December 2012

Providerfocus

Published Monthly for Physicians, Health Care Providers, and Their Office Staff

Blue Options V.4 Will Be Available Starting January 1, 2013

To maintain the affordability of our tiered network plans for our members and accounts, we periodically update the tiers with the most current available data.

Reclassifying our network from time to time also encourages network providers to continue to improve their cost and quality performance.

We are updating the tier placement of hospital and primary care provider groups within our Blue Options plans.

The reclassification is based on cost and quality methodologies that use well-accepted performance measurement principles and validated measures articulated by local and national physician leaders and measurement experts. It also reflects data changes that have occurred since the last update.

The changes will go into effect for employer groups currently offering a Blue Options plan on the group's first renewal date on or after January 1, 2013 and for all new accounts on or after January 1, 2013.

You will be able to identify members in the updated Blue Options product by the V.4 on their identification card.

You can find the tier status of a PCP or hospital using the Find a Doctor search tool available on our website.

Member communication and benefits

Depending on their Blue Options group anniversary date, members may continue to have the current V.3 plan design until December 2013.

Since accounts may customize their employees' benefit structure, we encourage you to check member benefits and eligibility using our provider technologies before rendering services or collecting copayments.

You will need to know your tier status and the member's version of the plan to collect the appropriate copayment.

Updates being made to Blue Options V.3 and plans with the Hospital Choice Cost Sharing benefit feature

As a result of favorable improvements in Boston Children's Hospital cost performance at three satellite locations, we will be updating the hospital tiering in our Blue Options

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In This Issue

In Brief

BCBSMA Earns Top Rankings for Medicare Advantage Plans

BCBSMA is the top-ranked Medicare Advantage PPO health plan in America, and the #25 Medicare Advantage plan, according to the National Committee for Quality Assurance's (NCQA) Medicare Health Insurance Plan Rankings 2012–2013.

Both BCBSMA's HMO/POS and PPO plans are also among the highest-ranked private commercial health plans in the nation at #12 and #5 respectively.

To read the full press release, go to **bluecrossma.com/visitor** and click on **Newsroom.**❖

Physician News

Coaching for Inner Strength™ Pilot Program to Address Stress, Resiliency in Members with Co-morbid Medical and Behavioral Health Disorders

Recent studies have shown that patients with co-occurring medical and behavioral health disorders have higher levels of medical services utilization than similar patients who have only medical disorders.

We have collaborated with clinicians at Brigham and Women's Hospital to develop a cognitive behavioral coaching intervention to enhance members' capacity to cope effectively with the stress of a major medical illness and their ability to make effective decisions about their care.

We will offer the Coaching for Inner Strength™ program to members who have a recent history of a behavioral health diagnosis along with one of these co-morbidities:

- Start of active treatment for cancer
- Recent acute myocardial infarction or angioplasty
- Planned surgery for back pain or for hip or knee replacement.

Engaged patients will have two telephonic coaching sessions each week for six weeks. Nurses trained in the use of cognitive behavioral principles will educate members on effective coping strategies that aim to enhance their resiliency in the face of their illness.

The nurses will follow up with members at three, six, and 12 months after the coaching sessions to assess its impact.

If one of your patients is offered an opportunity to participate in the program, we hope that you will encourage them to do so.

For more detailed description of the program's methods and goals, please contact Tammy Heran in our Case Management area at **617-246-6305**.❖

Enhanced Reports for PCPs Are Available Online

As part of our commitment to support primary care providers (PCPs), BCBSMA is providing updated reports to help PCPs improve the quality of care delivered to their patients. The reports, for dates of service from January 1, 2012 – October 31, 2012, are now available online.

We hope you find these reports useful in helping to identify, contact and remind your patients who could benefit from guideline-recommended preventive or chronic care screenings.

The reports focus on a wide range of NCQA HEDIS ambulatory care measures that evidence shows are important to the health of our members and which are used for the Massachusetts Health Quality Partners (MHQP) practice-level results.

The BCBSMA reports include:

- A year-to-date summary of your performance on each of the ambulatory care measures for which you have BCBSMA members, and
- For each measure, a list of the BCBSMA members in the measure population; whether they have the required screening; and the date, diagnosis, and procedure associated with the screening.

These reports are produced only for PCPs who are not affiliated with an AQC group (AQC groups receive other reports). Reports are produced only for measures for which you have a sufficient patient population to be evaluated.

To access your report, log on to our website, **www.bluecrossma.com/provider**, and click on **Manage Your Business>Access Your Reports**.

