Blue FOCUS

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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

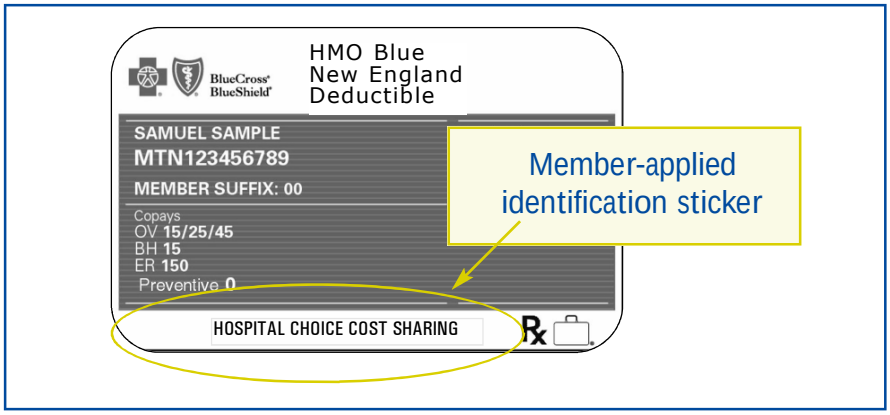
SUMMER 2011

Identifying Hospital Choice Cost-Sharing Members: Helpful Tips for Providers

As health care costs continue to increase, individuals, families, and employers are looking to us to do our part to make health care more affordable. That's why we are committed to providing them with the choices and flexibility they need to get the highest quality health care at the most affordable price.

One of these options is our Hospital Choice Cost-Sharing benefit design. More than 31,000 BCBSMA members are enrolled in a plan with this feature, and those numbers are expected to increase.

Because benefit designs like Hospital Choice Cost-Sharing are different from traditional HMO plans, one of our top priorities is educating both members and providers about this feature.



Our member education efforts have included outreach communications and our Plan Education Center—a one-stop, online tool to help them better understand costs, research options, and encourage them to make choices collaboratively with their physicians. It's also important for you to know which members have this benefit design so you can communicate with them about the most cost-effective and appropriate choices for them.

Here are some of the ways you can identify Hospital Choice Cost-Sharing members and better understand their benefits.

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In This Issue

Have You Started Preparing for HIPAA Version 5010?

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

All entities conducting electronic claim submissions, claim status requests and responses, referral/authorization requests and responses, eligibility/benefit requests and responses, and claim remittances will be required to use Version 5010. BCBSMA is targeting to begin external testing in Q3 2011.

All testing must be completed by December 31, 2011, as the new Version 5010 will be adopted January 1, 2012.

Questions?

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

Pharmacy Update

ExpressPA Now Accepts Prescription Authorization Renewal Requests

Through our pharmacy benefit manager, Express Scripts, Inc., we offer prescribers an online tool, ExpressPA, to submit requests for retail prior authorization, quality care dosing, and formulary exceptions.

ExpressPA was recently enhanced to allow prescribers the ability to renew an existing authorization before it expires. This enhancement to the web-based tool allows minimal disruption for your patient's therapy.

Once you've logged onto the site, simply click Initiate an Appeal or Renewal and follow the instructions. You'll see details about your existing request and will then be prompted to enter updated information about the renewal.

An immediate response will be posted once you have entered all the required information. If further clinical review by BCBSMA is necessary, the system will indicate this in the response.

For more details on the renewal process or to learn how to register for ExpressPA, please refer to our *Quick Start Guide*, available online. Simply log on to our website at www.bluecrossma.com/provider and click on Technology Tools> ExpressPA>Learn More.❖

ExpressPA's new "Initiate an Appeal or Renewal" option allows you to renew an existing authorization before it expires.

Payment Policy Update

Our Provider Payment Policies Are Available on BlueLinks for Providers

To access BCBSMA's provider payment policies, log on to www.bluecrossma.com/provider and click on Manage Your Business>Access Payment Policies.

Please note that BCBSMA's provider payment policies determine the rationale by which a submitted claim for service is billed, processed, and paid by BCBSMA.

