Empire BlueCross BlueShield

Working together to improve the health of our members.

Winter 2008

Empire News

NEW YORK

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Letter from the Medical Director

Welcome to this edition of *EmpireNews*, where our goal is to keep you up-to-date on changes in plans, policies and procedures that affect you and your business. In this issue, we'd like to offer you the latest need-to-know news including:

- Preventive Care changes
- NextRx transition
- ID card transition
- New provider web forms

And there's much more! In this time of change for the health care industry, you need meaningful and valuable information to stay ahead. We want to meet this need with *EmpireNews*, so let us know how we're succeeding and what we can do to improve. Please don't hesitate to contact us at **800-992-BLUE (2583)**, Monday – Friday, 8:30 a.m. – 5 p.m. or visit us online at **empireblue.com**.

Sincerely,

Luis Estevez
Medical Director

PNYNW4218Y (12/08)

Administrative news

New preventive care coverage

To encourage consumers to receive the appropriate services, we're making changes in how we classify certain services as preventive care. Effective January 1, 2009, these benefit changes will impact most of our health care plans.

All services defined as "preventive care services" under most Empire plans are now covered at 100 percent with no out-of-pocket costs (i.e., no co-payment or co-insurance) to members when the services are received from an in-network provider.

The change is accompanied by an update to the services covered as preventive care to help ensure a closer alignment with nationally recognized guidelines for preventive care. Those guidelines include preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society®, the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics.

Based on the nationally recognized criteria, certain services previously considered preventive will be covered as medical and/or diagnostic services, subject to any applicable cost-share member contract requirements. In particular, chest x-ray, electrocardiogram, breast ultrasound and breast MRI should only be ordered/performed when standard screening tools, such as mammography, reveals a suspicious finding. To ensure that Empire members receive the correct benefits it is extremely important to use the most appropriate CPT/HCPCS procedure code and diagnosis codes. For example, diagnostic mammography codes 77055, 77056 should not be reported for screening mammography testing. Reporting screening fecal occult blood testing (82270) with ICD9 diagnosis code V76.51 (special screening for malignant neoplasms colon) will ensure that the service is processed under the member's preventive benefit

Please note that services required to be covered as preventive care by state and federal law will continue to be classified/covered as such by Empire.

Coding for screening colonoscopies with removal of polyp/abnormalities

Most colonoscopies are performed as preventive screenings to help reduce the risk of colon cancer and are highly effective procedures. For this reason, colonoscopies are a recommended preventive procedure.

CMS billing guidance on preventive colonoscopies

Some preventive colonoscopies, however, result in the identification of polyps that are removed during the preventive procedure. Therefore, Empire endorses and will adhere to the CMS guidance on correct coding for this situation. In cases such as this, CMS states that an ICD-9-CM routine/preventive diagnosis code (such as V76.51) should be entered as the primary diagnosis and the ICD-9 code for any discovered pathology should be entered as a secondary diagnosis.

Accurate coding will help ensure that you receive the correct reimbursement for services rendered and that our members receive their maximum benefit coverage for colonoscopy codes considered under preventive care. All other medically necessary covered services will be considered under the members' medical benefits.

Please keep in mind that payment levels and the member's cost share may also vary under members' medical benefit coverage.

Reminder: Transition to NextRx in January of 2009

As you know, NextRx will become Empire's new pharmacy benefits manager on January 1, 2009.

The new formulary, quantity limitations list,and prior authorization list can be found online at **empireblue.com**. New NextRx Prior Authorization forms are also available on empireblue.com. Simply look for the forms under the "Learn More" section of the Provider/Facility page. Please remember that the information and forms are for reference only right now and should not be used until January 1, 2009.

Please continue to use the process you currently follow with respect to drug benefits for your Empire patients through December 31, 2008. Be sure to visit **empireblue.com** to view Empire's new formulary and related information.

For any additional questions regarding this transition to NextRx please contact **800-992-BLUE (2583)**, Monday – Friday, 8:30 a.m. – 5 p.m.

Change to reimbursement for non-participating ambulatory surgery centers

Effective May 1, 2008, reimbursement for non-participating ambulatory surgery centers in Empire's 28-county New York service area was changed to more closely align with our member contracts. This may limit payment for services rendered in facilities that aren't part of Empire's participating provider network

The change impacts your patients covered by multiple products, including the following:

- PPO
- Empire Total BlueSM and Prism
- DirectPOS and DirectShareSM POS plans

If you're a participating physician, make sure you're performing ambulatory surgery procedures in an Empire participating network ambulatory surgery center. You should also talk with your patients about the many benefits of performing services in a participating ambulatory surgery center to avoid the additional out-of-pocket expenses associated with care rendered in a non-participating ambulatory surgery center. In many cases, members are liable for the difference between the reimbursement amount specified in the member contract and the out-of-network provider's charge. Also, payment to the non-participating ambulatory surgery center for out-of-network services will be sent to the member and not the out-of-network ambulatory surgery center, and the member is responsible for paying the non-participating ambulatory surgery center directly.

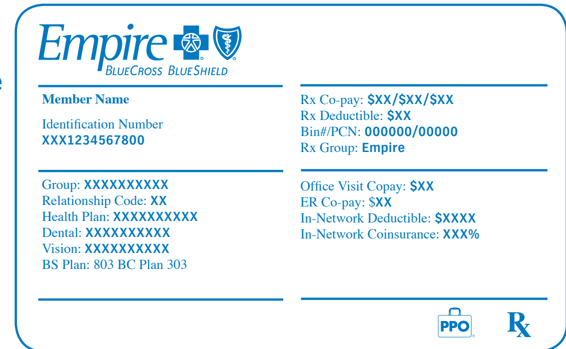
A listing of Participating Ambulatory Surgery Centers is available at **empireblue.com**.

Transition begins for newly formatted member ID cards

As you know, in November, Empire began the transition to a new format for our members' ID cards. We're making this change at the request of the Blue Cross and Blue Shield Association (BCBSA), the organization that governs all Blue Cross and Blue Shield plans nationwide.

The association has mandated the adoption of standardized ID cards across all Blue plans, effective January 1, 2009. The rest of the transition will be gradual and should be completed by 2011.

Please ask your patients to present their most current ID cards each time they receive services. For your reference, see the image on the right of the new member ID card.



Reminder: Outpatient spine surgeries will be reviewed for medical necessity in January of 2009

Beginning January 1, 2009, in addition to reviewing the medical necessity of inpatient spine surgery, we will begin reviewing certain types of outpatient spine surgeries for medical necessity. The spine surgeries that will be reviewed include but are not limited to fusion, excision of disc, and decompression surgery. We will utilize Milliman Care Guidelines medical necessity criteria to determine the medical necessity of these procedures when done on an inpatient or outpatient basis.

When these services are provided on an inpatient basis, the medically necessary review will be part of the inpatient pre-certification process that is already being performed today. When these procedures are provided on an outpatient basis, we will offer a voluntary pre-determination. The pre-determination enables the member and provider to verify the service meets our medical necessity criteria before delivering the care. Although a pre-determination is not required, we encourage providers to obtain one prior to performing any of these procedures. A pre-determination denial may be appealed before or after performing the procedure.

