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**Network Update** is produced bi-monthly by Blue Cross and Blue Shield of Georgia (BCBSGa) for their health care professionals. Articles and photographs published in **Network Update** are the sole property of BCBSGa. BCBSGa welcomes letters to the editor, requests for additional issues, and suggestions for article topics.

Address letters to the editor to:

**Blue Cross and Blue Shield of Georgia**  
NU Editor - Jennifer Louthan  
MC: GAG005-0001  
3350 Peachtree Road NE  
Atlanta, GA 30326  
404-682-9399

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Unless otherwise noted, the information contained in the **Network Update** applies to Blue Cross and Blue Shield of Georgia’s commercial plans and programs in Georgia.

Please note: All policies are subject to the terms, conditions and limitations of the member’s plan or program.

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Administration

Practitioners' rights during the credentialing process

The credentialing process must be completed before a practitioner begins seeing enrollees and enters into a contractual relationship with a health care insurer or HMO. As part of BCBSGa’s credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:
- Review information submitted to support their credentialing application.
- Correct erroneous information regarding a credentialing application.
- Be notified of the status of credentialing or re-credentialing applications.

BCBSGa encourages practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and patients' claims.
Statement regarding the delay of the ICD-10 compliance date

On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law. The bill includes a provision that effectively delays the implementation of ICD-10 diagnosis and inpatient procedure codes for at least one year.

BCBSGa is committed to meeting the requirements of all mandates, including the implementation of the ICD-10 code set. We are currently assessing the impact of this change. Our plans will continue to be updated as we receive more information about the ICD-10 implementation date.

BCBSGa is able to accept the revised CMS-1500 claim form (incorporating changes that will accommodate ICD-10) that became effective on April 1, 2014. No ICD-10 codes should be submitted on claims, however, until the mandated compliance date. Note that the new version of the form is not required, and BCBSGa will be able to accept and process claims submitted using either version of the form.

BCBSGa will continue to work to help ensure that our systems, supporting business processes, policies and procedures successfully meet the implementation standards and deadlines without interruption to day-to-day business practices. We will be capable of accepting and processing ICD-10 diagnosis and inpatient procedure codes on the mandated compliance date.

The final Mental Health Parity Rule released

The federal government released the final Mental Health Parity Rule on November 13, 2013. This replaces the temporary rule from February 2010. As a result, BCBSGa will apply this final rule to its new or renewing benefit plans, effective on or after July 1, 2014. The intent of the rule is to ensure that patient access to mental health or substance abuse services is the same access to medical services.

Note: The Affordable Care Act (ACA) or health care reform law expanded the mental health parity rule to affect small group and individual plans. Grandfathered small group are still exempt from the law and benefit plans (small group or individual) purchased under Medicare. For more on the rule please click here.

New 1500 Claim Forms should be submitted using appropriate claim software and data element requirements

In June 2013, the National Uniform Claim Committee (NUCC) announced the approval of an updated 1500 Claim Form (version 02/12) that accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3. On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law, and this bill includes a provision that effectively delays the implementation of ICD-10 diagnosis and inpatient procedure codes for at least one year.

BCBSGa continues to accept claims submitted using the updated 1500 Claim Form (version 02/12). Providers should take special care to ensure billing areas utilize claim software that supports the corresponding 1500 Claim Form version submitted to BCBSGa. For example, if you are submitting paper claims on version 02/12 of the 1500 Claim Form, please be sure that your office is using claim software that supports the 02/12 version of the 1500 Claim Form. Claims submitted with mismatched form types and data elements will be rejected. Additionally, please check the alignment of data elements on your paper claims to ensure they are properly aligned in their designated field(s).

Please follow the guidelines set forth by the NUCC for completing the new 1500 Claim Form, or your claim may be rejected. For more information about the revised 1500 Claim Form, please visit the National Uniform Claim Committee website.
Durable Medical Equipment Orthotic and Prosthetic modifier reminder

We would like to remind you of system changes that affect the way Durable Medical Equipment (DME) Orthotic and Prosthetic (O&P) modifiers are processed and paid. These system changes became effective August 1, 2011 and apply to all claims processed on or after that date.

To indicate a Member purchase of DME O&P, use the NU modifier rather than the LL modifier.

Continue to use RR (or equivalent) modifiers for items that can be both purchased or rented.

To indicate a Member rental of DME O&P, use the RR modifier as primary.

Claims submitted without any modifiers will be edited and may be denied.

If you have any questions about this information, please contact your local Network Consultant or call 303-831-2967.

Infusion therapy choice: lower out-of-pocket expenses and convenience for members

To promote member satisfaction and to help advance positive health care outcomes, we are working collaboratively with physicians regarding infusion therapy options available to our members. For our members who require infusion therapy services, out-of-pocket expenses, the place of infusion service, safety, time and convenience are contributing factors that can impact health care quality, value and member satisfaction.