Your feedback is important to us, so please contact your network manager with any questions related to these reports.❖

Physician News

Focus on HEDIS: Medication Recommendations for COPD Exacerbation

Your patient has recently been to the ER or was hospitalized for a COPD-related episode. Did you know that the post-discharge follow-up that you prescribe is a HEDIS measure of quality care that is publicly reported?

Evidence-based guidelines (see COPD guidelines in the companion article) for this scenario indicate the prescription of systemic corticosteroid and bronchodilator medication within the specified time period. The medications listed below meet this standard of care and are covered by BCBSMA.

To view a list of non-covered medications, refer to pharmacy medical policy 433, *Non-covered Drug List*, or pharmacy medical policy 023, *Medicare HMO Blue and Medicare PPO Blue Non-covered Drug List.*

This course of treatment is a best practice for decreasing the likelihood of post-episode exacerbation for your patients (our members).❖

For this HEDIS measure:	Two measures are reported:	During this time period:
Percentage of COPD exacerbations* for members 40 years of age and older who had an acute inpatient discharge or ED encounter and who were dispensed appropriate medications	▸ The percent of members dispensed a systemic corticosteroid within 14 days of the event ▸ The percent of members dispensed a bronchodilator within 30 days of the event	January 1-November 30 of the measurement year

**A COPD exacerbation is indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.*

Systemic Corticosteroids (dispensed within 14 days of the event)

Description:	Prescription:		
Glucocorticoids	▸ Betamethasone ▸ Dexamethasone ▸ Hydrocortisone	▸ Methylprednisolone ▸ Prednisolone	▸ Prednisone ▸ Triamcinolone

Bronchodilators (dispensed within 30 days of the event)

Description:	Prescription:		
Anticholinergic agents	▸ Albuterol-ipratropium	▸ Ipratropium	▸ Tiotropium
Beta 2-agonists	▸ Albuterol ▸ Arformoterol ▸ Budesonide-formoterol ▸ Fluticasone-salmeterol	▸ Formoterol ▸ Indacateroll ▸ Levalbuterol ▸ Mometasone-formoterol	▸ Metaproterenol ▸ Pirbuterol ▸ Salmeterol
Methylxanthines	▸ Aminophylline ▸ Dyphylline ▸ Dyphylline-guaifenesin	▸ Guaifenesin-theophylline ▸ Theophylline	

Physician News

Colonoscopy Screening Benefits Extended for PPO and Indemnity Members

Under the Patient Protection and Affordable Care Act (PPACA), group and individual health plans and group health insurers no longer require cost-sharing for members when they receive certain preventive services, and must provide coverage for some preventive services.*

To address recommendations from national organizations and the U.S. Preventive Services Task Force, we will eliminate the age and frequency limitations from our colonoscopy benefits for PPO plans to allow members to be screened more often or at an earlier age if medically indicated. This will align our PPO plans with our HMO plans which do not have these limits.

These changes take effect on January 1, 2013:

- For fully insured PPO and indemnity plan designs and
- On account anniversary date on or after January 1, 2013 for self-funded PPO and indemnity plan designs.

National Guidelines

National guidelines recommend colorectal cancer screening starting at age 50 then every 10 years.

However, more frequent or earlier screening is recommended for patients with certain increased risk factors, such as a family history of colon cancer or personal history of polyps. Screening in these situations will now also be covered when billed as a preventive service.**

Benefits Covered

Under the PPACA, we cover:

- Colorectal cancer screening with colonoscopy, sigmoidoscopy or barium enema when these services are billed as preventive services
- Associated anesthesiology, laboratory, and pathology services.

These preventive services are covered at no cost for members unless the account is grandfathered under the provisions of PPACA and has maintained cost-share for preventive services.❖

**Some grandfathered health plans may still apply a cost share.*

***Self-insured accounts may have more limited benefits.*

Billing for Screening Colonoscopy or Sigmoidoscopy

The AMA created modifier 33 to allow providers to identify a preventive service for which, under the Patient Protection and Affordable Care Act (PPACA), there is no patient cost sharing.

Use modifier 33 with a CPT code for a diagnostic/treatment service performed as a preventive service, such as a screening colonoscopy, even if a polyp is found and removed.

You may also use G codes intended for use for screening procedures for colorectal cancer screening:

- G0105: colonoscopy screening for individuals at high risk
- G0121: colonoscopy screening for individuals who are not high risk
- G0104: flexible sigmoidoscopy screening.

