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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

WINTER 2010

Trustee Advantage Program Engages Hospital Boards In Quality and Safety

In 2009, five Blue Cross Blue Shield of Massachusetts (BCBSMA) network hospitals partnered with us for Trustee Advantage, a 15-month grant program sponsored by BCBSMA. The program was designed to help boards of trustees advance their governance of clinical quality and patient safety improvement.

The goal of these forward-thinking hospitals was to accelerate their quality improvement efforts.

Trustee Advantage focused on the increasingly important role of the board in leading quality and safety, what constitutes governance excellence, and what specific steps boards must take to achieve excellence.

Participating Hospitals

- Beth Israel Deaconess – Needham
- Emerson Hospital
- Harrington Hospital
- Lowell General Hospital
- Winchester Hospital

To that end, BCBSMA provided $50,000 in grant funding to each hospital, and the hospitals agreed to commit an additional $25,000 to the Trustee Advantage effort, along with non-financial hospital resources.

About the Program

Trustee Advantage integrated three educational components:

- An ongoing peer learning community
- A six-month engagement with a coach expert in both governance and hospital quality and safety
- An in-depth experiential practicum of the hospital's choosing.

Working collaboratively with trustees and CEOs from each of the other hospitals, trustees learned to assess their performance and hear best practices in the areas of:

- Physician engagement
- Setting quality and safety goals
- Creating a culture of safety.

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In This Issue

Your 2010-2011 *Blue Book* Is Now Available Online

The BCBSMA *Blue Book* for facilities has been updated and posted on our BlueLinks for Providers website.

Log on to www.bluecrossma.com/provider and click Resource Center>Admin Guidelines & Info>Blue Books.

Our online version makes it easy for you to refer to the sections you need quickly to help with your administrative tasks.❖

Pharmacy Update

The Year Ahead: Pharmacy Program Updates for 2011

BCBSMA is introducing a number of carefully selected changes to our pharmacy program that will take effect on January 1, 2011.

These changes include:

Adding a new specialty pharmacy and updating specialty medications on our list of retail specialty pharmacies for certain medications.

Introducing prior authorization requirements for Dysport®˝, Ilaris®˝, Simponi™, and Stelara™ when administered in a clinician's office or outpatient setting, or by a home infusion therapy provider and billed under the member's medical benefits. We are updating existing medical policies to reflect this new requirement and requests should be submitted using the *Outpatient Medical Prior Authorization Form*.

Making updates to our standard, BlueValue Rx, Blue MedicareRx, and Medicare Advantage formularies.

Retiring medical policy 021: *Orphan Drugs for the Treatment of Rare Diseases* and updating our list of medications requiring prior authorization to reflect this change.

For complete details about the changes, please read our *F.Y.I.* (PC-1440) dated September 1, 2010. Refer to the chart on page 3 for instructions on accessing the *F.Y.I.* and related forms on our website.❖

Oncologists and Dialysis Providers: Updated Medical Policy for Aranesp, Epogen, and Procrit

We are updating our *Erythropoetin, Recombinant Human* medical policy to include new reporting requirements for prior authorization requests for these medications. Authorization requests that meet coverage criteria will now be approved in six-month intervals.

As you are aware, members do not have coverage for these medications under their medical benefit, unless the medication is administered on an inpatient basis or through a dialysis or home infusion therapy provider.

Please refer to page 15 for more information on this pharmacy medical policy update.❖

Reminder to Submit Authorization Requests for Proton Pump Inhibitors

Last January, we made changes to our *Proton Pump Inhibitors* pharmacy medical policy, including implementing authorization requirements for these medications.

We would like to remind you that authorization requests are typically approved for 90 days and we urge you to submit those requests in advance to prevent disruption for your patient.

Authorizations that meet coverage criteria for this class of medications are approved in intervals; this means that you will need to submit additional requests throughout the calendar year, when indicated, for your patient.

If the member is continuing his/her course of treatment and you are requesting an authorization extension, please fax the *Request for Outpatient Retail Pharmacy Prior Authorization for Proton Pump Inhibitors Form* to Clinical Pharmacy Operations using the fax number indicated on the form (see chart on page 5 for instructions on accessing the form). Or, call 1-800-366-7778.

Using Express PA to Submit Your Requests for New Starts

If the member is newly starting his/her course of treatment with the PPI, you may use ExpressPA to submit your authorization request.

At this time, ExpressPA will only accept authorization requests for prescription medications for renewals the day after the previous authorization has expired. We expect to expand this functionality in the future.❖

Pharmacy Update

CVS Caremark and Walgreens Specialty Pharmacy Are Preferred Vendors for Synagis

BCBSMA has designated CVS Caremark and Walgreens Specialty Pharmacy as preferred home infusion therapy providers for Synagis for all BCBSMA members who require respiratory syncytial virus (RSV) immunoprophylaxis.

You can purchase Synagis directly from a wholesaler and bill BCBSMA as a medical claim for the drug and its administration (if our medical policy guidelines have been met). Or, you may order the medication you need for the coming season from CVS Caremark or Walgreens Specialty Pharmacy; they will ship the medication to your office and bill BCBSMA directly.

