



Welcome to the BlueSpeak eNewsletter

BlueSpeak is published three times a year as a service to our valued Blue Cross and Blue Shield of Kansas City (Blue KC) network providers.

You can view a PDF copy via a link on the Blue KC web portal, or you can receive the newsletter via email. To receive an emailed copy, please send your current email address to BlueSpeak@BlueKC.com.

BlueCard Pre-Authorization/Pre-Certification Provider Requirement

Effective July 1, 2014 the Blue Cross and Blue Shield Association is requiring all participating providers to obtain Pre-certifications and Pre-authorizations for inpatient facility services. In instances where Pre-certification and Pre-authorization is required, Covered Individuals will be held harmless when Pre-Authorization/Pre-Certification is not received.

This initiative is proposing a shift from member to provider financial responsibility for pre-certification/pre-authorization services rendered from participating providers for inpatient facility services only.

Blue Cross and Blue Shield of Illinois (BCBSIL): New Fax Process to Request Hospital Length of Stay Benefit Extensions for BCBSIL PPO Members

Effective March 3, 2014 Blue Cross and Blue Shield of Illinois (BCBSIL) implemented a new fax process for submitting clinical information to support length of stay benefit extension requests for BCBSIL PPO members. The new fax process replaces the previous method of submitting clinical information to BCBSIL via voicemail.

Requests for length of stay benefit extensions for BCBSIL PPO members may be initiated by faxing clinical information prior to the new authorization date. The information may be transmitted via your electronic medical record system, if applicable. **The centralized fax number for BCBSIL Utilization Management is 312-946-3985.**

An approval letter will be mailed to provide notification of benefit authorization. If needed, the hospital representative may call BCBSIL Medical Management Customer Service at 800-572-3089 for status of the clinical review and determination. BCBSIL will continue to make outbound notification calls to facilities to help expedite transition of members moving to less intensive treatment settings. In the

event of an adverse benefit determination, notification will be made by phone within one business day of receipt of clinical information.

Please note that there are no changes to the current benefit preauthorization process for acute hospital inpatient admissions, which may be initiated by calling the number on the back of the member's ID card.

Please note that the fact that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

Healthier Generation Benefit

Blue KC is working with registered dietitians through the pilot program, Healthier Generation Benefit, to help kids and their parents learn healthy eating habits and focus on achieving healthy weight during childhood and beyond.

Benefits will pay at 100 percent of the allowable when received through an in-network provider. If you employ a dietitian in your practice, contact your Provider Relations Representative to have him or her added to your group. Please provide the name, NPI, license number and expiration date.

Here are three options to help patients find a registered dietitian. Please use these options as a resource or refer a dietitian who works with your practice.

[View Registered Dietician Locations](#)

HEDIS Spotlight

Every year Blue KC submits a standardized set of performance measures, the Healthcare Effectiveness Data Information Set (HEDIS), to the National Committee for Quality Assurance (NCQA). NCQA's Committee on Performance Measurement (CPM) gives the public information to reliably compare the performance of managed health plans. Blue KC encourages providers to pay close attention to these measures and set goals to improve them.

Adult BMI Assessment (ABA)

This measure includes the percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year. Height and weight alone are not acceptable. The calculated BMI must appear in the chart. Appropriate use of diagnosis codes V85 thru V85.45 will result in administrative compliance and negate the need to review medical records.

<http://www.guideline.gov/content.aspx?id=46240&search=bmi+monitoring>

Childhood Immunization Status

The Childhood Immunization Status measure assesses the percentage of children two years of age who had the CDC recommended childhood immunizations before their second birthday (see below). One immunization that frequently does not end up being administratively compliant through claims data, and thus requires medical record review, is the Rotavirus vaccination. Since there are two separate vaccines for Rotavirus, it is important to use the appropriate codes for each to ensure administrative compliance. Rotarix (RV1) is the two dose vaccine and should be coded using CPT

90681. RotaTeq (RV5) is the three dose vaccine and should be coded using CPT 90680. If a combination of the two vaccines is given, a three dose schedule is required for compliance. Both Rotavirus vaccines must be given between 42 days and two years of age, and each dose should be on a different date of service. Following these simple steps will help negate the need for medical record review.

In the event that medical record review is required for a given member, specifying the Brand name for the Rotavirus vaccine used is key for compliance; if the Brand name is not listed the three dose schedule must be assumed during our review. Also, as a friendly reminder, make sure to document childhood vaccinations from previous providers (including Hepatitis B given at birth) on the child's immunization record. These two steps will make the medical record review process more efficient if it ends up being necessary.

For the CDC recommended immunizations see:

<http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf>

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

This measure is focused on the percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- **BMI percentile documentation**

Appropriate use of diagnosis codes V85.5 thru V85.54 will result in compliance via claim data and negate the need to do medical record reviews.

If chart review is required, documentation of height, weight and BMI percentile must be from the same data source.

BMI percentile or BMI percentile plotted on an age-growth chart are both acceptable.

Documentation for patients under 16 should be expressed as a percentile, for patients 16 through 17 documentation of a BMI value is acceptable.