When a pre-determination is not obtained prior to the procedure, the claim for the service will be reviewed for medical necessity. Please be aware that records documenting the medical history and results of treatment and radiographic evaluations will be needed as part of this review whether done as a pre-determination or as part of the claim submission.

The spine surgeries that will be reviewed encompass the following CPT and ICD-9-CM procedure codes:

ICD-9 Procedure Code

Code	Description
03.09	Spinal Canal Explore Nec
80.50	Exc/Dest Intvrt Disc Nos
80.51	Excision Intervert Disc
80.59	Oth Exc/Dest Intvrt Disc
81.0	Spinal Fusion
81.00	Spinal Fusion Nos
81.04	Dorsal/Dorsolum Fus Ant
81.05	Dorsal/Dorsolum Fus Post
81.06	Lumbar/Lumbosac Fus Ant
81.07	Lumbar/Lumbosac Fus Lat
81.08	Lumbar/Lumbosac Fus Post

CPT Codes

0195T	Lumbar Spine Fusion
0196T	Lumbar Spine Fusion
22533	Lumbar Spine Fusion
22558	Lumbar Spine Fusion
22612	Lumbar Spine Fusion
22630	Lumbar Spine Fusion
63005	Remove Spinal Lamina
63012	Remove Spinal Lamina
63017	Remove Spinal Lamina
63030	Low Back Disk Surgery
63042	Low Back Disk Surgery
63047	Remove Spinal Lamina
63056	Decompress Spinal Cord

The following groups and or product types are not included in the spinal surgery pre-determination process at this time:

- FEP
- New York State BMP
- New York City
- Medi-gap
- Mediblue
- Medicare Primary and Empire Secondary
- Suffolk County
- National Accounts

Please note: This review does not replace any existing medical policies currently in place for other types of spine surgery not listed. For example, reviews for services such as artificial intervertebral disc or percutaneous disc decompression, for which medical policies currently exist, will continue to be reviewed using those medical policies whether done on an inpatient or outpatient basis.

Milliman Criteria is available upon request.

A pre-determination can be obtained by calling Empire Medical Management at **800-982-8089**.

If you have any questions, please contact Managed Care Provider Services at **800-552-6630**.

Have you returned your new provider agreement?

In August and September of this year we began an initiative to recontract with the entire participating provider network and sent you a new provider agreement. If you haven't returned the agreement, please do so as soon as possible.

Contact your Network Management Consultant by calling **800-992-BLUE (2583)**. Select the following prompts:

- Option 1: Medical Providers
- Option 4: Provider Updates and Other Information
- Option 1: Participation and Credentialing Information
- Enter your ZIP code

Empire Network Management Consultants heading your way

Historically, our Network manangement team has been solely office-based, with very limited face-to-face contact with our providers. Early in 2008, we began implementing a 3+2 program — a weekly work schedule which gives our team members the flexibility to meet face-to-face with providers in their respective territories two (2) days of the week. We look forward to meeting with each of you face-to-face, and hope to further improve your satisfaction and foster a more "personal touch" with our network. If we haven't already done so, we look forward to meeting with you very soon.

Fee schedules are available

If you need a copy of your fee schedule, you can fax a request to the attention of Provider Network Management at **718-312-6240.**

You can also obtain fee schedule information on our Physician Online Services at **empireblue.com**.

- Click on the "Physicians" tab and then register or log in.
- From your homepage, select "Searches" then "Fee Schedules."
- You can view fees by CPT code and modifier.

Blue coverage for Jamaican members terminated

Effective October 1, 2008, in-network health insurance coverage for international Blue members from Jamaica was terminated. Those membersor do carry ID cards with alpha prefix JAM.

Remember, to ensure eligibility and benefits, always verify patient coverage before rendering services by using one of your electronic technologies or by calling **800-676-BLUE**.

Please note the following

- You should not accept ID cards with alpha prefix JAM after September 30, 2008. Claims for services rendered after this date will not be reimbursed through the BlueCard® program.
- For services rendered before October 1, 2008, submit all claims to Empire by February 1, 2009.
- Original claims and adjustments submitted after February 1, 2009, for services provided prior to October 1, 2008, will not be reimbursed through BlueCard.

The CoverMe Foundation helps connect uninsured with free or reduced-cost health care

The CoverMe Foundation (CMF), a national nonprofit organization, is helping uninsured consumers by offering free, step-by-step assistance to identify and apply for health care coverage. It's part of the foundation's mission to improve the overall health of Americans throughout the United States.

CMF is aware that the application process can be confusing to many of the uninsured. The Foundation first educates and then helps the applicant gain access to health care resources. With the goal of long-term health, CMF seeks to serve communities on a variety of levels.

In addition to health care coverage assistance, CMF offers comprehensive health care information for groups that are often underserved, including the uninsured and underinsured, elderly and disabled, and children and pregnant women. CMF also provides information on prescription assistance programs and medical treatment programs.

The CoverMe Foundation is funded by a $2.5 million grant from the charitable giving arm of Empire's parent company, which supports innovative programs that help cover the uninsured.

For more information on The CoverMe Foundation and its services, or if you are an organization or individual interested in partnering with CMF in its efforts to help America's uninsured population, please call **877-NSURME-1** or visit the website at **covermefoundation.org**.

Behavioral health news

Keep us informed of changes to your practice

Help us keep your demographic information current and let us know about important practice changes by filling out the Behavioral Health Provider maintenance form. You'll find the form online at **empireblue.com**; select the "Provider/Facility" link and look under the "Provider Spotlight" for "Information on Empire's Behavioral Health," then choose "Forms."

Why keep us up-to-date?

- Allows us to offer the most current information online and in printed directories
- Provides accurate referral information
- Helps ensure prompt delivery of payments and Empire newsletters to correct addresses

You can also fax updates to Behavioral Health Provider Network Management at **718-312-6340**. If you have any questions, contact Behavioral Health Provider Network Management at **866-221-1395**.

Pass-through visit renewals

Empire recognizes that regular maintenance visits are often indicated for patients with chronic psychiatric illness. To simplify the administrative management of these patients, for those plans administered by Empire's Behavioral Health, you are not required to submit an Outpatient Treatment Report (OTR) until 12 pass-through visits have occurred.

In calendar year 2009, 12 behavioral health sessions per provider are eligible for coverage for Empire local members only, without prior authorization or an OTR submission. This applies to members who begin treatment in 2009, as well as to members who were in treatment in 2008, and who have exhausted any initial pass-through visits that were assigned by Empire prior to 2009.

Please note the following:

- This doesn't apply to Empire National Accounts, State of NY or City of NY
- FEP members are excluded from pass-throughs. All visits must be prior-authorized.
- Out-of-state members' Home Plans need to be contacted to determine utilization management rules.
- Psychiatrists and Nurse Practitioners: 90862s are not managed and no authorization is required.
- No prior authorization is needed for Empire local members for therapy visits.
- For local Empire members, any unused, authorized visits expire as of December 31, 2008.

For details, contact the Behavioral Health telephone number on the back of the member's card, or contact Behavioral Health Provider Relations at **866-221-1395**. To get a copy of the OTR form, visit **empireblue.com.**

Medical Necessity Criteria has been updated

Updates to Empire's Behavioral Health Medical Necessity Criteria (MNC) will be effective January 1, 2009. MNC can be found on **empireblue.com**. Select "Behavioral Health Information" in the "Spotlight" section, then select "Policies and Guidelines."

