MSMS Reimbursement Advocate Alert
MICHIGAN STATE MEDICAL SOCIETY

Blue Cross taking steps to improve its drug prior authorization process

In 2016, Public Act 30 of 2013 will amend the health insurance code by adding a standard process for prior authorizations. The standard process includes:

1. Updated requirements for turnaround times and additional information -- effective **Jan. 1, 2016**
2. A new standardized paper prior authorization form -- effective **July 1, 2016**

The original purpose of this law required the creation of a workgroup to standardize the way doctors and insurers request and receive prior authorizations for prescription drug benefits. Generally, prior authorization requests for medications involve one of the following:

- A brand-name product that may or may not have a generic equivalent.
- A drug that a patient has taken for years but now requires annual reauthorization.

Based on provider and insurer feedback, the State of Michigan's workgroup incorporated the suggested standards and the basic requirements for a paper drug prior authorization form.

As a result of the new Public Act requirements, the following standards will be in effect in 2016 for handling prescription drug benefit prior authorizations:

Handling 2016 prior authorization requirements

Beginning Jan. 1, 2016, Public Act 30 of 2013 defines prior authorization requirements for expedited and standard requests. However, this law doesn't apply to medical drug reviews.

- **Expedited requests:**
  - Exist when the prescriber certifies a standard review will seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. In these cases, the insurers will expedite drug prior authorization requests within 72 hours.**
  - New for 2016: If additional information from the prescriber isn't sent or received within five days of the original request, then the prior authorization is considered void.
- **Standard requests:**
  - Are all other non-expedited drug requests. In these cases, the insurer will respond within 15 days with an approval, a denial or a request for additional information from the prescriber.**
  - New for 2016: If additional information from the prescriber isn't sent or received within 21 days of the original request, the prior authorization is considered void.

****Note:** Insurers may request additional information or clarification to ensure that prior authorization requests are processed as accurately and efficiently as possible.

Beginning July 1, 2016, Public Act 30 of 2013 sets standards for prior authorization requests.

- Insurers will be required to use a new standard paper prior authorization form.
  - These new standards don't apply to an insurer's electronic prior authorization forms. This includes an insurer's prior authorization system that uses a Web page, Web page portal or similar Web-based system.

More information will be communicated about these requirements in spring 2016.

Blue Cross electronic prior authorization forms available

Currently, Blue Cross Blue Shield of Michigan makes prior authorization forms available electronically through **bcbsm.com** for commercial members. The use of this form applies to most lines of business, including self-funded Employee Retirement Income and Security Act groups.***

This Web-based system offers many advantages to health care providers:

- Ability to request prior authorizations 24 hours a day, seven days a week at their convenience
- Convenience of starting a prior authorization, saving it if interrupted and then returning to it later without losing any entered data
- Elimination of the need to wait on hold, make multiple calls or deal with multiple faxes relating to drug prior authorization requests
- The ability of prescribers to look up the status of a drug prior authorization request

How to submit an electronic prior authorization form

Go to bcbsm.com:

1. Log in to Provider Secured Services.
2. Click Medication Prior Authorization.
3. Enter the drug requested in Drug Search Form.
4. Click the drug name.
5. Enter patient and physician information.
6. Answer a few questions related to the drug selected.
7. Click Submit. (Once the form is submitted, you'll receive a tracking number for future reference.)

The request is forwarded to the prior authorization processing system, where it's placed in the queue for review by a member of the Blue Cross clinical staff. The requestor can go online to check the status of a request at any time.

Exclusions

***The law doesn't apply to Medicare Part D members or the Federal Employee Program®. Go to www.fepblue.org for more information about its drug prior authorization process.

If you receive questions from our members, please instruct them to contact Blue Cross Customer Service by calling the number on the back of their ID cards. If you have any questions about our pharmacy programs, call the Pharmacy Services Clinical Help Desk at 1-800-437-3803 and select Option 1.

New resource offers tips on how to meet HEDIS® standards

Blue Cross Blue Shield of Michigan and Blue Care Network continuously strive to improve the quality of care for your patients and our members.

Understanding the standards measured by the Healthcare Effectiveness Data and Information Set can help improve quality of care.

BCBSM developed a set of tip cards to help you improve medical record documentation, the Centers for Medicare & Medicaid star ratings and your HEDIS scores. Each card includes a HEDIS** measure description, associated medical record documentation requirements and performance improvement tips.

