Blue FOCUS

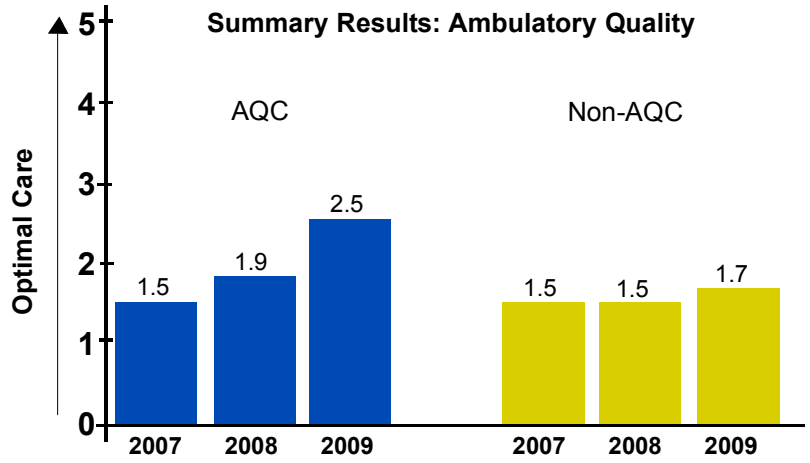
MASSACHUSETTS

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

SPRING 2011

Initial Results of BCBSMA's Alternative Quality Contract Are Promising



**The gate is calculated from a minimum and upper threshold for each measure. Actual performance is converted to 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.

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.

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In This Issue

How to Access Resources Previously on Fax-on-Demand

As a reminder, the only documents we now offer on our Fax-on-Demand system are InterQual® SmartSheets™. All other documents previously accessible through Fax-on-Demand, including our medical policies, are available solely on our BlueLinks for Providers website. (Please note: SmartSheets™ are also available on our website.)

To register for our website, go to www.bluecrossma.com/provider and click on Register Now in the blue box.

About Billing Agencies

Since billing agencies with whom you do business may have also used Fax-on-Demand to request medical policies and other information, be sure to notify them of this change.

Billing agencies that work on your behalf may also register for our website by going to the same link listed to the left. Once they have registered, you will be notified and asked to authorize them to work on your behalf.❖

Member Education

Helping Our Members Understand Their Plans, Make Affordable Choices

We often communicate with you about our ongoing efforts to offer businesses and members affordable choices for quality health coverage. More and more of our members' benefit designs provide incentives to seek care from high-quality, lower-cost providers. This includes hospital admissions, and lab and radiology services.

The Plan Education Center at www.bluecrossma.com/plan-education offers BCBSMA members valuable information and resources to help them make better health care choices.

But offering these plans is only part of the equation. We know that it's equally important for our members to *understand* how their health plan works and how to get the best value from their coverage.

That's why BCBSMA created the Plan Education Center, a comprehensive online resource for our members that helps them to:

- Learn how medical plans and support tools work
- Find out how BCBSMA dental benefits work
- Get information on pharmacy benefits and search for how medications are covered
- Link to health and value-added tools and benefits.

The Plan Education Center also offers information about our tiered network products and the new Hospital Choice Cost-Sharing plan. Members can access a list of higher- and lower-cost facilities, including hospital and non-hospital imaging and lab providers.

What You Can Do

While we are educating our members to discuss lower-cost settings of care with providers, we also encourage primary care providers in our network to initiate these conversations with members, particularly those who have increased financial responsibility. We are also developing tools to help providers identify members who have increased cost-sharing.

And remember—always check eligibility and benefits prior to rendering services. This will help to ensure you have the most up-to-date information on our members (see related article on page 9).

Visit www.bluecrossma.com/plan-education to learn more about the resources and information we are sharing with our members.❖

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.

Focus on Quality

BCBSMA Announces Initial Results of Alternative Quality Contract

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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 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.

"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

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.

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.❖

Pharmacy Update

Updates to BCBSMA's Retail Specialty Pharmacy Network

We recently made the following updates to our retail specialty pharmacy program:

Added five new medications that must be filled through one of the designated pharmacies in our network:

- Carbaglu
- Egrifta
- Halaven
- Krystexxa
- Xgeva.

