September 2011

Providerfocus

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

First Independent Review of AQC Finds Cost Savings and Quality Improvement

A recent study by a team of researchers at the Harvard Medical School has found that the global payment model being implemented by Blue Cross Blue Shield of Massachusetts (BCBSMA) is meeting its twin goals of slowing the growth in health care costs and improving the quality of patient care.

The comprehensive study, published July 13 in the *New England Journal of Medicine*, is the first independent review of BCBSMA's Alternative Quality Contract (AQC), first introduced in 2009. It is part of a multi-year evaluation of the AQC being led by renowned health care economist Dr. Michael Chernew, a professor at Harvard Medical School. The study is supported by a grant from The Commonwealth Fund.

Dr. Chernew and his colleagues evaluated year-one results of the AQC by studying 2006-2009 claims data for all BCBSMA HMO/POS members to compare quality and spending for members with primary care physicians in the AQC with those receiving care outside of the AQC. The researchers' findings affirm that, in year one, AQC groups achieved both reduced medical spending and significant quality improvements.

AQC Spotlight

In year one, AQC groups achieved both reduced medical spending and significant quality improvements.

Specifically, the study highlighted the following results:

- Overall, AQC groups reduced medical spending growth by about 2% in year one of the contract, and groups that did not previously have global budget contracts with BCBSMA achieved even larger reductions on medical spending (6%).
- Quality improvements achieved by AQC groups between 2008 and 2009 were significantly larger than those achieved by groups outside of the AQC—with particularly noteworthy improvements achieved for chronic care and pediatric care.
- Year-one medical savings were achieved largely through AQC changes in referral patterns, most notably for services such as lab, imaging, and routine outpatient procedures.

"We did not expect to achieve these significant reductions in medical spending in year one," says Dana Safran, BCBSMA's Senior Vice President of Performance Measurement and Improvement. "And to have those savings coupled with significant improvements in quality is even better news."

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In This Issue

In Brief

Reimbursement Change for Venipuncture

BCBSMA has recently reviewed our reimbursement policy for venipuncture to ensure that our payment aligns with industry standards. As a result, effective January 1, 2012, BCBSMA will make routine venipuncture (CPT® code 36415) incidental to—or inclusive of—an office visit and/or a laboratory blood test. The policy will apply to all provider types and to all places of service.

We believe that this change makes the reimbursement for venipuncture services consistent for all of our members and is competitive within our local market.

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

Physician News

MASSACHUSETTS

New Member Education Fact Sheet Encourages Discussions with Providers about Care Options

We continue to look at ways to educate our members about our Hospital Choice Cost-Sharing plan feature. To assist with this, we recently developed an educational fact sheet that can help members discuss treatment and referral options with their doctor.

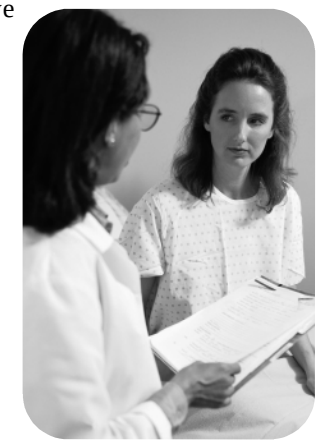
The *Talking with Your Doctor About Hospital Choice Cost Sharing* brochure and other member education materials are available in the Hospital Choice Cost-Sharing section of our Plan Education Center. Members who have the Hospital Choice Cost-Sharing plan feature pay different out-of-pocket costs for specific services, based on where they choose to seek care.

To view this document and other educational materials that we're sharing with our members, go to www.bluecrossma.com/hospitalchoice and click on Planning Guide, then click on Talk to Your Doctor.❖

Getting High-Tech—a New iPhone App

Our new GoalGetter℠ App for the iPhone and iPod Touch can help patients reach their health and fitness goals. With GoalGetter, members can track their progress, record all of their walking and running routes, and use the full-function pedometer and GPS mapping function. The simple navigation feature quickly links to their routes and settings. Patients can access GoalGetter at bluecrossma.com/goal-getter.❖

Mammography Screening Outreach Planned This Fall



Breast cancer death rates have been declining since 1990, and these decreases are believed to be the result of earlier detection through screening, increased awareness, and improved treatment. One of the most influential factors in whether a patient is screened for breast cancer is a recommendation from a physician.

