Blue FOCUS

MASSACHUSETTS

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

Final Issue– details below

A quarterly newsletter for hospitals and institutional ancillary providers

FALL 2013

Changing the Way We Communicate With You This Fall

This fall, we're making changes to the way we communicate news and information to you. We are:

- Launching a redesigned website—Provider Central
- Publishing all news to our online news center; we will be discontinuing the printed newsletters (including *Blue Focus*)
- Replacing *F.Y.I.* notices with new online News Alerts.

Three easy steps you can take to prepare for our new website

When our redesigned provider website launches later this fall, registered users will be able to log in with their existing BlueLinks for Providers username and password.

To prepare for your first login, we recommend that you take the following steps today to ensure a smooth experience:

1. Make note of your username and password.

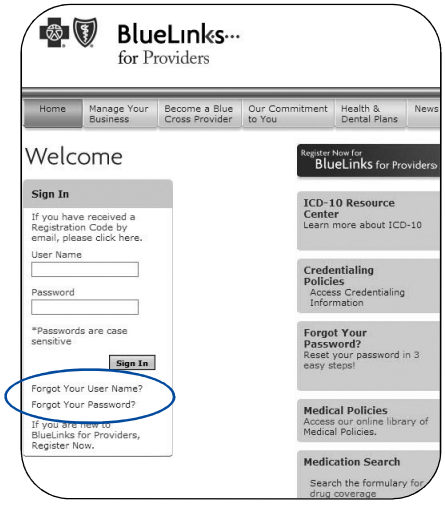
In the past, your username and password may have automatically populated upon log in, depending on your internet browser's settings. When Provider Central launches, your username and password may not automatically populate upon your first login.

2. You can retrieve lost usernames or passwords online.

Simply visit bluecrossma.com/provider, select Forgot Your Username or Forgot Your Password, and follow the screen prompts.

3. Verify that we have your current e-mail address on file.

We will send news and important plan information to you via e-mail. To view and update your email address of record, log on to bluecrossma.com/provider and click on Edit My Profile.



If you are not sure of your username or password, you can retrieve them at bluecrossma.com/provider.

If you have questions, please contact Provider Self Service at 1-800-771-4097.

Changes to our *F.Y.I.* notices starting in October

As part of our website improvements this fall, our *F.Y.I.* notices will have a new look and name—News Alerts—and will appear along with other news in our online news center.

continued on page 2

In This Issue

Dry Hydrotherapy Massage Reminder

Blue Cross does not cover dry hydrotherapy massage; we will not reimburse providers for this service. According to Medical Policy #400, Medical Technology Assessment Non-Covered Services, we consider dry hydrotherapy massage investigational.

To view this medical policy, log on to bluecrossma.com/provider and select Manage Your Business> Review Medical Policies>View Medical Policies and search for 400.❖

Website Updates

Defining Preventive Care vs. Diagnostic Care for Members

Under the Affordable Care Act (ACA), patients may be eligible for some important preventive services at no additional cost. While this new benefit can help patients avoid illness and improve their health, it can also be a source of confusion for providers and members.

Members have asked when their care will be free under the ACA as a preventive service, and when they will be responsible for a share of the cost. Confusion often arises when diagnostic care is provided in conjunction with a routine preventive visit.

New member fact sheet

We have created a new, customizable fact sheet you can share with members to help them understand preventive and diagnostic care. It presents typical care scenarios and explains whether the member may be responsible for a cost share.

The fact sheet provides examples of preventive care that, in most cases, will be free to members, such as well-child visits and routine adult physical exams*. It also illustrates common situations in which a member may be responsible for a share of the cost. To access this fact sheet, log on to bluecrossma.com/provider and select Resource Center>Admin Guidelines & Info>Fact Sheets and select Member Fact Sheet *Preventive vs. Diagnostic Care: What's the Difference.*❖

