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

SUMMER 2012

Are You Using Modifiers 25 and 59 Correctly on Your Claims?

If you currently use modifiers in your billing, it is important that you use standard modifiers to describe the service for which you are billing. It is also essential that you are using modifiers correctly. Modifiers indicate that a service or procedure you've performed has been altered by some specific circumstance, but has not changed in its definition or code.

During routine audits, we often find that providers are billing incorrectly with modifiers 25 and 59.

How to use modifier 25

Modifier 25 indicates a significant, **separately identifiable evaluation and management (E&M) service** by the same physician on the same day of the procedure or other service, that is above and beyond the other service(s) provided.

For same-day preventive and sick E&M, the lower valued E&M service is reimbursed at 50% of the fee schedule/allowable amount.

The submission of modifier 25 appended to a procedure code indicates that documentation is available in the patient's records for review (upon request) that will support the distinct or independent identifiable nature of the service submitted with modifier 25.

How to use modifier 59

Modifier 59 indicates a **distinct procedural service**. That means the procedure or service was distinct or independent from other non-E&M services performed on the same day.

About Medical Record Audits

BCBSMA expects that when you submit claims with modifiers 25 or 59, documentation is available in the patient's records to support the distinct or independent identifiable nature of the service submitted with these modifiers.

Please note: all claims submitted with modifiers 25 and 59 are subject to pre- and post-pay audit by BCBSMA.

Be sure to consult your CPT manual if you have questions about using modifiers.❖

In This Issue

Walgreens Returning to Express Scripts Pharmacy Network

Our pharmacy benefit manager, Express Scripts, Inc. (ESI), recently announced a multi-year agreement with Walgreens to return to the ESI traditional network of pharmacies.

As of September 15, most members with our pharmacy benefits will be able to fill prescriptions or receive a flu shot at a Walgreens pharmacy.

BCBSMA offers an alternative retail network, the Select Network, to some employers. At this time, Walgreens will not be a part of the Select Network or our retail specialty pharmacy networks.❖

Pharmacy Update

Specialty Pharmacy Network Expanded for Fertility Medications

Occasionally, we review our network of retail specialty pharmacies. We do this to ensure that the level of service and clinical programs and protocols meet the needs of our members. After a recent review, we decided to add Metro Drugs to our network as of July 1, 2012, in addition to the fertility specialty pharmacies currently in our network.

To find a complete list of specialty medications and the pharmacies that dispense them, log on to **bluecrossma.com/provider** and click **Manage Your Business>Search Pharmacy & Info>Specialty Pharmacy Medication List.** You may send fertility medication prescriptions for our members to any of the pharmacies shown below.❖

Retail specialty pharmacies for fertility medications:	
Ascend SpecialtyRx Phone: **1-800-850-9122** Fax: **1-800-218-3221** **www.ascendspecialtyrx.com**	Metro Drugs Phone: **1-888-258-0106** Fax: **1-201-253-1101** **www.metrodrugs.com**
Freedom Fertility Pharmacy Phone: **1-866-297-9452** Fax: **1-888-660-4283** **www.freedomfertility.com**	Village Fertility Pharmacy Phone: **1-877-334-1610** Fax: **1-877-334-1602** **www.villagefertilitypharmacy.com**

Clarifications on Opioid Management Policy That Took Effect July 1, 2012

Based on questions we have received from prescribers, we would like to provide clarifications about our opioid management program that went into effect on July 1, 2012:

- Prior authorization is not required for any patient who filled a prescription for an opioid between April 1, 2012 and June 30, 2012. This includes members who have been routinely receiving opioid prescriptions prior to July 1.
- Prior authorization to confirm the presence of evidence-based opioid prescribing is only required for patients newly starting opioids on or after July 1, 2012, as follows:
  - Members receiving long-acting opioid prescriptions for the first time after July 1 will require a prior authorization.
  - Members who need more than two 15-day supplies of a short-acting opioid within a 60 day period will need prior authorization.
- Opioid prior authorization will apply to all classes of opioids used to treat pain for the duration of the authorization. In other words, if a patient has an approved authorization, allshort-acting and long-acting opioids in our formulary will be covered.
- Prior authorization is not required for Lomotil®/ diphenoxylate or opioid-containing cough medicines.
- We are making special accommodations for members who have cancer and those who are at the end-of-life to make sure that their care is not affected by these changes. Prescriptions for opioids written by oncologists do not require prior authorization. Because we cannot identify patients at the end-of-life or patients with cancer being treated by physicians other than oncologists, you will need to indicate this on a prior authorization request.
- As of July 1, new-start prescriptions for Suboxone® and buprenorphine will require prior authorization.
- As of October 15, 2012, we will require prior authorization for members who began receiving Suboxone and buprenorphine prior to July 1. Providers with affected members will receive notification later this summer with member lists to aid in obtaining authorization for their patients.❖

Ancillary News

Home Health Care & Skilled Nursing Facilities: Reminder to Use Revised Notice of Medicare Non-Coverage

Earlier this year, the Centers for Medicare & Medicaid Services (CMS) updated the *Notice of Medicare Non-Coverage* (NOMNC) that you must distribute to Medicare Advantage and Original Medicare members upon discharge from home health care services or your skilled nursing facility. Please use the revised form now.

