

Empire News

N E W Y O R K

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Physician administrative news

Advance Patient Notice for Use of a Non-Participating Provider

It is important to us that our members be made fully aware of the financial implications when they are referred by their physician, on a non-urgent basis, to a non-participating provider in their own office for services such as laboratory, anesthesia, specialty drugs, infusion therapy or durable medical equipment. Likewise, members should be made aware if their selected participating surgeon has chosen to use a non-participating assistant surgeon in a scheduled surgery. While certain members may have out-of-network benefits, it is very disconcerting to them when they are presented with unexpected financial obligations for medical services. We hope you agree.

In our effort to assist you in ensuring that your patients are active participants in the decision to use a non-participating provider in the situations described, Empire has adopted a policy regarding disclosure to our members when a participating provider involves

(Continued on page 2)

a non-participating provider in their patient's care (the "Use of a Non-Participating Provider Advance Patient Notice Policy"). Based on input received, Empire will delay the effective date of this policy to October 15, 2009. This policy is intended to ensure that patients receive prior notification of the use of a non-participating provider when the provision of those services is within the control of the physician or other healthcare provider and the patient, in the absence of this notice, is unlikely to be aware that he/she will be receiving care from a non-participating provider until they receive a bill for the services rendered.

This policy is not intended to deter patients from using their out-of-network coverage to the extent available. To the contrary, this policy is designed to ensure that, in non-emergent situations, when our members receive services from a non-participating provider it is because they were involved in the decision making process and made a conscious election. Therefore, we have developed an Advance Patient Notice (APN) to be used when you deem it necessary to refer out of network for these services. This APN basically provides the patient with the information he or she would need to make an informed decision about coverage and options. We expect that you will provide the patient with this form before involving a non-participating provider in your patient's care in the situations noted and maintain it in your files for future verification and/or audit.

Please note that this policy does not apply to emergent situations. Likewise, this policy does not apply when you or the member have obtained Empire's prior approval for the referral. When you or your

patient has contacted us and received approval in advance to proceed with an out-of network service in your office or use a non-participating surgical assistant in a scheduled surgery, you may do so, without use of the APN form. As always, Empire will grant approval for the use of non-participating providers on an in network basis as provided in our network exception policies (such as when no in network surgeon practicing within an appropriate surgical specialty is available to assist in a surgery requiring a surgical assistant) and as provided or required under applicable law. Of course, we believe that we have a large enough network to accommodate the needs of your patients through participating providers and ask that you contact us if you feel this is not so. We welcome your feedback, whether through a phone call, letter or use of the APN form, regarding the quality and service level of our existing network of participating providers that support your care of our members.

This prior notification must be in the form of the APN form for the following non-participating services only:

- In Office Anesthesiologist (i.e., anesthesia for in-office surgeries or anesthesia provided in connection with surgery or services performed at a free standing surgical center owned in whole or in part by the referring physician)
- Surgical Assistant (regardless of surgical setting)
- Specialty Drug vendor for specialty drugs provided in the office
- In Office Home Infusion Therapy (HIT)
- In Office Durable Medical Equipment
- Laboratory services for specimens collected in the physician's office when the specimen is sent to a non-participating reference lab

Example: A participating gastroenterologist is scheduling an endoscopy and plans to use a non-participating anesthesiologist or assistant surgeon. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Empire's approval.

Example: A provider collects a lab specimen in the provider's office but plans to send specimens to a lab other than Quest or another participating laboratory. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Empire's approval.

Example: A participating Primary Care Physician refers to a non-participating specialist and the physician or member has obtained authorization. The use of the APN form is NOT required.

Example: A participating orthopedic surgeon refers a member to a non-participating neurosurgeon for a future consult in the neurosurgeon's separate office. The use of the APN form is NOT required.

As noted above, once completed, a copy of the signed form should be kept on file to be provided to Empire upon request. Although the use of the APN form will not be required under some circumstances, the referral shall be subject to member benefits and any applicable Empire policies including any policies applicable to referrals.

Empire will track the use of nonparticipating physicians and providers in the instances stated above and may request a copy of the APN. Other than an occasional administrative error that can occur, your failure to provide a copy of the signed APN will result in an initial warning from Empire. At this time, Empire will not invoke a financial penalty after the initial warning but may elect to update this policy

in the future. Repeated failure to comply with this policy, after initial warning, may result in termination from the Empire network.

For a complete listing of our participating physicians, please go to empireblue.com and click on "Find a Doctor".

The Advance Patient Notice (APN) form which can be found at empireblue.com > **Click on the Provider & Facility Tab > Services > then Forms and Quick Guides.**

Sunrise Medical Laboratories is not an Empire participating provider

It has come to our attention that there may be misleading information circulating about Empire's current laboratory network. Specifically, certain laboratories are claiming to participate in our network when they do not. Please be aware that **Quest Diagnostics Incorporated (Quest)**, together with its network of **QuestNet™** laboratory providers and other select participating laboratories providers, continue to have an exclusive arrangement with Empire to provide reference laboratory services to Empire members enrolled in the following products, which use our HMO network:

- HMO (includes group HMO and POS products, such as HMO, Direct HMO, Direct POS, and DirectShare POS),
- Direct Pay Product HMO (also referred to as Network One) (includes Direct Pay HMO, Direct Pay POS, Child Health Plus, and Healthy New York)
- MediBlue HMO

For a complete listing of laboratories participating in this select network, please go to empireblue.com > **Find A Doctor > Select Plan. In the Provider Type field select Hospitals, Facilities, Services and Equipment.**

In the Specialty Category list, select Laboratories.

Though broader than our HMO Network, Empire's network of laboratory providers for our PPO, EPO and Indemnity products **excludes** many local laboratories including Sunrise Medical Laboratories. Quest and other select providers continue to be part of Empire's network for our PPO, EPO and Indemnity products. For a complete listing of our PPO, EPO and Indemnity network laboratories, please visit the website and follow the instructions above.

As an Empire participating provider, you must refer Empire members to participating laboratories. In addition, under Empire's Non-Participating Provider Advance Patient Notice Policy, physicians and other participating providers are required to notify Empire members, in writing, of the intent to send lab specimens collected in the office to a non-participating provider and obtain the patient's prior written consent in the form of the Advanced Patient Notification Form. This ensures that the patient is made aware, prior to the specimen(s) being sent, that they may be responsible for higher out-of-pocket expenses for these services. For complete information regarding this policy, see the first article in this issue, "Non-Participating Provider Advance Patient Notice Policy" or visit empireblue.com > **Provider & Facility > Services > Forms and Quick Guides.**

Please comply with this policy before using Sunrise Medical Laboratories' services or any other non-participating laboratory. Likewise, if you have a computer system linked to a non-participating laboratory such as Sunrise, we recommend that it be set to direct Empire BlueCross BlueShield patients to Quest Diagnostics or other Empire participating providers for the applicable product. That way, you ensure that your Empire patients have the lowest possible out of pocket costs.

If you have any questions about our laboratory network, please call **1-800-992-BLUE** or visit empireblue.com. We appreciate your help in reducing unnecessary and costly out of pocket expenses for our members and your Empire patients.