Our payment policies do not contain information on coding services; however, they do provide links to applicable websites where you can find more information.❖

Billing Notes

Important Update on the Use of Modifier 50 on UB-04 Claims

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

This includes the acceptance of modifiers on UB-04 claims.

Effective August 1, 2011, UB-04 claims will be processed using the industry standard methodology for submitting services provided bilaterally, when appropriate.

Previously, when submitting a claim for bilateral services, facilities were required to submit the service on two separate lines.

The payment was then made at 100% of the contracted fee schedule amount for the first line and 50% of the contracted fee schedule amount for the second line.

Effective for claims we receive on or after August 1, 2011, please be sure to follow the industry standard methodology of submitting the service on one line with modifier 50; reimbursement will be 150% of the contracted fee schedule amount.

Please note that we will not make retroactive changes for claims submitted prior to August 1, 2011.

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.

Modifiers that affect payment should be placed in the first modifier field.❖

Update on BCBSMA's Provider Audit Notification Process

BCBSMA will be expanding our relationship with Connolly Inc. to assist us in conducting provider audits.

As part of our efforts to help manage the cost of health care for our members and employers, Connolly will support our Provider Audit team to help ensure accurate billing and payment for services performed.

Connolly will follow the same audit process outlined in our *Blue Book* manual, and will perform the following types of provider audits:

- Inpatient DRG validation and bill audit
- Outpatient hospital
- Non-participating/non-contracted for all provider type and specialties
- Pay subscriber claims.

Notification letters are being sent to impacted providers starting in the third quarter of 2011 to either request documentation or to schedule on-site visits.

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

Office Staff Notes

The Importance of Medical Record Documentation Reviews

In accordance with your BCBSMA Agreement, there are times when we may request copies of your medical records for internal review for various reasons, such as:

- Quality assessment or improvement activities
- Billing accuracy
- Utilization review requirements
- Compliance with state and federal review regulations.

This may include information from electronic medical records as well.

Continuity of Care Is Important

Consistent communication of important patient information among physicians and sites of care plays an important role in facilitating safe quality care, reducing medical errors, and strengthening the transition of care for members. Developing the right systems and processes can enhance this communication.

To help meet guidelines set by the National Committee for Quality Assurance (NCQA), BCBSMA evaluates these systems by reviewing PCP office medical records annually. Documents such as operative notes, discharge summaries, referral consultations, and follow-up reports provide key treatment summaries, helping primary care providers maintain a consistent plan of care and be fully engaged in all aspects of the patients' medical conditions.

Results from Our 2010 Review

Our 2010 records review shows significant improvement in relation to patient care documentation provided to PCPs by facilities and other providers.

By reviewing current processes of how PCPs receive follow-up documentation on their patient's treatment and future plan of care, we are able to analyze key quality issues such as, medical errors, high readmission rates, and patient satisfaction.

We look forward to working with all providers on medical record reviews toward the common goal of improved outcomes for our members.

For More Information

More details on our medical record guidelines can be found in Section 2: Utilization Management of your *Blue Book* manual, which is available on our BlueLinks for Providers website. Log on to www.bluecrossma.com/provider and click on Resource Center> Admin Guidelines & Info>Blue Books.❖

Keep BCBSMA Updated on NPI Changes

To avoid claim payment delays, be sure to notify BCBSMA should there be any change to your current national provider identifier (NPI) or if a new provider joins your practice/facility and has a new NPI. It's important that we keep our systems updated with the most current NPI information. You can either fax NPI information to 617-246-7771, or call our Network Management and Credentialing Services team at 1-800-419-4419.❖

Visit Function to Be Discontinued for Our Technologies

In preparation for the implementation of HIPAA Version 5010, BCBSMA has been reviewing the utilization of our technology tools. During this process, we found that the Record a Patient Visit function—currently available on Emdeon Office, the Point of Service device, and InfoDial®—has a low utilization rate by providers.

In an effort to streamline our processes, starting in fall 2011, we plan to eliminate the Record a Patient Visit function.

We encourage you to use the following functions, which are also currently available when using these technologies:

- Eligibility Request: Can be used to check eligibility
- Service Review Inquiry: Can be used to check for the presence of a referral, outpatient authorization, or inpatient authorization.