Changing the Way We Communicate With You This Fall

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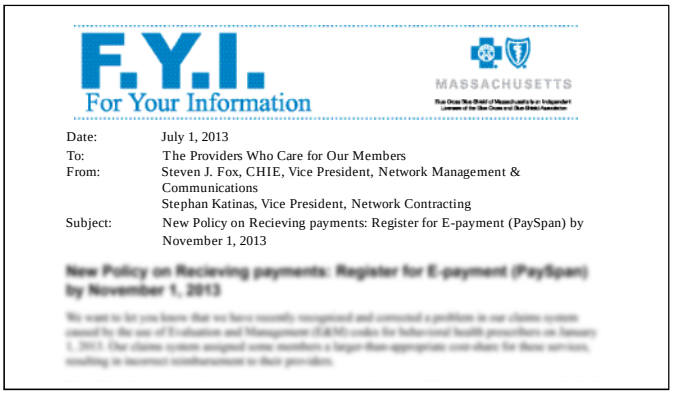
News Alerts will include notices that will:

- impact your reimbursement—including fee schedule updates, changes to reimbursement methodologies and policies, and payment policies
- impact your office operations—including plan benefit and network changes, billing changes, and medical management initiatives, such as new prior authorization programs
- impact your technology and systems—including claims processing rules
- ensure compliance with state and federal regulatory bodies.

These notices will continue to be delivered within agreed-upon time frames. We hope this change makes it easier for you to identify important changes in the way you do business with us. See below for a side-by-side comparison of the previous format and what you can expect. We'll start sending News Alerts in October.❖

Old Version



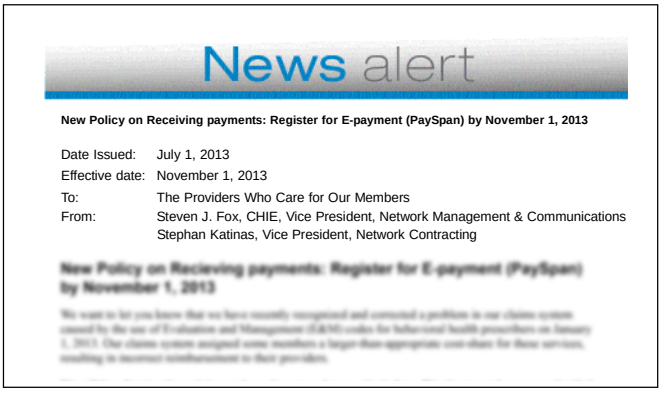
F.Y.I.
For Your Information

MASSACHUSETTS

Date: July 1, 2013
To: The Providers Who Care for Our Members
From: Steven J. Fox, CHIE, Vice President, Network Management & Communications
Stephan Katinas, Vice President, Network Contracting
Subject: New Policy on Recieving payments: Register for E-payment (PaySpan) by November 1, 2013

New Policy on Recieving payments: Register for E-payment (PaySpan) by November 1, 2013

New Version



News alert

New Policy on Receiving payments: Register for E-payment (PaySpan) by November 1, 2013

Date Issued: July 1, 2013
Effective date: November 1, 2013
To: The Providers Who Care for Our Members
From: Steven J. Fox, CHIE, Vice President, Network Management & Communications
Stephan Katinas, Vice President, Network Contracting

New Policy on Recieving payments: Register for E-payment (PaySpan) by November 1, 2013

Office Staff Notes

New Policy Requires You to Receive E-Payments

Register for E-payment with PaySpan by November 1, 2013

Effective November 1, 2013, e-payment will become our standard method of payment for provider reimbursement. An e-payment is a secure, direct deposit into your bank account that occurs via electronic funds transfer (EFT).

E-payment improves the efficiency and affordability of health care by providing you with innovative tools and services to manage your payments efficiently and conveniently. It also reduces unnecessary use of paper and offers you online access to your payment advisories.

If you are not already registered to receive e-payments through our vendor, PaySpan®, Inc., you must register by November 1, 2013 at payspanhealth.com. Registration is simple and secure. Network Management Services is available at 1-800-316-BLUE (2583)to assist with any questions or concerns.

PaySpan will also be the required method to verify weekly check status. By complying with this change, you can save time by getting this information online instead of calling the Provider Service line.

