January 2012

Providerfocus

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Alternative Quality Contract Continues to Show Impressive Results

Early results from year-two of the Alternative Quality Contract (AQC) show that the AQC is indeed advancing the goals of significantly improving quality and outcomes while moderating medical spending.

The impressive results are based on the performance of both the initial group of AQC participants (2009 cohort) and those whose contracts began in 2010 (2010 cohort).

Improving Quality and Outcomes

The 2009 AQC cohort showed continued success improving both ambulatory and inpatient quality and outcomes. In its first year, the 2010 AQC cohort made significant improvements in both ambulatory and hospital quality.

Improving Preventive and Chronic Care Management

Preventive care and chronic care management are two core domains of ambulatory quality.

AQC Spotlight

The 2009 AQC cohort made further gains in these dimensions of care and continues to significantly outperform the non-AQC segment of our network on preventive care and chronic care management.

The 2010 cohort made significant gains in preventive and chronic care—far outperforming their own prior performance and prior rates of performance improvement.

For several groups, performance was close to "best achievable" for a patient population on important clinical outcomes for diabetes, heart disease, and hypertension.

Reducing Medical Spending Growth

In the September 2011 issue of *Provider Focus*, we told you about an independent study of the AQC by Harvard Medical School (HMS). The study found that in year-one, the rate of growth on medical spending was approximately two points lower among AQC groups compared with those in traditional fee-for-service contracts.

HMS researchers will soon complete an analysis of year-two results and report on their findings. Meanwhile, BCBSMA internal analysis has found that, in year-two, AQC medical spending and spending growth continue to outperform non-AQC groups in several areas:

- **Reduced inpatient admissions.** AQC utilization trend for medical/surgical inpatient admissions was more than 2% lower than non-AQC groups in 2010. This equated to more than 300 avoided admissions, or $6 million in avoided fee-for-service costs.

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In Brief

Questions About ICD-10? Check Out Our *FAQs* Online

BCBSMA has launched an online resource center to provide you with important ICD-10 readiness information, and we recently posted *Frequently Asked Questions* about the ICD-10 transition.

To access the *FAQs* and other ICD-10 resources, including results of a statewide provider preparedness survey, log on to BlueLinks for Providers at **bluecrossma.com/provider** and click on the **ICD-10 Resource Center** link on the home page.

We'll continue to update you on ICD-10-related issues in upcoming issues of *Provider Focus*.❖

Physician News

Attention PCPs: Enhanced Reports Are Now Available Online

To improve the quality of care delivered by PCPs, BCBSMA has developed reports to help PCPs identify patients who could benefit from guideline-recommended preventive or chronic care screenings.

These reports focus on a wide range of National Committee for Quality Assurance (NCQA) Health Employer Data and Information Set (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 reports for dates of service between January 1, 2011 to October 31, 2011 are now available online. They 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 your BCBSMA members in the measure population, whether they have the required screening, and the date and procedure associated with the screening.

These reports will show you only the measures for which you have a sufficient patient population to be evaluated.

To access any BCBSMA reports that apply to you, log on to our website, **bluecrossma.com/provider** and click on **Manage Your Business> Access Your Reports.**

We expect that you will use and protect the data in all of these reports in accordance with the same standards of privacy and confidentiality that you apply to all protected health information.

Questions?

Your feedback is important to us, so please contact your network manager at **1-800-316-BLUE (2583)** with any questions.❖

Reimbursement for Services Rendered After-Hours and on Major Holidays

We occasionally receive questions about BCBSMA's reimbursement for care provided after a clinician's posted office hours.

To clarify our policy, BCBSMA reimburses participating clinicians for CPT®˝ code **99050** (Services requested after posted office hours in addition to basic service).

This means that we reimburse for this code in addition to reimbursing for the underlying evaluation and management (E&M) office visit.

Major holidays, for which this code would apply, include only the following six holidays:

- New Year's Day
- Memorial Day
- Independence Day (July 4th)
- Labor Day
- Thanksgiving Day
- Christmas Day.