New CPT Codes for H1N1 Vaccine Administration

Please note that effective 9/28/2009, the American Medical Association (AMA) CPT Editorial Panel published a new code specific to administration of the H1N1 vaccine. The newly created CPT code, 90470 should be used to bill the administration of H1N1 immunization.

CPT code 90663 is used specifically for the H1N1 vaccine and should be billed at \$0.01 (1 cent) for administrative purposes. The federal government will be providing the H1N1 vaccine at no charge.

The new CPT codes will help to efficiently report and track immunization and counseling services related to the H1N1 vaccine throughout the entire health care system.

Quick Reference:

CPT 90470 description: H1N1 immunization administration (intramuscular, intranasal).

CPT 90663 description: H1N1 vaccine to be billed at \$0.01.

For administration of both the seasonal flu vaccine and the H1N1 vaccine, the recommended billing is:

90470 for the H1N1 administration, and in addition 90466, 90468, 90472 or 90474 for the seasonal flu administration.

For information regarding reimbursement, please contact your local network management representative. Please visit our website at, empireblue.com for the latest information about the H1N1 flu vaccine and its coverage.

Changes to Medical Policy for the Prevention of Respiratory Syncytial Virus Infections

Empire has changed the medical policy on Prevention of Respiratory Syncytial Virus Infections (Drug.00015) based on the recommendations of the American Academy of Pediatrics (AAP). Some of the updated recommendations and major policy changes include:

- Modification of recommendations for initiation and termination of RSV prophylaxis based on current CDC descriptions of seasonality in different areas of the United States.
- Emphasis on need for not more than a maximum of five doses in all geographic areas for high risk patients meeting the criteria for five doses.
- Modification of risk factors in infants born between 32 and 35 weeks of gestation.
- For infants 32 through 35 weeks of gestation who qualify for prophylaxis based on the presence of risk factors, prophylaxis is recommended until 90 days of age with a maximum of 3 doses.

These policy changes will be effective for RSV season 2009/2010, subject to any applicable notice requirements. Please refer to Empire's Provider website at empireblue.com for details on our medical policy and specific effective dates.

For further details on the AAP Respiratory Syncytial Virus recommendations, refer to the 2009 Red Book (pages 562-568) or to the AAP Policy Statement, which was published in Pediatrics and is available online at <http://aapredbook.aappublications.org/news/RSVPolicy-082409.pdf>.

360° Health: same great programs, different names

Empire is excited to announce several name changes to our 360° Health programs. Many of our members are already familiar with the Future Moms program. However, some of our members use the program called Maternity Care, which became Future Moms on July 1.

Also on July 1, we moved eligible members to these disease management programs:

- Condition Management became ConditionCare, for support of diabetes, chronic obstructive pulmonary disease, asthma, heart failure, and coronary artery disease.
- Comprehensive Care became ComplexCare, a program that focuses on complicated health situations through education and care coordination.

For more information members can contact the programs at:

- **800-828-5891** — Future Moms
- **866-372-2932** — ConditionCare
- **866-670-6620** — ComplexCare (New number)

You may also notice that the 360° Health section of our website has a new look and feel to help ease navigation. All of these transitions will help us to offer a more integrated, holistic approach to serving our members and clients, and make a positive impact on their health.

Help moms and babies get a healthy start with Future Moms

Please remember that you're required to notify Empire of all pregnant members after each pregnancy is confirmed. Just fax the following information to **800-551-2410**:

- Member Name
- Member ID number
- Member DOB
- Member EDC
- Member telephone number
- Provider name and phone number

This helps us identify expecting members sooner and increase participation in our Future Mom's program, which helps promote healthy pregnancies and healthy babies. The program helps:

- Members be aware of signs and symptoms of pregnancy complications
- Reduce potential pregnancy-related medical costs
- Support the pregnancy provider's treatment plan

Changes effective May 18

American Specialty Health no longer reviewing complaints, grievances and appeals

Effective May 18, 2009, Empire transitioned its agreement with American Specialty Health (ASH) to administer and review complaints, grievances and appeals for chiropractic services provided to Commercial and Medicare members. ASH continues to manage the chiropractic services for Empire and the physical and occupational services for the Medicare Advantage business. The only change is now Empire, rather than ASH will handle and complete any complaints, grievances, and appeals you may have. You no longer go to ASH for these requests. This change is not

date-of-service driven. All complaints, grievances or administrative appeals for chiropractic services received on or after May 18, 2009, should be directed to Empire staff for review. Here's how to submit these complaints, grievances, or administrative appeals:

For Commercial business:

- Please send administrative appeals to:
Empire BlueCross BlueShield
PO Box 1407
Church Street Station
New York NY 10008-1407
- Telephone numbers:
Commercial HMO 800-453-0113
Direct Pay HMO 800-261-5962
Healthy NY 800-261-5962
Child Health Plus 800-431-1914
- TTY/TDD numbers:
Commercial HMO 800-241-6895
Direct Pay HMO 800-241-6894
Direct Pay POS 800-241-6894
Healthy NY 800-241-6894
Child Health Plus 800-241-6895
- Fax numbers:
Commercial HMO 800-829-2395
Direct Pay HMO 800-829-2393
Healthy NY 800-829-2393
Child Health Plus 866-829-2306
- Please send clinical appeals to:
Empire BlueCross BlueShield
Appeals Department
Mail Drop R/60
P.O. Box 11825
Albany, NY 12211
- Telephone number: 800-634-5605

For Medicare Advantage business:

- Please send appeals to:
Empire BlueCross BlueShield —
Medicare
Medicare Appeals Department
PO Box 1407
Church Street Station
New York NY 10008-1407

- Telephone numbers:
MediBlue HMO 800-499-9554
MediBlue PPO 866-395-5175
CT MediBlue HMO 866-673-4157
- TTY/TDD number: 800-241-6894
- Fax number: 888-458-1406
- Please send clinical appeals to:
Empire BlueCross BlueShield —
Medicare
Medicare Appeals Department
Mail Drop R/60
P.O. Box 11825
Albany, NY 12211
- Telephone numbers:
MediBlue HMO 800-499-9554
MediBlue PPO 866-395-5175
CT MediBlue HMO 866-673-4157
- TTY/TDD number: 800-241-6894
- Fax Number: 888-458-1406

NIA appeal changes effective July 15 for Medicare business only

Effective July 15, 2009, Empire will administer and review member and provider appeals for high-end radiology for Medicare business only. Before July 15, 2009, National Imaging Associates (NIA) handled first-level member and provider appeals for Medicare business. Please note that first-level member and provider appeals for Commercial business are still handled by NIA.

This change is not date-of-service driven. All Medicare member and provider appeals received on or after July 15, 2009, should be directed to Empire staff for review. The process for addressing complaints and grievances has not changed. Empire will continue to handle complaints and grievances for Commercial and Medicare business.

What do the changes mean to members/providers?

Effective July 15, all Medicare member and provider appeals regarding NIA's initial determination will now be handled by Empire staff. All standard appeals must be in writing. Please provide Medicare members and their providers with the following information for submitting these appeals.