To review our audio-visual presentation to learn more about PaySpan, including how to register, log on to bluecrossma.com/provider and select Resource Center>Training & Registration>Course List and scroll down to PaySpan Health.❖

How to Read Consumer Spending Account Information in Your PDAs

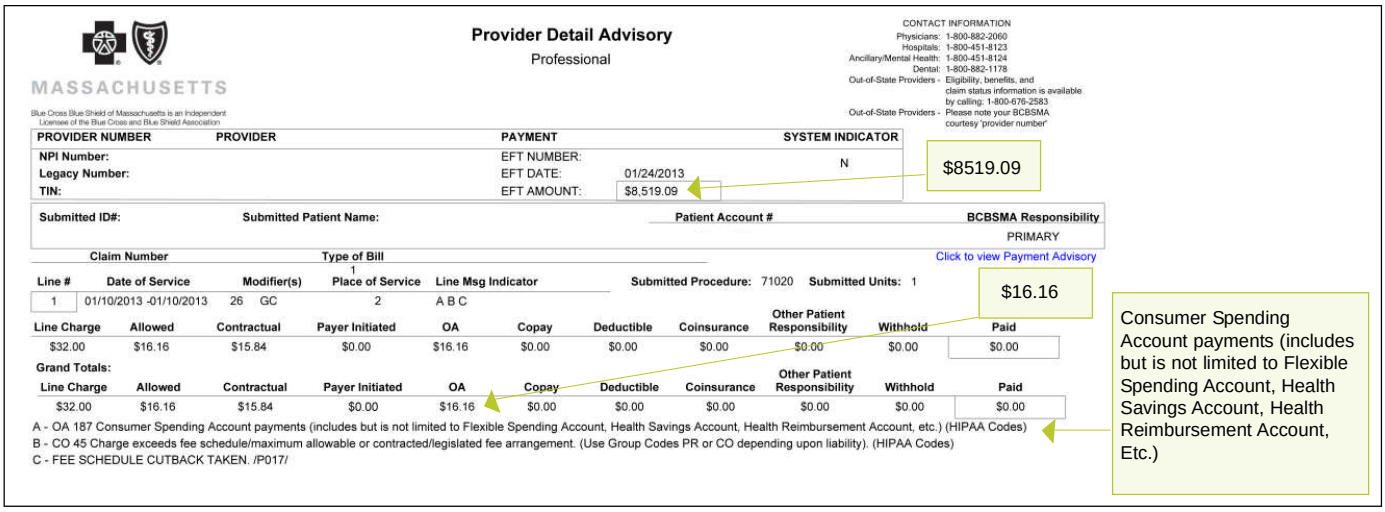
For BlueCard® (out-of-area) members who have a consumer spending account (e.g., a flexible spending account), it may appear that the EFT amount on your Blue Cross Provider Detail Advisory (PDA) shows an over-payment to you. This is because funds paid out of the member's consumer spending account are not listed in the paid field of the PDA, but are instead listed in the OA (other allowance) field.

Please add the amount in the OA field to the amount in the paid field in order to balance your accounts.

If the reimbursement you receive doesn't match the amount in the paid field of your PDA, please review the OA field of all patients listed on your PDAs for that date. Do this to validate if any claim has been paid out of the member's consumer spending account.

For example

In the example below, the EFT payment amount is $8,519.09. This payment includes $16.06 which is listed in the OA field and was paid out of the member's consumer spending account. ❖



Office Staff Notes

New CMS Patient Status Codes Effective October 1

CMS has released 16 new patient status codes which will be effective October 1, 2013. Included in this release are four new patient status codes that will be treated as Transfer cases for those facilities contracted as APR-DRG facilities. Below is CMS's complete list of new patient status codes, effective October 1, 2013.❖

*69	Discharge Transferred to a Designated Disaster Alternate Care
81	Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission
*82	Discharged/Transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
83	Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
84	Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
85	Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
86	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission
87	Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
88	Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
89	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
90	Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
91	Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission
92	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission
*93	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
*94	Discharged/Transferred To a Critical Access Hospital (CAR) with a Planned Acute Care Hospital Inpatient Readmission
95	Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission

** Codes which will be treated as APR/DRG Transfer cases for those facilities contracted as APR-DRG facilities.*

Acute, Rehab and Chronic Care Hospitals: Notify us on Day 85 of Medex®´ Members' Treatment

When a Medex member receives inpatient care and reaches day 85 of their Medicare benefit and Medex is the secondary payer, the facility must notify our Case Management Department by faxing the patient's clinical information to us at 617-246-4210. Be sure to indicate that the patient has reached day 85 of the Medicare benefit. If you have any questions, please call 1-800-392-0098, ext. 64159.❖

Office Staff Notes

How to Improve Coordination of Care from Inpatient to Outpatient Settings

The communication of patient information between sites of care is an important part of ensuring patient safety, improving favorable outcomes, and reducing readmissions. Timely notification of discharges improves handoffs and alerts the outpatient provider to the inpatient stay. As part of our commitment to improve the quality of patient care, we survey PCPs annually to evaluate the level of coordination between inpatient and outpatient settings.

