Empire BlueCross BlueShield

An Anthem Company

Working together to improve the health of our members.

October 2015

Network Update

NEW YORK

In this issue

empireblue.com

EBCBSNL 1015

Administrative news

We've updated our logo

As you can see from this edition of Network Update, we have updated our company logo.

Our updated logo reflects the strong relationship we have with our parent company. It will remind our stakeholders and customers of the national resources that support our longstanding local commitment and presence. This logo update does not change our corporate status or our products, benefits, networks, phone numbers, etc.

We appreciate your business. If you have any questions, please contact your Network Management Consultant.

New name, same great plan

Effective October 1, 2015, you will see new names in health care:

- HealthPlus, an Amerigroup Company, will operate under a new name, Empire BlueCross BlueShield HealthPlus. (Servicing the five NYC boroughs, Putnam and Nassau County)
- HealthPlus Amerigroup Fully Integrated Duals Advantage (FIDA) Plan will operate under a new name, Empire BlueCross BlueShield HealthPlus Fully Integrated Duals Advantage Plan. (Servicing 5 NYC Boroughs)

Empire BlueCross BlueShield HealthPlus services the five boroughs plus Nassau, Suffolk, Westchester and Putnam Counties.

How does this affect you?

There will be no change in your participation status with Empire BlueCross BlueShield. If your practice is currently not participating in the above plans through AmeriGroup, there will be no change in your status. Please note any members who present with the below prefixes will be out of network unless you are already participating with HealthPlus Amerigroup.

What is changing?

Members will receive a new ID card which contains a new prefix:

- Medicaid prefix is JLJ
- FIDA prefix is JLH
- Special Needs Plan (SNP) prefix is JLG

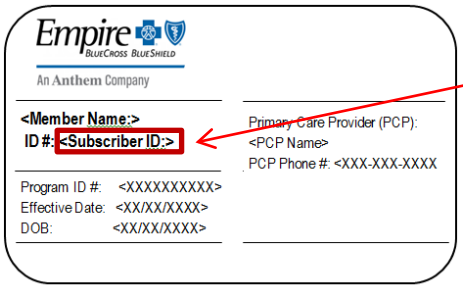
The chart below explains each prefix used and what it signifies.

Prefix	Former plan name	New plan name
JLJ	HealthPlus, an Amerigroup Company	Empire BlueCross BlueShield HealthPlus
JLH	HealthPlus Amerigroup Fully Integrated Duals Advantage (FIDA) Plan (Medicare-Medicaid Plan)	Empire BlueCross BlueShield HealthPlus Fully Integrated Duals Advantage (FIDA) Plan (Medicare-Medicaid Plan)
Y		Empire BlueCross BlueShield
E		Empire BlueCross BlueShield
JBD, JLB, JLC,		Empire BlueCross BlueShield

JLD, JLE, JLF		

Sample Empire BlueCross Blue Shield HealthPlus member card

Front



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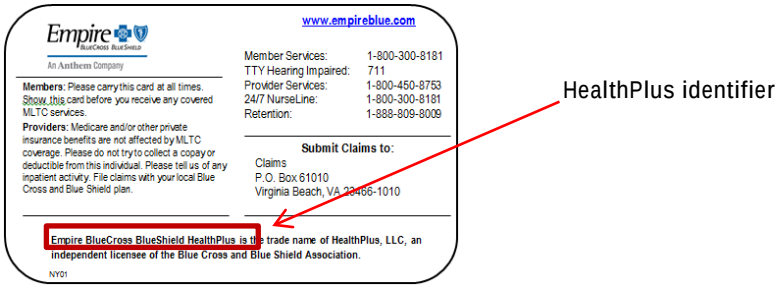
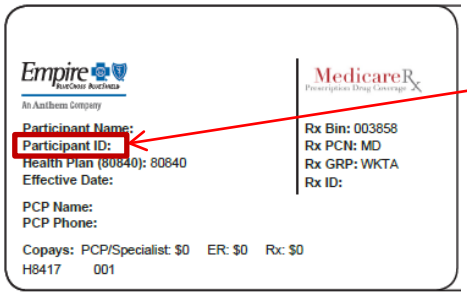


Sample Empire BlueCross BlueShield HealthPlus Fully Integrated Duals Advantage (FIDA) Plan (Medicare-Medicaid Plan) member card

Front



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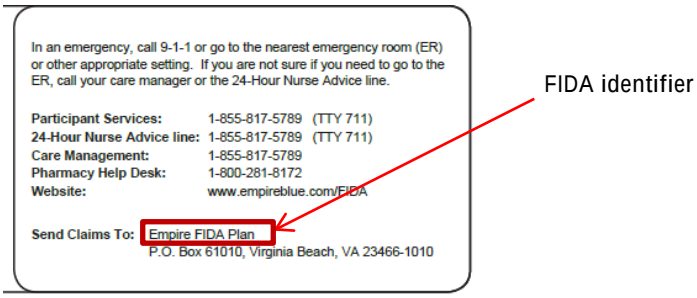


Note that any HealthPlus member ID card will also reference a Virginia Beach claim address.

The customer service phone numbers are changing.

Medicaid provider	1-800-450-8753
FIDA provider – no change	1-855-817-5790
Medicaid member	1-800-300-8181
FIDA member – no change	1-855-817-5789

The provider portal address will change to empireblue.com/nymedicaiddoc.

Member covered services, benefits, and billing procedures remain the same under the Empire BlueCross BlueShield HealthPlus name. As always you can confirm member benefits and eligibility through Availity.com.