Added Ascend SpecialtyRx, a specialty pharmacy that recently joined our network and that specializes in fertility medications for our members.

How to contact Ascend SpecialtyRx

Phone: 1-800-850-9122

Fax: 1-800-218-3221

Web: www.ascendspecialtyrx.com.

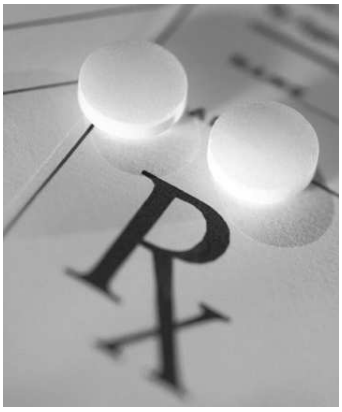
Resources Available on Our Website

To access a complete list of medications that must be filled using a network retail specialty pharmacy, download our *Specialty Pharmacy Medication List* from BlueLinks for Providers.

Log on to www.bluecrossma.com/provider and select Manage Your Business>Search Pharmacy & Info. Then, scroll down to the list.❖

Tips on Registering for ExpressPA, Our Pharmacy Authorization Tool

More provider offices are turning to ExpressPA for instant answers on pharmacy authorization decisions. This web-based tool allows you to submit prescription authorization requests, such as prior authorizations, formulary exceptions, and quality care dosing overrides for commercial members.



Before you begin using the tool, you must first register and activate your account. From our experience with other practices, we offer these tips to help ensure a smooth registration process:

Using your National Provider Identifier (NPI) to register is faster because it will pre-populate your contact information into the system. You'll then need to upload a copy of your NPI, DEA, or state medical license for confirmation.

ExpressPA will e-mail activation information to you; you'll need to respond using the user name and password entered during registration. (Adjust your e-mail settings if necessary so the activation e-mail from ExpressPA is not blocked.)

If you are a nurse or office manager (an agent) using ExpressPA to work on behalf of a prescriber, the prescriber will first need to be registered and activated on ExpressPA. That prescriber must assign privileges to his/her agents.

Agents must register for ExpressPA using the special physician ID number (PPI number) assigned during the prescriber's account activation. Be sure to obtain that PPI from the prescriber.

If there is more than one prescriber in your practice, you will need to register as an agent for each prescriber.

Please note that ExpressPA does not support MAC operating systems; we plan to enhance this functionality in the future.

For more information on the registration and activation process, refer to our *Quick Start Guide*.

Online Resources

To access ExpressPA's website, go to https:\\www.express-pa.com.

To find our *Quick Start Guide*, which contains helpful information on the registration process, log on to www.bluecrossma.com/provider and select Technology Tools; then scroll down to ExpressPA and click on Learn more.❖

Pharmacy Update

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. Use of the preferred network is encouraged, although not required.

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.*

Medicare News

Medicare Advantage Member Health Risk Assessments Planned

BCBSMA has selected Matrix Medical Network (Matrix) to conduct health risk assessments (HRAs) for our Medicare Advantage members receiving both short-term (sub-acute) and long-term (custodial) care in skilled nursing facilities and nursing homes.

Matrix specializes in assessing and formally documenting the health status of members in the nursing home, skilled nursing facility, and home settings.

Matrix nurse practitioners and physician assistants will see members in these settings in 2011 and will complete comprehensive HRAs of high-risk members.

These HRAs include a face-to-face bedside visit to assess clinical conditions, and they can determine which patients may benefit most from health management interventions.

Results of the completed HRAs will be shared with Medicare Advantage members' primary care providers and providers of choice to address any required follow-up.

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

Coding Corner

How to Code Diabetes Mellitus When Associated Conditions Exist

We understand that assigning the correct ICD-9-CM code for diabetes mellitus and associated conditions can be challenging.

Patients with diabetes mellitus are susceptible to one or more complicating associated conditions that particularly affect the cardiovascular, renal, nervous, and peripheral vascular systems, as well as the feet and eyes. The onset of symptoms may be early or late in the course of the diabetes.

For diabetes mellitus, the correct ICD-9-CM category is 250. In addition, the following are required:

A fourth digit to identify any condition or manifestation associated with diabetes

A fifth digit to identify Type 1 or Type 2 diabetes and whether the diabetes is controlled or uncontrolled

The ICD-9-CM Official Guidelines for Coding and Reporting Effective October 1, 2010 provides instructions on coding conditions that have an underlying cause and associated condition by use of "etiology/manifestation" code combinations.

