August 2010

Providerfocus

MASSACHUSETTS

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

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Certain National Health Care Reform Provisions Go Into Effect September 2010

On March 23, 2010, President Obama signed into law national health care reform. The Department of Health and Human Services (HHS) and other federal agencies continue to develop regulations for provisions of the new law. Blue Cross and Blue Shield of Massachusetts (BCBSMA) will make necessary adjustments in our business so we can continue to offer our members high-quality products at the best possible price.

For the most up-to-date information on national health care reform, please go to our visitor website at **www.bluecrossma.com/visitor.**

Provisions Effective in 2010 That Impact BCBSMA Benefit Plan Designs

Certain requirements of national health care reform are effective in 2010. Many of the advantages and requirements under national health care reform are currently in place in Massachusetts, as a result of Massachusetts' health care reform legislation and other regulations.

Of the new requirements, the most significant impact to our customers appears to be the elimination of cost-sharing for preventive care services.

Here's a brief overview of the new provisions. As always, we urge you to check member eligibility and benefits using our technologies before providing services.

1. Lifetime Limits. For plan years starting on or after September 23, 2010, health insurers and group health plans are prohibited from establishing lifetime limits on the dollar amount of "essential health benefits" for any participant or beneficiary. We removed lifetime dollar limits from our standard plans that currently have a lifetime limit.
2. Annual Limits. Before 2014, only "restricted" annual limits on the dollar value of "essential" benefits are permitted. We will remove annual dollar limits on essential services that currently have an annual dollar limit.
3. Preventive Care. Group health plans and group health insurers may not impose cost-sharing for certain preventive coverage, including but not limited to, certain immunizations, screenings, and other services as recommended by identified entities. Coverage of certain preventive services is also required. We will remove the copayment for appropriate preventive health services from those standard plans that currently apply a copayment.

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In This Issue

In Brief

Free, Online Claim Submission Coming Soon

This fall, Online Services will offer a new claim entry feature to help small- and medium-size health care provider offices electronically submit claims for BCBSMA and BlueCard® Program members.

Offered at no cost to you, it allows you to submit professional claims that do not require supporting documentation. Online Services is a single-payer, web-based tool powered by Emdeon Office.

All registered BlueLinks for Providers users will have access to this new feature.

For more information, contact our Provider Self-Service team at **1-800-771-4097** or **provider.self.service@bcbsma.com.**❖

Physician News

MASSACHUSETTS

Reminder About Payments for Consult Codes

As we communicated in our June 1, 2010 *F.Y.I.* to physicians, BCBSMA will no longer pay for consult codes (CPT 99241-99245 and 99251-99255) for dates of service on and after September 1, 2010. This change is in alignment with changes enacted by the Centers for Medicare & Medicaid Services (CMS).

Please note that CMS has increased the relative value units (RVUs) for Evaluation and Management codes to partially offset this change.❖

Double Your Patients' Chances to Stop Smoking

After smoking for 44 years and trying to quit numerous times, a hospital visit changed Corinne's life forever. Her attending physician told her it was time to pick a date to quit. She picked that same day. A nurse talked with her about the QuitWorks program and explained how, with a combination of stop-smoking medicines—like the patch and counseling—Corinne would double her chances of staying a non-smoker for good.

Eighteen months later, Corinne still has not had a cigarette. "My counselor was there for me—not just for the first phone call, but continually checking in on me," said Corinne. "She made me aware of what I was going to be feeling, so there were no surprises."

QuitWorks is a free, evidence-based fax referral service developed by the Massachusetts Department of Public Health in collaboration with all major Massachusetts health plans. The program connects patients with phone-based counseling to help them stop smoking.

Now **until June 30, 2011**, patients newly referred to QuitWorks will receive a free two-week supply of nicotine patches*.

For more information or a referral form, go to **www.quitworks.com.** Or, contact Elena List at **508-856-4427** or **elena.list@umassmed.edu.**❖

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

New Text Resources Available Through Our Living Healthy Babies℠ Website

BCBSMA's Living Healthy Babies program is an online resource for women who are pregnant or who are thinking about starting a family. The site's tools and resources cover everything from preconception and pregnancy to cognitive development throughout the baby's first year.

Now, our Living Healthy Babies website features a link to a valuable new resource—**text4baby**, a free mobile information service* designed to promote maternal and child health.

