September 2010

# Providerfocus

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



## South Shore PHO's PCP "Positive Touch" Quality Incentive Plan

South Shore Physician Hospital Organization (SSPHO) understands that incentives drive behavior change, and that the way health care providers are reimbursed ultimately helps improve the quality of patient care and outcomes. With that in mind, SSPHO has developed a quality incentive plan for their primary care providers (PCPs) they say really works.

SSPHO, a participant in Blue Cross Blue Shield of Massachusetts' (BCBSMA*) Alternative Quality Contract (AQC) since 2009, provides health care services to 33,000 BCBSMA members, and includes 104 primary care providers located in two large practices and numerous solo practices. More than 300 specialty care providers are also part of SSPHO.

Their quality incentive plan—"Positive Touch"—is designed to motivate and reward physicians for positive patient outcomes.

### Best Practice Spotlight

Points are earned solely for accomplishing evidence-based care for a patient, and are not awarded based on percent of patients in the PCP panel receiving such care. The more patients who receive more recommended tests, etc., the more points that are earned.

"It's called Positive Touch because having a positive patient outcome requires a 'touch' between the patient and the physician," says Gerri McNamara, SSPHO's Director of Medical and Performance Management.

To develop the plan, a subcommittee formulated guiding principles and goals that:

- Reward and foster success in meeting hospital and ambulatory AQC measures
- Maintain and expand access for patients in the network
- Incent PCPs to develop processes and infrastructures to improve the quality of care that patients receive as proven by meeting the AQC quality measures.

SSPHO purposely aligned its incentive program with the AQC measures to ensure success of both programs. PCP quality incentive payment earned is based on scores from a total of:

- 32 ambulatory-based measures
- Measures focused on process, outcomes, and patient experience.

*continued on page 5*

### Tell Us Your Story

Does your organization have a best practice you'd like to share? If so, contact your Network Manager to discuss, or call Network Management Services at **1-800-316-BLUE (2583).**❖

## In This Issue



## In Brief

### Learn About Stimulus Funds for Electronic Health Records

The Massachusetts e-Health Institute's Regional Extension Center is offering free summits throughout the fall to help providers implement electronic health records (EHRs). At the summits, providers will learn who qualifies for incentives, how to meet federal criteria, and how to receive help in selecting, implementing, and using EHRs.

Some venues will include vendor demonstrations.

Physicians and office staff, dentists, nurse practitioners, community health center providers, hospital administrators, ambulatory electronic health record champions, and physician organization directors are all welcome to attend.

Seating is limited. To view a list of dates/locations and to preregister, go to **www.maehi.org/index.html** and click on **REC Summits and Events** on the right-hand side of the page.❖

# Physician News

MASSACHUSETTS

## Educating Members on the Importance of Mammograms, Early Detection

The American Cancer Society's statistics estimate that one in eight women (12%) will develop invasive breast cancer at some time during her life. The ACS also estimates that among U.S. women in 2010:

- About 207,090 new cases of invasive breast cancer will be diagnosed
- About 54,010 new cases of carcinoma in situ (a non-invasive and earliest form of breast cancer) will be diagnosed
- About 39,840 women will die from breast cancer.

But there *is* good news. Breast cancer death rates have been declining since 1990, with larger decreases in women younger than 50. These decreases are believed to be the result of earlier detection through screening, increased awareness, and improved treatment.

### The Importance of Early Detection

A recommendation from a physician is one of the most influential

factors in whether a patient is screened for breast cancer. To support you in educating your female patients—and in recognition of Breast Cancer Awareness Month in October—BCBSMA is reminding eligible HMO, POS, and PPO members to speak with their doctors about when they should receive a mammogram.

Through September, eligible members will receive a reminder from BCBSMA via e-mail, postcard, or pre-recorded telephone message encouraging them to talk to their provider about getting screened.