Here’s how you can help. When possible, please consider and share with members the entire range of potential options available regarding infusion therapy. While the hospital is one option, please include alternative locations – such as office or home – when discussing/ordering infusion therapy for members who require these services. In addition, please inform members of any potential self-injection alternatives if appropriate, as members may prefer these convenient and lower-cost options. Referring members who require infusions therapy services to safe, lower-cost settings may result in significant savings in time and out-of-pocket expenses. Members will also appreciate the convenience and the flexibility.

Our members count on their physicians to provide comprehensive information so the members can make informed decisions about their health care choices. Members may have questions about alternate settings in which they can receive their intravenous infusions and costs associated with other aspects of their intravenous infusion therapy. To help members maximize their benefits, we may contact members and their physicians in the near future, informing them of opportunities for quality, lower-cost options for intravenous infusion services.

As always, you should refer members who require intravenous infusions to the location you deem appropriate. However, we encourage you to discuss with our members the options available to get their intravenous infusions safely and conveniently, at a lower out-of-pocket cost.

Clinical Practice and Preventive Health Guidelines available on the web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our

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The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. To access the guidelines, visit the Practice Guidelines page of our provider website.

**Coordination of Care**

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. BCBSGa would like to take this opportunity to stress the importance of communicating with your patient’s other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. BCBSGa urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
   - Diagnosis
   - Treatment plan
   - Referrals
   - Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, BCBSGa has several tools available on the Provider website including a Coordination of Care template and cover letters for both Behavioral Health and other Healthcare Practitioners. In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.

**Important information about Utilization Management**

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member’s coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. BCBSGa medical policies are available on our provider website.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. UM criteria are also available on our website by clicking “Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements” on the left side after you Enter the site.
We work with providers to answer questions about the utilization management process and the authorization of care. Here’s how the process works:

- Call us toll free from 8:00 a.m. – 5:00 p.m. Monday through Friday (except on holidays) for routine calls. For urgent issues, the phone line is available 24/7. For Medicare, Monday through Friday from 8:00 a.m. – 8:00 p.m. Eastern.
- After business hours, you can leave a confidential voicemail message. Please leave your contact information so one of our associates can return your call the next business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID card.

<table>
<thead>
<tr>
<th>To discuss UM Process and Authorizations</th>
<th>To Discuss Peer-to-Peer UM Denials</th>
<th>To Request UM Criteria</th>
<th>TTY/TDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please call the number listed on the back of the member ID card</td>
<td>Please call the number listed on the back of the member ID card</td>
<td>Please call the number listed on the back of the member ID card</td>
<td>711 Or TTY: 800-255-0056(T) Voice: 800-255-0135(V)</td>
</tr>
<tr>
<td>For Medicare:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>866-797-9884 opt 1</td>
<td></td>
<td></td>
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<tr>
<td>866-959-1537 – Fax</td>
<td></td>
<td></td>
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<tr>
<td>888-449-4642 – Fax (for providers who previously used 800-266-3504 or 877-236-5173)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>FEP Members</td>
<td></td>
<td></td>
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<tr>
<td>800-860-2156</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours: 8:00 a.m. – 7:00 p.m. EST</td>
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</tbody>
</table>

For language assistance, members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

**Operating systems upgrade changes**

As we continue to upgrade our internal operating systems, here are some of the key points you may need to know!

The upgrade of our operating systems will occur in several phases. Not all members will be impacted at the same time. Therefore, you may see differences in remittances, EOB’s, and information on the provider portals between members that have and have not been upgraded.

The following information was covered in more detail in the January edition of Network Update. It is critical that you understand this information:

- **Medical records** – A new Bar Code letter will be sent requesting Medical Records to follow a new process. The address to send the Medical Records to is a new address. Requests for Medical Records that do not have a Bar Coded letter attached should follow the existing process.


- **Remittance changes:**
  - All remittance will be cycled for payment each Friday.
  - Format and field revisions
- **EFT** – EFT payment information will be included in voucher and will continue to be available for immediate viewing on ProviderAccess.
- **Overpayment Letters** – *Overpayment letters* will no longer be generated
- **ePortals:**
  - ProviderAccess will temporarily continue to be used to access authorizations and remittances
  - The Availity portal will be used to access Claims Statuses, Eligibility and Benefits, Medical Referral and Preauthorization Inquiry

Additional valuable information that you will need to know:

- **IVR:** Changes in the IVR will occur as the operating systems are upgraded. The prompts and responses may be different.
- **EFT:** Because the EFT is transmitted electronically, and the voucher is sent via mail, it is possible that you will receive the EFT prior to receiving the voucher.
- **PO BOX:** As the member is moved to the upgraded operating system, (you will recognize this has occurred because you will receive the new voucher format), the PO Box that is used for you to submit correspondence and inquiries will be changing. Please use the new PO Box 105370. This PO Box information will also be included in the new voucher format.
- **Allowed Amount:** Currently, rounding is applied to the total allowed amount. As we upgrade, rounding will be applied on each claim line. The final allowed amount is the total of each line-level rounded amount.
- **Overpayments:** Accounts Receivable will replace letters that we previously sent requesting a refund. If you prefer to submit payment to us, please return the amount indicated to the address listed on the enclosed coupon in accordance to the timeframe noted in your contract of receipt of the remittance. Once the requested amount is returned, the claim adjustment will be complete.