To reach CVS Caremark, call 1-800-237-2767; to reach Walgreens Specialty Pharmacy, call 1-800-370-2510.

Medical Policy Requirements Apply

This medication is covered through the member's medical benefit, so medical policy requirements must be met. For our medical policy 422, *RSV Immune Globulin*, go to www.bluecrossma.com/provider and click Medical Policies in the blue box.❖

FAQs About Our Proton Pump Inhibitors (PPI) Policy Posted Online

One of the most frequently asked questions and a common misconception about our *Proton Pump Inhibitors Pharmacy Medical Policy* is about member coverage of omeprazole, which is a benefit of 90 days without an authorization.

To help you better understand our PPI policy, we recently posted *Frequently Asked Questions* on our provider website. See chart below for instructions on accessing this new document.❖

Pharmacy-related Resources for Providers

To:	Log on to www.bluecrossma.com/provider and click:
Link to ExpressPA (registration required)	Technology Tools>ExpressPA (Or, go directly to https://www.express-pa.com)
View an online audiovisual presentation about pharmacy benefits, prior authorization requirements, tools available to you on BlueLinks for Providers, and using ExpressPA	Resource Center>Training & Registration> Course List, then choose Your Pharmacy Questions Answered under the All Providers menu
View the *F.Y.I.* announcing prior authorization changes effective January 1, 2011	News for You>FYIs; select the September 1, 2010 *F.Y.I.* (PC-1440) and scroll down to the Resources section of the *F.Y.I.* to access a PDF with details on formulary changes.
Find our pharmacy forms related to prior authorization requests	Resource Center>Forms>Pharmacy Forms
Access BCBSMA's medical policies	Manage Your Business>Review Medical Policies> View Medical Policies
Search our standard and Blue Value Rx formularies	Manage Your Business>Search Pharmacy & Info>Medication Search
Download the new *Frequently Asked Questions* document on our *Proton Pump Inhibitors Pharmacy Medical Policy*	Manage Your Business>Search Pharmacy & Info>Drug Management Programs

See page 15 for Pharmacy Medical Policy Updates.

Office Staff Notes

Updates to Tiered Network Status

Because of improvements in providers' quality and cost data, we have updated hospital tiering in the following benefit designs:

- HMO Blue Options™
- HMO Blue New England Options™
- Network Blue® Options
- Network Blue New England Options℠
- Blue Precision™
- PPO Blue Options™
- Preferred Blue® PPO Options

Several hospitals have experienced improvements in either quality or cost, and are therefore changing their tiering status.

For members of our tiered network plans, the member's cost-share for care from a hospital or primary care provider (PCP) is based on the tier of the provider rendering services to them. This encourages members to consider the cost and quality of the PCP or hospital each time they seek care, and rewards them for choosing providers in best-performing tiers.

If your hospital changed tiers, you were notified via an *F.Y.I.* dated September 1, 2010. We encourage your facility to continue your existing quality and cost-improvement activities in preparation for our next tiering update, anticipated at the end of 2011.

As always, we encourage you to check member eligibility and benefits using one of our technologies prior to rendering services.❖

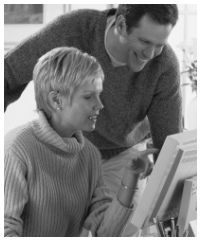
New Benefit Plan Design Options Starting in 2011

Hospital Choice Cost-sharing Offers Members Affordable Options

As part of our ongoing efforts to offer small businesses and members more affordable choices for quality health coverage, BCBSMA has received approval from the Division of Insurance to offer new benefit plan design options, beginning on January 1, 2011.

For these plans, acute care hospitals in Massachusetts are grouped into two different cost-sharing levels. These plan designs include higher member cost-sharing for certain inpatient and outpatient services at hospitals that are equivalent to the Basic Benefit tier of our Blue Options tiered network plans.

When members choose to have these services at a higher-cost-share hospital, they will pay higher out-of-pocket costs. Unlike our Blue Options plans, there will not be different levels of member cost-sharing among primary care providers in these plans.



As always, we urge you to check member eligibility and benefits before rendering services.

For more information, go to www.bluecrossma.com/provider and click on Health & Dental Plans.❖

National Consumer Cost Tool to Launch in 2011

The Blue Cross Blue Shield (BCBS) Association, working in partnership with BCBS plans, is developing a web-based national consumer cost tool that will give members comparative information about the approximate cost range of services and procedures that can be appropriately performed in a variety of settings (e.g., hospital outpatient, free-standing, ambulatory surgery centers).

Expected to be available early in 2011, the tool will allow members to compare the cost of specific services, based on providers' contracted rates, at any BCBS-contracted facility near them.

The tool will encourage members to consult with their physician in making any decision about where to seek care.

While this tool is of special interest to our members with substantial out-of-pocket responsibility, we anticipate that it will be of interest to all of our members as consumers become more conscious about how the decisions they make impact their overall health care costs.

We anticipate sending you more information about the tool later this year.

