Empire BlueCross BlueShield

An Anthem Company

Working together to improve the health of our members.

December 2015

Network Update

NEW YORK

In this issue

	Page
Administrative news	
• New precertification requirements for certain radiation therapy services begins March 1, 2016	3
• New precertification requirements added to the cardiovascular program	4
• Empire will discontinue mailing paper remittance vouchers to all ERA registered providers beginning March 1, 2016	6
• More news about what's new	6
• Enhancements to AIM Clinical Appropriateness Guidelines for Advanced Imaging	7
• REMINDER! Only collect co-payment at time of visit	8
• Updates to Blue Physician Recognition Program	8
• ICD Indicator Required on Paper Claim Forms	8
• EPHC: Referral Providers Benefit by Improving Quality and Controlling Costs	9
• Recent updates to the Cancer Care Quality Program	9
• Empire's Provider Manual available online	10
• 2016 FEP Benefit information available online	10
• GeoBlue - BlueCard Provider Outreach	10
• Clinical Practice and Preventive Health Guidelines are online	10
• Respiratory Antibiotic Use Performance	11
Behavioral Health news	
• Documentation and Reporting Guidelines for ABA and Treatments for Autism Spectrum Disorder	12
• 2016 Outpatient Visits	12
• New Behavioral Health Program	12
Pharmacy news	
• CVS/specialty is the exclusive in-network specialty pharmacy for Empire members	13
• Searchable Formulary Tool gives providers easier access to formulary/drug list information	13
• Pharmacy information available on empireblue.com	14
Health Care Reform updates	
• Health Insurance Exchange and Health Care Reform articles are available online	114
• Incentive opportunity for physicians treating patients with Empire plans purchased on or off the exchange	15

empireblue.com

EBCBSNL 1215

Medicare Advantage news

- Avoid denials of Medicare Advantage diagnostic claims by completing item 20 (CMS 1500) correctly 16
- Please include modifiers to help ensure accurate payment 16
- Oxygen DME prior authorizations will be reduced in 2016 17
- Empire to review ER Level 5 professional claims 17
- Register for imaging site scores by March 1, 2016 to avoid unnecessary line-item denials 17
- Radiation Therapy Brachytherapy, IMRT CPT codes prior authorization information updated 18
- More $0 Copay Medications Available to Medicare Advantage Members with Chronic Conditions 18
- Avastin for ophthalmic use – C9257 can be billed in office setting for network providers 18
- Enhanced reimbursement available for certain Part B injectable drugs 19
- Empire place of service claims adjudication mirrors CMS guidelines 19
- Dual Special Needs Plans Quality Improvement Program available 19
- Empire individual Medicare Advantage plan names changing for 2016 19
- Keep up with Medicare Advantage news at Important Medicare Advantage Updates 20

Medicaid news

- Introducing New York Essential Plan 20

  More news about what's new 20
- Update: Scoliosis and spinal deformity medical necessity reviews 21
- ICD-10 coding for diabetic complications 21

Quality Initiatives

- HEDIS® 2015 Results Are In 21
- Survey says... Patients see room for improvement with physician care 26
- Improving your patient's health care experience 28
- We believe in Continuous Improvement 29
- Case Management Program 29
- Coordination of Care 30
- Important Information about Utilization Management 30
- Members' Rights and Responsibilities 31

Policy updates

- Medical Policy updates 32
- Clinical Guideline updates 32
- Professional Reimbursement Policy updates 32

Administrative news

New precertification requirements for certain radiation therapy services begins March 1, 2016

On March 1, 2016, Empire BlueCross BlueShield ("Empire") is expanding its Radiation Therapy Program to require precertification of:

- Image Guided Radiation Therapy (IGRT).
- Fractions (also referred to as units) for breast and bone metastases for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT).
- Special treatment procedure and special physics consult (CPT® codes 77470 and 77370) (e.g., total body irradiation, hemibody radiation, or endocavitary irradiation and special medical radiation physics consultation).

The Radiation Therapy Program is managed by AIM Specialty Health® (AIM®), a separate company administering the program on behalf of Empire.

A complete list of CPT codes requiring precertification under the Radiation Therapy Program can be found on empireblue.com >Provider Homepage > Services Administered by AIM Specialty Health > Outpatient Radiation Therapy Services. The newly added CPT codes effective March 1, 2016, under the expanded radiation therapy program include:

	CPT Code
IGRT	G6001
	G6002
	G6017
	77387
	77014
IMRT	G6015 OR 77385-6
EBRT	G6003-6 OR 77402
	G6007-10 OR 77407
	G6011-14 OR 77412
Special Treatment	77470
Special Physics Consult	77370

All Empire local members who currently require precertification for non-emergency outpatient radiation therapy are included in this program. These precertification requirements do not apply to the following plans: Medicare Advantage, Medicare Supplement, Medicaid, Federal Employee Program® (FEP®), and National Accounts.

Determine if precertification is needed for an Empire member by clicking the "Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements" link on empireblue.com or by calling the precertification phone number printed on the back of the member's ID card.

Ordering physicians may submit a precertification request to AIM through the AIM *Provider*Portal℠ (available 24/7 to process orders in real-time), through the Availity Web Portal or by calling the AIM call center at 1-877-430-2288, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

Note: Retrospective requests received more than 2 business days after the date of service will not be accepted by AIM for precertification review. Any post-service clinical review would be handled by Empire according to the terms of the applicable health benefit plan and/or provider agreement.

Radiation therapy performed as part of an inpatient admission will continue to be reviewed through Empire's inpatient precertification process. Members currently undergoing radiation therapy treatment on March 1, 2016 will not be impacted by the new enhancements to this program. However, members starting treatment on or after March 1, 2016 must follow the enhanced Radiation Therapy Program precertification requirements noted above.

Thank you for your collaboration and ongoing support of the Radiation Therapy Program. If you have further questions, please contact your local Network Consultant by calling
1-800-992-BLUE (2583) and selecting the following prompts.

- Option 1: Medical Providers
- Option 4: Updates and Other Information
- Option1: Participation and Credentialing Information
- Enter your zip code

New precertification requirements added to the cardiovascular program

Empire is expanding its cardiovascular program to require precertification for arterial ultrasound, cardiac catherization, and percutaneous coronary intervention (PCI) beginning March 1, 2016. The program is managed by AIM Specialty Health® (AIM®), a separate company administering the program on behalf of Empire.