If you'd like to receive a set of Blue Cross and BCN HEDIS tip cards, please email your request to Laurie Latvis at llatvis@bcbsm.com.

As a reminder, BCBSM encourages providers to do the following:

- Help patients stay healthy through preventive screenings, tests and vaccinations, as recommended by HEDIS measures.
- Manage and document all acute and chronic patient conditions appropriately.
- Ensure that services provided and diagnoses are documented in the medical record.
- Submit accurate and timely claims for every office visit.

**HEDIS is a registered trademark of the National Committee for Quality Assurance.

Automated system to improve processing of replacement and void claims will be rolled out to professional providers

In September 2015, Blue Cross Blue Shield of Michigan implemented an automated process to improve the processing of replacement and void facility claims. BCBSM plans to implement this process for professional claims, including Federal Employee Program○ claims, by the end of first quarter 2016.

As BCBSM prepares for this change, they encourage professional providers to follow these steps when submitting electronic replacement or void 837 claims or CMS-1500 paper claims, effective immediately:

1. Include the proper claim frequency code in the 837 file to indicate that the claim is an adjustment of a previously approved or denied claim. Enter one of the following claim frequency codes in the CLM05-3 segment of loop 2300. For paper claims, these values should be reported in field 22 on the CMS-1500 form.
   Type of claim ... Claim frequency code
   Replacement of prior claim ... 7
   Voided or canceled claim ... 8
2. In the REF*F8 segment of loop 2300, include the 14 or 17 character internal claim number that was returned on the original claim. For paper claims, these values should be reported in field 22 on the CMS-1500 form.

The following reporting requirements apply to both professional and facility replacement and void claims:

- In utilizing the Claim Frequency Code 7 - Replacement - the payer is to operate on the principle that this voids the original bill, and that the information present on this bill represents a complete replacement of the previously issued bill.
- In utilizing the Claim Frequency Code 8 - Void/Cancel reflects the elimination in its entirety of a previously submitted bill for a specific Provider, Patient, Payer, Insured and "Statement Covers Period." The provider may wish to follow a Void Bill with a bill containing the correct information when a payer is unable to process a replacement to a prior claim. The appropriate frequency code must be used when submitting the new bill.
- Report the same provider NPI and billing information that was reported on the original claim.
- Use the contract number of the original, finalized claim.

Note: Don't report a replacement or void claim until your original claim has been finalized.

Want more information about submitting replacement and void facility claims?

For more details about reporting adjusted facility claims, see the September Record article.

Questions?

- If you have questions about submitting an 837 health care claim, contact the Electronic Data Interchange help desk at 1-800-542-0945.
- For assistance with reporting this information using your practice management system, contact your software vendor or clearinghouse.
- If you have any additional questions call Provider Inquiry.
- Any additional concerns that can't be addressed with Provider Inquiry, contact your provider consultant.

Clarification: Professional providers will get new message regarding NDC daily quantity maximums

Articles in the September and December Record should have stated that starting January 2016, **professional** providers, not all providers, will receive a new message when a submitted National Drug Code reaches or

exceeds its recommended daily quantity maximum.

The update doesn't apply to providers that don't submit claims using NDC, such as outpatient hospitals.

For the updated version of the December Record article about the new NDC message, click here.

2016 Fee Schedules

The revised 2016 Medicare Physician Fee Schedules (MPFS) are now available on the WPS GHA website. The fee schedules, effective January 1, 2016, are posted by state and locality. If you are unsure of the locality for your location, please see the Fee Schedule Localities web page.

Supporting End of Life Care

March 16, 2016
8:45 am - 4:15 pm
MSMS Headquarters, East Lansing

This conference will provide insight on the complexities of end-of-life care, and guidance on how to ensure the best quality of life for your patients.

- Explain best practices in communication and outreach strategies.
- Summarize the Physician's responsibility as the end of life draws near.
- Define the Patient Self Determination Act and other ethical and legal issues.
- Apply Advance Care Planning and implementation practices.
- Describe recommendations to assist in maintaining the best quality of life for the patient.
- Compare the Gunderson Model of end-of-life care to other models.

Full Details & Registration >>

Michigan State Medical Society
120 W. Saginaw St.
East Lansing, MI 48823

Phone: 517-337-1351
Email: **msms@msms.org**
Website: **www.msms.org**

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