December 2010

Providerfocus

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Signature Healthcare: Using IT to Improve Performance at Clinical Encounter

Signature Healthcare, an integrated system of physicians and Brockton Hospital, has developed an innovative technology solution over the past year to improve the clinical quality of a patient's visit—and they have positive results to show for it.

With more than 550 physicians, and 16 primary care sites located on the South Shore, Signature Healthcare has been a BCBSMA Alternative Quality Contract (AQC) provider since January 2009. Signature was one of the earliest groups to sign on to the AQC.

Developing a Data Warehouse

To tackle the many challenges and quality measures of the AQC, the organization realized it had data from many sources, but that it did not have the ability to integrate the data. Linking BCBSMA claims with internal practice data was achieved through the construction of a master data warehouse for all Signature patients.

Best Practice Spotlight

Sources included Signature's:

- Electronic Medical Record (EMR) system (lab results, vital signs, medications, and injections and immunizations)
- Practice Management System (billing, member demographics, scheduling)
- Hospital data from their Meditech system
- AQC quality measures registry information and claims data from BCBSMA.

According to Kerin Metcalf, Signature's Programmer Analyst, Managed Care Contracting and Performance, the data are pooled nightly, so Signature always has real-time data available, such as blood pressures for hypertensives or A1C levels for diabetics.

> "It's exciting to see the results and to know that patients might lead a healthier lifestyle because of the data."
>
> Mitchell Selinger, M.D.

The data can be sent internally by secure e-mail to clinical staff in "pods"—different office locations—just prior to a patient's visit to help ensure the visit is targeted to the patient's needs.

"This prompts clinical intervention and facilitates improvement and quality during the face-to-face encounter, which is crucial to ensuring more positive outcomes," says Metcalf.

She also explained that the master patient index allows nurses to make future appointments and alert the physician of upcoming patient visits with detailed information.

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In This Issue

In Brief

Changes Coming to Our Fax-on-Demand System

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.)

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.❖

Physician News

MASSACHUSETTS

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.❖

Pharmacy Update

Walgreens Has Been Added As a Preferred Vendor for Synagis

Walgreens Specialty Pharmacy has joined CVS Caremark (announced in the October-November issue *Provider Focus*) as one of our 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. We recently posted *Frequently Asked Questions* on our provider website to help you better understand the PPI policy.

Log on to **www.bluecrossma.com/provider** and select **Manage Your Business>Search Pharmacy & Info>Drug Management Programs.**❖

Click & Connect

BlueLinks Is a Gateway to Technology Tools

As a participating provider, you have access to a large network of electronic technologies that can help you to spend less time on paperwork and phone inquiries, and more time with your patients. These technologies include:

- PaySpan Health: A free service that delivers direct deposit and online Provider Payment and Provider Detail Advisories to our providers.
- Online Services: Perform administrative tasks for BCBS members without a separate sign-on (e.g., member benefits and eligibility, claim status, referrals and authorizations, name and family searches).
- ExpressPA: Submit prior authorization requests for retail prescriptions.
- NEHEN*Net*: A single gateway to the region's largest payers and their most popular and essential transactions.

To access these tools or to learn more, log on to our website at **www.bluecrossma.com/provider** and click on **Technology Tools.**❖

Signature Healthcare: Using IT to Improve Performance at Clinical Encounter

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For instance, if a patient has high blood pressure, the doctor is better prepared for a meaningful conversation with that patient. And in many cases, the nurse can address these issues with the patient before seeing the doctor.

The data warehouse also provides:

- Future appointment reports
- AQC quality outcomes and process measure status
- AQC referral pattern information
- AQC pharmacy utilization details.

"The data are sent to the Clinical Directors who filter the summary reports to the pods of physicians and clinical staff. It's a team effort and has produced positive results," says Metcalf.

The Results

According to Mitchell Selinger, M.D., Signature's Senior Medical Director, the data warehouse has allowed the PCPs' staff to understand the importance and relevance of the AQC quality goals, and interact as a team to provide real-time support and patient education.

Signature's team, from left: Pati Lima, RPh, PhD, Clinical/Managed Care Pharmacist; Kerin Metcalf, Programmer Analyst, Managed Care Contracting and Performance; Mitchell Selinger, MD, Medical Director, Managed Care Contracting and Performance; Al Holden, Director, Managed Care Contracting and Performance; Pat Cullen, RN, Vice President, Quality and Clinical Performance; Marc Greenwald, MD, Chief of Medicine.

This has tremendously improved Signature's results and the efficiency of their busy PCPs, according to Selinger.

"Our AQC relationship with BCBSMA drove this entire process. Now that we've seen the impact, we're planning to expand this resource to all of our patients," he said. "It's exciting to see the results and to know that patients might lead a healthier lifestyle because of the data."