For Medicare Advantage business:

- Please send administrative appeals and grievances to:
Empire BlueCross BlueShield —
Medicare
Medicare Appeals Department
PO Box 1407
Church Street Station
New York NY 10008-1407
- Telephone numbers:
MediBlue HMO 800-499-9554
MediBlue PPO 866-395-5175
CT MediBlue HMO 866-673-4157
- TTY/TDD number: 800-241-6894
- Fax number: 888-458-1406
- Please send clinical appeals to:
Empire BlueCross BlueShield —
Medicare
Medicare Appeals Department
Mail Drop R/60
P.O. Box 11825
Albany, NY 12211
- Telephone numbers:
MediBlue HMO 800-499-9554
MediBlue PPO 866-395-5175
CT MediBlue HMO 866-673-4157
- TTY/TDD number: 800-241-6894
- Fax Number: 888-458-1406

TestMinder helps patients comply with standing orders

E-mail your patients when they're due for tests

The TestMinder e-mail reminder program, offered exclusively by Quest Diagnostics Incorporated, is designed to work with the standing orders you prescribe for testing. TestMinder prompts patients to schedule their lab appointments by sending timely e-mails each time they're due for a lab test.

TestMinder is ideal for managing patients with chronic illnesses or who are on a particular drug regimen. It helps your patients stay healthier, while saving your office staff time and effort.

Automatic enrollment

When your patient brings a standing order to the Quest Diagnostics Patient Service Center (PSC), the phlebotomist will record the standing order along with the patient's e-mail address, automatically enrolling him or her in the program.

If you prefer to enroll your patient, you can do so by entering the patient's e-mail address in Care360™ Physician Portal. TestMinder does not disclose any personal information such as the test being performed or the name of the physician. There is no charge to you or your patient for this service.

Convenient appointment scheduling

Your patients will receive an e-mail reminder from Quest Diagnostics seven days before their next standing order. For easy scheduling, the e-mail will have a link to the online Quest Diagnostics PSC appointment scheduler. Each reminder will include a "Find a Patient Service Center" link so it's easy to find the center closest to where each patient works or lives.

Bringing value to your practice

TestMinder can be a valuable tool for your practice. It can help you:

- *Improve patient management* — patients may be more inclined to follow through on standing orders, helping to improve patient outcomes
- *Increase patient convenience* — e-mail reminders with helpful links to online appointment scheduling are an easy way for patients to make appointments.
- *Reduce administrative time* — your staff can spend less time making patient reminder calls
- *Increase HEDIS scores* — improved patient care can also help increase HEDIS scores and grow your practice

Talk to your Quest Diagnostics Account Executive for more information about TestMinder.

Express Scripts acquires NextRx

The parent company of Empire has signed an agreement with Express Scripts, one of the largest pharmacy benefits management (PBM) companies in North America, to acquire WellPoint's NextRx subsidiaries. WellPoint NextRx subsidiaries provide PBM services to approximately 25 million Americans and manage more than 265 million adjusted prescriptions annually. The transaction includes a 10-year contract for Express Scripts to provide services following closing of the transaction in late 2009.

This alliance will create an organization with greater resources and capabilities, which will provide members with more cost-effective solutions and access to state-of-the-art PBM services. The transition to Express Scripts will be coordinated to help ensure consistency of benefits and pharmacy services to members.

Following the transition, Empire and its affiliated companies, will retain control of medical policy, formulary and integrated disease management, and will work closely with Express Scripts to offer best-in-class pharmacy management and data analytics. Empire members will gain access to better web, home delivery and customer service capabilities, and clients will benefit from enhanced reporting.

It is not anticipated that following the close of this transaction there will be any changes to your practices or processing, however, we will continue to provide updates in future newsletter articles.

New provider record update forms 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.

Hospital administrative news

OSCAR: did you know?

The OSCAR (CMS Certification Number/Medicare Number) must be billed on Inpatient Claims. Per the Medicare Claims Processing Manual on Inpatient Hospital Billing, this is a required field in order to adjudicate the claim as it is used in claims pricing. The number is a depiction that symbolizes the type of provider and whether they require special handling. For more information please visit <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/psfpn06.pdf>.

REMINDER: You can submit your Empire claims electronically! For more information or to get started, please visit empireblue.com and click on the Electronic Data Interchange (EDI) link.

New co-pay for GHI/CBP Empire Members

Effective September 1, 2009, all City of New York Medicare primary members belonging to the GHI CBP/ Empire BlueCross BlueShield hospital only plan will be responsible for a \$50 copay for every emergency room visit.

Pharmacy updates

Formulary updates

The National Pharmacy and Therapeutic (P&T) Committee helps develop comprehensive formularies, with plan review and approval. The committee comprises doctors, pharmacists and other health care professionals. Medications are reviewed and recommended for their quality, efficacy and, when appropriate, cost. Medications are not evaluated based on cost until their therapeutic value has been established, and then cost is only one part of the review. Once a medication is identified for inclusion in a formulary, it is subject to ongoing review, based on clinical literature, pharmacy and medical claims data, and current patterns of use. Simultaneously, new medications are evaluated under this review process by WellPoint NextRx.

As a result of the second quarter 2009 National Pharmacy and Therapeutics (P&T) Committee meeting, the following changes will be made to the Empire Drug List/Formulary as indicated below:

<i>Drug Name</i>	<i>Additions</i>	<i>Deletions</i>
<i>Effective date of change:</i>	<i>07/01/2009</i>	<i>09/30/2009*</i>
Xopenex® Inhalation Solution	X	
Xopenex® HFA		X
Kristalose®		X
Risperdal® Consta	X	
Canasa®	X	
Lialda™	X	

New Generics 2Q09

The following preferred drug list/formulary products are now available in a generic alternative. The branded products were/will be removed from the Empire Drug List/Formulary once notification requirements are met.

<i>Brand name</i>	<i>Generic name</i>	<i>Effective date of change:</i>
Percocet 2.5-325	oxycodone/acetaminophen	08/19/2009
Risperdal M Tab	risperidone odt	08/19/2009

Behavioral health news

Behavioral Health Practice Guidelines updated and on the Web

As part of our commitment to provide you with the latest clinical information and educational materials, clinical practice guidelines are reviewed annually. The guidelines are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and most recent medical research.

The following recently updated guidelines are now available at empireblue.com > **Providers & Facilities > Plans and Benefits > Empire's Behavioral Health**.

- Identification and Treatment of Adult Depressive Disorder
- Identification and Treatment of Antenatal Depression (AND), Postpartum Depression (PPD) and Postpartum Psychosis (PPP)
- Identification and Treatment of Substance Use Disorders (SUD)
- Evaluation and Treatment of Bipolar Disorder
- Evaluation and Treatment of Children with Attention Deficit/Hyperactivity Disorder

Behavioral Health Medical Necessity Criteria updated for 2010

The Behavioral Health Medical Necessity Criteria has been updated for the year 2010. The Behavioral Health Medical Necessity Criteria is reviewed and updated annually to take into consideration new treatments, pharmaceuticals, benefit changes and other health-related factors. The revised criteria can be found online

at empireblue.com > **Providers & Facilities > Plans and Benefits > Empire's Behavioral Health**. The new criteria are effective on January 1, 2010.

New Outpatient Treatment Report form expanded and easier to use

We've recently updated our Outpatient Treatment Report (OTR) form, which is on our website at empireblue.com > **Providers & Facilities > Plans and Benefits > Empire's Behavioral Health**. We added and expanded some elements on the form, made it more user friendly, and included more information on substance abuse. Please call Behavioral Health Provider Relations at **866-221-1395** if you have questions.