An educational program of the National Healthy Mothers, Healthy Babies Coalition, text4baby provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life.

Women who sign up for the service by texting BABY to 511411 (or BEBE in Spanish) will receive free SMS text messages each week, timed to their due date or baby's date of birth, on topics ranging from health care access and immunization, to oral health and car seat safety.

To learn more about text4baby and other resources, go to **www.livinghealthybabies.com.**❖

**text4baby is offered at no additional charge through certain cell phone carriers.*

Click & Connect

Adding Users to Your BlueLinks for Providers Account

When setting up a BlueLinks account for your office, the first person who registers is considered the account administrator. The administrator has rights to add and delete users, and update information for other users in your organization. He/she may also grant administrative rights to other users.

We suggest that at least two people in your office have administrative rights for each account.

To Add a New User

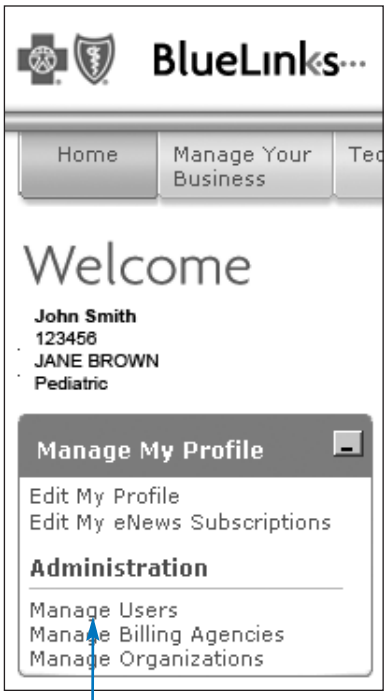
The account administrator must:

- Log on to BlueLinks at **www.bluecrossma.com/provider**.
- Under **Manage Users** on the left-hand side of the home page, click **Add a New User**.
- Enter the user profile information and click **Next**; then **Submit**. (To grant the user administrative privileges, click the associated box in this section.)

To Activate the Registration Code

We'll send a registration code to the user's e-mail provided during registration. To activate the code, click on the link in the e-mail, or go to **www.bluecrossma.com/provider** and select **Click Here** directly under the **Sign In** section. The new user should then follow these steps:

- Enter the registration code exactly as it appears in the e-mail and click **Submit**; then select the type of user (new or existing).
- Read and agree to the "Terms of Use" (not agreeing to the terms will cancel the registration process).
- Follow the instructions for creating a password. (BlueLinks will automatically generate a user name.)
- Sign up to receive eNews (optional, but recommended).
- The new user can now log on BlueLinks for Providers using their user name and password.❖



On the BlueLinks home page, look for the Manage Users link on the left-hand side of the screen. (Only BlueLinks account administrators will see this option.)

First National Health Care Reform Provisions Go Into Effect in September 2010

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4. Dependent Coverage up to Age 26. For fully insured and self-insured accounts for plan years beginning on or after September 23, 2010, plans that provide coverage to dependents are required to offer coverage to all adult children up to age 26, regardless of the dependent's IRS tax qualification status, marital status, or student status.

Recognizing that this timetable could result in a gap in coverage for some young people who would lose coverage prior to plan year renewal, BCBSMA and other Blue Cross Blue Shield plans are allowing covered individuals under the age of 26 to remain on their parents' health insurance policies effective June 1, 2010. This extension of coverage is automatically in effect for our fully insured accounts for their employees, and is available to self-insured accounts who would like to provide this same extension of coverage.

We'll continue to assess our plans and we will update you as further regulatory guidance is released.❖

Office Staff Notes

Tips for Using SmartSheets™ for Medical Prior Authorization Requests

As you know, BCBSMA uses InterQual®˝ criteria to make medical necessity determinations, and we ask that you use McKesson's InterQual®˝ SmartSheets™ to submit prior authorization requests. This expedites the review process, ensuring that we have all the information needed for the review.

