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Providerfocus

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Delivering on Our Promise to Put Our Members' Health First

The passage of health care reform was historic—first in Massachusetts, then nationally. While questions remain about the impact of health care reform on a state and national level and the changes that lie ahead, one thing remains the same—our commitment to always put our members' health first.

One way we deliver on this promise is through Member Central, our secure member website. Recently enhanced, Member Central empowers our members with tools to help them make important health care decisions, and to help them get the most out of their plan.

Everything Our Members Need—All in One Place

Member Central is designed to engage our members in the resources available, helping them to become more involved in their own health care.

Through the site, registered members and covered family members have immediate access to benefit and claim information.

They can:

- Look up copayments
- Search for a provider using Find a Doctor
- Choose a PCP
- Order an ID card
- Create a personal health record
- Manage their health reimbursement and health savings accounts
- Look up pharmacy coverage and potential savings
- Track medication history
- Update their contact information
- See personalized messages based on their data, read the annual member newsletter, and sign up to receive news and updates via e-mail
- Access money-saving benefits and wellness resources.

Empowering Our Members

Now more than ever, our members—especially those in high-deductible plans—are looking for ways to get more from their health

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In This Issue

In Brief

Go to BlueLinks for Providers for updates on national health care reform and state regulatory initiatives, including the Division of Insurance's 2010 premium rate review decision.

www.bluecrossma.com/provider

Physician News

MASSACHUSETTS

Collaborative Oncology Incentive Program Supports Plan of Care

Our Collaborative Oncology Incentive Program provides eligible oncologists with additional reimbursement for submitting chemotherapy treatment plans to BCBSMA. This program supports oncology practices and facilitates high-quality, best-practice care for our members.

We mailed information to eligible practices and contract administrators last fall explaining how to get started. If you have any questions about whether your practice is eligible, call Network Management Services at **1-800-316-BLUE (2583)**.

How to Get Started

- Download the *Treatment Plan* from the American Society of Clinical Oncology's website, **www.asco.org.**
- Complete and submit your patient's *Treatment Plan* to BCBSMA within seven days of the date of service on which the treatment plan is defined or the initial administration of chemotherapy is delivered. *Treatment Plans* should be submitted with our fax cover sheet indicating the patient's BCBSMA Member ID and confirmation that the program has been discussed with the patient. The program excludes members of the Federal Employee Program, Medex®, and other Blue Cross Blue Shield plans.
- Fax the cover sheet and completed forms to **1-888-641-8264**. Incomplete forms will be returned via fax noting the missing elements and requesting resubmission.

The *Treatment Plan* provides our nurse case managers with timely clinical information used to outreach to members in support of their treatment goals and their physician's plan of care. Because claims history indicates that a higher percentage of preventable events (such as emesis leading to dehydration) occur in the first or second round of chemotherapy, this referral allows us to identify members at the time they can most benefit from our Oncology Case Management Program.❖

Resource:	To access, log on to www.bluecrossma.com/provider and click on:
▸ *Collaborative Oncology Incentive Program Fact Sheet* ▸ Fax cover sheet	**Resource Center>Admin Guidelines & Info> Fact Sheets** (The *Fact Sheet* contains a link to our fax cover sheet)
Collaborative Oncology Incentive Program pre-recorded training	**Resource Center>Training & Registration**. Select **Collaborative Oncology Incentive Program Overview** from the Specialty Care drop-down course list.

Department of Public Health Announces Plans for the 2010-2011 Flu Season

The Massachusetts Department of Public Health (MDPH) is encouraging providers to start planning now for the 2010-2011 flu season.

As in past years, MDPH plans to provide the vaccine to certain providers, such as pediatric practitioners and obstetricians; however, MDPH will not supply the vaccine to nursing homes and private health care providers for vaccination of adults.

Providers should plan accordingly with respect to purchasing influenza vaccine for the upcoming season.

To read MDPH's March 2010 advisory, which includes a list of manufacturers and a list of vaccine products expected to be available for the 2010-2011 flu season, go to **www.mass.gov/dph/flu** and click on **Seasonal Flu>Advisories and Alerts.**❖

Pharmacy Update

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:

- 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.

For more information on the registration and activation process, refer to our new *Quick Start Guide* (see sidebar).❖

Online Resources

- Go to ExpressPA's website: **https:\\www.express-pa.com**
- Access the *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.**❖

Delivering on Our Promise to Put Our Members' Health First

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care. They look for resources and information to help make more educated, high-quality, and cost-effective decisions.