The specific CPT codes requiring precertification under the expanded cardiovascular program are listed below. The clinical guidelines that will be adopted by Empire to review arterial ultrasound, cardiac catheterization, and PCI for medical necessity are also available on empireblue.com.

Please note that all Empire local members who currently require precertification for high-tech imaging and echocardiograms are included in the program. These precertification requirements do not apply to the following plans:

- Federal Employee Program® (FEP®)
- Medicaid
- Medicare Advantage
- Medicare Supplemental plans
- NYS Benefit Management Program

Procedures performed in an inpatient setting or on an emergent basis are not included in the program.

Determine if precertification is needed for an Empire member by clicking the "Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements" link on empireblue.com, or by calling the precertification phone number printed on the back of the member's ID card.

Starting February 22, 2016, ordering physicians may submit a precertification request for the additional program requirements to AIM through the AIM ProviderPortalSM at aimspecialtyhealth.com/goweb (available 24/7 to process orders in real-time), through the Availity Web Portal at availity.com or by calling the AIM call center at 1-877- 430-2288, Monday–Friday, 8:30 a.m.–7:00 p.m. ET.

Empire recognizes that the necessity for arterial duplex imaging of the extremities may not be identified by providers until their patients have undergone a physiologic testing. Similarly, the need for percutaneous coronary intervention (PCI) is predicated upon the results of cardiac catheterization. In these cases, we ask that you contact AIM no later than 10 business days after you perform arterial duplex imaging or PCI, but before you submit the claim, to request precertification/clinical appropriateness review.

Thank you for your collaboration and ongoing support of the cardiology program. If you have further questions, please contact your local Network Consultant by calling 1-800-992-BLUE (2583) and selecting the following prompts:

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

CPT	Description
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	Duplex scan of extracranial arteries; unilateral or limited study
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93454	Catheter placement in coronary artery(s) for coronary angiography
93455	Catheter placement in coronary artery(s) for coronary angiography, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography
93456	Catheter placement in coronary artery(s) for coronary angiography, with right heart catheterization
93457	Catheter placement in coronary artery(s) for coronary angiography, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
93458	Catheter placement in coronary artery(s) for coronary angiography, with left heart catheterization including intraprocedural injection(s) for left ventriculography
93459	Catheter placement in coronary artery(s) for coronary angiography, with left heart catheterization including intraprocedural injection(s) for left ventriculography, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93460	Catheter placement in coronary artery(s) for coronary angiography, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography
93461	Catheter placement in coronary artery(s) for coronary angiography, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

93530	Right heart catheterization, for congenital cardiac anomalies
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
93533	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

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.

More news about what's new

As you may have noticed, we have included a Medicaid news section in our Network Update to include important updates for our affiliated company, Empire BlueCross BlueShield HealthPlus. Some of the products offered by Empire BlueCross BlueShield HealthPlus include Medicaid, Managed Long Term Care, Child Health Plus, and one commercial plan offered in year 2016 on the New York State Insurance Exchange (the Essential Health Plan). Providers contracted with Empire BlueCross BlueShield HealthPlus for these plans are on separate provider agreements from Empire BlueCross BlueShield, unless the Empire BlueCross Blue Shield contract was specifically assigned to Empire BlueCross BlueShield HealthPlus. Therefore, the Medicaid news updates do not apply to the commercial plans offered by Empire BlueCross BlueShield.

In addition, your participation status as a network provider with Empire BlueCross BlueShield has not changed. Your provider agreement with Empire BlueCross BlueShield has not been amended to include the Empire BlueCross BlueShield HealthPlus Medicaid, Managed Long Term Care, Child Health Plus plans or Essential Health Plan products. Similarly, if you have a provider agreement with Empire BlueCross BlueShield HealthPlus, your provider agreement has not been amended to include Empire BlueCross BlueShield's commercial plans.

The inclusion of the Medicaid section has been added to the Empire Network Update because the separate provider newsletter issued by Empire BlueCross BlueShield HealthPlus has been discontinued.

Enhancements to AIM Clinical Appropriateness Guidelines for Advanced Imaging

On February 22, 2016, the following changes to the AIM Clinical Appropriateness Guidelines for Radiology, Oncologic PET, and Cardiology will become effective.

Radiology guidelines

- MRI and CT
  - Expanded list of "red flag" indications for headache evaluation and added a requirement for conservative therapy in low-risk patients
  - Developed comprehensive new criteria for venous sinus thrombosis based on risk factors
- MRI/MRA or CT/CTA
  - Developed new criteria for headache evaluation for appropriate simultaneous imaging
- CT Neck (soft tissue) and CT Chest
  - Added new requirement of short course conservative therapy for low-risk patients with hoarseness
- CT Chest
  - Developed new criteria for immunosuppressed patients with persistent pneumonia
  - Aligned pulmonary nodule criteria with the Fleischner Society guidelines
- MRI Pelvis
  - Developed new criteria for sports hernia after sufficient initial evaluation and failed conservative management
  - Revised criteria for advanced imaging in low risk prostate cancer and in the surveillance of gynecologic malignancy
- MRI Upper and Lower Extremity
  - Expanded criteria for suspected occult fractures at high-risk sites following non-diagnostic radiographs

Oncologic PET guidelines

- Clarified language for surveillance PET imaging
- Clarified PET requirement for breast cancer to include invasive disease
- Expanded thyroid cancer to include well-differentiated follicular subtype
- Replaced "not covered" with "not medically necessary"

Cardiology guidelines

- Revised cardiac imaging criteria for management of patients with Kawasaki disease to align with published literature.
- Clarified appropriate frequency of echocardiography in children with established congenital heart disease. For younger children with complex congenital heart disease, evaluation based on symptoms is difficult. Therefore, the guideline has been liberalized to allow more frequent echocardiography in this cohort.
- Clarified language to reduce variability of guideline interpretation based on user feedback.

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.

