March 2011

Providerfocus

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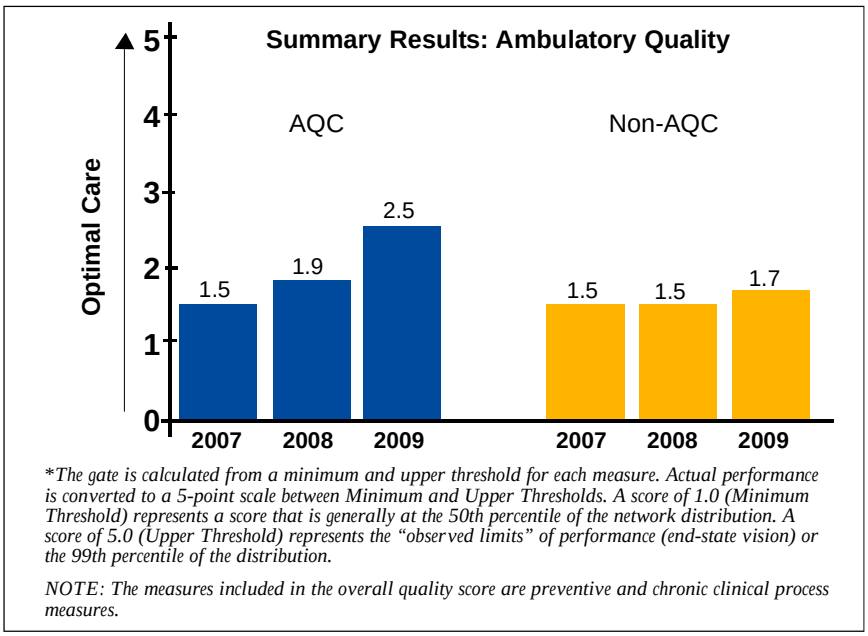
BCBSMA Announces Initial Results of Alternative Quality Contract

The first-year results from BCBSMA's Alternative Quality Contract (AQC) suggest the AQC will reduce the rate of increase in health care costs and improve the quality of patient care. These are promising results, considering that the AQC was designed to achieve the twin goals of improving quality and outcomes while significantly slowing the rate of growth in health care spending.

Based on 2009 data, the AQC groups all successfully managed their global budget and significantly improved quality and clinical outcomes compared to non-AQC providers.



**The gate is calculated from a minimum and upper threshold for each measure. Actual performance is converted to a 5-point scale between Minimum and Upper Thresholds. A score of 1.0 (Minimum Threshold) represents a score that is generally at the 50th percentile of the network distribution. A score of 5.0 (Upper Threshold) represents the "observed limits" of performance (end-state vision) or the 99th percentile of the distribution.*

NOTE: The measures included in the overall quality score are preventive and chronic clinical process measures.

Improving Patient Care

In year one, improvements in patient care quality exceeded any previous one-year change in our hospital and physician network. Specifically:

- Chronic Disease Care Measures. For diabetes and cardiovascular disease management—among the most costly and prevalent chronic care conditions—AQC groups improved screening and monitoring measures four times more than their prior accomplishments.
- Preventive Care Measures. For cancer screenings and well-child visits, the rate of improvement was three times that of non-AQC groups, and more than double the AQC groups' own previous efforts.
- Clinical Outcome Measures. Many AQC groups' performance on clinical measures is approaching or has reached the highest level of quality believed to be

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In This Issue

In Brief

BCBSMA Supports Antibiotics Awareness Campaign

Approximately 80% of adults with acute bronchitis receive a prescription for antibiotics; yet most bronchitis is viral and antibiotic therapy offers no benefit. Unnecessary use of antibiotics contributes to an increase in antimicrobial-resistant bacteria, as well as side effects and adverse outcomes for patients.

The Massachusetts Department of Public Health (MDPH) and the Massachusetts Medical Society (MMS) are providing physicians and patients with educational tools for treating viral upper respiratory infections without antibiotics.

To download materials, such as posters for your waiting or exam rooms, patient handouts, and tips for talking with your patients, go to www.massmed.org/antibiotics.

Supporters of this project include the MMS, MDPH, BCBSMA, the Partnership for Healthcare Excellence, the Massachusetts Association of Health Plans, and the Massachusetts Hospital Association.

