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Network Update

February 2015
Attention Oncologists, Urologists and Hematologists: Cancer Care Quality Program Begins March 1, 2015

If you specialize in oncology, urology or hematology most likely you recently received notification that Empire BlueCross BlueShield (“Empire”) will be implementing the new Cancer Care Quality Program (“Program”) beginning March 1, 2015. The Program includes online tools to provide decision support to oncologists in selecting cancer treatment regimens that are consistent with current evidence and consensus guidelines. In addition, the Program includes Cancer Treatment Pathways based on medical evidence and best practices developed with leading cancer experts to support oncologists in identifying therapies that are highly effective and affordable for our members. When you order a treatment regimen that is on a Cancer Treatment Pathway, you will be eligible for enhanced reimbursement if you are an in-network provider for the member’s health benefit plan.

Pathway regimens are widely accepted as a key component to manage oncology quality and costs. More specific than guidelines, pathway regimens identify treatments selected based on clinical effectiveness, favorable toxicity profiles, and cost. Organizations that have implemented pathway regimens have found that survival outcomes are equivalent for individuals treated on and off pathway regimens, while treatment costs decrease substantially for individuals treated on pathway regimens. The Cancer Treatment Pathways are based on a detailed review of efficacy, toxicity and cost informed by a clinical library that includes evidence drawn from:

- Peer-reviewed published literature
- Expert consensus statements and guidelines from professional organizations including ASCO, the American Society of Hematology (ASH), and The National Comprehensive Cancer Network (NCCN)
- Government agencies including the Food and Drug Administration (FDA) and the National Cancer Institute (NCI)

The Program will be administered by AIM Specialty Health® (AIM), a separate company, on behalf of Empire. AIM collaborates with payers to help improve healthcare quality and manage costs for some of today’s complex tests and treatments, promoting patient care that’s appropriate, safe and affordable.

How the Program works:

- Initiate a request to AIM (through the AIM ProviderPortal or the AIM Call Center) when a chemotherapy and/or biologic therapy cancer treatment regimen is prescribed for an Empire member.
- Information regarding the planned cancer treatment regimen, including supportive therapies, will be needed. Additional clinical information such as tumor type and stage, histology, key biomarkers and line of therapy will also be required.
- The planned cancer treatment regimen will be compared against evidence-based clinical Cancer Treatment Pathways; you will be notified if a Pathway regimen is appropriate and available for your patient and whether you are eligible for enhanced reimbursement. Please note that Cancer Treatment Pathways for enhanced reimbursement are determined by Empire and may not be available for every tumor type or line of therapy. (Note: At launch, the Program will include Cancer Treatment Pathways for breast, lung, colorectal, lymphoma, chronic myelogenous leukemia, myeloma, melanoma, central nervous system, ovarian, prostate and pancreatic cancers. Additional Pathway regimens for other malignancies may be added in 2015.)
- When the selected regimen is a Cancer Treatment Pathway, you will be eligible to receive an enhanced reimbursement, which is provided when you submit the following S-codes, if you are an in-network provider for the member’s health benefit plan:
  - S0353 ($350*) – Treatment planning and care coordination management for cancer initial treatment.
- S0354 ($350*) – Treatment planning and care coordination management for cancer, established patient (Billable no more than monthly).
- (*Any reimbursement, including the $350 for S0353 and S0354, is subject to contractual limitations of the lesser of billed charges)

- To receive payment for the S-codes, a notification is needed through the AIM Call Center, which will provide you with detailed instructions.
- Reimbursement of the S-codes will be limited as follows:
  - S0354 – no more than once monthly up to the maximum number of months specified by notification and instructions provided by AIM via the AIM ProviderPortal or the AIM Call Center.
- If you choose a regimen that is not a Cancer Treatment Pathway, the requested service(s)/regimen(s) will continue to be reviewed through the pre-certification or pre-determination review process and if consistent with plan medical policy will receive confirmation of coverage. However, these requested service(s) will not be eligible for the enhanced reimbursement.
- Additional detail information on the Program will be provided through webinars and newsletter articles in the coming weeks.

Note: The enhanced reimbursement is provided in accordance with Empire’s reimbursement policy EPRP-0043, “Cancer Treatment Planning and Care Coordination” which will be effective March 1, 2015. In addition, effective March 1, 2015, Empire's professional reimbursement policy EPRP – 0008, Bundled Services and Supplies, has been revised to remove the reference to treatment planning and care coordination management for cancer treatment. A copy of this policy can be found at empireblue.com > Reimbursement Policies.

All Empire members in your area are included except for the following groups:
- Federal Employee Program® (FEP®)
- BlueCard (except for members with health plans issued or administered by the following Anthem Affiliates: Anthem Blue Cross and Blue Shield in Indiana, Kentucky, Missouri, Ohio, Wisconsin, Colorado or Nevada; Blue Cross and Blue Shield of Georgia, and Anthem Blue Cross in California. (Additional Anthem Affiliates will be added in 2015.)
- Medicare Supplement
- Medicare Part D
- Hospital only (members with hospital only health plans)
- Child Health Plus

A special website offers tools and information about the Program. To view it, go to www.cancercarequalityprogram.com.

To request a prior authorization, please call 1-877-430-2288, Mon – Fri, 8:00 a.m. to 6:00 p.m.

Enhancements to AIM Clinical Appropriateness Guidelines for Advanced Imaging
On May 4, 2015, the following changes to our Clinical Appropriateness Guidelines for Radiology, Cardiology, and Oncologic PET will become effective.

Head & Neck Appropriate Use Criteria
- Expansion of criteria for MRI and CT brain allowing for evaluation prior to discontinuation of antiepileptic medications when a patient has not had a prior MRI
- Expansion of existing criteria for MRI and CT brain for evaluation of sensorineural hearing loss
- Addition of new criteria for MRI, MRA, CT, and CTA brain for evaluation of tinnitus
Addition of new criteria for MRI orbit, CT maxillofacial, and CT neck (soft tissue) for evaluation of osteonecrosis of the jaw

**Chest Appropriate Use Criteria**
- Infectious and inflammatory criteria for CT chest are further differentiated at the condition level
- Addition of several new criteria for CT chest include bronchopleural fistula, complications of pneumonia, and paraneoplastic syndrome with unknown primary tumor or origin

**Abdomen & Pelvis Appropriate Use Criteria**
- Addition of new criteria for MRI and CT abdomen for evaluation of iron deposition/overload in patients with hemochromatosis when they are candidates for chelation therapy
- Addition of new criteria for CTA abdomen and pelvis for evaluation of visceral artery aneurysms

**Musculoskeletal Appropriate Use Criteria**
- Clarification of criteria for MRI and CT spine when evaluating cord compression
- Removal of criteria allowing CT cervical and thoracic spine evaluation for MS, myelopathy, and spinal cord infarct (note: these are still available under MRI)
- Revision of criteria for MRI upper extremity evaluation of nonspecific upper extremity pain

**Oncologic PET Appropriate Use Criteria**
- Enhancement of clinical criteria for thyroid cancer

**Cardiology Appropriate Use Criteria**
- Addition of new criteria allowing stress echo and MPI evaluation of patients awaiting solid organ transplantation
- Clarification of criteria for stress echo and MPI evaluation of patients who have undergone percutaneous coronary intervention (PCI) greater than three years ago
- Clarification of criteria for stress echo, resting echo, and MPI evaluation for cardiac arrhythmias redefining frequent premature ventricular contractions
- Modification of criteria for resting echo reevaluation of patients who have undergone implantation of a bioprosthetic valve to allow imaging seven years after the procedure and then annually thereafter

**New Pediatric Guidelines**
- In addition to the changes above, AIM has developed a set of radiology guidelines that are specific to pediatric patients. These guidelines include:
  - Pediatric Abdomen & Pelvis
  - Pediatric Chest
  - Pediatric Head & Neck
  - Pediatric Musculoskeletal
  - Fetal MRI
- The guidelines listed above bring together criteria from AIM's adult guidelines applicable to pediatrics with new criteria specific to pediatric patients

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Click here to access and download a copy of the current guidelines.
Mandatory Electronic Prescribing
Effective March 27, 2015, a new law will require nurse practitioners, midwives, dentists, podiatrists, physicians, physician assistants and optometrists in New York State ("prescribers") to issue prescriptions electronically directly to a pharmacy, with limited exceptions. The law will not require a prescriber to issue a prescription electronically when:

- Electronic prescribing is not available due to temporary technological or electronic failure;
- The prescriber has a waiver granted by the New York State Commissioner of Health;
- The prescriber reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner; or,
- The prescription will be dispensed at a pharmacy located outside New York State.