Reminder: Behavioral Health benefits usually limited to one service per day

Behavioral health benefits are typically limited to one professional service per day, except for the following:

- Outpatient psychotherapy with a non-psychiatrist and medication management with a psychiatrist/psychiatric nurse practitioner provided on the same day.
- Outpatient psychotherapy and psychological testing provided on the same day.
- If the same provider is rendering both services please use Modifier 59 on the claim form next to the service provided.
- Comprehensive outpatient services (IOP and PHP), including group therapy.
- Individual therapy and Family Therapy on the same day with the same provider, usually at the convenience of the patient due to geographic issues. Please use Modifier 59 on the claim form next to the service provided.

Please be mindful of which services are being provided on the same day to prevent any claim adjudication issues. Some account-specific variations may exist. If you have questions, please call Behavioral Health Provider Relations at **866-221-1395**.

Medicare Advantage news

Fraud, waste and abuse training – Required by CMS

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plan sponsors to have policies and procedures to identify and address fraud, waste and abuse (FWA) in the delivery of health care services through the Medicare Advantage benefit. This regulation can be found within the Federal Code of Regulations, title 42 parts 422.503 and 423.504. CMS also requires Medicare Advantage plan providers to have a procedure in place to facilitate pharmacy fraud, waste and abuse training and education for vendors and providers.

In accordance with these CMS stipulations, Empire BlueCross BlueShield and its subsidiaries require vendors and providers to train employees in FWA. Many physicians and provider groups may be using a training program developed internally, by corporate headquarters or by their state's medical association.

If your practice does not have a training program, the National Health Care Antifraud Association (NHCAA), in conjunction with the Blue Cross and Blue Shield Association (BCBSA), has launched an online Fraud, Waste and Abuse General Compliance Training Course. This course was developed in collaboration with LearnSomething, Inc., a leading

producer of customized, multimedia training and learning management solutions. This online training program was specifically developed to help Medicare Advantage first tier and downstream contractors meet CMS compliance requirements. You can access the online training via the course portal at wellpoint.learnsomething.com.

This course is reasonably priced, with volume discounts available and can be purchased through this link.

Every provider and vendor that administers services to Medicare Advantage beneficiaries must complete a Fraud, Waste and Abuse training by December 31, 2009, and annually thereafter. You are only required to take training once a year to satisfy the CMS requirement for all insurers.

In an effort to collect physician and provider group data regarding the FWA training, we are diligently working to implement an attestation statement program for all providers and groups who have an internal FWA training program. Once this program is initiated we will post additional instructions via our website.

Additional information is available via our website empireblue.com or by contacting customer service. Please be sure to check our website for updates to this CMS required Fraud, Waste and Abuse training.

Medicare Part D: Medication Therapy Management Comprehensive Call Center

On June 15, 2009, NextRx launched the 2009 Medication Therapy Management (MTM) Comprehensive Call Center program. The call center is one component of MTM, which is a suite of CMS-mandated programs for health plans that sponsor Medicare Part D. MTM aims to help improve outcomes and help reduce adverse events for Medicare Part D members.

The Comprehensive Call Center is a pharmacist-based case management initiative for a subset of MTM members who are most at risk for adverse drug events. The purpose of the call center is to identify and help reduce medication-related problems in the elderly. It is part of the enhanced MTM program offering.

How it works

- Pharmacists call customers for a comprehensive medication review
- Pharmacists review medical and pharmacy data, along with information collected directly from the customer
- The pharmacists then make recommendations to the customer and physician

NextRx outsources this program to The University of Arizona Medication Management Center, which performs the reviews and phone calls. The outreach includes one comprehensive review each year. Additionally, pharmacists receive and review customer data on a monthly basis and make follow up phone calls if necessary.

Key Benefits

Since the comprehensive medication review is done over the phone, the program allows retail pharmacists to provide more targeted education at the point of sale, in a short amount of time. This program will also alert physicians of medication issues.

New Prior Authorization fax number for Medicare Part D

Our prescription Prior Authorization (PA) department now has one fax number for all of your Medicare Part D requests. Please begin using this number immediately:

PA Medicare Part D Fax number:
800-204-0015

The new number is noted on the updated PAB forms. To download new forms go to wellpointnextrx.com and click on the Provider tab. Then click on the Physician PAB Forms link and follow the login instructions.

The fax numbers for your non-Medicare Part D requests remain the same. For the best response times, please remember to use the Medicare Part D fax line and Medicare Part D PA forms for all Medicare Part D requests.

We hope this information will help simplify and expedite the prior authorization process for you and your Medicare Part D patients. If you still have questions, please call us at **800-203-0267**, Monday through Friday, 8 a.m. to 6 p.m.

C3 program offers targeted interventions for MediBlue members

MediBlue has introduced a total population management program as a unique offering of Custom Care Connection (C3). This program focuses on the over-65 population and “dual eligible” Medicare/Medicaid subset that are enrolled in Medicare Advantage plans. It offers specific population segmentation to deliver the right interventions to the right population.

The program includes the following tiered interventions that are based on the member's level of acuity and risk. These interventions are designed to address the broad-scope of senior-specific issues including dementia, fall/risk prevention, depression, self-care and caregiver support.

- **End of Life Program:** Provides personalized interventions to help members in the last six months of life. Skilled, empathetic clinicians initiate conversations on Advance Care planning, assess comfort and symptom management, support discussion with the family and doctors, coordinate education and services with hospice, educate family on benefits of palliative care, and assist in transitions from curative to palliative interventions.
- **Intensive Care Management:** Focuses on health care coordination and the provision of psychosocial support, post hospital discharge/coordination and planning, advance care planning, and resource utilization — all designed to help reduce the risk of hospitalization. Offers a primary nurse, one-to-one model delivered by experienced Care Managers.
- **Active Condition Management:** Offers an enhanced version of our core disease management programs (Chronic Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Asthma and Diabetes) plus a component for supporting and helping members manage their conditions currently not covered by any of our existing programs. The program is designed to help participants better manage their conditions by supporting healthy lifestyle changes and behaviors.
- **Surveillance Program:** Includes the lowest-risk participants in the program. All indicators demonstrate that this group is currently managing their health with reasonable outcomes. These participants are re-assessed quarterly to help ensure there are no deteriorations of health status. These members are also monitored and assessed for risk of hospitalization.

The referral group is made up of members who did not qualify for the active programs, but who have been referred for active management by the health plan. Doctors can team with the C3 program for members who are actively enrolled. The program staff will also continue to empower members to work closely with their providers. Program staff may be providing information to member's to take to their providers (additional question they can ask about their care, etc).

For general program information or to refer members to this program, call toll-free **866-563-4561**, Monday through Friday, 8:30 a.m. to 8 p.m. Eastern time; Saturdays, 9 a.m. to 5:30 p.m. Eastern time.

Advance directives reminder

Please remember to include documentation of advance directives in a prominent part of a Medicare Advantage member's medical record, and include a copy of the directive in the medical record. This is a NCQA/CMS requirement. For more information on Empire's Medical Record Standards, go to empireblue.com > **Providers & Facilities > Health Information > Policies & Procedures > Medical Record Standards.**

EDI news

Attention skilled nursing facilities and home health agencies: File claims electronically to save time and resources

Many providers already file Empire member claims electronically and are enjoying the benefits of improved cash flow. Electronic filing also helps save time, increase office efficiency and reduce administrative and postage expenses. If you are a

skilled nursing facility or home health agency filing paper claims, please consider "getting connected" and file claims electronically.