Changes may affect UM reviews for specific levels of care and diagnoses. For more information, contact Behavioral Health Provider Relations at **866-221-1395.**

MediBlue[SM] news

Annual benefits changes for Medicare Advantage plan members

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2009. The changes apply to members enrolled in Empire's MediBlue HMO, MediBlue PPO and MediBlue Total Solutions plans. We want you to be aware of these changes so you can help your patients manage their health care costs.

Each year, we recontract with the Centers for Medicare and Medicaid Services (CMS). CMS re-evaluates and gives approval to the benefits Empire will offer to our MediBlue members for the upcoming year. The following are notable changes by plan type.

Notable benefit changes by plan type

- *MediBlue HMO plans — 2009 changes*
  - Ensuring all preventive benefits are accessible without member cost-sharing including: routine physical exams, bone mass measurement, colo-rectal screening, mammogram, breast exam, abdominal aortic aneurysm, pap/pelvic and prostate screening.
  - Implementing member out-of-pocket limits to which cost-sharing for most Medicare covered expenses apply.
  - Instituting physician copayment changes on some plans. Member ID card will reflect the change, if any.
  - Standardizing days to which inpatient hospital copayment applies, to a maximum of seven (7) days.
  - Outpatient Part B drugs, including chemotherapy drugs, will move from a 10 percent to 20 percent co-insurance cost-share in-network.
    - When chemotherapy and Part B drugs are billed at the same time, 20 percent coinsurance will be applied to each.
    - We understand that Part B drugs are expensive, and we have conducted an analysis of competitor member cost sharing for this benefit category. The competitive analysis found that the Medicare Advantage industry in general applies cost sharing to this benefit category, and the most common cost share applied to this benefit category in 2008 is 20 percent.
    - We are adding an out-of-pocket maximum to our plans for 2009, which is intended to limit costs on a significant portion of the members taking expensive Part B drugs. For each service, the plan will pay 80 percent and the member will be responsible for 20 percent, until the member reaches the out-of-pocket maximum. Once the member reaches the out-of-pocket maximum, the member will not need to pay coinsurance and the plan will pay 100 percent of the cost of most Medicare covered services.
    - Please note that Original Medicare has a 20 percent coinsurance with no out-of-pocket maximum. Our Medicare Advantage plans are a good option to traditional Medicare coverage as they offer coordinated and comprehensive care, often with added benefits.
  - Addition of 10 percent coinsurance on renal dialysis and diabetic supplies, which will also be mitigated by the out-of-pocket maximum.
  - Travel benefit implemented last year is being eliminated.
  - Benefit details will be available at **empireblue.com/medicare**.

- *MediBlue PPO plans — 2009 changes*
  - Providing access to Medicare-covered preventive care tests and screenings in-network with no cost sharing for member/patient. This includes: routine physical exams, bone mass measurement, colorectal screening, mammogram, breast exam, abdominal aortic aneurysm, pap/pelvic and prostate screening.
  - Implementing member out-of-pocket limits to which cost-sharing for most Medicare covered expenses, whether in- or out-of-network, apply.
  - Eliminating all remaining out-of-network deductibles.
  - Outpatient Part B drugs, including chemotherapy drugs, will move from a 10 percent to 20 percent co-insurance cost-share in-network. (See above for additional information on this.)
  - Addition of 10 percent coinsurance on renal dialysis and diabetic supplies, which will also be mitigated by the out-of-pocket maximum.
  - We are pleased to be able to introduce a zero premium PPO Value plan in our 18-county service area.
  - Termination of all PPO plans for which Part D drugs were not integrated (i.e., MA-only)
  - Benefit details will be available at **empireblue.com/medicare**.
  - For more information on the transition of our Pharmacy benefits manager from CareMark to NextRx, see the article on page 2 or visit **empireblue.com**.
- *MediBlue Total Solutions plans*
  - The Empire product available to those dually eligible for Medicaid and Medicare has the following benefits changes for 2009:
    - A member Part D premium will be implemented at $22.50 per month to cover the inclusion of an integrated Part D drug benefit. Based on low income subsidy guidelines, members that qualify for "Full Extra Help" will not have to contribute toward the premium. Members that qualify for "Partial Extra Help" will have to pay part of the premium based on a sliding scale.
    - Medicare Part D Prescription drug coverage changes
    - To obtain information on copayments and prescription drug benefits changes for 2009, visit **empireblue.com/medicare** and access the summary of benefits, or contact Empire Physician Services at **800-992-BLUE (2583)**, Monday – Friday, 8:30 a.m. – 5 p.m.
  - We've changed the MediBlue Formulary. Please visit **empireblue.com/medicare** to view the most recent changes and assist members in selecting alternatives that help manage their out-of-pocket costs.
  - MediBlue continues to cover formulary generic drugs for MediBlue HMO and MediBlue PPO plans that offer Part D coverage, after a member reaches the Part D initial coverage limit. Members will receive coverage for generic drugs through the Medicare Part D coverage gap.
  - Initial coverage limit for Medicare Part D will increase from $2,510 to $2,700 a year.

Please visit **empireblue.com/medicare** to view 2009 benefit plan changes.

Working together to encourage seniors to get active

As always, we want to help you encourage older members to consider the benefits of physical activity in preventing a broad range of health problems, including:

- Helping to reduce risk of developing heart disease, overall mortality, colon cancer, diabetes, obesity, hypertension and injuries from falling
- Helping to reduce incident of dementia and depression

Physical activity also helps manage active problems such as high blood pressure, diabetes, obesity and high cholesterol. It improves function and helps older adults stay independent in the face of problems such as lung disease and arthritis.

2007 American College of Sports Medicine (ACSM) fitness recommendations

- Minimum of 30 minutes of moderate-intensity aerobic activity five days each week or a minimum of 20 minutes of vigorous-intensity activity three days each week.
- In addition, at least twice each week older adults should perform 8-10 muscular strength and endurance exercises on nonconsecutive days using the major muscle groups.
- Older adults should perform activities that maintain or increase flexibility at least two days each week for at least 10 minutes each day.
- To reduce risk of injury from falls, community-dwelling older adults with substantial risk of falls should perform exercises that maintain or improve balance.
- Older adults with one or more medical conditions for which physical activity is therapeutic should exercise in the manner that effectively and safely treats the condition(s).

You play a major role in encouraging physical activity in your older patients

Because you know your patients' health status, you have the unique ability to personalize the ACSM physical activity recommendations for them. Continue taking an active role in helping your patients achieve a healthier lifestyle by asking them about their current level and frequency of physical activity and encouraging them to increase it over time,

Tell your Medicare patients about the SilverSneakers® Fitness program

One way to get your patients more physically active is through a program especially designed for older adults. The SilverSneakers Fitness program includes a basic membership at any participating location (gym, YMCA, JCC, etc.) and offers group exercise classes that provide all the recommended types of physical activity: cardio, muscular strength and endurance, flexibility, balance and even a cognitive workout.

The SilverSneakers® Fitness Program is offered at no additional cost to MediBlueSM HMO*, PPO and Medicare Supplement members. To find a participating SilverSneakers Fitness Program location in your area, call **888-423-4632**, Monday – Friday, 8 a.m. – 8 p.m. Eastern Time or visit **silversneakers.com**.

