Behavioral health to see ’16 changes

This information was communicated in a letter in November and is being republished in this newsletter. Effective Jan. 1, Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) and New Directions Behavioral Health (NDBH) will no longer require authorization for most professional outpatient services.

The following outpatient services will be reviewed from the first service in 2016. Outpatient Treatment Request (OTR) forms for these services/codes shall be submitted in the same manner they were submitted before Jan. 1.

• Psychological testing
• Autism services
• Electroconvulsive Therapy (ECT)
• Intensive Outpatient (IOP)
• Partial Hospitalization (PHP)

NDBH will analyze claims data for all behavioral health providers in the BCBSKS network. As we identify variances in practice patterns, we will share information and educational materials with you. The goal is to ensure appropriate utilization and reduce outlier variation while supporting quality outcomes. Utilization will be compared based upon the mix of patient and case characteristics.

Please see CHANGES, page 3
**Pharmaceutical Formulary Update**

Prime Therapeutics updates the Blue Cross and Blue Shield of Kansas formulary (preferred medication list) on a quarterly basis. Please refer to the link below when prescribing or dispensing medications for your BCBSKS patients. Coverage is subject to the limitations of the member’s individual plan.

A searchable version of the formulary is available at:

► https://www.myprime.com/content/dam/prime/memberportal/forms/2015/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSPREFDRUG/KS_Alpha_Drug_List.pdf

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**Listen well for IVR changes**

Blue Cross and Blue Shield of Kansas customer service recently made changes to the Interactive Voice Response (IVR) System. As a result, providers are increasingly opting out of the IVR. Opting out connects the caller with our operators, which can further delay or misdirect your call. Carefully listen to the new menu BEFORE making a selection. This will ensure timely handling of your inquiry AND that you are connected with a specialist to best serve your needs.

Customer service contact information is available at http://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/BCBSKS-professional-contact-page.pdf OR refer to the back of the patient’s identification card.

As always, Availity continues to be the preferred method for obtaining benefits and/or simple claims status information.

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**NCRA benefits set to change**

The National Cooperative Refinery Association (NCRA) was purchased by CHS, Inc.

As a result, all former NCRA benefit plans will be incorporated into the CHS benefit programs effective Jan. 1. CHS will terminate its relationship with Harrington Health effective Dec. 31.

The process for submitting claims won’t be affected by the change.

**BCBSKS encourages all providers to be certain that they are using the appropriate member ID for members in this group when submitting claims.**

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**FEP benefits for 2016 available**

The Federal Employee Program (FEP) group health plan renewed with Blue Cross and Blue Shield of Kansas (BCBSKS) effective Jan. 1.

The 2016 Blue Cross Blue Shield Service Benefit Plan information can be located on the Blue Cross and Blue Shield Federal Employee Program website: https://www.fepblue.org/en/news/2015/09/25/14/38/new-for-2016/ Please review all information for changes.

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**Transition to ICD-10 has been smooth**

Blue Cross and Blue Shield of Kansas (BCBSKS) wants to recognize and congratulate our contracting providers on their hard work and dedication to the implementation and transition from ICD-9 to ICD-10.

The majority of claims BCBSKS has received, processed, and adjudicated from providers with ICD-10 codes have processed without delay.

As a reminder, there are front-end ICD-10 edits in place for BCBSKS claims regarding unspecified laterality diagnoses. Information regarding these edits can be found at http://www.ask-edi.com/icd-10/index.htm.
Changes: Consistency improved with changes

Additional objectives are:

• To establish a partnership with providers to positively impact the member’s experience in receiving outpatient behavioral health services.
• To provide information on practice guidelines to providers.
• To improve the efficiency of outpatient behavioral health services by eliminating most OTRs.
• To identify and connect members with additional support resources.
• To identify and reduce health-care spending that does not improve the outcome.
• To decrease variation in patterns of care not associated with differing clinical outcomes.
• To provide education and solicit feedback to promote alignment in practice patterns.