Empire does not charge a fee for electronic submissions. Clearinghouses and electronic vendors may assess a fee, and costs vary depending on the vendor and the services provided. However, it's still cost effective to file electronically.

We work closely with clearinghouses and software vendors to ensure electronically transmitted information complies with the Health Insurance Portability and Accountability Act (HIPAA) guidelines. Take the important first step. Contact a clearinghouse, vendor or Empire to learn more about electronic claims submissions.

Supporting Documentation

Is the need for supporting documentation preventing you from submitting claims electronically or from fully using your electronic claims submission capabilities? With the implementation of additional HIPAA requirements, more information can be submitted electronically, reducing the need for the submission of additional supporting documentation. When Empire pre-authorizes a service, the submission of additional supporting documentation with the paper or electronic claim is NOT needed as we have all the necessary information to process your claim. The following table identifies a few common examples when supporting documentation should be provided with the claim, along with an explanation of what documentation, if any, is needed.

<i>Provider Type</i>	<i>Common Supporting Documentation Reasons</i>	<i>Supporting Documentation Paper Submission</i>	<i>Supporting Documentation Electronic Submission</i>	<i>Comments</i>
Skilled Nursing /Home Health	Pre-authorization	No	No	Paper/Electronic: When an authorization (Health Services Review) has been obtained, there is no need to attach a plan of care and plan of treatment.
Skilled Nursing /Home Health	Coordination of Benefits (COB)	Yes	No	Electronic: All of the information found on the explanation of benefits (EOB) can be entered directly into the electronic claim file. Paper: Copy of the EOB and/or Explanation of Medicare Benefits (EOMB) is required.
Skilled Nursing	Level of Care	No	No	Paper/Electronic: Report Level of care I through IV on UB-04 claim form, locator field 80.

Additional Information

To learn more about filing electronically to Empire, visit our web site at empireblue.com > **Learn More** > **EDI**. Or, call us at **866-889-7322** to speak with an EDI specialist. Empire EDI Solutions Help Desk specialists are familiar with electronic submission requirements for UB-04 claims and HIPAA.

Professional claim errors you can avoid on electronic submissions

On the next page is a list of electronic submission errors that you can avoid by following the resolutions provided. Reducing errors prior to the electronic submission of claims will help reduce your account receivable days. The errors listed below are found on the Empire EMC RECEIPT REPORT after transmission of an electronic claim file. The resolutions provided adhere to Empire's requirements and submission formats as described in the Detail Transaction Instruction of the Companion Guide for electronic claims found on our website at empireblue.com.

Providers should work with their vendors and/or clearinghouses to ensure your systems code sets are up to date and automated solutions are installed to recognize errors allowing providers to correct claims prior to submission.

<i>Error code and description</i>	<i>Resolution</i>
Error: IGE0000020 ICD9 DX CODE INVALID	Use the most current and specific diagnosis codes Examples: Use 7880 or 7881 NOT 788 Use 27801 or 27802 NOT 278 Use 84500,84501,84502,84503 Not 8450
Error: BS00000006 CLAIM FILING INDICATOR CODE IN LOOP 2000B SBR09 MUST EQUAL 'BL' FOR BLUE SHIELD CLAIMS	Contact your vendor and ask them to make sure your software's Blue Shield set up has the correct indicator 'BL'. Clearinghouses should put an edit in place to avoid errors.
Error: BS00000017 SUBSCRIBER'S LAST NAME 837 Location: 2010BA NM103 BS00000018 PATIENT'S LAST NAME 837 Location: 2010CA NM103 BS00000019 SUBSCRIBER'S FIRST NAME 837 Location: 2010BA NM104 BS00000020 PATIENT'S FIRST NAME 837 Location: 2010CA NM104 BS00000021 SUBSCRIBER'S MIDDLE INITIAL837 Location: 2010BA NM105 BS00000022 PATIENT MIDDLE initial 837 Location: 2010CA NM105	A NAME MUST BE A-Z, MAY CONTAIN 1 SPACE AND/OR HYPHEN ALPHA MEANS IT MUST BE A LETTER (A-Z) not a number or a character such as a number sign # or an apostrophe as in O'Brien If USE OF hyphenated last names such as CHASE JENKINS CAN ENTER AS CHASEJENKINS, CHASE JENKINS OR CHASE-JENKINS If a name with an apostrophe such as O'Brien use OBRIEN The middle initial must be alpha (A-Z) or blank
BS00000027 SUBSCRIBER ID FORMAT IS INVALID The claim will reject with this edit if the subscriber id (Loop 2010BA/NM109) contains one or more of the following conditions (note: this edit does not apply to a subscriber ID that has a prefix of YLG, G, or GC): <ul style="list-style-type: none"> • First position equal to a space • All alphas • An embedded space (subscriber id body must begin immediately following the prefix) • Special characters • Low values • All 1's, 2's, 3's, 4's, 5's, 6's, 7's, 8's, 9's, or 0's • Literals equal to unknown, unk, individual, self, none, 123456789, or 1234567890 • 837 Location: 2010BA NM109 	EXAMPLES OF INVALID ID FORMATS: ABCDEFGH YLR 88175356 174432 1A YLN23#35477 #YLF81465203 YLT1111111 YLN110584596-02
BS00000028 SUBSCRIBER ID # MUST BE 6 TO 9 NUMERICS WHEN ID HAS NO PREFIX If the payer identifier (2010BB/NM109) is equal to 00803, the subscriber id body length (2010BA/NM109) can be no less than 6 and no greater than 9 numerics for an Empire subscriber id which does not contain a prefix. 837 Locations: 2010BA NM109 2010BB NM109	EXAMPLES OF INVALID ID FORMATS: 582831251C 45678 98398291200
IGE0000004 HCPCS/CPT4 CODE ENTERED IS INVALID	USE THE MOST CURRENT CODES

Level of Return for all these errors: Claim

Improve claim accuracy by using Empire Physician Online Services or submit an EDI inquiry request to verify benefit, eligibility or claim status information.

To learn more about EDI submission, Empire reports contact our EDI solutions help desk at **866-889-7322** or visit our website, empireblue.com > **Learn More** > **EDI**.

Quality initiatives

Random medical record review process

Our random medical record review process has recently undergone some revisions, with the goal of adopting a medical record review process across our enterprise. These changes will affect network PCPs.

Medical record audits/reviews will be performed annually on a percentage of randomly chosen primary care providers (PCPs) identified through claims and the HEDIS® process (Healthcare Effectiveness Data and Information Set) and contracted for Empire's managed care products. These products include POS, HMO, PPO, SSB and Medicare Advantage. Typically, the timeline for this process will be June through September annually. In order to pass the audits/reviews, an office must score 80% or greater on the medical record audit. If a practitioner fails to meet the company's standard of 80%, a re-review is conducted within six months.

Medical record audits/reviews are not required if the primary care provider (PCP) office has Electronic Medical Records (EMR) or their office has been recognized by the National Committee for Quality Assurance (NCQA) Physician Practice Connection Program.