Looking Ahead to 2011

Metcalf says Signature's goals for 2011 include:

- Adding inpatient data to the warehouse to ensure follow-up care is planned for patients after a hospital discharge
- Adding AQC criteria to the EMR
- Improving the way that reports are shared with the physicians/pods.

"While we've made great progress, this is an iterative process that can always be improved upon," she said.❖

Tell Us Your Story

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

BCBSMA News

Information About BCBSMA's Disaster Readiness Plan

As both a health plan and a community leader, BCBSMA would play an essential role in the event of a disaster. And, we know that working with our providers will be paramount in making sure our members have access to care.

That's why we have a comprehensive Disaster Readiness Program in place to support our network providers, our members, BCBSMA employees, and other important constituents. The program is based on well-established industry best practices and procedures.

Much of the strength of our program is our ability to support our providers and members from home and remote locations during a disruptive event.

Our Disaster Readiness Program Office works to ensure that BCBSMA is prepared to protect our associates and to provide critical services to our providers and members in the event of any disaster.

Our plans include preparations to facilitate access to care for our members during a disaster event. This includes coverage for emergency care, prescription refills, and assistance in locating a provider. Provider service, provider payment, and member access to care will be given top priority, and depending on the event, we may decide to relax referral, authorization, and eligibility policies, and other procedures to facilitate member access to care.

You can read our Disaster Readiness statement by going to **www.bluecrossma.com/visitor** and clicking on **About Us> Disaster Readiness.**❖

Town of Amesbury Joins New Program to Improve Health of Employees

The Town of Amesbury is the first municipality in Massachusetts to participate in Well Power, a three-year program designed to help the town and its employees gain a better understanding of how to navigate the health care system, lead healthier lives, and better manage health care costs.

Well Power was developed in partnership with the Massachusetts Interlocal Insurance Association (MIIA) and BCBSMA. MIIA is a non-profit, member-driven insurance arm of the Massachusetts Municipal Association.

Available at no additional cost to the town or its employees, Well Power rolled out in Amesbury this fall.

MIIA Well Power AMESBURY

Over the course of three years, participants will take part in several free programs, including:

- Personal health assessments
- Educational sessions
- Exercise, nutrition, stress reduction, and weight loss programs
- Onsite, online, and telephonic support.

Well Power uses incentives to encourage participation, including gift cards.

"The Well Power program combines wellness and member education in a way that leads to better health, while helping to manage the rising cost of health care for both the employer and member," said John Coughlin, Vice President of Select Markets for BCBSMA.

"We're committed to providing solutions that empower and educate members about the health care choices they make, so they can receive the right care, at the right time, in the right setting."❖

Office Staff Notes

BCBSMA's Recommendations for Appointment Wait Time Standards

The speed with which members obtain appointments to see their primary care provider (PCP) strongly influences their overall satisfaction with their care.

To benchmark patient satisfaction with appointment wait times across health plans nationwide, BCBSMA looks at Consumer Assessment of Healthcare Providers and Systems (CAHPS) data administered by the Agency for Healthcare Research and Quality (AHRQ). Our own data are then measured against CAHPS standards.

We've worked with participating physicians to develop appropriate access-to-care guidelines for primary care services and we recommend the general guidelines for wait times as shown in the chart below.

You can also find this information in Section 2: Utilization Management of your *Blue Book* manual online. Log on to **www.bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books.**❖

Type of Care:	Definition:	BCBSMA Recommendation:
Emergency care	A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine or as determined by a provider with knowledge of the person's condition, to result in severe pain that cannot be managed without such care, and to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).	Immediately
Urgent care	Those covered services that are medically necessary and immediately required to prevent serious deterioration of a member's health that results from an unforeseen illness, condition, or injury when the member is temporarily absent from the service area (or, under unusual and extraordinary circumstances, provided when the member is in the service area but the applicable plan's provider network is temporarily unavailable or inaccessible) and that cannot be delayed until the member returns to the service area, as determined by the applicable plan.	Within 24 hours
Symptomatic care	Needed for non-urgent symptomatic conditions.	Within 48 hours
Preventive care	Preventive care designed for the prevention and early detection of illness in asymptomatic people, generally including routine physical examinations, tests, and immunizations.	Within 45 days

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 will 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.

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 rendered to diagnose or treat an illness or injury, or when they are billed by the provider as such. Therefore, providers should bill services carefully, as that will determine if a service will be treated as "preventive" by BCBSMA for payment purposes.

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.❖

Questions About Benefits for Preventive Pediatric Care?

Our new *Standard Benefits for Pediatric Care Quick Tip* provides an overview of covered services and standard benefits for HMO, PPO, POS, and Indemnity plans.

