Blue FOCUS

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

A quarterly newsletter for hospitals and institutional ancillary providers

SUMMER 2010

Delivering on Our Promise to Put Our Members' Health First

The passage of health care reform was historic—first in Massachusetts, then nationally. While questions remain about the impact of health care reform on a state and national level and the changes that lie ahead, one thing remains the same—our commitment to always put our members' health first.

One way we deliver on this promise is through Member Central, our secure member website. Recently enhanced, Member Central empowers our members with tools to help them make important health care decisions, and to help them get the most out of their plan.

Resources All in One Place

Member Central is designed to engage our members in the resources available, helping them to become more involved in their own health care.

Through the site, registered members and covered family members have immediate access to benefit and claim information.

They can:

- Look up copayments
- Search for a provider using Find a Doctor
- Choose a PCP
- Order an ID card
- Create a personal health record
- Manage their health reimbursement and health savings accounts
- Look up pharmacy coverage and potential savings
- Track medication history
- Update their contact information
- See personalized messages based on their data, read the annual member newsletter, and sign up to receive news and updates via e-mail
- Access money-saving benefits and wellness resources.

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In This Issue

BCBSMA Ranks High in Eligibility, Claims Payment

BCBSMA was ranked first among all Blue Cross Blue Shield plans nationwide on eligibility accuracy in 2009, based on data from athenahealth, a provider of medical billing and electronic health record solutions to doctors. In addition, BCBSMA is one of only four payers nationwide that pays provider claims in less than 20 days.

The rankings are based on specific metrics compiled by athenahealth to encourage industry transparency.

According to athenahealth, "BCBSMA continues to be a center of excellence, ranked third among all payers, second among Blues, and second in the northeast."

For more details about the metrics and the rankings, go to **www.athenahealth.com** and click on **PayerView.**❖

BCBSMA News

BCBSMA Will Not Require Computerized Physician Order Entry for Participation in Our Hospital Incentive Programs

As you may know, the Commonwealth of Massachusetts will require hospitals to use computerized physician order entry (CPOE) starting in 2012 as a condition of licensure.

In light of this and recent federal efforts to stimulate the adoption and meaningful use of electronic health records (EHRs)—including the mandatory use of CPOE—BCBSMA has decided it will not require hospitals to implement and use CPOE as a threshold for participation in our incentive programs.

Our original decision to require CPOE, previously announced in 2008, was compelled by work done by the Massachusetts Hospital CPOE Initiative* that clearly demonstrated the quality, safety, financial benefits of these systems.

While we still support the Massachusetts Hospital CPOE Initiative's efforts and believe CPOE is an important tool in the effort to avoid preventable medical errors, we want to avoid creating any potential conflicts that may result from varying timelines set by BCBSMA, the state, and the Centers for Medicare & Medicaid Services.

CPOE systems enhance the provider's ability to collaborate with patient care networks and more effectively and accurately share knowledge in all facets of health care. These systems:

- Alert doctors when a medication order may pose a dosage, interaction or allergy danger
- Provide health care professionals with broader access to patient information
- Dispense critical information that can improve patient safety
- Streamline workflow efficiency and improve overall patient care.

BCBSMA applauds hospitals that have already implemented CPOE and those that are currently or planning to undertake this important work.❖

**The Massachusetts CPOE Initiative is a collaborative effort among the New England Healthcare Institute, the Massachusetts Technology Collaborative, and other community stakeholders.*

Health Care Organizations' "Audacious Goals" LEAD to Learning

Providers across the state now have an opportunity to learn from an ambitious collaboration between BCBSMA and five of the state's leading provider organizations.

Early in 2007, five health care organizations—Atrius Health, Beth Israel Deaconess Medical Center, Cooley Dickinson Hospital, Mount Auburn Hospital, and New England Baptist Hospital—were selected to take part in BCBSMA's Leading Edge Acceleration of Delivery and Design (LEAD) program. This unique effort, aimed at engaging these organizations in transformational change, required a two-year commitment from the participating organizations and their CEOs.

As part of LEAD, each CEO was asked to identify and set an "audacious goal" in quality improvement for his or her organization. These health care leaders then met regularly to discuss their progress and share lessons learned.

It is out of the LEAD program that Beth Israel Deaconess Medical Center (BIDMC) set a goal to eliminate all preventable harm by 2011—an aim that drew significant media attention to BIDMC early in 2008.

LEAD participants also found out just what it takes to achieve their goals.

"We had already set a series of whole system-level goals without knowing how we would fund the pace of advancement," says Craig N. Melin, President and CEO of Cooley Dickinson Hospital. "The Blue Cross LEAD program provided the resources, additional guidance, and the inspiration that comes from collaboration, to jump start and reach most of our goals faster than we'd have thought possible."

All five participating organizations want to share their LEAD experience with other organizations. To read detailed case studies, go to **www.qualityaffordability.com** and click on **Solutions>Working with the Community>LEAD Program.**❖

Pharmacy Update

Tips on Registering for ExpressPA, Our Online Pharmacy Authorization Tool

More providers are turning to ExpressPA for instant answers on pharmacy authorization decisions. This web-based tool allows you to submit prescription authorization requests, such as prior authorizations, formulary exceptions, and quality care dosing overrides for commercial members.

Before you begin using the tool, you must first register and activate your account. From our experience with practices that have incorporated the tool, we offer these tips:

- Using your National Provider Identifier (NPI) to register is faster because it will pre-populate your contact information into the system. You'll then need to upload a copy of your NPI, DEA, or state medical license for confirmation.
- ExpressPA will e-mail activation information to you; you'll need to respond using the user name and password entered during registration. (Adjust your e-mail settings if necessary so the activation e-mail from ExpressPA is not blocked.)
- If you are a nurse or office manager (an agent) using ExpressPA on behalf of a prescriber, the prescriber will first need to be registered and activated on ExpressPA. That prescriber must assign privileges to his/her agents.
- Agents must register for ExpressPA using the special physician ID number (PPI number) assigned during the prescriber's account activation. Be sure to obtain that PPI from the prescriber.
- If there is more than one prescriber in your practice, you will need to register as an agent for each prescriber.