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

Office Staff Notes

Expanded Coverage for Preventive Care Under National Health Care Reform

The Patient Protection and Affordable Care Act (PPACA), also known as national health care reform, was signed into law on March 23, 2010. As part of the new law, beginning with plan years on or after September 23, 2010, group and individual health plans, and group health insurers, can no longer require cost-sharing for certain preventive services.

In addition, coverage must be provided for some preventive services. These services may include screenings, immunizations, and other types of care, as recommended by the federal government.

Effect of the New Rules

BCBSMA is committed to implementing these coverage changes in a way that best suits the needs and expectations of our members. We will be removing member cost-sharing and/or adding coverage for certain preventive services in our standard plans that currently apply a cost-share or do not offer the required coverage.

These changes apply to our insured and self-insured medical accounts, unless the account's plan has grandfathered status. Grandfathered plans are not required to make the changes on renewal. The member ID card will indicate $0 as the copayment for preventive care where appropriate.

On account renewal, BCBSMA will offer the following services with no member cost-share when they are administered by network providers:

- Routine adult exams
- Routine Gyn exams
- Certain family planning services
- Routine hearing exams
- Routine vision exams
- Certain prenatal services
- Routine pediatric care.

You can access a complete list of services offered with no member cost-share, and information about the changes required by PPACA, at www.bluecrossma.com/nhcr. Some of these services may also be covered as part of routine physical exams, such as checkups, routine gynecological visits, or well-child exams. The services included on the list may not be considered preventive when they are received to diagnose or treat an illness or injury or billed by the provider as such.

The list of preventive care services and tests that will be covered with no member cost-share is subject to change upon the issuance of further guidance from the federal government related to PPACA.

BCBSMA has updated its products, and certain plan designs may have expanded preventive benefits beyond what is required by national health care reform. Some grandfathered and/or self-insured plans designs may have a more limited selection.

As always, we urge you to check member benefits and eligibility before rendering services.❖

Changes Coming to Our Fax-on-Demand System in March

With more widespread use and adoption of our provider website, we continue to encourage the use of electronic communication.

Effective March 1, 2011, the only documents we will offer on our Fax-on-Demand system will be InterQual® SmartSheets™.

All other documents currently on Fax-on-Demand, including BCBSMA medical policies, will be available solely on our BlueLinks for Providers website. (Please note: SmartSheets are also available on BlueLinks for Providers.)

We'll continue to update you as March 1 approaches.

Not Registered for Our Website?

Go to www.bluecrossma.com/provider and click on Register Now in the blue box.

About Billing Agencies

Since billing agencies with whom you do business may also use Fax-on-Demand service to request medical policies and other important information, be sure to notify them of this upcoming change.

As a reminder, you may also authorize billing agencies who work on your behalf to register for our website. To do so, they can go to the same link shown above. Once they have registered, you will be notified and asked to authorize them to work on your behalf.❖

Office Staff Notes

2011 CPT/HCPCS Changes for Ancillary and Behavioral Health Providers

We are currently reviewing the new CPT and HCPCS codes released for dates of service starting on January 1, 2011 to make any applicable fee schedule changes. Please:

- Do not bill for deleted codes after January 1, 2011.
- Ancillary and Behavioral Health Providers: bill only for codes that are on your current Agreement. We only provide reimbursement for codes included on your Agreement.

We anticipate notifying you of changes applicable to your specialty (including any additions, deletions, and narrative changes) in the first quarter of 2011. Your fee schedule will also be updated to reflect any changes and will be posted online.

You may also receive updates about these changes via our BlueLinks for Providers website. Therefore, if you have not already done so, we recommend that you register for updates via e-mail. (See instructions at the right.)

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

Registering for eNews Alerts

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 types of communications for which you want notification. (Be sure to select General News & Updates to receive news about CPT/HCPCS code changes that impact your provider specialty.

Click on Save.❖

Attention Acute Care Hospitals: Outpatient Fee Schedule Updates Go into Effect January 1

Effective for dates of service on or after January 1, 2011, BCBSMA is updating its HMO, PPO, Indemnity, and Medicare Advantage hospital outpatient fee schedules to include 2011 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes.

We are also deleting those codes no longer valid under the 2011 CPT/HCPCS coding structure.

You can access a summary of the additions and deletions to your outpatient fee schedules for 2010 online. Simply log on to our BlueLinks for Providers website at www.bluecrossma.com/provider and click on Resource Center>Admin Guidelines & Info>Fee Schedules. Then select the document titled *Medicare Advantage Product Hospital Outpatient Fee Schedule Adds & Deletes, Effective 1/1/11*.

Complete electronic versions of your hospital outpatient fee schedules will be available at the end of January by contacting your BCBSMA Network Manager at 1-800-316-BLUE (2583).❖

Medicare Product Changes Planned for 2011

A number of changes to our Medicare Advantage products (Medicare HMO Blue®, Medicare PPO Blue℠), and our Medicare Prescription Drug Plans (Blue MedicareRx) will take effect January 1, 2011. These include benefit enhancements and formulary changes for Medicare Advantage plans and Blue MedicareRx.

In addition, Blue MedicareRx will be consolidating its Value and Value Plus plans into one Value Plus plan offering.

