Blue FOCUS

MASSACHUSETTS

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

A quarterly newsletter for hospitals and institutional ancillary providers

FALL 2011

First Independent Review of AQC Finds Cost Savings and Quality Improvement

AQC Spotlight

A 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.

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.

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ICD-10 Provider Preparedness Survey Is Available

To help you meet the ICD-10 compliance date of October 1, 2013, Massachusetts health plans and MassHealth are collaborating to conduct an online ICD-10 provider progress survey.

The survey will help to assess statewide compliance efforts underway, and will be used to develop educational strategies and training materials, and to identify resources to assist providers in their ICD-10 preparations.

To avoid duplicate survey requests from various health plans, HealthCare Administrative Solutions (HCAS) has developed this survey on behalf of numerous Massachusetts Health Plans.

To access the survey, log on to www.bluecrossma.com/provider and click on the survey link on the home page. ❖

Pharmacy Update

Important Pharmacy Program Updates for 2012-2013

To offer our members a more affordable pharmacy benefit, we are making these changes to our pharmacy program:

Certain HMO Blue® members on chronic medications will be required to use our Exclusive Home Delivery program, which means filling prescriptions through Express Scripts, Inc.'s Mail Service Pharmacy.

Prior authorization requirements will be implemented for certain medications administered in a clinician's office or outpatient setting, or by a home infusion therapy provider and billed under the member's medical benefits. We are updating existing medical policies to reflect these new requirements.

Updates to our standard, BlueValue Rx, Blue MedicareRx, and Medicare Advantage formularies will take effect. These include tier changes, drugs moving to non-coverage, and quality care dosing limits

Changes will be made to medications provided through our retail specialty pharmacy network.

For additional details on these changes, including more specifics on formulary changes, please view our *F.Y.I.* on BlueLinks for Providers.❖

To:	Log on to www.bluecrossma.com/provider and select:
Download medical policies and pharmacy medical policies	Manage Your Business>Review Medical Policies>View Medical Policies. View an alphabetical listing or search by category. You can also use the Quick Search feature.
Obtain the *Outpatient Medical Prior Authorization Form*, used to fax request prior authorizations for medications administered in your office or in an outpatient setting	Resource Center>Forms>Pharmacy Forms.
View an updated *List of Medications that Require Prior Authorization When Administered in a Clinician's Office or Outpatient Setting*	Manage Your Business>Search Pharmacy & Info>Drug Management Programs.
View a complete list of standard and BlueValue Rx formulary changes	News for You>FYIs. Scroll down to the *F.Y.I.* dated September 1, 2011 (PC-1469). A PDF will display in the Resources section of the *F.Y.I.*
View our list of specialty medications and the retail specialty pharmacies that can dispense them	Manage Your Business>Search Pharmacy & Info>Specialty Pharmacy Medication List. This will be updated on January 1, 2012.

See page 10 for upcoming changes to our pharmacy medical policies.

Pharmacy Update

Walgreens to Terminate Its Agreement with Express Scripts, Inc.

Express Scripts, Inc. (ESI), the company chosen by BCBSMA to administer prescription benefits to our members and negotiate retail pharmacy agreements on our behalf, has notified us that Walgreens will no longer participate in ESI's retail pharmacy network as of January 1, 2012.

We are notifying providers because we anticipate that you may receive requests to obtain a prescription for a new pharmacy from your patients who use Walgreens. ESI has been working with Walgreens to negotiate a continuation of their current retail pharmacy agreement with ESI, which ends on December 31, 2011. As a result of these discussions, Walgreens has indicated that they will no longer participate in ESI's retail network as of January 1, 2012. This includes all retail prescriptions, including those for specialty medications.

With health care costs at the forefront, our hope is that these organizations can work together to offer our members a convenient, affordable pharmacy service.

For more details and late-breaking news if an agreement is reached between the two parties, log on to BlueLinks for Providers at www.bluecrossma.com/provider and click on Walgreens Termination with ESI.❖

Additional Choices Available 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.	1-888-823-9070
CVS Caremark	1-800-237-2767

Ancillary News

Clarification Regarding DME Items Provided During Inpatient Stay

In the Spring 2010 issue of *Blue Focus* (page 6), we wrote that it is the responsibility of a hospital/facility to reimburse the durable medical equipment (DME) provider for covered DME items rendered to a patient during an inpatient stay. Providers should follow the Centers for Medicare & Medicaid Services (CMS) two-day rule guidelines when providing covered DME, prosthetics, orthotics, and supplies (DMEPOS) to our members.