For many codes under category 250, an additional code must be included for any associated diabetic condition or manifestation. The ICD-9-CM index lists the diabetes code first, followed by the manifestation code in brackets.

Example

A 75-year-old male patient with Type 1 diabetes is admitted with a chronic obstructive pulmonary disorder (COPD) exacerbation.

During the admission history and physical, the patient also complains of blurred vision and admits he hasn't had an eye exam in two years. The consulting ophthalmologist diagnoses the patient with proliferative diabetic retinopathy.

To fully report the patient's diabetic status, the claim should be coded with both of the following ICD-9-CM codes:

250.51 (Type I diabetes with ophthalmic manifestations)

362.02 (Proliferative diabetic retinopathy).❖

Office Staff Notes

Submitting the Right Documentation for Individual Consideration Appeals

If you submit an appeal for individual consideration (IC), be sure to include all of the required documentation to support your appeal.

The charts below provide several examples to help give you an idea of what documentation is required for us to conduct a complete medical review of your appeal. By following these guidelines, you can help to expedite the process.

Questions?

For more information on appeals, please refer to Section 4: Reviews and Appeals of your *Blue Book* manual.

To access the *Blue Book* online, log on to www.bluecrossma.com/provider and click on Resource Center>Admin Guidelines & Info>Blue Books.❖

For an appeal involving:	Follow These Guidelines:
A "Not Otherwise Classified" (NOC) code	Include all reports that document the service rendered along with a detailed description of services performed (e.g., operative report). The entire medical record is not required when appealing a NOC code.
Denials based on medical technology assessment criteria or our medical policy guidelines	Submit relevant clinical information according to medical policy coverage criteria.
Multiple lesion removal	Submit legible office notes documenting the lesion location, size, and number, and the pathology report, if available.
Blepharoplasty/brow ptosis	Submit documentation of the functional impairment, visual field reports (taped and untaped), and pre-operative photos, if available.
Scar revision	Submit documentation of pain or interference with normal bodily function.

For a service within one of these CPT code ranges:	This documentation is required when you submit an individual consideration appeal:
00100-01999	Anesthesia record
10021-69990	Operative note; procedure note
70010-77084	Radiology report
77261-77799	Medical note; treatment record
78000-79999	Radiology report
80047-89398	Laboratory report; pathology report
90281-99499; J drug codes	Medical note; procedure note; radiology report; invoice (*whichever applies*)

Where to Send Individual Consideration Appeals

Please send all appeals for individual consideration to:

Blue Cross Blue Shield of MA
Provider Appeals
P.O. Box 986065
Boston, MA 02298

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.

The Department of Health Care Financing and Policy (DHCFP) concluded recently 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 this costly over-utilization can be addressed through an alternative care setting—an Urgent Care Center (UCC) network. This new network will soon be available to our HMO, PPO, Indemnity, and Medicare Advantage (Medicare HMO Blue® and Medicare PPO Blue℠) members 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 freestanding 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.* dated January 17, 2011 for more details. To view the *F.Y.I.* online, log on to www.bluecrossma.com/provider and click on News for You> FYIs. (Choose *F.Y.I.* PC-1435).❖

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

BCBSMA's Member Rights and Responsibilities Statement Is Available on Our Website

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 BlueLinks for Providers at www.bluecrossma.com/provider and click Resource Center>Admin Guidelines & Info>Blue Books.

Under the Facility Blue Book listing, select Appendix> Member Education.

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

ClaimCheck™ Will Be Updated On Our Website

BCBSMA will implement the latest version of ClaimCheck claims editing software this spring.

To access our Internet-based code auditing tool, log on to our website at www.bluecrossma.com/provider and click on Manage Your Business>Use Clear Claim Connection. Then, enter your NPI for secure access to code editing policies, rules, and clinical rationale.❖

Streamlined Appeals Process Is Coming Soon

Through our involvement in the Massachusetts Healthcare Administrative Simplification Collaborative, BCBSMA is working with other payers, the Massachusetts Hospital Association, the Massachusetts Medical Society, Employers Action Coalition on Healthcare (EACH), and others to simplify the appeals process for denied claims. Coming soon:

- All appeal definitions will be standardized among all Massachusetts payers.
- When requesting a claim review, providers will be able to use the same form for all Massachusetts payers.
- A reference guide will be available to help providers who are submitting appeals.