The new law requires electronic prescribing for all types of medications (controlled substances and non-controlled substances) and for syringes and other medical devices dispensed at a pharmacy in New York.

Information about this law (Public Health Law §281) is available on the New York State Department of Health website: http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/.

ICD-10 Updates: Clinical Documentation Improvement
Now is the time to focus on clinical documentation improvement (CDI). ICD-10 offers greater specificity than ICD-9, allowing documentation to be translated into an accurate and clear clinical picture. One of the best ways to prepare for the upcoming ICD-10 deadline is by improving your clinical documentation now. Visit the Empire’s ICD-10 webpage for additional information and resources on this topic.

Coming in April 2015! We will be launching a free scenario-based coding practice tool designed to give professional providers and their coders the opportunity to test their knowledge of the ICD-10 codes set by applying it to medical scenarios. Look for more details in the next edition of Network Updates.

Child Health Plus Network Update
Effective December 31, 2014 Empire discontinued participation in the Child Health Plus program in all counties within Empire’s Service Area, except Putnam County. Prior to withdrawing from the program, our impacted Child Health Plus members were advised that they needed to apply to the NY Marketplace to enroll in CHP with another health plan. Members currently enrolled in Empire’s CHP program, who live in Putnam county, will be transitioned to Amerigroup effective April 1, 2015.

Expanded List of Outpatient Procedures for Pre-determination
Empire has revised and standardized what is reviewed for outpatient services for pre-service clinical review. Effective May 16, 2015 pre-determination will be offered for the following services:

- SURG.00028- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
  - Codes added for clinical review: 52441, 52442
- SURG.00033- Implantable Cardioverter-Defibrillator (ICD)
  - Codes added for clinical review: 33270, 33271, 33272, 33273, 93260, 93261, 93644
- SURG.00055- Cervical Artificial Intervertebral Disc
  - Codes added for clinical review: 22858, 0375T
- SURG.00103- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Code added for clinical review: 0376T
- CG-SURG-09- Temporomandibular Disorders
  - Codes added for clinical review: 20606, S8262
- MED.00005- Hyperbaric Oxygen Therapy (Systemic/Topical)
  - Code added for clinical review: G0277 replaces C1300
- SURG.00067- Percutaneous Spinal Procedures (Vertebroplasty, Kyphoplasty, Sacroplasty)
  - Codes added for clinical review: 22510, 22511, 22512, 22513, 22514, 22515

These changes will apply only to Empire’s local plans. The changes do not apply to National Accounts, Medicare Advantage (MA), Federal Employee Plan® (FEP®). If the service is not requested as a pre-determination, records may be requested for post service clinical review based on the same criteria listed.

**Medical Necessity Review of Lumbar Spinal Surgeries**

Empire Medical Management has added codes to the current lumbar spinal surgery medical necessity review list. This change is effective May 1, 2015. The spine surgeries that will be reviewed include but are not limited to fusion surgeries, excision of disc, and decompression surgery.

We utilize Medical Policy, Clinical Guidelines and Milliman Care Guidelines (MCG) which provide review criteria for these procedures. These changes will apply only to Empire local plans. National Accounts, Medicare Supplement, Medicare Advantage (MA) and FEP are excluded.

Although a pre-determination is not required, we encourage providers to obtain one prior to performing any of these procedures.

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.

It is important to note that if a review of a spine surgery claim results in a denial of benefits due to medical necessity, the claim will be denied and will not be billable to the member.

This review does not replace any existing medical policies currently in place for other types of spine surgery not listed below.

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>63185</td>
<td>Laminectomy with rhizotomy; 1 or 2 segments [when specified as lumbar]</td>
</tr>
<tr>
<td>63190</td>
<td>Laminectomy with rhizotomy; more than 2 segments [when specified as lumbar]</td>
</tr>
<tr>
<td>63200</td>
<td>Laminectomy, with release of tethered spinal cord, lumbar</td>
</tr>
<tr>
<td>63252</td>
<td>Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar</td>
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<tr>
<td>63267</td>
<td>Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar</td>
</tr>
<tr>
<td>63272</td>
<td>Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar</td>
</tr>
<tr>
<td>63277</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar</td>
</tr>
<tr>
<td>63282</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar</td>
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63287  Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar

63290  Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level [when specified as lumbar]

Important Information Regarding 2015 CPT/HCPCS Code Updates and Reimbursement Treatment
On January 1, 2015, the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) will be releasing new CPT® and HCPCS codes. Many codes released as part of their updates will be accepted by Empire; however, the following new 2015 codes will not be eligible for reimbursement for our Commercial products only:

- Codes G6030 – G6058 (Definitive Drug Testing) – Reimbursement will only be provided for the applicable new 2015 CPT codes.
- Code G0276 (Blinded procedure for lumbar stenosis, clinical trial) – This code would only be payable for Medicare patients in their CED project.
- Code G0472 (Hepatitis C antibody screening for high risk) – Reimbursement will only be provided for the applicable existing CPT code.
- Code G0473 (Group behavioral obesity counseling) – Reimbursement will only be provided for the applicable existing CPT code.
- Code 99490 (Chronic Care Management service) – Chronic care management services are an integral component of Empire's value based payment innovation programs.
- Codes 99497 - 99498 (Advance Care Planning service) – Advance Care Planning services are an integral component of Empire’s value based payment innovation programs.
- Code 34839 (Physician planning for endograft) – Physician planning for surgery is an integral component of the surgical procedure.

Reminder for physicians ordering laboratory services
Please ensure that you are referring Empire members exclusively to participating labs. Not only does your Empire agreement obligate you to refer to participating labs but members will only receive their in-network benefits from participating providers. Participating labs include:

- Quest Diagnostics, Inc.
- Laboratory Corporation of America Holdings

A complete up-to-date list of in-network participating laboratories may be obtained online at empireblue.com > Provider > Find a Doctor.

Audit Vendor Partner for New York Market
Effective January 1, 2015, Connolly, Inc. (“Connolly”) will begin to support diagnosis related group (DRG) audits for Empire in addition to Carewise Health, Inc. (“Carewise”). The addition of Connolly is expected to be complete by March 30, 2015.

Empire is committed to the coordinated efforts between both Carewise and Connolly to prevent duplicate requests/contact with the providers. Both Carewise and Connolly are committed to maintaining a professional working relationship with all providers.

New York State to receive $100M in federal grant funds to test new care delivery models
On December 16th, 2014 Governor Cuomo announced that New York would be awarded $100 million as part of a Health Innovation Grant known as the State Innovation Model (SIM).
The SIM grant, which is part of the Governors State Health Innovation Plan (SHIP), will be awarded by the Centers for Medicare and Medicaid Innovation and will offer access to high quality, coordinated care throughout New York.