Effective Jan. 1, providers whose practice patterns vary significantly from their peer group will undergo review based on Medical Necessity Criteria. If such review determines services provided are not medically necessary, providers may be referred for an ongoing review process. Services denied under this review process also may result in recoupment of payment if denied as not medically necessary or not documented. This approach is consistent with how reviews are handled for medical service providers as well.

On behalf of BCBSKS, one way NDBH will review claims is to request treatment records (progress notes) for specific members. When requested, the treatment records should be sent to NDBH within the time allowed. NDBH will not be requesting private psychotherapy notes, which should be separate from the treatment records. Your CAP agreement requires you to provide documentation upon request.

DOCSUMTATION ERRORS

Please refer to the Behavioral Health Provider Manual for the complete list of documentation requirements. Below are a few that are commonly missed:

• Start and stop times
  ○ Not listing start and stop times with duration — Most CPT codes are time sensitive. It is good practice to document the face-to-face time and duration you spend with the members.

• Treatment planning
  ○ Indicate if you made changes to the treatment plan goals or if the goals remain unchanged.

• Follow up appointments
  ○ It is important to indicate when the next appointment is and, as appropriate, any discharge planning.

• Member’s presentation
  ○ Reflect the member’s presentation in each face-to-face encounter note. This should contain objective and subjective documentation of the patient’s presentation.

• Diagnosis
  ○ Be precise. Update as appropriate.

• Documentation
  ○ Documentation must match the requirements of the CPT code. Please refer to the most current CPT code book for specific requirements. Also, at www.ndbh.com, provider tab, there is documentation on how to determine what codes are most appropriate.

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Questions for cardiac care

As the nation increasingly focuses on ways to provide safer, higher-quality care, the overuse of health care resources is a concern. Many experts agree health care delivered in the U.S. is too wasteful, with some stating that as much as 30 percent of care is duplicative or unnecessary.

It is urgent that physicians and patients work together and have conversations about wise treatment decisions.

Choosing Wisely — an initiative of the American Board of Internal Medicine (ABIM) Foundation to help physicians and patients engage in conversations about overuse of tests and procedures and support physician efforts to help patients make smart and effective care choices — is part of a multi-year effort to help physicians be better stewards of finite health care resources.

As part of the initiative, participating specialty societies have created lists such as the following created by the American College of Cardiology (ACC).

The ACC is a nonprofit medical society of 40,000 physicians, surgeons, nurses, physician assistants, pharmacists and practice managers, and bestows credentials upon cardiovascular specialists who meet its stringent qualifications.

For more information on the initiative, visit www.choosingwisely.org.
For more information on the ACC, visit www.cardiosource.org/ACC.
For more information on the ABIM Foundation, visit www.abimfoundation.org.

1. Don’t perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.

Asymptomatic, low-risk patients account for up to 45 percent of unnecessary “screening.” Testing should be performed only when the following findings are present: diabetes in patients older than 40-years-old; peripheral arterial disease; or greater than 2 percent yearly risk for coronary heart disease events.

2. Don’t perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.

Performing stress cardiac imaging or advanced non-invasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one-to-two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures and excess radiation exposure without any proven impact on patients’ outcomes. An exception to this rule would be for patients more than five years after a bypass operation.

3. Don’t perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Non-invasive testing is not useful for patients undergoing low-risk non-cardiac surgery (e.g., cataract removal). These types of tests do not change the patient’s clinical management or outcomes and will result in increased costs.

4. Don’t perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.

Patients with native valve disease usually have years without symptoms before the onset of deterioration. An echocardiogram is not recommended yearly unless there is a change in clinical status.

Source: American College of Cardiology
Choosing Wisely — An initiative of the ABIM Foundation

Three to ponder for surgeons

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As part of the initiative, participating specialty societies have created lists such as the following created by the American College of Surgeons (ACS). The ACS is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the quality of care for surgical patients. The ACS is dedicated to the ethical and competent practice of surgery.

For more information on the initiative, visit www.choosingwisely.org. For more information on the ACS, visit www.facs.org. For more information on the ABIM Foundation, visit www.abimfoundation.org.

1. Don’t perform axillary lymph node dissection for clinical stages I and II breast cancer with clinically negative lymph nodes without attempting sentinel node biopsy.