*SilverSneakers is not offered to MediBlue℠ Total Solutions (SNP) plan members.

Web news

New provider record update forms now available on the Web

Update your online provider records to help reduce disruption to the payment process and make sure your claims are paid in a timely manner. Updates also help ensure that your patients are accessing the most accurate and up-to-date information about you.

To help you update your profile, we've created Provider Record Update forms that are available at **empireblue.com**. Click on the Provider/Facility tab and then look for the link to Forms and Quick Guides under the "Learn More" section.

You'll find three forms

- Individual Provider Tax ID Update
- Individual Provider Billing Address Update
- Individual Provider Record Update

Visit **empireblue.com** and make sure that the information we have displayed for you in our provider directory is accurate. If it isn't, please use the forms to update your information.

Now online: Coordination of Benefits questionnaire

As we continue to streamline our claims processing and help reduce the number of denials related to Coordination of Benefits (COB), we've added a COB questionnaire form to our website at **empireblue.com** that will help you and your patients avoid potential claim issues.

When you see any of our members and you're aware that they might have other health insurance coverage (e.g., Medicare), please give a copy of the COB questionnaire to them. Ask them to complete the COB questionnaire and send it to the Blue Plan through which they are covered as soon as possible after leaving your office. Members can obtain the address to which the COB questionnaire should be mailed from the back of their member ID card or by calling the customer service numbers also listed on the back of the card. Collecting COB information from members before you file their claims eliminates the need to gather this information later, thereby helping to reduce processing and payment delays.

Cancer Survivorship CME program extended — free and online

The clinically respected and well received course "Late Effects of Cancer Treatment and Survivorship: Strategies for Primary Care and Oncology Care Providers," has been extended through September 15, 2009.

The course was designed to help clinicians reduce adverse health outcomes for cancer survivors, and to promote communication between oncology and primary care providers.

The program also supports the Institute of Medicine's recommendation that each cancer patient receive a Survivorship Care Plan. The Survivorship Care Plan summarizes information that's critical to a cancer patient's long-term care, and is used in the transition of care following active cancer treatment. Survivorship Care Plans increase patients' and Primary Care Providers' comfort and confidence to monitor and manage late effects of cancer treatment.

To access the program, visit **cemedicus.com/cancersurvivorship**. Three AMA PRA category 1 credits and CEUs for nurses are provided. There is no charge for this activity.

Direct your questions to Lynn Stillman, RN, at **603-695-7848**.

Find more of the BlueCard® information you need

By year's end, you'll find more information about BlueCard members through our EDI system. You can access more eligibility, benefits and claims status information for most BlueCard members from other Blue Plans.

You can access the same up-to-date information that's available to our Customer Service Representatives. Just submit an EDI Eligibility Inquiry (270/271) or Claims Status Inquiry (276/277) transaction, or log in to Empire Physician Online Services at **empireblue.com**.

BlueCard information enhancements

Eligibility and benefits: Benefit Accumulators reflect data that has been updated within the last 36 hours.

- Accumulated deductible information (Health Savings and Health Reimbursement Accounts [HSAs and HRAs] are not available at this time)
- Accumulated benefit limitations
- Out-of-pocket benefit information, including static and real-time accumulated benefit information (Out-of-pocket amounts include copayments, deductibles and coinsurance unless otherwise noted or excluded)
- Accumulated data will be provided at the same level as the static deductible limits
- Accumulated amounts are not returned for service types that are specific to sensitive benefits (see list below), but static amounts are returned for deductibles/ maximum benefit limits for the follow service types:

  61 — In vitro fertilization

  69 — Maternity

  83 — Infertility

  84 — Abortion

  A6 — Psychotherapy

  A7 — Psychiatric – inpatient

  A8 — Psychiatric – outpatient

  AI — Substance abuse

Static amounts on these additional sensitive benefit service types may be returned for some plans, but accumulated amounts for deductibles/maximum benefit limits are not returned:

A4 — Psychiatric

A5 — Psychiatric – room and board

A9 — Rehab

AA — Rehab – room and board

AB — Rehab – inpatient

AC — Rehab – outpatient

AJ — Alcoholism

AK — Drug Addiction

BB — Partial Hospitalization (Psych)

BC — Day Care (Psych)

BD — Cognitive Therapy

Claim status: Search process

- A standard process that searches member verification first then searches claim information
- Member verification includes
  - Subscriber ID
  - Patient date of birth (DOB)
  - Patient first name
  - Patient last name
  - Note: New enhancements will correct names for Claim Status transactions, but patient DOB and Subscriber ID must be an exact match. Even if a member isn't found, the system will attempt to find the claim.
- Additional claims search is based on Provider ID, Subscriber ID, Patient DOB and Service Data Range.

What do these changes mean for you?

- Fewer "not found" responses for Claim Status transactions
  - If the system doesn't find an exact match for a claim number, it will return all claims that match your other search criteria.
  - Patient information is automatically corrected. For example, if a patient is mistakenly submitted as a subscriber instead of a dependent, or vice versa, the system will display the correct information.
- Lower administrative costs and more robust patient information. It means that the same up-to-date information can be accessed via an EDI transaction or through empireblue.com that is available to you when calling our Customer Service Representatives.

If you have questions about electronic transactions, please contact one of our EDI Solutions Specialists at **866-889-7322**, Monday – Friday, 8:30 a.m. – 4:30 p.m.

REGISTER TODAY FOR FREE EMPIRE PHYSICIAN ONLINE SERVICES

If you're not already registered for Empire Physician Online Services, just visit empireblue.com and select "Providers/Facility." Choose the "Register Now" link to sign up today.

EDI news

CAQH streamlines process for eligibility and benefit inquiries

As a founding member of the Council for Affordable Quality Healthcare (CAQH), Empire supports the CAQH initiatives to help reshape the health care environment to improve the health care experience and streamline administrative processes. CAQH is a not-for-profit collaborative alliance of the nation's leading health plans and networks and their trade associations.

CORE's all payer solution

In its latest efforts, CAQH created the Committee on Operating Rules for Information Exchange (CORE), which provides agreed-upon business rules for using and processing transactions to make it easier for you to find pertinent information about our members. Using a CORE-enhanced electronic data interchange (EDI) format, you have secure access to more expanded insurance information — such as eligibility and benefits — for any patient or health plan before or at the time of service using the *electronic system of your choice*.

Providers realize benefits of payer CORE certification

Empire supports the CORE initiatives and is already "CORE certified." We continue to work to help ensure our certification keeps step with CORE enhancements.

The availability of consistent information in real-time at the point of care can help reduce the administrative burden and improve the provider/patient experience and satisfaction. There are several reasons why we urge you to consider using these transactions electronically.

Creates a standardized process, improving identification of members and their benefits.

- Increases capability to request payer administrative data electronically.
- Increases speed and accuracy of claims processed through cleaner claims submissions.
- Provides real-time and batch access to eligibility, benefits (such as accumulated deductibles, benefit limitations and out-of-pocket information) and claim status information.
- Offers an all-payer administrative data exchange solution by using self-service electronic tools/transactions.
- Complies with Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations.