For more information on the registration and activation process, refer to our new *Quick Start Guide.*

Online Resources

- Go to ExpressPA's website: **https:\\www.express-pa.com**
- Access the *Quick Start Guide*, which has helpful information on the registration process. Log on to **www.bluecrossma.com/provider** and select **Technology Tools**; then scroll down to **ExpressPA** and click on **Learn more.**❖

Have Pharmacy-Related Questions? Take Our New Online Course

BCBSMA is now offering a new audiovisual presentation about our pharmacy benefits, prior authorization requirements, and the pharmacy tools available to you on BlueLinks for Providers.

By completing this online course, you'll learn about:

- Using our Medication Search tools to look up the coverage status and tiering for a medication
- Submitting authorization requests using ExpressPA
- Quality care dosing, step therapy, and prior authorization guidelines.

How to register

Log on to our website at **www.bluecrossma.com/provider** and click on **Resource Center>Training & Registration> Course List.** Under the **All Providers** subheading, choose **Your Pharmacy Questions Answered.**❖

Pharmacy Medical Policy Updates

Dopamine Agonists, Non-ergot Derived, 119. Updated to include new generic product pramipexole covered as a Step 1 medication. Effective 2/1/10.

Phosphodiesterase Type-5 Inhibitors, 036. Updated to include coverage criteria for new FDA-approved product Adcirca™. Effective 1/15/10.

Proton Pump Inhibitor, 030. Added coverage exclusion to Zegerid (20 mg capsules) since it is now available over-the-counter. Effective 7/1/10.❖

See pages 11-15 for all other medical policy updates.

Clinical Notes

QuitWorks: A Stop Smoking Solution for Massachusetts Hospitals and Practices

What is QuitWorks?

QuitWorks is a free evidence-based referral service offered by the state that connects Massachusetts health care providers and their patients with phone-based counseling to help patients stop smoking. Referring a patient is as simple as filling out an enrollment form.

Launched in 2002 through a unique collaboration with the Massachusetts Department of Public Health (MDPH) and all major commercial and Medicaid health plans in the state, QuitWorks provides smoking cessation services to any patient, regardless of health insurance status.

Results Show Success

As of January 2010, 60 of 71 hospitals in Massachusetts actively participate in the QuitWorks program. Through March 2010, more than 21,700 tobacco users have been referred for QuitWorks services. According to the Centers for Disease Control and Prevention, tobacco users who quit with no support or medications typically have sustained quit rates of about 5%, while QuitWorks users achieve an overall quit rate of 15% to 30%, depending on the type of treatment used (counseling or medications).

QuitWorks for Hospitals and Health Care Facilities

QuitWorks' goal is not just to treat individual smokers, but to work with health care facilities to institute a continuum of effective treatment interventions, from admission to post-discharge or post-outpatient visit. The MDPH provides:

- Special technical assistance on workflow design for integration of QuitWorks and tobacco interventions into existing systems and electronic health records (EHRs)
- Provider and staff training for health care facilities that use QuitWorks
- New data-sharing agreements for improved evaluation.

For hospitals, QuitWorks can produce aggregate reports and patient-level data to satisfy Joint Commission core measures, as well as the facility's own quality improvement initiatives.

In the near future, QuitWorks will be integrated into EHRs and will be able to provide faster data reports to facilities.

Now, for a limited time, when patients are referred to QuitWorks, they can receive a free two-week supply of nicotine patches*—in addition to free, phone-based counseling. Smokers who quit by using medication and counseling together are more than twice as likely to quit smoking for good.

Questions?

For more information about how to implement QuitWorks at your hospital or facility, contact John Bry at **john.bry@state.ma.us** or **617-624-5973**.

**QuitWorks will conduct a medical eligibility screening on all patients.*

Click & Connect

Be the First to Know: Sign Up for eNews Alerts

To stay up-to-date with the latest BCBSMA news, sign up for our **eNews alerts**. We'll send you announcements via e-mail when new *F.Y.I.*s and training opportunities for your specialty become available. We'll also notify you when the latest issue of *Provider Focus* is posted on our website. To register:

- Log on to our website at **www.bluecrossma.com/provider**.
- Click on **Edit My eNews Subscriptions** (listed under Manage My Profile on the left-hand side of your screen).
- Select the communications you would like to receive.
- Click on **Save.**❖

Ancillary News

SNFs: Deadline for Incentive Program 2010 Submission Is July 15

We remind Skilled Nursing Facilities (SNFs) that they must complete the online *Questionnaire and Attestation* by July 15, 2010 to be eligible for incentive payments as part of the 2010 program.

Use our electronic reporting tool to provide us with information on your facility's quality improvement processes for three measures:

- Medication Safety Quality Improvement
- Post-acute Quality Improvement
- Preventable Admissions and Transitions of Care.❖

To:	Log on to www.bluecrossma.com/provider and click on:
■ Link to our online *Questionnaire and Attestation* to report on the three measures ■ Learn about 2010 Incentive Program requirements by reading our August 2009 *F.Y.I.*	**SNF Incentive Program 2010** from the blue box on the right-hand side of the home page.
Access a training on the online reporting tool	**Resource Center>Training & Registration>Course List.** Choose **SNF Incentive Program 2010** from the Ancillary drop-down menu.

