests:

- Late charges/credits (changes to revenue codes 036X, 0278, 075X and 049X require the operative report for review)
- Units change
- Modifier changes (with the exception of 26, TC, RT, LT and 52)
- CPT, HCPCS code changes
- Provider number (when changing from a non-payable to payable provider)
- Diagnosis code changes (supporting medical documentation is only required for diagnosis code change requests for pre-existing services and maternity ultrasounds).

Submission of supporting documentation:

- **UPDATED:** Supporting documentation can be submitted through The Healthcare Online Resource (THOR). The use of THOR creates efficiencies for providers and expedites the payment process. To submit the documentation, click the "Add Attachments" button and follow the instructions. **Exception: Due to system limitations all diagnosis code changes submitted through THOR require an attachment. Please attach a blank document if the diagnosis code change that is being requested is not related to any of the above services as any attached documents will not be reviewed.**
- When the adjustment request and the supporting documentation have been uploaded, a file name is assigned to the document and it will appear on the application and printed copy of the adjustment.
- If providers have not used the claims adjustment request on THOR, providers are strongly encouraged to participate in a walk-through of this process. Call 1-800-544-8467 or e-mail thor.support@thor.org to schedule training.
- **UPDATED: Periodic audits may be conducted in accordance with your provider contract at which time additional documentation might be requested. Please reference instructions received in the post audit communications regarding how to submit this documentation.**

Claim adjustment submission:

Providers are encouraged to use the Claim Adjustment application available online through THOR. To become a THOR user, go to www.thor.org/Registration/SysReq.asp.

Claim Adjustment forms are also available at: www.BCBSND.com/web/providers/forms.

2016 coding updates

In late December, professional and institutional providers received an addendum to the July 2015 fee schedules. The addendums reflect the pricing associated with the new Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes that will go into effect on January 1, 2016.

The existence of a procedure code on the addendum fee schedules is not a guarantee the code is valid or covered. The fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT codes. Edits in the Blue Cross Blue Shield of North Dakota (BCBSND) system check for procedure validity and will reject invalid codes. Some codes may represent services for which benefits are not available.

Preauthorization

Preauthorization requirements and contact phone information

Preauthorization is the process by which the member or member's representative contacts Blue Cross Blue Shield of North Dakota (BCBSND) through THOR, telephone or fax to receive authorization for inpatient admissions or specific outpatient services.

Preauthorization is required for the following services:

- Inpatient Medical and Surgical Admissions for non-participating providers
- Inpatient Psychiatric and Substance Abuse Admissions
- Residential Treatment Center Psychiatric and Substance Abuse Admissions
- Ambulatory Behavioral Health Care (Partial Hospital Program) – Psychiatric and Substance
- Intensive Outpatient Program – Substance Abuse
- Home Health Care
- Hospice
- Skilled Nursing Facility/Swingbed/Transitional Care Unit
- Long Term Acute Care Admissions
- Acute Rehabilitation Admissions

Preauthorization requirements for Federal Employee Program (FEP) differ from what is listed above.

Please reference the following updated phone list when calling for the required preauthorizations.

Psychiatric and substance abuse services are available at:

Toll-free

1-800-825-6614

Local

1-701-282-1881

Fax

1-701-277-2253

Medical and surgical services are available at:

Toll-free

1-800-952-8462

Fax

1-701-277-2253

If you have questions about preauthorization requirements or benefits, please contact the BCBSND Provider Service department at 1-701-282-1090 or 1-800-368-2312.

Policy/Benefits

Federal Employee Program benefit changes for 2016

Here are the Federal Employee Program (FEP) benefit changes for 2016.

Preventive benefits

- Pregnant members can receive low-dose aspirin to prevent preeclampsia when they order the drug from a Preferred retail pharmacy or through the Mail Service Pharmacy Program.
- Members age 13 and older can receive one preventive hepatitis B screening per calendar year.
- Children up to age 5 are eligible for a fluoride varnish application by a primary care provider. Limited to two per calendar year.
- Members age 65–75 can receive one preventive ultrasound for aortic abdominal aneurysm per lifetime.
- Testing for large genomic rearrangements in the BRCA1 and BRCA2 genes, once per lifetime, for members 18 or older when they meet the criteria for preventive BRCA.
- One Osteoporosis screening per calendar year for all women 65 and older, and women 50–65 at increased risk for osteoporosis.
- Allergy care and prescription drug benefits for specific FDA-approved allergy desensitization drugs.

Cost share changes

- Standard option: The out-of-pocket maximum for preferred providers is $5,000 for Self Only contracts, and $10,000 for Self Plus One (new in 2016) and Self and Family contracts. For non-preferred providers, the Self Only maximum is $7,000 and the Self Plus One (new in 2016) and Self and Family maximum is $14,000.
- Basic option: The out-of-pocket maximum is $5,500 for the Self Only contracts and $11,000 for Self Plus One (new in 2016) and Self and Family contracts.