A DME provider may deliver a DMEPOS item to a patient in a hospital/facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patent's anticipated discharge to their home. The DME provider must bill the date of service on the claim as the date of discharge and should use place of service (POS) code 12 (patient's home). The item must be for subsequent use in the patient's home.❖

Medicare News

Osteoporosis Testing Van Provides Mobile Bone Densitometry Tests

Providers and members have told us that the number one barrier preventing patients from receiving a bone mineral density (BMD) test is transportation. That's why we are working with Imaging Resource Center (IRC), a BCBSMA provider of a mobile testing service. IRC can travel to your facility to help 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, 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.❖

First Independent Review of AQC Finds Cost Savings and Quality Improvement

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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."

Harvard Study Offsets AG'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/visitor and click on the Making Quality Health Care Affordable link on the bottom of the page.❖

Office Staff Notes

Use New Form to Submit Appeals to BCBSMA and Other Payers

As a reminder, when submitting appeals to BCBSMA, you should now use the *Request for Claim Review Form*.

This document replaced our *Provider Appeal Form* effective October 1, 2011.

You may use this new form to submit appeals to the following participating health plans:

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

To access the form and accompanying *Reference Guide* on our website, log on to www.bluecrossma.com/provider and click on Forms> Review and Appeals. Or, you may also access the form and guide on the HCAS website at www.hcasma.org.

Questions?

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

Important Update: Change to Our Provider Appeals Address

Please note that as of October, 1, 2011, BCBSMA has eliminated the following appeals address:

BCBSMA Provider Services
P.O. Box 986090
Boston, MA 02298-6090

This P.O. box was previously reserved for providers submitting individual consideration (IC) appeals for claims that were denied for reasons related to our medical technology assessment criteria or our medical policy guidelines.

Please begin sending all appeals for UB-04 claims to the address below. Mail sent to the expired P.O. box will be forwarded to the new address for a limited time.❖

For this type of appeal:	Please send to:
Individual consideration (IC) appeal related to our medical technology assessment criteria or medical policy guidelines	BCBSMA Provider Appeals P.O. Box 986065 Boston, MA 02298
Non-clinical appeals, such as: Member benefits Coding adjustments Referral/authorization adjustments IC appeals not related to our medical technology assessment criteria or medical policy guidelines	

Office Staff Notes

Diagnosis and Treatment Code Statement Coming to Claim Notices in January

A provision of the Patient Protection and Affordable Care Act (PPACA) of 2010 will go into effect by January 1, 2012, which will require that BCSMA include a statement in all member-directed adverse benefit determination notices informing members that diagnosis and treatment codes and their descriptions are available at the member's request.

The notice will also indicate that the member or their authorized representative must submit such a request to BCBSMA in writing.

The most common form of an adverse benefit determination notice is the Explanation of Benefits (EOB), but also includes other adverse notices to members about utilization management and appeals determinations.

As a health care provider, you may receive inquiries from your patients about the diagnosis and treatment codes submitted to BCBSMA. It is important to continue to ensure that the diagnosis and treatment codes you submit reflect the correct treatment and diagnosis for the services received by the member. ❖

Ambulance Authorization Function to be Eliminated from Our Technologies

In preparation for the implementation of HIPAA 5010, we are reviewing the utilization of our technology tools. During this process, we found that the ambulance authorization submission option is not used because of the challenges of automating this authorization type.

To streamline our processes, starting in fall 2011, we plan to eliminate the electronic ambulance authorization option. We will continue to evaluate opportunities to increase automation.

Just as you do today, if you need to obtain an ambulance authorization, please call Clinical Coordination at 1-800-327-6716. ❖

Google Health Personal Health Record™ Program to be Discontinued in 2012

Google Health will discontinue its Google Health Personal Health Record™ (PHR) service, effective January 1, 2012. Google will continue to operate its Health site through January 1, 2012 and will allow users to access and download the data they have stored in Google Health through January 1, 2013. Google Health is a free online tool that allows patients to voluntarily create a personal health record in a secure, central location.

To read more, go to Google's website at www.google.com/health.

BCBSMA believes that personal health records can be a valuable tool for members to manage, store, and share their health and medical information, and we'll evaluate options to continue providing our members with this functionality. ❖

Update on Checking Eligibility and Claim Status for Blue Benefit Administrators of Massachusetts Plans

Blue Benefit Administrators (BBA) of Massachusetts has announced that eligibility and claim status inquiry and response for BBA plans are now available via NEHEN and NEHEN*Net*. BBA, a wholly owned subsidiary of BCBSMA, offers administrative service-only plans to self-insured accounts.