To help you with this process, we offer these tips:

- Prior to submitting a request, verify that a specialist referral has been submitted to the ordering/attending physician.
- Use our electronic technologies to verify the need for an authorization. Please note that emergency surgeries do not require prior authorization review. Also, authorization is not required for our PPO, EPO, and Indemnity members for outpatient services.
- Access SmartSheets™ via McKesson's CareEnhance®˝ Review Manager. Log on to **www.bluecrossma.com/provider** and click **Manage Your Business>Medical Review Resources**. Then click **InterQual®˝ Behavioral Health and Medical/Surgical Level of Care Criteria** and follow the steps to access the associated SmartSheet™.
- Submit requests with complete clinical information in a timely manner (no less than 72 hours prior to date of service).
- Print the completed form and fax it to BCBSMA at:
  - **1-888-641-1375** (Commercial members)
  - **1-888-282-1315** (Federal Employee Program members)
  - **617-246-4299** (BCBSMA employees)

For more information, please refer to our *Fact Sheet*, available under the **Medical Review Resources** section of our website.❖

Submitting Address and Telephone Number Changes

If you are currently contracted with BCBSMA as an individual provider and your primary or billing address or telephone number has changed, please submit a *Change of Address Form* to our Provider Enrollment area. For auditing purposes, all changes must be submitted to us in writing, and this form provides an accurate record of all changes.

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

Important: If you are affiliated with a group and you are joining a different group, or if you are adding a secondary site, please do not use this form. Instead, please complete a *Contract Update Form*, available on our website.

To access either the *Change of Address Form* or the *Contract Update Form*, log on to our website at **www.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.❖

Keep BCBSMA Updated on NPI Changes

To avoid claim payment delays, be sure to notify BCBSMA should there be any change to your current national provider identifier (NPI) or if a new provider joins your practice/facility and has a new NPI.

It's important that we keep our systems updated with the most current NPI information.

You can either fax NPI information to **617-246-7771**, or call Provider Enrollment at **1-800-419-4419.**❖

Office Staff Notes

BlueCard® Update: Be Sure to Use Correct ID Number for Walmart Members

Effective January 1, 2010 Arkansas Blue Cross and Blue Shield became the Home plan for Walmart members and now administers health plan benefits for these members. Walmart associates received new ID cards with the alpha prefix **WMW**.

For a limited time this year, when Arkansas Blue Cross received a claim with an old (invalid) ID number, they rerouted the claim back to the host plan, asking that they resubmit with the correct prefix of WMV.

Please note that for Walmart member claims that are submitted with an invalid prefix **for dates of service on or after July 1, 2010**, Arkansas Blue Cross will reject the claim. The claim will be returned to the provider with instructions for resubmitting with the correct alpha prefix.

Invalid prefixes:	Valid prefix:
WLA, WMR, & MRT	WMW

Claims with dates of service between January 1 and June 30, 2010 will continue to be rerouted appropriately.

If you provide services to a Walmart member, be sure to ask him/her to present the new ID card, and submit all 2010 claims to BCBSMA using the exact ID number as it appears on the card. This will help avoid delays in processing your claim.❖

Scheduling Visits When There's a Benefit Schedule for Routine Care

When scheduling appointments for BCBSMA members, please keep in mind that the member's benefits may be subject to a visit limit for certain routine benefits such as well care, pediatric, vision, and hearing. For example, the member's subscriber certificate may provide coverage for one routine vision care visit every 24 months, or for one well visit every 12 months.

If the member visits your practice before the allowed timeframe, BCBSMA will not provide benefits for the claim. This will result in an unpaid claim and member liability.

As always, we remind you to verify benefits and eligibility using one of our technologies prior to rendering services to BCBSMA members.❖

Billing Notes

Modifier 52 change will take effect December 1, 2010

Effective December 1, 2010 BCBSMA will expand the use of Modifier 52. CPT®[1] and HCPCS codes submitted with Modifier 52 appended will be paid at 50% of the contracted rate.

Modifier 52 is used when a provider has elected to reduce or eliminate a portion of a service or procedure. It is not necessary to submit additional documentation with these claims.

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

Training Update

You're Invited to Attend Our September *Technology Solutions 2010* Webinar

Join two of our most popular presenters—Tom Madden and Patrick Collins—for our *Technology Solutions 2010* webinar on Wednesday, **September 22, 2010**, from 11 a.m. to noon. This will be the final session offered this year.

During this presentation, they'll update you on BCBSMA's technology tools. You'll learn about:

- 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.

Patrick Collins, left, and Tom Madden, right will present our *Technology Solutions* webinar on September 22.

Please register at least one week prior to the session by going to **www.bluecrossma.com/provider** and selecting **Resource Center>Training & Registration>Course List.** Under the Primary Care, Specialty Care, or Ancillary menu, choose **Technology Solutions 2010.**❖

Questions About RBRVS Methodology?