**Members’ rights and responsibilities**

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, BCBSGa has a Members’ Rights and Responsibilities statement that can be found on the Quality page of our provider website.

**Health care reform updates (including Health Insurance Exchange)**

Health care reform updates and notifications and Health Insurance Exchange information are posted as they become available on the communications page of bcbsga.com.

Articles titled “Verify member grace period status electronically using Availity or EDI” and “New member ID cards for plans purchased on and off the Exchange UPDATED” were posted to the Health Insurance Exchange information page of bcbsga.com in May.
New online processes for ERA only registration and provider management of paper remittance vouchers

BCBSGa will soon implement a new online ERA only registration process, replacing current paper forms. We expect this online process to begin in August 2014. Once available, providers and third party billing agents will be able to access the new online registration link via BCBSGa's EDI website. This new online process will eliminate the use of paper ERA registration forms.

BCBSGa will introduce an online capability for providers to control their receipt of paper remittance vouchers by mail. In support of HIPAA Administrative Simplification requirements, BCBSGa will discontinue mailing paper remittance vouchers for providers receiving ERA. We expect cessation of mailed remittance vouchers to begin in September 2014. For providers initially registering for ERA, paper suppression will automatically begin 31 days after a provider registers for ERA. We expect the new online capabilities for providers to control their receipt of mailed paper remittances to be available beginning in August 2014, which will allow providers to elect to continue receipt of paper remittance vouchers by mail. This online paper remit election process will replace all paper remittance election processes currently used today.

BCBSGa will provide additional details about these upcoming changes as information is available.

Providers registering for ERA and EFT at the same time should continue to use the CAQH website. Information about registering for ERA and EFT at the same time can be found here.

This article can also be found on the Health Care Reform updates and notification page of our provider website.

Products and programs

Oncology practices go online to learn about the WellPoint Cancer Care Quality Program

The WellPoint Cancer Care Quality Program ("Program"), a quality initiative, provides participating physicians with evidence-based cancer treatment information that will allow them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based WellPoint Cancer Treatment Pathways ("Pathways"). Participating physicians that are in-network for the member’s benefit plan are eligible to participate in the Program and to receive enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program website, cancercarequalityprogram.com, helps support BCBSGa network oncology practices as they get ready to participate.

Since its launch, the Cancer Care Quality Program website has drawn more than 1,000 visitors, and more than half have returned to the site multiple times to view content and download materials designed to help educate practices about the Program.

Practices are finding information on WellPoint’s Cancer Treatment Pathways of strong interest such as:

- A comprehensive list of current Pathways that can allow physicians and other clinicians to better understand our Pathways and how they were developed.
- Pathways worksheets for each cancer type managed under the Program. These worksheets are an ideal way for practice staff to gather the information they need to submit cancer regimens for review.
- Many other resources and tools, tips and timelines.
Online process simplifies practice workflow

The Program will be administered by AIM Specialty Health® (AIM), a separate company. Participating practices are likely to find entering their information via the AIM Provider Portal both quick and convenient. In testing, users have provided positive feedback on this online process, with most saying they will be able to submit orders in fifteen minutes or less. Additionally, participating providers in need of support may call the AIM Call Center at 800-554-0580.

AIM will begin taking orders for the Program on June 23, 2014 for treatment that begins on or after July 1, 2014.

Helpful links

- Register for access to the AIM Provider Portal
- View the Cancer Care Quality Program website
- Get more information on WellPoint Cancer Treatment Pathways
- Access program FAQs, including information on enhanced reimbursement

Enhanced Personal Health Care Program

We began enrolling practices in our Enhanced Personal Health Care Program (“Program”) during third quarter 2013 and will continue our expansion in Georgia throughout 2014. To date we have enrolled 941 physicians. The next effective date for new groups to begin participation will be July 1, 2014.

The Program provides financial incentives and tools to help practices adopt the principles of patient-centered care, including:

- Care management focused on high risk patients
- Coordination of care across the delivery system
- Promotion of wellness and prevention
- Shared decision making between physicians and patients
- Ensured access to care
- Measurement of outcomes and compliance with evidence-based guidelines

We designed the Program to provide:

- An inclusive and flexible framework – Any practice willing to adhere to Program terms can participate whether a small independent practice or large integrated delivery system. We collaborate with physicians based on their current readiness regardless of practice size
- Financial rewards – Care coordination payments* as well as a shared savings opportunity
- Practice support – Tools, resources, and services for each participating practice to adopt a patient-centered model that improves patient engagement, optimizes the health of the population, and reduces medical cost trend

For additional information on the Program, please visit the Enhanced Personal Health Care Program page of our provider website, bcbsga.com. If you have any questions or would like additional information on participation in the Program, please send us an email, contact your Network Consultant, or call provider customer service at 800-428-4446.