NEHEN will send a follow-up mailing to their members with technical details and instructions. ❖

Billing Notes

Important Reminder on the Use of Modifiers on UB-04 Claims

In compliance with Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Health Care*, BCBSMA is continuing to implement updates to the claims processing system.

One of these enhancements is the acceptance of modifiers on UB-04 claims.

We communicated previously that as of August 1, 2011, UB-04 claims submitted for bilateral services should be billed using the industry standard methodology—placing the service on one line with modifier 50; reimbursement will be 150% of the contracted fee schedule amount.

About Modifier 59

Currently, our system can only recognize modifier 59 when it's placed in the first modifier field. BCBSMA is in the process of upgrading our system to allow the use of modifier 59 in subsequent fields. We hope to accommodate this change later in 2011, and will inform you when this issue is resolved.

Diagnosis Codes

As a reminder, when submitting claims for reimbursement, be sure to report all services using the most up-to-date industry standard procedure, revenue, and diagnosis codes, including modifiers, when applicable.

Note: When billing services for which BCBSMA has a medical policy, our system can now read all diagnosis codes included on the claim. Previously, we were capable of reading only the first five diagnosis codes for these services.❖

Reimbursement Change for Venipuncture Services, Effective January 1, 2012

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 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).❖

Are You Preparing for the Implementation of HIPAA Version 5010?

In preparation for the implementation of HIPAA version 5010, please make sure you're in touch with your vendor, or check with your IT staff on their 5010 preparation status.

In addition, if you are a direct submitter and you have not yet set up a time to test with BCBSMA, please contact us as soon as possible by sending an e-mail to EDIsupport@bcbsma.com.

BCBSMA is now in the process of conducting external testing. All testing must be completed by December 31, 2011 and the new Version 5010 will be implemented January 1, 2012.

As a reminder, 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.

Questions?

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

Medical Policy Update

All updates will be available on our website. Go to www.bluecrossma.com/provider and click on 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. Revised to include the 2/17/11 FDA safety announcement on terbutaline. Effective 12/1/11.

Aqueous Shunts and Devices for Glaucoma, 223. Revised to include the covered criteria and provide additional specificity for the non-covered criteria for canaloplasty. Effective 1/1/12.

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.

Botulinum Toxin, 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 screening or diagnosis of breast cancer. Effective 12/1/11.

Donor Lymphocyte Infusion for Malignancies Treated with an Allogeneic Hematopoietic Stem-Cell Transplant, 338. New medical policy describing the covered and non-covered indications for donor lymphocyte infusion. Information formerly included in medical policy 051, *Cancer Treatment*. Effective 1/1/12.

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.

Genetic Testing for Lipoprotein(a) Variant(s) as a Decision Aid for Aspirin Treatment, 339. New medical policy describing the non-covered criteria in patients who are being considered for treatment with aspirin to reduce risk of cardiovascular events. Effective 1/1/12.

Genotyping for 9p21 Genetic Polymorphisms to Predict Cardiovascular Disease Risk, 340. New medical policy describing the non-covered criteria for 9p21 genotyping for cardiovascular disease, abdominal aortic aneurysm, or intracranial aneurysm. Effective 1/1/12.

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.

Implantable Cardioverter Defibrillator, 070. Revised to provide additional specificity for the covered criteria for the use of ICD in adults, and to include covered and non-covered criteria for the use of ICD in pediatric patients. Effective 1/1/12.

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.

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Medical Policy Update

Changes (continued)

Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions, 343. New medical policy describing the covered and non-covered criteria for antivascular endothelial growth factor therapies in disorders of choroidal circulation. Effective 1/1/12.

Kidney Transplant, 196. Revised to provide additional clinical criteria for covered and non-covered indications for kidney transplantation. Effective 1/1/12.

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.

Magnetic Resonance MRI, MRA, MRV, MRS, Positional Magnetic Resonance Imaging, Functional MRI, 106. Revised to include the covered and non-covered criteria for magnetoencephalography/magnetic source imaging. Also changed policy title to *Magnetic Resonance MRI, MRA, MRV, MRS, Positional Magnetic Resonance Imaging, Functional MRI and MEG/MSI* to reflect scope of the policy. Effective 1/1/12.

Medical and Surgical Management of Obesity including Anorexiants, 379. Revised to include additional criteria and additional specificity for the covered and non-covered criteria for bariatric surgeries. Effective 1/1/12.

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.

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.

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Medical Policy Update

Clarifications

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

Corneal Topography/Computer-Assisted Corneal Topography/Photokeratoscopy, 301. The policy statement has been clarified related to coverage for Medicare HMO Blue and Medicare PPO Blue.