We will keep you posted on this change in *Blue Focus* as more details become available.❖

Office Staff Notes

Always Check Benefits and Eligibility to Determine Member Cost-share

Since we've introduced several new benefit designs, and with the introduction of National Health Care Reform (NHCR), we'd like to remind you to use our technologies to check benefits and eligibility before performing services.

With NHCR, many preventive services will no longer have a cost-share. (Note: this change becomes effective at different times for our employer accounts, and some accounts can opt out of these provisions). Also, some of our employer accounts choose to customize benefits, including making choices about the copayments that our members pay for services, like diagnostic laboratory tests and imaging services.

Questions About Our Technologies?

To learn more about the technologies available to check benefits and eligibility, log on to our website at www.bluecrossma.com/provider and select Technology Tools. Click either Online Services or NEHEN*Net* and select Learn More to find out how these tools can be used 24 hours a day, 7 days a week.

National Health Care Reform Resources

Our online National Health Care Reform Information Center at www.bluecrossma.com/national-health-care-reform offers helpful information for providers, members, and employers, including a fact sheet about expanded coverage of preventive services. To find the fact sheet, click on News & Updates, then scroll down and click on the Expanded Coverage link (dated October 21, 2010)❖

Members with Questions Should Always Call Our Dedicated Member Service Number

As a reminder, our Provider Services number, 1-800-882-2060, is set up exclusively for providers to call with claim-related issues.

When our members have questions about their coverage or claims, please refer them to the Member Service number located on the back of their ID card. By referring members to the appropriate number, our Provider Services associates can devote more time to helping providers with complex claim issues, when necessary.❖

Communicating With You Regarding Overpayments

We've recently made improvements in the way that we communicate claim overpayments to you.

In addition to the current information that you receive from us, such as new *Provider Detail Advisories* and a *Claims Recovery Invoice*, in many cases you will now also receive a letter from us that provides you with notice of a claim overpayment.

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

Updated *Quick Tips* Are Available on Our Website

We have updated the following *Quick Tips*, which are available on BlueLinks for Providers:

- *Checking the Status of a Claim*
- *Verifying a Member's Medical Eligibility*

To access our *Quick Tips*, log on to www.bluecrossma.com/provider and click on Resource Center> Admin Guidelines & Info>Quick Tips.❖

Revised Radiology Privileging Requirements for Cardiac CT Studies, Effective April 1

BCBSMA has privileging criteria in place for radiologists to officially interpret cardiac CT (CCT) studies. Currently, one of our requirements is that radiologists interpret at least 50 studies per year to maintain privileging status.

To align with criteria of the America College of Radiology, effective April 1, 2011, we revised our criteria to require radiologists to interpret 75 studies over 36 months to maintain privileging status.

If you have any questions, or if you need to send documentation to us related to privileging, please send a fax to 617-246-7771.❖

Ancillary News

Update on Our Skilled Nursing Facility Incentive Program

In early January, we e-mailed SNFs about the online availability of reporting templates for the 2011 SNF Incentive Program. We recommend using the templates throughout the data collection period (January 1, 2011 – June 30, 2011) so that you can easily track your facility's information. Then, when you use our online reporting tool to report your data, you will be able to paste the information directly from your desktop into the reporting tool.

For other best practices for submission, a timeline, and important information about the program, please refer to our *Frequently Asked Questions* document (see chart).