Per the Governors announcement, this grant will help to:
- institute a state-wide program of regionally-based primary care practice transformation to help practices across New York adopt and use the APC model
- expand the use of value-based payments so that 80% of New Yorkers are receiving value-based care by 2020
- support performance improvement and capacity expansion in primary care by expanding New York's primary care workforce through innovations in professional education and training
- integrate APC with population health through Public Health Consultants funded to work with regional Population Health Improvement Program contractors
- develop a common scorecard, shared quality metrics and enhanced analytics to assure that delivery system and payment models support three-part aim objectives
- provide state-funded health information technology, including greatly enhanced capacities to exchange clinical data and an all-payer database

The SIM project has the support of New York Senators Charles Schumer and Kirsten Gillibrand, as well as a number of those in Congress, private practice and local New York healthcare associations. Empire has supported program reform and payment innovation programs for a number of years with initiatives such as; Quality-In-Sights, The Adirondack Patient Centered Medical Home (PCMH), The Mid-Hudson (THINC) PCMH, Comprehensive Primary Care initiative and their Enhanced Personal Health Care program and we welcome the opportunity to be part of this initiative.

For more information about the grant and Governor Cuomo’s announcement please go to:

No cost cultural competency trainings for providers - CME/CEU credits awarded

Your patients are becoming more racially, culturally and linguistically diverse. As such, there is an increased emphasis on cultural competence training for physicians, nurses, and other healthcare professionals who interact with these patients on a daily basis. Research shows that clinicians that are provided with multicultural training are better able to serve these growing patient populations, and are more likely to improve patient satisfaction, adherence, and patient outcomes, as well as increase their market share from some of the nation’s fastest growing communities.

We are excited to offer providers the following two culturally and linguistically targeted e-learning courses:
- Viewpoints: Clinical Competence in a Globally Mobile World and

These courses are offered to providers and appropriate office staff at no cost and provide AMA Category 1 CME/CEU credits. To learn more about how to register for and complete these free trainings, visit our course summaries web page.

Guidance for Grievances

As a provider, you may submit grievances for any issues you are experiencing with us. The complaints against the plan can be for unsatisfactory interactions, inappropriate responses, staff behavior, delays, phone access, and insufficient reasons for denial. You may also file complaints about a remittance advice if it seems unclear, inaccurate, if there are HIPAA concerns, or any other issues. You may also submit complaints about our Availity system or membership issues such as eligibility information on a card. You would submit these complaints as you do today through the standard dispute/appeals process.

Clinical Practice and Preventive Health Guidelines Available online

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our
website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to the "Provider" home page at empireblue.com. From there, select "Provider & Facility" > Enter > Health & Wellness > Practice Guidelines.

FEP news

**Advanced Benefit Determination Process**

Empire's Federal Employee Program® would like to share information about our Advanced Benefit Determination (ABD) process. This is a voluntary process offered to physicians and/or their representatives to prospectively submit a request for member-specific services to the Utilization Management staff for medical necessity review and benefit determinations. ABDs are assigned a Reference/Authorization number when the review determines the medical necessity criteria have been met and/or benefits are available. This Reference/Authorization number will be included in the top right hand corner of the letter sent to the provider. The letter includes direction for the provider regarding how to use the Reference/Authorization number for claims submission. If the ABD is approved, the provider can include the Reference/Authorization number on the post-service claim and the claim will be processed. This eliminates the need for the provider to submit the approval letter with each claim.

The following statement is included in the approval letter:

“Note to Provider: To ensure efficient and timely payment of claims when submitted, please include the authorization number from this letter on your claim.”

**FEP® changes call in hours for UM/CM**

The Federal Employee Program, Utilization and Case Management Department, is changing the hours of operation effective March 1, 2015. The new hours of operation will be 8:00 a.m. to 6:00 p.m. EST.

**Maternity-Related HEDIS Measures Frequently Asked Questions**

In the December 2014 newsletter, we discussed the HEDIS measure related to postpartum care that should occur between 21 and 56 days after delivery and what you can do to improve your rates. A couple of questions around documenting the postpartum visit arose that we would like to clarify.

In addition to scheduling and reminding patients about the postpartum visit and documenting those visits in the chart well, what else can I do?

Specify the postpartum visit date on the claim and use the Category II CPT Code 0503F (indicating a postpartum visit) on the global delivery code with the delivery date. When this supplemental tracking code is used on a claim, less time and disruption to your office is required by the health plan to review patient charts for evidence of postpartum care.

How do I indicate a postpartum visit date and the Category II CPT Code on the global bill when the postpartum visit has not occurred yet?

There isn't a way to code for a service that has not occurred yet (i.e., the postpartum visit). You can simply report code 0503F when the actual postpartum visit is conducted.

What should you do if your patient does not return for the postpartum visit before 8 weeks, or not at all? In this case, how should the global delivery be billed?
You would need to bill the appropriate delivery only code (either 59409, 59514, 59612, 59620), plus the antepartum care only code (either 59425 or 59426).

*When I submit a claim using the Category II CPT Code of 0503F with a date, why might the claim be denied for payment?*
If you are paid for a global delivery code (59400, 59510, 59610, 59618), then you have already been paid for the postpartum care. It is included as an integral part of these codes. AMA CPT Category II codes are supplemental tracking codes only and are only used for administrative purposes. Anthem does not use them for reimbursement of health services. Using code 0503F signals that the postpartum visit was conducted, which allows for claim captures of postpartum data for HEDIS.

*Besides postpartum care, what other maternity-related HEDIS measures is the National Commission for Quality Assurance (NCQA) concerned about?*
In addition to the postpartum care measure looking at the percentage of women who have delivered a baby and received a postpartum care visit 21 to 56 days after delivery, there are 2 other HEDIS measures related to maternity care:
- Timeliness of Prenatal Care as determined by the percentage of women receiving a prenatal visit within the first trimester or within 42 days of health plan enrollment. Using Category II cpt code 0500F will signal the initial prenatal visit. The date of the initial prenatal visit should be included.
- Frequency of On-going Prenatal Care as determined by the percentage of Medicaid deliveries that had the expected number of prenatal visits.

An additional HEDIS measure is under consideration to look at early elective deliveries among low risk patients.

*Where does the information come from?*
Patient information from a random sample about compliance with the maternity HEDIS measures is obtained from a combination of looking at claims and by looking at patient records. When looking at patient records, the review team is looking for documentation of pregnancy diagnosis, dates of service, delivery date, evidence of physical exam, and counseling/discussion points. Using supplemental tracking codes, such as 0503F for postpartum visit or 0500F for the initial prenatal visit, along with corresponding dates on the claim forms reduces the time and disruption to your office that the health plan would need to review patient charts for evidence of care.

**Pharmacy news**

**Pharmacy information available online**
For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit empireblue.com/pharmacyinformation. The commercial drug list is reviewed and updates are posted to the web site quarterly (the first of the month for January, April, July and October).

**Health Care Reform updates (including Health Insurance Exchange)**

**New Health Insurance Exchange article available online**
- [2015 Health Insurance Marketplace Quick Reference Guide](#)
We invite you to visit our website, empireblue.com, to learn about the many ways health care reform and the health insurance exchange may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance exchange, and all archived articles, go to empireblue.com, select the Provider link in the top center of the page, and click Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange Information.

Inovalon requests for 2015
Just as in 2014, we have engaged Inovalon – an independent company that provides secure, clinical documentation services – to help us comply with provisions of the Affordable Care Act that require us to assess members’ relative health risk level. In the coming weeks and months, Inovalon will begin sending providers letters as part of a new risk adjustment cycle, asking for their help with completing health assessments for some of our members.