*Some exclusions may apply.

ConditionCare information is available online

BCBSGa members have additional resources available to help them better manage chronic conditions. The ConditionCare program is designed to help participants improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.
The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor’s orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

Engagement methods vary by risk level but can include:
- **Education** about their condition through mailings, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Coaches and other health professionals.

**Physician benefits:**
- **Save time** for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.
- **Inform** the physician with updates and reports on the patient’s progress in the program.

Nurse coaches encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Please visit the [Health and Wellness page](#) on the BCBSGa provider website to find more information about the ConditionCare program such as program guidelines, educational materials and other resources. Also on our website is the [Patient Referral Form](#), which you can use to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call 877-681-6694. Our nurses are available Monday-Friday, 9:30 a.m. to 10:00 p.m., and Saturday, 10:00 a.m. to 8:30 p.m.

**AIM Specialty Health expanded to the Federal Employee Program®**

BCBSGa is dedicated to meeting the evolving needs of our members. With consumers looking for tools to guide better health care decision making, we are pleased to announce that our Imaging Management Solution program has been expanded and will soon include the Federal Employee Program®, but not until August of 2014. Look for additional information and details about the program in the August edition of Network Update.

**Cost and Quality Program expands to include surgical procedures**

BCBSGa offers a Cost and Quality program to help members compare facility costs on imaging and sleep services. This program involves proactive outreach to our members and is administered in partnership with AIM Specialty Health® (AIM). A member outreach is triggered when AIM is contacted as part of the pre-notification process.

On September 1, 2014, we will expand this program to include the following surgical procedures:
- Colonoscopy -- screening, biopsy, and lesion removal
- Endoscopy – upper GI with biopsy
- Arthroscopic ACL Repair
- Knee arthroscopy with cartilage repair
Shoulder arthroscopy
Shoulder arthroscopy with rotator cuff repair

Provider notification
- You may contact AIM when your patient requires one of the surgical procedures listed above.
- Both ordering and servicing providers may contact AIM.

Provider/patient transparency
- Once AIM is notified, surgical facility cost information will be shared with you and your patient. This information can help our members select a cost-effective option.
- Cost information is based on BCBSGa’s historical paid claims data for the various services in scope. This data is updated twice per year.

You may contact AIM one of two ways:

1. Online through ProviderPortalSM
2. Via telephone at (800) 554-0580 or by using the number displayed on the back of the member ID card

Members will not be denied access to services if they do not choose a lower-cost option. Our goal is simply to provide members with information to make informed choices about their health care.

Note: FEP is not currently included in this program.

If you have any questions about this information, please contact your local Network Consultant or call provider customer services at 800-428-4446.

We believe in continuous improvement

Commitment to our members’ health and their satisfaction with the care and services they receive is the basis for the BCBSGa Quality Improvement Program. Annually, we prepare a quality program description that outlines the plan’s clinical quality and service initiatives. We strive to support the patient-physician relationship, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of our quality program and most current outcomes, visit the Quality page of our provider website.

Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

BCBSGa is available to offer assistance in these difficult moments with our Case Management Program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.
Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-353-0923</td>
<td><a href="mailto:GaLocalCaseManagement@bcbsga.com">GaLocalCaseManagement@bcbsga.com</a></td>
<td>Monday – Friday 8:00 a.m. – 5:00 p.m.</td>
</tr>
<tr>
<td>Medicare 866-797-9884</td>
<td><a href="mailto:CM-concierge@wellpoint.com">CM-concierge@wellpoint.com</a></td>
<td>Monday – Friday 8:00 a.m. – 5:00 p.m.</td>
</tr>
<tr>
<td>National 866-202-8727</td>
<td><a href="mailto:CMNATIONALACT-ATL@anthem.com">CMNATIONALACT-ATL@anthem.com</a></td>
<td>Monday – Friday 8:00 a.m. – 8:00 p.m.</td>
</tr>
<tr>
<td>FEP 800-711-2225</td>
<td>None</td>
<td>Monday – Friday 8:00 a.m. – 4:30 p.m.</td>
</tr>
</tbody>
</table>

Two important programs we're highlighting this month

BCBSGa members, including SHBP members, have access to numerous programs and services. Future Moms and our 24 hour nurse line are just two of our member programs that can benefit your BCBSGa patients.

**BCBSGa Future Moms program**

Future Moms is a free service that gives moms-to-be access to the care that is best for them with one-on-one support from a registered Personal Health Maternity Nurse. Program features include:

- Welcome kit and resources – available as soon as the members enrolls
- Personal Health Maternity Nurses – available 24/7, so expectant moms can talk to a nurse about maternity questions anytime, any day.
- Easy enrollment – Expectant moms are encouraged to enroll as soon as they can to take advantage of the service. Moms can even enroll as late as their 36th week.

To enroll members:

- BCBSGa members call: 800-828-5891 or fill out the referral form.
- SHBP members call: 866-901-0746, option 2.

You can learn more about our Future Moms program on the Health & Wellness page of our provider website.