REMINDER! Only collect co-payment at time of visit

Please note that according to the physician agreement and the Empire Provider Manual, (Chapter 1 -Legal & Administrative Requirements Overview page 21), except for co-payments, which may be collected at the time of service or discharge, you should not bill the member for any cost-sharing amounts until he/she has received an explanation of benefits (EOB). In no event should you require a deposit from a member prior to providing covered services to the member.

Updates to Blue Physician Recognition Program

Empire is committed to providing members with the tools they need to effectively partner with their doctors and make more informed health care choices. As part of that effort, Empire is pleased to participate in the Blue Cross and Blue Shield Association's consumer engagement initiative.

The Blue Physician Recognition (BPR) Program is designed to reinforce Blue Plans' commitment to quality by providing more meaningful and consistent information on physician quality improvement and recognition on the Blue National Doctor & Hospital Finder site and on Empire's online provider directories. A BPR indicator is used to identify physicians, groups and/or practices who have demonstrated their commitment to delivering quality and patient-centered care by participating in local, national, and/or regional quality improvement programs as determined by the local Blue Plan.

Empire recognizes primary care physicians practicing in the specialties of Family Practice, Internal Medicine and General Practice with a BPR designation if they have achieved recognition from either the National Committee for Quality Assurance (NCQA) or Bridges to Excellence (BTE) based on their successful completion of a care recognition program. Information regarding these recognition programs can be found at http://www.ncqa.org or http://www.hci3.org.

At a minimum, we will update these recognitions annually to reflect the current status as identified by the Blue Cross and Blue Shield Association's Quality Recognition Extract.

If you have questions regarding the update, please contact your network management consultant.

ICD Indicator Required on Paper Claim Forms

With the October 1, 2015 implementation of ICD-10, it may be appropriate to report either ICD-9 or ICD-10 codes depending upon the dates of service.

Paper claim forms have an ICD Indicator that identifies the ICD code set being reported on the claim.

Empire is requiring the ICD Indicator field be populated on paper claim forms.
Claims with this field not populated will be rejected.

This requirement applies to both the UB-04 and CMS 1500 forms.

- UB-04 form (also known as the CMS-1450 form) – The ICD Indicator is Field 66.
  (also known as the Diagnosis and Procedure Code Qualifier)

- CMS 1500 form version 02/12 – The ICD Indicator is Box 21.
  (Reminder: We only accept the 02/12 form version)

Providers need to enter the qualifier code that denotes the version of the ICD code set being reported on the claim.

Indicator	Code Set
9	ICD-9 diagnosis codes and/or procedure codes
0	ICD-10 diagnosis codes and/or procedure codes

Enhanced Personal Health Care: Referral Providers Benefit by Improving Quality and Controlling Costs

A key goal of the Enhanced Personal Health Care Program is to improve quality while controlling health care costs. One of the ways this is done is by giving primary care physicians ("PCPs") in the Program quality and cost information about the health care providers to which the PCPs refer their Attributed Members (the "Referral Providers"). If a Referral Provider is higher quality and/or lower cost, this component of the Program should result in their getting more referrals from PCPs. The converse should be true if Referral Providers are lower quality and/or higher cost. Empire will share data on which it relied in making these evaluations upon request, and will discuss it with Referral Providers including any opportunities for improvement. Any such requests should be directed to your network management consultant.

Reminder of the most recent updates to the Cancer Care Quality Program

Attention Oncologists, Hematologists and Urologists

As a reminder, Empire's Cancer Care Quality Program ("Program"), a quality initiative, provides participating physicians with evidence-based cancer treatment information that allows them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based Cancer Treatment Pathways ("Pathways"). Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program is administered by AIM Specialty Health® (AIM), a separate company.

Effective December 1, 2015 Empire added the following cancer treatment Pathways for the Cancer Care Quality Program.

New Pathways added to the Program include:

- Pathways for kidney cancer
- Pathways for gastric and esophageal cancers
- Pathways for head and neck cancers

Effective January 1, 2016 the following Pathways are moving from "on" pathway to "off" pathway status:

- Fludarabine+cyclophosphamide+mitoxantrone+rituximab (FCMR) for follicular lymphoma, 2nd and subsequent lines of therapy
- Rituximab for chronic lymphocytic leukemia (CLL), 1st line therapy

This means that providers will not be eligible for an enhanced reimbursement when these regimens are prescribed. This does not restrict the use of these regimens for members when clinically appropriate, and claims will be adjudicated in accordance with the members' benefit plans.

The Pathways developed for this Program are intended to support quality cancer care. To access the full Pathways document, go online to CancerCareQualityProgram. com, our dedicated provider website.

Note: Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway.

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.

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.

2016 FEP Benefit information available online

To view the 2016 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to fepblue.org>select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2016. For questions please contact FEP Customer Service at 1-800-522-5566.

GeoBlue - BlueCard Provider Outreach

GeoBlue, in partnership with Blue Cross Blue Shield of Michigan began serving over 3,000 internationally-based General Motors employees effective January 1st, 2015. Many of these members will be seeking care in the U.S. and presenting the GeoBlue identification card. These members are enrolled in a Blue Cross Blue Shield product and have full access to the BlueCard provider network. Their identification card follows all BlueCard specifications and all BlueCard processes apply. If you have any questions please contact our Customer Service team at 1-855-282-3517.

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.

Respiratory Antibiotic Use Performance

The National Committee for Quality Assurance (NCQA) has identified three Healthcare Effectiveness Data and Information Set (HEDIS) measures around antibiotic use:

- Children (2 to 18 years) who present with Pharyngitis who are first given a group A streptococcus (strep) test and then appropriately receive an antibiotic.
- Children (3 months to 18 years) with a diagnosis of Upper Respiratory Infection who are not given an antibiotic prescription.
- Adults with a diagnosis of Acute Bronchitis who are not given an antibiotic prescription.

The ratings for each of these metrics are determined by claims data only. Furthermore, it only takes one time of an antibiotic being inappropriately prescribed (and filled) in the one year measurement period to lower the scores.