If you worked with Inovalon in 2014, many thanks for your help. This year will bring a new round of assessments. As always, if you have questions about the requests you receive, you can reach Inovalon directly at 1-877-448-8125.

Medicare Advantage news

Routine physical exams are covered in 2015
Empire Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2015 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member’s plan.

Empire Medicare Advantage plans also will continue to provide benefits for the following Medicare covered services:
- Initial Preventive Physical Exam (IPPE) also known as the “Welcome to Medicare Preventive Visit”
- Annual Wellness Visit (AWV)

The IPPE (preventive physical exam) and AWV (wellness visit) are not a routine physical exam. Please refer to the chart on the next page to ensure accurate coding for each type of exam.
Welcome to Medicare Visit/Initial Preventive Physical Exam:
A preventive evaluation and management service; a face-to-face evaluation. This exam is a preventive physical exam and not a comprehensive physical checkup. This service is limited to new beneficiaries during the first 12 months of Medicare enrollment. This is a once in a lifetime benefit.

Initial Annual Wellness Visit (AWV):
Services limited to beneficiary during the Second year the patient is eligible for Medicare Part B. Only one first AWV per beneficiary per lifetime. Includes a personalized prevention plan of services; face-to-face visit.

Subsequent Annual Wellness Visit (AWV):
One year after the patient’s Annual Wellness Visit. Once every 12 months. Includes a personalized prevention plan of services; face-to-face visit. This exam is a preventive physical exam and not a comprehensive physical checkup.

Note: The AWV is intended to build upon the previously established “Welcome to Medicare Visit” physical exam.

Preventive Medicine Services:
The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient’s age, gender, and identified risk factors; face-to-face visit.

Ob/Gyn providers please note: A Pap test and pelvic exam for our Medicare Advantage members is covered annually only if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past three years. Otherwise a Pap test and pelvic exam is covered every two years for women at normal risk. These services should be filed as separate codes from the routine physical, if they are rendered.

Medicare Advantage member benefits are subject to change from year to year – please review 2015 benefits on the Medicare Advantage Providers page of the Empire provider portal. Annual summaries of Medicare Advantage plan changes also can be found under Important Medicare Advantage Updates. This will advise what coverage of what will and/or will not take place for routine physcials.

For further information or to verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member’s identification card.

Individual MA membership has moved to a new claims system
Effective Jan. 1, 2015, Empire moved Individual (non-group) MA members to a new claims processing system. This new system will have some new and updated MA reimbursement policies. These policies will be in effect unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Please continue to check Important Medicare Advantage Updates on your provider portal for additional information.

Home Health Claims – Split dates of service for 2014 and 2015
Jan. 1, 2015 individual Medicare Advantage members (not group sponsored plan members) moved to a new claims system. Please review the following information to help ensure your claims are processed accurately and efficiently. To expedite the processing of your claims, please split the date of services for your 2014 and 2015 services.

When billing for your Home Health services please bill the dates of services using calendar year format.
Example:
- Actual Dates of Services 12/18/2014 thru 01/20/2015
- Submit a claim for:
  - Dates of Service 12/18/2014 thru 12/31/2014
  - Dates of Service 01/01/2015 thru 01/20/2015

**Submit no more than one place of service per claim**
Medicare Advantage providers should not submit claims with more than one place of service. Please submit separate claims for each place of service.

**Law excludes some Part D drugs; customer service ready to help with members’ questions**
There are some drugs that are excluded from the majority of Medicare Part D coverage by law. These include:

Drugs for:
- Anorexia, weight loss or weight gain (except to treat physical wasting caused by AIDS, cancer or other diseases)
- Fertility
- Cosmetic purposes or hair growth
- Relief of the symptoms of colds, like a cough and stuffy nose
- Erectile dysfunction
- Durable medical equipment
- Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs (over-the-counter drugs)

A few plans may cover the above as an Enhanced Benefit. If there is a question of coverage, please have the member call their customer service line on the back of their benefit card.

**$0 copay medications available to Medicare Advantage members with chronic conditions**
New to Individual MAPD plans in 2015, select drugs will be available at a $0 member co-pay for the following conditions: high blood pressure, high cholesterol and diabetes. Medications include Glipizide, Lisinopril, Losartan, Metformin Hcl and Simvastatin.

Group-sponsored plans will continue to offer the Select Generics benefit, which offers $0 copay for select generic drugs.

**Avoid second fills of high-risk medications**
Empire is required to monitor prescription activity for high-risk medications as defined by The Centers for Medicare and Medicaid Services (CMS) to improve patient safety.

To ensure providers are aware of any high-risk medications prescribed for our Medicare Advantage members, we fax a list of high-risk medication claims to providers each week.

Empire also distributes a monthly report to prescribers detailing the number of members on high-risk medications and the number of high-risk medications prescribed year-to-date. We also contact members who have filled prescriptions for high-risk medications and suggest that they discuss the prescription with their physician and ask if there is a safer alternate drug.

If you receive a high-risk medication fax or report from us, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed at [www.empireblue.com/maprovidertoolkit](http://www.empireblue.com/maprovidertoolkit).

**Compounded drugs no longer a covered benefit for Individual MAPD and PDP Plans**
Effective Jan. 1, 2015, compounds are no longer a covered benefit for individual MAPD and PDP plans. Members who had a compound prescription filled in the last six months of 2014 were notified of this coverage change via mail and/or phone.

Please note that members of group sponsored MAPD and PDP plans will have coverage for only the Part D eligible drugs that are part of a compound.

If you believe the compounded medication you have prescribed is medically necessary, the patient may request an exception. The prescriber must provide a statement along with the exception request that explains the medical reasons for supporting the exception.

**Provider Requirements and Medicare Notices**

The Centers for Medicare and Medicaid Services (CMS) requires providers to deliver the *Notice of Medicare Non-Coverage (NOMNC)* to every Medicare beneficiary at least two (2) days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires providers to deliver the Important Message from Medicare About Your Rights (IM) notice to every Medicare beneficiary within 2 calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than 2 calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, Empire periodically conducts IM and NOMNC Audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.

Our audit findings show providers would benefit from focusing in on the following elements required by CMS:

- **NOMNC Notices:**
  - Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
  - Include the beneficiaries Health Care Identification Number or Medical Record Number on page one
  - Include the specific type of services ending on page one
  - Include the Health Plans contact information on page two
  - Have the beneficiary or authorized representative sign and date page two at least two (2) days prior to the end of services
  - Retain a copy of the signed notice, both page one and page two.

- **IM Notices:**
  - Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
  - Include the physician's name on page one
  - Have the beneficiary or authorized representative sign and date page one within 2 calendar days of the date of an inpatient hospital admission
  - Call the authorized representative to deliver the IM when the beneficiary is unable to sign
  - Deliver the IM, or copy of the IM again, no sooner than 2 calendar days before discharge
  - Retain a copy of the signed notice, both page one and page two.

To download the standardized IM/NOMNC Notices required by CMS, along with accompanying instructions, go to CMS website at [www.cms.hhs.gov/bni](http://www.cms.hhs.gov/bni) or refer to the specific links below:

- **IM Notice:** [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html)
IMPORTANT UPDATE: Quality Improvement Organizations (QIO’s) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see http://www.qioprogram.org/contact to locate your QIO.

For more information on compliance with the Notice of Medicare Non Coverage or the Important Message from Medicare, contact Mary Heapes, RN, BSN in the Federal Clinical Compliance Department at (212) 476-2908.

ICD-10-CM: ICD-9 vs. ICD-10 for Atrial Fibrillation and Flutter

In previous articles, we shared some basic information and recommendations to help identify how specific ICD-9 codes will be impacted by the implementation of ICD-10.