If you have questions, please contact your Provider Relations representative.

Changes to AIM Specialty Health's Sleep Disorder Management Diagnostic & Treatment Guidelines

An important component of AIM Specialty Health's (AIM) Sleep Disorder Management program focuses on the management of Obstructive Sleep Apnea (OSA) through the use of custom made oral appliances. These appliances include mandibular repositioning appliances that are billed using HCPCS E0486.*

Effective January 1, 2016 AIM will be revising this guideline to ensure that oral appliances used in the treatment of OSA meet the criteria established by CMS for mandibular repositioning appliances. The CMS specifies that to be coded as E0486, custom fabricated mandibular advancement devices must:

- Have a fixed mechanical hinge at the sides, front or palate, and,
- Have a mechanism that allows the mandible to be advanced in increments of one millimeter or less, and,
- Be able to protrude the mandible beyond the front teeth at maximum protrusion, and,
- Be adjustable by the beneficiary in increments of one millimeter or less, and,
- Retain the adjustment setting when removed, and
- Maintain mouth position during SLEEP so as to prevent dislodging the device.

In addition to this addition to the preamble section of the Guideline, a question will be added to the pre-authorization request.

The question will read:

Does the mandibular repositioning device requested comply with CMS criteria?
Cases in which the provider responds “No” or “I don’t know” will be routed for review.

**Prefabricated oral appliances (HCPCS code E0485) are not considered appropriate therapy for OSA in any clinical situation.*

Empire will discontinue mailing paper remittance vouchers to all ERA registered providers beginning March 1, 2016

Empire began notifications to providers about HIPAA Administrative Simplification requirements to discontinue the mailing of paper remit vouchers for providers registered for electronic remittance advice (ERA) in May 2014. In support of these requirements, Empire will discontinue mailing paper remittance vouchers to all providers currently registered for ERA beginning March 1, 2016. As previously communicated, in-network providers can continue to conveniently access their online remittance advices via the Availity Web Portal. If you are an ERA registered provider, please ensure you have completed the steps to access your online remittances via Availity immediately. Read instructions to access online remits via Availity here.

Please note, providers may continue to receive some paper remittance vouchers up to four weeks after March 1, 2016 to allow for the delivery of paper remittances already in queue.

Providers can manage the mailing of paper remits by using the online paper remittance election form.

ICD-10: Empire is ready

The U.S. Department of Health and Human Services (HHS) has issued a rule finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

Empire has worked to ensure that our systems, supporting business processes, policies and procedures meet the implementation standards set to bring them into compliance with ICD-10.

Empire is ready to accept and process ICD-10 diagnosis and inpatient procedure codes on the October 1, 2015 compliance date

Some of the highlights and information available on our ICD-10 Updates webpage:

- ICD-10 Coding Guidelines for Preauthorization and Claims Submission
- EDI Edits for ICD-10
- Paper Claims with ICD-10 codes
- Effective October 1, 2015, we will only accept paper claims on the CMS 1500 Claim Form version 02/12.
  - Consult www.nucc.org for guidance on how to complete the form
  - Our medical policies and clinical UM guidelines have been updated to include ICD-10 coding
- Available on the ICD-10 Updates webpage - Our Response to the CMS/AMA Announcement on ICD-10 in July 2015
- FAQs with Empire-specific Information

Please note once ICD-10 goes live on 10/1/2015 and providers are ready, these preparation tools and resources will no longer be available on our webpage:

- TIBCO Validator claims file acceptance testing
- Coding Practice Tool for Professional Providers

- e-Cast on Preparing for ICD-10: A Provider's Perspective
- Dedicated email box for ICD-10 inquiries and surveys

Effective 10/1/2015, all questions and claims inquiries should be handled as they are today.

Contact the PROVIDER SERVICES UNITS FIRST - Provider Services units have been trained to handle questions on ICD-10 and resolve ICD-10 claims issues.

ICD-10: Splitting Bills Could Cause Overpayments

Empire is requiring that outpatient services with dates of service that span from 9/30/2015 to 10/1/2015 are required to be split so services rendered up to 9/30/2015 are filed with ICD-9 codes on one claim and services rendered on/after 10/1/2015 are filed on a separate claim with ICD-10 codes.

However, some provider reimbursement agreements limit the reimbursement amounts for certain outpatient services, such as when combined services are negotiated as a case rate. Splitting the claim could cause these episodes of care to be overpaid.

Should you receive any overpayments, here is how you can help resolved these claims quickly.

Be Proactive – Should you discover an overpayment for services due to splitting the claim into ICD-9 and ICD-10 coded claims, notify Empire immediately and refund the overpaid amount back to us.

Be Responsive – Empire will request a refund of any overpayment amounts discovered. Please remit refunds promptly once notified.

Working together, we can resolve these overpayments in a timely manner as we partner for a smooth transition to ICD-10.

Introducing Empire Togetherworks

At Empire, we look for ways to get results and achieve goals together. Every day we bring our tools, information, and expertise to the table in ways that benefit our members and providers. With this effort, we introduce Empire Togetherworks – a new name for our provider collaboration strategy. Empire Togetherworks refers to a broad spectrum of partnership options already in place at Empire, and includes programs like Enhanced Personal Health Care (EPHC) and the Quality-In-Sights®: Hospital Incentive Program (Q-HIP®). Empire Togetherworks also includes tools we offer, such as our web-based Provider Care Management Solutions and Care Delivery Transformation support. Through Empire Togetherworks, we'll continue to offer a wide range of provider collaboration programs and offerings based on your needs, to help us work together to meet the challenges of a new era in health care.

