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Providerfocus

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Healthy Actions Program Launched to Improve Member Health

Healthy Actions is a new, unique wellness program we began offering on August 1 for small employer groups.

The program provides incentives to members to take responsibility for their health.

With Healthy Actions:

- Subscribers earn incentives for taking an active role in their health.
- Accounts receive lower premiums based on employee success and participation.
- Providers are reimbursed for working with their patients to achieve health goals.

The Healthy Actions incentive can be earned only by the plan subscribers, not by family members.

Also, the employer must choose the program, so not all patients will automatically have Healthy Actions as part of their plan.

How the program works

To earn the incentive, eligible subscribers must take an online health assessment. They will then ask their doctor to complete a simple *Clinician Health Review* form that asks for health information about weight, blood pressure, smoking status, and preventive screenings.

Physicians can complete the form using biometric data from a recent physical, or they can schedule a new physical.

The member is responsible for submitting the form to IncentiSoft Solutions, a national leader in results-based wellness that BCBSMA chose to administer the Healthy Actions program.

The chart on page 2 provides additional details on the program.

Want to learn more?

To learn more about this program, view our audiovisual presentation, *Healthy Actions*, which will be available on our BlueLinks for Providers

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In Brief

Submitting Claims for Members With New "XXS" ID Prefix

As we've reported in *Provider Focus*, BCBSMA is upgrading our claims system throughout 2012 and 2013.

In relation to this transition, approximately 40,000 members have received updated ID cards with a new alpha-prefix—XXS.

To ensure timely and accurate claims processing, please remember to check member eligibility prior to rendering services and submit the most up-to-date member ID, including the correct alpha prefix. Claims submitted with an outdated alpha-prefix will be denied.

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

Physician News

Association Creates Quality Tools for National Blue Cross Members

In collaboration with the Blue Cross Blue Shield Association, BCBSMA is committed to providing Blue plan members with the tools they need to make informed health care choices in partnership with their doctors. As part of that effort, the BCBS Association launched two quality reporting tools in July on its National Doctor & Hospital Finder℠ website.

Physician Quality Measurement (PQM) assists patients in choosing a PCP by displaying group-level results for select quality measures. The PQM tool features select HEDIS®´´ measures and will use the same group-level results currently displayed on our local Find a Doctor tool.

Blue Physician Recognition (BPR) supports informed health care choices by recognizing and highlighting physician practices nationally that have formally accepted accountability for quality, value, and outcomes in their work with their local Blue plans. For this program, BCBSMA recognizes practices contracted under our Alternative Quality Contract (AQC).

The BCBS Association will also launch **Patient Review of Physicians (PRP)**, a tool that allows patients to post reviews of physicians on the National Doctor & Hospital Finder website. All reviews go through a rigorous authentification process before they are posted. While patient reviews are just one of many factors to consider when patients choose a doctor, consumer research shows that they are one of the most sought after types of physician information.

The BCBS Association and member plans will continue to collaborate with national medical specialty societies, medical boards, and measurement experts to identify data and programs that can be leveraged to recognize performance and support informed health care choices for our members.❖

Healthy Actions Program Launched to Improve Member Health

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website in mid-August. Log on to **bluecrossma.com/provider** and click on **Resource Center>Training and Registration>Course List**. Then select **Healthy Actions** from the Primary Care or Specialty Care menu.❖

If the patient is:	Then the patient:	And you:
Within range for all measures	Is eligible for the total $300 incentive after he or she submits a completed initial assessment portion of the *Clinician Health Review* form.	May submit a claim to BCBSMA using CPT code 99420 to indicate that you completed the form and returned it to the member.
Out of range on any measure	Is eligible for a partial ($100) incentive. To qualify for the balance, you and the patient must choose one clinical topic and set an actionable goal to achieve prior to the due date on the form. The patient will provide you with a simple follow-up form later in the year. Patients who do not achieve their clinical target are not eligible for the remaining incentive.	Should indicate the goal on the form and give it to the member to submit. Once the target has been achieved, complete and sign the follow-up section of the *Clinician Health Review* form and return it to the patient. Then, you may bill using CPT code 99420. You may submit up to two claims using code 99420 per patient, per year. Reimbursement for each submission will be $50, and will be paid in addition to any office visit claims.