Physician News

MASSACHUSETTS

Practice Pattern Variation Analyses to Be Shared with Certain Specialists

To address the long-term sustainability of health care, while improving health care quality and patient outcomes, BCBSMA has been examining clinically significant, unexplained variations in practice patterns among physicians caring for several common medical conditions. Initial discussions with clinical leaders and experts regarding these unexplained variations in care suggest that they are, indeed, compelling and worthy of consideration by the profession.

For that reason, we will begin sharing data with individual physicians in certain specialties throughout our network beginning this spring (see list below). The data will include your own practice pattern for the conditions of interest, compared with your peers. Data will be blinded so that individual physicians will know which results are their own, but they will not know the identity of other clinicians. We hope that you will begin to discuss these results with your peers to begin to understand and address the significant, unexplained differences in treatment patterns revealed in the data.

Webinar Sessions Offered This Month

Before we send your data, we encourage you to attend a webinar for your specialty to learn about the methodology and results. During the session, Dana Safran, Sc.D., Senior Vice President, Performance Measurement & Improvement, will share a clinical example from your specialty and you will have the opportunity to ask questions. If you cannot attend, you'll be able to access a recording of the session on our BlueLinks for Providers website.❖

If you participate in one of these physician specialties:	To access:	Log on to BlueLinks for Providers at www.bluecrossma.com/provider, then:
▸ Allergy/Immunology ▸ Cardiology ▸ Dermatology ▸ Gastroenterology ▸ Neurology ▸ Orthopedic Surgery ▸ Otolaryngology	Our January 25, 2011 letter about sharing PPVA data with you; it includes an invitation to the webinars	From the home page, click on the link under the heading Practice Pattern Variation Analysis.
	The webinar session registration and more information	Click on Resource Center>Training & Registration>Course List. From the specialty drop-down menu, select the webinar that is scheduled for your specialty.

Preferred Home Infusion Therapy (HIT) Provider List Updated

We have updated our Preferred HIT providers list by:

- Adding a new HIT provider—Walgreens Infusion Services—for enzyme, hemophilia , IVIG, and pulmonary arterial hypertension therapies only
- Extending the list of therapies Coram offers for hemophilia

Preferred HIT providers offer our members* cost-effective therapies in a variety of therapeutic classes. While members can use any BCBSMA-participating HIT provider for these specific services, we encourage use of the preferred network.

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

Contact Information:
Walgreens Infusion Services Phone: 1-800-431-4250 Fax: 1-888-431-4999 Web: www.walgreenshealth.com
Coram Therapeutic Services (hemophilia division) Phone: 1-888-699-7440 Fax: 1-888-699-7441

**Excludes Federal Employee Program members.*

Physician News

What Your Medicare Patient Is *Not* Telling You. Survey Suggests Room for Dialogue

To understand the well-being of our members, BCBS-MA relies on reported data such as that from the Centers for Medicare & Medicare Services (CMS), the Health Effectiveness Data and Information Sets (HEDIS), and the Medicare Health Outcomes Survey (HOS), which is conducted every two years.

The goal is to gather valid and reliable health status data on our Medicare managed care members for a variety of purposes:

- Quality improvement activities
- Plan accountability
- Public reporting
- Improving health.

What the 2009 Data Shows

In 2009:

- The HOS found that 36% of our Medicare HMO Blue® members felt their health was worse than expected and may not have discussed this with their physician. Medicare HMO Blue's performance was identical to the national average for this measure.
- HEDIS results showed that 15% of our Medicare HMO Blue members and 14% of our Medicare PPO Blue℠ members for whom osteoporosis screening was recommended did not seek bone densitometry screening. This was better than the national average of 31% and the New England average of 22%.
- The HOS found that only 38% of Medicare HMO Blue members with urinary incontinence informed their physician about the condition. This compares with 36% nationwide and 37% in New England.

These examples show some of the health issues Medicare patients may not be sharing with you. Because you play an essential role in your patients' health care, you can help address potential concerns by proactively addressing such topics with them.

Tell Us About Your Experience

Do you have a story to share about how you're communicating in a meaningful way with your Medicare Advantage patients? We'd like to hear from you. Send us an e-mail at focus@bcbsma.com.❖

The "GOLD" Standard of Chronic Obstructive Pulmonary Disease Diagnosis

Did you know that according to Health Effectiveness Data and Information Sets (HEDIS) measurements collected from our claims in 2009, only 27% of our Medicare HMO Blue members newly diagnosed with chronic obstructive pulmonary disease (COPD) received spirometry testing to confirm the diagnosis?