- **Counseling for nutrition**

Appropriate use of the following codes will result in compliance via claim data and negate the need to review medical records. (97802, 97803, 97804, G0270, G0271, G0447, S9449, S9452, S9470 and V65.3)

If chart review is required, documentation must include a note indicating the date and at least one of the following.

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
 - Checklist indicating nutrition was addressed.
 - Counseling or referral for nutrition education.
 - Member received educational materials on nutrition during a face to face visit.
 - Anticipatory guidance for nutrition.
 - Weight or obesity counseling.
- **Counseling for physical activity**
Appropriate use of the following codes will result in compliance via claim data and negate the need

to review medical records. (G0447, S9451 and V65.41) If chart review is required, documentation must include a note indicating the date and at least one of the following

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face to face visit.
- Anticipatory guidance for physical activity.
- Weight or obesity counseling.

[Benefits/Harms of Implementing the Guideline Recommendations](#)

Member Rights and Responsibilities

Blue KC members have certain rights and responsibilities as follows:

Member Rights and Responsibilities—*Blue-Care Open Access*

You have the right to:

- Receive considerate and courteous care with respect for personal privacy, dignity and confidentiality.
- Receive information about your HMO services, utilization review policies, clinical guidelines, and Member rights and responsibilities.
- Choose a primary care physician (PCP) from those available to coordinate your healthcare, and change your PCP as defined in your contract.
- Receive all medically necessary and appropriate care or services from your PCP or a healthcare professional in the Open Access Network, as well as access for emergency services 24 hours a day, 7 days a week.
- Receive information and diagnosis in clear and understandable terms, and ask questions to ensure you understand what you are told by your physician and other medical personnel.
- Receive full information about treatment options, regardless of cost, from providers and practitioners.
- Participate with Providers and practitioners in making decisions about your care, including accepting and refusing medical or surgical treatments.
- Give informed consent to treatment and make advance treatment directives, including the right to name a surrogate decision maker in the event you cannot participate in decision making.
- Discuss your medical records with your PCP and have health records kept confidential, except when disclosure is required by law or to further your treatment.
- Be provided with information about your HMO managed healthcare plan, its services and the practitioners providing care.
- Communicate any concerns with your HMO managed care plan regarding care or services you received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if you are not satisfied.

You have the responsibility to:

- Respect the dignity of other members and those who provide care and services through your HMO managed healthcare plan.
- Coordinate all healthcare services through your physician or a specialist in the BCBSKC network.
- Ask questions of your PCP or treating specialist physician or treatment provider until you fully understand the care you are receiving.
- Follow the advice of your healthcare practitioner, including those regarding medications. Comply with all treatment follow-up plans, and be aware of the medical consequences of not following instructions.
- Communicate openly and honestly with your treatment provider regarding your medical history, health conditions, and the care you receive.
- Keep all scheduled healthcare appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.
- Know how to use the services of your HMO managed healthcare plan properly.

Member Rights and Responsibilities—*Preferred-Care Blue, Preferred-Care*

You have the right to:

- Receive considerate and courteous care with respect for personal privacy, dignity and confidentiality.
- Have a candid discussion of medically necessary and appropriate treatment options or services for your condition from any participating physician, regardless of cost or benefit.
- Receive medically necessary and appropriate care or services from any participating physician or other participating healthcare provider from those available as listed in your managed care plan directory or from any nonparticipating physician or other healthcare provider.
- Receive information and diagnosis in clear and understandable terms, and ask questions to ensure you understand what you are told by your physician and other medical personnel.
- Participate with Providers and practitioners in making decisions about your healthcare, including accepting and refusing medical or surgical treatments.
- Give informed consent to treatment and make advance treatment directives, including the right to name a surrogate decision maker in the event you cannot participate in decision making.
- Discuss your medical records with your physician and have health records kept confidential, except when disclosure is required by law or to further your treatment.
- Be provided with information about your PPO managed healthcare plan, its services and the practitioners and providers providing care, as well as have the opportunity to make recommendations about your rights and responsibilities.
- Communicate any concerns with your PPO managed healthcare plan regarding care or services you received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if you are not satisfied.

You have the responsibility to:

- Respect the dignity of other members and those who provide care and services through your PPO managed healthcare plan.
- Ask questions of your treatment physician or treatment provider until you fully understand the care you are receiving and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the mutually agreed upon plans and instructions for care that you have discussed with your healthcare practitioner, including those regarding medications.
- Comply with all treatment follow-up plans, and be aware of the medical consequences of not following instructions.
- Communicate openly and honestly with your treatment provider regarding your medical history, health conditions, and the care you receive.
- Keep all scheduled healthcare appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.
- Know how to use the services of your PPO managed healthcare plan properly.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

New Member ID Card

The new member ID cards (sample below) will be issued with a 2-D bar code reflected on the back of the card versus the magnetic strip used with swipe card entry. If your office is using the new card to check eligibility, you will need to manually input the information into either Blue KC's Provider web portal or the Availity portal.