To support you in educating your female patients—and in recognition of Breast Cancer Awareness Month in October—BCBSMA is reminding eligible female members, ages 42-69, to speak with their doctors about when they should receive a mammogram.

Through September, eligible HMO, POS, and PPO members who have not yet been screened (based on our data) will receive a reminder from BCBSMA via e-mail, postcard, or pre-recorded telephone message encouraging them to talk to their provider about getting screened.

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

Pharmacy Update

Additional Choices for Members Who Require Synagis

This season, BCBSMA is offering additional choices to our members who require RSV immuno-prophylaxis and who meet requirements outlined in pharmacy medical policy 422: *RSV Immunoprophylaxis.* For members who have BCBSMA pharmacy benefits, we have contracted with most of our retail specialty pharmacies to offer the medication. If the member does not have pharmacy benefit coverage through BCBSMA and meets pharmacy medical policy requirements, coverage is available through the member's medical benefits.

Please contact one of the BCBSMA specialty pharmacies listed in the chart to obtain Synagis for your BCBSMA members who require respiratory syncytial virus (RSV) immunoprophylaxis.

Pharmacy Medical Policy Requirements Apply

This medication is subject to prior review under BCBSMA pharmacy medical policy 422 *RSV Immune Globulin.* To access this policy, go to our website at www.bluecrossma.com/provider and click on Medical Policies in the blue box.❖

Retail Specialty Pharmacy:	Phone Number:
Accredo Health Group, Inc.	1-877-988-0058
CuraScript Pharmacy, Inc.	1-800-237-2767
CVS Caremark	1-888-823-9070

Medicare News

Osteoporosis Testing Van Provides Mobile Bone Densitometry Tests

Focus on Bone Health—a Five-Star Initiative

We want to let you know about Imaging Resource Centers (IRC), a BCBSMA provider of a mobile testing service that can travel to your practice location to provide bone mineral density (BMD) testing.

Providers and members have told us that transportation to facilities to receive the test is the number one barrier to actually receiving it, keeping our members—your patients—from having this test. Therefore, we are working with IRC to improve access to this important test for our Medicare Advantage members.

The IRC van travels throughout Massachusetts, setting up screening clinics in the parking lot of a physician's office, at skilled nursing facilities, and other locations. They perform state-of-the art dual energy X-ray absorptiometry (DEXA) testing, a widely used technique to measure BMD. The test takes 15 minutes and is available to members of our Medicare Advantage, as well as our HMO, PPO, and Indemnity plans. IRC shares the results with the patient's ordering provider. All that's needed is the physician's customary order for the test to be conducted.

Rx for Bone Health

In addition, we are offering a "Prescription for Healthy Bones" prescription pad with useful tips for your patients to maintain healthy bones. The "prescription"

is something that you can give to your members to remind them about their BMD, encourage physical activity, and offer useful links to other bone health websites.

Ask your BCBSMA Network Manager about receiving a prescription pad or about IRC's clinics by calling 1-800-316-BLUE (2583).

Osteoporosis Management Coverage

You can find coverage criteria for screenings in BCBSMA medical policy 034, *Bone Densitometry*. Go to www.bluecrossma.com/provider; from the home page, click on Medical Policies in the blue box.❖

** BCBSMA's CMS Star Rating is 4.5 out of 5, which falls between "Above Average and "Excellent."*

First Independent Review of AQC Finds Cost Savings and Quality Improvement

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Harvard Study Offsets Attorney General's Report

The study offers important scientific documentation of early accomplishments and successes of the AQC. These were unfortunately overlooked by the Massachusetts Attorney General's Office report Examination of *Health Care Cost Trends and Cost Drivers* (June 2011). Notably, the Attorney General's report considered only total payments to providers, without consideration of or distinction among the nature and types of payments. While a total view of payments is important, distinctions among the types of payments—for example, medical expenditures versus payments for quality versus infrastructure investments—are essential in evaluating whether new payment models and incentives are helping to change health care in ways that will truly improve quality and affordability.