Hospice Providers: *Inpatient Clinical Review Form* Has Been Updated

We've recently updated our *Inpatient Hospice Clinical Review Form*, used by hospice providers that perform inpatient services, to provide BCBSMA with more detailed servicing information. An electronic version of the form is now available so that you can complete it online—just print and fax back to us. Here are some best practices for using the form:

- Complete this form upon admission and send it to the fax number indicated;
- Use it for commercial and Federal Employee Program program members receiving inpatient hospice services only.

To access the form, log on to **www.bluecrossma.com/provider** and select **Resource Center>Forms>Authorization Forms.**❖

Ancillary Providers: Don't Miss Our *Technology Solutions 2010* Webinar This Fall

Join two of our most popular presenters—Tom Madden and Patrick Collins—for our *Technology Solutions 2010* webinar. During this presentation, they'll update you on BCBSMA's technology tools. You'll learn about:

- NEHEN*Net*'s professional claim direct data entry tool
- Registering for ExpressPA, our web-based pharmacy authorization tool
- Using ExpressPA to request authorization for retail pharmacy prescription medications that process through the member's pharmacy benefit
- Using Online Services to inquire on the status of a referral or authorization.

How to Register

To let us know you'll be attending, please register at least one week prior to the session.

For online registration, log on to **www.bluecrossma.com/provider** and click on **Resource Center> Training & Registration>Course List.** Under the Ancillary subheading, choose **Technology Solutions 2010**. Then, select the September 22 session.❖

Office Staff Notes

InfoDial® Now Responds With Cancellation Dates When Checking Eligibility

We recently updated InfoDial, our free, interactive telephone system, to include policy cancellation dates.

Now, when you check eligibility for a member who no longer has an active policy, InfoDial will provide one of the responses listed in the chart to the right.

To use InfoDial, call **1-800-443-6657.**❖

When you check eligibility for a member whose policy was canceled:	InfoDial will respond with:
Less than 180 days from the transaction date	The cancellation date for the member ID entered.
180 days or more from the transaction date	The following message: *This member has no active coverage for the last 180 days.*

Details on Conversion to HIPAA Version 5010 Now Available on Our Website

All health plans, providers, and clearinghouses that conduct business electronically are preparing to convert to the next Health Insurance Portability and Accountability Act (HIPAA) standard for electronic transactions—Version 5010.

HIPAA will require entities conducting electronic claim submission, claim status requests and responses, and referral and eligibility requests and responses to use Version 5010.

All testing must be completed by January 1, 2012, when the new 5010 version must be adopted. We encourage you to begin testing with your business partners by early 2011.

To help you to start preparing, we've added helpful links to our provider website.

Log on to BlueLinks for Providers at **www.bluecrossma.com/provider**, click on **Resource Center**, then click on **HIPAA Version 5010** in the blue box on the right-hand side of the page.❖

Update on the Facility *Blue Book* Administrative Manual

To keep you up-to-date on BCBSMA administrative policies and procedures, we continually revise the online version of the *Blue Book* manual. To make it easier for you to track changes, you'll now see a note next to the text or section that has been revised. We've also created a *Facility Blue Book Changes Summary*, which lists revisions, their location, and the date of the change. Please check back often for the most current version.

We'll send you a postcard later this year when the annual *Blue Book* update is available online.

To access the *Blue Book* and the *Changes Summary*, log on to **www.bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books.**❖

Office Staff Notes

New HCAS Eligibility Verification Resource Available

To help streamline the eligibility verification process, Health Care Administrative Solutions, Inc. (HCAS) now offers providers access to online health plan eligibility verification tools from one centralized location. Visit **www.hcasma.org** and select the **Solutions** tab to access the following resources:

- An eligibility grid that describes how to check eligibility electronically for various health plans
- A sample health insurance plan ID card, with common terminology and ID card elements
- Links to health plan eligibility technology.

HCAS plans to add additional provider resources in the future We will keep you posted on updates in *Blue Focus*.❖

Easier Precertification/Preauthorization Access for BlueCard® Program Members

The BlueCard Eligibility℠ line has been enhanced to improve your experience in verifying eligibility and obtaining precertification and preauthorization information for out-of-area Blue Cross Blue Shield patients. See chart below for details. If you have any questions, please call BCBSMA at **1-800-882-2060**.❖

When you call 1-800-676-BLUE (2583) for:	Follow these instructions:
■ Precertification/ preauthorization only	■ Select the precertifications/preauthorizations option. ■ Choose the appropriate prompt for type of service for which you are calling (medical/surgical; behavioral health; diagnostic imaging/radiology; or durable medical equipment (DME). ■ Upon making your selection, you will be transferred to the appropriate area of the member's plan to address your specific request.
■ Eligibility only ■ Eligibility and precertification/ preauthorization	■ Select the option to obtain eligibility and precertification/preauthorization information. ■ The eligibility inquiry will be addressed first. ■ You'll then be transferred to the appropriate precertification/preauthorization area.

Radiology Reminder: Verify Member Eligibility Before Contacting AIM

As part of our radiology quality program, BCBSMA requires precertification for outpatient high-technology radiology services for members of: HMO Blue®, HMO Blue New England®, Network Blue®, and Medicare HMO Blue® plans, and for Blue Choice® members with a Massachusetts-based primary care provider (PCP). At this time. precertification is not required for members of our PPO, EPO, Indemnity, and Managed Blue for Seniors products.

As a reminder, always check member eligibility and benefits using one of our technologies before submitting precertification requests to our vendor, American Imaging Management (AIM). You can access Online Services, InfoDial®, or the POS device 24 hours a day, 7 days a week. Once you have verified eligibility, you may submit precertification requests at **www.americanimaging.net** or by calling **1-866-745-1783**. Receipt of a precertification number is required for reimbursement.

For out-of-area BlueCard® Program members, please call BlueCard Eligibility℠ at **1-800-676-BLUE (2583), Option 5**.