Approximately three-quarters of payers use the Resource-Based Relative Value Scale (RBRVS) to help them determine what they pay providers who render medical services. View our short audiovisual presentation to learn about elements of the RBRVS payment methodology, such as relative value units, conversion factors, and geographic practice cost indices.

To access this presentation, log on to **www.bluecrossma.com/provider**, click on **Resource Center>Training & Registration>Course List**, then select **RBRVS Payment Methodology** from the drop-down menu for your provider type.❖

Ancillary News

Short-Term Rehabilitation Speech Therapy Extension Request Form Is Updated

BCBSMA has updated our *Short-Term Rehabilitation Speech Therapy Extension Request Form* to make it easier for you to complete. To access the new version, log on to our website at **www.bluecrossma.com/provider** and click on **Resource Center>Forms>Authorization Forms.**❖

Technical Diagnostic Imaging Services for Union Blue Members

We've received provider requests to make available a copy of the *Union Blue Questionnaire* form* that our Union Blue members—your patients—must complete for claim processing purposes only. We recently placed the form on our BlueLinks for Providers website so that you can help facilitate the administrative process for our members, if you choose.

This is not a provider authorization program and you are not required to participate. If you'd like to assist the member, you may give him/her a copy of the form to complete when coming into your center for HTR services. Then, fax it to the number indicated on the form. The form also lists some tips for identifying Union Blue members.

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

**The Questionnaire form was developed in conjunction with the Union Blue accounts that use it. BCBSMA assumes no responsibility for completing or processing this form. Returning this form to the Union Blue account is not a guarantee of payment.*

Ancillary News

Code Updates for Audiologists, Nurse Practitioners, and Physical Therapists

Code Added to Physical Therapy Fee Schedule

For services rendered on or after August 1, 2010, contracted physical therapists (PTs) may be reimbursed for CPT®* code 97113 (Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises).

Aquatic therapy is considered a "procedure or modality" and subject to the four-unit maximum, per day.

BCBSMA covers aquatic therapy provided by PTs in the same way we cover other medically necessary physical medicine services for treatment of a variety of conditions, such as musculoskeletal and neurological deficits related to illness or injury. Aquatic therapy must be used for restoring the level of function the member had prior to illness or injury.

Aquatic therapy that is used to maintain a level of function (i.e., the member is not improving or regressing) is not considered medically necessary. Contraindications to pool therapy include: seizure disorder, open wounds, non-healing ulcers, infection, cardiac failure, chlorine allergy, and/or fear of water.

Aquatic therapy must be administered by the PT in direct, one-on-one contact with the member. BCBSMA will not provide reimbursement when a PT provides aquatic therapy for multiple patients in a pool at one time and then bills for each of these patients per 15 minutes of therapy. In addition, BCBSMA does not reimburse charges for aquatic exercise programs or separate charges for the use of a pool.

Although standard treatment duration for pool therapy is two to four weeks, or six to 12 visits, all requests will be considered and viewed for medical necessity. Documentation should note the objective loss of motion, strength, mobility, and/or function to be addressed, and subsequent notes to reflect objective progress in these areas.

Codes Added to Audiologist Fee Schedule

For services rendered on and after January 1, 2010, we have added the following new CPT codes to the audiology fee schedule:

- 92540-TC
- 92540-26
- 92550
- 92570.

Additionally, we now require that the following codes be billed with the applicable modifer(s) of TC and/or 26:

- 92541
- 92542
- 92543
- 92544
- 92545
- 92546
- 92585
- 92587
- 92588.

Please note that these codes cannot be billed as global services. To bill for both the technical and professional components of one of these codes, please bill on two separate lines with the corresponding modifier on each line. To bill for one component, bill on one line with the appropriate modifier (either TC or 26). BCBSMA will reject any claims not billed correctly.

Codes Added to Nurse Practitioner Fee Schedule

For services rendered on and after January 1, 2010, we have added the following new CPT codes to the nurse practitioner fee schedule:

- 51727-TC
- 51727- 26
- 51728-TC
- 51728-26
- 51729-TC
- 51729-26
- 96360.❖

How to Find Your Fee Schedule Online

To access your fee schedule on our website, log on to BlueLinks for Providers at **www.bluecrossma.com/provider** and click on **Resource Center> Admin Guidelines & Info> Fee Schedules.**❖

Coding Corner

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

Correct Coding and Documentation of Coronary Artery Disease for Medicare Advantage Members

Background

According to the National Heart Lung and Blood Institute, coronary artery disease (CAD) is the most common type of heart disease and the leading cause of death for both men and women in the United States. Each year more than 500,000 Americans die from CAD.