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

Office Staff Notes

BCBSMA Improves Response Time for BlueCard® Program Appeals

BCBSMA recently implemented an automated process that has significantly streamlined our communication with other Blue Cross Blue Shield (BCBS) plans regarding claims issues.

Now when you submit an appeal related to an out-of-area BCBS member, our system is able to identify claim responses we receive from the other BCBS plan quickly, allowing our Provider Services associates to resolve issues for you in a more timely manner.

You will continue to receive Provider Detail Advisories (PDAs) for adjusted claims, as well as other correspondence with the out-of-state plans' responses when adjustments are not warranted. This is typically generated within three to five business days of the member's home plan's response.

We encourage you to use our technologies to check the status of your claim. To learn more about the BlueCard Program, see the chart below.❖

To access:	Log on to www.bluecrossma.com/provider and click on:
The dedicated BlueCard Program section of our website	The BlueCard Program link in the blue box on the right-hand side of the home page.
BlueCard Program information in your *Blue Book* manual	Resource Center>Admin Guidelines & Info>Blue Books; under the Professional *Blue Book* listing, click on Billing and Reimbursement> Out-of-Area Programs.
An online presentation about the BlueCard Program	Resource Center>Training & Registration>Course List; under the menu for your provider type, click on The BlueCard Program.

New Form for Submitting Appeals to BCBSMA, Other Payers

You can now submit appeals to us using the *Request for Claim Review Form*. The form and its accompanying *Reference Guide* was developed by the Massachusetts Health Care Administrative Simplification Collaborative* to streamline the claim review process, and may be used to submit appeals to these participating health plans:

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

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

Important: the new multi-payer form will replace our *Provider Appeal Form*, effective October 1, 2011.❖

** The Mass. Health Care Administrative Simplification Collaborative, a multi-stakeholder group committed to reducing health care administrative costs, includes: BCBSMA, HCAS, the Employers Action Coalition on Healthcare, Mass. Association of Health Plans, Mass. Health Data Consortium, Mass. Hospital Association, Mass. Medical Society, Harvard Pilgrim Health Care, Tufts Health Plan, Neighborhood Health Plan, Network Health, Fallon Community Health Plan, Health New England, Boston Medical Center HealthNet Plan, MassHealth, Unicare, Wellpoint, UnitedHealthcare, Partners HealthCare, Winchester Hospital, North Adams Regional Health Center, Jordan Hospital, Harrington Hospital, Baystate Medical Center, & Atrius Health.*

Copayments Have Been Added for Some Medex® members

Effective July 1, 2011, large and small accounts that offer Medex with medical and pharmacy benefits (OBRA) now have the option to add copayments.

For accounts that choose to add a copayment, the copayment amount will show on the front of the member's BCBSMA ID card.

As always, be sure to check eligibility and benefits to determine a member's appropriate cost-share amount.❖

Office Staff Notes

Change in Reimbursement for Certain Non-Participating Ambulance Services

In the Fall 2010 issue of *Blue Focus*, we reported we would be updating our reimbursement policy for services rendered by non-participating providers as it pertains to ambulance services.

We remind you that effective March 14, 2011, we began paying claims directly to our subscribers for services rendered on or after November 15, 2010 for any ambulance services provided by privately owned for-profit ambulance providers and ambulance services provided by Children's Hospital*.

This includes payment for emergent *and* non-emergent services.

A non-participating provider is defined as a provider who does not have a contract with BCBSMA for the member's product.

We will continue to pay municipally owned and operated (town) ambulance providers, and privately owned not-for-profit providers (excluding Children's Hospital*), directly for all ambulance services provided to our members.

See chart for a summary of ambulance payment guidelines (retroactive to November 15, 2010).

Questions?