When billing for preventive screening colonoscopy or sigmoidoscopy for any BCBSMA member, use modifier 33 or one of the G codes above so that the claim pays without any member cost share, according to the member's benefits.

Do not use modifier 33 to bill for individuals receiving procedures due to signs or symptoms, or to rule out or confirm a suspected diagnosis. In this case, the procedure would be considered a diagnostic exam, not a screening exam.

For coding examples, click here.

As always, be sure to check eligibility and benefits to determine coverage and appropriate member cost-sharing.❖

Physician News

Updated Disease Guidelines Are Available on BlueLinks for Providers

Several updated disease guidelines have been reviewed and adopted, and are now on our website. These guidelines are available to help you manage your patients. Our care managers also refer to these guidelines when facilitating care for our members.

To access links to these evidence-based guidelines, log on to our website at **www.bluecrossma.com/provider** and click on **Manage Your Business>Manage Patient Care.** After selecting the appropriate condition from the drop-down menu, you can find the guidelines listed under the **Medical Decision Support** tab.❖

Condition:	Guidelines:	Status:
Asthma	Asthma: National Guideline Clearinghouse: Diagnosis and management of asthma Pediatric Asthma: National Guideline Clearinghouse: Managing asthma long term in children 0-4 years of age and 5-11 years of age: Expert panel report 3: guidelines for the diagnosis and management of asthma	Reviewed and endorsed
Congestive Heart Failure	National Guideline Clearinghouse: Heart failure in adults	Reviewed and endorsed
COPD	National Guideline Clearinghouse: Diagnosis and management of chronic obstructive pulmonary disease (COPD)	Reviewed and endorsed
Coronary Heart Disease	National Guideline Clearinghouse: Coronary heart disease	Reviewed and endorsed
Depression	American Psychiatric Association (APA) Practice Guidelines for the Treatment of Major Depressive Disorder, Third Edition	Reviewed and endorsed
	Care Guide for Major Depression in Adults in Primary Care and Pharmacy Guidelines for Major Depression	Updated to reflect our current formulary
Diabetes	National Guideline Clearinghouse: Standards of medical care in diabetes. V. Diabetes care.	Reviewed and endorsed

Physician News

Clarification on Our Signature Requirements in Medical Records

In response to questions we've received, we'd like to clarify our policy on medical record standards:

- Services performed or ordered should be authenticated by handwritten or electronic signature. If the documentation is unsigned at the time of our audit, we will not accept a signature attestation added at a later date.
- Notes must be documented, reviewed, and signed in the medical record on the date that the service is performed. If further transcribed documentation is needed, it must be corrected, signed and available in the medical record within seven days. In such situations, the chart must be signed on the date of service and must include at least a brief entry indicating that full documentation will follow in dictated form.
- Provide legible documentation and original signature. The use of signature stamps is not acceptable. If the signature is illegible, you must submit a signature log or attestation to support the identity of the illegible signature. A printed signature below the illegible signature is also acceptable.
- We do not accept changes (signature additions or addendums to documentation) as a result of a BCBSMA audit request or audit chart review.

These clarifications are now included in our *Blue Book* manual. To access the *Blue Book* online, log on to **bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books.** Then select Section 2: Utilization Management and go to the "Guidelines for Medical Records" section. ❖

Pharmacy Update

Fertility Specialty Pharmacy Changes Its Name

Ascend SpecialtyRx is now BriovaRx™ and has an updated website. Although its name has changed, it still dispenses fertility medications for our members through its participation in our retail specialty pharmacy network. You can contact BriovaRx at:

Phone: 1-800-850-9122
Fax: 1-800-218-3221
briovarx.com

We have updated our Specialty Pharmacy Medication List to reflect this change. To access it, log on to **bluecrossma.com/provider** and select **Manage Your Business>Search Pharmacy & Info.**❖

Medicare Advantage Pharmacy Updates

Short-cycle dispensing of brand name medications is required

Effective January 1, 2013, CMS requires solid (non-liquid), oral doses of brand-name drugs be dispensed in 14-day or less increments to patients staying in long-term care facilities.

Medication described as "difficult to dispense," such as blister packs and prescriptions that cannot be split conveniently or accurately, are excluded from this mandate.

This change is expected to help reduce drug diversion and unnecessary dispensing of prescription drugs.

Opioid drug management to expand to Medicare Advantage patients

Inadequate pain management and prescription opioid addiction and abuse are growing public health issues. CMS has asked us to review opioid use among our Medicare Advantage members to help facilitate safe, appropriate use of these medications. This is part of our continued effort to reduce the risk of opioid prescription drug abuse.