For more information, please refer to the Utilization Management section of your *Blue Book* manual, available online. Log on to **www.bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books**.❖

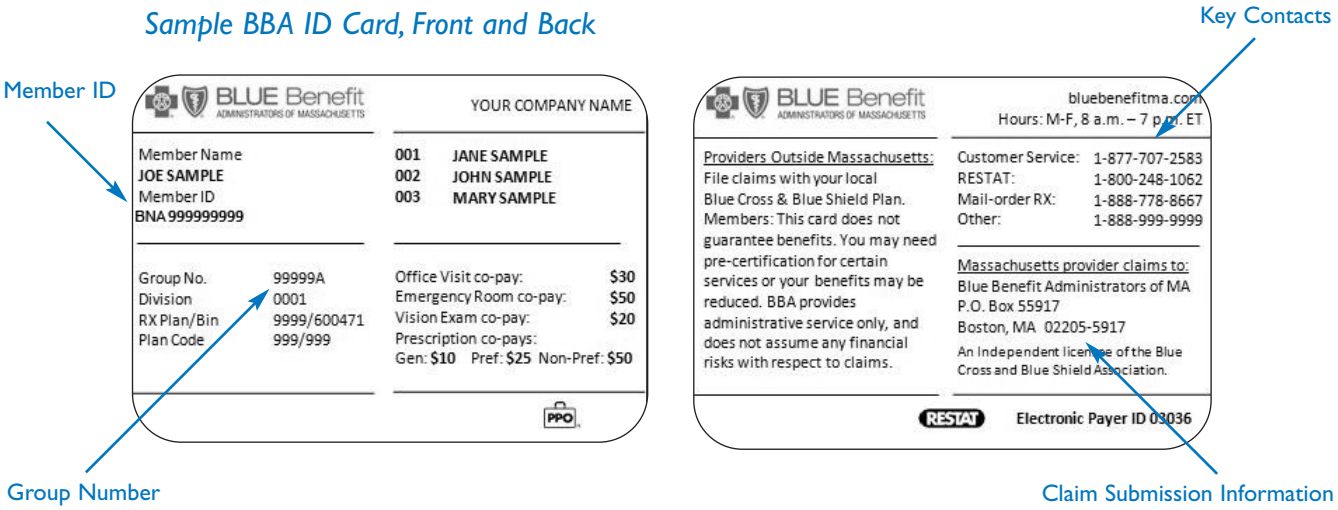
Office Staff Notes

Blue Benefit Administrators of Massachusetts Member Information

Blue Benefit Administrators of Massachusetts (BBA) is a wholly owned subsidiary of BCBSMA that offers self-insured PPO plans that can be customized by each employer group. These plans offer in- and out-of-network benefits and give the member the flexibility to coordinate his or her own care. BBA members have access to the BCBSMA network of providers and to the National BlueCard® Program network for in-network benefits. A copy of the BBA member ID card is shown below; the standard alpha-prefix on the member ID cards will be "BNA".

For more information about the BBA benefit designs and information about how to do business with BBA, refer to your recent *F.Y.I.* from BBA; call their customer service number at **1-877-707-BLUE (2583)**; or go to their website at **www.bluebenefitma.com.**❖

Sample BBA ID Card, Front and Back



Billing for Nutritional Counseling for Federal Employee Program Members

When billing for nutritional counseling services for Federal Employee Program (FEP) members using HCPCS codes 97802, 97803, and 97804, **be sure to use revenue code 942**. Please note that FEP does not recognize revenue code 510 for nutritional counseling/education.

Please refer to BCBSMA medical policy 375, *Medical Nutrition Therapy and Diabetes Out-Patient Self Management Training*, for additional coding information.❖

Billing for Services Rendered During a Medicare Advantage Member's Inpatient Stay with Denied Days

Based on Center for Medicare & Medicaid Services (CMS) guidelines, there are times when certain days during a Medicare Advantage member's inpatient stay are denied, even if the stay is partially approved. In these cases, services rendered by the attending physician on denied days are not payable.

Facility services rendered on inpatient dates that have been determined to be denied dates are not payable under the Medicare Advantage policies.

In addition, facilities may not bill BCBSMA for these denied dates as outpatient or observation services.

For more information, see the Billing and Reimbursement section of your *Blue Book* manual. Log on to our website at **www.bluecrossma.com/ provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books.**❖

Office Staff Notes

Be Sure You Receive APR-DRG Grouper Update from 3M

We've received inquiries from hospitals about differences between the severity of illness (SOI) indicators submitted by their version of 3M's APR-DRG software grouper and the SOI indicator returned by the BCBSMA APR-DRG software.

Please note that 3M has identified an issue with the APR-DRG software versions sold to hospitals, and has sent a notice to hospitals regarding an updated service pack.

To ensure you receive the updated service pack, contact your 3M representative, call 3M at **1-800-367-2447**, or go to 3M's website at **www.3MCustomerCare.com**.❖

ClaimCheck™ Will Be Updated on Our Website

BCBSMA will implement the latest version of McKesson ClaimCheck claims editing software in early fall.

To access our Internet-based code auditing tool, log on to **www.bluecrossma.com/provider** and click **Manage Your Business>Use Clear Claim Connection**.

Then enter your NPI for secure access to code editing policies, rules, and clinical rationale.❖

Clarification: Never Events Related to FEP Members

As a clarification to our March 1, 2010 *F.Y.I.* about the Blue Cross Blue Shield Association's Never Events policy, the FEP benefit change preventing payment for services related to Never Events was effective on January 1, 2010. Our previous communication implied that the change would take effect on June 1, 2010. Please be aware that your bills for Never Events for FEP members for dates of service on or after January 1, 2010 will result in claims denials.