For full details, go to www.bluecrossma.com/provider and click on Health and Dental Plans. Then scroll down and click on the Medicare 2011 Changes link.❖

Office Staff Notes

Mandated Autism Spectrum Disorder Benefits, Effective January 1, 2011

Massachusetts recently enacted a new law requiring health insurers to provide coverage for the diagnosis and treatment of autism spectrum disorders. Currently, BCBSMA provides coverage for many services for patients with autism spectrum disorders, such as evaluations and consultations with psychiatrists and psychologists, and pharmacy benefits.

In accordance with the new mandate, BCBSMA will begin adding new benefits to most group plans on or after January 1, 2011, for new plans starting January 2, 2011, and for existing plans on the plan's renewal/ anniversary date on or after January 1, 2011.

Certain self-funded plans may have the option to exclude such benefits.

Benefits for the diagnosis of autism spectrum disorders will cover medically necessary assessments, evaluations, or testing.

For individuals diagnosed with one of the autism spectrum disorders, our policies will cover the following medically necessary treatment services when provided or ordered by a licensed physician or psychologist:

- Habilitative or rehabilitative care
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care.❖

Federal Employee Program Benefit Changes, Effective January 1

Several benefit changes for Federal Employee Program (FEP) members will take effect January 1, 2011, including:

- In accordance with the federal mental health parity law, prior approval will no longer be required for outpatient mental health and substance abuse services. This applies to services provided by both professional providers and outpatient facilities.

Prior authorization will no longer be required for intensity-modulated radiation therapy (IMRT) in treatment of the following cancers: head (not brain), neck, breast, and prostate. Please note that prior authorization will still be required for all other cancers.

Services performed or billed by residential treatment centers (RTCs) or their staff members will no longer be covered.

- Outpatient facility claims for pharmacy services billed by Veteran's Affairs (VA) providers will be processed by Caremark, FEP's pharmacy benefits manager.

As always, we encourage you to check member eligibility and benefits using one of our technologies prior to rendering services.❖

Trustee Advantage Program Engages Hospital Boards In Quality and Safety

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Key Findings

The impact of the boards' dedication and collaborative efforts to improve quality is evident in the Trustee Advantage evaluation results. The program led to dramatic gains in participants' reported quality and safety knowledge, the boards' role, and specific steps, tools, and strategies.

Participating hospitals made governance improvements and have planned for further improvements in the coming year around performance monitoring and quality and safety improvement. For example, hospitals are focusing on quality performance in their board meetings and spending more time discussing quality at each meeting.

As champions for quality improvement, trustees play a critical leadership role and have the opportunity to drive significant change. While participants view the program as accelerating their journeys significantly, they also recognize that it's an ongoing process. By dedicating immense time and resources to the program, these five hospitals made a commitment to continued excellence in leadership of quality and safety.❖

Office Staff Notes

Reminder About BCBSMA's Policy on Observation Services

BCBSMA reimburses medically necessary observation services according to your facility's agreement with us. We do not allow for the payment of outpatient observation services for greater than 48 hours. In the rare case that a member is kept for more than 48 hours, they must meet the inpatient criteria for continued payment.

BCBSMA uses nationally recognized, evidence-based criteria consistent with reasonable standards of medical practice to determine the medical necessity of inpatient services. In addition, we do not reimburse in the following situations:

- Observation for the normal recovery period following surgical day care
- Observation for the convenience of the provider, the member, or the member's family
- Observation that exceeds 48 hours in the absence of medical necessity.

Resources Available Online

You can find more information about observation services by logging on to www.bluecrossma.com/provider and clicking on the following links:

For our *Observation Services Payment Policy*, select Manage Your Business>Access Payment Policies.

For the Billing and Reimbursement section of our *Blue Book* manual,select Resource Center>Admin Guidelines & Info>Blue Books.❖

BCBSMA Encourages Completion of Fraud, Waste and Abuse Training

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage – Prescription Drug health plans to have an effective compliance training and education program. This includes Fraud, Waste, and Abuse (FWA) training, which was previously required annually.

In the Final Rule published in the *Federal Register* on April 15, 2010, CMS clarified that providers who are *not* required to participate in FWA training and education include:

- Providers who participate in Medicare and accept Medicare patients
- Providers accredited as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier.

While this training is not required, your continued cooperation in the prevention, detection, and reporting of suspected FWA is requested. Therefore, we encourage all providers to participate in training.

To streamline the process, an online FWA training program was developed and is available through the HealthCare Administrative Solutions (HCAS) website, www.hcasma.org. Click on Solutions>Medicare Training. Then, follow the steps listed.

To report suspected fraudulent activity to BCBSMA, call 1-800-992-4100.❖

From the HCAS home page, you can find the Medicare Training section under the Solutions tab.

Office Staff Notes

The Importance of Medical Record Documentation Reviews

In accordance with your BCBSMA Agreement, there are times when we may request copies of your medical records for internal review for various reasons, such as:

- Quality assessment or improvement activities
- Billing accuracy
- Utilization review requirements
- Compliance with state and federal review regulations.

This may include information from electronic medical records as well.