If you have any questions, please call your Network Manager.❖

For this type of Ambulance Service:	BCBSMA will reimburse:
Non-participating privately owned, for-profit ambulance services (not owned by municipalities)	The subscriber directly
Children's Hospital*	The subscriber directly
Privately owned, not-for-profit ambulance providers, with the exception of Children's Hospital*	The ambulance provider directly
Municipally owned and operated ambulance companies (ambulance services run by local towns and cities in Massachusetts)	The ambulance provider directly

Exceptions to BCBSMA's Non-participating Provider Reimbursement Policy

We'll continue to reimburse non-participating providers directly for the following types of claims:

- Indemnity
- Blue Choice® 1
- HMO Blue New England℠, Blue Choice New England℠, and Access Blue New England℠ members who have a PCP outside of Massachusetts
- Medicare products and Medicaid
- Veteran's Administration services
- Federal Employee Program
- Owned and operated municipal ambulance services
- Dental products
- Privately owned, not-for-profit ambulance companies (except Children's Hospital Ambulance*)
- BlueCard® Program claims that originated from the following provider types:
  - A Massachusetts non-contracted provider—this may result in payment to the subscriber based on the subscriber's benefits
  - A Massachusetts participating provider (who has some type of contract with BCBSMA)—this may result in payment to the provider based on the subscriber's benefits.❖

**Children's Hospital operates an ambulance service (private not-for-profit) that does not contract with us for all products. The other private not-for-profit ambulance providers are operated by municipalities and are excluded from this initiative.*

Office Staff Notes

Identifying Hospital Choice Cost-Sharing Members: Helpful Tips for Providers

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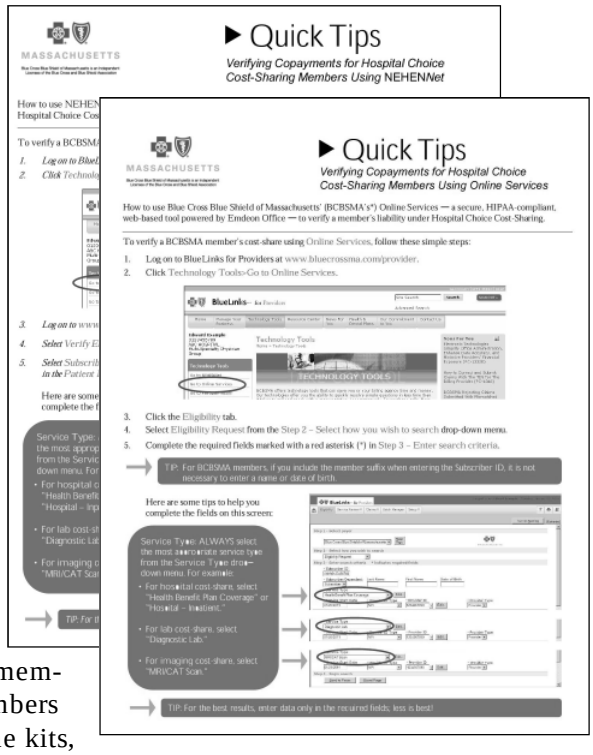
Member ID Cards

ID cards for these members currently do not indicate "Hospital Choice Cost-Sharing." In the future, we plan to provide these members with ID cards with the Hospital Choice Cost-Sharing information printed on them. Until then, we are providing these members with a sticker to adhere to the bottom of their ID card, which identifies them as member with this benefit design. (See sample ID card on page 1.)

Provider *Quick Tips*

We have developed two *Quick Tips* to help you understand how to verify cost-sharing for these members using Online Services and NEHEN*Net*. The *Quick Tips*, which you can download from our website, provide step-by-step instructions and visuals to help you identify members with this benefit design.



Provider Training

We encourage you to view our online presentation, *BCBSMA Hospital Choice Cost-Sharing Overview*, which provides information on cost-share amounts for lower- and higher-cost-share hospitals, a list of higher-cost-share hospitals, and tips for determining the member's cost-share. We also talk about how we're educating our members about Hospital Choice Cost-Sharing through phone calls, welcome kits, e-mails, and the Plan Education Center.

Questions?

Refer to the chart below for instructions on accessing Hospital Choice Cost-Sharing tools online. Or, if you have any questions after reviewing these tools, please call Network Management Services at 1-800-316-BLUE (2583).❖

Hospital Choice Cost-Sharing Resources for Providers

To access:	Follow these instructions:
Our *Quick Tips* for Online Services and NEHEN*Net*	Log on to www.bluecrossma.com/provider and click on Resource Center>Admin Guidelines & Info>Quick Tips.
The *Hospital Choice Cost-Sharing Overview* presentation	Log on to www.bluecrossma.com/provider and click on Resource Center>Training & Registration. Under the All Providers drop-down menu, select the course title.
The Hospital Choice Cost-Sharing section of our Plan Education Center	Go to www.bluecrossma.com/hospitalchoice and click on HCCS Planning Guide on the left-hand side. Scroll to the bottom of the page for lists of: Lower- and higher-cost hospitals Lower-cost freestanding labs and imaging facilities.

Medical Policy Update

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

Changes

Acute and Maintenance Tocolysis, 518. Excluding coverage for maintenance tocolysis therapy via home infusion. Effective 9/1/11.

Endovascular Procedures (Angioplasty and/or Stenting) for Intracranial Arterial Disease (Atherosclerosis and Aneurysms), 323. New policy adding coverage for angioplasty and stenting of intracranial vessels for aneurysms for commercial products. Information on endovascular procedures (angioplasty and/or stenting) for intracranial arterial disease (atherosclerosis and aneurysms) was removed from medical policy 077, *Percutaneous Transluminal Angioplasty*. Effective 11/1/11.

Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Patients with Non-Small Cell Lung Cancer (NSCLC), 563. New medical policy adding coverage of analysis of two types of somatic mutation within the EGFR gene—small deletions in exon 19 and a point mutation in exon 21 (L858R) to predict treatment response to erlotinib in patients with advanced NSCLC. Effective 9/1/11.

Hematopoietic Stem Cell Transplantation for Non-Hodgkin Lymphomas, 143. Adding explicit coverage and non-coverage indications for mantle cell lymphoma, and revising coverage and non-coverage indications for peripheral T-cell lymphoma. Effective 11/1/11.

Implanted Devices for Deafness: Cochlear Implants; Implantable Bone-Conduction Hearing Aid [Bone Anchored Hearing Aid (BAHA)]; and Auditory Brainstem Implant Semi Implantable Hearing Aid, 087. Removing the requirement for a hearing-aid rider for implantable bone-conduction devices. Effective 9/1/11.

Medical Technology Assessment Non-covered Services, 400. Adding coverage for A9277 (transmitter; external, for use with interstitial continuous glucose monitoring system) for Medicare Advantage members. Effective 7/1/10.

Serological Diagnosis of Celiac Disease, 138. Adding non-coverage of deaminated gliadin peptide antibodies. Effective 9/1/11.

Special Foods (Special Infant Formula, Enteral Formula, Ketogenic Diet for Seizures, and Formula Infusion Pumps), 304. Removing statement that ketogenic diets are initiated on an inpatient basis (based on clinical evidence that inpatient initiation does not improve outcomes compared to outpatient initiation). Effective 11/1/11.

Surgical Vision Services and Vision Training, 241. Adding indication for office-based vergence/accommodative therapy for patients with symptomatic convergence insufficiency. Effective 9/1/11.

New Medical Policies for Intensity-Modulated Radiation Therapies

Intensity-Modulated Radiation Therapy of the Abdomen and Pelvis, 165. New medical policy describing evidence-based community standards for coverage and non-coverage of this radiation therapy. Effective 9/1/11.

Intensity-Modulated Radiation Therapy of the Breast and Lung, 163. New medical policy describing evidence-based community standards for coverage and non-coverage criteria of this radiation therapy. Effective 9/1/11.

Intensity-Modulated Radiation Therapy of the Head and Neck Cancers, 164. New medical policy describing evidence-based community standards for coverage criteria of this radiation therapy. Effective 9/1/11.❖

For more details on these three IMRT-related policies, please refer to our May 1 F.Y.I. online. Log on to www.bluecrossma.com/provider and click on News for You>FYIs. Then select F.Y.I. PC-1462.