Last year's survey results indicate that behavioral health inpatient units and skilled nursing facilities are significantly less likely to send discharge summaries/transition of care information to PCPs than other medical inpatient settings.

The PCPs who responded indicated that 71% of medical acute facilities always/almost always send discharge summaries/transition of care information to the PCP. Comparatively, 30% of skilled nursing facilities and 18% of behavioral health inpatient units always/almost always provide discharge summaries or transition of care information to the PCP.

You can help

Coordination of care and discharge planning can begin at the time of admission.

Consider taking the measures below to improve the transition from skilled nursing facility or behavioral health unit to home:

- Coordinate with the PCP and other treating providers at the time of admission.
- Notify the PCP and other treating providers upon discharge.
- Encourage the patient to schedule a follow-up appointment with their PCP and/or other treating providers before discharge.
- SNF providers: complete the Department of Public Health's *Universal Transfer Form* or equivalent, and send it to the PCP.
- Behavioral Health Inpatient Units: complete a discharge plan and send it to the PCP and other treating providers.

We hope that these evidence-based best practices will help you improve patient care transitions through improved communication and coordinated patient hand offs.❖

Updated Credentialing Guidelines to Reflect Provider Requests for Change

In response to your requests to improve our enrollment process for new providers joining our networks, we've decided to review our credentialing policies and implement some changes. We'll be updating the *Credentialing Guidelines* on our website shortly to reflect these changes. Here are details about the changes:

DEA certificates. Blue Cross prefers that clinicians with prescriptive authority maintain Drug Enforcement Agency (DEA) certification. However, beginning in November 2013, we will credential clinicians with prescriptive authority and who do not have DEA certificates. These clinicians must sign a waiver indicating: 1) why they do not prescribe, and 2) the name of the Blue Cross provider who will be prescribing for them.

Exceptions to this change: Nurse Practitioner PCPs and Physician Assistant PCPs are contractually required to prescribe and maintain a current and valid federal DEA.

Board certification. Since 2009, we have required new physician applicants to be board certified by the American Board of Medical Specialties/American Osteopathic Association (ABMS/AOA).

Blue Cross still prefers that all physicians in a contracted network be ABMS/AOA board-certified and maintain that certification. However, starting in November 2013, we will credential initial physician applicants if they meet the Accreditation Council for Graduate Medical Education (ACGME) training requirements of an ABMS/AOA board.

Oral and Maxillofacial Surgeons who provide care under the medical benefit plan(s) must be board certified by the American Board of Oral and Maxillofacial Surgery (ABOMS) for Oral and Maxillofacial Surgeons.

If you have questions about these changes, please contact Network Management and Credentialing Services at 1-800-316-BLUE (2583).❖

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.

Malnutrition: Documentation and Coding Overview

Malnutrition is a clinical problem for many adults in the U.S., resulting in adverse patient outcomes, increased hospital stays and higher health care costs.

The Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) has recommend that a standardized set of diagnostic characteristics be used to identify and document adult malnutrition in routine clinical practice. Diagnosing and treating malnutrition is an important factor in promoting positive patient outcomes and reducing health care costs.

Guidelines for coding malnutrition

Correctly documenting and assigning ICD-9-CM codes for malnutrition can be challenging for providers and coders but is easily accomplished if you keep in mind the guidelines below:

- For patients diagnosed with malnutrition, the medical note should include the clinical evaluation and management plan by the treating physician or health care professional. Remember to document the specific type of malnutrition and the degree of severity.
- A code assignment for malnutrition based solely on a nutritionist's note *is not appropriate.* When the nutritionist's assessment indicates malnutrition, the treating physician or health care professional should be consulted to confirm the diagnosis and its significance to patient-care management.