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

### Resources on Our Website

To access breast cancer screening guidelines and other resources to educate your patients, log on to **www.bluecrossma.com/provider,** click **Manage Your Business> Manage Patient Care,** then choose Breast Health from the drop-down menu.❖

### ACS Breast Cancer Facts

- Breast cancer is the second most common cancer among American women, after skin cancers.
- Breast cancer is the second leading cause of cancer death in women, exceeded only by lung cancer.
- There are now over 2.5 million breast cancer survivors in the United States.❖

## New Preferred Home Infusion Therapy (HIT) Provider for IVIG

We recently added a new HIT provider, Home Solutions, to our list of preferred providers for IVIG therapies only. Preferred HIT providers offer our members* cost-effective therapies in a variety of therapeutic classes. Use of the preferred network is encouraged, although not required.

To download our *Preferred HIT Provider List*, log on to **www.bluecrossma.com/provider** and select **Manage Your Business>Search Pharmacy & Info.**❖

**Excludes Federal Employee Program members.*

**Contact information for Home Solutions' Offices:**

| | |
|---|---|
| 295 Main Street<br>Falmouth, MA 02540<br><br>Phone: **508-548-4266**<br>Toll-free phone: **1-800-244-1227**<br>Fax: **508-540-9475**<br><br>**www.infusionreferral.com** | 780 Dedham Street, Suite 300<br>Canton, MA 02021<br><br>Phone: **617-989-0888**<br>Toll-free phone: **1-888-660-1660**<br>Fax: **617-989-0188**<br>Toll-free fax: **1-888-660-2660**<br><br>**www.infusionreferral.com** |

# Physician News

## Treating Your Patients When They Have Dental Emergencies

There are two common causes of dental emergencies: accidents, such as motor vehicle accidents or sports-related injuries, and those that result from improper preventive care. In both cases, your patients may seek care from from you before seeing a dentist.

According to the American Academy of Pediatrics' Oral Health Initiative, up to 30% of children injure their primary teeth[1]. Emergency orofacial injuries may include damage to soft tissue (e.g., lacerations or swelling) or hard dental structures (e.g., tooth or jaw fracture).

BCBSMA's Dental Director Robert Lewando, DDS, recommends that physicians familiarize themselves with oral conditions that require an immediate referral to the emergency room, such as:

- Broken jaw
- Breathing issues and significant facial swelling
- Facial injury, particularly when leading to loss of consciousness.

Once the patient has been treated for the emergent condition, it's important for you to encourage follow-up care from a dental provider.


### Other Causes of Emergencies

Often the issues that cause the member to seek care in an emergency room setting have dental causes that could have been delayed or prevented by regular dental care. A prospective study by the Dental, Oral, and Craniofacial Data Resource Center found that almost 69% of hospital dental emergency patients did not see a dentist regularly and still had not done so one year later[2]. Lack of regular dental care can often cause repeat visits to the emergency room that are both costly and do not necessarily address the member's underlying dental problems.

In some instances, such as a toothache or gum abscess, you can provide the patient with an antibiotic and/or analgesic to treat the swelling and then refer him/her to a dentist for follow-up. Lewando says the role of the physician is not to provide definitive care in these instances, but to either ease the member's pain or help to control any localized swelling until the patient sees the dentist.

"Many dentists set aside time in their daily schedules for emergencies, making it easier for a patient to get an immediate appointment," says Lewando.

There are other dental situations patients believe are emergent, such as a broken or lost filling, broken denture or partial, or lost or broken crown. While these instances may not constitute an emergency, members should still be referred to their dentist for care. In these circumstances, the dentist will determine how soon a member needs to be seen.

### Locating a BCBSMA Dentist

If your patient is a Dental Blue®, member, you can help them locate a BCBSMA-participating dentist by using our website's Find a Doctor feature. Log on to **www.bluecrossma.com/provider** and select **Manage Your Business.**❖

[1] Source: Oral Health Initiative, a program of the American Academy of Pediatrics. http://www.aap.org/oralhealth/pact/ch10_intro.cfm

[2] Source: Annual Report: Oral Health 2002, The Dental, Oral, and Craniofacial Data Resource Center. http://drc.hhs.gov/report/11_1.htm

## Oral Health Continuing Education Opportunity for Physicians

The Society of Teachers of Family Medicine and American Academy of Family Physicians has developed its latest edition of *Smiles for Life: A National Oral Health Curriculum*, designed for primary care clinicians.

The seven-module course covers the relationship of oral to systemic health and includes training on dental emergencies, child and oral health, oral examination and other topics relevant to clinicians.