The diagnoses data we receive from providers is critical for helping meet the health care needs of our members and remain compliant with Centers for Medicare & Medicaid (CMS) regulatory requirements. The information below supports accurate and complete diagnoses reports and ensures the medical chart documentation for each encounter supports and validates the reported diagnoses codes. This helps avoid unnecessary and costly administrative revisions as a result of an audit.

This article focuses on atrial fibrillation and flutter. According to the ICD-10 codebook, atrial fibrillation and flutter are the most common abnormal heart rhythms (arrhythmia) presenting as irregular/regular, rapid beating (tachycardia) of the heart’s upper chamber. The ICD-10 code set provides multiple codes that represent a progressive path (severity of illness) for atrial fibrillation, requiring more specificity for accurate code assignment. The table below demonstrates what terms need to be documented in ICD-10 to appropriately capture the type of atrial fibrillation and flutter.

<table>
<thead>
<tr>
<th>ICD-9 (Single code)</th>
<th>ICD-10 (Multiple specific codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>427.31 (Established</td>
<td>I48.0 Paroxysmal</td>
</tr>
<tr>
<td>or Paroxysmal)</td>
<td>- Occurs periodically</td>
</tr>
<tr>
<td></td>
<td>I48.1 Persistent</td>
</tr>
<tr>
<td></td>
<td>- Rapid contractions of the upper</td>
</tr>
<tr>
<td></td>
<td>heart chamber</td>
</tr>
<tr>
<td></td>
<td>I48.2 Chronic</td>
</tr>
<tr>
<td></td>
<td>- Permanent atrial fibrillation</td>
</tr>
<tr>
<td>Atrial Flutter</td>
<td>Atrial Flutter</td>
</tr>
<tr>
<td>427.32</td>
<td>I48.3 Typical</td>
</tr>
<tr>
<td></td>
<td>- Type I atrial flutter</td>
</tr>
<tr>
<td></td>
<td>I48.4 Atypical</td>
</tr>
<tr>
<td></td>
<td>- Type II atrial flutter</td>
</tr>
<tr>
<td>Unspecified</td>
<td>Unspecified atrial fibrillation</td>
</tr>
<tr>
<td>atrial fibrillation</td>
<td>I48.91 Unspecified atrial fibrillation</td>
</tr>
<tr>
<td>and flutter</td>
<td>- Type not specified</td>
</tr>
<tr>
<td></td>
<td>I48.92 Unspecified atrial flutter</td>
</tr>
<tr>
<td></td>
<td>- Type not specified</td>
</tr>
</tbody>
</table>

In future articles, we will continue to bring you helpful coding tips to assist you and your coding staff with the transition from ICD-9 to ICD-10.
CMS will not accept ICD-9 codes for dates of service beginning on Oct. 1, 2015. It will be critical to keep this in mind as all encounters/claims submitted with ICD-9 codes will reject beginning Oct. 1, 2015 resulting in delay or denial of payment. We all must be prepared to meet CMS guidelines.

To further assist you in your preparation we are providing the following references, helpful links and additional resources:

- The one-page reference sheet produced by AAPC shows how the code sets are organized, with easy color coding to help you find what you're looking for. It also has mnemonic tips (such as "C is for cancer" and "T is for toxicity") to help you remember where the new codes are located.
- American Medical Association physician resource page
- Centers for Medicare & Medicaid Services (CMS) Provider Resources
- AAPC ICD-10 Implementation and Training Opportunities

**New D-SNP plans offered in 2015; D-SNP training available**

Empire now offers Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs coordinate Medicare and Medicaid programs and provide enhanced member benefits.

Empire is offering an introduction to D-SNP plans, including claims submission, coding procedures and model of care information. Providers can access the training at the Medicare Advantage Public Provider Portal.

**Prior authorization required for members**

Empire wants to remind providers that they are required to request a prior authorization for Medicare Advantage members for services that require prior authorization. Failure to obtain a prior authorization will result in an administrative denial. The 2015 prior authorization requirements were posted to the Provider Forms section of the Empire Medicare Advantage Public Provider Portal October 4, 2014.

Members cannot be balance billed for an administrative denial.

To obtain prior authorization or to verify member eligibility, benefits or account information, please call the telephone number listed on the member’s plan membership card.

Please visit the Provider Forms section of the Empire Medicare Advantage Public Provider Portal at www.empireblue.com/medicareprovider to see the prior authorization list that is effective for 2015 as well as prior authorization requirements for 2014.

**New 2015 precertification fax number for Skilled Nursing, Long Term Acute Care and Inpatient Rehab**

Effective Jan. 1, 2015, we have a separate fax number for providers and facilities to use. The new fax numbers should only be used when submitting precertification requests or additional clinical information for the following services:

- Skilled Nursing Facility (SNF)
- Long Term Acute Care (LTAC)
- Inpatient Rehabilitation

Precertification fax number for Skilled Nursing, Long Term Acute Care and Inpatient Rehab: 1-877-744-2319
Please note, submitting requests for services not listed above may cause a delay in processing requests.

**Individual Medicare Advantage membership enforces CLIA & ADI July 1, 2015**

Effective July 1, 2015 Empire Individual Medicare Advantage will deny claims billed without CMS required criteria back to the provider who submitted the claim. The denials will include:

- Advanced Diagnostic Imaging (ADI) supplier not accredited for the service being billing
- Clinical Laboratory Improvement Amendment (CLIA) certification is missing or invalid, based on the laboratory code billed. CLIA certification should be billed in Box 23 on the claim form. Starting in March an informational message will be included on your remittance when you bill a laboratory code that requires certification reminding you effective July 1st claims will be denied when CLIA certification is not included.

Please ensure your billing staff is aware of these changes. If you have any questions, please contact the Provider Services number on the back of the member’s ID card.

**Second-level provider appeals eliminated for Medicare Advantage plans effective May 1, 2015**

To further clarify and distinguish between provider and member appeals, effective May 1, 2015, Empire’s MediBlue HMO and PPO Medicare Advantage plans will establish a separate and distinct Contracted Provider Appeal Process. Contracted Providers who appeal any determination that does not involve Medicare Advantage member liability under Federal regulations [CFR §422.568(c) and (d)], will have separate Medicare Advantage processing and timeframe guidelines. For Medicare Advantage Provider Appeals, there will no longer be a second level appeal available after April 30, 2015. The elimination of second level appeals applies to Medicare Advantage products only.

As previously required, the Provider Appeal should be accompanied by a letter that explains why the provider believes the decision should be overturned. Any information necessary to review the appeal must be included with the letter, such as the complete medical records needed to justify the services for which the provider is seeking payment. Appeals will be acknowledged within fifteen (15) days of receipt. As Empire will only be reviewing one level of appeal, we expect providers to provide all the information needed to justify the requested services with the request for appeal.

Please note that Empire MediBlue HMO and PPO Medicare Advantage plans administer Medicare coverage for our Medicare Advantage Members and follows Medicare guidelines with regard to coverage of certain items and services. If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can only be made when the documentation supports the service/item.

A Medicare Advantage appeal is initiated by writing or sending a fax to the Empire Medicare Advantage Appeals Department within one hundred eighty (180) calendar days of our initial decision at:

Medicare Advantage Grievance and Appeals
Mail location OH0205-A537
4361 Irwin Simpson Road
Reminder: Clinical information required for Medicare Advantage members

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Medicare Advantage members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential.

Please refer to your provider agreement and the Medicare Advantage HMO & PPO Provider Guidebook to ensure that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.