When It's Not Depression, But Something Doesn't Seem Right

You've noticed a change in behavior of your older adult patient. It's not clinical depression, but you know something is not right. What should you do?

The Centers for Disease Control and Prevention (CDC) and the National Association of Chronic Disease Directors (NACDD) report that depression is the most prevalent mental health problem among older adults.

Most of the time feeling blue, sad, or lonely does not indicate that the patient is depressed, but it may reveal issues which can affect their quality of life and their ability to cope effectively with other health issues.

"Feelings, thoughts and memories can contribute to mood changes even when it's not depression," says Dr. Cornelia Cremens, Director of Geriatric Psychiatry at Massachusetts General Hospital. "Encouraging older adults to resume social activities, exercise, and be more engaged in their self-care will lead to attitudinal shifts and more enjoyment in their life."

Recognizing the signs

How can you spot these mental health issues during your brief appointment with your patients? Dr. Cremens recommends that you listen carefully for what might not be said overtly.

"Listen for things that are changing in their lives, that might put them at risk for feeling down," she says.

Dr. Cornelia Cremens

These signs might include:

- Mood changes
- Negative thoughts
- Feelings of demoralization or discouragement
- Weight gain or weight loss
- Lack of participation in typical hobbies or social events with family or friends, volunteering, or working a part-time job
- Inattentiveness to health issues or hygiene.

How you can help

Dr. Cremens says once you've ruled out any major health problems or depression, help your patient to take action. Evaluate their diet and if necessary, prescribe a healthy diet. In fact, she recommends writing a prescription for any activity that could help improve the quality of life for the patient, such as exercising or something as simple as going to the movies once a week.

According to Dr. Cremens, older adults are more likely to make lifestyle changes if you send them home with a prescription, even if it's not for medication.❖

Tools:

Dr. Cremens says simple activities like walking have proved to have a positive impact on mood. Use our *Prescription for Healthy Bones* to get them started on bone health and on an activity that will help their wellbeing. Don't have the *Prescription for Healthy Bones* pad? Contact your Network Manager at **1-800-316-BLUE (2583)**. Or, write your own prescription for activity to help improve the mental and physical health of your patient.❖

Survey results:

Last year, the Centers for Medicare & Medicaid (CMS) surveyed 9,225 of our Medicare HMO Blue℠ members about their mental health. Each participant was asked the same question: *Compared to one year ago, would you say your emotional problems, such as feeling anxious, depressed, or irritable have improved, stayed the same, or gotten worse?*

Of the respondents:

- 6% (568) said they got worse.
- 13 % (1,243) said they got better.
- 80% (7,414) said they stayed the same.❖

Office Staff Notes

Updated DME Codes for Physicians, Podiatrists, NPs, NPPCPs, and UCCs

BCBSMA has added the codes listed in the chart to its list of reimbursable durable medical equipment (DME) items for physicians, podiatrists, nurse practitioners (NPs), NP Primary Care Providers (NPPCPs), and Urgent Care Centers. These codes are effective for dates of service on or after August 1, 2012.

To access the revised document, titled *Durable Medical Equipment and Supplies That Can Be Billed by a Physician, Podiatrist, Nurse Practitioner, Nurse Practitioner Primary Care Provider (NPPCP), and Urgent Care Center*, log on to **bluecrossma.com/provider** and click **Resource Center>Admin Guidelines & Info**, then scroll down to **Updated DME Codes**.

Be sure to bill only codes within the scope of your practice specialty, and always check member benefits and eligibility prior to rendering services.❖

HCPCS code:	Modifier:	Fee for all products, effective 8/1/12:
L3760	NU	$350.47
L3982	NU	$313.62
L3984	NU	$311.98

Need to Submit a Prior Authorization Request? Use These Fax Numbers

BCBSMA and other Massachusetts health plans recently unveiled the new *Standardized Prior Authorization Request Form* to provide a uniform way for providers to submit prior authorization requests. Because the form does not currently list BCBSMA's prior authorization fax numbers, we thought you'd find these lists helpful.