Important information about coverage for Digital Breast Tomosynthesis (DBT) or 3-D mammography

In 2015, the USPSTF reviewed screening recommendations for breast cancer and concluded in a draft recommendation statement that Digital Breast Tomosynthesis (DBT) or 3-D mammography does not meet evidence level A or B and should not be recommended in place of digital mammography for routine breast cancer screening. The draft statement also notes that DBT may expose women to approximately twice the radiation of 2-D digital mammography.

Based on the USPSTF conclusion and Empire's independent review of the available evidence, Empire considers Digital Breast Tomosynthesis **investigational and not medically necessary** for all indications.

Please note that two imaging vendors currently have FDA approval for DBT and actively promote their services to academic centers and private hospitals or imaging centers. As marketing and adoption of DBT increases, we expect an increase in interest and use of this service, which is why ***it is important for providers to be aware that DBT is a non-covered service.***

Empire has extensively reviewed the available evidence addressing the use of Digital Breast Tomosynthesis and presented this data to the Medical Policy and Technology Assessment Committee (MPTAC) for discussion and evaluation. The MPTAC agrees with the USPSTF concerns and recommendations.

To read more about the USPSTF's conclusion, please see the USPSTF Breast Cancer Screening Draft Recommendation Statement. Providers can also review Empire's medical policy for Digital Breast Tomosynthesis on empireblue.com.

New Fax Numbers for Federal Employee Program® members at Empire

Effective October 9, 2015, the Blue Cross and Blue Shield Service Benefit Plan will change the toll free fax number for the Utilization Management (UM) Department at Empire Blue Cross Blue Shield in New York. To submit an authorization request via fax for Federal Employee Plan members at Empire Blue Cross and Blue Shield, please use the toll free numbers listed below.

Precertification Fax: 1-800- 732-8318
Advanced Benefit Determinations Fax: 1-877- 606-3807

As a reminder, please do NOT include protected health information (PHI) on fax cover sheets.

Coming April 2016! The Blue Cross and Blue Shield Service Benefit Plan will reissue membership identification cards to members who have Empire Blue Cross Blue Shield as their Home Plan. The identification cards will include the new toll free number for the Medical Management Department. Providers will receive notification of the change in the Network Update newsletter for February 2016.

Empire's Provider Manual available online

Empire is committed to helping you with hassle-free healthcare administration by providing you with the information you need, when you need it. Our Provider Manual has been updated and restructured with you in mind–to make it easier for you to do business with us.

Periodically, Empire may release updates to the Provider Manual. The updated Manual will be conveniently located on our website, empireblue.com. We will inform you of these changes via this newsletter. The following are some highlights of the recently made changes:

- Updated Chapter Names – including new chapters - Blue Card, FEP and Health Insurance Marketplace (Exchange)
- New Information Sources Page – page 3 – comprehensive list of the information services available from Empire
- Demographic Updates / Changes – Chapter 1- explains new Empire yearly verification process
- New Reference Guides in Chapter 2

We strive to partner with our participating physicians and other participating healthcare providers to promote healthcare quality, access and affordability. We thank you for your participation in our network and for the care you provide, every day, to our members and your patients. We look forward to continuing to work with you in our efforts to simplify the connection between healthcare and value.

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.

Behavioral Health news

2015 Updated Outpatient Treatment Report

We have updated our Outpatient Treatment Report (OTR) to reflect the ICD10 diagnosis code set. The revised form has been posted on anthem.com > Provider > Empire Behavioral Health> Forms> 2015 Outpatient Treatment Report. In 2012, we removed the behavioral health outpatient management for fully-insured products and plans, however, Medicare Advantage and some self-funded groups that continue to require outpatient management after the pass-through visits have been exhausted. In these instances, please submit the updated form to us with the requested number of units for ongoing treatment.

Behavioral Health Outpatient Coding

In 2013, CPT updated behavioral health outpatient CPT codes and issued new coding guidelines for their use. The new guidelines included CPT code 90834, 45-53 minutes face to face with the patient, and CPT code 90837, 53-60 minutes with the patient.

Prior to 2013 the psychotherapy “hour” was billed using a code for 45-50 minutes of time with the patient. With the release of the new CPT codes, Empire has observed that over half of the billing for this type of psychotherapy is now claiming 53-60 minutes spent face to face with the patient at each session.

Empire would like to remind you of specific guidelines per the AMA CPT codebook for commonly billed codes:

If you use an E/M code:

- The type and level of an E/M service is selected based on key components of history, examination and medical decision-making, therefore, time may not be used as the basis of E/M code selection.
- Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy add-on service.

If you use a psychotherapy code which is defined by time:

- Documentation should include the time spent face to face with the patient and give specific details to what was done in the session
- The American Psychological Association 2013 guidelines state:
  "When billing a private insurer that does not require authorization for 90837 and has not indicated that this code should be used infrequently, you should bill this code if your session time falls into the 53-minute or more time frame that pertains to 90837. We recommend, however, that you record your exact session start and stop times in your clinical note (for example, 1:02 to 1:57) when billing the new codes, as Medicare providers must do. At any point, a company can ask you for appropriate documentation or explanations. Also be mindful that if you have historically billed a company primarily the 45-50 minute code and switch to primarily using the new 60-minute code, that company may ask you to explain this change."

As always, Empire retains the right, based on a provider's agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed. Please refer to the AMA's CPT codebook for further code definitions and details.

Central Nervous System (CNS) Assessments

An education and audit program for central nervous system (CNS) assessments begins later this fall; the purpose of this program will ensure proper documentation for the services billed.