**24/7 NurseLine**

This dedicated line gives BCBSGa members, including SHBP members, and their families access to registered nurses any time, day or night for answers to general health questions, to help them understand their symptoms, and to help them determine the right care at the right time.

**Contact information:**

- BCBSGa members can call the number on the back of their member ID card.
- SHBP members can call 866-787-6361
E-business

Medical Referral and Preauthorization Inquiry on ProviderAccess moving exclusively to Interactive Care Reviewer on the Availity Web Portal

Our Interactive Care Reviewer (ICR) tool continues to evolve, improving the precertification process. In the latest upgrade, ordering and servicing physicians and facilities can make an inquiry to view information on any precertification previously submitted via phone, fax, ICR, or other online tool) for any member covered by Anthem Blue Cross and Blue Shield, Anthem Blue Cross (California) or BCBSGa.

BCBSGa is transitioning Medical Referral and Preauthorization Inquiry from ProviderAccess to ICR on the Availity Web Portal. To minimize business disruption, it’s important that users discontinue using Medical Referral and Preauthorization Inquiry on ProviderAccess and become familiar with ICR. While medical referrals can be submitted and inquired on ProviderAccess, only precertification inquiry is currently available by using Medical Referral and Preauthorization Inquiry.

If your organization is NOT currently registered for Availity:
- The designated Administrator for your organization should go to availity.com.
- Click on “Get Started” under Register now for the Availity Web Portal, and then complete the online registration wizard.
- The administrator will receive an e-mail from Availity with a temporary password and next steps.

Not sure if your organization is registered?
Call Availity Client Services at 800-AVAILITY (800-282-4548) for registration status of your Tax ID.

If your organization is registered for Availity and just needs access to inquiry:
- Your Primary Access Administrator can grant you access to Authorization and Referral Inquiry and you can start using our tool right away.

In addition, you can now submit both inpatient and outpatient pre-certifications online. These are the most recent enhancements to our online precertification tool but not the last. Your Primary Access Administrator can give you access to Authorization and Referral Request to allow you to start utilizing ICR today!

Need training?
To learn more about how you can streamline the precertification process by taking advantage of our ICR’s many features, register today by clicking here.

For questions regarding our ICR, please contact your local Network Management consultant. For questions on accessing our tool, call Availity Client Services at 800-AVAILITY (800-282-4548) or email questions to support@availity.com. Availity Client Services is available Monday-Friday, 8:00 a.m. to 7:00 p.m. ET (excluding holidays) to answer your registration questions.

Note: ICR is not currently available for Medicare Advantage, Medicaid, FEP®, BlueCard®, and some National Account members; requests involving Behavioral Health or transplant services; or services administered by AIM Specialty HealthSM. For these requests, follow the same precertification process that you use today.

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Availity, an independent company, provides claims management services for Blue Cross Blue Shield of Georgia, Inc.

State Health Benefit Plan

State Health Benefit Plan information is posted as it becomes available on the State Health Benefit Plan information page of bcbsga.com.

The article titled New member ID cards for State Health Benefit Plan members was updated and posted to the State Health Benefit Plan information page of bcbsga.com in April.

Change in SHBP plan design requires provider refunds

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) is working with the Department of Community Health (DCH) to implement co-pays within the State Health Benefit Plan (SHBP) plan designs as approved by the DCH Board of Community Health. As previously communicated, you can find SHBP benefits-at-a-glance and sample member ID cards on the SHBP dedicated webpage of our provider website, bcbsga.com.

The SHBP plan design changes require providers to retroactively collect co-pays and provide refunds for BCBSGa claims from January 1, 2014 through March 14, 2014. We would like to remind you of our refund recovery process.

Solicited refunds including overpayment letter with coupon
Please detach the coupon and mail it along with a check made payable to "BCBSHP" to:

BCBSGa
P.O. Box 5281
Carol Stream, IL 60197-5281

Early or immediate recoupment
Early recoupment is an option for those providers who wish to forego the refund check submission process. Please sign the overpayment letter and fax an approval for early recoupment to (317) 287-8463.

Bulk pay option
Submit one refund check for the total overpayment amount. Attach the coupons or letters to the refund which must match the refund check amount.

Complaints related to overpayment letters
A letter detailing your complaint should be sent to the address listed below within 30 days of the date of the letter received from BCBSGa. Please include a copy of the BCBSGa letter and any supporting documentation to the undersigned. You will be notified as soon as the review is completed.

BCBSGa
P.O. Box 105557
Atlanta, GA 30348-5557
Automated deduction

We have an automated deduction collection process in an effort to recover payments issued in error, and when routine collection efforts have not been successful. This process is as follows:

- The first notice is mailed to the Provider’s remittance address office asking for payment within thirty (30) days.
- If payment is not received before the thirty (30) day period ends, a second notice is mailed to the Network Participating/Provider asking for payment within thirty (30) days.
- If the account remains open after a total of sixty (60) days, auto-deduction will occur.
- Resulting remittance advices will report the item(s) deducted and will include the related contract numbers to assist the Provider.