Medical Policy Update

Clarifications

Actigraphy, 533. New medical policy describing ongoing non-coverage. This test is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Acute and Maintenance Tocolysis, 518. New medical policy clarifying covered indication and ongoing non-covered indication. The non-covered indication is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Allogeneic Pancreas Transplant, 328. Clarifying non-coverage statements. Information on islet cell transplantation was removed from this policy and transferred to medical policy 324, *Islet Transplantation*.

Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening, 557. 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*.

Balloon Sinuplasty for Treatment of Chronic Sinusitis, 582. 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*.

Cooling Devices Used in the Outpatient Setting, 510. New medical policy describing ongoing non-coverage. These devices are currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Epiretinal Radiation Therapy for Age-Related Macular Degeneration, 610. New medical policy describing ongoing non-coverage. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Extracorporeal Photopheresis after Solid-Organ Transplant and for Graft-versus-Host Disease, Autoimmune Disease, and Cutaneous T-Cell Lymphoma, 248. Removing information on the latter three conditions from medical policy 071, *Pheresis*, and clarifying that photopheresis is not covered for bullous diseases of the skin.

Fecal Analysis in the Diagnosis of Intestinal Dysbiosis, 556. New medical policy describing ongoing non-coverage. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Heart Transplant, 197. Clarifying medical necessity criteria.

Heart/Lung Transplant, 269. Clarifying medical necessity criteria.

Hematopoietic Stem-Cell Transplantation for Primary Amyloidosis, 181. Removed information on stem-cell transplantation for Waldenstrom's macroglobulinemia and transferred to medical policy 322, *Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia*.

Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood, 208. Clarifying non-coverage for allogeneic stem cell transplants for pediatric solid tumors.

Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia, 322. New medical policy clarifying coverage of autologous stem-cell transplantation for Waldenstrom's macroglobulinemia. This information was previously included in medical policy 181, *Hematopoietic Stem-Cell Transplantation for Primary Amyloidosis*.

Ingestible pH and Pressure Capsule, 045. 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 Antibiotic Therapy and Associated Diagnostic Testing for Lyme Disease, 171. Clarifying ongoing non-coverage of CXCL13 for diagnosis or monitoring treatment of Lyme disease.

Intravenous Immunoglobulin, 310. Clarifying coverage of stiff-man syndrome for Medicare HMO Blue® and Medicare PPO Blue℠ members.

Islet Transplantation, 324. New medical policy containing information that was removed from medical policy 328, *Allogeneic Pancreas Transplant*.

Clarifications, continued on page 10

Medical Policy Update

Clarifications, continued from page 9

KIF6 Genotyping for Predicting Cardiovascular Risk and/or Effectiveness of Statin Therapy, 129. New policy describing ongoing non-coverage of this test.

KRAS Mutation Analysis in Non-Small Cell Lung Cancer (NSCLC), 194. Clarifying non-coverage of this lab test for predicting non-response to cetuximab.

Laboratory Testing to Allow Area Under the Curve (AUC) Targeted 5-Fluorouracil (5-FU) Dosing for Patients Administered 5-FU for Cancer, 318. New medical policy describing ongoing non-coverage of this test.

Lung and Lobar Lung Transplant, 015. Clarifying medical necessity criteria for patients with histories of recent malignancies.

Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Asthma and Other Respiratory Disorders, 524. 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 Technology Assessment Non-Covered Services, 400. Clarifying non-coverage of Category III CPT codes:

0260T: Total body systemic hypothermia, per day, in the neonate 28 days of age or younger

0261T: Selective head hypothermia, per day, in the neonate 28 days or younger

Nerve Graft in Association with Radical Prostatectomy, 590. 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*.

Ocular Photoscreening in the Primary Care Physician's Office as a Screening Tool to Detect Amblyogenic Factors, 605. 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*.

Important Update on Medical Policy 199, *Minimally Invasive Hip and Total Knee Arthroplasty*

We are removing this policy, as the same coverage information is included on InterQual® SmartSheets™. To access InterQual SmartSheets:

Log on to BlueLinks for Providers at www.bluecrossma.com/provider

Click on Manage Your Business>Medical Review Resources.