Continuity of Care Is Important

Consistent communication of important patient information among physicians and sites of care plays an important role in facilitating safe quality care, reducing medical errors, and strengthening the transition of care for members. Developing the right systems and processes can enhance this communication.

To help meet guidelines set by the National Committee for Quality Assurance (NCQA), BCBSMA evaluates these systems by reviewing PCP office medical records annually. Documents such as operative notes, discharge summaries, referral consultations, and follow-up reports provide key treatment summaries, helping primary care providers maintain a consistent plan of care and be fully engaged in all aspects of the patients' medical conditions.

Results from Our 2009 Review

Our 2009 records review shows that opportunities for improvement still exist in relation to patient care documentation provided to PCPs by facilities and other providers. By reviewing current processes of how PCPs receive follow-up documentation on their patient's treatment and future plan of care, we are able to analyze key quality issues such as, medical errors, high readmission rates, and patient satisfaction. We look forward to working with all providers on medical record reviews toward the common goal of improved outcomes for our members.

For More Information

More details on our medical record guidelines can be found in Section 2: Utilization Management of your *Blue Book* manual, which is available on our BlueLinks for Providers website. Log on to www.bluecrossma.com/provider and click on Resource Center> Admin Guidelines & Info>Blue Books.❖

Attention Freestanding Radiology Providers: Notification of *Off-Site Emergency Radiology Services* Form Is Now Available on Our Website

If you are a freestanding radiology provider who uses the *Notification of Off-site Emergency Radiology Services* form to notify our vendor (American Imaging Management) of imaging services that you provide in conjunction with an emergency room visit for a BCBSMA member, you can now access the form on our provider website.

To download the form, log on to www.bluecrossma.com/provider and click on Resource Center> Forms>Authorization Forms.

Please note: as of March 1, 2010, this form will no longer be available on Fax-on-Demand, and will only be available on our website. (See related Fax-on-Demand article on page 5.)❖

Acute, Rehab, and Chronic Care Hospitals: Notify Us on Day 85 of a Medex® Member's Treatment

When a Medex member is receiving inpatient care and has reached day 85 of his or her Medicare benefit, and Medex is the secondary payer, the facility must notify BCBSMA's Case Management Department.

To do this, please fax the patient's clinical information to us at 617-246-4210. Be sure to indicate that the patient has reached day 85 of the Medicare benefit.

If you have any questions, please call 1-800-392-0098, ext. 64159.❖

Office Staff Notes

Reminder About BCBSMA's Standards in Utilization Management

As stated 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 www.bluecrossma.com/provider and clicking on Resource Center>Admin Guidelines & Info>Blue Books.❖

Ancillary News

Codes Added to the Physical Therapy Fee Schedule

The codes shown below will be added to the physical therapy fee schedule for dates of service on and after January 1, 2011.

We will post your updated fee schedule online on January 1. To download a copy, log on to www.bluecrossma.com/provider and click on Resource Center> Admin Guidelines & Info>Fee Schedules.❖

Code:	Narrative:	Unit Limit:
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment); direct one-on-one contact by provider, each 15 minutes	Four units
97542*	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes	One unit
97602	Removal of devitalized tissue from wound(s),non-selective debridement, without anesthesia (e.g., wet-to moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	One unit
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	One unit

**For this and any other procedure and modality code, you will be reimbursed up to four units per date of service (e.g., one code at four units or any combination of these codes at one unit).*

Ancillary News

Skilled Nursing Facility (SNF) Incentive Program 2011 Announced

We recently announced the measures for the 2011 SNF Incentive Program, including new measures that require:

- Use of contracted ground ambulance providers for non-emergent transports. If you meet our threshold for this eligibility measure, we'll consider your SNF for the process and outcomes measures.
- Use of the INTERACT II tool and the development of collaborations to reduce hospital readmissions and improve transitions of care.
- Reporting on resident transfers to the emergency room or inpatient/observation status admissions, and improved quality improvement processes or initiatives for your residents' transfers to the hospital.

You must use our online reporting tool to submit your process and performance tracking measures on or before July 15, 2011. We will not accept information submitted after July 15, 2011. We encourage you to familiarize yourself with the online reporting tool prior to July 15.

Online Resources

For these resources, log on to www.bluecrossma.com/provider:

- *F.Y.I.* announcing the program. Select News for You>FYIs and scroll to the September 1, 2010 notification (PC-1441)
- Recording of the October 5 webinar about the program. Select Resource Center> Training & Registration and choose the webinar about the program from the drop-down.
- Templates for the online reporting tool will be available on January 1 and the online tool will be available after June 30, 2011.

Register for e-mail Alerts

We urge you to sign-up to receive all e-mail alerts from BCBSMA, including General News & Updates, newsletters, and *F.Y.I.* announcements. This will help to ensure that you receive reminders and other news about the SNF Incentive Program. Follow these steps 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 types of communications for which you want notification. (Be sure to select General News & Updates to receive updates about the SNF Incentive Program.)
- Click on Save.❖

SNFs: Level of Care Form for Medex® Members Has Been Updated

We've updated the *SNF Level of Care Form* that's used only for BCBSMA Medex members who have exhausted their 100-day SNF benefit. You can complete the form online and fax it to the number indicated. If you have questions about the form, please call 617-246-4159.❖

New *Respiratory Services Payment Policy* Is Available for DME Providers

BCBSMA has posted a new *Respiratory Services Payment Policy* online for Durable Medical Equipment providers. To view any of our payment policies, log on to www.bluecrossma.com/provider and click on Manage Your Business>Access Payment Policies.