Empire has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. We perform medical record reviews to assess network PCPs relating to current medical record standards recognized by NCQA. All reviews are conducted by a nurse under the supervision of the local Medical Director.

There are two sections on the audit tool: Office Specific Questions (written policies) and Chart Elements/Content and Clinical Documentation (organization of medical records and preventive health service documentation). To view the medical record standards, please visit our website at empireblue.com. Thank you in advance for your assistance in this very important quality initiative.

2009 Provider Relationship Survey

Your opinion matters. The annual Provider Relationship Survey will be conducted during the months of September and October. Providers and Office Managers will be randomly selected and will receive the Provider Relationship Survey by mail. The survey can be completed online by using the link provided in the survey packet, or you may return surveys by mail. Your input is essential in identifying the key areas for improvement in our business, and your experience. Please watch for the survey, and take a few moments to provide us with your valuable feedback.

Medical policy

Policy updates for Provider Newsletter Fall 2009

These updates list the new and/or revised Empire medical policies, clinical guidelines and reimbursement policies. The implementation date for each policy or guideline is noted for each section. Implementation of the new or revised medical policy, clinical guideline or reimbursement policy is effective for all claims processed on and after the specified implementation 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's contract benefits in effect on the date that the services are rendered must be used. This document supplements any previous medical policy and clinical guideline updates that may have been issued by Empire. Please include this update with your provider manual (currently known as the "Sourcebook") for future reference.

Please note that medical policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Empire's medical policies and clinical guidelines can be found at empireblue.com.

Reimbursement Policy updates

Anesthesia Claim Processing Modifications

In early 2010 we will modify anesthesia processing to be more consistent with CMS in the following way.

Time units will be calculated by dividing the total minutes of time by 15 and then rounding up to the nearest 10th. For example 61 minutes divided by 15 equals 4.066 which will be rounded up to 4.1 units.

Claims reporting supervision modifier AD will be processed as 3 based units. Claims reporting other supervision modifiers QY, QK, QX will be reimbursed at 50% of the anesthesia allowed amount consistent with CMS rules.

Additional base units will be allowed with physical status modifiers as follows:

- P3 = 1 additional base unit
- P4 = 2 additional base units
- P5 = 3 additional base units

No additional base units will be reimbursed with modifiers P1, P2, and P6.

Qualifying circumstance procedures 99100-99140 will continue to be reimbursed at a flat rate without time units. Code 99140 will not be reimbursed with routine maternity delivery diagnoses.

Separate reimbursement for anesthesia for oral surgical procedures reported by the oral surgeon is available only when the HCPCS D codes are reported for both the procedure and the anesthesia service. Anesthesia will not be reimbursed separately when the oral surgical procedure is reported with CPT codes.

The following reimbursement policy updates will be effective for all claims processed on and after January 21, 2010, regardless of the date of service.

Chemotherapy

According to CPT guidelines, codes 96401-96402, 96409-96425, 96521-96523 are not intended to be reported by the physician in the facility setting in light of the fact that these services are typically provided by facility staff. Claims reporting these codes in the facility settings will be denied

Dispensing and Delivery Fees (A9901, G0333)

Separate charges for dispensing and delivery are not reimbursed separately. Delivery is considered an incidental component of the DME item.

Essure Device

The allowed amount for the procedure includes the cost of the kit. Separate charges for the kit will be denied as incidental to the procedure.

Medical Errors

Claims reporting the modifiers identifying medical errors, such as surgery on the wrong patient, wrong body part and wrong surgical procedure (PA, PB, and PC) will be denied. It is the expectation that claims for medical error services will not be submitted.

Pain Pump

Insertion of a pain pump during an operative session is considered incidental to the surgical procedure. Separate reimbursement will not be allowed.

Photography

Unless described in a medical policy all photography is not considered for separate reimbursement.

Physician Standby Service (CPT 99360)

CPT 99360 will not be reimbursed separately. The CPT coding instructions indicate that standby services involve prolonged attendance without direct patient contact. When the standby physician renders a specific service then it is that service that will be reimbursed. For example, newborn resuscitation will be reimbursed and the standby charge will not be reimbursed.

Place of Service Restrictions

There are many codes for which the appropriate setting for a procedure or service is indicated either by the descriptive verbiage of a Current Procedural Terminology (CPT®) or HCPCS code, or by published CPT coding guidelines which may indicate that a specific procedure or service is not intended to be reported in certain settings. For example, evaluation and management services designated for the office or outpatient department should not be reported in the inpatient or home setting. In another example CPT 99050 (service requested after office hours) will be limited to the office place of service.

For new and revised CPT codes and/or guidelines, we will update the claims editing system to include a place of service restriction whenever the code definition or coding guideline specifies an appropriate place of service for the reporting of the code(s). In addition, we will conduct an annual review of surgical codes with an assigned place of service restriction and update the claims editing system when it is determined that a place of service restriction is no longer applicable for a particular procedure. New surgical procedure codes will also be reviewed to determine if a place of service restriction is applicable. For example, consistent with CPT guidelines, injection, infusion and chemotherapy codes should not be reported by the physician in the facility setting.

Prolonged Services

Coverage for prolonged services (99354-99355) is available for limited and unique conditions. These include but are not limited to whooping cough, toxic shock syndrome, volume depletion, cystic fibrosis, malignant essential hypertension, malignant hypertensive disease, acute myocardial infarction, angina, acute bronchitis and acute bronchiolitis, laryngeal spasm, asthma, pneumothorax, pulmonary congestion, acute respiratory failure, appendicitis, bile duct calculus with acute cholecystitis, acute pancreatitis, syncope and collapse, febrile convulsions, and epistaxis.

Non-direct patient care codes (99358, 99359) and inpatient prolonged care codes (99356, 99357) will not be reimbursed in addition to the primary evaluation and management care.

Inpatient prolonged care codes indicate unit floor time and not necessarily direct patient care. Prolonged care codes should not be reported when counseling, extensive review of records and coordination of care dominate the visit. Recording of patient history, review of past records, physical exam, medical decision making, treatment plan discussion and counseling are components of the medical visit and do not warrant prolonged care code reporting.

Removal of Sutures (15850)

As a reminder, removal of sutures by the same provider performing the repair is not reimbursed separately. The suture removal is considered a component of the repair.

Supplies

As a reminder, supplies used by the treating provider in the office setting are considered an integral component of the procedure and office overhead. Separate reimbursement will not be allowed. This includes needles, syringes, sterile water, and saline. Infusion pumps are not separately reimbursed when reported with infusion and chemotherapy services. Supplies also used during sleep studies, such as tubing and filters for CPAP, electrodes, oral/nasal mask and cushions, face mask, head gear, chin strap, rental of CPAP or BiPAP are incidental to the sleep study. Also note that initiation and management of CPAP and education and training for self management are also considered an integral component of the sleep study.

Medical policy updates

Reminder — Upcoming RSV season: Please note the updated guidelines of the American Academy of Pediatrics Redbook 2009 for immune prophylaxis for the upcoming RSV season.

Revised Medical Policies Effective 05-21-2009

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

DME.00010 — Premature Labor Therapies

OR-PR.00002 — Adjustable Cranial Orthosis for Synostotic and Non-Synostotic Indications

TRANS.00016 — Umbilical Cord Blood Progenitor Cell Collection, Storage and Transplantation

Revised Medical Policies Effective 05-21-2009

(The following policies were reviewed and may have additional word changes or clarifications, but had no significant changes to the policy position or criteria.)