For both basic and standard option Self Plus One (new in 2016) and Self and Family enrollments, once an individual on the contract reaches the Self Only out-of-pocket maximum, the maximum is met for that individual for the remainder of the calendar year.

Residential treatment center

- Benefits are available for Inpatient Residential Treatment Center (RTC) for all members for treatment of medical, mental health and/or substance abuse conditions when the following criteria is met, coverage for RTC will no longer be covered under the flexible benefit option:
  - Prior approval must be received prior to the start of RTC stay, no retrospective approvals.
  - Member must be enrolled in Case Management prior to, during and following an approved RTC stay.
  - Member must complete consent form. If member withdraws consent, coverage of inpatient RTC care will terminate the same day.

Intensity Modulated Radiation Therapy (IMRT)

- The prior approval requirement for IMRT services related to the treatment of anal cancer is no longer required.

Privacy

Remove Protected Health Information when submitting Explanation of Benefits

Providers are reminded to black out any Protected Health Information (PHI) of those who are not the patient or subscriber on the claim when submitting Explanation of Benefits (EOB) and payment listings with adjustment requests or claim prints (CMS-1500 or UB-04).

This applies regardless whether the payer listed on the EOB is Blue Cross Blue Shield of North Dakota (BCBSND) or another entity. Not blacking out this information is a violation of the federal Health Insurance Portability and Accountability Act (HIPPA). Doing this will assist BCBSND in the timely review of claims and claim adjustments.

Additional information regarding claims filing can be found at www.BCBSND.com/web/providers/services.

Provider Webinars

Blue Cross Blue Shield of North Dakota (BCBSND) hosts regular webinars for providers. For more information on how to register, please review the "Upcoming Webinars" on the Provider Webinars page of the BCBSND website: www.BCBSND.com/web/providers/provider-webinars.

Claims submission tips

January webinar

When: Thursday, January 21, 2016
12:15 – 1 p.m. Central

Topic: Provide tips on how to submit claims to ensure more efficient processing and avoid claims being returned.

Audience: North Dakota providers that submit claims.

Agenda:

- Overview of claim submission tips

Credentialing

February webinar

When: Thursday, February 18, 2016
12:15 – 1 p.m. Central

Topic: BCBSND's URAC accreditation has led to changes that affect credentialing and re-credentialing.

There are also exciting updates to the information and resources available on www.BCBSND.com that will help to assist all providers and credentialing staff in this process.

Audience: Anyone with responsibilities related to credentialing activity with BCBSND.

Agenda:

- Overview of credentialing application and contract process.
- Reminders/updates to credentialing and re-credentialing.
- Navigation of www.BCBSND.com provider webpage/online resources.

Coordination of benefits

March webinar

When: Thursday, March 17, 2016
12:15 – 1 p.m. Central

More details on this webinar will be available in the March issue of *HealthCare News*.

HealthCare News is published as a service to health care providers.

Please send all written inquiries to:

Provider Service
Blue Cross Blue Shield
of North Dakota
4510 13th Avenue S.
Fargo, ND 58121

Provider Service

800-368-2312
701-282-1090

8 a.m.– 4:30 p.m. CST
Monday, Tuesday,
Thursday, Friday

10 a.m.– 4:30 p.m. CST
Wednesday

FEP

800-548-4026
701-282-1468

8 a.m.– 4:30 p.m. CST
Monday through Friday

Case Management

800-336-2488
701-277-2100
Fax: 701-277-2253

8 a.m.– 4:30 p.m. CST
Monday through Friday

THOR
The Healthcare Online Resource

Welcome to THOR (The Healthcare Online Resource)

THOR is a self-service website that allows providers, payers and other professionals secure access 24/7 to information regarding claims, patients and a wide range of electronic services to help do business faster, more accurately and at less cost. Register online at www.bcbsnd.com/providers.

THOR provides secure access to the following functions and more:

- Submit professional claims online and receive payment information within seconds.
- View claim status and submit claim adjustments.
- Correct claims electronically in a real-time environment.
- Verify eligibility, benefits and coverage information.
- Check deductible and out-of-pocket status.
- Create, update and view referrals and admission notifications.
- Receive your weekly remittances electronically.

E-Services offered: Bulletin Board, Chiropractic Fee Schedule, Claim Inquiry, Claim Adjustment, Claim Correction, Electronic Payment Listing, Membership, Injectables/Other Pharmacy Fee Schedule, Physician Payment Schedule, Preauthorization and Referral, Provider Data Exchange, Real Time Claims Submission and Provider Directory.

Call Application Support Services at 800-544-THOR (8467) or e-mail thor.support@thor.org for a demonstration or training on any of the THOR applications.