Local Performance for Appropriate Testing and Antibiotic Prescribing

Based on New York Commercial Health Plan claims data, the reported HEDIS rates were as follows:

	Measurement Period	Rate Guide	HMO Rates	PPO Rates
Appropriate testing for Pharyngitis in Children	7/1/13-6/30/14	Higher is better.	85.26%	83.98%
Appropriate treatment for Children with Upper Respiratory Infection	7/1/13-6/30/14	Reported as an inverted rate. Higher is better.	93.47%	89.47%
Appropriate treatment for Adults with Acute Bronchitis	1/1/13-6/30/14	Reported as an inverted rate. Higher is better.	31.01%	23.29%

Things that might help you

In an effort to help slow the emergence of antibiotic resistant bacteria and prevent the spread of antibiotic resistant infections, please commit to:

- Avoid prescribing antibiotics inappropriately: Recent studies have shown that displaying poster-sized commitment letters in exam rooms to avoid inappropriate antibiotic prescribing was a simple, low-cost, and effective method for improvement. Write a prescription for symptom relief instead of an antibiotic and educate patients on comfort measures that may work without antibiotics.
- Communicate with patients: Parents indicate that they would be satisfied with their medical visit even if antibiotics are not prescribed, provided that the physician explains the reasons for the decision. Discuss realistic expectations for recovery time, explain that antibiotics do not significantly reduce the duration of symptoms, and that unnecessary use of antibiotics may cause adverse effects that lead to antibiotic resistance.
- Test for bacterial infections: If a child presents with a sore throat, do a strep test and prescribe accordingly. Don't send a script home with the patient "just in case," but rather offer to call it in if the test comes back positive.
- Code claims correctly and accurately: If your patient has comorbidities, bacterial infections, or competing diagnoses, the standard codes for adults with acute bronchitis (AAB) and upper respiratory infection (URI) may not be applicable. Ensure proper documentation is in the medical record and use correct diagnosis and procedure codes on claim/encounter.

Here are some Resources that might help you and your patients:

- Empire one-minute video: www.empireblue.com/cold

- Choosing Wisely—www.choosingwisely.org: 5 Patient Questions to ask Before Taking Antibiotics and Antibiotics: When you Need them and When you Don't in English and Antibiotics: When you Need them and When you Don't in Spanish
- AWARE program materials-- Physician-Patient Resources in English and Spanish
- CDC "Get Smart about Antibiotics"-- Patient and Provider Materials and References including Clinical Guidelines

1 Meeker, Daniella, et al. "Nudging Guidelines—Concordant Antibiotic Prescribing: A Randomized Clinical Trial." JAMA Internal Medicine. 2014; 174 (3): p 425-431.
2 Barden, LS, et al. "Current Attitudes regarding use of Antimicrobial Agents: Results from Physicians' and Parents' Focus Group Discussions." Clinical Pediatrics (Phila). Nov 1998; 37(11): p 665-671.

Behavioral Health news

Documentation and Reporting Guidelines for Applied Behavior Analysis (ABA) and Treatments for Autism Spectrum Disorder

Empire implemented the new ABA CPT codes effective January 1, 2015. Empire's new policy is effective December 1, 2015, that outlines the Health Plan's documentation and reporting guidelines for ABA and treatments for autism spectrum disorder utilizing this code set. Please refer to the AMA's CPT codebook and Empire's documentation policies to ensure your practice is in compliance with these documentation requirements. The documentation policies can be found at empireblue.com. Please review the policy and ensure that all aspects are being addressed.

2016 Outpatient Visits

Please note that Empire no longer manages traditional behavioral Health outpatient therapy for all fully insured products including health insurance exchange products. Many of our self-funded groups have also removed review of the traditional outpatient therapy visits; however, some groups continue to require a review after a certain number of pass-through visits. With the new calendar year please be certain to verify benefits for new patients to ensure you are aware of any requirements.

Partial hospitalization, intensive outpatient, applied behavior analysis, trans-cranial magnetic stimulation (TMS) services continue to require prior authorization from the first visit.

New Behavioral Health Program

Empire is making a new treatment option available in Manhattan and the Bronx for adolescents and young adults with serious substance use disorders. The New York Foundling, a non-profit organization providing services to New York City children and families, will offer Functional Family Therapy, an evidence-based intervention for substance use and related behavioral disorders. The treatment is delivered in the member's home and actively engages all family members in improving relationships and behaviors. More information about The Foundling's FFT program may be obtained by calling them at 1-212-660-1342.

Pharmacy news

CVS/specialty is the exclusive in-network specialty pharmacy for Empire members with medical benefit coverage for specialty medications.

As the exclusive Empire provider for specialty injectable and infusion medication, CVS is able to ship to a physician's office or to the patient's location of choice. Through Coram, a division of CVS they can also administer infusion drugs in one of their infusion suites or in the patient's home. Whether it is an infusion or injection medication, CVS/specialty can support ongoing patient care.

Injectables

Patients have 24/7 access to a pharmacist-led Care Team that includes specially-trained nurses, nutritionists, and support staff. This team supports, motivates, and educates patients and caregivers throughout treatment.

Patients can have their specialty medications delivered to the location of their choice which may be their home or physician's office. CVS/specialty is the only pharmacy that can ship medications to physician offices. If CVS is not utilized by the treating provider for specialty drugs shipped to physician office, claims will process according to the member's out-of-network benefits as applicable.

Phone, fax, or e-scribe your prescription to any CVS/pharmacy or CVS/specialty pharmacy.
phone 1-800-237-2767 | fax 1-800-323-2445

Infusions

As a division of CVS/specialty, Coram's infusion nurses are experienced in administering infusion medications to complex patients with rare or autoimmune disorders.

Patients can choose to receive infusions from experienced staff nurses in the convenience of their home, or at a local Coram infusion suite. Both options may reduce the risk of infection and help patients save money by moving infusions to lower cost sites of care.

Coram offers convenient care nationwide in more than 65 infusion suites. To find a Coram infusion suite near you, go to coramhc.com/locations.

Phone or fax your infusion referral to Coram.
phone 1-866-899-1661 | fax 1-866-843-3221

Searchable Formulary Tool gives providers easier access to formulary/drug list information

Empire recently launched a new Searchable Formulary Tool, providing access to all relevant medication information about five of Empire's drug lists, including – clinical edits like prior authorization or step therapy, dosage/strength options, and details about brands and generics.