Due to the high incidence of CAD, accurate coding is essential for depicting the acuity of your patients.

The tendency is to code all coronary artery diseases using a generic ICD-9-CM code—414.0x; however, this does not completely describe the condition because it doesn't take into account whether the involved vessels are native or grafts, and whether or not there are sequelae. For example, how many of your patients are you monitoring for continued symptoms of CAD, such as angina? It is important to consider the extent of the CAD and which vessels are involved.

Scenario

A 74-year-old male patient presents for an annual visit. He has a history of hypertension and CAD. He has been taking isosorbide 5 mg bid for control of angina for the past year following a myocardial infarction (MI). You note in your documentation that he has had no episodes of angina since his last visit.

Question: Should angina be coded as an additional diagnosis? What other codes should be assigned to fully capture the health status of your patient?

Answer: Yes, although it is asymptomatic, angina (413.9) is under treatment and would qualify as a reportable additional diagnosis. In addition, coders should assign code 414.00 (Coronary atherosclerosis of unspecified type of vessel, native or graft), since your note does not specify which vessel is affected. The history of an MI continues to be information that is an essential part of your patient's complexity, and ICD-9-CM code 412 should also be assigned.❖

View Our *Medicare Advantage Data Verification and Improvement Program* Presentation Online

BCBSMA offers an audiovisual presentation that describes the Centers for Medicare & Medicaid Services Hierarchical Condition Category Risk Adjustment Payment methodology and the *Medicare Advantage Data Verification and Improvement Program* that supports it.

The 20-minute presentation covers common diagnostic coding errors for chronic conditions and how to correct them. It also provides a comprehensive diagnostic coding tool to help capture and communicate your Medicare Advantage patients' health status annually.

To access this presentation, log on **www.bluecrossma.com/provider** and click on **Resource Center>Training & Registration>Course List**. Then choose **BCBSMA Medicare Advantage Data Verification and Improvement Pgm** from the Specialty Care or Primary Care menu.❖

Medical Policy Update

All updated medical policies will be available via:

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

Changes

Autologous Chondrocyte Implantation, 374.

- Adding "*and Other Cell-Based Treatments of Focal Articular Cartilage Lesions*" to the title.
- Excluding coverage of the following, effective 11/1/10:
  - Treatment of focal articular cartilage lesions with autologous minced cartilage
  - Treatment of focal articular cartilage lesions with allogeneic minced cartilage or cartilage cells.

Endovascular Grafts for Abdominal Aortic Aneurysms (AAA), 098. Adding coverage for endoprostheses for AAA for ruptured abdominal aortic aneurysms. Effective 11/1/10.

Esophageal pH Monitoring, 069. Adding coverage for 48- to 96-hour catheter-free, wireless esophageal monitoring for patients who are unable to tolerate catheter-based testing (and are unable to complete this testing) but meet the policy criteria. Effective 11/1/10.

Extracorporeal Photopheresis as Treatment for and Prevention of Organ Rejection After Solid-Organ Transplant, 248. New medical policy describing coverage/non-coverage for this procedure. Effective 11/1/10.

Gait Analysis, 236. New medical policy describing coverage and non-coverage. Current non-coverage information will be removed from benefit information document 215, *Physical Therapy, Occupational Therapy* and *Speech Therapy*. Effective 11/1/10.

Genetic Testing for Hereditary Breast and/or Ovarian Cancer, 245. New medical policy describing the covered/non-covered criteria. Information regarding this testing will be removed from clinical recommendation 365, *Genetic Testing and Counseling*. Effective 11/1/10.

Image Guided Minimally Invasive Lumbar Decompression (IG-MLD) for Spinal Stenosis, 240. New medical policy describing non-coverage of this surgical procedure for all indications. Effective 11/1/10.

Maze Surgery, 356. Implementing editing to support coverage of maze surgery when billed with CPT® code 33259 (Operative tissue ablation and reconstruction of atria, performed at the same time of other cardiac procedure[s] extensive [e.g., maze procedure] with cardiopulmonary bypass) for our commercial products, and for Medicare HMO Blue® and Medicare PPO Blue℠. Effective 11/1/10.