ADMIN.00002 — Preventive Health Guidelines

DRUG.00002 — Tumor Necrosis Factor Antagonists

DRUG.00017 — Hyaluronan Injections for Musculoskeletal Conditions

DRUG.00038 — Bevacizumab (Avastin®) for Oncologic Indications

TRANS.00011 — Pancreas Transplantation and Pancreas-Kidney Transplantation

TRANS.00013 — Small Bowel and Multivisceral Transplant Including Small Bowel/Liver

TRANS.00024 — High-Dose Chemotherapy with Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome

TRANS.00025 — Laboratory Testing as an Aid in the Diagnosis of Heart Transplant Rejection

TRANS.00031 — High-Dose Chemotherapy with Hematopoietic Stem Cell Transplantation for Autoimmune Disease and Miscellaneous Solid Tumors

Revised Medical Policies Effective 05-21-2009

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

TRANS.00028 — Hematopoietic Stem Cell Transplantation for Hodgkin's Disease and non-Hodgkin's Lymphoma

New Medical Policies Effective 07-01-2009

(The following policy was created with no significant changes to the position or criteria.)

MED.00101 – Physiologic Recording of Tremor using Accelerometer(s) and Gyroscope(s)

Revised Medical Policies Effective 07-01-2009

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

SURG.00067 – Percutaneous Spinal Procedures (Vertebroplasty, Kyphoplasty, Sacroplasty)

SURG.00092 – Implanted Devices for Spinal Stenosis

New Medical Policies Effective 07-15-2009

(The following policy was created with no significant changes to the position or criteria.)

SURG.00113 – Artificial Retinal Devices

Revised Medical Policies Effective 07-15-2009

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

DRUG.00036 – Cetuximab (Erbix[®])

GENE.00001 – Genetic Testing for Cancer Susceptibility

Revised Medical Policies Effective 07-15-2009

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

ANC.00009 – Cosmetic and Reconstructive Services of the Truck and Groin

BEH.00001 – Opioid Antagonists Under Heavy Sedation or General Anesthesia as a Technique of Opioid Detoxification

BEH.00004 – Treatment of Autism, Asperger Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Development Disorder

DME.00002 – Phototherapy for the Treatment of Seasonal Affective Disorder and Other Conditions

DME.00011 – Electrical Stimulation as a Treatment of Pain and Related Conditions: Surface and Percutaneous

DME.00014 – Computerized Dynamic Posturography

DME.00022 – Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)

DME.00025 – Patient Operated Spinal Unloading Devices

DME.00032 – Automatic External Defibrillators for Home Use

DRUG.00026 – Aerosolized Anti-infective Therapy for Sinusitis

GENE.00003 – Genetic Testing and Biochemical Markers for the Diagnosis of Alzheimer's Disease

GENE.00007 – Cardiac Ion Channel Genetic Testing

GENE.00008 – Analysis of Fecal DNA for Colorectal Cancer Screening and Surveillance

GENE.00009 – Gene-based Tests for Screening, Detection or Management of Prostate Cancer

GENE.00014 – Analysis of KRAS Mutation in Metastatic Colorectal Cancer

LAB.00002 – Salivary Estriol Testing for Preterm Labor

LAB.00003 – In Vitro Chemotherapy Sensitivity Assays and In Vitro Chemoresistance Assays

LAB.00009 – Pharmacogenomic and Metabolite Markers for Patients with Inflammatory Bowel Disease Treated with Azathioprine or 6-Mercaptopurine

LAB.00012 – Hyaluronan Binding Assay

LAB.00015 – Detection of Circulating Tumor Cells in the Blood as a Prognostic Factor in Patients with Metastatic Cancer

LAB.00020 – Intraepidermal Nerve Fiber Density Testing

LAB.00022 – Breast Lymph Node (BLN) Assay

LAB.00024 – Immune Cell Function Assay for the Management of Organ Transplant Rejection

LAB.00025 – Topographic Genotyping (PathFinder TB[®] Test)

MED.00003 – Thermography/Temperature Gradient Studies

MED.00004 – Technologies for the Evaluation of Skin Lesions

MED.00007 – Prolotherapy / Sclerotherapy for Joint and Ligamentous Injections

MED.00010 – Enhanced External Counterpulsation (EECP) in the Outpatient Setting

MED.00011 – Sensory Stimulation for Brain-Injured Patients in Coma or Vegetative State

MED.00012 – Gait Analysis

MED.00024 – Adoptive Immunotherapy and Cellular Therapy

MED.00026 – Hyperthermia for Cancer Therapy

MED.00043 – Low Level Laser Therapy

MED.00046 – Electrical Stimulation and Electromagnetic Therapy for Wound Healing

MED.00050 – Skin Contact Monochromatic Infrared Energy Therapy (MIRE)

MED.00053 – Non-Invasive Measurement of Left Ventricular End Diastolic Pressure (LVEDP) in the Outpatient Setting

MED.00057 – MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids

MED.00058 – Ocular Photoscreening

MED.00059 – Idiopathic Environmental Illness (IEI)

MED.00060 – End Diastolic Pneumatic Compression Boot

MED.00061 – Biofeedback for Fecal Incontinence

MED.00063 – Treatment of Acne Vulgaris using Pulsed Dye Laser or Photodynamic Therapy

MED.00066 – Cooling Devices and Combined Cooling/Heating Devices in the Outpatient Setting

MED.00087 – Imaging Techniques for Screening and Identification of Cervical Cancer

MED.00093 – Corneal Hysteresis

MED.00094 – ECG Body Surface Mapping

RAD.00001 – Computed Tomography to Detect Coronary Artery Calcification

RAD.00012 – Ultrasound for the Evaluation of Paranasal Sinuses

RAD.00016 – Intravascular Brachytherapy

RAD.00019 – Magnetic Source Imaging (MSI) and Magnetoencephalography

RAD.00022 – Magnetic Resonance Spectroscopy

RAD.00031 – Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy

RAD.00040 – PET Scanning using Gamma Cameras

RAD.00044 – Magnetic Resonance Neurography

RAD.00052 – Positional MRI

RAD.00056 – Intraocular Epiretinal Brachytherapy

REHAB.00003 – Hippotherapy

SURG.00009 – Refractive Surgery

SURG.00014 – Cochlear Implants and Auditory Brainstem Implants

SURG.00016 – Stereotactic Radiofrequency Pallidotomy

SURG.00022 – Lung Volume Reduction Surgery

SURG.00028 – Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions

SURG.00036 – Fetal Surgery for Prenatally Diagnosed Malformations

SURG.00043 – Electrothermal Shrinkage of Joint Capsules, Ligaments and Tendons

SURG.00045 – Extracorporeal Shock Wave Therapy for Orthopedic Conditions

SURG.00047 – Transendoscopic Therapy for Gastroesophageal Reflux Disease

SURG.00053 – Unicdylar Interpositional Spacer

SURG.00054 – Endovascular/Endoluminal Repair of Aortic Aneurysms

SURG.00056 – Transanal Radiofrequency for Fecal Incontinence

SURG.00058 – Prophylactic Bilateral Oophorectomy and Prophylactic Hysterectomy

SURG.00061 – Presbyopia and Astigmatism-Correcting Intraocular Lenses

SURG.00062 – Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome

SURG.00069 – Transpupillary Thermotherapy

SURG.00070 – Photocoagulation of Macular Drusen

SURG.00072 – Lysis of Epidural Adhesions Using Hypertonic Solutions

SURG.00073 – Epiduroscopy

SURG.00075 – Intervertebral Stabilization Devices

SURG.00079 – Nasal Valve Suspension

SURG.00103 – Intraocular (anterior segment) Aqueous Drainage Implant/Shunt

Archived Medical Policies Effective 07-18-2009

(The following policies were archived.)