Continuing education credits are offered. To get started, visit **smilesforlifeoralhealth.org.**❖

# Training Update

## Learn About ExpressPA and Other BCBSMA Technology Tools

Want to learn how BCBSMA's technologies can simplify your administrative efforts? Attend our online *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, you'll learn how to:

- Register for ExpressPA, our web-based pharmacy authorization tool
- Use ExpressPA to request authorization for retail pharmacy prescription medications that process through the member's pharmacy benefit
- Use Online Services to check the status of a referral or authorization.

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

## Check Out Our Updated Online Services Training on BlueLinks

Online Services was recently redesigned to make navigation easier. To help you perform eligibility and claims status inquiries using the new navigation, we have updated our *Introduction to Online Services* presentation.

This presentation highlights Online Services' most frequently used functions, such as:

- Verifying member eligibility and benefits
- Checking claim status
- Requesting simple claim adjustments.

To register, log on to **www.bluecrossma.com/provider**, click on **Resource Center>Training & Registration>Course List,** then select **Introduction to Online Services** from the drop-down menu for your provider type.❖

# Ancillary News

## Assisted Reproductive Technology Providers: Reminder About Cryopreservation of Embryos

As we previously communicated, effective February 1, 2010, BCBSMA no longer separately reimburses for cryopreservation/storage because the fee allowance for this service is now considered part of the global infertility case rate payment.

It has come to our attention that some members may have been billed after one year for this service because they are no longer in "active" infertility treatment.

Please note that the global case rate payment includes 24 months of cryopreservation/storage and members should be billed for this service only after 24 months.

If members were billed and paid for this service inappropriately, please refund all payments received from these members immediately.

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

# Pharmacy Update

## Reminder About Benefit Change for Specialty Medications

*All Affected Members Will Be Transitioned As Of October 1*

As we previously communicated, we have implemented a benefit change resulting in certain specialty medications no longer being provided through the member's BCBSMA medical benefit. Coverage for these medications is available through the BCBSMA pharmacy benefit for members who have such coverage.

This benefit change for members was based on their policy renewal date. As of October 1, 2010, all policies will have transitioned to this new benefit.

We remind you to check benefits and eligibility to determine the member's coverage.

For more information about the products affected and how to check benefits and eligibility, please refer to our *Medical to Pharmacy Benefit Transition Fact Sheet*, available by logging on to **www.bluecrossma.com/provider** and selecting **Resource Center>Admin Guidelines & Info>Fact Sheets.**❖

## South Shore PHO's PCP "Positive Touch" Quality Incentive Plan

*continued from page 1*

Key elements of the plan include:

- Aligning incentives to drive and reward positive outcomes
- Rewarding PCPs who have an increased number of chronic care patients in their panels
- Using straightforward, easily understandable metrics
- Providing physicians with frequent reporting to help them chart their progress. This includes transparent peer comparison reporting, which aims to motivate improvement, not to judge the physician.

### Challenges Encountered

Developing the program wasn't without its challenges. McNamara says the biggest obstacle was getting physicians to change their workflows and way of thinking. The PHO spent a lot of time educating physicians about how the care paradigm had changed—from reacting to sick patients, to proactively reaching out for care.

"Physicians are used to seeing patients when they are called to be seen," she says. "This was all about setting up a dynamic to pull patients into the system, rather than waiting for them to come to us."

Another challenge was getting the office staff involved in new workflows and understanding the incentive plan. This was solved by holding routine educational office staff meetings.

### The Results

McNamara says they've experienced measurable improvement since the plan began in 2009.

"We are delighted to report that our HbA1c testing improved by 19%, our aggregate process measure score improved by 95%, and we showed improvement in every measure," says McNamara.

There has been increased awareness of chronic care guidelines, and the PHO physicians and office staff are fully committed to sharing ideas and best practices.

SSPHO physicians have also embraced the new incentive program. McNamara credits this success to having developed meaningful incentives that reward care for patients with chronic conditions.

"Our plan acknowledges variation in severity of illness among patients, and the effort required to manage patients with chronic conditions," she says. "Our physicians see this incentive plan as a motivating tool that enables them to continually improve the care their patients receive. They are truly dedicated to quality improvement."❖

### Considering Developing a Quality Incentive Plan?

Gerri McNamara says SSPHO had these essential elements in place to develop their successful quality incentive plan:

- A history of focus on quality with well-established quality incentive plans for PCPs and specialists.
- A history of successful risk contracting supported by medical management, information technology, and physician relations
- Experienced medical and financial leadership.❖

# Office Staff Notes

## What You Need to Know About the 2010-2011 Flu Season

We are committed to helping limit the spread of the flu virus. To do this, our HMO, POS, Access Blue, and Medicare Advantage plans provide members with coverage for vaccination under their medical benefits without a copayment. However, if the member receives a flu shot along with other covered services, he/she will be subject to any applicable cost sharing for the other services in accordance with his/her benefits.

Starting October 1, 2010, we will be:

- Eliminating any cost share for Blue Care Elect℠ PPO members receiving a flu shot from a participating provider.
- Contracting with vendors to provide our members with flu shots at specific public access/retail clinic locations.

As always, be sure to check benefits and eligibility before performing services.

### Billing and Reimbursement Information On Our Website

The flu information page on our BlueLinks for Providers website provides more details on how to bill for flu vaccine not supplied by the Massachusetts Department of Public Health, and on how to bill for vaccine administration. Log on to **www.bluecrossma.com/provider** and click on the **Flu** link on the home page.❖

## BCBSMA to Reimburse Members for Services from Non-Participating Providers

In an effort to deliver more affordable products to employers and members, BCBSMA is implementing a change in the way we reimburse non-participating providers. A non-participating provider is defined as a provider who does not have a contract with BCBSMA for the member's product.

Currently, when a provider treats a member of a BCBSMA product in which the provider does not participate, BCBSMA reimburses that provider directly. For dates of service on or after October 1, 2010, when a non-participating provider treats a member of a plan in which they do not participate, we will reimburse the member directly, based on the provider's allowed charges for covered services*.

This reimbursement change applies to all products and services, ***with the exception of***:

- Indemnity
- Blue Choice® 1
- HMO Blue New England℠, Blue Choice New England℠, and Access Blue New England℠ members with a PCP outside of Massachusetts
- Medicare products and Medicaid
- Dental services
- Veteran's Administration Services.

Non-participating BCBSMA providers will receive notification from BCBSMA that the claims have been processed, and that the member has been reimbursed. The member will be responsible for paying the non-participating provider directly, and the non-participating provider will be responsible for coordinating collection with the member. We have notified employers and members of this change so they are aware that the non-participating provider will be collecting payment from the subscriber.

### Questions?

For more information, please refer to our recent *F.Y.I.* (PC-1431), which we mailed to you in August. To access the *F.Y.I.* online, log on to **www.bluecrossma.com/provider** and click on **News For You>FYIs.**❖

**In some instances, we will pay the provider directly for certain approved individual case management services.*

# Office Staff Notes

## Healthcare Recoveries, Inc. Is Assisting BCBSMA with Provider Audits

BCBSMA will be expanding our relationship with Healthcare Recoveries, Inc. (HRI), a subsidiary of Trover Solutions, to assist us in conducting provider audits. As part of our efforts to manage the cost of health care for our members and employers, HRI will support our Provider Audit team to ensure accurate billing and payment for services performed.

HRI will follow the same audit process outlined in our hospital and professional *Blue Book* manuals. HRI will be performing the following types of provider audits:

- DRG validation
- Inpatient hospital bill audit
- Outpatient Hospital Bill Audit
- Physician Audit
- Specialty Audit.

Notification letters are being sent to impacted providers in the third quarter of 2010 to either request documentation or schedule on-site visits.

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

## Find BlueCard® Member Precertification, Medical Policy Information Faster on Our Website

Starting October 1, 2010, a new feature on BlueLinks for Providers will make it easier for you to find information to help you treat patients who have coverage from an out-of-state Blue Cross Blue Shield (BCBS) plan.

With our new online search tool, you'll be able to find medical policies and general precertification/preauthorization requirements for BlueCard Program members, along with the contact information to initiate precertification/preauthorization.

Go to **www.bluecrossma.com/provider** and scroll down to the new search tool. Click on the information you'd like to access (medical policy or precertification/preauthorization), then enter the **three-character** alpha-prefix exactly as it appears on the member's ID card. **Login is not required**.

If you have trouble accessing information for a BlueCard member, please call BlueCard Eligibility℠ at **1-800-676-BLUE (2583).**❖

## Questions About Member ID Cards? See Our New *Quick Tip*

BCBSMA has developed a new *Member ID Card Quick Tip* to help you understand the key features of ID cards. The document helps you identify the member's ID number and prefix, copayment amounts, pharmacy coverage, logos, and contact information.

Our *Quick Tip* also helps you differentiate between BCBSMA and out-of-state BCBS members.

To download a copy, log on to **www.bluecrossma.com/provider** and click on **Resource Center> Admin Guidelines & Info> Quick Tips.**❖

## 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 healthcare 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.❖

# 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.*

## Attention Oral Surgeons: How to Bill for Impacted Wisdom Teeth

### Scenario

You're a BCBSMA-contracted oral surgeon and have removed impacted wisdom teeth from a BCBSMA member in your office. How should you code your claim?

### Coding the CMS-1500 Claim Form

Bill diagnosis 520.6 (disturbances in tooth eruption) in Block 24E and place of service 3 for your office.

### For Completely Imbedded Bony Impacts

If the member's teeth were completely imbedded in the bone, bill procedure code D7240.

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C EMG | D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E DIAGNOSIS POINTER | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I ID QUAL. | J RENDERING PROVIDER ID # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 09 01 10 | 09 01 10 | 3 | | D7240 | | 520.6 | 800 00 | 4 | | | 1234567890 |
| 09 01 10 | 09 01 10 | 3 | | D9220 | | 520.6 | 100 00 | 1 | | | 1234567890 |
| 09 01 10 | 09 01 10 | 3 | | D9221 | | 520.6 | 90 00 | 2 | | | 1234567890 |

### For Partially Imbedded Bony Impacts

For teeth partially imbedded in the bone, bill procedure code D7230.

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C EMG | D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS | MODIFIER | E DIAGNOSIS POINTER | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I ID QUAL. | J RENDERING PROVIDER ID # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 09 01 10 | 09 01 10 | 3 | | D7230 | | 520.6 | 800 00 | 4 | | | 1234567890 |
| 09 01 10 | 09 01 10 | 3 | | D9241 | | 520.6 | 100 00 | 1 | | | 1234567890 |
| 09 01 10 | 09 01 10 | 3 | | D9242 | | 520.6 | 90 00 | 2 | | | 1234567890 |

### Billing for Anesthesia and Sedation

| For: | Bill: | And: | With: |
|---|---|---|---|
| General anesthesia | D9220 (for the first half-hour) | D9221 (for each additional 15-minute increment) | Appropriate units |
| Intravenous sedation | D9241 (for the first half-hour) | D9242 (for each additional 15-minute increment) | Appropriate units |

### View Our Online Presentation for Oral and Maxillofacial Surgeons

Our *2010 Oral Surgery Presentation* for oral and maxillofacial surgeons shows you how our technologies—PaySpan Health, Emdeon DPS, and Online Services—can help save you time and enhance your ability to collect reimbursement faster and more easily. To access the presentation, log on to our website at **www.bluecrossma.com/provider**, click on **Resource Center>Training & Registration>Course List**, then select **2010 Oral Surgery Presentation** from the Dental 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*

Biventricular Pacemakers for the Treatment of Congestive Heart Failure, 101. Adding coverage for sinus rhythm to the list of medical criteria. Effective 12/1/10.

Cytochrome p450 Genotyping, 256. New medical policy describing coverage and non-coverage indications for clopidogrel (Plavix®) using this test. Effective 12/1/10.

Endometrial Ablation, 331. Effective 12/1/10:

- Removing coverage statements and coding information for robotic-assisted myomectomy from this policy. (To access our Robotic Surgical Systems payment policy, log on to **www.bluecrossma.com/provider** and click on **Manage Your Business>Access Payment Policies.**)
- Removing the following coverage statement regarding endometrial ablation:
  - Endometrial sampling prior to the ablation has excluded cancer, pre-cancer, or structural abnormalities that require surgery.
- Adding to the endometrial coverage statement women who otherwise are considered a candidate for hysterectomy.
- Removing endometrial ablation coverage exclusion of enlarged uterus (greater than 10 cm or equivalent to 12 weeks gestation).
- Excluding coverage of endometrial ablation when the patient has one of the following situations:
  - An active genital or urinary tract infection at the time of the procedure
  - Active pelvic inflammatory disease
  - An intrauterine device (IUD) currently in place
  - Any anatomic or pathologic condition in which weakness of the myometrium could exist, such as history of previous classical cesarean section or transmural myomectomy
  - Essure contraceptive micro-inserts in place
  - Myometrial thickness less than 10 mm
  - Uterine sounding length less than 6 cm.

In Vitro Chemoresistance and Chemosensitivity Assays, 253. New medical policy describing non-coverage of these tests. Effective 12/1/10.

Insulin Pumps, 332. Adding Type 1 diabetes mellitus diagnoses codes to align with coverage for insulin pumps. Effective 12/1/10.

Magnetic Resonance Imaging to Monitor Integrity of Silicone-Gel-Filled Breast Implants, 139. Removing claims system coverage editing that is applied to MRI of the breast services. Effective 12/1/10.

*Changes, continued on page 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. That's why BCBSMA publishes advance notice of medical policy changes in *Provider Focus* 90 days prior to their effective date.

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 that contains the draft statements*:

- Go to **www.bluecrossma.com/provider** and click on **Medical Policies**.
- Go to the **What's New** heading on the right-hand side of the page.
- Click on **Advance Announcement of Draft New and Revised Medical Policy Statements**.

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.*

# Medical Policy Update

*Changes, continued from page 9*

Medical Technology Assessment Non-Covered Services, 400. Adding coverage for video-assisted thoracoscopic spinal (VATS) release and fusion. Effective 12/1/10.

MRI of the Breast, 230.

- Excluding coverage for the following indications, effective 12/1/10:
  - Personal history of ovarian cancer
  - Family history of ovarian cancer.
- Removing claims system coverage editing that is applied to MRI of the breast services, effective 12/1/10.

Occlusion of Uterine Arteries Using Transcatheter Embolization, 242:

- Adding the following coverage criteria for transcatheter embolization as a treatment for uterine fibroids, effective 12/1/10:
  - Asymptomatic fibroid of such size that they are palpable abdominally and are a concern to the patient
  - Excessive uterine bleeding as evidenced by either profuse bleeding lasting more than 8 days, or anemia due to acute or chronic blood loss
  - Pelvic discomfort caused by myomata, either acute severe pain, chronic lower abdominal pain, or low back pressure or bladder pressure with urinary frequency not due to urinary tract infection.
- Excluding coverage of a second transcatheter embolization for patients who have undergone a failed uterine artery embolization. Effective 12/1/10.

Orthopedic Applications of Stem Cell Therapy, 254. New medical policy describing non-coverage of this procedure. Effective 12/1/10.

Proteomics-based Testing for the Evaluation of Ovarian (Adnexal) Masses, 249. New medical policy describing coverage and non-coverage of proteomics-based testing. Effective 12/1/10.

Quantitative Sensory Testing, 258. New medical policy describing non-coverage of these tests. Effective 12/1/10.

Sleep Disorders, 293. Removing the following coverage guideline for oral appliances for sleep apnea, effective 12/1/10:

- As a trial of reversible therapy in severe sleep apnea patients undergoing evaluation for orthognathic surgery; patients who obtain appropriate results with appliance therapy may not require surgery.

Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, 130. Excluding coverage of tongue base suspension reported with CPT code 41512, and all other minimally invasive procedures not addressed in this policy. Effective 12/1/10.

Systems Pathology for Predicting Risk of Recurrence in Prostate Cancer, 250. New medical policy describing non-coverage of this testing. Effective 12/1/10.

Use of Common Genetic Variants to Predict Risk of Nonfamilial Breast Cancer, 252. New medical policy describing non-coverage of this test for use in predicting non-familial breast cancer. Effective 12/1/10.