Please note that Empire Medicare Advantage plans administer Medicare coverage for our Medicare Advantage members and follow Medicare guidelines. If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:
- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

Medicare Advantage HMO referral reminder – PCPs do not need to call Empire to obtain a referral

Empire values the role that primary care physicians play in helping to coordinate care for our Medicare Advantage HMO members. As such, we ask that you serve as their primary contact for referring them to other specialist and providers and that you document such referrals in individual member’s medical records.

To ensure the highest level of benefits and coordination of care for Empire members and streamline the approval process for your office, it’s important that you refer members to in network providers whenever possible. When you do, you will not need to contact the plan (Empire) for preapproval of those referrals. Additionally, for in-network providers, members do not need a new referral simply because they are being seen in a new calendar year. Referrals from a PCP are not required for emergency care or urgently needed care.

Certain routine care can be obtained without having an approval in advance from their PCP, such as routine women’s health care (breast exams, screening mammograms, Pap tests and pelvic exams) and routine dental and vision care.

Please visit our website for more detailed information on when referrals are required or contact Provider Services at the number on the back of the member’s ID card. You can find Important Medicare Advantage Updates here.

Medicare Advantage member identification prefixes updated for 2015

Network Update

February 2015
Empire moved Individual (non-group) Medicare Advantage members to a single claims processing system Jan. 1, 2015. Member identification prefixes were updated as part of that transition. The 2015 member identification prefixes for individual Medicare Advantage plans are listed below.

Please file 2014 charges with the 2014 prefix and 2015 charges with the 2015 prefix to ensure claims are delivered to the appropriate claim system for processing.

### 2015 Individual Medicare Advantage plans

<table>
<thead>
<tr>
<th>Prefix</th>
<th>State/Area</th>
<th>Plan Type</th>
<th>Plan Name</th>
<th>Provider and member service</th>
<th>CMS contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOF</td>
<td>NY</td>
<td>MA HMO</td>
<td>MediBlue HMO</td>
<td>1-800-499-9554</td>
<td>H3370</td>
</tr>
<tr>
<td>VOG</td>
<td>NY</td>
<td>MA PPO</td>
<td>MediBlue PPO Plus</td>
<td>1-866-395-5175</td>
<td>H3342</td>
</tr>
<tr>
<td>JWX</td>
<td>NY</td>
<td>MA HMO/SNP</td>
<td>Empire Dual Advantage (HMO SNP)</td>
<td>1-800-499-9554</td>
<td>H3370</td>
</tr>
</tbody>
</table>

Sample ID cards for 2015 are available at the [Medicare Advantage public provider portal](#).

**Group-sponsored Medicare Advantage plan members are not affected by these changes.** Members with the following member identification prefixes on their member card will represent group sponsored business only and will remain on the current claims processing platform:

- JQF
- JWM
- VZM
- VZP
- WGK
- WSP
- XDK
- XDT
- XGH
- XGK
- XKJ
- XVJ
- XLV
- YCG
- YGJ
- YGS
- YLR
- YLV
- YRA
- YRE
- YRU

**OrthoNet authorization phone and fax numbers updated; Use for Medical Necessity Reviews and Professional Service Coding Reviews**

Empire is collaborating with OrthoNet, LLC to conduct medical necessity reviews for physical therapy, occupational therapy and spine and back pain management for our individual Medicare Advantage members. Group sponsored members are not impacted.

**What does this mean to you?**

As previously published, effective Jan. 1, 2015, the following services/treatment requests must be reviewed by OrthoNet for precertification.

- Outpatient Physical therapy
- Outpatient Occupational therapy
- Spine and Back Pain Management procedures:
  - Epidurals
  - Facet Blocks
  - Pain Pumps
  - Neurostimulators
  - Spinal Fusion
  - Spinal Decompression
  - Vertebro/Kyphoplasty
In addition, OrthoNet will conduct post service prepayment coding review of professional services for our individual and group-sponsored Medicare Advantage members, including:

- Orthopedic Surgery
- Plastic Surgery
- Neurosurgery
- Sports Medicine
- Podiatry
- Hand Surgery
- Neurology
- Pain Management
- Psychiatry/Physical Medicine and Rehabilitation (PM&R)
- ENT
- General Surgery
- Dermatology
- Cardiology
- Urology
- Percutaneous Coronary Intervention (PCI)

Precertifications can be obtained at the following phone or fax numbers:
Outpatient Physical and Occupational Therapy
Fax 1-844-340-6419
Phone 1-844-340-6418

Spine and Back Pain Management procedures
Fax 1-844-788-4806
Phone 1-844-788-4805

A complete list of precertification requirements can be found at the Provider Forms section of the Empire Medicare Advantage Public Provider Portal (www.empireblue.com/medicareprovider).

Quality Initiatives

HEDIS® 2015: Controlling High Blood Pressure Measure
One of the HEDIS measures we are collecting this year is Controlling High Blood Pressure. This measure is collected on members ages 18 to 85 with a diagnosis of hypertension. The following items are needed from the member’s medical record:

- The earliest documented date of hypertension (prior to 7/1/14) found in your medical record. This diagnosis date can be any time prior to 7/1/14, but cannot be on 7/1/14 or after. For example, the earliest documented date does not have to be in 2014 – it can be in 1998, 2000, 2005, and 2010 – ANYTIME prior to 7/1/14. The diagnosis can be found on a dated history form, a problem list, or a progress note.
- Blood pressure (BP) reading(s) from the LAST TWO visits in 2014. This does not have to be from a hypertension diagnosis; the last two blood pressure readings can be from any diagnosis in 2014. Please note – the blood pressure readings cannot be from the same date as the earliest documented hypertension date listed above, or from...
the same day as a major diagnostic or surgical procedure. Please include all BP readings for the last two visits documented in progress notes and/or vital signs flow sheets.

If the following applies to the member please submit this additional documentation:
- Documentation of End Stage Renal Disease, renal dialysis or renal transplant with date of occurrence
- If the member was pregnant in 2014, provide documentation of pregnancy
- If the member had a non-acute inpatient admission during 2014 provide documentation

Our goal is to make the record retrieval process as easy as possible for your office. We also want you to know that we are available to answer any questions you have about HEDIS or any of the measures. We look forward to working with you this HEDIS season and thank you in advance for your continued cooperation and support of HEDIS.

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

HEDIS® 2015: Easy Submission of Commercial HEDIS Medical Records

We want to make returning HEDIS medical records as easy as possible for your office. To return the time sensitive medical record documentation back to us in the recommended 5 day turnaround time, simply choose one of these options:
- Upload to our secure portal. This is quick and easy. Logon www.submitrecords.com, enter the password: wphedis57 and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.
- Send a secure fax to 1-888-251-2985
- Mail to us via the US Postal Service to:
  Empire BlueCross BlueShield
  10897 S. River Front Parkway, Suite 110H
  South Jordan, UT  84095-9984

We will begin requesting medical records in January via a phone call to your office followed by a fax. Contact information will be included with the fax should you have any questions. We thank you in advance for your support of HEDIS.

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 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 or 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 www.empireblue.com.