MED.00014 – Home Spirometry and Home Overnight Oximetry Services

MED.00034 – Noninvasive Measurements of Cardiac Output in the Outpatient Setting including Thoracic Electrical Bioimpedance and Inert Gas Rebreathing

MED.00068 – Electrical Stimulation for the Treatment of Facial Palsy

(Note: for MediBlue members' diagnoses 351.0,-351.9 and 767.5 will continue to be denied for CPTs 97014, 97032 and HCPCS code G0283 consistent with CMS NCD.)

New Medical Policies Effective 07-18-2009

(The following policy was created with no significant changes to the position or criteria.)

MED.00102 – Ultrafiltration in Decompensated Heart Failure

Revised Medical Policies Effective 07-18-2009

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

DME.00019 – Continuous Passive Motion Devices

DRUG.00028 – Intravitreal and Periocular Injection Treatments for Retinal Vascular Conditions

RAD.00014 – Brachytherapy for Oncologic Indications

RAD.00017 – Intraoperative Radiation Therapy

SURG.00050 – Radiofrequency Ablation to Treat Tumors Outside the Liver

SURG.00100 – Cryoablation for Plantar Fasciitis and Plantar Fibroma

Revised Medical Policies Effective 07-18-2009

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

DRUG.00003 – Chelation Therapy

MED.00056 – Techniques for the Measurement of Body Composition

RAD.00038 – Use of 3-D and 4-D Ultrasound in Maternity Care

SURG.00011 – Autologous, Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting

SURG.00026 – Deep Brain Stimulation

Revised Medical Policies Effective 08-21-2009

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

DRUG.00039 – Trastuzumab (Herceptin®)

Revised Medical Policies Effective Late January 2010

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

DRUG.00015 – Prevention of Respiratory Syncytial Virus Infections

DRUG.00040 – Abatacept (Orencia®)

GENE.00010 – Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status

MED.00032 – Treatment of Hyperhidrosis

RAD.00011 – Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE)

RAD.00017 – Intraoperative Radiation Therapy

RAD.00036 – MRI of the Breast

New Medical Policies Effective Late January 2010

(Some of the policies below might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

SURG.00110 – Transanal Endoscopic Microsurgical (TEM) Excision of Rectal Lesions

SURG.00111 – Axial Lumbar Interbody Fusion

SURG.00112 – Occipital Nerve Stimulation

The following policy changes will be applied to the MediBlue products only Effective 11-06-2009

SURG.00045 – Extracorporeal Shock Wave Therapy for Orthopedic Conditions

(Note: for MediBlue members, claims will be reviewed consistent with the CMS NCD.)

TRANS.00024 – High-Dose Chemotherapy with Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome

(Note: for MediBlue members, claims will be reviewed consistent with the CMS NCD.)

TRANS.00031 – High-Dose Chemotherapy with Hematopoietic Stem Cell Transplantation for Autoimmune Disease and Miscellaneous Solid Tumors (Note: for MediBlue members, claims will be reviewed consistent with the CMS NCD.)

The following policy changes will be applied to the MediBlue products only Effective late January 2010

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

MED.00031 – Apheresis (Plasmapheresis, Plasma Exchange, Lipid Pheresis and Protein A Column Pheresis) (Note: for MediBlue members, claims will be reviewed consistent the CMS NCD.)

RAD.00022 – Magnetic Resonance Spectroscopy

(Note: for MediBlue members all diagnoses will be denied for CPT 76390 consistent with CMS NCD.)

Clinical guideline updates

Revised Clinical Guidelines Effective 05-21-2009

(The following guideline was revised to expand medical necessity indications or criteria.)

CG.DRUG.03 – Beta Interferons or Glatiramer Acetate for Treatment of Multiple Sclerosis

Revised Clinical Guidelines Effective 05-21-2009

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

CG.DRUG.12 – Biologics for Psoriasis and Psoriatic Arthritis

Revised Clinical Guidelines Effective 07-15-2009

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

CG.DME.24 – Manual Wheeled Mobility Devices

CG.DME.31 – Power Wheeled Mobility Devices

CG.DME.32 – Continuous Positive Airway Pressure (CPAP) for the Treatment of Obstructive Sleep Apnea in Adults and Children, and Related Devices for the Treatment of Obstructive Sleep Apnea in Adults – (Note: This guideline applies to claims for MediBlue members only.)

CG.DRUG.05 – Recombinant Erythropoietin Products

CG.DRUG.08 – Pharmacotherapy for Gaucher Disease

CG.DRUG.21 – Naltrexone (Vivitrol®) Injections for the Treatment of Alcohol Dependence

CG.DRUG.25 – IV vs. Oral Drug Administration

CG.LAB.05 – Lipoprotein-Associated Phospholipase A2

CG.MED.29 – Inpatient Subacute Care

CG.RAD.14 – CT/MRI Spine (Cervical, Lumbar, Thoracic)

CG.REHAB.01 – Vestibular Rehabilitation and Canalith Repositioning

CG.SURG.03 – Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Empire BlueCross BlueShield
One Liberty Plaza
165 Broadway
New York, NY 10006
empireblue.com



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EMPIRE NEWS

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Revised Clinical Guidelines Effective 07-18-2009

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

CG.DRUG.24 – Repository Corticotropin Injection (H.P. Acthar® Gel)

Clinical Guidelines Effective 08-21-2009

(The following guidelines will no longer be applied to any member claims)

CG.DRUG.14 – Dihydroergotamine Mesylate (DHE) Injection for the Treatment of Migraine or Cluster Headaches in Adults

CG.DRUG.19 – Progesterone Therapy as a Technique to Prevent Preterm Delivery in High-Risk Women

Clinical Guideline Effective 09-04-2009

(The following guideline will no longer be applied to any member claim)

CG.DME.32 – Continuous Positive Airway Pressure (CPAP) for the Treatment of Obstructive Sleep Apnea in Adults and Children, and Related Devices for the Treatment of Obstructive Sleep Apnea in Adults

New Clinical Guidelines Effective late January 2010

(The following guidelines were adopted and might result in services that were previously covered but may now be found to be not medically necessary)

CG.DRUG.11 – Oral and Injectable Infertility Drugs

CG.DRUG.15 – Gonadotropin Releasing Hormone (GnRH) Analogs

CG.MED.37 – Intensive Programs for Pediatric Feeding Disorder

CG.SURG.17 – Trigger Point Injections

New Clinical Guidelines Effective early April 2010

(The following guideline was adopted and might result in services that were previously covered but may now be found to be not medically necessary)

CG.DRUG.16 – White Blood Cell Growth Factors