Note: All procedures are evaluated periodically to determine “Best Business Practices” and to remain consistent with business standards. Please be assured every effort will be made to collect the refund without activating the automated deduction collection process.

Contact information

All SHBP inquiries should be directed to 855-641-4862.

A full SHBP contact list for providers is also posted to the SHBP webpage of our provider website, bcbsga.com.

For your convenience, additional provider services numbers are listed below:

- Facilities: 800-284-2609
- Professional: 800-241-7475
- ITS: 800-628-3988
- FEHBP: 800-282-2473

BCBSGa SHBP contact list for providers

ACTIVE EMPLOYEES ON HRA - Alpha Prefix SJN

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Phone Number</th>
<th>Fax Number</th>
<th>Website</th>
<th>Mailing Address</th>
</tr>
</thead>
</table>
P.O. BOX 105370  
Atlanta. GA 30348-5370 |
|                          |              |            | [www.availity.com](http://www.availity.com) |                               |
| Pre Certification        | 855-668-6442 | 855-410-4455 | [www.bcbsga.com](http://www.bcbsga.com)  
Step 1: Select Providers  
Step 2: To Enter Site Click “HERE”  
Step 3: Select Precertification Requirements and Forms  
Step 4: Select SHBP Precertification Requirements List  
Interactive Care Reviewer  
[www.availity.com](http://www.availity.com) |                               |
<p>| AIM Specialty            | 866-714-1103 | N/A        |                               | N/A                           |</p>
<table>
<thead>
<tr>
<th>Health</th>
<th>Radiology - Diagnostic Services (CT Scan, CTA, MRA, MRI, PET Scan) - Cardiac – Diagnostic Services (Echocardiography, Nuclear Cardiology) - Sleep Testing and Therapy Services - Radiation Therapy</th>
<th></th>
<th></th>
<th><a href="http://www.aimspecialtyhealth.com/goweb">www.aimspecialtyhealth.com/goweb</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>855-668-6442</td>
<td>855-410-4455</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Appeals</td>
<td>855-641-4862</td>
<td>855-398-1276</td>
<td><a href="http://www.bcbsga.com/shbp">www.bcbsga.com/shbp</a></td>
<td>BlueCross BlueShield of Georgia P.O. BOX 105449 Atlanta, GA 30348-5449</td>
</tr>
</tbody>
</table>

**BCBSGa SHBP Medicare Advantage contact list for providers**

*Retiree Medicare Advantage - Alpha Prefix WGK*

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Phone Number</th>
<th>Fax Number</th>
<th>Website</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Customer Services</td>
<td>855-322-7062</td>
<td>N/A</td>
<td><a href="http://www.bcbsga.com">www.bcbsga.com</a></td>
<td>BlueCross BlueShield of Georgia P.O. BOX 105370 Atlanta, GA 30348-5370</td>
</tr>
<tr>
<td>Pre Certification</td>
<td>855-747-1131</td>
<td>855-747-1132</td>
<td><a href="http://www.bcbsga.com">www.bcbsga.com</a></td>
<td>Step 1: Select Providers Step 2: To Enter Site Click “HERE” Step 3: Select Precertification Requirements and Forms Step 4: Select Medicare Advantage Precertification Requirements List</td>
</tr>
<tr>
<td>AIM Specialty Health Radiology - Diagnostic Services (CT Scan, CTA, MRA, MRI, PET Scan) - Cardiac – Diagnostic Services</td>
<td>866-714-1103</td>
<td>N/A</td>
<td><a href="http://www.aimspecialtyhealth.com/goweb">www.aimspecialtyhealth.com/goweb</a></td>
<td>N/A</td>
</tr>
<tr>
<td>(Echocardiography, Nuclear Cardiology) - Sleep Testing and Therapy Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>Transplants</td>
<td>855-668-6442</td>
<td>855-410-4455</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>855-747-1131</td>
<td>800-265-9866</td>
<td></td>
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<tr>
<td>Appeals</td>
<td>855-322-7062</td>
<td>888-458-1406</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Peer to Peer</td>
<td>888-476-8920</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

### Senior business and Medicare Advantage

#### CPAP/BiPAP devices and related supplies

The Continuous Positive Airway Pressure Device (CPAP) and Bi-level Positive Airway Pressure Device (BiPAP) are covered pieces of Durable Medical Equipment (DME) for BCBSGa Medicare Advantage members when medically necessary. In order to make sure that your claims are not unnecessarily delayed or denied we strongly encourage you to obtain prior authorization from BCBSGa.

For a more detailed list of the criteria used to determine coverage of CPAP/BiPAP devices click here.

#### New 2014 Medicare Advantage precertification requirements effective July 1, 2014

There are new 2014 precertification requirements for BCBSGa Medicare Advantage plans that BCBSGa made available March 28, 2014 on the Provider Forms section of the BCBSGa Medicare Advantage Public Provider Portal. These new precertification requirements will go into effect on July 1, 2014. The main changes effective in July are the requirement for providers to precertify select procedures for; **Knee Arthroscopy, Pain Management, Cardiac Catheterization, and Pacemakers (with defibrillators)**. Some of these services were listed as required since January 1, 2014 but are called out here as reinforcement.

Please visit the Provider Forms section of the BCBSGa Medicare Advantage Public Provider Portal to see the new precertification list that is effective July 1, 2014 as well as the precertification requirements that were effective January 1, 2014 through June 30, 2014. To obtain precertification or to verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member’s identification card.

Y0071_14_19693_I_003
House Call Program helps coordinate care for Medicare Advantage members

The House Call Program gives our Medicare Advantage members the opportunity to receive non-invasive health services and a health evaluation in the comfort of their own home. Both members and providers benefit from the additional care coordination the program provides:

- The visiting licensed and credentialed clinician is able to collect information that helps BCBSGa identify patients who may benefit from case management programs.
- Our members’ physicians can use the evaluation forms to match health care needs with the appropriate level of care.
- BCBSGa is able to meet it's Centers for Medicare & Medicaid Services annual obligation for reporting all required diagnoses to CMS for each member for the purpose of risk adjustment.

During the visit, the clinician uses a health evaluation form to document all medical conditions that exist on the date of the visit. We will make copies of the completed forms available to the members' physicians to include in their records. We will also provide copies of the forms to members at their request. In addition, based on the outcome of the health evaluation, BCBSGa may conduct post-visit outreach with a member’s physician and may make a case management referral.

The House Call Program is a voluntary program that we offer at no out-of-pocket cost to our Medicare Advantage members.

Providers may request a copy of member evaluations by emailing or calling Cheryl Young at 513-770-7088 or Lisa Ware at 513-770-7515.

Medicare Advantage members to receive monthly summary statements

BCBSGa Medicare Advantage members received a new monthly Explanation of Benefits (EOB) beginning May 2014. The monthly EOB called the “Monthly Report” is a summary of medical and supplemental services claims processed in the previous month. Medicare Advantage members also will continue to receive “per claim” Medicare Advantage EOBs. This new monthly report is required by the Centers for Medicare & Medicaid Services. We bring this new EOB to your attention in case members bring their Monthly Report with them to upcoming office visits.

2014 Medical Chart Review Program for Medicare Advantage Members under way

Each year, BCBSGa requests your assistance in our retrospective medical chart review program. This program, which includes a request for our Medicare Advantage members’ medical charts for 2013 dates of service, is a vital part of BCBSGa’s compliance with CMS guidance that requires Medicare Advantage health plans to collect and report to CMS all member diagnosis data. CMS requires that this data be supported by the member’s medical record documentation.

To assist with our medical chart review program, BCBSGa will be collaborating with Verisk Health (Verisk), formerly known as MediConnect Global, Inc. (MediConnect). Verisk Health is a leading records retrieval and electronic document management company that specializes in medical records retrieval, coding and delivery via the internet. Verisk’s web based workflows will help reduce time and improve efficiency and costs associated with record retrieval, coding and document management. BCBSGa will be working with Verisk in retrieving and reviewing our Medicare Advantage member medical records. As in previous years, the request for medical records began in the spring of 2014 and will continue throughout the year.

As the physician for our Medicare Advantage members, you play a critical role in the success of this program and our compliance with CMS requirements. By maintaining quality coding and documentation practices and by cooperating with our
medical chart requests, you will be instrumental in helping BCBSGa meet its CMS obligations and will help ensure risk adjustment payment integrity and accuracy.

**BCBSGa helps members schedule office visits, preventive screenings**

BCBSGa analyzes claim records to identify Medicare Advantage members who may be missing important preventive screenings or other services to manage chronic conditions.

We call members to tell them about these services and to offer help scheduling an appointment. If the member would like help scheduling an office visit or screening, we will place a call to the member's physician or screening facility to schedule an appointment while we’re on the phone with the member.

We continue to make these reminder calls to help ensure our Medicare Advantage members receive the key services recommended by the Centers for Medicare & Medicaid Services.

**HEDIS measures help promote quality health care**

Medicare Advantage health plan ratings are in place to improve an individual’s health care experience, improve the overall health of individuals and to promote cost-efficient, quality health care. Health Effectiveness Data Information Set (HEDIS)® measures associated with these health plan ratings include, but are not limited to:

- Colorectal Cancer Screening
- Breast Cancer Screening
- Comprehensive Diabetes Care
- Controlling Blood Pressure

Helping ensure that our members receive these important screenings and preventive services will help members better manage chronic conditions and also presents a good opportunity to discuss the importance of early detection.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

**BCBSGa Works to prevent opioid overutilization among Medicare Advantage members**

BCBSGa continues to mail and/or call providers upon identification of Medicare Advantage members with suspected patterns of opioid overutilization due to multiple prescribers and multiple pharmacies. During the phone call, our pharmacists attempt to facilitate a conversation with providers about the appropriate use, medical necessity and safety of the high opioid dosage for their patient.

Our goal is to work with providers to prevent overutilization and to determine the appropriate amount of opioids for our members.

For more information, please reference:


Y0071_14_19540_I 03/17/2014
Pharmacy

Pharmacy information available on bcbsga.com

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. The drug list is reviewed and updates are posted to the web site quarterly.

Policy updates

Professional and facility reimbursement policies on bcbsga.com

BCBSGa professional and facility reimbursement policies can now be found on the new Reimbursement Policy page of our public provider website.

Facility Implant Reimbursement policy update

Policy #: EFRST 006
Effective date: September 1, 2014

Description:
The Policy is intended to outline our definition of implants and to describe our reimbursement policy regarding implants that are deemed contaminated and/or considered waste and/or were not implanted in the Covered Individual.

Policy:
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert, placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Covered Individual’s body upon discharge from the inpatient stay or outpatient procedure. Staples, sutures, clips, as well as temporary drains, tubes, and similar temporary medical devices shall not be considered implants.

Facility shall not bill BCBSGa for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Covered Individual. Additionally, BCBSGa will not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Covered Individual.

Use of Reimbursement Policy: This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.
Observation services or hours billing reimbursement policy update

Policy #: EFRST 005
Effective date: September 1, 2014

Description:
The health plan considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute facility on that facility’s premises that includes the use of a bed and monitoring by that acute facility’s nursing or other staff and are required to observe a patient’s condition to determine if the patient requires an inpatient admission to the facility. Observation services include services provided to a patient designated as “observation status”, and in general, shall not exceed 24 hours. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the patient is stabilized.
- The patient has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the normal recovery time.
- The patient care required is initially at or near the inpatient level; however, such care is expected to last less than a 24 hour time frame.
- The patient requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment protocol.
- The patient requires short term medical intervention of facility staff which requires the direction of a physician.
- The patient requires observation in order to determine if the patient requires admission into the facility.

Policy:
The payment, if any, for observation services is specified in the Plan Compensation Schedule or Contract with the applicable facility. Nothing in this Policy is intended to modify the terms and conditions of the facility's agreement with the health plan. If the facility’s agreement with the health plan does not provide for separate reimbursement for observation services, then this Policy is not intended to and shall not be construed to allow the facility to separately bill for and seek reimbursement for observation services.

The patient’s medical record documentation for observation status must include a written order by the physician or other individual authorized by state licensure law and facility staff bylaws to admit patients to the facility that clearly states “admit to observation”. Additionally, such documentation shall demonstrate that observation services are required by stating the specific problem, the treatment and/or frequency of the skilled service expected to be provided,

The following situations are examples of services that are considered by the health plan to be inappropriate use of observation services:

- Physician, patient, and/or family convenience
- Routine preparation and recovery for diagnostic or surgical procedures
- Social issues
- Blood administration
- Cases routinely cared for in the Emergency Room or Outpatient Department
- Routine recovery and post-operative care after outpatient surgery
- Standing orders following outpatient surgery
- Observation following an uncomplicated treatment or procedure

Use of Reimbursement Policy: This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member’s benefits. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.
Professional Reimbursement policy updates

Update to claims processing edits and reimbursement policies

On June 1, 2014, we will update our provider website with the following revised professional reimbursement policies. The following professional reimbursement policies received an annual review and may have word changes or clarifications, but do not have significant changes to the policy position or criteria:

- Global Surgery
- Moderate Sedation

Frequency Editing

Effective September 01, 2014, BCBSGa will no longer reimburse multiple units for CPT codes J1560 (Injection, gamma globulin intramuscular), 22830 (Exploration of spinal infusion) and 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT)) as there is a limit to the total number of times for a single date of service that a given procedure may be appropriately submitted. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service across all anatomic sites. After the maximum number of times is reached, additional submissions of the procedure are not recommended for reimbursement. Coding is assessed for accuracy based on the number of submissions of a specific procedure according to anatomic sites and CPT/CMS guidelines.

Bundled Services and Supplies

There are services and supplies that are always considered part of providing another service and therefore are not eligible for separate reimbursement when reported by a professional provider. These bundled services may be performed or provided either on the same or different date of service as the primary service. The services listed below are being added to the Bundled Services and Supplies policy:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9279</td>
<td>Monitoring feature or device, stand-alone or integrated, any type, including all accessories, components and electronics</td>
<td>09/01/2014</td>
</tr>
<tr>
<td>22841</td>
<td>Internal spinal fixation by wiring of spinous processes</td>
<td>09/01/2014</td>
</tr>
</tbody>
</table>

Place of Service

Effective September 01, 2014 BCBSGa will consider CPT code 92587 (Distortion product evoked otoacoustic emissions) when performed in a facility setting included under the facility’s reimbursement. Therefore, this service is not eligible for separate reimbursement when reported by a professional provider on a Form CMS-1500 with a facility place of service.

View BCBSGa Professional Reimbursement policies on our provider website, bcbsga.com.