Providers can quickly access the Searchable Formulary Tool through the Pharmacy Microsite, where Empire's drug lists are housed. The following five drug lists are set up with searchable capabilities:

- National
- Select
- Preferred
- Essential
- Generic Premium

Once you select the applicable drug list, you can search the drug list for a wealth of information including:

- Tier status
- Clinical programs/edits including quantity limits, dose optimizations, prior authorizations and step therapies
- Drug label name
- Generic drug name
- Generic drug indicator
- Therapeutic class and category
- Available dosage/strength options

If needed, you are also able to access printable versions of these drug list PDFs.

Additionally, members with our pharmacy benefit will have the added functionality of benefit-specific drug list search capabilities, which eliminates the need to identify and select the drug list that applies to their pharmacy benefit.

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 "Marketplace Select Formulary" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List." For State-sponsored Business, visit SSB Pharmacy Information. Website links for the Federal Employee Program formulary Basic and Standard Options are:

- Basic Option: https://www.caremark.com/portal/asset/z6500_drug_list807.pdf;
- Standard Option: https://www.caremark.com/portal/asset/z6500_drug_list.pdf.

This drug list is also reviewed and updated regularly as needed. FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies.

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. The following articles have recently been added:

- Updated contact information for ERA and EFT registration – October 2015

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.

Incentive opportunity for physicians treating patients with Empire plans purchased on or off the exchange

In 2014, you were notified that Empire would engage Inovalon – an independent company that provides secure, clinical documentation services – to conduct outreach efforts for our health care exchange business. Empire is working with Inovalon to help ensure that our members, who have purchased health care plans on and off the exchange, get their diagnoses confirmed, corrected, and updated every year, as well as have potential preventive care gaps addressed. To accomplish this goal, Empire network providers - usually primary care physicians - may receive letters from Inovalon, asking you to perform patient outreach and assessments, followed by submission of a SOAP Note (also called Encounter Facilitation Form). SOAP Note stands for Subjective, Objective, Assessment, and Plan which is the standardized document format of a medical record.

If you receive a request from Inovolan, we understand that completing these SOAP Note requests may take time, and we would like to offer contracted exchange providers the opportunity to increase your reimbursement. As a reminder, you are eligible to receive $100 in addition to your office visit fee for each properly submitted electronic SOAP Note submitted through Inovalon's ePASS tool.

You may also elect to submit your patient assessment data for the members we request using the paper SOAP Note option via Inovalon's secure fax line at 1-866-682-6680. For each paper SOAP Note properly submitted for patient assessments performed, you are eligible to receive $50 in addition to your office visit fee.

Submitting a SOAP Note

Paper: You have the option to fax in a completed paper SOAP Note to Inovalon at 1-866-682-6680. To ensure that the paper SOAP Note is fully processed, all required fields must be completed and signed by the member's physician.

Electronically: You may use ePASS (Electronic Patient Assessment Solution Suite), an electronic tool that retrieves information about your Empire patients, including potential preventive care gaps, and drops this data into the SOAP Note to document your patients' conditions. The ePASS® tool may be used for members Inovalon identifies, and the members have purchased individual and small group health plans on and off the exchange. To utilize ePASS®, please sign up online at the following Web address: https://ePASS.inovalon.com

Overview of the ePASS® tool

If you receive a request from Inbovolan to complete a SOAP note and you're interested in an overview of the ePASS® tool, please see below for various webinar dates. We encourage you to register in advance by sending an email to ePASSProviderRelations@Inovalon.com with your name, organization, contact information and date of the webinar you'd like.

This webinar provides a practical overview of how ePASS can be used to access a supplemental clinical profile and complete a compliant electronic encounter SOAP Note for patients identified by Inovolan on Empire's behalf. The webinar typically lasts 30 minutes with time for questions.

Tips for joining an ePASS® tool overview webinar:

First: Join by calling the toll-free number and enter the access code.
Second: click on WebEx Link and enter meeting code.

Webinar Date	Time
December 02, 2015	3:00 - 3:30 p.m. EST
December 09, 2015	3:00 - 3:30 p.m. EST
December 16, 2015	3:00 - 3:30 p.m. EST
January 06, 2016	3:00 - 3:30 p.m. EST
January 13, 2016	3:00 - 3:30 p.m. EST
January 20, 2016	3:00 - 3:30 p.m. EST
January 27, 2016	3:00 - 3:30 p.m. EST

The following dial-in information and WebEx link/entry code are the same for all webinar dates.

- Phone Number/Access Code: 1-888-850-4523. Enter Access Code: 10860
- WebEx Link/Meeting Code: visit:https://inovalon.webex.com. Enter: 745 497 369

For more information on the outreach process or the ePASS tool, please click HERE. Or, go to empireblue.com > Providers & Facilities > Enter > Information about Health Insurance Exchange > Empire engages Inovalon to conduct outreach efforts for our ACA individual and small group on and off exchange business – FAQs. You may also contact Inovalon toll free at 1-877-448-8125.

Medicare Advantage news

Avoid denials of Medicare Advantage diagnostic claims by completing item 20 (CMS 1500) correctly - individual membership only

The Centers for Medicare & Medicaid Services requires that providers billing for diagnostic tests subject to the anti-markup payment limitation complete Item 20 on the CMS-1500 form. A “YES” check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "NO" check indicates "no anti-markup tests are included on the claim." When "YES" is annotated, Item 32 is required to be completed.

Claims for Empire individual Medicare Advantage members received with Item 20 checked as “YES” and incomplete or missing information in Item 32 will be denied with denial Z01 “Claim must be billed with Provider’s NPI”. To prevent unnecessary denial of claims, only complete Item 20 when you are billing diagnostic tests subject to the anti-markup payment limitation.

For more information on diagnostic tests subject to the anti-markup payment limitation refer to Medicare Claims Processing Manual, Chapter 35, Section 30.

Please include modifiers to help ensure accurate payment

Codes not recognized by Original Medicare are considered by Empire Medicare Advantage as not reimbursable unless otherwise noted for both individual and group-sponsored claims.

During the past year, some providers have found that certain individual and group-sponsored claims are denied for missing or inconsistent modifiers as the claims are not consistent with CMS payment guidelines. Please ensure you use the most current and appropriate CMS codes and modifiers when submitting your claims.

Check Important Medicare Advantage Updates at www.empireblue.com/medicareprovider for additional information.