   Sentinel node biopsy is proven effective at staging the axilla for positive lymph nodes and is proven to have fewer short and long term side effects, and in particular is associated with a markedly lower risk of lymphedema (permanent arm swelling). When the sentinel lymph node(s) are negative for cancer, no axillary dissection should be performed.

   When one or two sentinel nodes are involved with cancer that is not extensive in the node, the patient received breast conserving surgery and is planning to receive whole breast radiation and stage appropriate systemic therapy, axillary node dissection should not be performed.

2. Avoid the routine use of “whole-body” diagnostic computed tomography (CT) scanning in patients with minor or single system trauma.

   Aggressive use of “whole-body” CT scanning improves early diagnosis of injury and may even positively impact survival in polytrauma patients. However, the significance of radiation exposure as well as costs associated with these studies must be considered, especially in patients with low energy mechanisms of injury and absent physical examination findings consistent with major trauma.

3. Don’t do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.

   Although CT is accurate in the evaluation of suspected appendicitis in the pediatric population, ultrasound is the preferred initial consideration for imaging examination in children. If the results of the ultrasound exam are equivocal, it may be followed by CT. This approach is cost-effective, reduces potential radiation risks and has excellent accuracy, with reported sensitivity and specificity of 94 percent in experienced hands. Recognizing that expertise may vary, strategies including improving diagnostic expertise in community based ultrasound and the development of evidence-based clinical decision rules are realistic goals in improving diagnosis without the use of CT scan.

Source: American College of Surgeons
Blue Cross and Blue Shield of Kansas is updating components of the claims processing system. Until final implementation, some claims may not process in accordance with medical policy.

If a claim has not processed according to the policy, please submit a request for retrospective review as outlined in Policy Memo No. 1 for Professional Providers and the Policies and Procedures for Institutional Providers.

In network for Solutions

A reminder all referrals for Blue Cross and Blue Shield of Kansas (BCBSKS) Solutions Inc. members need to be to other providers in the BCBSKS network unless no such provider is contracting. Solutions members do not have coverage for services rendered out of network. Johnson and Wyandotte counties are excluded from the BCBSKS network. Contact Customer Service at (800) 432-3990 or (785) 291-4180 to verify a provider is in network.

Web Changes — Medical Policy

Since the publication of Blue Shield Reports S-4-15, the following new or revised medical policies have been posted to our website at:

http://www.bcbsks.com/CustomerService/Providers/MedicalPolicies/

- Afrezza (human insulin)
- Antidepressant Agents
- Antihypertensive Medications
- Aqueous Shunts and Stents for Glaucoma
- Automated Percutaneous and Endoscopic Discectomy
- Automated Point-of-Care Devices for Nerve Conduction Testing
- Bone Mineral Density Studies
- Cardiac Rehabilitation in the Outpatient Setting
- Computed Tomography (CT) to Detect Coronary Artery Calcification
- Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis
- Facet Joint Denervation (Cervical and Lumbar)
- Gene Expression Profiling for Uveal Melanoma
- Home Prothrombin Time Monitoring
- Human Growth Hormone
- Image-Guided Minimally Invasive Lumbar Decompression (IG-MLD) for Spinal Stenosis
- Interspinous Fixation (Fusion) Devices
- Miscellaneous Genetic and Molecular Diagnostic Tests
- Multiple Sclerosis Agents
- Noninvasive Prenatal Testing for Fetal Aneuploidies and Microdeletions Using Cell-Free Fetal DNA
- Off-Label, Approved Orphan, and Expanded Access (Compassionate Use) Drugs
- Oral Immunotherapy Agents (Grastek®, Oralair®, Ragwitek™)
- Positron Emission Tomography (PET) Scanning: Oncologic Applications
- Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis
- Regional Nerve Block and General Anesthesia
- Scanning Computerized Ophthalmic Diagnostic Imaging Devices
- Testing for Vitamin D Deficiency
- Treatment of Tinnitus
- Ultraviolet Light Therapy for Skin Conditions
- Urea Cycle Disorders
- Vagus Nerve Stimulation
- Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon