Blue FOCUS

MASSACHUSETTS

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

A quarterly newsletter for hospitals and institutional ancillary providers FALL 2010

First 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. Please go to **www.bluecrossma.com/visitor** for the most up-to-date information on national health care reform.

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.

Below is 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.

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In This Issue

Andrew Dreyfus Is New CEO of BCBSMA

Andrew Dreyfus recently assumed the role of BCBSMA's new President and Chief Executive Officer. Over the past five years, Dreyfus served as Executive Vice President for Health Care Services, and was previously President of the BCBSMA Foundation. Prior to joining BCBSMA, Dreyfus was an Executive Vice President at the Massachusetts Hospital Association and held senior positions in the Massachusetts Executive Office of Human Services and the Executive Office of Consumer Affairs and Business Regulation.

"I want to thank the Board for giving me the privilege to lead such a highly regarded company during this critical time in health care. Making health care more affordable is, and will continue to be, our company's highest priority," said Dreyfus.

Dreyfus succeeded Bill Van Faasen, who had served as interim President and CEO since March 2010.❖

Office Staff Notes

Find BlueCard® Member Precertification, Medical Policy Info Faster Online

Starting October 1, 2010, a new feature on our BlueLinks for Providers website will make it easier for you to find information to help treat your out-of-area Blue Cross Blue Shield (BCBS) patients. With our new online search tool, you'll be able to find the 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.

Please note that login is not required to access this tool.

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

BlueCard® Program 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.

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

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

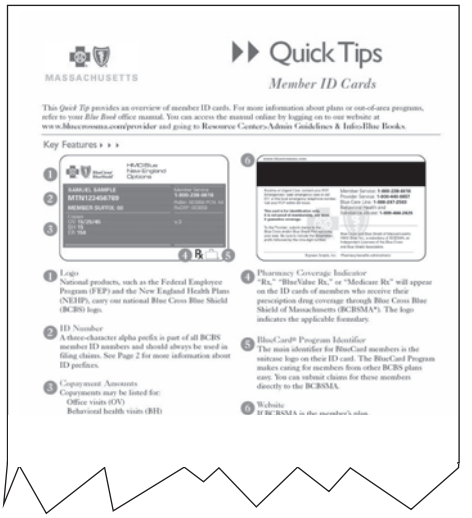
If you provide services to a Walmart member, be sure to ask him/her to present the new ID card, and submit all 2010 claims to BCBSMA using the exact ID number as it appears on the card. This will help avoid delays in processing your claim.❖

Questions About Member ID Cards? Download Our New *Quick Tip* from BlueLinks

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.**❖



Office Staff Notes

Healthcare Recoveries, Inc. Is Assisting BCBSMA with Upcoming 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 accounts, HRI will be supporting BCBSMA's Provider Audit team to ensure services performed were accurately billed and paid.

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.

We are currently notifying affected providers to request documentation or schedule on-site visits.

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

Billing Information for Flu Vaccine On Our Website

In preparation for the upcoming flu season, we have updated the flu information page on our BlueLinks for Providers website. The site provides 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.

For more information, 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

BCBSMA Re-instituting Site of Service Differential for Hospital-based GI Services

In 2002, BCBSMA eliminated the "site of service" fee differential for 41 gastrointestinal (GI) procedure codes performed in the hospital outpatient setting.

After a careful, market-based review of our reimbursement methodology—and keeping in line with industry standards—BCBSMA has decided to re-institute the site of service fee differential for services provided in a hospital outpatient setting.

However, we will not implement the site of service differential if the procedure is performed at a freestanding (non-hospital licensed) ambulatory surgical center.

We mailed an *F.Y.I.* to physicians this summer notifying them of this decision and that we will be phasing in the change over a two-year period. If you have any questions, please call Network Management Services at **1-800-316-BLUE (2583).**❖

Billing for Multiple Surgeries Performed in an Ambulatory Surgical Center (ASC)

ASC procedures are time-based and each facility may have a different way of reporting time increments on claims (i.e., minutes, 15 minutes, half-hour, etc.).

When reporting multiple procedures performed during the same surgical session, report the appropriate CPT codes as separate line items. The total surgical charges/time should be evenly divided among all procedures on the claim.

Do not place the charges for all of the procedures on one line, while reporting a zero or a penny charge on the additional lines. Billing in this manner will cause inaccurate payment/reimbursement for the services provided.

For more information about billing guidelines for ASC services, please refer to Section 3, Billing and Reimbursement, of your *Blue Book* manual online. Log on to **www.bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books.**❖

Bill for All "Covered" Services, Including Observation

As a reminder, your BCBSMA Agreement requires you to bill for all "covered" services you provide to our members. This includes observation services.

When listing observation services on your claim, be sure to use revenue code 762, in addition to the appropriate HCPCS code.

For more information on observation services billing guidelines, please refer to Section 3, Billing and Reimbursement, of your *Blue Book* manual, which is available online. Log on to our website at **www.bluecrossma.com/provider** and click on **Resource Center> Admin Guidelines & Info>Blue Books.**❖

Click & Connect

Access *Blue Focus* on Our Website

Did you know you can access *Blue Focus* online before the mail carrier delivers it to your office? To receive an e-mail from us when the latest issue of *Blue Focus* is available on BlueLinks for Providers, sign up for our eNews alerts.

You can also sign up to receive announcements via e-mail when new *F.Y.I.s* and training opportunities are available.

To sign up:

- Log on to **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 and click on **Save**.

You can also access past issues of *Blue Focus* by going to the News for You section of our website and clicking on **Blue Focus>Past Issues** on the left-hand side of the page.

Questions?

If you have questions about using BlueLinks for Providers, please refer to our *User Guide*, available by clicking on **Help** on the top of our website.❖

Coding Corner

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

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 these 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 if there are any associated conditions or manifestations.

Scenario

A 74-year-old male patient is admitted to an acute care hospital with unstable angina due to CAD. He has a history of a two-vessel coronary artery bypass following a myocardial infarction (MI) in the past. A cardiac catheterization on this admission indicates that there is an occlusion in a native vessel graft.

Question: What ICD-9 diagnosis codes would be assigned for this admission?

Answer: Assign code 414.01 (Coronary atherosclerosis, of native coronary artery, for atherosclerosis of the native vessel) as the principal diagnosis. Assign code 411.1 (Intermediate coronary syndrome) as an additional diagnosis. As an additional diagnosis, code 412 should be also assigned for the previous history of MI. This is consistent with advice given in *AHA Coding Clinic*, Second Quarter 1997 and Second Quarter 2001.❖

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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.

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.❖

Pharmacy Update

New Preferred Home Infusion Therapy (HIT) Provider Added 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 preferred networks is encouraged, though not required. To access 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 Falmouth, MA 02540 Phone: **508-548-4266** Toll-free phone: **1-800-244-1227** Fax: **508-540-9475** **www.infusionreferral.com**	780 Dedham Street, Suite 300 Canton, MA 02021 Phone: **617-989-0888** Toll-free phone: **1-888-660-1660** Fax: **617-989-0188** Toll-free fax: **1-888-660-2660** **www.infusionreferral.com**

Reminder: Benefit Change for Specialty Medications Go into Effect October 1

As we previously communicated, we have implemented a benefit change that no longer provides coverage for certain specialty medications through the member's BCBSMA medical benefit.

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

Pharmacy Medical Policy Update

Changes, Effective January 1, 2011

Bisphosphonates Infusion/Injection, 061. Implementing prior authorization for Prolia™ when administered in outpatient sites of service for managed care members, except PPO.

Botulinum Toxin, 006. Implementing prior authorization for Dysport® inj. when administered in outpatient sites of service for managed care members, except PPO.

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.

Retired Policies

We are retiring the following policies on the effective date shown. Authorization requirements for the drugs listed in these policies will no longer be in place:

Aldosterone Receptor Antagonists, 026. Effective 9/1/10. (This policy included step therapy requirements for Inspra™ [eplerenone].)

Banzel™ (rufinamide), 115. Effective 9/1/10.

Lubiprostone (Amitiza®˝), 093. Effective 9/1/10.

Orphan Drugs for the Treatment of Rare Diseases, 021. Effective 1/1/11. (This policy included prior authorization requirements for outpatient sites of service for Aldurazyme™ [laronidase)] Fabrazyme® [agalsidase beta], Naglazyme™ [galsulfase], Somatuline® Depot [lanreotide], and Somavert® [pegvisoman].)

Oncology, Oral, 063. Effective 1/1/11. (This policy included step therapy and prior authorization requirements for Sprycel®˝ [dasatinib], Sutent®˝ [sunitinib], and Tasigna®˝ [nilotinib].)❖

Medical Policy Update

All updates will be available via:

- **www.bluecrossma.com/provider>Medical Policies**
- Fax-on-Demand: **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.

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 covered and non-covered indications for clopidogrel (Plavix®) using this test. Effective 12/1/10.

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

- Adding to the endometrial coverage statement women who are otherwise candidates for hysterectomy.
- Removing endometrial ablation coverage exclusion of enlarged uterus (greater than 10 cm or equivalent to 12 weeks gestation).
- 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.
- Removing coverage statements and coding information for robotic-assisted myomectomy. (To access our *Robotic Surgical Systems Payment Policy*, log on to **www.bluecrossma.com/provider**; click on **Manage Your Business>Access Payment Policies**.)
- 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.

Endovascular Grafts for Abdominal Aortic Aneurysms, 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.

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

We understand medical policy changes can impact your practice and member treatment. That's why we publish advance notice of medical policy changes in *Blue Focus* 90 days prior to their effective date. To help you better understand any changes, we now provide draft versions of the complete new and revised policy statements on our website 45 days prior to the effective date of a policy*. To access a document with the draft statements:

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

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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.

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.

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 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 (***Note:*** our new medical policy 236, *Gait Analysis* (see this page), will address coverage/non-coverage of these procedures):
  - **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.
- 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 and family history of ovarian cancer.
- Removing claims system coverage editing applied to MRI of the breast services. Effective 12/1/10.

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.

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 it is palpable abdominally and are a concern to the patient
  - Excessive uterine bleeding, evidenced by either profuse bleeding lasting more than 8 days, or anemia due to acute or chronic blood loss

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Medical Policy Update

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- 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.

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 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.

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.

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

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

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 95805 with additional covered indications reported with ICD-9 CM diagnoses codes 327.11 (idiopathic hypersomnia with long sleep time) and 327.12 (idiopathic hypersomnia without long sleep time) for our commercial products and for Medicare HMO Blue/Medicare PPO Blue. Effective 11/1/10.

- 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.

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.

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

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.

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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.

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*.

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*.

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.

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

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.

Minimally Invasive Surgery for Snoring, Obstructive Sleep Apnea/Upper Airway Syndrome, 130. Policy title is changing to *Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome*.) Also adding coverage/ non-coverage of hyoid suspension, traditional surgical approaches to tongue modification, maxillofacial surgery including mandibular or maxillary advancement surgery and uvulopalatopharyngoplasty (UPPP). Current coverage/non-coverage statements for 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*.

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 the removal of creatinine criteria as an indication for kidney transplantation in diabetic patients.

Clarifications, continued on page 11

Medical Policy Update

Clarifications, continued from page 10

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

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 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.

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.

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
- 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
- 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.

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

Clarification: Prior Authorization for Prosthetics

In Summer *Blue Focus*, we stated that starting 9/1/10, 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.❖

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Ancillary News

Helping to Facilitate 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 online, 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.*

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