BCBSMA does not provide coverage of CPT code **99051** (Service[s] provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service).❖

Physician News

Our 2012 Plan to Engage Specialists with Practice Pattern Variation Analyses

In 2011, BCBSMA began an effort to engage physicians and societies in each of seven specialties (cardiology, orthopedics, allergy and immunology, dermatology, otolaryngology, neurology and gastroenterology) with evidence of significant practice pattern variation for clinically defined patient populations.

Our intent was to gain feedback on the specialty-specific analytics, encourage professional leadership and the development of best practices within clinical areas, and to stimulate peer-to-peer discussions that seek to understand root causes of variation. Overall, we have sought to support improved quality and affordability by understanding variation in care in these specific areas.

For those of you who received practice pattern variation analysis (PPVA) data, we hope you found it informative. At BCBSMA, we are most appreciative of your engagement with us in such substantive PPVA discussions in 2011.

In 2012, BCBSMA plans to engage specialist physicians with this data as outlined below:

- BCBSMA will continue to send AQC groups their PPVA reports two times per year, including analyses related to specialist care.
- AQC group leaders will continue to engage specialists around PPVA.
- BCBSMA will complete the current round of engagement activities with seven specialty societies—but following that series of discussions, future engagement with specialists and specialty societies will be done in partnership with AQC clinical leaders.
- Some AQC groups expressed a preference for future specialty engagement efforts to be a shared effort—involving multiple AQCs, BCBSMA and specialty society leaders and members—using the PPVA data to work toward developing local "best practice" standards. Other AQC leaders expressed a preference for working solo in engaging the specialists in their groups.
- AQC groups will continue to receive data for physicians who are formally part of their contract, and will not receive PPVA data for physicians outside of their contract.

If you have questions about PPVA, please send an e-mail to **specialists@bcbsma.com** or call Network Management Services at **1-800-316-BLUE (2583)**.❖

Pharmacy Update

Reminder: Walgreens Terminating Its Agreement with Express Scripts, Inc.

As we've communicated previously, Walgreens is no longer participating in the Express Scripts, Inc. (ESI) retail pharmacy network, effective January 1, 2012.

This means our members will need to transition retail prescriptions for medications—including specialty medications—to a new pharmacy. Therefore, you may receive requests for new prescriptions from your patients who use Walgreens.

We've notified our members that they may also transfer their prescription simply by bringing their prescription bottle to the new pharmacy, or by calling the new pharmacy and asking them to contact the Walgreens pharmacy to make the transfer.

For more details and late-breaking news if an agreement is reached between the two parties, log on to our website at **bluecrossma.com/provider** and click on the **Walgreens** termination link.❖

See Medical Policy Update section, page 7, for an important update to medical policy 013, Antihyperlipidemics.

Office Staff Notes

BCBSMA Announces New HEDIS Medical Record Review Vendor for 2012

BCBSMA conducts an annual medical record review to meet our NCQA Healthcare Effectiveness Data and Information Set (HEDIS) data collection requirements. Starting in February 2012, Health Data Vision, Inc. (HDVI), our new medical record retrieval vendor, will begin the process of collecting medical record data from physicians on behalf of BCBSMA.

HDVI will retrieve information for a sample of our HMO/POS and PPO members. Medical record information requested and collected by HDVI will be securely handled in accordance to HIPAA regulations.

After receiving your patients' medical record data, HDVI will examine the documentation promptly and provide timely feedback when additional information or clarification is needed.

As a reminder, PCPs who are contracted with BCBSMA are required to participate in quality improvement initiatives. By cooperating with us on data collection and improvement activities, such as HEDIS, your office has the opportunity to inform future initiatives that will support the delivery of high-quality health care.

If you have any questions about this process, please contact Network Management Services at **1-800-316-BLUE (2583)**.

About Health Data Vision, Inc.

HDVI is an industry leader in medical record collection for HEDIS and will strive to collect the required clinical information with the least amount of disruption to your office operations.

To learn more about HDVI, go to **healthdatavision.com.**❖

Reminder About BCBSMA's Standards in Utilization Management

As noted in Section 2 of your *Blue Book* manual, it is our position that decisions regarding health services should be made solely on the appropriateness of care and the existence of coverage.