Next Steps for Using the Revised NOMNC

CMS asks you to deliver the notice to the member no later than 48 hours prior to the end of coverage. This helps to ensure that members are offered their right to a review by the local Quality Improvement Organization (QIO). If the member requests an appeal through the QIO, we will send the member a detailed *Explanation of Non-Coverage* (DENC), including the reason that services are being terminated.

Then, fax BCBSMA a copy of each member's (patient's) NOMNC once it has been received, signed, and dated by the member.

We ask you to take this step because CMS requires BCBSMA to demonstrate that providers are compliant with the NOMNC regulation. Please send the completed NOMNC to the attention of BCBSMA's Medicare Advantage Program at **617-246-4189**.

Thank you for your cooperation with this process.❖

Office Staff Notes

Submitting Claims for Members With New "XXS" ID Prefix

As we've reported in *Blue Focus*, BCBSMA is upgrading our claims system throughout 2012 and 2013.

In relation to this transition, approximately 40,000 members have received updated ID cards with a new alpha-prefix—XXS.

To ensure timely and accurate claims processing, please remember to check member eligibility prior to rendering services and submit the most up-to-date member ID, including the correct alpha prefix. Claims submitted with an outdated alpha-prefix will be denied.

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

The 2012 *Blue Book* Is Now Available Online

The 2012 *Blue Book* for facilities is available on our website. Our online version makes it easy for you to quickly access and print the sections you need. Log on to **bluecrossma.com/provider** and click **Resource Center> Admin Guidelines &Info> Blue Books.**❖

We've Consolidated Telephone Numbers for Providers

To help streamline your interactions with us, we have consolidated the phone numbers for our Network Management Services and Provider Enrollment and Credentialing areas to one number.

Please call Network Management and Credentialing Services at **1-800-316-BLUE (2583)** if you need help:

- Getting the status of a previously submitted provider contract
- Credentialing
- Changing a current contract
- Resolving other non-claims related issues.

The old number for Provider Enrollment and Credentialing, **1-800-419-4419**, is no longer in use.❖

Office Staff Notes

Provider Directory Now Includes Cost-sharing Levels

Members and providers can now use our online Find-A-Doctor directory to determine their cost-sharing level when their plan includes the Hospital Choice Cost Sharing benefit feature.

Hospital Choice Cost Sharing is a benefit feature available to members of our Blue Care® Elect, HMO Blue®, HMO Blue® New England, and Preferred Blue® PPO health plans.

The tool lets members filter results to show their level of cost-share for services they receive from hospitals, labs, imaging providers, high-tech radiology providers, and independent physical therapists, occupational therapists, and speech-language pathologists.

This will help our members better plan their out-of-pocket expenses, especially since they pay more for these types of services at certain hospitals.

Members can use this information in consultation with their PCP or specialist to select the provider who best meets their needs.❖

Guide to Working with Blue Benefit Administrators of Massachusetts

Blue Benefit Administrators (BBA) of Massachusetts is an administrative service-only plan offered to Blue Cross accounts who wish to self-insure. Because the claim submission process and ID cards are unique for members with BBA benefit designs, we'd like to offer some tips to help you when rendering services to these members.❖

To:	Then:
Download our new *Quick Tip* to help you identify BBA members and process claims	■ Log on to **bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Quick Tips** *OR* ■ Go to **bluebenefitma.com** (registration required)
Check benefits and eligibility for BBA members	Call **1-877-707-2583**
Obtain precertification or authorization for services	Call BBA at **1-877-707-2583** or fax your request to **1-877-596-2583**
Submit electronic BBA claims	Be sure to use electronic payer ID 03036
Submit paper BBA claims	Mail to: Blue Benefit Administrators of MA P.O. Box 55917 Boston, MA 02205-5917
Access the BBA-specific *Blue Book* manual	■ Log on to bluecrossma.com/provider and click on **Resource Center>Admin Guidelines>Blue Book.** Under the Professional *Blue Book* heading, select Appendix. *OR* ■ Go to **bluebenefitma.com** (registration required)

Medical Policy Update

All updated medical policies will be available online. Go to www.bluecrossma.com/provider>Medical Policies.