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

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 on these changes, go to **www.bluecrossma.com/provider** and click on **Health and Dental Plans**. Scroll down and click on the **Medicare 2011 Changes** link.❖

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**.❖

Check Out HCAS Eligibility Training Materials and Provide Your Feedback

Earlier this year, we reported that HealthCare Administrative Solutions, Inc. (HCAS) now offers providers access to health plan online eligibility verification tools from one centralized location, to help streamline the eligibility verification process.

We encourage you to view the training materials and resources on the HCAS website, then complete a brief survey to provide your opinion of the materials.

- To access the training materials and resources, go to **www.hcasma.org**; click on **Solutions**, select **Eligibility**, then **Tools & Resources**.
- To complete the survey to provide feedback on these materials and resources, go to **www.surveymonkey.com/s/2KQZYCC**

Streamlined Appeals Process Coming

Through it's involvement in the Employers Action Coalition on Healthcare BCBSMA is working with other payers, the Massachusetts Hospital Association, the Massachusetts Medical Society, and others to simplify the appeals process for providers.

The new process will include one form that providers can submit to any Massachusetts payer when requesting a claim review.

We will provide more details about these changes early next year.❖

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.
- Outpatient facility claims for pharmacy services billed by Veteran's Affairs (VA) providers will be processed by Caremark, FEP's pharmacy benefits manager.
- Services performed or billed by residential treatment centers (RTCs) or their staff members will no longer be covered.❖

Coding Corner

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

Coding Cancers: Active Versus History Code?

Below are some questions and answers to assist you with the correct ICD-9-CM code assignment for submitting CMS-1500 claims for cancer services.❖

Question:	Answer:	Source:
How should a primary malignancy that has been previously excised be coded?	Assign a code from category V10, personal history of malignant neoplasm, when a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy.	*ICD-9-CM Official Guidelines for Coding and Reporting*, Section 2: Neoplasms, effective December 1, 2009.
How should lymphoma be coded when the patient is in remission?	Lymphoma patients who are in remission are still considered to have lymphoma and should be assigned the appropriate code from categories 200-202. Code category V10.7, other lymphatic and hematopoietic neoplasms, excludes listed conditions in 200-203 when stated as in remission.	*Coding Clinic*, Second Quarter 1992, page 3.
A patient had malignant breast cancer two years ago and comes in for routine follow-up status post-mastectomy. There is no active disease; however, the patient is currently taking Tamoxifen. Would I use the active cancer code (174.9) or a history of breast cancer code (V10.3)?	If this patient is taking Tamoxifen for the breast cancer, use the appropriate active breast cancer code from code category 174, malignant neoplasm of female breast. This would also apply to any drug used to prevent a recurrence of breast cancer after surgery.	*Advance for Health Information Professionals*, Coding Q&A: July 18, 2006.

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).*

Payment Policy Update

Attention DME Providers: *Respiratory Services Payment Policy* Is Available on BlueLinks

BCBSMA has posted a new *Resipiratory 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

All updated medical policies will be available via:

- www.bluecrossma.com/provider>Medical Policies.
- Fax-on-Demand at 1-888-633-7654 (until 2/28/11)

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

Plastic Surgery, 068. 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.

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.

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.

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 May 2010 issue of *Provider Focus*.

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*.

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
- 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.

Clarifications, continued on page 11

Medical Policy Update

Clarifications, continued from page 10

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*.

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*.

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

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

Pharmacy

Botulinum Toxin, 006. 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.❖

Changes to the Medical Policy Group Meetings in 2011

As we reported previously, the number of topics reviewed during our Medical Policy Group meetings in 2011 will be disbursed more evenly throughout the year to allow more discussion time. Some specialties will be discussed in a different month than in the past.

The next meeting will be held on **January 25, 2011** and will focus on **Neurology and Neurosurgery** at BCBSMA, Landmark Center, 401 Park Drive, Boston. Any BCBSMA-contracted clinician may attend and provide feedback.

If you have any questions, please send an e-mail to **philip.brazao@bcbsma.com**.

To access policies being reviewed, log on to **www.bluecrossma.com/provider**, click on **Manage Your Business>Review Medical Policies**, then scroll down to the "How to Review" section. You can also access the full 2011 meeting schedule on the same page.❖

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.❖

Reminder About Submitting Comments to the e-Blue Review Mailbox

Our e-Blue Review e-mail address, **ebr@bcbsma.com**, is available for participating clinicians to e-mail comments and recommendations on medical policies that are scheduled for review by our Medical Policy Group. This e-mail address should ***not*** be used for benefits, claims, payment and reimbursement, or pricing questions.

For claims and billing issues, please contact Provider Services at **1-800-882-2060**.❖

MASSACHUSETTS
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Providerfocus

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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 *Provider 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.❖

Providerfocus is published monthly for BCBSMA physicians, health care providers, and their office staff. Please submit letters and suggestions for future articles to:

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