## *Clarifications*

Hematopoietic Stem Cell Transplantation in the Treatment of Germ Cell Tumors, 247. New medical policy describing coverage and non-coverage of this treatment for this diagnosis. The same information will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Manipulation Under Anesthesia for Treatment of Chronic Spinal or Pelvic Pain, 099:

- Clarifying non-coverage of CPT code 22505 (Manipulation of spine requiring anesthesia, any region) for the following indications:
  - Spinal manipulation (and manipulation of other joints [e.g., hip joint] performed during the procedure) with the patient under anesthesia
  - Spinal manipulation under joint anesthesia
  - Spinal manipulation after epidural anesthesia and corticosteroid injection for the treatment of chronic spinal (cranial, cervical, thoracic, lumbar) pain and chronic sacroiliac and pelvic pain.

*Clarifications, continued on page 11*

# Medical Policy Update

*Clarifications, continued from page 10*

Medical Technology Assessment Non-Covered Services, 400:

- Clarifying non-coverage for commercial products and coverage for Medicare HMO Blue® and Medicare PPO Blue℠ for C9800 (Dermal injection procedure[s] for facial lipodystrophy syndrome [LDS] and provision of Radiesse or Sculptura dermal filler, including all items and supplies). This new HCPCS Level II code is effective 3/23/10.
- Clarifying non-coverage of CPT code 22505 (Manipulation of spine requiring anesthesia, any region) for:
  - Spinal manipulation (and manipulation of other joints [e.g., hip joint] performed during the procedure) with the patient under anesthesia
  - Spinal manipulation under joint anesthesia
  - Spinal manipulation after epidural anesthesia and corticosteroid injection for the treatment of chronic spinal (cranial, cervical, thoracic, lumbar) pain and chronic sacroiliac and pelvic pain.

Renal (Kidney) Transplantation, 196. Clarifying the removal of creatinine criteria as an indication for kidney transplantation in diabetic patients.

Sleep Disorders, 293. Clarifying the following:

- Coverage of split-night study as an alternative to one full night of diagnostic polysomnography followed by a second night of titration, when identified coverage criteria are met
- Coverage guidelines for oral appliances for sleep apnea in patients with a respiratory distress index (RDI) >50 who are clinically candidates for apnea surgery
- Definition of clinically significant obstructive sleep apnea for adult patients to include RDI and documented symptoms
- Definition of clinically significant obstructive sleep apnea for pediatric patients as follows:
  - AHI or RDI of at least 5 per hour, or
  - AHI or RDI of at least 1.5 per hour in a patient with excessive daytime sleepiness, behavioral problems, or hyperactivity.

Surgical Treatment of Snoring and Obstructive Sleep Apnea, 130. Clarifying the following:

- Definition of clinically significant obstructive sleep apnea for adult patients to include RDI and documented symptoms
- Defintion of clinically significant obstructive sleep apnea for pediatric patients as follows:
  - AHI or RDI of at least 5 per hour, or
  - AHI or RDI of at least 1.5 per hour in a patient with excessive daytime sleepiness, behavioral problems, or hyperactivity
- Coverage of adenotonsillectomy in pediatric patients with clinically significant obstructive sleep apnea (OSA) and hypertrophic tonsils
- Coverage of uvulopalatopharyngoplasty (UPPP), hyoid suspension, surgical modification of the tongue, and/or maxillofacial surgery for appropriately selected adult patients
- Non-coverage of minimally invasive procedures, including:
  - Radiofrequency of volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues
  - Laser-assisted palatoplasty (LAUP)
  - Radiofrequency volumetric reduction of the palatal tissues
  - Palatal stiffening procedures, including but not limited to, cautery-assisted palatal stiffening operation, injection of sclerosing agent, and implantation of palatal implants.❖

## Pharmacy Medical Policy Update: Several Policies Retired, Effective September 1, 2010

As part of a regular review of our pharmacy medical policies, we have decided to retire the following policies, effective immediately. Any authorization requirements for the drugs listed within these pharmacy medical policies will no longer be in place.

Aldosterone Receptor Antagonists, 026. Policy included step therapy requirements for Inspra™ (eplerenone).

Banzel™ (rufinamide), 115.

Lubiprostone (Amitiza®), 093.

Oncology, Oral, 063. Policy included step therapy and prior authorization requirements for Sprycel® (dasatinib), Sutent® (sunitinib), and Tasigna® (nilotinib).❖

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