Medical Policy Updates

Revised Medical Policies Effective 11-17-2014
(The following policies were revised to expand medical necessity indications or criteria.)
- DRUG.00002 - Tumor Necrosis Factor Antagonists
- DRUG.00015 - Prevention of Respiratory Syncytial Virus Infections
- SURG.00064 - Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure

Revised Medical Policy Effective 01-01-2015
(The following policy was revised to expand medical necessity indications or criteria.)
- SURG.00121 - Transcatheter Heart Valve Procedures

Revised Medical Policies Effective 01-01-2015
(The following policies were reviewed and had no significant changes to the policy position or criteria.)
- GENE.00001 - Genetic Testing for Cancer Susceptibility
- GENE.00025 - Molecular Profiling for the Evaluation of Malignant Tumors
- GENE.00030 - Genetic Testing for Endocrine Gland Cancer Susceptibility
- GENE.00033 - Genetic Testing for Inherited Peripheral Neuropathies
- GENE.00035 - Genetic Testing for TP53 Mutations (Li-Fraumeni Syndrome)
- MED.00032 - Treatment of Hyperhidrosis
- RAD.00060 - Digital Breast Tomosynthesis
- SURG.00017 - Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- SURG.00028 - Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
- SURG.00055 - Cervical Artificial Intervertebral Disks
- SURG.00120 - Open Treatment of Rib Fracture(s) Requiring Internal Fixation

Revised Medical Policies Effective 01-10-2015
(The following policies were revised to expand medical necessity indications or criteria.)
- DRUG.00028 - Intravitreal and Periocular Injection Treatment for Retinal Vascular Conditions
- DRUG.00032 - Intravitreal Corticosteroid Implants

Revised Medical Policy Effective 01-13-2015
(The following policy was revised to expand medical necessity indications or criteria.)
- DRUG.00059 - Romiplostim (Nplate®)

Revised Medical Policies Effective 01-13-2015
(The following policies were reviewed and had no significant changes to the policy position or criteria.)
- ADMIN.00002 - Preventive Health Guidelines
- DME.00034 - Standing Frames
- DME.00035 - Electric Tumor Treatment Field (TTF)
- DME.00036 - Ultraviolet Light Therapy Delivery Devices for Home Use
- DRUG.00034 - Insulin Potentiation Therapy
- DRUG.00042 - Ustekinumab (Stelara®)
- DRUG.00046 - Ipilimumab (Yervoy™)
- DRUG.00048 - Eribulin mesylate (Halaven®)
- DRUG.00051 - Ziv-aflibercept (Zaltrap®)
- DRUG.00053 - Carfilzomib (Kyprolis™)
- DRUG.00055 - Denosumab (Prolia®, Xgeva™)
- DRUG.00060 - Plerixafor Injection (Mozobil™)
- DRUG.00063 - Ofatumumab (Arzerra™)
- GENE.00004 - Janus Kinase 2 (JAK2) V617F Gene Mutation Assay
- GENE.00017 - Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)
- GENE.00018 - Gene Expression Profiling for Cancers of Unknown Primary Site
- GENE.00019 - BRAF Mutation Analysis
- GENE.00020 - Gene Expression Profile Tests for Multiple Myeloma
- GENE.00022 - In Vitro Companion Diagnostic Devices
- GENE.00023 - Gene Expression Profiling for Uveal Melanoma
- GENE.00027 - The Panexia™ Test for Oncologic Indications
- LAB.00026 - Systems Pathology Testing for Predicting Risk of Prostate Cancer Progression and Recurrence
- LAB.00028 - gMS® Dx and the gMS® Pro EDSS Serum Biomarker Tests for Multiple Sclerosis
- MED.00082 - Quantitative Sensory Testing
- MED.00083 - Melanoma Vaccines
- MED.00085 - Antineoplastin Therapy
- MED.00089 - Quantitative Muscle Testing Devices
- MED.00095 - Anterior Segment Optical Coherence Tomography
- MED.00096 - Low-Frequency Ultrasound Therapy for Wound Management
- MED.00099 - Electromagnetic Navigational Bronchoscopy
- MED.00103 - Automated Evacuation of Meibomian Gland
- OR-PR.00003 - Microprocessor Control led Lower Limb Prostheses
- RAD.00004 - Peripheral Bone Mineral Density Measurement
- RAD.00017 - External Beam Intraoperative Radiation Therapy
- RAD.00023 - Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
- RAD.00029 - CT Colonography (Virtual Colonoscopy) as a Screening or Diagnostic Test for Colorectal Cancer
- RAD.00036 - MRI of the Breast
- RAD.00037 - Whole Body Computed Tomography Scanning
- RAD.00047 - Neutron Beam Radiotherapy
- RAD.00049 - Low-Field and Conventional Magnetic Resonance Imaging (MRI) for Screening, Diagnosing and Monitoring
- RAD.00057 - Near-Infrared Coronary Imaging and Near-Infrared Intravascular Ultrasound Coronary Imaging
- RAD.00061 - PET/MRI
- RAD.00062 - Intravascular Optical Coherence Tomography (OCT)
- RAD.00064 - Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT)
- SURG.00008 - Mechanized Spinal Distraction Therapy for Low Back Pain
- SURG.00044 - Breast Ductal Examination and Fluid Cytology Analysis
- SURG.00059 - Recombinant Human Bone Morphogenetic Protein
- SURG.00082 - Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- SURG.00092 - Implanted Devices for Spinal Stenosis
SURG.00095 - Viscocanalostomy and Canaloplasty
SURG.00098 - Mechanical Embolectomy for Treatment of Acute Stroke
SURG.00101 - Suprachoroidal Injection of Pharmacologic Agent
SURG.00104 - Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
SURG.00114 - Facet Joint Allograft Implants for Facet Disease
SURG.00128 - Implantable Left Atrial Hemodynamic (LAH) Monitor
SURG.00129 - Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
SURG.00135 - Radiofrequency Ablation of the Renal Sympathetic Nerves
TRANS.00013 - Small Bowel, Small Bowel/Liver and Multivisceral Transplantation
TRANS.00018 - Donor Lymphocyte Infusion for Hematologic Malignancies after Allogeneic Hematopoietic Progenitor Cell Transplantation
TRANS.00023 - Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias
TRANS.00027 - Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors
TRANS.00028 - Hematopoietic Stem Cell Transplant for Hodgkin Disease and non-Hodgkin Lymphoma
TRANS.00029 - Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias
TRANS.00033 - Heart Transplantation
TRANS.00034 - Hematopoietic Stem Cell Transplantation for Diabetes Mellitus
TRANS.00036 - Stem Cell Therapy for Peripheral Vascular Disease

New Medical Policy Effective 02-14-2015
(The following policy was created and has no significant changes to the policy position or criteria.)
- OR-PR.00006 - Powered Robotic Lower Body Exoskeleton Devices

Revised Medical Policies Effective 02-14-2015
(The following policies were revised to expand medical necessity indications or criteria.)
- DRUG.00039 - Trastuzumab (Herceptin®)
- DRUG.00041 - Rituximab (Rituxan®)
- GENE.00028 - Genetic Testing for Colorectal Cancer Susceptibility
- GENE.00029 - Genetic Testing for Breast and/or Ovarian Cancer Syndrome
- MED.00113 - Therapeutic Apheresis

Revised Medical Policies Effective 02-14-2015
(The following policies were reviewed and had no significant changes to the policy position or criteria.)
- DRUG.00061 - Radium Ra 223 Dichloride (Xofigo®)
- MED.00005 - Hyperbaric Oxygen Therapy (Systemic/Topical)
- MED.00080 - Cryopreservation of Oocytes or Ovarian Tissue
- RAD.00031 - Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy

Revised Medical Policy Effective 03-14-2015
(The following policy was revised to expand medical necessity indications or criteria.)
- RAD.00015 - Proton Beam Radiation Therapy

Revised Medical Policies Effective 03-14-2015
(The following policy was reviewed and had no significant changes to the policy position or criteria.)
- RAD.00058 - Real-Time Intra-Fraction Target Tracking During Radiation Therapy

New Medical Policies Effective 05-16-2015
(The policies below were created and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

- DME.00038 - Static Progressive Stretch (SPS) and Patient-Actuated Serial Stretch (PASS) Devices for the Treatment of Joint Stiffness and Contracture
- DRUG.00066 - Antihemophilic Factor and Clotting Factors
- DRUG.00067 - Ramucirumab (Cyramza™)
- DRUG.00068 - Vedolizumab (Entyvio™)
- DRUG.00069 - Recombinant Antihemophilic Factor, Fc Fusion Protein (Eloctate™)
- DRUG.00070 - Siltuximab (Sylvant™)
- DRUG.00071 - Pembrolizumab (Keytruda®)
- GENE.00044 - Analysis of PIK3CA Status

Revised Medical Policies Effective 05-16-2015
(The policies below were revised and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

- DRUG.00024 - Omalizumab (Xolair®)
- DRUG.00032 - Intravitreal Corticosteroid Implants
- DRUG.00035 - Panitumumab (Vectibix®)
- GENE.00028 - Genetic Testing for Colorectal Cancer Susceptibility
- SURG.00024 - Surgery for Clinically Severe Obesity
- SURG.00037 - Treatment of Varicose Veins (Lower Extremity)
- SURG.00060 - Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- SURG.00066 - Percutaneous Neurolysis for Chronic Neck and Back Pain

Clinical Guideline Updates

Revised Clinical Guidelines Effective 11-17-2014
(The following adopted guidelines were reviewed and had no significant changes to the policy position or criteria.)