Oxygen DME prior authorizations will be reduced in 2016

Providers who prescribe durable medical equipment for oxygen delivery for Empire individual and group-sponsored Medicare Advantage members will find that fewer items will require prior authorization in 2016. Detailed Prior Authorization requirements for individual MA members are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. Go to Auths and Referrals/Authorizations from the left navigation menu. Select Empire Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well via the Precertification look-up tool.

Please visit www.empireblue.com/medicareprovider to learn more about this online provider self-service tool.

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.

Empire to review ER Level 5 professional claims

Empire is initiating a review of ER professional claims billed with a level 5 ER E/M code (99285 or G0384) to ensure the documentation meets or exceeds the components necessary to support its billing. The review for the necessary components will be based on the coding guidelines outlined in the AMA CPT coding reference. Documentation will be requested and the review will be performed on a pre-pay basis. The review for selected ER professional claims with level 5 E/M codes is scheduled to begin January 1, 2016.

Register for imaging site scores by March 1, 2016 to avoid unnecessary line-item denials

On Nov. 1, 2015, Empire Medicare Advantage plans began collecting information about the imaging capabilities of all Empire Medicare Advantage contracted providers who provide the technical component of a number of outpatient diagnostic imaging services for our individual Medicare Advantage members.

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).

This 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 for the applicable modality will see no change in reimbursement. Providers who score less than 76 or who do not complete the survey by March 1, 2016, will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Globally billed claims will deny in total if the provider scores less than 76 or if the provider does not complete the survey. If billing globally and the claim is denied, the provider has the option to resubmit a

corrected claim for the professional component (interpretation) with modifier 26 for payment consideration. 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.

Empire strongly encourages any provider who scores below 76 to improve their site score for the applicable modality before the line item denial of claims begins on claims submitted for dates of service on or after March 1, 2016. Providers who have not registered and therefore have no score also will be subject to line-item denials for claims submitted for dates of service on or after March 1, 2016.

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.

Check Important Medicare Advantage Updates at www.empireblue.com/medicareprovider for additional information.

56997WPPENMUB 10/21/2015

Radiation Therapy Brachytherapy, IMRT CPT codes prior authorization information updated

Prior authorization procedures for the following outpatient radiation therapy CPT codes for our individual Medicare Advantage members have been updated:

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

Prior Authorization requirements for individual Medicare Advantage members are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. Go to Auths and Referrals/Authorizations from the left navigation menu. Select <Plan Name> Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well via the Precertification look-up tool. Providers also may contact Provider Services at the number on the back of the member's ID card.

Check Important Medicare Advantage Updates at www.empireblue.com/medicareprovider for additional information.

57215WPPENMUB 11/02/2015

More $0 Copay Medications Available to Medicare Advantage Members with Chronic Conditions

Individual MAPD plans in 2016 will continue to offer select drugs at a $0 member co-pay for the following conditions: high blood pressure, high cholesterol and diabetes. The 2015 medication list (glipizide, lisinopril, losartan, metformin, and simvastatin) will continue to be included. New medications on this list in 2016 include benazepril, enalapril, enalapril-hctz, lisinopril-hctz, glimepiride, glipizide ER, losartan-hctz, metformin ER, atorvastatin, lovastatin and pravastatin.

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

Avastin for ophthalmic use – C9257 can be billed in office setting for network providers

Beginning Jan. 1, 2016, C9257, Avastin 0.25mg (for ophthalmic use), will be payable for facilities and professional providers when other criteria are met for individual Medicare Advantage claims. In addition, Empire will no longer require a prior

authorization for Avastin for ophthalmic injection. Check Important Medicare Advantage Updates at www.empireblue.com/medicareprovider for more information.

Enhanced reimbursement available for certain Part B injectable drugs

Beginning 1Q16, Empire individual Medicare Advantage plans will reimburse providers with enhanced payments for using less expensive but therapeutically equivalent select Part B injectable drugs. The reimbursement change is specific to only the following drugs.

- Therapeutic Class – Antiemetics. HCPCS (drug) – J1626 (Kytril), J2405 (Zofran)
- Therapeutic Class – Folinic Acid. HCPCS (drug) – J0640 (Leucovorin)
- Therapeutic Class – Osteoporosis. HCPCS (drug) – J3489 (Reclast)

Check Important Medicare Advantage Updates at www.empireblue.com/medicareprovider for additional information.

Empire place of service claims adjudication mirrors CMS guidelines

CMS recently revised Place of Service code sets by adding new POS code 19 for "Off Campus-Outpatient Hospital" and revising POS code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital." Please ensure your claims include these new and revised POS codes where applicable. Empire mirrors CMS guidelines when performing Place of Service claims adjudication.

Dual Special Needs Plans Quality Improvement Program available

The Centers for Medicare & Medicaid Services requires that Medicare Advantage plans provide a Model of Care program for our Dual Special Needs Plan members. The program's goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. To see a summary of Empire's quality program and most current outcomes, go to empireblue.com/medicareprovider then choose Important Medicare Advantage Updates.

Empire individual Medicare Advantage plan names changing for 2016

Empire has introduced a standard nomenclature to its affiliated MA plans. In most instances, plan names start with the local brand name, followed by the word "MediBlue," then a plan descriptor, such as "Access," and finally the plan type. For instance, a standard HMO would be referred to as "Empire MediBlue Essential (HMO)," while a standard PPO would be called "Empire MediBlue Access (PPO)." Group-sponsored Medicare Advantage plans are not impacted by these changes. No member ID prefixes are changing for 2016. Check Important Medicare Advantage Updates at www.empireblue.com/medicareprovider for a list of current and 2016 plan names.

Empire MediBlue HMO and PPO Changing 2016 Medicare Advantage Individual Plans

Empire wants you to know about changes to Medicare Advantage Individual plan service areas that will take effect January 1, 2016. Employer group plans will not be impacted.

- Empire will add a MediBlue Plus HMO plan in Orange County.
- Empire will no longer offer Empire MediBlue Plus HMO plans in Richmond, New York and Putnam counties. A new MediBlue Plus HMO will be introduced in New York County.
- Empire will no longer offer Empire MediBlue Freedom I PPO in Fulton, Richmond, Nassau and Suffolk counties.
- Empire will no longer offer Empire MediBlue Freedom II PPO in Saratoga and Schoharie counties.