Central nervous system (CNS) assessments and/or tests involve the testing of cognitive processes, visual motor responses and abstractive abilities and are accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate useful information for treating and caring for the patient. This includes psychological and aphasia assessments; neuropsychological, and developmental testing; and a neurobehavioral status exam.

Neuropsychological testing uses standard techniques to objectively evaluate behavioral and cognitive abilities of patients by comparing the patient's results to established normal results. Neuropsychological testing generally involves the use of paper/pencil and mechanical procedures and carries little, if any, risk to the patient. A complete neuropsychological evaluation includes:

a) review of information from the referral
b) face-to-face evaluation with the patient and/or the family, at which time some screening tests may be done
c) administration of various neuropsychological tests tailored to the patient's condition
d) test scoring and interpretation, which is reviewed with the referring clinician and/or the patient, for example Halstead-Reitan, LURIA, and WAIS-R testing

The Health Plan requires that the medical record documentation for CNS assessments/tests be legible, signed, dated, and contain, at a minimum, the following elements:

a) relevant medical and personal history
b) results of initial evaluation determining the need for testing
c) suspected mental illness and/or neuropsychological abnormality/dysfunction
d) types of testing indicated
e) previous testing (if conducted) by same or different provider and efforts to obtain those results
f) tests administered, scoring, and interpretation
g) time involved for each test performed;\
h) when the testing is done over several days, the testing time should be reported all on the last date of service

i) treatment report and recommendations

The time spent in interpreting and preparing the report and any explanation of the report to the patient and family are to be billed with the applicable code used to perform the test.

Code	Description
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report,
96111	Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report
96116 (See also our Frequency Editing Policy.)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

As always, Empire appreciates the care provided to our members.

Empire retains the right, based on a per provider's agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed. Please refer to the AMA's CPT codebook and Empire documentation policies to ensure your practice is in compliance with these documentation requirements.

Pharmacy news

Pharmacy information available on empireblue.com

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 http://www.anthem.com/pharmacyinformation . The drug list is reviewed and updates are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate the "Marketplace Select Formulary" and pharmacy information for Health Plans offered on the Exchange Marketplace, go to Customer Support, select your state, Download Forms and choose "Select Drug List".

Health Care Reform updates (including Health Insurance Exchange)

Health Insurance Exchange and Health Care Reform articles are available online

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.

Medicare Advantage news

Routine physical exams are covered in 2016

Empire Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2016 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.

the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay as applicable by the member's plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider.

Additional details can be found at Important Medicare Advantage Updates.

Radiation Therapy: Select Brachytherapy, IMRT CPT codes to require prior authorization

Effective Nov. 1, 2015, Empire will require prior authorization of the following outpatient radiation therapy CPT codes for our individual Medicare Advantage members:

- Brachytherapy 77316, 77317 and 77318
- Intensity Modulated Radiation Therapy (IMRT) 77386, G6016

Prior authorization requests will be handled by AIM Specialty HealthSM (AIM), an affiliate of Empire.
Prior authorization can be obtained by contacting AIM at https://www.providerportal.com/ or (800) 714-0400. Additional information, including required information for radiation therapy requests, can be found here.

HRM program designed to reduce risk for Medicare Advantage members

Empire is working to decrease the amount of High Risk Medications (HRM) prescribed by primary care providers. A HRM contains a heightened risk for causing significant harm when Medicare Advantage members use them in error. Examples of commonly prescribed HRMs include zolpidem (Ambien®) and zaleplon (Lunesta®). Falls and fractures may occur when these HRMs are used.

Empire identifies providers who have prescribed HRMs and will contact the prescriber's office to validate the prescriber/patient relationship. Empire then will schedule an appointment for an Empire pharmacist to speak with the provider about HRMs.

Precertification requirements updated for 2016

Please refer to your provider agreement, Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Empire provider home page at www.empireblue.com for further information on existing precertification requirements and new precertification requirements for 2016. Non-contracted providers should contact the Health Plan.

Keep up with Medicare Advantage news at Important Medicare Advantage Updates

Please continue to check Important Medicare Advantage Updates on your provider portal for the latest Medicare Advantage information

Correction: CMS colorectal cancer screening guidelines

In August, we published incorrect information regarding CMS guidelines for colorectal cancer screening. Here is the correct information:
For members ages 50 to 75, colorectal cancer screenings include Fecal Occult Blood Test (FOBT) during the year, flexible sigmoidoscopy during the year or the four years prior to and/or colonoscopy during the year or the prior nine years.

55290WPPENMUB 08/11/2015

Imaging site scores for outpatient diagnostic imaging could impact reimbursement

Empire is dedicated to meeting the evolving needs of our members and ensuring that they receive the most appropriate care possible. We are pleased to introduce a new program for imaging services administered by AIM Specialty Health® (AIM).

What Does This Mean to You?

Effective November 1, 2015, Empire Medicare Advantage plans will begin collecting information about the imaging capabilities of all Empire Medicare Advantage contracted providers who provide the technical component of the following outpatient diagnostic imaging services for our individual Medicare Advantage members:

- Computed Tomography (CT)
- Magnetic Resonance (MR)
- Positron Emission Tomography (PET)
- Nuclear Medicine (NUC)
- Ultrasound
- X-Ray
- Echocardiograph

Emergency room outpatient diagnostic imaging services are excluded.

AIM's online registration tool, OptiNet®, will continue to collect modality-specific data from providers who render imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment, and technical registration. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

That data will continue to be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. Each modality or piece of equipment will receive its own score. Providers with an imaging site score of 76 or higher will see no change in reimbursement.