The Harvard Medical School's research has helped to illuminate these important accomplishments and early successes achieved by organizations participating in the AQC. The study has already been important both locally and nationally to policy makers and clinical leaders who are continuing to consider how best to reform payment to achieve better care and patient outcomes with significantly lower rates of annual spending growth.

To learn more about the AQC, go to www.bluecrossma.com/aqc.❖

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.

Getting Specific When Coding Chronic Kidney Disease

When coding for your patients with chronic kidney disease, keep in mind that the ICD-9-CM classifies Chronic Kidney Disease (CKD) Category 585, based on severity. The chart below outlines the stages of severity that should be used.

It's important for the provider to document the stage so the coder can code it correctly. The provider determines the stage after evaluating the patient's kidney function, often through a blood test called glomerular filtration rate (GFR) which is based on the amount of creatinine in the blood.

Stage:	ICD-9-CM classification:
1	585.1 Chronic kidney disease, Stage I
2	585.2 Chronic kidney disease, Stage II (mild)
3	585.3 Chronic kidney disease, Stage III (moderate)
4	585.4 Chronic kidney disease, Stage IV (severe)
5	▸ 585.5 Chronic kidney disease, Stage V ▸ 585.6 ESRD

Coders should be aware that ICD-9-CM dictates cause and effect rules in the setting of some comorbid conditions. For example, when documentation states both chronic kidney disease and hypertension, a cause and effect relationship is assumed. A combination code from category 403 should be assigned instead of separate kidney disease and hypertension codes.

ICD-9-CM also provides rules for coding diabetes with kidney disease when the provider has clearly documented the cause and effect between the diabetes and kidney disease. For example, when a provider documents chronic kidney disease, stage IV due to diabetes or secondary to diabetes, a combination code is assigned with code 250.40, Diabetes with renal manifestations sequenced first, followed by the code 585.4 for CKD.

Putting It All Together

The provider documents in the visit note that patient has chronic kidney disease, stage IV due to diabetes and also the diagnosis of hypertension.

The appropriate diagnosis code(s) are: 250.40, 585.4, 403.90. ICD-9-CM coding guidelines dictate the diabetes code be sequenced first and the manifestation code sequenced in a secondary position. Because the patient has CKD and also hypertension, the combination code 403.90 should be assigned due to the cause-and-effect relationship implied in ICD-9-CM between chronic kidney disease and hypertension.

There is a lot to remember when documenting and coding for patients with CKD. However, documenting CKD with the greatest degree of specificity allows for a more accurate and comprehensive picture of the patient's overall health and potential need for treatment, education, and disease management.❖

If you have any comments about Coding Corner or an idea for a future topic, please send an e-mail to focus@bcbsma.com.

Office Staff Notes

What You Need to Know About the 2011-2012 Flu Season

We're committed to helping limit the spread of the flu virus and facilitate member access to flu vaccine from many participating providers,with whom we contract, including public access/retail clinics.

Our HMO, POS, Access Blue, PPO, and Medicare Advantage plans provide members with coverage for vaccination under their medical benefits without a cost share. Many Indemnity members also have coverage.

However, if the member receives a flu vaccine along with other covered services, he/she will be subject to any applicable cost sharing for the other services in accordance with his/her benefits.

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

Billing and Reimbursement Information On Our Website

The flu information page on our BlueLinks for Providers website provides details on how to bill for flu vaccine not supplied by the Massachusetts Department of Public Health, and how to bill for vaccine administration.

Log on to our website at www.bluecrossma.com/provider and click on the Flu link on the home page.❖

Use New Form to Submit Appeals to BCBSMA and Other Massachusetts Payers

As a reminder, you can now use a single form to submit appeals to a number of participating health plans. The *Request for Claim Review Form* may be used to submit appeals to these participating health plans:

- BCBSMA
- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- Neighborhood Health Plan
- Network Health
- Tufts Health Plan.