The national average for this HEDIS measures was just over 28%, according to 2010 CMS HEDIS public use files. For BCBSMA commercial HMO/POS and PPO members, the averages were 39% and 41% respectively on this measure.

The National Heart, Lung, and Blood Institute worked with the Global Initiative for Chronic Obstructive Pulmonary Disease (GOLD) and developed guidelines for COPD. These include the recommendation that spirometry be performed to confirm a new diagnosis of COPD for patients with dyspnea on exertion, chronic cough (may be intermittent or nonproductive), chronic sputum production, and history of risk factors for COPD.

To learn more, go to www.goldcopd.com.❖

eHealth Update

BCBSMA 2010 e-Prescribing License Sponsorship Program Results

BCBSMA's efforts to enhance the safety, quality, and affordability of patient care in Massachusetts include supporting the adoption of e-prescribing (eRx). We have helped more than 6,700 providers get started with eRx technology and our work has been recognized by Surescripts, which operates the nation's largest eRx network.

More than 20 million e-prescriptions have been transmitted by BCBSMA-sponsored prescribers in Massachusetts over the last seven years and currently, nearly 60% of Massachusetts providers use eRx/electronic health record (EHR) technology to write prescriptions.

In 2010, Surescripts recognized Massachusetts as the top eRx state for the fourth year in a row with its Safe-Rx Award.

BCBSMA promoted Health Information Technology adoption in Massachusetts last year by offering subsidies that helped 340 eligible first-time users implement eRx. The subsidies helped 277 providers acquire a stand-alone eRx system and 63 providers upgrade their EHR systems with eRx functionality. This has helped these providers move a step closer to achieving "meaningful EHR use" as defined by the federal HITECH Act.

The HITECH Act provides incentive payments to eligible providers who demonstrate a certain threshold of EHR use. In addition, these subsidies will help providers meet BCBSMA's 2011 requirement to use eRx in order to qualify fully for earned incentives available through our provider incentive programs.

Given the high rate of prescriber adoption of eRx in Massachusetts and the availability of alternate technology funding sources, such as federal incentive programs like HITECH and the Medicare Improvements for Patients and Providers Act, BCBSMA will channel its support for health care system transformation in new directions in 2011.

About the HITECH Act

The HITECH Act provides grants and financial incentives for physicians and other providers to adopt and utilize EHRs that include eRx functionality.

Under the HITECH Act provisions, physicians and medical practices can qualify for Medicare and Medicaid incentive payments if they can demonstrate "meaningful use" of certified EHR starting in 2011. Requirements include the use of a certified EHR technology with eRx.

Starting in 2015, providers are expected to have adopted and be actively using a certified EHR in compliance with the "meaningful use" definition, or their Medicare reimbursement rate will be decreased by 1% per year, up to a potential maximum penalty of 5%.❖

Office Staff Notes

BCBSMA's Member Rights and Responsibilities Statement Is Available Online

A copy of BCBSMA's "Member Rights and Responsibilities" statement is available in the Member Education section of your *Blue Book* manual online.

To view this information, log on to www.bluecrossma.com/provider and click Resource Center>Admin Guidelines & Info>Blue Books. Under the Professional Blue Book listing, select Appendix> Member Education.

The Rights and Responsibilities section appears on pages 7-12.❖

New Medical Necessity Criteria for Short-term Rehabilitation Are Online

BCBSMA now has medical necessity criteria for physical therapy for pelvic floor dysfunction and lymphedema. To access the criteria online, log on to www.bluecrossma.com/provider and click on Manage Your Business>Medical Review Resources.❖

Office Staff Notes

New Urgent Care Center Network Will Address ED Overutilization

To attain greater affordability in health care, we must provide opportunities to increase efficiencies in the current health care delivery system. The overutilization of the hospital emergency department (ED) for certain types of care has been discussed as a public policy issue for some time. Earlier this year, the Department of Health Care Financing and Policy (DHCFP) concluded that nearly one-half of outpatient ED visits were considered preventable or avoidable in 2008, amounting to more than $514 million in health care costs*.

We believe that this costly over-utilization can be addressed through an alternative care setting—an Urgent Care Center (UCC) network. This new network will be available to our HMO, PPO, Indemnity, and Medicare Advantage (Medicare HMO Blue® and Medicare PPO Blue℠) members beginning April 1, 2011 to help them receive care for urgent conditions at times when it may not be possible to see their primary care provider (PCP).