Medical and Surgical Management of Obesity Including Anorexiants, 379. Adding covered indications for bariatric revision surgery, and adding prior authorization requirement for bariatric surgery when performed as an outpatient service for managed care and PPO products, excluding Medicare Advantage. Effective 11/1/10.

Medical Technology Assessment Non-Covered Services, 400. Adding coverage for the following CPT codes, effective 11/1/10:

- **96000:** Comprehensive computer-based motion analysis by video-taping and 3-D kinematics
- **96001:** Comprehensive computer-based motion analysis by video-taping and 3-D kinematics; with dynamic plantar pressure measurements during walking
- **96002:** Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
- **96003:** Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle
- **96004:** Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report.

Note: Our new medical policy 236, Gait Analysis (see left), will address coverage/non-coverage of these procedures.

Multigene Expression Assay for Predicting Recurrence in Colon Cancer, 239. New medical policy describing non-coverage of this test for predicting the likelihood of disease recurrence in patients with stage II colon cancer following surgery. Effective 11/1/10.

Occipital Nerve Stimulation, 237. New medical policy describing non-coverage of this procedure for any indication. Effective 11/1/10.

Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders, 120. Adding coverage criteria for intrapulmonary percussive devices and non-covered indications. Effective 11/1/10.

Perforator Vein Surgery for Chronic Venous Insufficiency, 176. This policy will be removed from our BlueLinks for Providers website, effective 11/1/10. Coverage and

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Medical Policy Update

Changes, continued from page 9

non-coverage statements regarding this procedure will be found in our new medical policy 238, *Treatment of Varicose Veins/Venous Insufficiency*. Effective 11/1/10.

Pheresis, 071. Adding covered indications for plasma exchange for Guillain-Barré syndrome (GBS): severity grade 1-2 within 2 weeks of onset; severity grade 3-5 within 4 weeks of onset; and children younger than 10 years old with severe GBS and severe manifestations of mixed cryoglobulinemia, when used in combination with immunosuppressive therapy. Effective 11/1/10.

Pulmonary Function Tests & Treatments, 395. This billing guideline will be removed from our BlueLinks for Providers website. Effective 11/1/10. (To access our *Pulmonary Function Tests and Treatments Payment Policy*, log on to **www.bluecrossma.com/provider** and click on **Manage Your Business>Access Payment Policies**.)

Sclerotherapy, Radiofrequency Ablation and Laser Ablation of Varicose Veins in Lower Extremities; Treatment of Telangiectasias, 045. This policy will be removed from our BlueLinks for Providers website. Coverage/non-coverage statements regarding these procedures will appear in our new medical policy 238, *Treatment of Varicose Veins/Venous Insufficiency*. Effective 11/1/10.

Sleep Disorders, 293. Implementing editing to support coverage of multiple sleep latency testing when billed using CPT code 95806 with additional covered indications reported with ICD-9 CM diagnoses codes 327.11

Treatment of Telangiectasias, 045. This medical policy will be removed from our BlueLinks for Providers website. Coverage and non-coverage statements regarding these procedures will be found in our new medical policy 238, *Treatment of Varicose Veins/Venous Insufficiency*. Effective 11/1/10.

Treatment of Varicose Veins/Venous Insufficiency, 238. New medical policy describing coverage/non-coverage of various varicose vein treatments noted type of veins treated (i.e., greater/lesser saphenous veins, accessory saphenous veins, symptomatic varicose tributaries, perforator veins, telangiectasias, etc). Effective 11/1/10.

Clarifications

CT scan, 009. Clarifying the covered indications for CT scan for the head, brain, pelvis, and abdomen.

Endovascular Stent Grafts for Thoracic Aortic Aneurysms or Dissections, 199. Clarifying coverage of aortic dissections.

Genetic Testing for Warfarin Dose, 214. Clarifying coverage of HCPCS code G9143 (Warfarin responsiveness for testing by genetic technique using any method, any number of specimens) for Medicare HMO Blue and Medicare PPO Blue only.

Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids, 244. New medical policy describing non-coverage of these techniques. The same information regarding these procedures will be removed from medical policy 331, *Endometrial Ablation*.

Medical Nutrition Therapy and Diabetes Outpatient Self-Management Training, 375. Clarifying the Medicare HMO Blue authorization information.