To access the form on our website, log on to **bluecrossma.com/provider** and click on **Resource Center>Forms>Authorization Forms.**❖

Authorization & Referral Fax Numbers by Product

For these members:	Fax your request to:
Commercial	**1-888-282-0780**
Medicare Advantage	**1-800-447-2994**
Federal Employee Program	**1-888-282-1315**
BCBSMA employees	**617-246-4299**

Pre-certification/Recertification Request Fax Numbers by Service Type

For these services	For these members:	Fax your request to:
Long-term Acute Care Hospital Rehabilitation Inpatient Hospice or Respite Skilled Nursing Facility	Commercial	**1-888-641-5330**
	Medicare Advantage	**1-800-205-8885**
	Federal Employee Program*	**1-888-282-1315**
	BCBSMA employees	**617-246-4299**

**Federal Employee Program members do not have benefits for long-term acute care services.*

Office Staff Notes

Submitting Referrals: Important Information for PCP and Specialist Offices

Our HMO plans, including senior plans, require a PCP referral before a member can receive covered services from a specialist. Submitting a referral within 90 days of the date of service is required to:

- Facilitate claim processing for specialists
- Avoid unnecessary involvement of the member in the process
- Reduce the specialist's administrative efforts.

When entering the number of visits in your referral, please consider the care the member may need from the specialist. Many PCP offices enter three visits as a default, but this may not be sufficient, or the patient may only need a one-time consultation.

Specialist referrals can be entered for up to 99 visits, and are good for 365 days.

Specialists should use technologies to verify referrals

Before rendering services, a specialist should verify that a referral is on file and that the number of visits requested matches the services required.

Taking this step helps facilitate claims processing and avoids unnecessary appeals or inquiries by you, the member, and the member's PCP.

Referral verification can be completed easily using any of the following technologies: Online Services, Online Services Batch Manager, BCBSMA Direct Connection, Point-of-Service (POS) Device, and InfoDial®˝.

Please note: Obtaining a valid referral does not guarantee reimbursement. Benefits and medical and payment policies may affect coverage and reimbursement.❖

Inquiring on the Status of a Referral Using Online Services

Performing an inquiry using Online Services is easy:

- Begin by performing an eligibility inquiry. After verifying that the member is active, click on **HCS Review Inquiry**.
- Select **Specialist Inquiry** from the Step 2 drop-down list.
- Enter the physician specialist's NPI.
- Results will be returned if:
  - The member's coverage is active at the time of the inquiry
  - The number of visits has not been exhausted
  - The referral timeframe has not lapsed.

Need help entering referrals?

For assistance entering a referral in Online Services, call our Provider Self Service team at **1-800-771-4097**.

Be sure to have the NPI of the specialist you are referring our member to.

If you do not have the NPI, you can search for it using the Find a Doctor feature, available in the Manage Your Business section of BlueLinks for Providers.

Want to learn more?

To learn more about using Online Services, view our brief presentation, *Introduction to Online Services*, available on BlueLinks.

Log on to our website at **bluecrossma.com/provider** and select **Resource Center> Training & Registration> Course List**. Then select the course title from the menu for your provider type.❖

Billing Notes

Are You Using Modifiers 25 and 59 Correctly on Your Claims?

If you currently use modifiers in your billing, it is important that you use standard modifiers to describe the service for which you are billing. It is also essential that you are using modifiers correctly.

Modifiers indicate that a service or procedure you've performed has been altered by some specific circumstance, but has not changed in its definition or code.

During routine audits, we often find that providers are billing incorrectly with modifiers 25 and 59.

How to use modifier 25

Modifier 25 indicates a significant, **separately identifiable evaluation and management (E&M) service** by the same physician on the same day of the procedure or other service, that is above and beyond the other service(s) provided.

For same-day preventive and sick E&M, the lower valued E&M service is reimbursed at 50% of the fee schedule/allowable amount.

The submission of modifier 25 appended to a procedure code indicates that documentation is available in the patient's records for review (upon request) that will support the distinct or independent identifiable nature of the service submitted with modifier 25.