Credentialed clinicians affiliated with the UCC will treat unforeseen conditions that are not life-threatening, but that may cause serious medical problems if not properly treated in a timely manner.

If you are part of a free-standing UCC, a physician practice, or community health center that has either urgent care hours or UCCs, or part of an acute care hospital with an on-site or satellite UCC, please refer to our *F.Y.I.* (PC-1435) dated January 17, 2011 for more details.

To view the *F.Y.I.* online, log onto www.bluecrossma.com/provider and click on News for You> FYIs.❖

* Source: *DHCFP: Preventable/Avoidable ED Use in Massachusetts: Opportunities for Mitigating Cost and Improving Care Coordination, Fiscal Years 2004 to 2008*, July 2010.

BCBSMA Announces Initial Results of Alternative Quality Contract

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attainable for a patient population. Results of outcome measures such as control of blood pressure, blood sugar, or cholesterol signify that patients' chronic conditions are being well-managed.

"We saw remarkable improvements in quality and patient health outcomes achieved by every AQC organization in the first year of these multi-year contracts," said Dana Safran, ScD., BCBSMA's Senior Vice President, Performance Measurement and Improvement. "These results demonstrate that by aligning payment incentives with accountability for important quality and outcome measures, significant improvements in patient care can be accomplished."

Moderating Health Care Costs

The AQC has positively influenced two major health care cost drivers—hospital readmissions and the use of emergency departments (ED) for non-emergent care. For example:

- The AQC groups' improvement in their hospital readmission rates equated to $1.8 million in avoided readmission costs for the AQC groups. For the rest of the network, readmission rates increased over the past year.
- One AQC group reduced its non-emergency ED visits by 22% over the past year, which translates into $300,000 in avoided ED costs.

About the AQC

The AQC is an example of the kind of innovative payment models encouraged by the new federal health care reform law. This model also aligns with Governor Deval Patrick's focus on payment reform in Massachusetts.

Currently, one-third of our HMO network physicians (approximately 6,600) are in an AQC arrangement, and 40% of our Massachusetts-based HMO members (approximately 430,000) are receiving care from AQC providers.

"These results demonstrate that by aligning payment incentives with accountability for important quality and outcome measures, significant improvements in patient care can be accomplished."

Dana Safran, ScD.,
BCBSMA's Senior Vice President,
Performance Measurement and Improvement

To read more about the results, go to www.bluecrossma.com/provider. In the AQC Results section, you'll find links to a fact sheet, white paper, and press release.❖

Billing Notes

Questions and Answers on Reporting Aspiration/Injection Procedures

Q. When aspiration of fluid from the knee joint is performed and medication is injected into the knee joint, can I report code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) twice—once for the aspiration of fluid and once for the injection of medication?

A. The term "and/or" in the code descriptor of code 20610 indicates that the code includes the performance of one or all of the procedures described in the same major joint or bursa. Therefore, code 20610 should only be reported one time when both aspiration and injection are performed in the same major joint or bursa.

Q. How should an injection into a joint be reported when an injection is performed in both the left and right knees?

A. When submitting a claim for bilateral surgical services, report CPT 20610 on one line with Modifier 50 and only one unit of service. In this instance, BCBSMA will allow 150% of our normal allowance for this procedure to account for the bilateral service.

Q. How should I be using CPT codes 20600, 20605, and 20610?

A. When submitting claims using these codes:

- Report CPT codes 20600, 20605, and 20610 once per aspiration/injection. Both aspiration and injection in same site should be reported only once.
- 20600-20610 are unilateral procedures and should be reported with modifier 50 when aspiration/injection is performed bilaterally on the right and left.❖

Source: CPT Assistant, March 2001 Pages: 10-11 Category: Coding Consultation

Use Appropriate Place of Service for Care Delivered in the Emergency Department

In conjunction with requirements of National Health Care Reform, when billing for professional services rendered in the hospital Emergency Department, please use HIPAA place of-service (POS) value 23. This will ensure timely and accurate reimbursement of your claims.❖

Medical Policy Update

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

Changes

Pheresis, 071. Adding coverage for Wegener's granulomatosis. Effective 6/1/11.

Vertical Expandable Prosthetic Titanium Rib, 305. Adding coverage. Effective 6/1/11.

Clarifications

Allogeneic Stem Cell Transplants: Allogeneic Peripheral, Umbilical Cord Blood, & Bone Marrow Transplants 092. Retiring this medical policy; information from this policy will be included in other policies related to specific conditions.