Through Member Central, members can access interactive cost and quality tools, including:

- **Coverage Advisor:** Allows members to compare estimated out-of-pocket costs of BCBSMA plan options before making a selection.
- **Treatment Cost Estimator:** Available through a link to the BCBS Association's website, this tool allows members to explore typical costs for 21 categories of medical conditions. It includes a glossary that explains medical terms, conditions, and potential treatments.
- **Hospital Advisor:** Allows members to quickly and easily create a comparison of hospitals near their home or work.

"As BCBSMA responds to consumers' and employers' demands for more affordable health plans and more transparency, we understand the importance of supporting our members by offering them tools to help them make wiser choices about their health care," said Steven J. Fox, BCBSMA's Vice President of Network Management and Contract Operations.

How You Can Help

Encourage your BCBSMA patients to take advantage of Member Central. To register, they can go to **www.bluecrossma.com** and click on **Member** to complete the quick and easy registration process. Within minutes, they'll have access to tools to help them become more engaged in their health care.❖

Coding Corner

This section offers tips on how to code services for complex cases and how to complete your CMS-1500 claims accurately to ensure prompt payment.

Coding Correctly for Medicare Advantage Members

BCBSMA will begin its 2010 medical record review this spring for physicians treating BCBSMA Medicare Advantage members. Our goal with this data verification process is to accurately identify medical conditions that BCBSMA is required to report to the Centers for Medicare & Medicaid Services (CMS) for our Medicare Advantage members. Medicare Advantage plans, such as BCBSMA, must ensure that billing accurately reflects medical record documentation, and that members' chronic conditions are addressed and billed at least once per calendar year.

Correct Coding for Malnutrition

From medical record reviews conducted in 2009, we found that many of the most common diagnoses for Medicare Advantage patients were not reported on submitted claims. For example, if the provider includes a diagnosis from a nutritionist, the medical record must also document the pertinent exam, as well as lab or clinical findings that are consistent with malnutrition. Malnutrition cannot be coded based solely on a nutritional consult. Additionally, if the provider includes a diagnosis from a nutritionist, the medical record must also document the pertinent exam, as well as lab or clinical findings that are consistent with malnutrition.

As the U.S. population ages, adequate nutrition in the elderly will be an increasingly important issue—so will adequate medical record documentation.

Example

Suppose an 85-year-old female patient comes in for a follow-up appointment for her diabetes. During the visit, you determine that the patient is at risk for malnutrition based on the several factors, which are documented in the patient's medical record, including:

- Age
- Slightly low albumin
- Weight loss over the past several months
- Diagnosis of diabetes
- Score <10 on the mini-nutritional assessment
- Possible depression.

How to Code the Claim

Based on the factors listed above, the correct ICD-9 code is 263.1 Malnutrition of Mild Degree.❖

Office Staff Notes

Billing for Services Rendered During a Medicare Advantage Member's Inpatient Stay

Based on Center for Medicare & Medicaid Services (CMS) guidelines, there are times when certain days during a Medicare Advantage member's inpatient stay are denied, even if the stay is partially approved. In these cases, services rendered by the attending physician on denied days are not payable. Please note that attending physicians may not bill these services to BCBSMA as outpatient or observation services.

For more information, see the Billing and Reimbursement section of your *Blue Book* manual. Log on to **www.bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books.**❖

Office Staff Notes

New HCAS Eligibility Verification Resource Available

To help streamline the eligibility verification process, Health Care Administrative Solutions, Inc. (HCAS) now offers providers access to health plan online eligibility verification tools from one centralized location.

Visit the HCAS website at **www.hcasma.org** and select the **Solutions** tab to access the following resources:

- An eligibility grid that describes how to check eligibility electronically for various health plans
- A sample health insurance plan ID card, with common terminology and ID card elements
- Links to health plan eligibility technology.