- Effective March 1, 2016 for providers who have not completed the online registration: Claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.
- Effective March 1, 2016 for providers with an imaging site score below 76 for the applicable modality for any of the outpatient diagnostic imaging services listed above: Claims with dates of service on or after March 1, 2016 for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

Members cannot be balance billed if a line-item denial occurs.

Please note that any decision to deny reimbursement and/or approval of an imaging service is separate and apart from the determination of the medical necessity of the same service.

Please note that the line-item denial for a site score below 76 for the applicable modality applies only to individual Medicare Advantage claims at this time.

Please see Important Medicare Advantage Updates for additional information.

55688WPPENMUB 08/27/2015

Medicaid news

New name. Same great plan.

As of October 1, 2015, we are now:

- Medicaid: Empire BlueCross BlueShield HealthPlus
- Medicare-Medicaid Plan: Empire BlueCross BlueShield HealthPlus Fully Integrated Duals Advantage Plan (FIDA) Plan (Medicare-Medicaid Plan)

While our names have changed, the excellence you expect from our plans has not. It is business as usual, but with a few small enhancements to help us provide you with the support you need to bring consistent, quality care to our members.

Your contract and participation status with us has not changed. If you contract only with Empire BlueCross BlueShield HealthPlus, you will not be able to see patients enrolled in Empire BlueCross BlueShield. If you would like to see Empire BlueCross BlueShield members, you will need to contract separately with that health plan by calling 1-800-992-2583.

Remember, some of our phone numbers have changed.

- Our Medicaid Provider Services number changed to: 1-800-450-8753.
- Our FIDA Provider Services number did not change. FIDA providers should call: 1-855-817-5790.

Member ID numbers

All HealthPlus Amerigroup members should have received a new ID card already. Members may forget to the present their new card, so please remember to ask to see it when they come in for a visit. Please make a copy and keep this on file.

If a member has misplaced the new card or believes he or she did not receive it, please call or direct them to Member Services to request a replacement card:

- Medicaid members: 1-800-300-8181
- FIDA participants: 1-855-817-5789 (TTY 711) Monday through Friday from 8 a.m. to 8 p.m.

The prefix on the member's ID card will help you identify your patients' health plan. It is essential to use the member's new prefix when completing normal business tasks such as filing claims, checking contracts or submitting authorization requests.

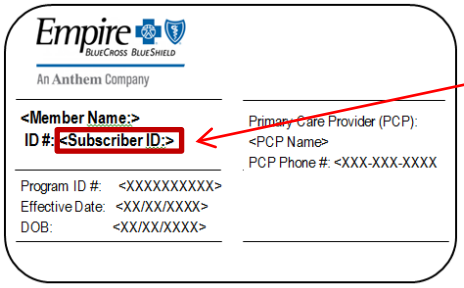
The chart below explains each prefix used and what it signifies.

Prefix	Former plan name	New plan name
JLJ	HealthPlus, an Amerigroup Company	Empire BlueCross BlueShield HealthPlus
JLH	HealthPlus Amerigroup Fully Integrated Duals Advantage (FIDA) Plan (Medicare-Medicaid Plan)	Empire BlueCross BlueShield HealthPlus Fully Integrated Duals Advantage (FIDA) Plan (Medicare-Medicaid Plan)
Y		Empire BlueCross BlueShield
E		Empire BlueCross BlueShield
JBD, JLB, JLC, JLD, JLE, JLF		Empire BlueCross BlueShield

Below is an image of the new cards. Our health plan name and important phone numbers are on the back of each card for easy reference.

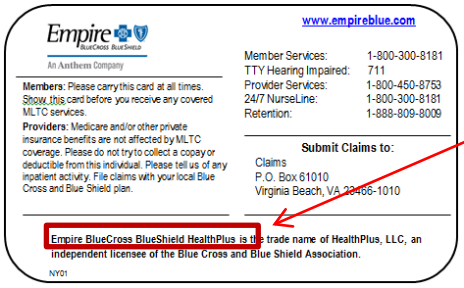
Sample Empire BlueCross BlueShield HealthPlus member card

Front



Location of member ID with prefix

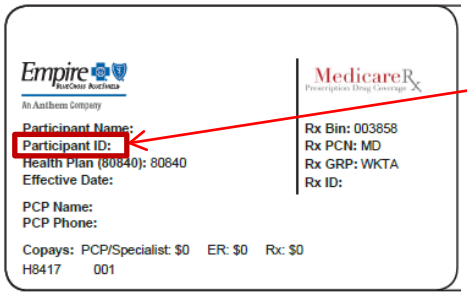
Back



HealthPlus identifier

Sample Empire BlueCross BlueShield HealthPlus Fully Integrated Duals Advantage (FIDA) Plan (Medicare-Medicaid Plan) member card

Front



Location of member ID with prefix

Back

FIDA identifier

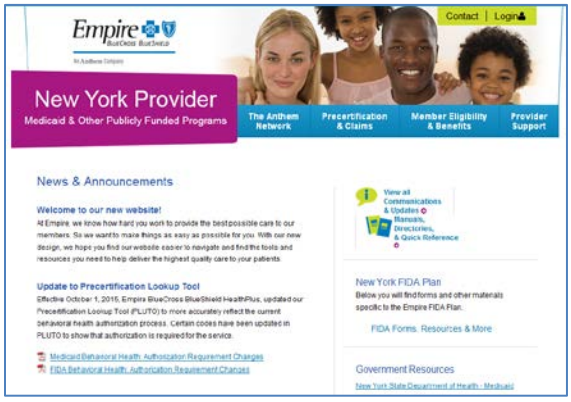
Our new website experience

Our website will have a new look and feel! These changes have been made to make your web experience more pleasant as well as to help you offer even better quality care to our members.