We are reviewing claims data and may contact you to gather information to help improve prescription drug safety among this population.❖

MEDICARE ADVANTAGE QUALITY CARE NEWS

2013 5-Star Quality Rating Scores Released by CMS

Thanks to the quality care you provide to our members, our Medicare Advantage HMO and PPO plans earned 4.5 stars through the 2013 CMS 5-star rating system—an increase from our HMO plan score of 4.0 last year.

CMS ranks health plans on a scale of 1 to 5 stars to drive improvement in health care for Medicare Advantage beneficiaries; a 5-star score represents the highest quality.

"We are pleased with the 2013 CMS ratings for our Medicare products, but we see opportunity for improved performance with certain measures," said Dana Safran, BCBSMA's Senior Vice President, Performance Measurement & Improvement. "We have seen how sharing data has assisted with improving performance for our commercial HMO members, and we are evaluating whether we can share similar data with you on our Medicare population to help close these gaps in care."

Improving low quality measures

We've been reaching out to our members, through case management, outreach phone calls, and newsletter articles, to help educate them on improving their health, including:

- The use of ACE/ARB with diabetes medication
- Osteoporosis management, especially in women who have suffered a fracture
- Increasing physical activity.

CMS surveys our members to make sure that physicians are addressing specific items during office visits (including the topics above).

You may want to use the annual wellness visit to talk to your patients about some of these topics.

Learn more about the rating system

To learn more about the 5-star measures, log on to **bluecrossma.com/provider** and select **CMS Medicare Quality Ratings** in the blue box on the right side of the home page. Here you will also find a complete table of our performance scores, as well as tools and resources to assist you with the measures.❖

Clinical measures for which we scored three stars or less in HMO or PPO plans on 2013 quality and performance ratings

Measure Name:	HMO stars earned:	PPO stars earned:
Diabetes Treatment (HTN ACE/ARB)	★	★★
Improving Bladder Control	★★	★★★
Improving or Maintaining Mental Health	★★★	★★
Monitoring Physical Activity	★★	★★★
Osteoporosis Management in Women who had a Fracture	★	★
Reducing Plan All-Cause Readmissions	★★★	★★★★
Reducing the Risk of Falling	★★★★	★★★

Coding Corner

This section offers tips on how to code services for complex cases and how to complete your CMS-1500 claims accurately to help ensure prompt payment.

Strokes: Know the Difference When Coding 'Acute' versus 'Old' CVA

The National Stroke Association reports that cerebral vascular accidents (CVA), commonly known as strokes, are the fourth leading cause of death and a leading cause of serious, long-term adult disability in the United States.

When coding for your patients who have experienced a stroke, you must first determine if the stroke is an **acute *or* old CVA**, since the ICD-9-CM codes are very different.

Per *ICD-9-CM Official Guidelines for Coding and Reporting*, you should use codes from categories **430-434** only during the **initial episode or onset** of an acute CVA or stroke.

Additional code(s) should be assigned for any neurologic deficits associated with the acute CVA.

When the medical note does not provide additional information, the terms 'CVA', 'stroke', and 'cerebral infarction' should be coded using ICD-9-CM default code **434.91** - cerebral artery occlusion, unspecified, with infarction (*Coding Clinic*, Fourth Quarter 2004).

Once your patient has completed the **initial treatment** or is **discharged from care**, the codes from the **430-434** series **should not be used**. Be sure to update your office notes and EMR to reflect the correct code when the patient is beyond the initial episode of an acute CVA or stroke.

The correct code assignment beyond the **initial episode** depends upon the presence of any residual neurologic deficits:

- If there are **any residual neurologic deficits**, use codes from **category 438** to identify the residual neurologic deficits. In some cases, the neurologic deficits diminish or disappear within weeks or months of the CVA, while in others the neurologic deficits persist.
- If there are **no residual neurologic deficits** use code **V12.59**, personal history of other diseases of the circulatory system.

There's a lot to remember when documenting and coding for patients who have had a stroke, however correct documentation and coding provides a more accurate and comprehensive picture of your patient's overall health and potential need for treatment, education, and disease management.❖

Example 1

The office note states the patient is seen with hemiplegia on the dominant side due to an old CVA in 2005. The correct code would be **438.21**, late effects of cerebrovascular disease, hemiplegia affecting the dominant side.