As a reminder, the Never Events policy will go into effect for members of other BCBS plans and Medicare Advantage host members on June 1, 2010, as noted in our March *F.Y.I.* In addition, participating hospitals are required to hold members of other BCBS plans, FEP plans, and Medicare Advantage host members harmless for any inpatient services related to Never Events.❖

Payment Policy Update

Pass-Through Billing Payment Policy Reminder

Your BCBSMA Agreement prohibits you from billing for any services, performed in any setting, that you did not render to a BCBSMA member (commonly referred to as "pass-through billing"). One exception relates to services already reimbursed as a component of a DRG or per diem payment, so long as such services are not also billed by the servicing provider.

All BCBSMA participating providers rendering services are required to bill us directly for that service.

We began auditing compliance with this policy on January 1, 2010 and will recoup non-complying payments through our standard recovery procedures.

For more details and requirements, please see the resources below.❖

To find:	Log on to www.bluecrossma.com/provider and click on:
Our October 10, 2009 *F.Y.I.* (PC-1405)	**News for You>FYIs**
Our provider payment policies, including the *Pass-Through Billing Payment Policy*	**Manage Your Business>Access Payment Policies**
Participating providers	**Manage Your Business>Find a Doctor**

Coding Corner

Coding Correctly for Medicare Advantage Members

BCBSMA will begin its 2010 medical record review this spring for physicians treating BCBSMA Medicare Advantage members. Our goal with this data verification process is to accurately identify medical conditions that BCBSMA is required to report to the Centers for Medicare & Medicaid Services (CMS) for our Medicare Advantage members. Medicare Advantage plans, such as BCBSMA, must ensure that billing accurately reflects medical record documentation, and that members' chronic conditions are addressed and billed at least once per calendar year.

Correct Coding for Malnutrition

From medical record reviews conducted in 2009, we found that many of the most common diagnoses for Medicare Advantage patients were not reported on submitted claims, or when submitted on claims, not documented in the medical record. In order to code a diagnosis of malnutrition, the medical record must document the pertinent exam, as well as lab or clinical findings that are consistent with malnutrition. As the U.S. population ages, adequate nutrition in the elderly will be an increasingly important issue—so will adequate medical record documentation.

Scenario

An 83-year-old female patient is admitted with mild congestive heart failure. As part of her work-up, she receives a Mini Nutritional Assessment, the case manager requests a nutritional consultation. The registered dietician documents mild protein calorie malnutrition and recommends supplemental Ensure feedings.

Should the facility submit ICD 9 code 263.1, malnutrition of mild degree on the claim? No. This is a coding scenario that is frequently misunderstood. In order to correctly code malnutrition the provider must include an interpretation of the nutrition consult in a progress note. Malnutrition cannot be coded based solely on a nutritional consult.❖

Delivering on Our Promise to Put Our Members' Health First

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Empowering Our Members

Now more than ever, our members—especially those in high-deductible plans—are looking for ways to get more from their health care dollars. They look for resources and information to help make more educated, high-quality, and cost-effective decisions. Through Member Central, they can access interactive cost and quality tools, including:

- **Coverage Advisor:** Allows members to compare estimated out-of-pocket costs of BCBSMA plan options before making a selection.
- **Treatment Cost Estimator:** Available through a link to the BCBS Association's website, this tool allows members to explore typical costs for 21 medical condition categories. It includes a glossary explaining medical terms, conditions, and potential treatments.
- **Hospital Advisor:** Allows members to quickly and easily create a comparison of hospitals near their home or work.

"As BCBSMA responds to consumers' and employers' demands for more affordable health plans and more transparency, we understand the importance of supporting our members by offering them tools to help them make wiser choices about their health care," said Steven J. Fox, BCBSMA's Vice President of Network Management and Contract Operations.

How You Can Help

Encourage your BCBSMA patients to take advantage of Member Central.

To register, they can go to **www.bluecrossma.com** and click on **Member** to complete the quick and easy registration process. Within minutes, they'll have access to tools to help them become more engaged in their health care.❖

Medical Policy Update

All updates will be available via:

- **www.bluecrossma.com/provider>Medical Policies**
- Fax-on-Demand: **1-888-633-7654**

Changes to Previously Announced Medical Policies

The following medical policies, announced in Spring 2010 *Blue Focus*, were not implemented March 1, 2010:

- *Charged-Particle (Proton or Helium Ion) Radiation Therapy*, 162.
- *Intensity-Modulated Radiation Therapy: Abdomen and Pelvis*, 165.
- *Intensity-Modulated Radiation Therapy of the Breast and Lung*, 163.
- *Intensity-Modulated Radiation Therapy: Head and Neck Cancers*, 164.

Claims for these services will continue to process as they currently do. Any updates on the status of the policies will appear in future issues of *Blue Focus*.❖

Changes

Aqueous Shunts and Devices for Glaucoma, 223. New medical policy describing coverage/non-coverage criteria for this procedure. Effective 8/1/10.

Array Comparative Genomic Hybridization (aCGH) for the Genetic Evaluation of Patients with Developmental Delay/ Mental Retardation or Autism Spectrum Disorder, 228. New medical policy describing non-coverage of array comparative genomic hybridization to determine genetic etiology. Effective 9/1/10.

Assays of Genetic Expression in Tumor Tissue: Technique to Determine Prognosis of Breast Cancer, 055.

- Adding coverage criterion addressing testing ordered within six months following diagnosis. Effective 7/1/10.
- Clarifying coverage exclusion of THEROS Breast Cancer Index (SM). Effective 7/1/10.
- Clarifying coverage exclusion for the 21-gene RT-PCR assay testing to include determination of recurrence risk in breast cancer patients who are lymph node-positive. Effective 7/1/10.
- Excluding coverage for ICD-9-CM diagnosis code 198.81 (secondary malignant neoplasm of other specified sites, breast). Effective 9/1/10.