Real-time EDI transactions available

You can access information from an electronic system of your choice for the following HIPAA electronic standard transactions:

- *270/271 Health Care Eligibility Benefit Inquiry and Response* — The "270" and "271" electronic standard transactions work together. The "270" inquiry standard transaction is a request for information such as patient eligibility, coverage verification and patient liability (deductible, co-payment or co-insurance). The "271" standard transaction is the corresponding electronic reply to the inquiry. Depending on the payer's systems, information may be electronically transmitted in a real time or batch request environment
- *276/277 Health Care Claim Status Request and Response* — You can use the "276" standard transaction to verify claim status through a real time or batch transmission. The corresponding "277" response transaction indicates whether the claim has been paid, denied or is in process.

Many clearinghouses/EDI vendors already transmit 270/271 and 276/277 transactions

We encourage you to contact your clearinghouse and/or software vendor to learn more about electronically submitting and receiving eligibility, benefits and claim status inquiries/responses. Clearinghouses and vendors often have easy-to-use Web and automated solutions that can further enhance the benefits of utilizing these transactions electronically.

Advantages of using clearinghouses/ EDI vendors

- Verifies coverage before services are provided
- Collects copayments at the time of service
- Streamlines claim management and reduces payer callbacks
- Reduces rejections and denials due to eligibility errors
- Verifies information in a consistent format for multiple payers simultaneously through one portal
- Uses responses to track claim status and correct patient information for future claims submission

Empire Companion Guides

To learn more about sending and receiving 270/271 Health Care Eligibility Benefit and 276/277 Health Care Claim Status standard transactions, just visit our website at **empireblue.com** to view our Empire Companion Guide. Or, if you prefer, contact our EDI specialists at **866-889-7322**, Monday – Friday, 8:30 a.m. – 4:30 p.m.

To learn more about CAQH, CORE certification or a listing of CORE participating organizations, visit **caqh.org**.

Reviewing your EDI reports

Taking time to review your electronic reports is a vital part of the electronic claims billing process. Timely delivery and review of reports allows you and/or the submitter of the file to identify submission errors and make necessary corrections for re-submission, often without missing a remittance cycle. Empire reports provide valuable resources to assist in discussions with your clearinghouse or EDI vendor and resolving errors. Below is an explanation of key Empire reports delivered to the submitters' mailboxes when an electronic claim submission is made to Empire.

Short Confirmation Report

Provides high level status of a production or test file upload. Created immediately after file upload and can be downloaded one time only.

Functional Acknowledgement – 997

Report confirms our initial acceptance and/or rejection of claim files you've submitted to us. Empire validates the files we receive to ensure the file is addressed appropriately and its contents are valid based on file structure and submission requirements mandated by HIPAA. Errors identified on this HIPAA report cause the entire file to reject.

Confirmation Report

Provides notification of a server error condition for X12 837 and X12 276 version 4010A1. Report is created within 24 hours after upload.

EMC Receipt Report

Report results of validation performed in the EMC Front-end system. Provides summary and detail information on claim submissions. Summary advises if submission was accepted and Detail section identifies errors and individual claims rejected. This report validates code sets, data structure and balancing based on HIPAA file structure and submission requirements. The report also provides a summary detail for total claim(s) and charge(s) submitted, passed and failed. Errors identified will cause individual claims to reject. Claims that are rejected on the EMC Receipt Report do not get forwarded to the claims adjudication system.

If you have contracted with a third party (e.g., a billing service or clearinghouse) to submit your claims, you will not receive an EMC Receipt Report from Empire. Your billing service or clearinghouse should give you reports that allow you to track the claims they have submitted to Empire on your behalf. Please take the time to familiarize yourself with those reports to alleviate any potential delay with your claims process.

Any claim that is rejected by Empire is not considered a clean claim and therefore, is not considered to have been timely submitted within the claim submission timeframe specified in your provider agreement (e.g. 180 days).

Work with vendors to ensure timely report delivery

Providers are responsible for working with their EDI vendors (clearinghouse, billing agencies and/or software vendors) to ensure they're receiving electronic reports in a timely manner. In addition, providers should make sure that office personnel receive the appropriate training on retrieving and processing reports. If claims with errors or rejections are not corrected and resubmitted, you may not receive reimbursement for the work your practice performs. Please note that all providers are encouraged to archive reports should they need to show proof of timely filing.

Need more information about electronic reports and other EDI transactions?

Contact an EDI Specialist for assistance at **866- 889-7322**. EDI Specialists are available Monday – Friday, 8:30 a.m. – 4:30 p.m. If you prefer, visit our website at **empireblue.com** and view the Empire EDI Companion Guide for specifics on acknowledgements and reports.

Health reminders

For your patients: ConditionCare program

It's an innovative program that offers a coordinated, personalized approach to health care. The ConditionCare program identifies and addresses specific health issues and lifestyle challenges for your patients who are diagnosed or are at risk for chronic conditions such as pediatric and adult diabetes (types 1 and 2), chronic kidney disease, congestive heart failure, cystic fibrosis, lupus and asthma.

Our collaborations with Accordant Health Services, Village Health and American Healthways allow us to further support providers by offering the following voluntary services at no additional cost to help empower our members with the goal of positively impacting their conditions and decreasing complications.

- 24-hour toll-free access to registered nurses who can offer educational information and materials, and answer questions to help the member manage their condition.
- Personalized regular telephonic case management by a registered nurse, who assesses our members' progress and offers support, encouragement and education on how best to manage their conditions, make positive healthy choices and help avoid complications through monitored compliance.
- Mailings of educational materials and tools such as workbooks, newsletters, flow meters, care guide and self-care tips.
- Regular data reports to you (in designated programs and with a member's agreement), which identify at-risk members and changes in clinical status or other pertinent information.

How can you empower your patients and enroll them in the ConditionCare Program? Call us toll-free at **866-596-9812** (NY) or **866-332-0131** (CT).

Quality initiatives

Access standard guidelines for wait times

Visit empireblue.com to access the standard guidelines for wait times in physician's offices for regular and routine appointments, urgent care appointments and after-hours care, as well as information on physician back-up coverage responsibilities. Once you're on the site, select "Provider Sourcebook" then "Physician Responsibilities." Next, choose "Chapter 4: Physician Responsibilities."

You can also request a paper copy of the "Provider Sourcebook," which explains standards and responsibilities for appropriate back-up coverage. Contact Empire Physician Services at **800-992-BLUE (2583)**.

HEDIS® 2008: Opportunities to improve

Thanks to those of you who participated in the Healthcare Effectiveness Data and Information Set (HEDIS®) project this year. The timeframe for collecting HEDIS information is very limited and we thank you for cooperating, promptly submitting the requested medical record information and/or accommodating the on-site appointment with the review nurses. As is the case every year, Empire's overall HEDIS 2008 scores for New York HMO products increased significantly. Congratulations for providing such good care to your patients!

You play a central role in promoting the health of our members. One way to help improve care is to document services in a consistent way, so that it's easy to track the care that's been provided and the additional care that may be needed within recommended timeframes. Consistent documentation will also help improve HEDIS scores, both by improving care itself and by improving our ability to report validated data.

The table on page 13 shows several areas where we have opportunities to do even better. These key measures show where aggregate plan performance decreased from HEDIS 2007 to HEDIS 2008, and/or rates do not yet meet the benchmark national 90th percentile.