We'd also like to remind you that you are required to submit information on the performance tracking and process measures using our online reporting tool. Your submission is due by July 15, 2011; data submitted after this date will not be accepted.❖

Program Tools & Information

This resource:	Can be used to:	And you can access it by logging on to www.bluecrossma.com/provider and:
Reporting templates	Begin tracking data now before submitting it to us via our online tracking tool	From the blue box on the right-hand side of the home page, select *SNF Incentive Program 2011*.
Frequently Asked Questions	Learn answers to your most frequently asked questions about the program. Best practices and a timeline are also included.	
Find-a-Doctor online directory	Find a participating ambulance provider for member transports	Select Manage Your Business> Find a Doctor>Find Other Medical Services/Supplies. Be sure to select the member's network plan from the drop-down menu and select Ambulance from the specialty drop-down selection.
eNews announcements	Provide you with important updates and reminders about the program	From the home page, click Edit My eNews Subscriptions. Then select FYIs, newsletters, and General News & Updates to receive news of the SNF Incentive Program *Note:* Registered BlueLinks for Providers user are not automatically enrolled to receive eNews announcements. You must go through the process of opting to receive these e-mails from us.

Ancillary News

Clinical Laboratories and Durable Medical Equipment Providers: BlueCard® Program Claims for Services Rendered Outside of Massachusetts

When you provide services outside of Massachusetts to members of BCBSMA or other Blue Cross Blue Shield plans across the country (out-of-area BlueCard Program claims), we ask that you submit claims to the local Blue plan.

We'd like to clarify which plan is considered to be local for clinical laboratories and durable medical equipment (DME) providers.

How to Submit Claims for Blue Cross Blue Shield Members

Please submit claims to the plan in the area where the services are rendered. Here is how these claims will be processed:

If you have a provider contract in place with the local Blue plan, the claim must be filed to the local plan, and it will be considered a participating provider claim.

If you do not have a provider contract in place with the local Blue plan, the claim still must be filed to the local plan, but it will be considered a non-participating provider claim.

Resources

For information on out-of-area programs, please refer to our *Blue Book* administrative manual, available online. Simply log on to www.bluecrossma.com/provider and select Resource Center> Admin Guidelines & Info.

Or, to access our *BlueCard Program* audio-visual training, click Resource Center>Training & Registration>Course List. Select BlueCard Program from the Ancillary sub-heading. ❖

Example

A BCBSMA member has her lab specimen drawn in California and sent to a Massachusetts lab for analysis.

How your claim will process:

Submit the claim to the California Blue plan. If you have an agreement with the California Blue plan, the claim will process as a participating provider claim. If you do not have an agreement with the California Blue plan, it will process as a non-participating provider claim.❖

For this type of provider:	The local plan is defined as:
Clinical Laboratory	The plan in the service area where the specimen was drawn
DME provider	The plan in the service area where the equipment was shipped or purchased at a retail store.

New Fax Number for *Short-Term Rehabilitation Speech Therapy Extension Request Form*

We recently updated one of our fax numbers for submitting authorization extension requests for speech therapy services for our members. When using the *Short-term Rehabilitation Speech Therapy Extension Request Form*, please fax the completed form to 1-866-577-9901.

Please refer to the form for the correct fax information.

To download a copy of the updated form, log on to our website at www.bluecrossma.com/provider and select Resource Center> Forms>Authorization Forms.

We appreciate your help in directing these requests to the correct fax number.❖

Medical Policy Update

All updates will be available on our website. Go to www.bluecrossma.com/provider and click on Medical Policies.

Changes

Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting, 287. New medical policy describing ongoing non-coverage for commercial products and for Medicare HMO Blue® and Medicare PPO Blue℠ and ongoing coverage of thoracic electrical bioimpedance for Medicare HMO Blue and Medicare PPO Blue. Also adding diagnosis editing on claims. Effective 11/10/10.

Catheter Ablation of Arrhythmogenic Foci, 123. Removing Holter monitoring from title and body of policy and revising coverage and non-coverage criteria. Effective 7/1/11.

Corneal Topography/Computer-Assisted Corneal Topography/Photokeratoscopy, 301. New medical policy describing non-coverage of this procedure. Effective 5/1/11.

Infertility Diagnosis and Treatment, 086. Adding infertility treatment for a member with recurrent pregnancy loss in accordance with Massachusetts law (M.G.L.c. 175, section 47H and 211 C.M.R 37.09). Effective 12/15/10.

Injectable Clostridial Collagenase for Fibroproliferative Disorders, 225. Adding coverage for this procedure only for Medicare Advantage members who meet the criteria noted in the policy. Effective 1/15/11.

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

Radioembolization for Primary and Metastatic Tumors of the Liver, 292. New medical policy describing covered and non-covered indications for this procedure. (Information currently listed in medical policy 278, *Intraoperative Radiation Therapy*, will be moved to this policy.) Effective 4/1/11.