About Our Payment Policies

BCBSMA's payment policies determine the rationale by which a submitted claim for service is processed and paid by BCBSMA. Payment policies are distinct from our medical policies, which address coverage of services.

BCBSMA payment policies do not contain information about how to code services; however, we do provide links to applicable websites where providers can find more information.❖

Medical Policy Update

Changes

Ambulatory Event Monitors; Mobile Cardiac Outpatient Telemetry; Transtelephonic Transmission of Post-symptom Electrocardiograms and Cardiac Event Monitors, 347. Adding coverage for mobile cardiac outpatient telemetry for Medicare Advantage products. Effective 10/27/2010.

Cellular Immunotherapy for Prostate Cancer, 268. New medical policy addressing coverage and non-coverage of Sipuleucel-T therapy (Provenge®). Effective 1/1/11.

Cognitive Rehabilitation, 439. Adding coverage for traumatic brain injury when specific conditions are met for specific diagnoses, effective 1/1/11.

Intravitreal Implant, 272. New policy adding coverage for specific indications. Effective 3/1/11.

Plastic Surgery, 68.

Adding coverage of pulsed dye laser treatment of hypertrophic scars when there is documented functional impairment. Effective 1/1/11.

Removing claims system editing that addresses coverage of port wine stain laser treatments (tunable dye laser) billed with the CPT codes listed below. Effective 1/1/11.

- 17106 (destruction of cutaneous vascular proliferative lesions [e.g., laser technique]; less than 10 sq cm)
- 17107 (destruction of cutaneous vascular proliferative lesions [e.g., laser technique]; 10.0 to 50.0 sq cm)
- 17108 (destruction of cutaneous vascular proliferative lesions [e.g., laser technique]; over 50.0 sq cm).

Adding non-coverage of laser treatment of port wine stains when performed in combination with photodynamic therapy or with topical angiogenesis inhibitors. Effective 3/1/11.

Radiofrequency Ablation of Primary or Metastatic Liver Tumors, 286. New policy describing covered and non-covered indications for this procedure. Similar information will be removed from medical policy 369, *Intra-arterial Chemotherapy; Chemoembolization of Liver Cancer; Cryosurgical Ablation of Liver Tumors; & Radiofrequency Ablation of Liver Tumors*. Diagnosis editing on claims being removed. Effective 3/1/11.

Sacral Nerve Neuromodulation/Stimulation for Pelvic Floor Dysfunction, 153.

Adding coverage of sacral nerve stimulation for the treatment of fecal incontinence when identified criteria are met. Effective 1/1/11.

Implementing editing to support coverage of sacral nerve stimulation when billed with CPT codes 64561, 64581, 64585, and 64595 and HCPCS Level II code A4290 with additional covered indication reported with ICD-9 CM diagnosis 787.6 (incontinence of feces) for our commercial products and for Medicare HMO Blue and Medicare PPO Blue. Effective 1/1/11.

TMJ Diagnosis and Management, 035. Adding non-coverage of acupuncture to non-surgical treatment of TMJ disorders. Effective 3/1/11.

Ultrasound, 007. Including coverage for a "once-in-a-lifetime" ultrasound screening for abdominal aortic aneurysms for males ages 65-75 in commercial products. (Mandated by Patient Protection and Affordable Care Act.) Effective 9/25/10.

Clarifications

Artificial Intervertebral Disc: Cervical Spine, 585. New medical policy describing ongoing non-coverage of this procedure.

Artificial Intervertebral Disc: Lumbar Spine, 592. New medical policy describing ongoing non-coverage of this procedure.

Automated Point-of-Care Nerve Conduction Tests, 222. New medical policy describing ongoing non-coverage of this procedure.

Bioimpedance Devices for Detection of Lymphedema, 261. New medical policy clarifying non-coverage for bioimpedance devices for detection of lymphedema.

Bronchial Thermoplasty, 284. New medical policy describing ongoing non-coverage of this procedure.

Computer-Aided Evaluation of Malignancy with Magnetic Resonance Imaging of the Breast, 578. New medical policy describing ongoing non-coverage of this procedure.

Clarifications, continued on page 13

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Clarifications, continued from page 12

Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid, 107. Continuous or intermittent monitoring of glucose in interstitial fluid does not require a prior authorization. An announcement to this effect was erroneously published in the Summer 2010 issue of *Blue Focus*.

Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors, 260. New medical policy describing coverage and non-coverage of this procedure. The same information will be removed from medical policy 369, *Intra-arterial Chemotherapy; Chemoembolization of Liver Cancer; Cryosurgical Ablation of Liver Tumors; & Radiofrequency Ablation of Liver Tumor*.

Extracranial Carotid Angioplasty/Stenting, 219. Clarifying the prior authorization language for Indemnity and PPO products.

Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty), 271. New medical policy describing non-coverage of these procedures. Clarifying non-coverage of radiofrequency coblation (disc nucleoplasty) to align with BCBSA national policy. The same information will be removed from medical policy 099, *Percutaneous Annuloplasty; Intradiscal Radiofrequency Thermocoagulation; Intradiscal Electrothermal Therapy (IDET); and Manipulation under Anesthesia for Treatment of Chronic Spinal or Pelvic Pain*.

Detection of Circulating Tumors Cells in the Management of Patients with Cancer, 265. Developing a new medical policy to clarify non-coverage of these tests.

Diagnosis and Management of Idiopathic Environmental Intolerance (i.e., Clinical Ecology), 264. Developing a new medical policy to clarify non-coverage of these tests.

Implanted Devices for Deafness-Cochlear Implants, 087. Clarifying a typographical error, 100 HZ changed to read 1000 HZ.

Lung Volume Reduction Surgery for Severe Emphysema, 364. Clarifying criterion that abstinence from cigarette smoking must be documented for at least four months prior to surgery. Information on thorascopic laser ablation of emphysematous pulmonary bullae is now separately addressed in medical policy 275, *Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae*.

New Non-covered CPT and HCPCS Level II Codes

We have updated medical policy 400, *Medical Technology Assessment Non-Covered Services*, to include the new CPT and HCPCS Level II codes. These codes, which become effective January 1, 2011, have been identified as non-covered.❖

Magnetic Resonance, 106. Clarifying the covered ICD-9-CM diagnosis codes when billed with CPT codes 74181, 74182, and 74183 (MRI abdomen) by including: V10.50, V10.51, V10.52, V10.53, and V10.59.

Measurement of Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) in the Assessment of Cardiovascular Risk, 558. New medical policy describing ongoing non-coverage of this procedure.

Medical Technology Assessment Guidelines Non-Covered Services, 400.

Clarifying non-coverage of the following CPT codes:

- 74263: Computed tomographic (CT) colonography, screening, including image postprocessing (for commercial products only)
- 90664: Influenza virus vaccine, pandemic formulation, live, for intranasal use
- 90666: Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use
- 90667: Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use
- 90668: Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use.

Clarifying non-covered treatments for tinnitus.

Clarifying non-coverage of vertebral body stapling for the treatment of scoliosis.

Novel Lipid Risk Factors in Risk Assessment and Management of Cardiovascular Disease, 283. New medical policy describing ongoing non-coverage of tests for apolipoprotein B, apolipoprotein A-I, apolipoprotein E, LDL subclass, HDL subclass, lipoprotein[a] for commercial products and coverage for Medicare HMO Blue® and Medicare PPO Blue℠. The same information is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Clarifications, continued on page 14

Medical Policy Update

Clarifications, continued from page 13

Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome, 266. Developing a new medical policy to clarify non-coverage of this procedure.

PathFinderTG® Molecular Testing, 566. New medical policy describing ongoing non-coverage of this procedure.

Placental/Umbilical Cord Blood as a Source of Stem Cells, 285. New medical policy describing coverage and non-coverage of this procedure. Same information removed from medical policy 092, *Allogeneic Stem Cell Transplants*.

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors, 259. New medical policy describing coverage and non-coverage of this procedure. The same information will be removed from medical policy 369 *Intra-arterial Chemotherapy; Chemoembolization of Liver Cancer; Cryosurgical Ablation of Liver Tumors; & Radiofrequency Ablation of Liver Tumors*.

Serial Endpoint Testing for the Diagnosis and Treatment of Allergic Disorders, 270. New medical policy describing coverage of this procedure. Clarifying the term "severe systemic allergic reaction" to align with BCBSA national policy coverage statement. The same information will be removed from medical policy 217, *Allergy Testing and Treatment*.

Serum Antibodies for the Diagnosis of Inflammatory Bowel Disease, 551. New medical policy describing ongoing non-coverage of this procedure.

Treatment of Tinnitus, 267. New medical policy clarifying non-coverage for treatment of tinnitus. The same information is addressed on medical policy 400, *Medical Technology Assessment Guidelines Non-covered Services*.

Ultrafiltration in Decompensated Heart Failure, 542. New medical policy describing ongoing non-coverage of this procedure.

Wearable Cardioverter Defibrillators, 042. Changing the title of this policy to *Wearable Cardioverter Defibrillators as a Bridge to Implantable Cardioverter Defibrillator Placement* in alignment with Blue Cross Blue Shield Association policy.❖

Correction

In Fall 2010 *Blue Focus*, we published the following coverage update for *Esophageal pH Monitoring, 069* with an effective date of 11/1/10:

"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."

Please note: the correct effective date is 8/1/10.❖

Advance Drafts of New and Revised Policy Statements Are Now Available on Our Website

We understand that changes to medical policy can impact your practice and member treatment.

To help you better understand medical policy changes, we are providing draft versions of new and revised policy statements on the Medical Policy page of our website 45 days prior to the policy effective date.

To access a document with the draft statements:

Go to www.bluecrossma.com/provider and click on Medical Policies.

Click on Advance Announcement of Draft New and Revised Medical Policy Statements (listed under the What's New heading).