The new website is available at www.empireblue.com/nymedicaiddoc. Please be sure to save this URL as one of your Favorites on your browser.

Important Note: Because healthplus.amerigroup.com also serves Medicare providers, the website will be live until December 31, 2015.

To help you become familiar with our new site, a web tour is available on the homepage of the new provider website under News and Announcements:



When entering a member number online using our new website, it is important to enter the new three-letter prefix to ensure the most accurate results and service.

Submitting claims

Although our name has changed, the method in which a claim should be submitted has not. Please continue to submit your claims via:

- Our website at www.Availity.com or by logging in at www.empireblue.com/nymedicaiddoc using your Availity credentials
- Postal mail to:
  Empire BlueCross BlueShield HealthPlus
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

Your provider Explanations of Payments (EOPs) will continue to look the same and can be found on Emdeon or PaySpan.

If you submit a claim via the Anthem Portal or via Empire Online Services with the member prefix, the claim will be routed and processed. However, the EOP can still only be viewed on Emdeon or Payspan. Remittances are not available via the Anthem Portal or Empire Physician Online Services at this time.

Experimental/Investigational Services update for Empire BlueCross BlueShield HealthPlus Providers

When providers submit claims to Empire BlueCross BlueShield HealthPlus for services that may be deemed experimental/investigational, clinical justification is needed to determine medical necessity as per the New York Medicaid Managed Care Agreement.

If we do not receive clinical justification with your paper claim submission, your claim may be denied.

To determine if services may be deemed experimental/investigational, please refer to the provider website, Medical Policies and Clinical UM Guidelines using this link. You can search by CPT code or procedure narrative to review applicable medical policy and determine if the service is considered experimental/investigational.

Submitting Your Claim

To ensure your claim and clinical documentation are properly reviewed, please submit the paper claim and documents to
Empire BlueCross BlueShield HealthPlus,
Claims Dept.,
P.O. Box 61010,
Virginia Beach, VA 23466-1010.

If your explanation of payment contains the explanation code C37 “submit medical records for review,” additional clinical documentation can be submitted to have the claim denial reviewed. Please submit your appeal to:
Empire BlueCross BlueShield HealthPlus
Appeals Dept.
P.O. Box 62429
Virginia Beach, VA 23466-2429.

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 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 www.empireblue.com.

Medical Policy Updates

New Medical Policy Effective 08-10-2015
(The following policy was created and has no significant changes to the policy position or criteria.)

- DRUG.00078 - Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors

Revised Medical Policies Effective 08-10-2015
(The following policies were revised to expand medical necessity indications or criteria.)

- DRUG.00046 - Ipilimumab (Yervoy™)
- GENE.00010 - Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status
- GENE.00026 - Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy
- SURG.00055 - Cervical Total Disc Arthroplasty

Revised Medical Policies Effective 08-10-2015
(The following policies were reviewed and had no significant changes to the policy position or criteria.)

- ADMIN.00006 - Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline
- DRUG.00015 - Prevention of Respiratory Syncytial Virus Infections

Revised Medical Policies Effective 10-06-2015
(The following policies were revised to expand medical necessity indications or criteria.)

- GENE.00021 - Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- SURG.00014 - Cochlear Implants and Auditory Brainstem Implants
- SURG.00037 - Treatment of Varicose Veins (Lower Extremity)

Revised Medical Policies Effective 10-06-2015
(The following policies were reviewed and had no significant changes to the policy position or criteria.)

- ADMIN.00002 - Preventive Health Guidelines
- ADMIN.00004 - Medical Necessity Criteria
- ADMIN.00005 - Investigational Criteria
- ANC.00006 - Biomagnetic Therapy
- ANC.00007 - Cosmetic and Reconstructive Services; Skin Related
- ANC.00009 - Cosmetic and Reconstructive Services of the Trunk and Groin
- BEH.00004 - Behavioral Health Treatments for Autism Spectrum Disorders and Rett Syndrome
- DME.00004 - Electrical Bone Growth Stimulation
- DME.00009 - Vacuum Assisted Wound Therapy in the Outpatient Setting
- DME.00024 - Transtympanic Micropressure for Treatment of Ménière's Disease
- DME.00027 - Ultrasound Bone Growth Stimulation
- DME.00030 - Altered Auditory Feedback (AAF) Devices for the Treatment of Stuttering
- DME.00037 - Cooling Devices and Combined Cooling/Heating Devices
- DRUG.00002 - Tumor Necrosis Factor Antagonists
- DRUG.00006 - Botulinum Toxin
- DRUG.00017 - Hyaluronan Injections in Joints Other than the Knee
- DRUG.00031 - Subcutaneous Hormone Replacement Implants
- DRUG.00041 - Rituximab (Rituxan®)
- DRUG.00043 - Tocilizumab (Actemra®)