Important: this new form will replace our *Provider Appeal Form* effective October 1, 2011.

To access the form and guide, log on to www.bluecrossma.com/provider and click on Forms> Review and Appeals. Or, go to www.hcasma.org.❖

TIP: When you click on the link for the *Request for Claim Review* form, the document includes the one-page form, followed by a 14-page *Reference Guide*. If you do not wish to print the entire document each time you access the form, be sure to print the first page only.

Is Your Organization Preparing for HIPAA Version 5010?

In preparation for the implementation of HIPAA version 5010, please be sure you're in touch with your vendor, or check with your IT staff on their 5010 preparation status. All entities conducting electronic claim submissions, claim status requests and responses, referral/authorization requests and responses, eligibility/benefit requests and responses, and claim remittances will be required to use Version 5010.

BCBSMA is targeting to begin external testing this fall. All testing must be completed by December 31, 2011 as the new Version 5010 will be implemented January 1, 2012.

Questions?

To help assist you, please refer to our *Frequently Asked Questions* document, available on our website. Go to www.bluecrossma.com/provider, click on Manage Your Business, then scroll down to the HIPAA Version 5010 section and click on the link.❖

Medical Policy Update

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

Changes

Accelerated Breast Irradiation after Breast-Conserving Surgery for Early Stage Breast Cancer and Breast Brachytherapy as Boost with Whole-Breast Irradiation, 326. New medical policy describing covered criteria for accelerated whole breast irradiation and non-covered criteria for partial breast irradiation. Effective 12/1/11.

Acute and Maintenance Tocolysis, 518. The policy statement on acute tocolysis has been revised to include the 2/17/11 FDA safety announcement on terbutaline. Effective 12/1/11.

Bisphosphonates and Monoclonal Antibodies, Infusion/Injection: 061. Implementing prior authorization for Prolia®˝ injection and Xgeva™ injection when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/12.

Biventricular Pacemakers for the Treatment of Heart Failure (formerly Biventricular Pacemakers for the Treatment of Congestive Heart Failure), 101. Revised to specify the covered and non-covered criteria for biventricular pacemakers with or without an accompanying implantable cardiac defibrillator. Effective 12/1/11.

BotulinumToxin, 006. Implementing prior authorization for Xeomin®˝ injection when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/12.

Digital Breast Tomosynthesis, 327. New medical policy describing non-coverage of tomosynthesis for the screening or diagnosis of breast cancer. Effective 12/1/11.

Esophageal pH Monitoring, 069. Revised to include the non-covered criteria for 24-hour catheter-based impedance-pH monitoring. Effective 12/1/11.

Fecal Calprotectin Testing, 329. New medical policy describing ongoing non-coverage of fecal calprotectin testing. Effective 12/1/11.

Gene-Based Tests for Screening, Detection and/or Management of Prostate Cancer, 333. New policy clarifying the ongoing non-covered criteria for gene-based tests for screening, detection, and/or management of prostate cancer. Effective 12/1/11.

Hematopoietic Stem-Cell Transplantation in the Treatment of Germ-Cell Tumors, 247. Revised the non-covered criteria for autologous hematopoietic stem-cell transplantation. Effective 12/1/11.

Implanted Devices for Deafness, 087. Revised to include the non-covered criteria for fully implantable middle ear hearing aids. Effective 12/1/11.

Immune Modulating Drugs, 004. Implementing prior authorization for Actemra®˝ when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/12.

Intravitreal Implant, 272. Revised to provide additional clinical criteria for covered and non-covered indications for the use of intravitreal corticosteroid implants. Policy title changed to *Intravitreal Corticosteroid Implants* to reflect scope of policy. Effective 12/1/11.

Left-Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation, 334. New medical policy including non-coverage of left-atrial appendage closure devices for stroke prevention in atrial fibrillation. Effective 12/1/11.

Meniscal Allografts and Collagen Meniscus Implants, 110. Revised to include the covered criteria for meniscal allografts in patients under 55 years of age. Coverage criteria for combined procedures are also included in the revised policy. Effective 12/1/11.