How to use modifier 59

Modifier 59 indicates a **distinct procedural service**. That means the procedure or service was distinct or independent from other non-E&M services performed on the same day.

About Medical Record Audits

BCBSMA expects that when you submit claims with modifiers 25 or 59, documentation is available in the patient's records to support the distinct or independent identifiable nature of the service submitted with these modifiers.

Please note: all claims submitted with modifiers 25 and 59 are subject to pre- and post-pay audit by BCBSMA.

Be sure to consult your CPT manual if you have questions about using modifiers.❖

Medical Policy Update

All updated medical policies will be available online. Go to bluecrossma.com/provider>Medical Policies.

Changes

Ambulatory Event Monitors; Mobile Cardiac Outpatient Telemetry; Transtelephonic Transmission of Post-symptom Electrocardiograms and Cardiac Event Monitors, 347. Adding coverage for use of autotrigger devices in treated patients with atrial fibrillation to evaluate for asymptomatic episodes. Effective 11/1/12.

BRAF Gene Mutation Testing to Select Melanoma Patients for BRAF Inhibitor Targeted Therapy, 398. New policy describing coverage in tumor tissue from patients with stage IIIC or IV melanoma to select patients for treatment with vemurafenib, and investigational for all other indications. Effective 11/1/12.

Contrast Enhanced Computed Tomographic Angiography (CTA) for Coronary Artery Evaluation, 355. Medically necessary indication added for acute chest pain in the emergency setting. Effective 11/1/12.

Facet Joint Denervation, 140. Added laser denervation, cryodenervation, and therapeutic blocks as investigational. Effective 11/1/12. Clarifying statement on radiofrequency denervation. *Radiofrequency* was removed from the title.

Intraepidermal Nerve Fiber Density Testing, 393. New policy describing coverage and non-coverage information. Effective 11/1/12.

Intravitreal Angiogenesis Inhibitors for Retinal Vascular Conditions, 401. New policy describing coverage and non-coverage information. Effective 11/1/12.

Quantitative Assay for Measurement of HER2 Total Protein Expression and HER2 Dimers, 397. New policy describing non-coverage. Effective 11/1/12.

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors, 259. Policy statements added to indicate medically necessary options for primary and metastatic pulmonary tumors. Effective 11/1/12.

Screening for Lung Cancer Using CT Scanning, 355. Changed low-dose CT scans for lung cancer screening to medically necessary annually for three consecutive years for selected individuals, and investigational in all other situations. Policy statement on chest radiographs removed and title changed accordingly. Statement added to "Policy Guidelines" that evidence does not support the use of chest radiographs as a screening technique. Statement also added to "Policy Guidelines" that the policy does not apply to symptomatic individuals. Effective 11/1/12.

Transcatheter Aortic-Valve Implantation for Aortic Stenosis, 392. New policy describing coverage for patients who are not surgical candidates, and investigational for all other indications. 11/1/12.

Transcatheter Closure of Patent Ductus Arteriosus, 336. New policy describing coverage and non-coverage information. Effective 11/1/12.

Transcutaneous Electrical Nerve Stimulation (TENS), 003. Changing coverage for TENS for chronic low back pain for Medicare Advantage members in accordance with CMS final decision memo of June 8, 2012. Coverage will only be provided to Medicare Advantage members enrolled in a randomized, controlled clinical trial using validated and reliable instruments. Effective 11/1/12.

Clarifications

Extracorporeal Photopheresis after Solid-Organ Transplant and for Graft-versus-Host Disease, Autoimmune Disease, and Cutaneous T-Cell Lymphoma, 248. Clarifying coverage of extracorporeal photopheresis for Medicare HMO Blue℠ and Medicare PPO Blue℠ members for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation.

Positron Emission Tomography (PET) Scans, 358. Clarifying specific aspects of body habitus that would increase the likelihood of a suboptimal SPECT imaging study for cardiac applications.❖

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  Th: 9:30 a.m. - 4:30 p.m.
- Fraud Hotline: **1-800-992-4100**
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  M-T-W-F: 8:30 a.m. - 4:30 p.m.
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