Auditory Brain Stem Implant, 087. Effective 7/1/10.

- Excluding coverage of bilateral use of an auditory brain stem implant.
- Excluding coverage of penetrating electrode auditory brain stem implant.

Autologous Chondrocyte Implantation, 374. Excluding coverage of matrix-induced autologous chondrocyte implantation. Effective 7/1/10.

Automated Percutaneous Discectomy, 231. New medical policy describing non-coverage of automated percutaneous discectomy. Coverage statements regarding this procedure will be removed from medical policy 099, *Percutaneous Lumbar Discectomy*. Effective 9/1/10.

Automated Point-of-Care Nerve Conduction Tests, 222. New medical policy describing non-coverage. Effective 8/1/10.

Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid, 107.

- Adding coverage for Medicare HMO Blue® and Medicare PPO Blue℠ products. Effective 7/1/10.
- Prior authorization will be required for commercial and Medicare HMO Blue products when billed with the following CPT®˝ codes: 95250 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording) and 95251 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report). Effective 8/1/10.

Electromagnetic Navigation Bronchoscopy 203. New medical policy describing non-coverage. Effective 8/1/10.

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus, 218. New medical policy addressing coverage/non-coverage. Effective 8/1/10.

ERCP with Laser or Electrohydraulic Lithotripsy, 209. New medical policy describing coverage/non-coverage criteria for this procedure. Effective 7/1/10.

Extracranial Carotid Angioplasty/Stenting, 219. New medical policy describing coverage/non-coverage. Comparable non-coverage information for commercial products will be removed from medical policy 077, *Percutaneous Transluminal Angioplasty*. Effective 8/1/10.

Genetic Testing for Inherited Susceptibility to Colon Cancer, including Microsatellite Instability Testing, 226. New medical policy describing coverage of genetic testing for inherited susceptibility to colon cancer and microsatellite instability testing. The same information regarding these tests will be removed from clinical recommendation document 365, *Genetic Testing & Counseling*. Effective 9/1/10.

Changes, continued on page 12

Medical Policy Update

Changes, continued from page 11

Genetic Testing for Warfarin Dose, 214. New medical policy describing coverage for Medicare HMO Blue and Medicare PPO Blue products, and non-coverage for commercial products. Effective 8/1/10.

Hematopoietic Stem Cell Transplantation for Acute Lymphocytic Leukemia and Small Lymphocytic Lymphoma 074. New medical policy describing coverage/non-coverage of this treatment for these diagnoses. The same information will be removed from medical policy 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*. New statement regarding allogeneic transplant in patients with markers for poor risk disease changed to covered. Effective 9/1/10.

Home Apnea Monitoring, 224. New medical policy describing coverage/non-coverage of home apnea monitoring. Effective 9/1/10.

Home Apnea Monitors & Pneumograms, 151. This clinical recommendation will be removed from our BlueLinks for Providers website and replaced with new medical policy 224, *Home Apnea Monitoring*. Effective 9/1/10.

Implanted Devices, 087. Adding new coverage criteria of five years and older for implantable bone conduction/bone anchored hearing aids (BAHA) when this device is covered under a member's benefits. Effective 8/1/10.

Iontophoresis, 095. Excluding coverage of phonophoresis alone or in combination with iontophoresis as a transdermal drug delivery technique for any medical indication. Effective 7/1/10.

Isolated Limb Perfusion//Infusion for Malignant Melanoma, 124. Adding coverage for isolated limb infusion (ILI) as a therapeutic treatment of local recurrence of nonresectable melanoma (i.e., satellite lesions or "in transit" melanoma), with melphalan. Effective 8/1/10.

Keratoprosthesis, 221. New medical policy describing new coverage/ongoing non-coverage criteria of keratoprosthesis (i.e., Boston Keratoprosthesis/Boston KPro). Comparable non-coverage language will be removed from medical policy 241, *Surgical Vision Services*. Effective 8/1/10.

Laboratory Testing for HIV Tropism, 008. Adding coverage of HIV tropism testing for patients who are treatment-naïve. Effective 8/1/10.

Medical Technology Assessment Non-covered Services, 400.

- Adding coverage for the following, effective 8/1/10:
  - 37215: transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection
  - 37216: transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection
  - 0075T: transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous; initial vessel
  - 0076T: transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous;each additional vessel
- Adding coverage for CPT code 43265 (Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of stone(s), any method). Effective 7/1/10. (See listing for new medical policy 209, *ERCP with Laser or Electrohydraulic Lithotripsy*, which addresses coverage/non-coverage of this procedure.)

Meniscal Allograft Transplantation and Collagen Meniscus Implants, 110. Adding body mass index (BMI) less than 35 as a covered criterion for meniscal allograft transplantation. Effective 9/1/10.

Microprocessor Controlled Prostheses for the Lower Limb, 133. Implementing prior authorization for our commerical managed care products only. Effective 9/1/10.

Minimally Invasive Hip and Total Knee Arthroplasty, 199. New medical policy describing coverage/non-coverage for these indications. Effective 7/1/10.

MRI of the Breast, 230. New medical policy describing coverage/non-coverage for MRI of the breast. The same information will be from medical policy 106, *Magnetic Resonance*. Also adding coverage to evaluate a documented abnormality of the breast prior to obtaining an MRI-guided biopsy when there is documentation that other methods, such as palpation or ultrasound, are not able to localize the lesion for biopsy. Effective 9/1/10.

Myoelectric Prosthetic Components for the Upper Limb, 227. New medical policy describing coverage/non-coverage. Effective 9/1/10.

Oncologic Applications of PET Scanning, 229. New medical policy document describing coverage/non-coverage for oncologic applications of PET scanning. The same information will be removed from medical policy 358, *PET Scan*. Also adding covered indications for ovarian, cervical, and testicular cancer. Effective 9/1/10.