- DRUG.00057 - Canakinumab (Ilaris®)
- DRUG.00058 - Pharmacotherapy for Hereditary Angioedema (HAE)
- DRUG.00064 - Enteral Carbidopa and Levodopa Intestinal Gel Suspension
- GENE.00002 - Preimplantation Genetic Diagnosis Testing
- GENE.00040 - Genetic Testing for CHARGE Syndrome
- GENE.00041 - Short Tandem Repeat Analysis for Specimen Provenance Testing
- GENE.00042 - Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome
- LAB.00011 - Analysis of Proteomic Patterns
- LAB.00016 - Fecal Analysis in the Diagnosis of Intestinal Disorders
- LAB.00027 - Selected Blood, Serum and Cellular Allergy and Toxicity Tests
- MED.00005 - Hyperbaric Oxygen Therapy (Systemic/Topical)
- MED.00055 - Wearable Cardioverter Defibrillators
- MED.00081 - Cognitive Rehabilitation
- MED.00090 - Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders
- MED.00098 - Hyperoxemic Reperfusion Therapy
- MED.00107 - Medical and Other Non-Behavioral Health Related Treatments for Autism Spectrum Disorders and Rett Syndrome
- MED.00112 - Autonomic Testing
- OR-PR.00005 - Upper Extremity Myoelectric Orthoses
- RAD.00019 - Magnetic Source Imaging and Magnetoencephalography
- RAD.00034 - Dynamic Spinal Visualization (Including Digital Motion X-ray and Cineradiography/ Videofluoroscopy)
- RAD.00042 - SPECT/CT Fusion Imaging
- RAD.00045 - Cerebral Perfusion Imaging using Computed Tomography
- RAD.00046 - Cerebral Perfusion Studies using Diffusion and Perfusion Magnetic Resonance Imaging
- RAD.00063 - Magnetization-Prepared Rapid Acquisition Gradient Echo Magnetic Resonance Imaging (MPRAGE MRI)
- SURG.00005 - Partial Left Ventriculectomy
- SURG.00020 - Bone-Anchored and Bone Conduction Hearing Aids
- SURG.00023 - Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- SURG.00026 - Deep Brain, Cortical, and Cerebellar Stimulation
- SURG.00028 - Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
- SURG.00032 - Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- SURG.00047 - Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- SURG.00049 - Mandibular/Maxillary (Orthognathic) Surgery
- SURG.00051 - Hip Resurfacing
- SURG.00054 - Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection
- SURG.00071 - Percutaneous and Endoscopic Spinal Surgery
- SURG.00074 - Nasal Surgery for the Treatment of Obstructive Sleep Apnea (OSA) and Snoring
- SURG.00076 - Nerve Graft after Prostatectomy
- SURG.00077 - Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques
- SURG.00084 - Implantable Middle Ear Hearing Aids
- SURG.00085 - Mastectomy for Gynecomastia
- SURG.00090 - Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia (TGN)
- SURG.00093 - Treatment of Osteochondral Defects

- SURG.00103 - Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- SURG.00105 - Bicompartmental Knee Arthroplasty
- SURG.00116 - High Resolution Anoscopy Screening for Anal Intrathelial Neoplasia (AIN) and Squamous Cell Cancer of the Anus
- SURG.00118 - Bronchial Thermoplasty
- SURG.00122 - Venous Angioplasty with or without Stent Placement
- SURG.00125 - Radiofrequency and Pulsed Radiofrequency Treatment of Trigger Point Pain
- SURG.00126 - Irreversible Electroporation (IRE)
- SURG.00127 - Sacroiliac Joint Fusion
- SURG.00132 - Devices for Maintaining Sinus Ostial Patency Following Sinus Surgery
- SURG.00133 - Alcohol Septal Ablation for Treatment of Hypertrophic Cardiomyopathy
- SURG.00134 - Interspinous Process Fixation Devices
- TRANS.00014 - Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)

Revised Medical Policy Effective 10-10-2015
(The following policy was reviewed and had no significant changes to the policy position or criteria.)

- DRUG.00074 - Alemtuzumab (Lemtrada™)

New Medical Policies Effective 02-13-2016
(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.)

- DRUG.00077 - Secukinumab (Cosentyx™)
- SURG.00141 - Doppler-Guided Transanal Hemorrhoidal Dearterialization

Revised Medical Policies Effective 02-13-2016
(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.)

- GENE.00021 - Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- GENE.00043 - Genetic Testing of an Individual's Genome for Inherited Diseases
- MED.00064 - Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
- SURG.00048 - Panniculectomy and Abdominoplasty
- SURG.00066 - Percutaneous Neurolysis for Chronic Neck and Back Pain
- TRANS.00035 - Mesenchymal Stem Cell Therapy For Orthopedic Indications

Clinical Guideline Updates

Revised Clinical Guideline Effective 08-10-2015
(The following adopted guideline was revised to expand medical necessity indications or criteria.)

- CG-SURG-12 - Penile Prosthesis Implantation

Revised Clinical Guidelines Effective 10-06-2015
(The following adopted guidelines were revised to expand medical necessity indications or criteria.)

- CG-BEH-02 - Adaptive Behavioral Treatment for Autism Spectrum Disorder
- CG-SURG-27 - Gender Reassignment Surgery

Revised Clinical Guidelines Effective 10-06-2015
(The following adopted guidelines were reviewed and had no significant changes to the policy position or criteria.)