Changes

Ambulatory Event Monitors; Mobile Cardiac Outpatient Telemetry; Transtelephonic Transmission of Post-symptom Electrocardiograms and Cardiac Event Monitors, 347. Adding coverage for use of autotrigger devices in treated patients with atrial fibrillation to evaluate for asymptomatic episodes. Effective 11/1/12.

Auricular Electrostimulation, 362. New medical policy describing non-coverage. Effective 9/1/12.

BRAF Gene Mutation Testing to Select Melanoma Patients for BRAF Inhibitor Targeted Therapy, 398. New policy describing coverage in tumor tissue from patients with stage IIIC or IV melanoma to select patients for treatment with vemurafenib, and investigational for all other indications. Effective 11/1/12.

Contrast Enhanced Computed Tomographic Angiography (CTA) for Coronary Artery Evaluation, 355. Medically necessary indication added for acute chest pain in the emergency setting. Effective 11/1/12.

Cytoreductive Surgery and Perioperative Intraperitoneal Chemotherapy for the Treatment of Pseudomyxoma Peritonei, Peritoneal Carcinomatosis of Gastrointestinal Origin, and Peritoneal Mesothelioma, 048. Effective 9/1/12:

- Adding coverage for cytoreductive surgery and perioperative intraperitoneal chemotherapy for the treatment of peritoneal mesothelioma.
- Policy title was changed to include peritoneal mesothelioma.
- Use of the term "hyperthermic" was changed to "perioperative" in the title and policy statements to include early postoperative intraperitoneal chemotherapy.
- Use of the term "cytoreduction" was changed to "cytoreductive surgery" to be more specific.

Electrical Bone Growth Stimulation; Ultrasound Accelerated Fracture Healing Device, 157. Adding coverage for low-intensity ultrasound treatment for delayed union of bones. Effective 9/1/12.

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus, 218. Adding coverage for treatment of Barrett's esophagus with low-grade dysplasia. Effective 9/1/12.

Endovascular Stent Grafts for Thoracic Aortic Aneurysms or Dissections, 233. Adding coverage for complicated Type B dissections. Effective 9/1/12. Also clarifying non-coverage of thoracic aortic arch aneurysms.

Facet Joint Denervation, 140. Added laser denervation, cryodenervation, and therapeutic blocks as investigational. Effective 11/1/12. Clarifying statement on radiofrequency denervation. *Radiofrequency* was removed from the title.

Gas Permeable Scleral Contact Lens, 371. New medical policy describing coverage when all other treatments have failed. Effective 9/1/12.

Infertility Diagnosis & Treatment, 086. Removing coverage for sperm penetration assay. Effective 9/1/12.

Intraepidermal Nerve Fiber Density Testing, 393. New policy describing coverage and non-coverage information. Effective 11/1/12.

Intravitreal Angiogenesis Inhibitors for Retinal Vascular Conditions, 401. New policy describing coverage and non-coverage information. Effective 11/1/12.

Liver Transplantation, 198. Adding neuroendocrine tumor metastases to the investigational statement. The policy statement on hepatocellular carcinoma that has extended beyond the liver and ongoing alcohol and/or drug abuse was moved from "investigational" to "not medically necessary." Also removed "Patients with an active infection" from the investigational policy statement. Effective 9/1/12.

NOTCH3 Genotyping for Diagnosis of CADASIL, 357. New medical policy describing non-coverage. Effective 9/1/12.

Changes, continued on page 6

Medical Policy Update

Changes (continued)

Posterior Tibial Nerve Stimulation for Voiding Dysfunction, 583. Adding coverage for PTNS for the treatment of overactive bladder symptoms for Medicare Advantage products. The effective date of this coverage is retroactive to 5/22/11.

Quantitative Assay for Measurement of HER2 Total Protein Expression and HER2 Dimers, 397. New policy describing non-coverage. Effective 11/1/12.

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors, 259. Policy statements added to indicate medically necessary options for primary and metastatic pulmonary tumors. Effective 11/1/12.

Screening for Lung Cancer Using CT Scanning, 355. Changed low-dose CT scans for lung cancer screening to medically necessary annually for three consecutive years for selected individuals, and investigational in all other situations. Policy statement on chest radiographs removed and title changed accordingly. Statement added to "Policy Guidelines" that evidence does not support the use of chest radiographs as a screening technique. Statement also added to "Policy Guidelines" that the policy does not apply to symptomatic individuals. Effective 11/1/12.

Transcatheter Aortic-Valve Implantation for Aortic Stenosis, 392. New policy describing coverage for patients who are not surgical candidates, and investigational for all other indications. 11/1/12.

Transcatheter Closure of Patent Ductus Arteriosus, 336. New policy describing coverage and non-coverage information. Effective 11/1/12.