Radioimmunotherapy in the Treatment of Non-Hodgkin's Lymphoma, 146. Adding an additional indication. Effective 4/1/11.

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 condition-specific policies.

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 fecal incontinence. Similar information removed from medical policy 072, *Incontinence Therapy*.

Biofeedback for Miscellaneous Indication, 187. Clarifying ongoing non-coverage for sleep bruxism and motor function after stroke or brain injury.

Bone Turnover Markers for Diagnosis and Management of Osteoporosis, 549. 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*.

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

439, Cognitive Rehabilitation. In Fall 2010 *Blue Focus*, we announced that effective January 1, 2011, we would be adding coverage of cognitive rehabilitation for traumatic brain injury when specific conditions are met for specific diagnoses. Please note that we are postponing implementation of this coverage until further notice.

Computerized 2-lead Resting Electrocardiogram Analysis for the Diagnosis of Coronary Artery Disease, 312. 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*.

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.

Dermatoscopy, 519. 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*.

Medical Policy Update

Clarifications, continued

Dynamic Posturography, 263. Updating with revised formatting and references.

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*.

Electrocardiographic Body Surface Mapping, 289. 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*.

Endobronchial Valves, 313. Clarifying non-coverage.

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*.

Fetal Fibronectin Enzyme Immunoassay, 298. New medical policy describing covered and non-covered indications for this test. The same information will be removed from medical policy 043, *Preventing Premature Delivery*.

Genetic Testing for Cutaneous Malignant Melanoma, 300. New medical policy describing ongoing non-coverage of this test. The same information will be removed from clinical recommendation document 365, *Genetic Testing & Counseling*.

Genetic Testing for Helicobacter Pylori Treatment, 288. New policy describing ongoing non-coverage of this procedure. The same information was removed from clinical recommendation document 365, *Genetic Testing and Counseling*.

Heart Transplants, 197. Clarifying coverage and non-coverage statements for patients with histories of cancer.

Heart-Lung Transplants, 269. Clarifying coverage and non-coverage statements related to patients with histories of cancer.

Hematopoietic Stem Cell Transplantation for Breast Cancer, 213. Clarifying coverage according to the Massachusetts state mandate.

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

H-wave Electrical Stimulation, 311. 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* and in medical policy 083, *Spinal, Vagal, Deep Brain, Cerebellar Stimulation*.

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

Infertility Diagnosis and Treatment, 086. Updated benefit exclusions and specialty pharmacy information in the Designated Retail Specialty Pharmacy Network section.

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

Insulin Potentiation Therapy, 532. 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*.

Interferential Stimulation for Treatment of Pain, 509. 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*.

Intravenous Anesthetics for the Treatment of Chronic Neuropathic Pain, 291. New medical policy describing ongoing non-coverage of this procedure.

In Vivo Analysis of Colorectal Polyps, 521. 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*.

KRAS Mutation Analysis in Metastatic Colorectal Cancer, 104. Changed to KRAS and BRAF Mutation Analysis in Metastatic Colorectal Cancer. Also clarified ongoing non-coverage of BRAF mutation analysis and updating references and procedure-to-diagnosis editing.

Laboratory Tests for Heart Transplant Rejection, 530. 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*.

Clarifications, continued on page 14

Medical Policy Update

Clarifications, continued

Medical Technology Assessment Non-Covered Services, 400. Clarifying non-coverage of the following:

Transoral gastroplasty (TOGA®˝) system for gastric stapling.

3-D tomosynthesis imaging of the breast for screening or diagnostic purposes (e.g., Selenia technology).

ScoliScore™ AIS (adolescent idiopathic scoliosis) prognostic DNA-based test.

Treatment of chronic cerebrospinal venous insufficiency (also known as liberation treatment).

Microarray-Based Gene Expression Testing for Cancers of Unknown Primary, 614. 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*.

MRI; MRA; MRV; MRS; Positional Magnetic Resonance Imaging; and Functional MRI, 106. Clarifying coverage of MRA for complex migraine headache with suspicion of a structural lesion.