Example 2

The office note states the patient had a prior CVA in 2002 and has no residual conditions. The correct code would be **V12.59**, personal history of other diseases of circulatory system. **Note:** ICD-9-CM code **434.91** is not appropriate after the **initial episode** of an acute CVA or stroke.

Billing Notes

Billing Tips for Federal Employee Program Members

Submitting claims for ambulance services

To be reimbursed correctly for ambulance services, please follow the guidelines below:

- Prior to submitting additional documentation, please carefully read the message on your advisory to determine if additional information is being requested, or if the claim was strictly denied as non-covered.
- Please do not submit appeals for chair van services, as these services are not a covered benefit under the Federal Employee Health Benefit Plan.

When submitting trip sheets, please include documentation of reason for transport, especially related to short term rehabilitation stays or hospice.

Submitting claims for blood or marrow stem cell testing services

When submitting claims for blood or marrow stem cell transplant donor testing services for Federal Employee Program members, be sure to use CPT code 86812, 86813, 86816, or 86817.

The Federal Employee Program provides coverage for donor screening tests for up to three non-full siblings (such as unrelated) potential donors, for any full sibling potential donors, and for the actual donor used for the transplant.

To help your claims process quickly, be sure to include the donor relationship on your claims.❖

Billing and Reimbursement Information for Flu Vaccine is on Our Website

The flu information page on our BlueLinks for Providers website provides details on how to bill for flu vaccine not supplied by the Massachusetts Department of Public Health, and how to bill for vaccine administration.

For details, log on to **bluecrossma.com/provider** and click on the **Flu** link on the home page.❖

Blue Options V.4 Will Be Available Starting January 1, 2013

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benefit designs for V. 3 and for Hospital Choice Cost Sharing benefit design for services at these satellite facilities.

Boston Children's locations in Lexington, Waltham, and Peabody will move to the Standard Benefits Tier for Blue Options and to Lower Cost Share for Hospital Choice Cost Sharing. As a result, members will have lower out-of-pocket costs.

The updates will be effective in a one-day change for all Blue Options plans and accounts on January 1, 2013.

The main campus of Boston Children's Hospital will remain in the Basic Benefits Tier/Higher Cost Share.

Reminder: Depending on where they receive care, members with our Hospital Choice Cost Sharing benefit design pay differing cost share for inpatient care, surgical day care services and outpatient services including diagnostic high-tech radiology, diagnostic X-rays and other imaging tests, diagnostic lab tests, and short-term rehabilitation therapy.❖

HealthCare Reform News

Three New State-Mandated Changes Will Take Effect in January

In August, Governor Deval Patrick signed into law two health care-related bills along with Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation." We are updating our plans, medical policies, coverage, and benefits to comply with the mandates. See changes listed below.

Giving Consumers Choices for Care: Physician Assistants

To help improve access to primary care for Massachusetts residents, the new law requires carriers to recognize physician assistants as primary care providers and include coverage for care provided by participating physician assistants for the purposes of health maintenance, diagnosis, and treatment.

Physician assistants must be included on the list of participating providers, and members must be given the opportunity to select a physician assistant as a primary care provider.

This will be added to our members' subscriber certificates on a one-day change for all members on January 1, 2013.

We will provide additional information as we work to implement this law.❖

Hearing Aids for Children, and Cleft Lip and Cleft Palate Treatment for Children

Hearing Aids

The law mandates that children (age 21 and younger) have coverage for one hearing aid per ear, up to $2,000 for each hearing aid and related covered services every 36 months. This includes services prescribed by a licensed audiologist or a hearing instrument specialist, such as the initial evaluation, hearing aid fitting and adjustments, and qualifying supplies.

The member may choose a higher-priced hearing aid, but will need to pay the difference in cost above the $2,000 coverage limit.

We will notify audiologists of applicable codes once we receive DOI approval. We will also be developing a hearing instrument specialist network for members to access for hearing aids and qualifying supplies.

Cleft Lip/Cleft Palate

Coverage is required for treatment of a cleft lip and cleft palate for children up to age 18. Coverage must include benefits for:

- Medical, dental, oral, and facial surgery
- Surgical management and follow-up care by oral and plastic surgeons
- Orthodontic treatment and management
- Preventive and restorative dentistry
- Speech therapy
- Audiology
- Nutrition services

While we currently provide medical coverage for many of these services, we will update our health plans to include coverage for the necessary dental and orthodontic services to treat these conditions.