New Mobile App

Introducing Blue KC's free mobile app, Live Blue™ designed to help users find healthy locations right around the corner.

Use it to check-in and find nearby parks and trails, gyms, walks and runs, Live Blue KC locations, B-cycle B-stations, farmers markets and more in the Kansas City area. This is a great tool to provide patients access to information on a healthy and active lifestyle. Please encourage your patients who are Blue KC members to visit the iTunes Mobile App Store to download it now!

Provider Alert Tool

Blue KC has developed a Provider Alert tool in an effort to assist you with the coordination and documentation of high-risk members.

The objective of the Provider Alert tool is to bring to your attention diagnosis and coding elements most frequently overlooked. The Provider Alert includes a summary of clinical history (procedures, labs, and diagnoses), medication history (prescribed, filled, quantity, refills) and targeted conditions that require your verification for persisting and suspecting conditions. Persisting conditions have been previously diagnosed and at least one valid claim has been submitted in the member's encounter history. Suspecting conditions indicate the member has clinical data that are likely to be associated with the presence of the condition such as prescriptions, CPT codes, or claims. Subsequently, suspected conditions do not have a valid claim in the member's encounter history to support the condition.

As part of a scheduled office visit, please confirm the presence of these conditions and indicate the appropriate diagnosis in the patient's chart and on the claim filed to Blue KC. In an effort to assist you with patient outreach, Blue KC has provided the specific contact information.

Important Considerations:

- Health status should be assessed at face-to-face visit in conjunction with any new visit.
- Report all diagnoses (not only primary diagnosis) that impact the patient's evaluation, care and treatment.
- All conditions should be documented in the medical record.
- Medical record must support codes reported on the claim or encounter form.
- Document and code to the highest level of specificity/certainty.

If you have questions regarding the Provider Alert tool, please contact your provider relations representative.

United Auto Workers-Medicare Advantage PPO

Members of the UAW Retiree Medical Benefits Trust living in Missouri may choose medical and surgical coverage through Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO.

Members of the UAW Retiree Medical Benefits Trust who reside in Missouri who choose Medicare Plus Blue Group PPO for 2014 will have new ID cards reflecting alpha prefix XYL for Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO. UAW Trust Medicare Advantage PPO members will have medical and surgical benefits as well as coverage for hearing, routine vision exams provided by VSP and the SilverSneakers® Fitness Program.

Member Cost Sharing

Members who reside in Missouri can receive medical benefits from any provider in the United States and its territories, regardless of their network affiliation and pay all cost-sharing as if the provider or facility were in the plan's network. Members pay the same cost share for services from both in-network and out-of-network providers.

Provider Reimbursement

If you are not part of a Blue Medicare Advantage PPO network but participate with Medicare and you treat a Medicare Plus Blue member, you are entitled to payment up to the original Medicare allowed amount for covered services. This includes services for urgent or emergency care. Cost-sharing amounts are defined by the benefit policies of the member's plan. If you do not accept any form of Medicare reimbursement, you have the right to refuse non-emergency services to this patient.

Eligibility

You can identify a member's coverage plan by viewing his or her new ID card. To verify benefits and eligibility, call BlueCard® Eligibility at 1-800-676-BLUE (2583) and provide the member's alpha prefix located on the ID card. A copy of a sample ID card is included. Information obtained regarding member eligibility is not a guarantee or a promise of payment. Payment determination only occurs after the claim is processed according to the member's benefits.

While member servicing will be centralized in Michigan, you should still use your normal claim submission method with your local plan. Your local plan will then use the BlueCard® Program to forward the claims to BCBSM.

Utilization Management—How It Operates

Blue KC's Medical Management Division makes utilization of services decisions about our member's healthcare needs based on the medical appropriateness of the care and service. Blue KC does not reward its Medical Management staff for issuing denial of coverage decisions and there is no financial incentive offered to Medical Management staff to make decisions that would encourage inappropriate utilization of services. Our goal is to identify and promote appropriate usage and cost-effective healthcare resources to ensure quality healthcare services are delivered to our members.

ICD-10 Update

Learn more through the Provider Relations Seminars scheduled at various locations through the area. [View the registration](#) form for more information.

1500 Claim Form

The National Uniform Claim Committee (NUCC) has approved an update to the current HCFA 1500 paper claim. This change only impacts the filing of claims using a HCFA 1500. Claims filed electronically will not be impacted in any way. If there are situations in which you need to file a paper claim, please be aware of the following details below regarding the revised "HCFA 1500" (version 2/12).

Beginning April 1, 2014, Blue KC accepted and processed paper claims submitted only on the revised HCFA 1500 claim form (version 02/12). Any paper claims received on the old version 08/05 claim form will be returned.

Please keep in mind that in order to improve service, reduce errors and expedite the claims payment process, **Blue KC encourages you to file all claims electronically.**

Corrected Electronic Professional Claims (837P)

Guidelines on accepting corrected electronic professional claims (837P) are included below. All of the following information (data elements) must be provided on the electronic claim:

[View Guidelines](#)

CONTACT US

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