This document will be updated as new draft statements are developed*.❖

** The draft medical policy coverage statements are provided by BCBSMA for informational and review purposes only. The draft policy statements do not constitute or imply member coverage or physician reimbursement. The summary information is not an authorization, explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. BCBSMA reserves the right to revise the content of the draft statements prior to their effective date.*

Pharmacy Medical Policy Update

Changes

Ampyra (Dalfampridine), 246. New medical policy addressing coverage of Ampyra. Initial coverage criteria include diagnosis of multiple sclerosis, documentation of significant limitations of instrumental activities of daily living attributable to slow ambulation, prescription from a neurologist, and completion of a timed 25-foot walk test (T25FW) or expanded disability status score (EDSS). Continuation criteria include documentation of improvement in either T25FW or EDSS. Effective 1/1/11.

Antidepressant Drugs, 024. Moving Celexa®˝, Effexor®˝, Effexor XR®˝, Paxil®˝, Prozac®˝, Wellbutrin®˝, Wellbutrin SR®˝ and Zoloft®˝ to Step 3. Effective 1/1/11.

Asthma Management, 011. Updating this medical policy to include both of the following requirements for Step 2 medications that do not meet the online point of service criteria. Effective 1/1/11:

A diagnosis of asthma

Evidence of a BCBSMA-paid claim or physician documentation confirming use of one of the following medications within the previous 130 days: inhaled corticosteroid; inhaled beta2 agonist, inhaled mast cell stabilizer, oral albuterol product, or a product containing oral theophylline.

Botulinum Toxin, 006.

Implementing prior authorization for Dysport®˝ inj. when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/11.

Updated to specify that CPT codes 64612-64614 for chemodenervation of muscles of single or multiple extremities, as well as muscles of the face, neck, and trunk, should be reported only one time per session. This policy is consistent with American Medical Association guidelines. In addition, these codes should not be reported bilaterally with use of modifier 50. Effective April 1, 2011, modifier 50 pricing will no longer be allowed for CPT codes 64612-64614.

Erythropoietin, Recombinant Human, 262. Updating this medical policy to include the following information, effective 1/1/11:

Approval timeframes for initial and continuation requests given in six-month intervals.

Confirmation of myelodysplastic syndromes via biopsy or aspirate

Definition of anemia of chronic renal failure in terms of GFR and/or dialysis treatment.

Requirement to indicate recent hemoglobin (Hb) levels for initial and continuation requests for review and approval. For most diagnoses covered under this policy:

- Initial Hb level $\leq$ 10 g/dL
- Continuation Hb level $\leq$ 12 g/dL.

Glucagon-like Peptide-1 (GLP-1) Receptor Agonist, 282. New pharmacy medical policy addressing the following step therapy requirements: Step 1 Byetta®˝ (exenatide); Step 2 Victoza®˝ (liraglutide). Effective 1/1/11.

Immune Modulating Drugs, 004. Implementing prior authorization for Ilaris®˝, Simponi™, and Stelara™ when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/11.

Proton Pump Inhibitors, 030. Moving pantoprazole to Step 2 and omeprazole/sodium bicarbonate to Step 3. Effective 1/1/11.

Serotonin 5-HT 1B,1D Receptor Agonists, 169. Moving Amerge®˝ and all formulations of Imitrex®˝ to Step 3. Effective 1/1/11.

Retired

Antifungal Therapy (Oral and Topical), 022. Retiring this pharmacy medical policy, which includes coverage criteria for ciclopirox nail lacquer, CNL8®˝ nail kit (ciclopirox), itraconazole capsules, Lamisil®˝ granules (terbinafine), Lamisil®˝ tablets (terbinafine), Penlac™ nail lacquer (ciclopirox), Sporanox®˝ capsules (itraconazole), and terbinafine tablets. Effective 1/1/11.

Orphan Drugs for the Treatment of Rare Diseases, 021. Retiring this medical policy, which includes prior authorization requirements for outpatient sites of service for Aldurazyme™ (laronidase), Fabrazyme®˝ (agalsidase beta), Naglazyme™ (galsulfase), Somatuline®˝ Depot (lanreotide), and Somavert®˝ (pegvisomant). Effective 1/1/11.❖

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HIPAA Version 5010 News

Details on Version 5010 Conversion Are on Our Website

Do you have questions about the upcoming conversion to HIPAA Version 5010? To help answer your questions, refer to our *HIPAA Version 5010 Frequently Asked Questions* (FAQs) document, available on our website.

All health plans, providers, and clearinghouses that conduct business electronically are preparing to convert to Version 5010, the next HIPAA standard for electronic transactions.

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 prior to January 1, 2012, when the new 5010 version must be adopted. BCBSMA is currently developing our provider testing strategy and we expect to begin provider testing in the second quarter of 2011.

We will continue to communicate information about HIPAA 5010 in future issues of *Blue Focus*.

How to Find Resources Online

To access our *FAQs* and links to other HIPAA 5010 resources, log on to www.bluecrossma.com/provider, click on Resource Center, then select HIPAA Version 5010 in the blue box on the right-hand side of the page.❖

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