MRI of the Breast, 230. In Fall 2010 *Blue Focus*, we announced that effective December 1, 2010, we would be excluding coverage for personal history of ovarian cancer and for family history of ovarian cancer. *Please note:* we are continuing coverage for these indications.

Neurofeedback, 515. New medical policy describing ongoing non-coverage of this procedure. Similar information removed from medical policy 423, *Outpatient Psychotherapy*.

Paraspinal Surface Electromyography (SEMG) to Evaluate and Monitor Back Pain, 517. 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*.

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.

Positron Emission Tomography (PET) Scans, 358. Clarifying non-coverage of vasculitis.

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*.

Preventing Premature Delivery, 043. Changed policy name to *Home Uterine Activity Monitoring*; removed information on salivary estriol testing, which continues to be non-covered.

Radiofrequency Ablation of Pulmonary Veins for Treatment of Atrial Fibrillation, 141. Clarifying ongoing non-coverage of cryoablation of pulmonary veins for treatment of atrial fibrillation. Also changing policy title to *Catheter Ablation of Pulmonary Veins for Treatment of Atrial Fibrillation*.

Radiofrequency Facet Joint Denervation, 140. Clarifying:

Non-coverage of pulsed radiofrequency denervation.

The number of required nerve blocks from 3 to 2.

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*.

Serum Biomarker Human Epididymis Protein 4 (HE4), 290. 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*.

Serum Holotranscobalamin as a Marker of Vitamin B12 (Cobalamin) Status, 561. 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*.

Speculoscopy, 568. 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*.

Spinal, Vagal, Deep Brain, Cerebellar Stimulation, 083. Removing information on H-wave electrical stimulation; information moved to new medical policy 311, *H-wave Electrical Stimulation*.

Subtalar Arthroereisis, 299. New medical policy describing 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*.

Medical Policy Update

Clarifications, continued

Temporary Prostatic Stent, 531. 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*.

Thermal Capsulorrhaphy as a Treatment of Joint Instability, 591. New medical policy describing ongoing non-coverage of this procedure, which. 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*.❖

Pharmacy Medical Policy Update

Angiotensin II Receptor Antagonists, 012. Including coverage for losartan and losartan/hctz as Step 1 medications. Effective 5/1/11.

Bisphosphonates Infusion/Injection, 061. Including coverage of Reclast®˝ for FDA-approved indication of prevention of osteoporosis/osteopenia (ICD-9-CM 733.90). Effective 5/1/11.

Botulinum Toxin, 006. Including the following coverage criteria for Botox®˝ for new FDA-approved indication of chronic migraine. Effective 5/1/11:

- Age 18 years or older
- Prescribed by a neurologist or pain specialist
- Chronic migraine defined as episode of migraine 15 days/month with four hours/day pain duration
- Previous treatment with or contraindication to at least a 3-month trial of each of the these therapeutic categories: Beta blockers (propranolol, timolol), topiramate, divalproex sodium, non-steroidal anti-inflammatory drugs, and serotonin receptor agonists.

Gilenya™ (Fingolimod), 295. New medical policy describing coverage of Gilenya. Effective 5/1/11. Criteria include:

- Documented diagnosis of relapsing form of multiple sclerosis including relapsing-remitting
- Prescribed by a neurologist
- Secondary progressive with relapses and progressive relapsing
- Previous treatment failure with one of the following: interferon beta-1a IM (Avonex®˝), interferon beta-1a SC (Rebif®˝), interferon beta-1b (Betaseron®˝, Exatvia®˝), or glatiramer acetate (Copaxone®˝).

New Drug Approval Program, 005. Clarifying approval of new-to-market medications during the evaluation period. These medications will continue to be non-covered until the evaluation process is completed. Providers may request a medical necessity exception during the evaluation process; approval will be based on the FDA-approved indications. For exception requests for a new-to-market medication for a non-FDA approved indication, individual consideration will be applied and providers must submit supporting clinical documentation for review. Effective 5/1/11.

Repository Corticotropin Injection (H.P. Acthar®˝ Gel), 294. New medical policy describing coverage of H.P. Acthar gel. Effective 5/1/11. Criteria include:

- Treatment of infantile spasm (West Syndrome)
- Diagnostic testing of adrenocortical function
- Treatment of corticosteroid-responsive conditions after failure with or contraindication to corticosteroids.❖

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