Minimally Invasive Lumbar Interbody Fusion, 335. New policy including covered criteria for minimally invasive ALIF, PLIF, TLIF, non-covered criteria for laparoscopic ALIF, AxiaLIF, and continued non-coverage of lateral interbody fusion (e.g., XLIF, DLIF). Effective 12/1/11.

Medical Policy Update

Changes, continued

Monitored Anesthesia Care (MAC) during Gastrointestinal Endoscopy, 154. Revised to provide additional clinical criteria for medical necessity and for non-covered criteria when monitored anesthesia care is used for gastrointestinal endoscopy, bronchoscopy, and interventional pain procedures. Policy title changed to *Monitored Anesthesia Care (MAC)* to reflect scope of policy. Effective 12/1/11.

Percutaneous Axial Anterior Lumbar Fusion, 617. Revised to include the covered criteria and additional non-covered criteria for minimally invasive lumbar interbody fusion. Policy title changed to *Minimally Invasive Lumbar Interbody Fusion* to reflect scope of policy. Effective 12/1/11.

Percutaneous Vertebroplasty and Sacroplasty, 105. Revised to include the non-covered criteria for percutaneous sacroplasty. Policy title changed to *Percutaneous Vertebroplasty and Sacroplasty* to reflect scope of policy. Effective 12/1/11.

Radioembolization for Primary and Metastatic Tumors of the Liver, 292. Revised to specify the clinical criteria for medical necessity in treating hepatic metastases from colorectal carcinoma. Effective 12/1/11.

Repository Corticotropin Injection (H.P. Acthar Gel), 294. New medical policy describing prior authorization for H.P. Acthar® Gel when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/12.

Sleep Disorders Diagnosis and Treatment, 293. Revised to specify the covered criteria for supervised polysomnography, to include covered criteria for repeated supervised polysomnography and intra-oral appliances, and to include non-covered criteria for multiple sleep latency testing. Policy title changed to *Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome* to reflect scope of policy. Effective 12/1/11.

Sensory Evoked Potentials, 211. Revised to include the covered criteria for motor-evoked potentials using transcranial electrical stimulation and non-covered criteria for motor-evoked potential using transcranial magnetic stimulation. Effective 12/1/11.

Wound Healing, 435. Revised to include covered and non-covered criteria for negative pressure wound therapy in an outpatient setting. Effective 12/1/11.

Clarifications

Catheter Ablation for Atrial Fibrillation, 141. Clarifying information regarding repeated procedures involving catheter ablation for atrial fibrillation.

Hematopoietic Stem Cell Transplantation for Multiple Myeloma, 075. Clarifying coverage criteria for tandem sequence transplantation.

Treatment of Hyperhydrosis, 144. Clarifying information describing the class effect of botulinum toxin.❖

Pharmacy Medical Policy Update

Interferons Alpha and Gamma, 052. Implementing prior authorization for Sylatron™ injection when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/12.

Makena (hydroxyprogesterone caproate, 314. New pharmacy medical policy describing prior authorization for Makena™ inj. when administered in outpatient sites of service for managed care members, except PPO. Effective 1/1/12.❖

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  www.bluecrossma.com/provider
  Our website has the resources to help you care for our members, and offers you the ability to check claim status, and eligibility and benefit information. Available 24 hours a day, 7 days a week.
- Claims-related issues:
  Provider Services: 1-800-882-2060
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
  Ancillary Provider Services: 1-800-451-8124
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
- Fraud Hotline: 1-800-992-4100
  Please call our confidential hotline if you suspect fraudulent billing or health care activities.
- Non-claims-related issues:
  Network Management Services, all provider types:
  1-800-316-BLUE (2583)
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.
- Provider Enrollment and Credentialing: For credentialing, changing a current contract, or obtaining the status of a previously submitted provider contract: 1-800-419-4419
  M-T-W-F: 8:30 a.m. - 4:30 p.m.
  Th: 9:30 a.m. - 4:30 p.m.

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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