Any health care provider who delivers services to our members must also ensure that the care is both effective and efficient.

BCBSMA believes that our members are best served when their care is well-coordinated and appropriate for their needs.

Care decisions should be based only on whether they are appropriate for the member and are consistent with evidence-based, high-quality, cost-effective care. As a matter of policy, we do not provide financial incentives that encourage practitioners to deny medically necessary, appropriate health care services.

While over-utilization of health care services can be harmful, costly, or inconvenient to members' health, under utilization is a special concern as well.

Adverse outcomes that can result from under-utilization, include:

- Missed opportunities to prevent illness
- Missed opportunities to diagnose and treat illness at an early stage, which can lead to significant complications
- Inadequate treatment resources for chronic illness, which can contribute to poor outcomes and higher costs.

You can access your *Blue Book* Online by logging on to **bluecrossma.com/provider** and clicking on **Resource Center> Admin Guidelines & Info> Blue Books.**❖

Office Staff Notes

Is Your Information Up-to-Date? How to Submit Address and Telephone Number Changes to Us

Having accurate address and telephone information for BCBSMA providers is important so that we can provide the most up-to-date information to our members.

If you are currently contracted with BCBSMA as an individual provider and your primary or billing address or telephone number has recently changed, please submit a *Change of Address Form* to our Provider Enrollment area. All changes must be submitted to us in writing.

For the primary telephone number, please indicate the number your patients would call to schedule an appointment.

Important: Please complete a *Contract Update Form* if you are affiliated with a group and you are:

- Leaving a group practice/location
- Joining a different group
- Adding a secondary site.

To access either the *Change of Address Form* or the *Contract Update Form*, log on to our website at **bluecrossma.com/provider** and click on **Resource Center> Forms>Administrative Forms.**

Then select the appropriate form for your provider type. Be sure to complete all fields on the form and fax it to us at the number listed on the form.

Please do not use the CMS-1500 claim form to notify us of address changes.❖

Click & Connect Learn How to Use Our New Direct Claim Entry Tool

Join us for one of our upcoming *Online Services Claim Entry* webinars and hear about how you can submit professional claims to BCBSMA via direct data entry in Online Services.

Please register at least one week prior to the session by logging on to **bluecrossma.com/provider** and selecting **Resource Center> Training & Registration> Course List**.

Under the Primary Care, Specialty Care, Behavioral Health, or Ancillary subheading, choose **Online Services Claim Entry Webinar**.

New to Online Services?

If you are new to Online Services, we suggest you first view our *Introduction to Online Services* audio-visual presentation, also available under our online Course List.❖

Date:	Time:
Wednesday, February 22	10 – 11 a.m.
Wednesday, March 21	2 – 3 p.m.

FEP Benefit Changes, Effective January 1, 2012

The following benefit changes went into effect January 1, 2012 for Federal Employee Program (FEP) members:

Sleep Study Tests (Basic Option). Subject to a $75 member copayment when performed and billed by either a preferred facility or professional provider; previously, members had no cost share for these services.

Hearing Aids (Basic and Standard Options). Dispensing fees and supplies were added to the hearing aid maximum benefit. The benefit was enhanced to $1,250 per benefit period to offset additional supplies added to the maximum.

Speech Generating Devices (Basic and Standard Options). The benefit maximum was enhanced to $1,250.

Applied Behavior Analysis (ABA). This treatment is a benefit exclusion.

Gastric Surgery Pre-surgical Requirements Clarification.

- The member must meet all requirements listed in the Service Benefit Plan brochure (page 54).
- Psychological clearance of the member's ability to understand and adhere to the pre-and post-operative program.
- The member has not been treated for substance abuse, with no evidence of substance abuse during the one-year period prior to surgery.❖

Ancillary News

Reimbursement Change for CPT®˝ Code 77014 Takes Effect in March

We have updated the Radiation Oncology fee schedule to include both a technical component reimbursement and a global reimbursement retroactive to March 1, 2011, for CPT code **77014** (Computed tomography guidance for placement of radiation therapy fields).