All of the provisions of the member's health plan govern coverage for both hearing aids and cleft lip/cleft palate services for children.

For most accounts, the hearing aid and cleft lip/cleft palate benefit changes takes effect on account renewal beginning January 1, 2013. Self-insured non-municipal accounts have the ***option*** of adding the benefits on account renewal.❖

Office Staff Notes

How to Handle Lab Tests for Novartis Members

Novartis, one of our employer accounts, recently purchased Genoptix Medical Laboratory, a laboratory specializing in diagnosing cancers and disorders in bone marrow, blood, and lymph nodes, and with expertise in the most challenging hematology and solid tumor workups.

As of May 1, 2012, clinical laboratory services must be submitted to Genoptix Medical Laboratory for enrolled Novartis members. This only applies to Novartis members. Continue to follow standard procedures for other Blue Cross Blue Shield members.

The services provided at Genoptix Medical Laboratory will be reimbursed at 100% of charges if provided on an out-of-network basis, or at 100% of our allowance, if provided on an in-network basis.❖

Reminder About Submitting Claims for Members With New "XXS" ID Prefix

As we've reported in *Provider Focus*, BCBSMA is upgrading our claims system throughout 2012 and 2013.

In relation to this transition, approximately 40,000 members have received updated ID cards with a new alpha-prefix—**XXS**.

To ensure timely and accurate claims processing, please remember to check member eligibility **prior to rendering services** and submit the most up-to-date member ID, including the correct alpha prefix.

Claims submitted with an outdated alpha-prefix will be denied.❖

Reminder About Our Consolidated Telephone Numbers

Please call Network Management and Credentialing Services at **1-800-316-2583 (BLUE)** if you need help with:

- Credentialing
- Changing a current contract
- Getting the status of a previously submitted provider contract
- Resolving other non-claims related issues.

As a reminder, the old Enrollment and Credentialing number, **1-800-419-4419,** was eliminated over the summer and is no longer in use.❖

BCBSMA Will Introduce a Limited Network in 2013

Provider organizations were recently notified via *F.Y.I.* about a new limited network, Select Blue PPO, a more affordable option we're making available to our self-insured customers.

We'll primarily market commercial PPO and EPO benefit plans with the Select Blue PPO network to our municipal employees.

Members with the Select Blue PPO network will be able to receive in-network care from a limited network of providers, except in emergent or urgent situations.

We anticipate rolling out plans with the Select Blue PPO network no sooner than the third quarter of 2013.

In the future, we may expand our portfolio of limited network offerings to various insured plans. At this time, however, the primary focus is on this targeted municipal market.

If you have questions about the Select Blue PPO limited network, please call Network Management Services at **1-800-316-BLUE (2583).**❖

Office Staff Notes

Updated Forms Have Been Posted on BlueLinks for Providers

We have updated the following authorization and services extension request forms to include additional fields for provider NPIs:

- *Inpatient Hospice Clinical Review Form*
- *Medical Nutrition Therapy Authorization Extension Request Form*
- *Initial Precertification Form for SNF/Rehab/LTCH*
- *SNF/Rehab/LTCH Clinical Recertification Form*
- *Behavioral Health Out-of-Network Request Form*
- *Pre-Authorization for Non-Emergent Ground Ambulance Transport.*

The additional NPIs requested on the forms help us process requests efficiently and accurately.

To download or print the new versions, log on to our website at **bluecrossma.com/provider** and click on **Resource Center> Forms.**❖

CAQH/CORE Eligibility Benefit Response Changes Go into Effect January 1

In mid-December, BCBSMA plans to implement changes to Eligibility Benefit Responses in accordance with the January 1, 2013 Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) guidelines. The updated guidelines include changes to the response for certain service types and enhanced deductible information.

For more information on these changes, go to **caqh.org**. Or, go to **bluecrossma.com/provider** and click on **Manage Your Business**. Then scroll down and click on the **HIPAA 5010** link.

Questions?

For additional assistance, please send an e-mail to **hipaafaq@bcbsma.com.**❖

Health Care Technology Survey Required by Year-End

To meet the Center for Health Information and Analysis' requirements, health plans must collect information about the technologies used by hospitals and physician practices.

HealthCare Administrative Solutions (HCAS) has developed an online survey to collect this information for its member organizations*.

If you haven't completed the *Provider Technology Adoption Survey* yet, please do so by going to **www.hcasma.org/Survey.aspx**.