Transcutaneous Electrical Nerve Stimulation (TENS), 003. Changing coverage for TENS for chronic low back pain for Medicare Advantage members in accordance with CMS final decision memo of June 8, 2012. Coverage will only be provided to Medicare Advantage members enrolled in a randomized, controlled clinical trial using validated and reliable instruments. Effective 11/1/12.

Viscocanalostomy and Canaloplasty, 372. New policy describing non-coverage of viscocanalostomy. Effective 9/1/12. Ongoing coverage and non-coverage indications of canaloplasty were transferred from medical policy 223, *Aqueous Shunts for Glaucoma*.

Clarifications

Aqueous Shunts for Glaucoma, 223. Transferring ongoing coverage and non-coverage indications of canaloplasty to medical policy 372, *Viscocanalostomy and Canaloplasty*.

Biofeedback for Miscellaneous Indications, 187. Clarifying non-coverage of biofeedback for the treatment autism and motor function after stroke, injury, or lower-limb surgery.

Botulinum Toxin: Injection for Muscle and Nerve Conditions, 006. Clarifying investigational indications: prevention of pain associated with breast reconstruction after mastectomy, Hirschsprung's disease and gastroparesis.

Extracorporeal Photopheresis after Solid-Organ Transplant and for Graft-versus-Host Disease, Autoimmune Disease, and Cutaneous T-Cell Lymphoma, 248. Clarifying coverage of extracorporeal photopheresis for Medicare HMO Blue℠ and Medicare PPO Blue℠ members for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation.

Genetic Testing for Familial Cutaneous Malignant Melanoma, 300. Clarifying the policy title with the word "Familial" and replacing "hereditary" with "familial" in the policy statement.

Intra-arterial Chemotherapy; Chemoembolization of Liver Cancer; Cryosurgical Ablation of Liver Tumors, 369. Clarifying the transcatheter hepatic arterial chemoembolization policy statements with the phrase: including the use of drug-eluting beads.

Intravenous Anesthetics for the Treatment of Chronic Pain, 291. Removing "Neuropathic" from the title and clarifying non-coverage of fibromyalgia.

Clarifications, continued on page 7

Medical Policy Update

Clarifications (continued)

Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions, 343. Clarifying coverage of EYLEA (aflibercept) intravitreal injection.

Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders, 120. Clarifying the list of covered diagnoses for HCPCS codes: E0483, A7025, and A7026 for commercial products.

Plasma Exchange, 071. Clarifying non-coverage of systemic lupus erythematosus (SLE) nephritis and thyrotoxicosis.

Plastic Surgery: Chemical Peels, 068. Adding medically necessary (covered) indications and to clarify not medically necessary (non-covered) indications of chemical peels. Effective 8/1/12.

Positron Emission Tomography (PET) Scans, 358. Clarifying specific aspects of body habitus that would increase the likelihood of a suboptimal SPECT imaging study for cardiac applications.

Quantitative Sensory Testing, 258. Clarifying additional non-covered indications: vibration threshold testing and thermal threshold testing.

Total Artificial Hearts and Implantable Ventricular Assist Devices, 280. Clarifying non-coverage of percutaneous ventricular assist devices (pVADs).❖

Correction to Update Announced in Spring 2012 *Blue Focus*

In the spring 2012 issue of *Blue Focus*, we announced the following medical policy update:

- Balloon Sinuplasty for Treatment of Chronic Sinusitis, 582. Corrected to include CPT codes specific to this procedure. Providers are reminded that balloon sinuplasty is investigational (non-covered) as a stand-alone procedure and is not reimbursed separately when used as a tool during sinuplasty surgery. Effective 4/1/12.

Please note the correct effective date for this change is 5/1/12.❖

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

At Your Service

- **Hospital providers:**
  - For claims-related questions, call Provider Services at 1-800-451-8123 (hours: M - W, F: 8:30 a.m. to 4:30 p.m., Th: 9:30 a.m. to 4:30 p.m.)
  - For all other questions, call your Network Manager at 1-800-316-BLUE (2583).
- **Ancillary providers:**
  - For claims-related benefit and eligibility questions, call Ancillary Provider Services at 1-800-451-8124 (hours: M - W, F: 8:30 a.m. to 4:30 p.m., Th: 9:30 a.m. to 4:30 p.m.)
  - For all other questions, call Network Management Services at 1-800-316-BLUE (2583), Option 2.
- **Fraud Hotline:** 1-800-992-4100
  Please call our confidential hotline if you suspect fraudulent billing or health care activities.
- **All providers:**
  - To access BCBSMA's medical policies and administrative tools, go to www.bluecrossma.com/provider and click on Medical Policies. Or, call Fax-on-Demand at 1-888-633-7654. Request document 411 for a list of all available documents.❖

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