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Percutaneous Transluminal Angioplasty, 077. Adding complicated distal thoracic aortic dissections as covered indications for endovascular stent grafting. Effective 9/1/10.

Perforator Vein Surgery for Chronic Venous Insufficiency, 176.

- Implementation of this new medical policy addressing non-coverage of subfascial endoscopic perforator surgery as a treatment of leg ulcers associated with chronic venous insufficiency has been postponed. (Previously listed in Fall 2009 *Blue Focus* as effective 4/1/10.)
- New medical policy describing coverage/non-coverage of surgical ligation (including subfascial endoscopic perforator vein surgery) and endoluminal ablation of incompetent perforator veins. Effective 6/1/10.

Sleep Disorders, 293. Coverage/non-coverage of unattended home sleep studies will be added. Effective 9/1/10.

- Adding coverage of auto-adjusting continuous positive airway pressure (CPAP) during a 2-week trial to initiate and titrate CPAP in adult patients with clinically significant obstructive sleep apnea (OSA). Effective 9/1/10.
- Adding coverage of supervised polysomnography as a diagnostic test in patients with the following:
  - Obesity, defined as a body mass index greater than 35kg/m2 in adults, or greater than 90th percentile for the weight/height ratio in pediatric patients
  - Craniofacial or upper airway soft tissue abnormalities, including adenotonsillar hypertrophy, or neuromuscular disease
  - Moderate or severe congestive heart failure, stroke/transient ischemic attack, coronary artery disease or significant tachycardia or bradycardic arrhythmias in patients who have nocturnal symptoms suggestive of a sleep-related breathing disorder. or otherwise are suspected of having sleep apnea.
- Clarifying coverage of repeated supervised polysomnography to initiate and titrate CPAP in adult patients with clinically significant OSA.
- Adding coverage of repeated supervised polysomnography under the following circumstances:
  - Failure of resolution of symptoms or recurrence of symptoms during treatment, or
  - To assess efficacy of surgery (including adenotonsillectomy) or oral appliances/devices, or
  - To re-evaluate the diagnosis of OSA and the need for continued CPAP (if there's significant change of weight or symptoms suggesting that CPAP should be retitrated or possibly discontinued).
- Adding coverage of repeat unattended home sleep studies.
- Excluding coverage of unattended home sleep studies for pediatric patients (under age 18).
- Clarifying non-coverage of unattended sleep studies in adult patients who are considered at low-to-moderate risk for obstructive sleep apnea. Effective 9/1/10.

Stereotactic Body Radiation Therapy, 277. Spring 2010 *Blue Focus* stated we would require prior authorization for stereotactic body radiation therapy for our managed care products, excluding Medicare HMO Blue, for these CPT codes, effective 6/1/10: 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions) and 77435 (Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions). ***Note: we will not*** be implementing prior authorization for our managed care products.

Total Hip Resurfacing, 046. Changing policy title to *Hip Resurfacing*, describing coverage/non-coverage of total and partial hip resurfacing. Effective 8/1/10.

Transanal Endoscopic Microsurgery (TEMS), 200. New medical policy describing coverage/non-coverage for this indication. Effective 7/1/10.

Treatment of Damaged Myocardium, Transmyocardial Laser Revascularization, 424. Adding required coverage criteria for transmyocardial laser revascularization. Effective 9/1/10.

Tyrosine Kinase Mutations in Myeloproliferative Neoplasms 079. New medical policy describing coverage/non-coverage of genetic testing in the diagnosis of patients presenting with clinical, laboratory, or pathological findings suggesting classic forms of myeloproliferative neoplasms (MPN), such as, polycythemia vera (PV), essential thrombocythemia (ET), or primary myelofibrosis (PMF). Effective 9/1/10.

Unattended Home Sleep Studies, 129. This policy will be removed from our BlueLinks for Providers website effective 9/1/10. Coverage/non-coverage statements regarding this procedure will be found in medical policy 293, *Sleep Disorders*, effective 9/1/10.

Clarifications

Biofeedback for Miscellaneous Indications, 187. New medical policy describing non-covered indications for biofeedback, with removal of the same information from medical policy 178, *Complementary Medicine*.

Biofeedback as a Treatment of Chronic Pain, 210. New medical policy describing non-covered indications for biofeed-

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back; same information will be removed from 178, *Complementary Medicine*.

Biventricular Pacemakers for the Treatment of Congestive Heart Failure, 101. Clarifying non-coverage of biventricular pacemakers for treating NYHA class I or II heart failure.

Chelation Therapy, 122. Clarifying non-covered indication of arthritis, which now includes rheumatoid arthritis.

CT Scan, 009. Removed the policy statement regarding virtual colonoscopy/CT colonography. See new medical policy 179, *Virtual Colonoscopy/CT Colonography* (posted 5/1/10).

FDG-SPECT, 330. Clarifying non-coverage of FDG-SPECT for commercial & Medicare HMO Blue/Medicare PPO Blue products as follows:

- Other cardiac applications including, but not limited to, evaluation of coronary artery perfusion defects
- As a technique to evaluate patients with known or suspected malignancies
- Other applications including, but not limited to, evaluation of neurological disorders, dementias, psychiatric disorders, or motor neuron disorders.