Measure	HEDIS 2007	HEDIS 2008	HEDIS 2008 90th percentile of health plans
Preventive Health and Acute Care			
Childhood Immunizations - Polio	88.32%	87.47%	97.04%
Childhood Immunizations – DtaP	83.94%	83.06%	93.45%
Childhood Immunizations – MMR	91.97%	90.72%	97.12%
Colorectal Cancer Screening	57.18%	56.26%	69.21%
Breast Cancer Screening	65.02%	64.72%	77.01%
Chronic Disease Care			
Comprehensive Diabetes Care			
Screening for Nephropathy	75.82%	79.78%	86.49%
Annual Monitoring for Patients on Persistent Medications			
Anticonvulsants	65.07%	64.20%	68.82%
Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	86.07%	82.20%	90.64%
Mental Health Care			
Antidepressant medication management for new episodes of depression			
Continuation phase treatment (medication compliant first 180 days)	52.53%	49.87%	53.64%
Follow-up care for children newly prescribed with ADHD medication			
Initiation Phase (one visit in first 30 days)	34.02%	30.06%	44.86%
Continuation and Maintenance Phase (two additional follow-up visits within nine months)	45.24%	34.03%	51.26%

HEDIS® 2009: Changes in documentation

We'll begin collecting HEDIS data once again in February 2009. There are a few changes that we want to make you aware of before the medical record information is collected.

Important new documentation requirements

- *Two new measures require documentation of Body Mass Index (BMI).*
  - Children and adolescents ages 2 to 17 — Documentation of BMI percentile, counseling regarding physical activity and counseling regarding nutrition in 2008
  - Adults age 18 to 74 — Documentation of BMI result in 2008
- *Childhood Immunization measure* — Starting in 2010 we will require documentation of two (2) Hepatitis A, three (3) rotavirus and two (2) influenza vaccines in addition to the current immunizations required in 2007. This means that your office will need to ensure documentation of these vaccines in 2009 to be compliant in 2010.
- *Reappearance of an Adolescent Immunization measure* — Starting in 2010 we will require documentation of one meningococcal and one DTaP or Td vaccination by the time the adolescent reaches age 13.

Again, we thank you and your staff for demonstrating teamwork and partnership as we work together to improve the health of our members, your patients. Let's look forward to the next HEDIS season!

Survey says: Patients see room for improvement with physician care

Every year, Empire sends out the Consumer Assessment of Health Plans Survey (CAHPS) to its HMO/POS members. The survey gives Empire members an opportunity to share their perceptions of the quality of care and services provided by our HMO/POS network physicians. This same survey is used by all HMO/POS plans that undergo accreditation review by the National Committee for Quality Assurance (NCQA).

Survey results show Empire members' satisfaction with network physicians is mixed

The charts on the right compare results from the year 2007 with those in the year 2008. You'll also see two other columns. One shows the 2008 Percentile Achieved comparing Empire's network scores to scores from other HMO plans across the country. The other column references the 90th percentile score, which reflects the score achieved by plan networks that are the best in the country. This is the score we encourage our network physicians to achieve.

We encourage you to assess your own medical practice

When you're reviewing these results, we encourage you to focus on and address those areas of your own practice that may have room for improvement. Addressing those areas will help ensure our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the level of services provided.

2008 New York HMO/POS CAHPS Adult Member Satisfaction Survey results

Survey Question	2007	2008	Percentile Achieved[4]	90th Percentile Goal[4]
Rating of physician[1]				
Rating of personal doctor	78%	76%	<10th	86%
Rating of specialist seen most often	81%	74%	<10th	86%
Rating of all health care provided in past 12 months	72%	73%	25th	80%
Getting care quickly[2]				
Got appointment for non-urgent care as soon as needed	85%	82%	10th	89%
Got appointment for urgent care as soon as needed	91%	86%	25th	92%
Got needed care after regular office hours	52%	57%	NA	N/A
Communication with patients[2]				
How often doctors/health providers listen carefully to you	92%	92%	25th	95%
How often doctors/health providers explained things understandably to you	93%	92%	10th	97%
How often doctors/health providers showed respect for what you had to say	95%	93%	10th	97%
How often doctors/health providers spent enough time with you	89%	88%	10th	93%
Shared Decision Making[3]				
Doctor discussed pros and cons of each treatment choice?	62%	62%	25th	70%
Doctor asked you which treatment choice was best for you?	54%	57%	50th	61%
You and your doctor discussed ways to prevent illness?	58%	56%	25th	65%
Continuity of Care[2]				
How often did your personal doctor seem informed about care you received from other health providers?	77%	75%	10th	84%

1 Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 Percent responding "Usually" or "Always."
3 Percent responding "Definitely Yes"
4 Percentile Definition — A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.

NOTE: The source of data contained in this report is Quality Compass® 2008 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

New measure on CAHPS survey targets patient treatment plans

The CAHPS Member Satisfaction survey from the NCQA has a new measure related to "Shared Decision Making." It asks members the following questions about their treatment choices:

- Doctor discussed pros and cons of each treatment choice? (2008 CAHPS score = 62.1 percent answered "Usually or Always")
- Doctor asked you which treatment choice was best for you? (2008 CAHPS score = 56.9 percent answered "Usually or Always)

Share treatment options with patients

It's important that you share treatment options with their patients because we measure this via our CHPS surveys and are held accountable by NCQA for the providers' actions. However, what's most important is that providers follow the treatment protocols because they enhance patients' health care experience and involve patients in their own treatment plans. For more information, please contact Empire Physician Services at **800-992-BLUE (2583)** from Monday – Friday, 8:30 a.m. – 5 p.m.

You can access clinical practice guidelines on the Web

As part of our commitment to give you the latest clinical information and educational materials, clinical practice guidelines are reviewed annually and are available to you on our website. The guidelines are adopted from recognized sources and are used for our Quality programs. They're based on reasonable medical evidence, the newest technological advances and most recent medical research. *The guidelines provide recommendations and are the generally accepted "standards of care" for specific conditions.* Empire's clinical practice guidelines help providers and their patients make decisions about appropriate health care for specific clinical conditions as well as staying healthy through the prevention care.

To view the guidelines, go to **empireblue.com** and select "Providers & Facilities." Choose "Enter" and select "Health Information," then "Clinical Practice Guidelines."

If you'd like a paper copy of any of the guidelines, please contact our Clinical Quality Department at **203-985-6171** or **800-545-0948, ext. 6171.**

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Policy updates

These updates list the new and/or revised Empire medical policies, clinical guidelines and reimbursement policies. The implementation date is noted for each section. Implementation is effective for all claims processed on and after the specified date, **regardless of date of service**. Previously processed claims will not be reprocessed as a result of the changes. If there is any inconsistency or conflict between the brief description provided below and the actual policy or guideline, the policy or guideline will govern.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and Clinical Guidelines (and Medical Policy takes precedence over Clinical Guidelines) and must be considered first in determining eligibility for coverage. The member must be eligible for coverage and membership must be active at the time services are rendered. This document supplements previous Medical Policy and Clinical Guideline Updates. Please place this update with your Sourcebook for future reference. The medical policy and clinical guideline details can be found at **empireblue.com**.

Reimbursement policies online – good news!