- CG-REHAB-05 - Occupational Therapy
- CG-REHAB-06 - Speech-Language Pathology Services (NOTE: Applicable to National Accounts only)

Revised Clinical Guidelines Effective 01-13-2015
(The following adopted guidelines were revised to expand medical necessity indications or criteria.)

- CG-DRUG-08 - Enzyme Replacement Therapy for Gaucher Disease
- CG-DRUG-09 - Immune Globulin (Ig) Therapy
- CG-DRUG-15 - Gonadotropin Releasing Hormone (GnRH) Analogs

Revised Clinical Guidelines Effective 01-13-2015
(The following adopted guidelines were reviewed and had no significant changes to the policy position or criteria.)

- CG-DME-06 - Pneumatic Compression Devices for Lymphedema
- CG-SURG-12 - Penile Prosthesis Implantation
- CG-SURG-28 - Transcatheter Uterine Artery Embolization
- CG-SURG-30 - Tonsillectomy with or without Adenoidectomy for Children
- CG-TRANS-02 - Kidney Transplantation
New Clinical Guideline Effective 05-16-2015
(The following guideline will be applied and might result in services that were previously covered but may now be found to be not medically necessary.)
- CG-DRUG-38 - Pemetrexed Disodium (Alimta®)

Revised Clinical Guidelines Effective 05-16-2015
(The following adopted guidelines were revised and might result in services that were previously covered but may now be found to be not medically necessary.)
- CG-DRUG-03 - Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
- CG-DRUG-15 - Gonadotropin Releasing Hormone (GnRH) Analogs
- CG-SURG-09 - Temporomandibular Disorders
- CG-SURG-33 - Lumbar Fusion or Lumbar Artificial Intervertebral Disc (LAID)

Reimbursement Policy updates

Assistant Surgeon Coding
We have updated our Assistant Surgeon Coding table to reflect changes for Current Procedural Terminology (CPT®) codes effective January 1, 2015 that are not eligible for reimbursement for assistant at surgery services reported with modifiers 80, 81, 82, or AS.

Bundled Services and Supplies
For claims processed on or after February 16, 2015, the following codes will be included in Section 1 of our policy to reflect that these services will not be eligible for reimbursement:
- 34839 (Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time)
- 99490 (Chronic care management), 99497, and 99498 (Advance care planning)
- 77061, 77062, 77063, and G0279 (Digital breast tomosynthesis (DBT)); this information is also included in our Three-Dimensional (3D) Radiology Services Reimbursement Policy
- G0276 (Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial)
- G0472 (Hepatitis C antibody screening for individual at high risk and other covered indication(s))
- G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes)
- G6030 – G6058 (Drug screening)

As we advised in our August 2014 Network Update, we are reviewing and adding Healthcare Common Procedure Coding System (HCPCS Level II) “S” codes to our always bundled services edit. According to the Health Plan, unless there are specific, specialized contracts or criteria for a provider to report their services using a HCPCS temporary “S” code, the Health Plan will consider “S” codes to be always bundled codes. Therefore, effective with dates of service on or after May 1, 2015 codes S0257, S1015, S1016, S3005, S4005, S4025, S8096, S8097, S8100, S8101, S9900 and S9901 will not be eligible for reimbursement.

In addition, we are adding HCPCS code G0431 and G0434 to our always bundled services edit effective for dates of service on or after May 1, 2015. This information will be included in Section 1 of our policy.

For claims processed on or after February 16, 2015, Section 2 of our policy will be updated to reflect that supplies and/or professional services such as an IV pole (HCPCS code E0776), infusion supplies (A4221 and A4222) and/or home therapy
professional services (S9810) will not be eligible for separate reimbursement when reported with a per diem home infusion therapy (HIT) (for example S5492-S5502, S9061, S9325-S9379, S9490-S9504, S9537-S9590) service that includes supplies or home therapy professional services. Modifiers will not override this edit; therefore, this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

We are adding information to Section 2 of the policy that for claims processed on or after February 16, 2015, HCPCS code A4250 (Urine test or reagent strips or tablets (100 tablets or strips)) will not be eligible for separate reimbursement when reported with CPT codes 81000-81003 (urinalysis). Modifiers will not override this edit therefore this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

For dates of service on or after May 1, 2015, Section 2 of our Bundled Services and Supplies Reimbursement Policy will be updated to reflect that when reported with electrical stimulator supplies (A4595) on the same date of service and/or within a 30 day period, electrodes (A4556) and lead wires (A4557) will not be eligible for separate reimbursement. Modifiers will not override this edit; therefore this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

**Documentation Guidelines for Psychotherapy Services**
A new policy outlining our documentation guidelines for reporting psychotherapy services will be effective February 1, 2015.

**Duplicate Reporting of Diagnostic Services**
We will be posting a new policy titled Duplicate Reporting of Diagnostic Services. Effective for claims processed on or after March 16, 2015, if the ordering provider and the provider who actually performed the diagnostic services both report the same CPT/HCPCS code for the same patient on the same date of service only the first claim processed by the Health Plan will be eligible for reimbursement. ClaimsXten®, our claim editing system, will consider subsequent claims from any provider reported for the same diagnostic services for the same patient on the same date of service to be a duplicate service and the subsequent same service will not be eligible for separate reimbursement. For example: when the ordering provider sends a specimen to the laboratory, and the ordering provider and the laboratory both report the same CPT or HCPCS code to the health insurance company, only the first claim processed by the Health Plan will be eligible for reimbursement.

**Frequency Editing**
Beginning with dates of service on or after May 1, 2015, the Health Plan will apply a frequency limit of 2 units per 30 day period for electrodes per pair (A4556) and a frequency limit of 4 units per 365 days for lead wires per pair (A4557).

**Surgical Pathology and Related Prostate Needle Biopsy**
Effective January 1, 2015, HCPCS codes G0417, G0418, and G0419 have been deleted and the definition of HCPCS code G0416 has been revised to remove the reference to 10-20 specimens. Our policy dated January 1, 2015 reflects these changes.

**Coding Tip: Vaccine Administration and Skin Tests**
According to CPT Guidelines for Immunization Administration for Vaccines/Toxoids, it is stated to, “...report vaccine immunization codes, 90460, 90461, 90471-90474 in addition to the vaccine toxoid code(s) 90476-90749.” Therefore, vaccine administration codes should only be used to report the administration of vaccines and toxoids reported with codes that fall within the range of 90476-90749 and should not be reported for skin testing of bacterial, viral, or fungal extracts. (See the CPT Professional Edition Medicine Section—Immunization Administration for Vaccines/Toxoids.)