Hematopoietic Stem Cell Transplantation for Acute Lymphoblastic Leukemia 076. New medical policy describing coverage and non-coverage of this treatment for this diagnosis. The same information will be removed from medical policy 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Breast Cancer, 213. New medical policy describing non-coverage of this treatment for this diagnosis. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Chronic Myelogenous Leukemia, 212. New medical policy describing coverage and non-coverage of this treatment for this diagnosis. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for CNS Embryonic Tumors and Ependymoma, 205. New medical policy describing coverage and non-coverage of this treatment for these diagnoses. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Epithelial Ovarian Cancer, 204. New medical policy describing non-coverage of this treatment for this diagnosis. Comparable language will be removed from medical policy 092, *Allogeneic Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Hodgkin Lymphoma, 207. New medical policy describing coverage and non-coverage of this treatment for this diagnosis. Comparable language will be will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Multiple Myeloma 075. New medical policy describing coverage/non-coverage of this treatment for this diagnosis. Same information to be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Solid Tumors of Childhood, 208. New medical policy describing coverage non-coverage of this treatment for these diagnoses. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Injectable Clostridial Collagenase for Fibroproliferative Disorders, 225. New medical policy addressing non-coverage of this injectable for fibroproliferative disorders.

Laboratory Testing for HIV Tropism, 008. Clarifying non-coverage of HIV tropism testing statements for commercial & Medicare HMO Blue/Medicare PPO Blue products:

- HIV tropism testing using other assay techniques
- HIV tropism testing without immediate plans to prescribe HIV co-receptor antagonists.

Laser Prostatectomy, 384. Clarifying coverage of laser prostatectomy for patients with benign prostatic hypertrophy who are candidates for transurethral resection of the prostate, for commercial products and for Medicare HMO Blue and Medicare PPO Blue.

Update on Previously Announced Medical Policies

The following new medical policies, originally announced in Spring 2010 *Blue Focus* with an effective date of 6/1/10, have been assigned new policy numbers.

- *Endovascular Stent Grafts for Thoracic Aortic Aneurysms or Dissections*, 233
- *Intraepidermal Nerve Fiber Density*, 234
- *Implantation of Intrastromal Corneal Ring Segments*, 235.❖

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Magnetic Resonance, Breast, 106. Clarifying non-coverage of MRI of the breast for diagnosis of a suspicious breast lesion in order to avoid biopsy.

Mammography, 125. Clarifying coverage of full field digital mammography both as a screening or diagnostic technique.

Medical Technology Assessment Non-Covered Services, 400.

- Clarifying coverage of surgical techniques requiring use of robotic surgical system, which is addressed in our *Robotic Surgical Systems Payment Policy*. BCBSMA reimburses contracted providers for covered surgical services at a global rate, in accordance with their provider contract and network fee schedules. BCBSMA does not provide additional reimbursement for surgical services that use a robotic surgical system. The underlying surgery is reimbursed based on the provider's fee schedule. Will be posted 6/1/10.
- Clarifying non-coverage of OVA1™ ovarian cancer risk test.
- Clarifying non-coverage for non-invasive optimal vessel analysis (NOVA).
- Removing ImPACT™ concussion management test from the list of non-covered services. This test is part of the evaluation and management of patients with sports-related injuries. The provision of and/or the interpretation of the ImPACT test will not receive any additional reimbursement above and beyond the reimbursement for an appropriately billed office visit. Will be posted 6/1/10.

Ophthalmogic Techniques to Evaluate the Retinal Nerve Fiber Layer, 053.

- Clarifying title to include pulsatile ocular blood flow and blood flow velocity with doppler ultrasonography, which are non-covered in the diagnosis and follow-up of patients with glaucoma. The statement of non-coverage is currently listed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.
- Clarifying coverage of scanning laser ophthalmoscopy and scanning laser polarimetry for identified medically necessary indications.

Percutaneous Vertebroplasty and Kyphoplasty, 105. Clarifying non-coverage for acute vertebral fractures for commercial products.

PET Scan, 358. Clarifying the following:

- The ICD-9-CM diagnosis codes for petit mal status (345.2) and grand mal status (345.3) listed as covered indications, footnote 30
- PET scan for prostate cancer and surveillance imaging is considered investigational
- The investigational non-covered applications for PET scan for soft tissue sarcoma.

Phototherapy, 059. Clarifying UV-B language, covered indications, and formatting changes.

Plastic Surgery, 068:

- Clarifying coverage exclusion of laser hair removal as a treatment of a pilonidal cyst
- Clarifying coverage of excess skin removal when there is documentation of functional impairment or recurrent documented rashes or non-healing ulcers.

Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents, 184. New medical policy clarifying non-coverage of joint sclerotherapy and ligamentous injections with sclerosing agents. Information on these procedures is currently in benefit information document 215, *Therapies: Physical, Occupational & Speech* and medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Recombinant and Autologous Platelet-Derived Growth Factors as a Treatment of Wound Healing and Other Miscellaneous Conditions, 186. As communicated in Spring *Blue Focus*, this new medical policy will be posted 5/1/10.

- Clarifying non-coverage of autologous blood-derived preparations for adjunctive use in surgical procedures.
- Removing comparable information regarding this treatment from medical policy 435, *Wound Healing: Hyperbaric Oxygen Therapy, Vacuum-Assisted/Negative Pressure Closure Therapy, Procuren, Graftskin, Electrostimulation and Electromagnetic Therapy, Noncontact Radiant Heat Bandage, Non-contact Ultrasound Wound Treatment*.

Spinal, Vagal, Deep Brain, Cerebellar Stimulation, 083. Clarifying non-coverage of the use of these stimulators as a treatment for critical limb ischemia as a technique to forestall amputation and as a treatment for refractory angina pectoris.

Ultrasound, Obstetrical, 007. Clarifying that covered clinical indications for CPT code 76815 include ICD-9-CM diagnosis 634.92 (complete spontaneous abortion without mention of complication).

Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of Small Bowel, Esophagus, and Colon, 185. New medical policy describing covered and non-covered indications for this procedure, with removal of the same information from medical policy 007, *Ultrasound: Breast, Cranial, Duplex, Fetal, Obstetrical, Intravascular, Prostate, Transvaginal, Transrectal and Other Uses.*❖

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