In continuing efforts to better serve you, beginning in the early second quarter 2009 we will start posting reimbursement policies on **empireblue.com**.

The following reimbursement policy updates will be effective for all claims processed on or after **March 20, 2009**, regardless of the date of service.

Assistant surgeon

Reimbursement for assistant surgeon services will continue at 16 percent of the allowed amount when modifiers 80, 81 and 82 are reported. Modifier AS identifies the physician assistant and registered nurse first assistant providing assistant surgery services. Reimbursement will be at 14 percent of the allowed amount when modifier AS is reported. The 14 percent is an increase from the current 10 percent.

Counseling (99401-99404)

Counseling services (99401-99404) will be allowed separately with evaluation and management (E&M) (99201-99215) and denied as an integral component of preventive services (99391-99397). The counseling codes are currently considered an integral component of E&M and preventive services.

Global obstetric

Currently, the global obstetric allowed amount includes a number of high risk prenatal diagnoses and services provided to the member by different providers. The updated global obstetric allowed amount will include prenatal visits for routine maternity diagnoses, the delivery and post natal care by the provider performing the delivery. Claims reporting non routine diagnoses or care by a different provider will no longer be considered part of the global obstetric allowed amount. The current routine maternity diagnoses follow; however, this list may be updated as new ICD9 diagnoses codes are developed:

V220	upervision of normal first pregnancy
V221	Supervision of other normal pregnancy
V222	Pregnant state; incidental
V2381	Elderly primigravida (first pregnancy for woman who will be 35 yrs or older at delivery
V2382	Second or more pregnancy for woman who will be 35 years or older at delivery
V2383	First pregnancy in female less than 16 at time of delivery
V2384	Second or more pregnancy in female less than 16 at time of delivery
V240	Postpartum care/exam after delivery
V241	Postpartum care/exam lactating mother
650	Normal delivery
6500	Unspecified as to episode of care or not applicable

Modifier reimbursement updates

22 Unusual services — Documentation describing the services must be attached to determine if eligible for additional reimbursement of 20 percent. If documentation is not submitted, the claims will process in accordance with the fee schedule amount allowed for the procedure without the modifier. Currently, no additional consideration is given to claims reporting modifier 22.

63 Procedures performed on infants less than 4kg — Documentation describing the services must be attached to determine if eligible for additional reimbursement. If no attached documentation is submitted, the claims will process in accordance with the fee schedule amount allowed for the procedure without the modifier. Currently, no additional consideration is given to claims reporting modifier 63. Note that modifier 63 should not be reported with procedures in appendix F of the AMA CPT book.

Procedures in the post-operative period

Procedures reported in the global period of a prior procedure must be reported with either modifier 58 (staged), modifiers 78 (return to operating room) or 79 (unrelated procedure). Claims submitted without the appropriate modifier will be considered to be part of the initial procedure and denied. The submission of the modifier will help facilitate faster and more efficient claim payments.

Tissue marker (A4648)

Tissue marker procedure may be reimbursed separately. Currently, the charge for the tissue marker is considered to be an integral component of the procedure and is not allowed separately. Please note that when reported in the facility setting the facility agreement will determine reimbursement.

Multiple surgery and endoscopy procedures — applied to MediBlue member claims only

Multiple endoscopy surgical procedures performed in the same operative session and are within the same base code family will be subject to multiple procedure reduction according to a methodology that approximates the CMS logic. The reduction will be applied using specific percentage reductions which will vary by code family. The code ranges and percentages are as follows:

Base Family	Codes	Percentages
Shoulder arthroscopy	29805–29826	100% primary; 30% subsequent
Elbow arthroscopy	29830–29838	100% primary; 25% subsequent
Wrist arthroscopy	29840–29847	100% primary; 25% subsequent
Hip arthroscopy	29860–29863	100% primary; 25% subsequent
Knee arthroscopy	29870–29887	100% primary; 35% subsequent
Bronchoscopy	31622–31631, 31635-31636, 31638, 31640–31641, 31645	100% primary; 25% subsequent
Upper GI endoscopy	43231, 43232, 43235–43259	100% primary; 25% subsequent
Colonoscopy	45378–45392	100% primary; 25% subsequent
Retrograde Cholangiopancreatography (ECRP)	43260–43265, 43267–43269, 43271-43272	100% primary; 25% subsequent

Other endoscopy code families and surgery procedures, not specified above, will be reimbursed based on multiple surgery reduction (MSR) policy of 100 percent for the primary and 50 percent for each payable subsequent procedure.

The primary surgery designation for all MSR will be based on the highest relative value based on CMS National Physician Fee Schedule Relative Value File using either facility or non-facility based on the place of service. The appropriate facility or non-facility relative value will be determined based on the place of service billed for the procedure.

Claims editing software update

In a continuing effort to achieve consistency with nationally accepted coding guidelines as well as to enhance accurate, efficient claims processing, Empire will be migrating to a new claims editing software program early in the second quarter of 2009. In implementing this new software, we will continue to employ all existing payment policies with the changes noted above. (We will continue to communicate future changes ninety (90) days in advance of the implementation date.)

As we migrate to this new software from a different vendor, please keep in mind that although the payment rules are the same, there may be minor differences in the system logic the vendor used to implement these rules. As a result, you may see some minor differences in edits even though the rule upon which they are based is consistent with current edits and policies. The software program will be updated on a quarterly basis as new procedure codes are developed in the CPT and HCPCS code updates of codes, including CMS' Correct Coding Initiative (CCI). The quarterly updates will be incorporated without specific notification.

Medical policies

Revised medical policies effective 08-28-2008
(The following policies were reviewed and had no significant changes to the policy position or criteria.)

ADMIN.00002	Preventive Health Guidelines
ADMIN.00006	Medical Necessity and Investigational and Not Medically Necessary (in the absence of policy or guideline)
TRANS.00014	Mechanical Circulatory Assist Devices (Ventricular Assist Devices and Artificial Hearts)

New medical policies effective 10-01-2008

MED.00098	Hyperoxemic Reperfusion Therapy

Revised medical policies effective 10-01-2008
(The following policies were reviewed and had no significant changes to the policy position or criteria.)

DRUG.00030	Histamine Desensitization Therapy
MED.00065	Hepatic Activation Therapy
MED.00084	Intradialytic Parenteral Nutrition and Intraperitoneal Nutrition
SURG.00086	Reduction Mammaplasty

New medical policies effective 10-22-2008

SURG.00104	Subtalar Arthroereisis
SURG.00106	Radiofrequency Ablation as a Treatment for Barrett's Esophagus
TRANS.00035	Mesenchymal Stem Cell Therapy for Orthopedic Indications

Revised medical policies effective 10-22-2008
(The following policies were reviewed and had no significant changes to the policy position or criteria.)