Minimally Invasive Surgery for Snoring, Obstructive Sleep Apnea/Upper Airway Syndrome, 130.

- Changing title of this policy to *Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome*
- Adding coverage and non-coverage of hyoid suspension, traditional surgical approaches to tongue modification, maxillofacial surgery including mandibular or maxillary advancement surgery and uvulopalatopharyngoplasty (UPPP). Current coverage and non-coverage statements regarding these procedures will be removed from medical policy 293, *Sleep Disorders*. Effective 9/1/10.

MRI-Guided Focused Ultrasound for the Treatment of Uterine Fibroids and Other Tumors, 243.

- New medical policy describing non-coverage of this procedure; same information will be removed from medical policy 331, *Endometrial Ablation*.
- Clarifying non-coverage of MRI-guided high-intensity ultrasound ablation of other tumors for palliative treatment of bone metastases.

Occlusion of Uterine Arteries Using Transcatheter Embolization or Laparoscopic Occlusion to Treat Uterine Arteries, 242. New medical policy describing coverage and non-coverage. The same information regarding these procedures will be removed from medical policy 331, *Endometrial Ablation*.

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Medical Policy Update

Clarifications, continued from page 10

Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders, 120. Clarifying non-covered indications for high-frequency chest wall compression devices.

Percutaneous Vertebroplasty & Percutaneous Kyphoplasty, 105. Clarifying non-coverage of percutaneous vertebroplasty or kyphoplasty for acute vertebral fractures due to osteoporosis or trauma, for our commercial products.

Pheresis, 071. Clarifying the non-covered indications for plasma exchange.

Renal (Kidney) Transplantation, 196. Clarifying exclusion criteria for members with a history of malignancy.

Stereotactic Radiosurgery, 277:

- Clarifying non-coverage of stereotactic radiosurgery for the treatment of seizures, chronic pain and functional disorders other than trigeminal neuralgia, and for any other indications not listed under coverage section, for our commercial products.
- Clarifying coverage of stereotactic radiosurgery for certain epileptic disorders and for primary or recurrent glioma that are less than 4 centimeters in diameter, for Medicare HMO Blue and Medicare PPO Blue only to align with retired Medicare Local Coverage Determination issued by NHIC, Corp.

Ultrasound, First-Trimester Detection of Down Syndrome, 007. Clarifying the non-covered indications for fetal nasal bone assessment.❖

Physicians/DME Providers: Reminder About Prior Authorization Requirements for Prosthetics

In June-July *Provider Focus*, we announced that starting September 1, 2010, we would implement prior authorization requirements in two medical policies: *Microprocessor Controlled Prostheses for the Lower Limb*, 133, and *Myoelectric Prosthetic Components for the Upper Limb*, 227 for managed care members, excluding Medicare HMO Blue. The medical necessity criteria listed in these policies remain unchanged. The member's ordering physician should submit a medical necessity request letter for the prosthetic device to our Case Creation/Medical Policy area as listed in the medical policy. Participating durable medical equipment providers may also facilitate the request for our members.❖

Changes to the Medical Policy Group Meetings in 2011

BCBSMA's Medical Policy Group meets monthly to review policies for specific specialty areas. Any contracted clinician may attend and provide feedback. Currently, the group discusses three specialty topics in some meetings and one topic in others. In 2011, the number of topics reviewed per meeting will be disbursed more evenly throughout the year to allow more discussion time. All meetings are held at BCBSMA, Landmark Center, 401 Park Drive, Boston. If you have any questions, please e-mail **philip.brazao@bcbsma.com**.

To access a policy being reviewed, log on to **www.bluecrossma.com/provider**, click on **Manage Your Business>Review Medical Policies**, then scroll down to the "How to Review" section.❖

2011 Medical Policy Group Meeting Schedule

Date:	Specialty:
January 25	Neurology and Neurosurgery
February 22	Psychiatry and Ophthalmology
March 29	Allergy and ENT/Otolaryngology
April 26	Cardiology and Pulmonology
May 31	Pediatrics and Endocrinology
June 28	Orthopedics, Rehabilitation Medicine, and Rheumatology
July 26	Hematology and Oncology
August	*No Meeting*
September 27	Urology and Obstetrics/Gynecology
October 25	Gastroenterology, Nutrition, and Organ Transplantation
November 29	Plastic Surgery and Dermatology
December	*No Meeting*

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