Diagnostic Coding for Malnutrition

ICD-9-CM Codes:	ICD-10-CM Codes:
■ 260 Kwashiorkor ■ 261 Nutritional marasmus ■ 262 Other severe protein-calorie malnutrition ■ 263.0 Moderate degree protein-calorie malnutrition ■ 263.1 Mild degree protein-calorie malnutrition ■ 263.2 Arrested development following protein-calorie malnutrition ■ 263.8 Other protein-calorie malnutrition ■ 263.9 Unspecified protein-calorie malnutrition	■ E40 Kwashiorkor ■ E41 Nutritional marasmus ■ E42 Marasmic kwashiorkor ■ E43 Unspecified severe protein-calorie malnutrition ■ E44.0 Moderate degree protein-calorie malnutrition ■ E44.1 Mild degree protein-calorie malnutrition ■ E45 Retarded development following protein-calorie malnutrition ■ E46 Unspecified protein-calorie malnutrition

Note: the ICD-9-CM index instructs coders to report code ICD-9-CM 260, kwashiorkor for malnutrition (protein only). However *Coding Clinic,* Third Quarter 2009, p. 6, states for code assignment 260, kwashiorkor *must be specifically* documented by the provider. ICD-10-CM will correct this issue by indexing malnutrition (protein only) to E46, unspecified protein-calorie malnutrition.❖

Medical Policy Update

Lists of New, Revised, and Clarified Medical Policies are Now Available Online

Log on to bluecrossma.com/provider, select Manage Your Business>Review Medical Policies>View Medical Policies. In the middle of the page, you will find summaries of Medical and Pharmacy Policy Updates, grouped by the month in which the policy or update is effective. Each month's list is organized alphabetically by policy title. Click on the policy title to view a summary of the update.

FEP Medical Policies Now Online

To view Federal Employee Program Medical Policies, visit fepblue.org and search for Medical Policies.❖

Prescribers of Antipsychotics: New Medical Policy Takes Effect October 1

A new step therapy medical policy for antipsychotic medications, Atypical Antipsychotic Medication Step Therapy Policy 458, will be implemented on October 1, 2013. The policy is intended to direct members to generic medications in this therapeutic class, when clinically appropriate, which may help to save them money on their medications.

Policy Overview

- Applies to new prescriptions for members[1] who are starting on a course of treatment with an antipsychotic medication.
- Members currently taking an antipsychotic may continue receiving that medication without further authorization.
- No prior authorization is required for Step 1 medications (generics)—see list below.
- Step 2 medications will be covered at the point of sale for your patient if pharmacy prescription claim history shows the use of either a Step 1 and/or a Step 2 medication within the past 180 days, or if a current prior authorization has been approved for your patient.
- Step 3 medications require the use of both a Step 1 and a Step 2 medication, or an approved prior authorization request.
- Non-covered medications require an approved formulary exception request and proof of the use of Step 1 and Step 2 medications.

Step therapy/formulary exception requests based exclusively on the use of samples will not be approved. You will need to submit clinical documentation explaining why the higher step drug is necessary.

A full draft version of the policy will be available by request for participating ordering clinicians on September 1, 2013. To request a draft, contact Medical Policy Administration at ebr@bcbsma.com. Information on how you can request individual consideration is available in the medical policy.❖

[1]The member must use our standard, commercial formulary; this policy doesn't apply to Medicare Advantage, Blue MedicareRx, or Federal Employee Program formularies.

Step 1 Medications do not require prior authorization

Step 1 Medications (Generic medications)	Tier (offers the lowest cost-share for our members)
Chlorpromazine	Tier 1
Clozapine/ODT	Tier 1
Fluphenazine	Tier 1
Haloperidol	Tier 1
Lithium Carbonate/ER	Tier 1
Lithium Citrate	Tier 1
Loxapine	Tier 1
Olanzapine	Tier 1
Perphenazine	Tier 1
Quetiapine	Tier 1
Risperidone, M/ODT	Tier 1
Thioridazine	Tier 1
Thiothixene	Tier 1
Trifluoperazine	Tier 1
Ziprasidone	Tier 1

How to request prior authorization or formulary exception

Use ExpressPAth at https://provider.express-path.com (registration required). Or, fax us the *Prior Authorization and Formulary Exception* form that's included at the end of the medical policy.

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