When billing for the technical component of 77014, please use modifier TC to ensure that you receive the correct reimbursement.❖

Code:	Modifier:	Fee:
77014	TC	$185.74
77014	Global	$253.44

DME Providers: Quantity Limit for CPT®˝ Code A9274 Takes Effect in February

As noted in an *F.Y.I.* mailed to you in December 2011, effective February 1, 2012, the following quantity limit will take effect for DME providers:

CPT®˝ code A9274: External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories (a quantity limit of insulin pump reservoirs of 15 units per 30 days, effective February 1, 2012).

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

Alternative Quality Contract Continues to Show Impressive Results

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- **Reduced use of high-tech radiology.** AQC groups' careful management of imaging resulted in a lower high-tech radiology trend among AQC vs. non-AQC groups, resulting in approximately 1,500 avoided scans and $2 million in avoided fee-for-service costs in 2010.
- **Less-costly care settings.** AQC groups continue to shift care to lower-cost facilities, particularly for basic tests and procedures, such as outpatient radiology, laboratory, and surgery services. These site-of-service changes resulted in approximately $2.5 million in savings in 2009 and 2010.

"We are delighted with the strong evidence of continued improvements in both the quality and affordability of care among AQC groups," says Dana Safran, BCBSMA's Senior Vice President, Performance Measurement and Improvement. "It is impressive to now see a second cohort of AQC groups—the 2010 cohort—make similarly strong quality improvements in year-one of their contract. Moreover, the further gains in quality and spending among the 2009 cohort this year undercore the momentum these groups are building as they transform care under a payment model that rewards quality, outcomes, and affordability."

We will communicate more about HMS' findings in *Provider Focus*.

About the AQC

As of January 1, 2012, 60% of PCPs and 75% of specialist participate in the AQC, and 68% of our in-state HMO/POS membership—913,000 BCBSMA members—receive care from an AQC physician.❖

"The further gains in quality and reduced spending among AQC groups this year undercore the momentum these groups are building as they transform care under a payment model that rewards quality, outcomes, and affordability."

Dana Safran, ScD.,
BCBSMA's Senior Vice President,
Performance Measurement and Improvement

Medical Policy Update

All updated medical policies will be available online. Go to bluecrossma.com/provider>Medical Policies.

New Medical Policies

The following is a list of new medical policies describing ongoing non-coverage. These procedures were previously addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*:

- *Acoustic Cardiography*, 537.
- *Baroreflex Stimulation Devices*, 595
- *Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure*, 594.
- *DNA-Based Testing for Adolescent Idiopathic Scoliosis*, 545.
- *Intracavitary Balloon Catheter Brain Brachytherapy for Malignant Gliomas or Metastasis to the Brain*, 602.
- *Interspinous Distraction Devices (Spacers)*, 584.
- *Low-Level Laser Therapy*, 522.
- *Lysis of Epidural Adhesions*, 598.
- *Plugs for Fistula Repair*, 528.
- *Skin Contact Monochromatic Infrared Energy as a Technique to Treat Cutaneous Ulcers, Diabetic Neuropathy, and Miscellaneous Musculoskeletal Conditions*, 507.
- *Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea*, 570.
- *Surgical Ventricular Restoration*, 544.
- *Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress Incontinence*, 523.
- *Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis*, 547.
- *Whole Body Dual X-ray Absorptiometry (DEXA) to Determine Body Composition*, 577.

Change

Computer-Assisted Corneal Topography, 301. Adding coverage for this procedure. Effective 3/1/12.

Clarification

Medical Technology Assessment Non-Covered Services, 400. Clarifying non-coverage of Solesta for the treatment of fecal incontinence.

Correction

In the September issue of *Provider Focus*, we announced a new medical policy, *Minimally Invasive Lumbar Interbody Fusion*, but listed an incorrect policy number. The correct number for this policy is 617.

Pharmacy

Antihyperlipidemics, 013. Updated to include new generic atorvastatin amlodipine/atorvastatin covered as Step 1 medications. Effectived January 1, 2012.❖

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Providerfocus

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www.bluecrossma.com/affordability

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  Please call our confidential hotline if you suspect fraudulent billing or health care activities.
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