- Dual Eligibility Special Needs Plans will be offered in Nassau and Orange counties in 2016 in addition to Bronx, Kings, New York, Queens, Richmond and Westchester counties.

Empire will continue to offer Medicare Advantage HMO plans in Bronx, Kings, Nassau, Queens, Richmond, Rockland, Saratoga, Suffolk and Westchester counties.

Empire will continue to offer Medicare Advantage LPPO plans in Albany, Bronx, Kings, Rensselaer, Saratoga and Schoharie counties.

Check Important Medicare Advantage Updates at www.empireblue/medicareprovider for more information.

Keep up with Medicare Advantage news at Important Medicare Advantage Updates

Please continue to check Important Medicare Advantage Updates at www.empireblue.com/medicareprovider for the latest Medicare Advantage information, including:

- Important 2016 coverage changes for diabetic supplies
- Medicare Advantage reimbursement policies
- 2016 Medicare Advantage plan changes
- New 2016 Prior Authorization Requirements Effective January 1, 2016
- ICD-10-CM Educational Material Now Available
- Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning June 1, 2016
- Empire encourages high-risk members to get a flu shot

6815WPPENMUB 10/16/2015

Medicaid news

Introducing New York Essential Plan

On January 1, 2016, Empire BlueCross BlueShield HealthPlus (Empire) is offering a new comprehensive and affordable health insurance program. The Essential Plan is a health benefit coverage program for low to moderate income residents who would otherwise be ineligible to purchase coverage through the Health Insurance Marketplace or to qualify for Medicaid or Child Health Plus.

As an Empire provider, your continued commitment to providing quality care across all products to our members is central to helping them achieve and maintain good health.

Use this link to learn more about the Essential Plan, including who is eligible, how members enroll and types of coverage.

More news about what's new

Although our name changed, your contract and participation status with our plan did not change. If you contract only with Empire BlueCross BlueShield HealthPlus, you will not be able to see patients enrolled in Empire BlueCross BlueShield. If you have questions or need assistance, please contact our Medicaid Provider Services team at 1-800-450-8753 or our FIDA Provider Services team at 1-855-817-5790.

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.

Click here for additional information about new ID cards, the new website and some helpful hint.

Update: Scoliosis and spinal deformity medical necessity reviews

Empire BlueCross BlueShield HealthPlus collaborates with OrthoNet to conduct medical necessity reviews for certain services related to surgical interventions for scoliosis and spine deformity. Effective January 1, 2016, surgical interventions for scoliosis and spine deformity procedure requests must be reviewed by OrthoNet for precertification. Use this link to learn more about this change to precertification and for code-specific requirements.

ICD-10 coding for diabetic complications

A benefit of ICD-10 codes is that providers can now report more clinical details concerning diabetic complications than they could in ICD-9. The increased specificity is possible because ICD-10 contains expanded combination codes for diabetic complications. A combination code describes two or more conditions within a single code. The ICD-10 code categories E08-E13 contain the combination codes for diabetic complications. The codes include the type of diabetes mellitus, the body system affected and the complications affecting that body system.

Get this helpful ICD-10 coding for diabetic complications tip sheet here.

Quality Initiatives

HEDIS® 2015 Results Are In

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) data collection for 2015. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner, eliminates follow up calls to your office and also helps improve HEDIS scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided.

Further information regarding documentation guidelines can be found on the HEDIS page of our Provider Portal. The Provider Portal can be accessed by signing in to www.anthem.com and clicking on “Provider”, followed by “Health and Wellness”, “Quality”, and finally “HEDIS”. You will find reference documents entitled “HEDIS 101 for Providers” and “HEDIS Documentation Guidelines”.

The table below shows comparison of some of our key measure rates in New York.

- Yellow boxes indicate rates that are above the national average.
- Bold indicates improvement in rate over the previous year.
- Comprehensive Diabetes Care - Poor HbA1c Control (>9): Lower rate is good

Commercial HMO/POS Measures	HEDIS 2015 Rate (Percent)
Adult BMI Assessment	78.35
Weight Assessment and Counesling – BMI - (3-11 yrs)	69.60
Weight Assessment and Counesling – BMI - (12-17 yrs)	78.80
Weight Assessment and Counesling – BMI Total	73.72
Weight Assessment and Counseling – Nutrition Counseling - (12-17 yrs)	82.61
Weight Assessment and Counseling – Nutrition Counseling Total	79.32
Weight Assessment and Counseling – Physical Activity - (3-11 yrs)	60.35
Weight Assessment and Counseling – Physical Activity - (12-17 yrs)	76.63
Childhood Immunization Status - DTAP	80.43
Childhood Immunization Status – MMR	86.96
Childhood Immunization Status – HIB	90.58
Childhood Immunization Status – VZV	85.87
Childhood Immunization Status – PCV	77.17
Childhood Immunization Status – HEP A	63.41
Childhood Immunization Status - ROTAVIRUS	72.46
Childhood Immunization Status – Influenza	63.41
Immunizations for Adolescents - MENINGITIS	71.09
Immunizations for Adolescents – TDAP/TD	93.22
Human Papillomavirus Vaccine for Female Adolescents	12.42
Breast Cancer Screening Total	71.52
Colorectal Cancer Screening	68.86
Chlamydia Screening in Women -(21-24 yrs)	61.27
Chlamydia Screening in Women – Total	58.18
Antibiotic Treatment Adults w/ Acute Bronchitis	31.01
Use of Appropriate Medications for People with Asthma -(19-50 yrs)	91.23
Medication Management for People with Asthma – (19-50 yrs) 75%	51.92