HCAS plans to add additional provider resources in the future We will keep you posted on updates in *Provider Focus*.❖

Easier Precertification/Preauthorization Access for BlueCard® Program Members

The BlueCard Eligibility℠ line has been enhanced to improve your experience in verifying eligibility and obtaining precertification and preauthorization information for out-of-area Blue Cross Blue Shield patients. See chart for details. If you have any questions, please call BCBSMA at **1-800-882-2060**.❖

When you call 1-800-676-BLUE (2583) for:	Follow these instructions:
• Precertification/ preauthorization only	• Select the option for precertifications/preauthorizations. • Choose the appropriate prompt for type of service for which you are calling (medical/surgical; behavioral health; diagnostic imaging/radiology; or durable medical equipment (DME). • Upon making your selection, you will be transferred to the appropriate area of the member's plan to address your specific request.
• Eligibility only • Eligibility and precertification/ preauthorization	• Select the option to obtain eligibility and precertification/preauthorization information. • The eligibility inquiry will be addressed first. • You'll then be transferred to the appropriate precertification/preauthorization area.

Radiology Reminder: Verify Member Eligibility Before Contacting AIM

As part of our radiology quality program, BCBSMA requires precertification for outpatient high-technology radiology services for members of: HMO Blue®, HMO Blue New England®, Network Blue®, and Medicare HMO Blue® plans, and for Blue Choice® members with a Massachusetts-based primary care provider (PCP). At this time. precertification is not required for members of our PPO, EPO, Indemnity, and Managed Blue for Seniors products.

As a reminder, always check member eligibility and benefits using one of our technologies before submitting precertification requests to our vendor, American Imaging Management (AIM). You can access Online Services, InfoDial®, or the POS device 24 hours a day, 7 days a week. Once you have verified eligibility, you may submit precertification requests at **www.americanimaging.net** or by calling **1-866-745-1783**. Receipt of a precertification number is required for reimbursement.

For out-of-area BlueCard® Program members, please call BlueCard Eligibility℠ at **1-800-676-BLUE (2583), Option 5**.

For more information, please refer to the Utilization Management section of your *Blue Book* manual, available online. Log on to **www.bluecrossma.com/provider** and click on **Resource Center>Admin Guidelines & Info>Blue Books**.❖

Medical Policy Update

All updated medical policies will be available via:

- www.bluecrossma.com/provider>Medical Policies.
- Fax-on-Demand at 1-888-633-7654

Changes

Aqueous Shunts and Devices for Glaucoma, 223. New medical policy describing coverage and non-coverage criteria for this procedure. Effective 8/1/10.

Automated Point-of-Care Nerve Conduction Tests, 222. New medical policy describing non-coverage. Effective 8/1/10.

Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid, 107. Prior authorization will be required for commercial & Medicare HMO Blue® products when billed with the following CPT®˝ codes, effective 8/1/10:

- 95250: Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.
- 95251: Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report.

Electromagnetic Navigation Bronchoscopy 203. New medical policy describing non-coverage. Effective 8/1/10.

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus, 218. New medical policy addressing coverage and non-coverage. Effective 8/1/10.

Extracranial Carotid Angioplasty/Stenting, 219. New medical policy describing coverage and non-coverage. Comparable non-coverage information for commercial products will be removed from medical policy 077, *Percutaneous Transluminal Angioplasty*. Effective 8/1/10.

Genetic Testing for Warfarin Dose, 214. New medical policy describing coverage for Medicare HMO Blue® and Medicare PPO Blue℠ products, and non-coverage for commercial products. Effective 8/1/10.

Implanted Devices, 087. Adding new coverage criteria of five years and older for implantable bone conduction/bone anchored hearing aids (BAHA) when this device is covered under a member's benefits. Effective 8/1/10.

Isolated Limb Perfusion//Infusion for Malignant Melanoma, 124. Adding coverage for isolated limb infusion (ILI) as a therapeutic treatment of local recurrence of nonresectable melanoma (i.e., satellite lesions or "in transit" melanoma), with melphalan. Effective 8/1/10.

Keratoprosthesis, 221. New medical policy describing new coverage and ongoing non-coverage criteria of keratoprosthesis (i.e., Boston Keratoprosthesis/Boston KPro). Comparable non-coverage language will be removed from medical policy 241, *Surgical Vision Services*. Effective 8/1/10.

Laboratory Testing for HIV Tropism, 008. Adding coverage of HIV tropism testing for patients who are treatment-naïve. Effective 8/1/10.

Medical Technology Assessment Non-Covered Services, 400.

- Adding coverage for the following CPT codes, effective 8/1/10:
  - 37215: transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection
  - 37216: transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection
  - 0075T: transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous; initial vessel
  - 0076T: transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous;each additional vessel
- Adding coverage for CPT code 43265 (Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of stone(s), any method). Effective 7/1/10. ***Note:*** Implementation of new medical policy 209, *ERCP with Laser or Electrohydraulic Lithotripsy*, which addresses coverage and non-coverage of this procedure, was previously published in April 2010 *Provider Focus*.