ANC.00006	Biomagnetic Therapy
DME.00009	Vacuum Assisted Wound Therapy in the Outpatient Setting
DME.00010	Premature Labor Therapies
DME.00023	IBOT Mobility Wheelchair
DME.00024	Transtympanic Micropressure for the Treatment of Meniere's Disease
DME.00030	Altered Auditory Feedback (AAF) Devices for the Treatment of Stuttering
DME.00033	TempTouch® Dermal Thermometer
DRUG.00006	Botulinim Toxin
DRUG.00024	Omalizumab (Xolair) for the Treatment of Asthma
DRUG.00032	Flucinolone Acetonide Intravitreal Implant (Retisert)
GENE.00002	Preimplantation Genetic Diagnosis Testing
LAB.00011	Analysis of Proteomic Patterns
LAB.00016	Fecal Analysis in the Diagnosis of Intestinal Dysbiosis
MED.00017	Photodynamic Therapy
MED.00041	Microvolt T-Wave Alternans Testing
MED.00062	Biofeedback for Muscle Re-education and Chronic Pain
MED.00067	Dry Hydrotherapy (Hydromassage)
MED.00068	Electrical Stimulation for the Treatment of Facial Palsy
MED.00069	Carotid Intimal Medial Thickness Measurement
MED.00070	Nocturnal Enuresis Correction Interventions
MED.00072	Rhinomanometry and Acoustic Rhinometry
MED.00073	Treatment of Tinnitus
MED.00075	Correlated Audioelectric Cardiography
MED.00077	In Vivo Analysis of Colorectal Polyps
MED.00078	Cutaneous Electrogastrography
MED.00079	Spinal Manipulation Under Anesthesia
MED.00080	Cryopreservation of Oocytes or Ovarian Tissue
MED.00081	Cognitive Rehabilitation
RAD.00034	Dynamic Spinal Visualization (Including Digital Motion X-ray and Cineradiography/ Videofluoroscopy)
RAD.00042	SPEC/CT Fusion Imaging
RAD.00045	Cerebral Perfusion Imaging using Computed Tomography
RAD.00046	Cerebral Perfusion Studies using Diffusion and Perfusion Magnetic Resonance Imaging
SURG.00005	Partial Left Ventriculectomy
SURG.00020	Bone-Anchored Hearing Aids
SURG.00055	Artifcial Intervertebral Disc
SURG.00074	Nasal Surgery for the Treatment of Obstructive Sleep Apnea (OSA) (Including Radiofrequency Ablation of Nasal Turbinates for Nasal Obstruction with or without OSA)
SURG.00076	Nerve Graft After Prostatectomy
SURG.00077	Laparoscopic and Percutaneous MRI – Image Guided Techniques for Myolysis as a Treatment of Uterine Fibroids
SURG.00080	Implanted Cerebral Thermal Perfusion Probe for Monitoring Regional Cerebral Blood Flow
SURG.00082	Computer-Assisted Musculoskeletal Surgical Navigation Orthopedic Procedures
SURG.00084	Semi-Implantable Middle Ear Hearing Aids as a Treatment of Hearing Loss
SURG.00090	Radiofrequency Ablation for Trigeminal Neuralgia
SURG.00092	Interspinous Spacer Devices

Revised medical policies effective 10-22-2008
(The following policy was revised to expand medical necessity indicators or criteria.)

DME.00028	Stretching Devices for the Treatment of Joint Stiffness and Contracture

Archived medical policies effective 10-24-2008

(The following policy was archived)

DRUG.00037	Intravenous Ketamine and Intravenous Lidocaine for Chronic Pain Management

Revised medical policies effective 10-24-2008

(The following policies were reviewed and had no significant changes to the policy position or criteria.)

DME.00004	Electrical Bone Growth Stimulation
OR.PR.00003	Microprocessor Controlled Lower Limb Prosthesis
RAD.00030	Wireless Capsule Endoscopy for Esophageal and Small Bowel Imaging and the Patency Capsule
SURG.00049	Mandibular/Maxillary (Orthognathic) Surgery
SURG.00051	Hip Resurfacing
SURG.00068	Implantable Infusion Pumps
SURG.00085	Mastectomy for Gynecomastia

Revised medical policies effective 10-24-2008

(The following policies were revised to expand medical necessity indicators or criteria.)

DME.00019	Continuous Passive Motion Devices
DRUG.00031	Subcutaneous Hormone Replacement Implants
MED.00005	Hyperbaric Oxygen Therapy
RAD.00041	Intensity Modulated Radiation Therapy (IMRT)
SURG.00023	Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures

New medical policies effective 03-20-2009

SURG.00105	Bicompartmental Knee Athroplasty

Revised medical policies effective 03-20-2009

(The policies listed below might result in services that were previously covered found to be either not medically necessary and/or investigational.)

DRUG.00028	Intravitreal and Periocular Injection Treatment for Age Related Macular Degeneration Prophylactic
DRUG.00029	Nebulized Corticosteroids for the Treatment of Nasal Polyps
MED.00054	Treatment of Obstructive Sleep Apnea
RAD.00041	Intensity Modulated Radiation Therapy (IMRT)

Clinical guidelines

Clinical guidelines effective 8/28/08

(The following adopted guideline was revised and had no significant changes to the policy position or criteria.)

CG.DRUG.05	Recombinant Erythropoietin Products

Clinical guidelines effective 10/22/08

(The following adopted guidelines were revised and had no significant changes to the policy position or criteria.)

CG.ANC.03	Acupuncture
CG.DME.04	Electrical Nerve Stimulation, Transcutaneous, Percutaneous
CG.DME.08	Infant Home Apnea Monitors
CG.DME.15	Hospital Beds and Accessories
CG.DRUG.03	Beta Interferons (interferon beta-1a [Avonex®, Rebif®], interferon beta-1b [Betaseron®]) or Glatiramer Acetate [Copaxone®] for Treatment of Multiple Sclerosis
CG.DRUG.12	Biologics for Psoriasis and Psoriatic Arthritis
CG.MED.09	Vision Therapy
CG.MED.23	Home Health
CG.MED.31	Skilled Nursing Facility Services
CG.RAD.13	CT/MRI Hips, Pelvic Bones, Knee, Ankle, Foot
CG.REHAB.03	Pulmonary Rehabilitation
CG.REHAB.04	Physical Rehabilitation
CG.REHAB.05	Occupational Rehabilitation
CG.REHAB.09	Acute Inpatient Rehabilitation
CG.SURG.23	Arthroscopic Lavage and Arthroscopic Debridement as a Treatment for Osteoarthritis of the Knee

Clinical guidelines effective 10/24/08

(The following adopted guideline was revised and had no significant changes to the policy position or criteria.)

CG.DME.06	Pneumatic Compression Devices

Injectable drug update

The following policy updates will be effective for all claims processed on or after **March 20, 2009**, regardless of the date of service. In addition to current policy the following updates and processing changes will be applied.

- **Palonosetron HCl (J2469) –** Claims reporting diagnosis V58.12 will be reviewed for criteria: Diagnoses 995.2 and V66.2 will be considered not medically appropriate.
- **Bortezomib (J9041) –** Claims reporting diagnoses 200.20-200.28, 202.80 will be reviewed for criteria.
- **Pemetrexed Disodium (J9305) –** Claims reporting diagnosis 162.0 will be reviewed for criteria.
- **Rituximab (J9310) –** Claims reporting diagnosis 287.4 will be considered not medically appropriate: 287.4.
- **Fulvestrant (J9395) –** Claims reporting diagnosis 175.0-175.9 will be reviewed for criteria: 175.0-175.9.
- **Zoledronic acid (Zometa) (J3487) –** Claims reporting diagnoses 200.00-202.98, 203.10-203.82, 204.00-208.91 will be reviewed for criteria.

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