Autologous Stem Cell Transplants: Autologous Peripheral Stem Cell Support & Autologous Bone Marrow Transplants 126. Retiring this medical policy; information from this policy will be included in other policies related to specific conditions.

Biofeedback for Fecal Incontinence or Constipation, 308. New medical policy clarifying non-coverage of this technology for constipation and for fecal incontinence. Similar information is being removed from medical policy 072, *Incontinence Therapy*.

Chemoembolization of Liver Cancer (TACE), 369. Clarifying non-coverage of this procedure as adjuvant or neoadjuvant therapy for hepatocellular carcinoma that is resectable.

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Medical Policy Update

Clarifications, continued from page 6

Cytoreduction and Hyperthermic Intraperitoneal Chemotherapy for the Treatment of Peritoneal Carcinomatosis of Gastrointestinal Origin, 048. Changing policy name to *Cytoreduction and Hyperthermic Intraperitoneal Chemotherapy for the Treatment of Pseudomyxoma Peritonei and Peritoneal Carcinomatosis of Gastrointestinal Origin* and clarifying non-coverage of peritoneal carcinomatosis from colorectal cancer.

Electrical Stimulation for the Treatment of Arthritis, 302. New medical policy describing ongoing non-coverage of this procedure. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Enhanced External Counterpulsation; End Diastolic Pneumatic Compression Boots as Treatment of Peripheral Vascular Disease or Lymphedema, 388. Removing information on total artificial hearts and ventricular assist devices. Details are now included in new medical policy 280, *Total Artificial Hearts and Implantable Ventricular Assist Devices*.

Hematopoietic Stem Cell Transplantation for Autoimmune Diseases, 192. Clarifying additional non-covered connective tissue disorders.

Incontinence Therapy, 072. Changing policy title to Treatment of Urinary Incontinence and removing information about treatments for fecal incontinence.

Injectable Clostridial Collagenase for Fibroproliferative Disorders, 225. Clarifying coverage for Medicare HMO Blue® and Medicare PPO Blue℠ when medical necessity criteria are met.

Percutaneous Annuloplasty; Intradiscal Radiofrequency Thermocoagulation; Intradiscal Electrothermal Therapy (IDET); and Manipulation under Anesthesia for Treatment of Chronic Spinal or Pelvic Pain, 099. Changing policy title to *Percutaneous Annuloplasty; Intradiscal Radiofrequency Thermocoagulation; Intradiscal Electrothermal Therapy (IDET); and Manipulation under Anesthesia*, and clarifying non-coverage of manipulation under anesthesia.

Posterior Tibial Nerve Stimulation for Voiding Dysfunction, 583. New medical policy describing ongoing non-coverage of this procedure. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Radiofrequency Facet Joint Denervation, 140. Clarifying non-coverage of pulsed radiofrequency denervation.

Saturation Biopsy for Diagnosis and Staging of Prostate Cancer, 307. New medical policy describing ongoing non-coverage of this procedure. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Suprachoroidal Delivery of Pharmacologic Agents, 609. New medical policy describing ongoing non-coverage of this procedure. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Total Artificial Hearts and Implantable Ventricular Assist Devices, 280. New policy describing ongoing covered and non-covered indications. The same information will be removed from medical policy 388, *Enhanced External Counterpulsation; End Diastolic Pneumatic Compression Boots as Treatment of Peripheral Vascular Disease or Lymphedema*.

Transanal Radiofrequency Treatment of Fecal Incontinence, 309. New medical policy containing information removed from policy 072, *Incontinence Therapy*, clarifying ongoing non-coverage of this technology.

Transtympanic Micropressure Applications as a Treatment of Meniere's Disease, 508. New medical policy describing ongoing non-coverage of this procedure. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Ultrasonographic Evaluation of Skin Lesions, 303. New medical policy describing ongoing non-coverage of this test. The same information will be removed from medical policy 007, *Ultrasounds*.

Ultrasounds, 007. Clarifying that the term “combined test” when screening for Down’s Syndrome is also known as “serial sequential testing.”

Vertebral Axial Decompression, 603. New medical policy describing ongoing non-coverage of this procedure. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Wireless Pressure Sensors in Endovascular Aneurysm Repair, 306. New medical policy describing ongoing non-coverage of this procedure. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.❖

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  Ancillary Provider Services: 1-800-451-8124
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  Th: 9:30 a.m. - 4:30 p.m.
- Fraud Hotline: 1-800-992-4100
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  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.
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