Stereotactic Body Radiation Therapy, 277. Prior authorization will be required for Medicare HMO Blue® for stereotactic body radiation therapy billed with the following CPT codes, effective 8/1/10.

- 77373: Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

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Medical Policy Update

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- 77435: Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions.

Total Hip Resurfacing, 046. Change in policy title to *Hip Resurfacing*, describing coverage and non-coverage of total and partial hip resurfacing. Effective 8/1/10.

Clarifications

FDG-SPECT, 330. Clarifying non-coverage of FDG-SPECT for commercial & Medicare HMO Blue/ Medicare PPO Blue products as follows:

- Other cardiac applications including, but not limited to, evaluation of coronary artery perfusion defects
- As a technique to evaluate patients with known or suspected malignancies
- Other applications including, but not limited to, evaluation of neurological disorders, dementias, psychiatric disorders, or motor neuron disorders.

Hematopoietic Stem Cell Transplantation for Breast Cancer, 213. New medical policy describing non-coverage of this treatment for this diagnosis. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Chronic Myelogenous Leukemia, 212. New medical policy describing coverage and non-coverage of this treatment for this diagnosis. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for CNS Embryonic Tumors and Ependymoma, 205. New medical policy describing coverage and non-coverage of this treatment for these diagnoses. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Epithelial Ovarian Cancer, 204. New medical policy describing non-coverage of this treatment for this diagnosis. Comparable language will be removed from medical policy 092, *Allogeneic Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Hodgkin Lymphoma, 207. New medical policy describing coverage and non-coverage of this treatment for this diagnosis. Comparable language will be will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Hematopoietic Stem Cell Transplantation for Solid Tumors of Childhood, 208. New medical policy describing coverage and non-coverage of this treatment for these diagnoses. Comparable language will be removed from medical policies 092, *Allogeneic Stem Cell Transplants*, and 126, *Autologous Stem Cell Transplants*.

Injectable Clostridial Collagenase for Fibroproliferative Disorders, 225. New medical policy addressing non-coverage of this injectable for fibroproliferative disorders.

Laboratory Testing for HIV Tropism, 008. Clarifying non-coverage of HIV tropism testing statements for commercial & Medicare HMO Blue/Medicare PPO Blue products as follows:

- HIV tropism testing using other assay techniques
- HIV tropism testing without immediate plans to prescribe HIV co-receptor antagonists.

Laser Prostatectomy, 384. Clarifying coverage of laser prostatectomy for patients with benign prostatic hypertrophy who are candidates for transurethral resection of the prostate for commercial products and for Medicare HMO Blue and Medicare PPO Blue.

Mammography, 125. Clarifying coverage of full field digital mammography both as a screening or diagnostic technique.

Medical Technology Assessment Non-Covered Services, 400. Clarifying non-coverage for non-invasive optimal vessel analysis (NOVA).

Percutaneous Vertebroplasty and Kyphoplasty, 105. Clarifying non-coverage for acute vertebral fractures for commercial products.❖

MASSACHUSETTS
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_____

Attention PCPs: The *2010 Guide to the PCP Incentive Program* is now online.
Log on to **www.bluecrossma.com/provider** and click on the link on the home page.

Ancillary News

Attention Chiropractors: Tips for Members With Personal Injury Protection Benefits

In March *Provider Focus*, we referred you to page 13 of the *Chiropractic Services Authorization Guide* to review the process for requesting authorization and submitting claims for members with personal injury protection (PIP) benefits (when the member participates in a plan that requires authorization for visits 13+).

Here are some additional tips to help you with this process:

- BCBSMA and Healthways WholeHealth Networks (HWHN) recommend submitting authorization requests after the member's PIP has exhausted. This allows for correct claims processing for PIP, the unmanaged 12 visits, and any additional visits that need to be authorized through HWHN.
- Since HWHN reviews authorization requests for medical necessity, the point in time when you make the request is critical for assessing the member's continued treatment.
- Visits approved through HWHN should be used within the designated timeframe on the authorization and cannot be "banked" for future dates of service.❖

Providerfocus is published monthly for BCBSMA physicians, health care providers, and their office staff. Please submit letters and suggestions for future articles to:

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