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

Asthma and Chronic Obstructive Pulmonary Disease Medication Management, 011. Updated to include policy name change to reflect additional coverage criteria for COPD diagnosis, and removal of physician-documented use as coverage criteria for requested medications. Effective 1/1/12.

Growth Hormone and Insulin-like Growth Factor, 257. Updated to include a requirement to use preferred medications first before providing coverage for non-preferred medications. Effective 1/1/12.

Hepatitis C Medications, 344. Introducing this new medical policy for Incivek™ and Victrelis™. Pharmacy prior authorization is required and coverage criteria to include Hepatitis C genotype 1, combination therapy with peginterferon alpha and ribavirin, and HCV RNA monitoring for efficacy. Effective 1/1/12.

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.

Ophthalmic Prostaglandin, 346. Implementing this new pharmacy medical policy to include step therapy requirements. We will require the use of latanoprost (Tier 1) before covering: Lumigan®˝ (bimatoprost) (Tier 2); Travatan/Z®˝ (travoprost) (Tier 2); and Xalatan®˝ (latanoprost) (Tier 3). Effective 1/1/12.

Topical Testosterones, 345. Implementing this new pharmacy medical policy with step therapy requirements. We will require the use of products in the following order before coverage is granted: Step 1: Testim®˝ (Tier 2); Step 2: Androderm®˝ (Tier 3); Step 3: AndroGel®˝ (Non-covered); Axiron®˝ (Non-covered); Fortesta™ (Non-covered). Effective 1/1/12.❖

Changes Coming to Medical Policy 400, *Medical Technology Assessment Non-Covered Services*, Effective January 1, 2012

BCBSMA is in the process of revising medical policy 400, *Medical Technology Assessment Non-Covered Services*. Effective January 1, 2012, this policy will include entries only for non-covered services that *do not* have an associated BCBSMA medical policy. For example, the following service currently appears in medical policy 400 as non-covered:

31627: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation.

However, non-coverage of this service is also addressed in existing BCBSMA medical policy 203, *Electromagnetic Navigation Bronchoscopy*.

Therefore, effective January 1, 2012, non-coverage information for this service will only appear in medical policy 203, and not in medical policy 400.

Questions?

If you have any questions about this change, please send an e-mail to ebr@bcbsma.com.❖

Medical Policy Update

Changes to Medical Policy Terminology Will Take Effect December 1, 2011

Beginning in December 2011, revised language will begin to appear in BCBSMA medical policies. As BCBSMA medical policies undergo their annual review, the terms "medically necessary," "investigational," and "not medically necessary" will be incorporated into the policies, based on scientific evidence. *(See chart for definitions.)* BCBSMA will also continue to include the terms "covered" and "not covered." in all policies.

The revisions will help align the purpose of our medical policies, the language in the documents, and the terminology in our subscriber certificates (Evidence of Coverage or EOC).

We will continue to:

Announce changes to coverage status in *Blue Focus* 90 days prior to any change in the coverage status of a service

Post summaries of the revised coverage statement online in our *Medical Policy Draft Summary Statement Table* 45 days prior to the change. (To access this document, go to our website at www.bluecrossma.com/provider and click on Medical Policies; then select the first listing on the right-hand side of the page.)

In addition, draft medical policies are available upon request 30 days prior to the effective date of a policy. Please e-mail your requests to ebr@bcbsma.com.❖

Type of service:	Explanation:
Medically Necessary	Meets BCBSMA's *Medical Technology Assessment Guidelines* (medical policy 350) and Evidence of Coverage. Medically necessary services are *covered* by BCBSMA.
Investigational	Does not meet BCBSMA's *Medical Technology Assessment Guidelines* (medical policy 350) and Evidence of Coverage. Investigational services are *not covered* by BCBSMA.
Not Medically Necessary	May meet BCBSMA's Medical Technology Assessment Guidelines (medical policy 350); however, following the medical policy review process, BCBSMA has determined the services are considered not medically necessary for a particular member, as defined in the BCBSMA subscriber certificate (Evidence of Coverage) filed with the Massachusetts Division of Insurance. Services we deem not medically necessary are *not covered* by BCBSMA.

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Boston, MA 02215

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Not registered for BlueLinks for Providers?

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 Provider Relations 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 your Ancillary Provider Relations Representative 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.

Blue Focus is published quarterly for BCBSMA hospitals and institutional ancillary providers. Submit letters and suggestions for future articles to:

Provider Education and Communications
Blue Cross and Blue Shield of MA
Landmark Center, MS 01/08
401 Park Drive
Boston, MA 02215-3326
or e-mail the editor at:
focus@bcbsma.com

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