Select InterQual Behavioral Health and Medical/Surgical Level of Care Criteria and follow the steps provided.❖

Ophthalmologic Techniques to Evaluate the Retinal Nerve Fiber Layer; Pulsatile Ocular Blood Flow; Blood Flow Velocity with Doppler Ultrasonography, 053. Clarifying ongoing non-coverage of ocular blood flow measurement.

Outpatient Pulmonary Rehabilitation, 136. Clarifying non-coverage of home-based pulmonary rehabilitation.

Percutaneous Transluminal Angioplasty; Pulmonary Thromboendarterectomy, 077. Removed information on intracranial endovascular procedures and transferred to medical policy 323, *Endovascular Procedures for Intracranial Arterial Disease*.

Plastic Surgery, 068.

Clarifying continued coverage of tunable dye laser treatment of port wine stains of the face and neck without other medical necessity requirement.

Clarifying documentation and authorization requirements and CPT code information for laser treatment of hypertrophic scars.

Positron Emission Mammography (PEM), 176. New medical policy clarifying ongoing non-coverage for this imaging test.

Clarifications, continued on page 11

Medical Policy Update

Clarifications, continued from page 10

Retinal Prosthesis, 606. New medical policy describing ongoing non-coverage. These prostheses are currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Thoracic-Lumbo-Sacral Orthosis with Pneumatics, 511. New medical policy describing ongoing non-coverage. These orthoses are currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

Threshold Electrical Stimulation as a Treatment of Motor Disorders, 321. New medical policy describing ongoing non-coverage. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.

T-Wave Alternans, 539. New policy describing ongoing coverage for Medicare HMO Blue® and Medicare PPO Blue℠ and ongoing non-coverage for commercial products. This procedure is currently addressed in medical policy 400, *Medical Technology Assessment Non-Covered Services*.❖

Pharmacy Medical Policy Update

Makena™ (hydroxyprogesterone caproate), 314. New medical policy for coverage of Makena™ to reduce the risk of preterm birth in women with singleton pregnancy who have a history of spontaneous preterm birth (delivery < 37 weeks gestation) with previous singleton pregnancies. Effective 9/1/11.

Parathyroid Hormone, 018. Removed coverage criteria requiring documented treatment failure or intolerance to other medications used to treat osteoporosis such as Actonel®˝, Boniva®˝, Fosamax®˝, calcitonin, Evista®˝, or estrogen within the last six months. Effective 3/1/11.

Pradaxa® (Dabigatran Etexilate), 315. New medical policy for coverage of Pradaxa®˝ for prevention of stroke and systemic embolism. Effective 9/1/11. Coverage criteria to include:

Age 18 years of age or older

Documented paroxysmal, persistent, or permanent atrial fibrillation (AF) not complicated by valvular disease with at least one of the following:

- History of previous stroke, transient ischemic attack, or systemic embolism
- Ejection fraction less than 40% documented by echocardiogram, radionuclide, or contrast angiogram in the last six months
- Symptomatic heart failure (New York Heart Association class 2 or higher in the last six months)
- Age of at least 75 years, *or* at least 65 years with one of the following: diabetes mellitus, documented coronary artery disease, or hypertension requiring medical treatment
- CrCl greater than 30mL/min.❖

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Go to www.bluecrossma.com/provider and click on Register Now in the blue box.

Important Reminder

Always Use Our Technologies to Check Claim Status

BCBSMA requires that you use electronic technologies to resolve simple claim status inquiries and verify routine eligibility, rather than calling our Provider Services number. This helps our associates devote more time to helping providers with complex issues. To access these tools or to learn more, log on to www.bluecrossma.com/provider and click on Technology Tools.❖

Technology:	How you can benefit from using it:
PaySpan Health	A free service that provides direct deposit and online Provider Payment and Provider Detail Advisories.
Online Services	Perform a variety of tasks for BCBSMA members—and members from other BCBS plans—without a separate sign-on, including member benefits and eligibility, claim status, referrals and authorizations, and name/family searches.
ExpressPA	Submit prior authorization requests for retail prescriptions.
NEHEN*Net*	A single gateway to the region's largest payers and their most popular and essential transactions.

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

- Andrew Dreyfus, *President and Chief Executive Officer*
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