Facilities and groups may also submit survey responses on behalf of their providers. HCAS will submit completed surveys to the participating health plans and to the state.❖

** Organizations participating in this survey include Blue Cross Blue Shield of Massachusetts, Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, Network Health, and Tufts Health Plan.*

Electronic News Coming Your Way in 2013

As part of BCBSMA's company-wide commitment to reduce paper use, waste, and energy, we have decided to publish the news that currently appears in *Provider Focus* soley online in the spring of 2013.

Instead of printing and mailing a newsletter to you each month, we'll provide news and updates electronically on our provider website and via e-mail.

That means you'll be able to get your news faster and in a more convenient format.

We will provide more details on this exciting change in the coming months.

In the meantime, if you have any questions, please send an e-mail to **focus@bcbsma.com.**❖

Office Staff Notes

BCBSMA's Guidelines for Appointment Wait Times and Access to Care

The speed with which members obtain appointments to see their primary care provider (PCP) strongly influences their overall satisfaction with their care.

To benchmark patient satisfaction with appointment wait times across health plans nationwide, BCBSMA looks at Consumer Assessment of Healthcare Providers and Systems (CAHPS) data administered by the Agency for Healthcare Research and Quality (AHRQ). Our own data are then measured against CAHPS standards.

We have worked with participating physicians to develop appropriate access-to-care guidelines for primary care services and we recommend the general guidelines for wait times as shown in the chart below. Please note these guidelines are recommendations only; individual circumstances may require attention sooner than listed below.

You can also find this information in Section 1: Health Plan Overviews of your *Blue Book* manual, available online. Log on to **bluecrossma.com/provider** and click on **Resource Center> Admin Guidelines & Info> Blue Books.**❖

If a member needs:	Defined as:	We expect the member to be seen:
Emergency care	A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine or as determined by a provider with knowledge of the person's condition, to result in severe pain that cannot be managed without such care, and to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).	Immediately
Urgent care	Those covered services that are medically necessary and immediately required to prevent serious deterioration of a Member's health that results from an unforeseen illness, condition, or injury when the Member is temporarily absent from the service area (or, under unusual and extraordinary circumstances, provided when the Member is in the service area but the applicable Plan's provider network is temporarily unavailable or inaccessible) and that cannot be delayed until the Member returns to the service area, as determined by the applicable Plan.	Within 24 hours
Symptomatic care	Needed for non-urgent symptomatic conditions.	Within 48 hours
Preventive care	Designed for the prevention and early detection of illness in asymptomatic people, generally including routine physical examinations, tests, and immunizations.	Within 45 days of calling for an appointment

Ancillary News

2013 CPT/HCPCS Codes for Ancillary and Behavioral Health Providers

We are currently reviewing the new CPT and HCPCS codes released for dates of service starting on January 1, 2013 to make any applicable fee schedule changes.

This year's update includes significant changes to codes billed by behavioral health providers.

You may also wish to consult with your professional society and the CPT coding update manual to learn how these codes replace codes you currently use.

Please remember:

- Do not bill for deleted codes after January 1, 2013.
- Bill only for codes that are on your current Agreement. We only provide reimbursement for codes included on your Agreement.

We anticipate posting changes (including any additions, deletions, and narrative changes) and a revised fee schedule online early in 2013.

We will send behavioral health providers more information about the code changes that affect them. For all other ancillary providers, we will only communicate these updates via our BlueLinks for Providers website and will not send a printed *F.Y.I* If you have not already done so, we urge you to register for updates via e-mail.

If you have questions, please call Network Management Services at **1-800-316-2583 (BLUE).**❖

Chiropractors: Request Form Updated Online

Earlier this fall, we notified you via e-mail that the *UM Department Request Form* has been updated.

This form is used to request a modification to a start or end date of a chiropractic services authorization, or to appeal an authorization decision.

Completed forms should be directed to Healthways WholeHealth Networks, our chiropractic services authorization program vendor.

The form now includes the timeframe for responding to appeal requests. We are not making changes to the process you follow for these requests.

Please update your files with this new form.

To download a copy, log on to **bluecrossma.com/provider** and click **Chiropractic Services Authorization Program** in the blue box on the home page. Then, in the pop-up window, scroll down to the form.❖

Early Intervention Providers: ABA Codes Have Been Added to Your Indemnity Fee Schedule

As of November 1, 2012, we have added codes for ABA services to your fee schedule for Indemnity members.

We recently e-mailed you with this update and remind you that these codes are now listed on your fee schedule for HMO, PPA, and Indemnity products.
You need prior authorization before coordinating these services for our members.