- CG-BEH-03 - Psychiatric Disorder Treatment
- CG-BEH-04 - Substance-Related and Addictive Disorder Treatment
- CG-BEH-07 - Psychological Testing
- CG-DME-07 - Augmentative and Alternative Communication (AAC) Devicess/Speech Generating Devices (SGD)
- CG-DRUG-05 - Recombinant Erythropoietin Products
- CG-DRUG-11 - Infertility Drugs
- CG-DRUG-24 - Repository Corticotropin Injection (H.P. Acthar® Gel)
- CG-DRUG-28 - Alglucosidase alfa (Lumizyme®, Myozyme®)
- CG-MED-31 - Skilled Nursing Facility Services
- CG-REHAB-09 - Acute Inpatient Rehabilitation
- CG-SURG-05 - Maze Procedure
- CG-SURG-08 - Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- CG-SURG-24 - Functional Endoscopic Sinus Surgery (FESS)
- CG-SURG-34 - Diagnostic Infertility Surgery
- CG-SURG-35 - Intracytoplasmic Sperm Injection (ICSI)
- CG-SURG-38 - Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy and/or Discectomy

Revised Clinical Guidelines Effective 02-13-2016
(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-MED-46 - Ambulatory and Inpatient Video Electroencephalography
- CG-SURG-27 - Gender Reassignment Surgery

New Clinical Guideline Effective 02-13-2016
(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-SURG-50 - Assistant Surgeons

Professional Reimbursement Policy updates

Review of Reimbursement policies
The following professional Reimbursement policies received an annual review and include minor language revisions but do not have changes to the policy position or criteria:

- "Incident To" Services
- Moderate Sedation
- Modifier 22
- Overhead Expense for Surgical Procedures and Diagnostic Testing
- Place of Service
- Screening Services with Related Evaluation & Management Services
- Standby Services

Bundled Services
Based on coding changes effective January 1, 2014, providers should no longer separately report CT guidance, represented by CPT® code 77014 (Computed tomography guidance for placement of radiation therapy fields), when reporting simulation services represented by codes 77280-77290. The use of CT guidance is considered integral to the simulation procedure

therefore for claims processed on or after November 16, 2015, CPT code 77014 will no longer be eligible for separate reimbursement when reported with CPT codes 77280-77290. This information is included in our Modifiers 59, XE, XP, XS, and XU policy since modifiers will not override this edit.

Frequency Editing

For claims processed on or after November 16, 2015, when the same provider reports an unmodified procedure and the same procedure with modifier 62 on the same date of service, the claim will be subject to our frequency editing logic.

Based on CPT Appendix A - Modifiers, when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the applicable procedure code.

Modifiers 59 and XE, XP, XS, and XU

Our current bundling edit logic denies CPT code 76098 (radiological examination, surgical specimen) as mutually exclusive when reported with CPT codes 19081 – 19086 (breast biopsy with placement of breast localization device(s)). Based on CPT instructions which state "Do not report 76098 in conjunction with 19081 – 19086," beginning with claims processed on or after November 16, 2015, modifiers will no longer override the mutually exclusive edit.

Telehealth Services – CT/ME/NH – Professional

Our Telemedicine and Telehealth policy has been revised to remove reference to telemedicine since telemedicine is the means by which telehealth services are provided. The policy will now be listed as "Telehealth Services" to reflect our reimbursement guidelines.

Unit Frequency Maximums for Drugs and Biologic Substances

In the August 2015 issue of our Network Update we advised that for dates of service on or after November 16, 2015 we would be implementing a maximum unit limit for specific drugs and biologic substances. Please note we will be delaying the implementation of these edits and will post updated information in a future Network Update.

Coding Tip for Reporting Modifiers 54, 55, and 56: Split Surgical Care

According to CPT Surgical Package Definition, the global surgical package includes pre-operative care, the surgical care, and typical postoperative care. When a provider renders care that does not include all the components of the global surgical package, the following modifiers should be used with the reported surgical procedure code to indicate which portion of the care was rendered:

- Modifier 54---surgical care only
- Modifier 55---postoperative management only; postoperative care begins on the next day following the surgical procedure
- Modifier 56---preoperative management only; preoperative care begins on the day before and/or the day of the surgical procedure

For example, when an emergency room (E/R) provider reports the surgical service for the closed treatment of a radial shaft fracture; without manipulation (CPT code 25500), and postoperative care is transferred to another provider, the E/R provider should report the surgical procedure code 25500 with modifiers 54 and 56 on one line to indicate surgical care only and preoperative management only. The provider who accepts the patient for postoperative management only should report the surgical procedure code 25500 with modifier 55 to indicate the postoperative care only.

Coding Tip for Reporting Imaging Guidance with Intensity Modulated Radiation Treatment (IMRT)

Effective January 1, 2015, the American Medical Association (AMA) with input from the American Society for Therapeutic Radiology and Oncology (ASTRO) released the following new CPT codes for Intensity Modulated Radiation Treatment delivery (IMRT) services.

- 77385 – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
- 77387 – Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

With the release of the new CPT codes, ASTRO also released the following coding guidance:
The nomenclature for the new IMRT delivery CPT codes (77385 and 77386) includes the following language: “includes guidance and tracking, when performed”.

The technical component of the image guidance and tracking (IGRT) part of the procedure is now packaged into the IMRT delivery CPT codes 77385 and 77386, and is not reported or allowed separately. Consequently, the total component for CPT code 77387 is not separately reimbursed with CPT codes 77385 and/or 77386.

When the professional component of IGRT (77387 -26) is a separately identifiable service, the most appropriate modifier that designates the service as a distinct procedural service should be used.

Coding Tip for Reporting a Separate Procedure with a Related Procedure

According to CPT, some procedures or services that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at the same time, the “separate procedure” may be reported by itself, or in addition to other procedures/services by appending the most appropriate modifier to the code to indicate that the procedure is a distinct, independent procedure. This may represent a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury.

For example, when 99195 (phlebotomy, therapeutic (separate procedure)) is reported with 36415 (collection of venous blood by venipuncture), 99195 must include the most appropriate modifier that designates the service as a distinct procedural service.