Questions?

To learn more about how to request an authorization or how to bill for ABA services, please refer to our June 1, 2012 *F.Y.I.*

To find the *F.Y.I.* online, go to **bluecrossma.com/provider and clicking on News for You>FYIs.**❖

Code Update for Durable Medical Equipment Providers

In accordance with the updates made to medical policy 133: *Microprocessor Controlled Prostheses for the Lower Limb*, we will be removing L5973 from the DME Fee Schedule because this procedure is considered investigational and will no longer be covered, effective February 4, 2013.❖

Medical Policy Update

Medical Policy Announcements Effective March 1, 2013

A large number of new medical policies and medical policy revisions will take effect in March 2013, and have been posted online. Go to **bluecrossma.com/medicalpolicies** and scroll down to the link for **March updates**.

Policy Drafts Available upon Request

Full drafts of each policy are available by request one month prior to the effective date of the policy by sending an e-mail to our Medical Policy Administration team at **ebr@bcbsma.com**.

For example, for policies with an effective date of March 1, 2013, you may request a draft copy as of February 1, 2013.❖

Our Medical Policies Will Have a New Look Starting in February 2013

In February, we'll unveil rewritten, reorganized medical policies. Longer, more complex policies will be separated into single-topic documents. Also, the new documents will all follow a consistent format. (See summary of new format below.) To view a sample policy online, go to **bluecrossma.com/medicalpolicies**. If you have any questions now or after reviewing the policy, please contact us at **ebr@bcbsma.com**.

Please note that current policy coverage statements will remain the same in the new documents.

If we need to communicate revisions or changes to medical policy coverage statements, we will continue to do so in *Provider Focus* or on the medical policy website 90 days prior to the effective date.❖

Title: The name of the BCBSMA medical policy; usually the name/description of the service discussed in the policy.
Table of Contents: Provides links to each major section of the policy; allows the user to skip to the section of interest.
Policy Number: The BCBSMA medical policy number before 2013; for your convenience, we will maintain this number for at least one year after the new policy number goes into effect.
New Policy Number: These new numbers group medical policies into categories (medicine, radiology, etc.) by the leading digit.
Related Policies: Lists the policy title and policy number of other policies that deal with a similar topic.
Policy: Describes the medical policy coverage or non-coverage statement for commercial (HMO, POS, PPO, and Indemnity) and Medicare (HMO and PPO) members.
Prior Authorization Information: Shows whether pre-authorization is required for the service described in the medical policy. This section also contains links to general utilization guidelines for managed care, PPO, and Indemnity.
CPT Codes/HCPCS Codes/ICD-9 Codes: Contains all clinical coding related to the medical policy are listed for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. A member's contracted benefits in effect at the time of service determine coverage or non-coverage as it applies to an individual member. Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.
Description: Presents a clinically correct explanation of the service addressed by the policy.
Summary: Supplies a short explanation of the how the policy decision was made based on available medical literature.
Policy History: Tracks the review of and any changes made to the medical policy in the last 5 years.
Information Pertaining to All Medical Policies: Consists of a series of links to documents that are related to medical policies, including descriptions of the clinical exception process and our technology assessment guidelines.
References: Citations from all the medical literature used to develop the medical policy are listed.
Endnotes: Documents the source of the policy statement.

MASSACHUSETTS
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Landmark Center
401 Park Drive
Boston, MA 02215

Providerfocus

ROUTING BOX
Date received:_____
Please route to:
- ☐ **Office manager**
- ☐ **Physician**
- ☐ **Nurse**
- ☐ **Billing manager**
- ☐ **Billing agency**
- ☐ **Receptionist**
- ☐ **Other:** _____

Questions about billing for the flu vaccine?
Log on to **bluecrossma.com/provider** and click on the **Flu** link.

At Your Service

- BlueLinks for Providers
  www.bluecrossma.com/provider
  Our website has the resources to help you care for our members, and offers you the ability to check claim status, and eligibility and benefit information. Available 24 hours a day, 7 days a week.
- Claims-related issues:
  Provider Services: **1-800-882-2060**
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
  Ancillary Provider Services: **1-800-451-8124**
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
- Fraud Hotline: **1-800-992-4100**
  Please call our confidential hotline if you suspect fraudulent billing or health care activities.
- Non-claims-related issues:
  Network Management & Credentialing Services:
  Reach your Network Manager or inquire about contracting and credentialing issues (all provider types):
  1-800-316-BLUE (2583)
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.

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—or—
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