Medication Management for People with Asthma – (51-64 yrs) 75%	63.64
Medication Management for People with Asthma – Total 75%	56.36
Asthma Medication Ratio – 19-50	83.33
Asthma Medication Ratio – 51-64	88.04
Asthma Medication Ratio – Total	84.48
Controlling High Blood Pressure	65.69
Comprehensive Diabetes Care – HbA1c >9[1]	25.79
Comprehensive Diabetes Care – HbA1c <8	65.45
Comprehensive Diabetes Care – Eye Exams	59.37
Comprehensive Diabetes Care – Nephropathy	81.51
Comprehensive Diabetes Care – Blood Pressure <140/90	71.05
Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	79.41
Antidepressant Medication Mgmt - Acute	65.85
Antidepressant Medication Mgmt - Continuation	42.68
Follow Up Care Children's ADHD Medication - Initiation	29.41
Follow Up After Hospitalization For Mental Illness – 30 days	64.89
Follow Up After Hospitalization For Mental Illness – 7 days	53.19
Annual Monitoring Persistent Meds - ACE or ARB	84.83
Annual Monitoring Persistent Meds - Diuretics	85.11
Annual Monitoring Persistent Meds - Total	84.55
Adults' Access to Preventive/Ambulatory Health - (20-44 yrs)	90.37
Adults' Access to Preventive/Ambulatory Health – (65+)	96.15
Children & Adolescents' Access to PCP - (12-24 mos)	86.64
Children & Adolescents' Access to PCP (12-19 yrs)	92.29
Initiation of Alcohol and Other Drug Dependence Treatment – (18+ yrs)	33.98
Initiation of Alcohol and Other Drug Dependence Treatment – Total (Combined Ages)	35.54
Engagement of Alcohol and Other Drug Dependence Treatment – (18+ yrs)	11.70

Engagement of Alcohol and Other Drug Dependence Treatment – Total (Combined Ages)	13.00
Prenatal/Postpartum Care – Postpartum Care	81.60
Well-Child Visits in the first 15 Months of Life (6+ visits)	72.43
Well-Child Visits 3 to 6 Years of Life	81.51
Adolescent Well-Care Visits	56.19

*The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period

The table below shows comparison of some of our key measure rates in the PPO line of business.

- Yellow boxes indicate rates that are above the national average.
- Bold indicates improvement in rate over the previous year.
- Comprehensive Diabetes Care - Poor HbA1c Control (>9): Lower rate is good

Commercial PPO Measures	HEDIS 2015 Rate (Percent)
Adult BMI Assessment	79.56
Weight Assessment and Counseling – BMI – (3-11 yrs)	62.50
Weight Assessment and Counseling – BMI – (12-17 yrs)	66.67
Weight Assessment and Counseling – Nutrition Counseling – (3-11 yrs)	75.83
Weight Assessment and Counseling – Nutrition Counseling – (12-17 yrs)	71.93
Weight Assessment and Counseling – Nutrition Counseling Total	74.21
Weight Assessment and Counseling – Physical Activity - (12-17 yrs)	69.59
Childhood Immunization Status – DTAP	83.70
Childhood Immunization Status – IPV	88.32
Childhood Immunization Status – MMR	86.13
Childhood Immunization Status – HIB	89.29
Childhood Immunization Status – VZV	85.64
Childhood Immunization Status – PCV	81.51
Childhood Immunization Status – Hep A	70.80
Childhood Immunization Status – ROTAVIRUS	75.67
Childhood Immunization Status – INFLUENZA	63.99

Immunizations for Adolescents – MENINGITIS	76.40
Immunizations for Adolescents – TDAP/TD	92.46
Breast Cancer Screening – Total	67.07
Colorectal Cancer Screening	54.26
Chlamydia Screening in Women – (16-20 yrs)	56.15
Chlamydia Screening in Women – (21-24 yrs)	63.76
Chlamydia Screening in Women – Total	60.47
Appropriate Treatment Childred w/ URI	89.47
Avoidance of Antibiotic Treatment Adults w/ Acute Bronchitis	23.29
Spirometry Testing for COPD	54.80
Pharmacotherapy Mgmt COPD – Systemic Corticosteroid	78.57
Pharmacotherapy Mgmt COPD – Bronchodilator	79.22
Use of Appropriate Medications – Asthma – (19-50 yrs)	89.92
Medication Management for People with Asthma (5-11 yrs) 75%*	33.25
Medication Management for People with Asthma (19-50 yrs) 75%*	41.34
Medication Management for People with Asthma (51-64 yrs) 75%*	57.19
Medication Management for People with Asthma (Total) 75%	43.64
Asthma Medication Ratio – (5-11 yrs)	87.00
Asthma Medication Ratio – (12-18 yrs)	76.49
Asthma Medication Ratio – (Total)	80.66
Controlling High Blood Pressure	63.26
Persistence of Beta-Blocker Treatment after AMI	84.66
Comprehensive Diabetes Care – HbA1c Testing	86.13
Comprehensive Diabetes Care – HbA1c <9[1]	28.22
Comprehensive Diabetes Care – Eye Exams	49.88
Comprehensive Diabetes Care – Medical Attention for Nephropathy	77.37
Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.39

Antidepressant Medication Mgmt – Acute	68.28
Antidepressant Medication Mgmt – Continuation	52.81
Follow Up Care Children's ADHD Medication – Initiation	38.70
Follow Up Care Children's ADHD Medication – Continuation	41.57
Follow Up After Hospitalization for Mental Illness – 30 days	69.08
Follow Up After Hospitalization for Mental Illness – 7 days	51.65
Annual Monitoring Persistent Meds – ACE or ARB	84.80
Annual Monitoring Persistent Meds – Digoxin	45.05
Annual Monitoring Persistent Meds – Diuretics	83.92
Annual Monitoring Persistent Meds – Total	84.26
Children & Adolescents' Access to PCP (12-24 mos)	90.72
Children & Adolescents' Access to PCP (25 mos-6 yrs)	89.89
Initiation of Alcohol and Other Drug Dependency Treatment – (13-17 yrs)	39.72
Initiation of Alcohol and Other Drug Dependency Treatment - (18+ yrs)	39.53
Initiation of Alcohol and Other Drug Dependency Treatment – Total (Combined Ages)	39.54
Engagement of Alcohol and Other Drug Dependency Treatment – (13-17 yrs)	21.76
Prenatal/Postpartum Care – Timeliness of Prenatal Care	89.78
Prenatal/Postpartum Care – Postpartum Care	72.02
Well-Child Visits in the First 15 Months of Life (6+ Visits)	75.16

*The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period

[1] Lower rate indicates better compliance

In New York, many scores for the Commercial HMO plan improved and exceeded the national average, especially those in Colorectal Cancer Screening, Weight Assessment and Counseling – both BMI and Nutrition Counseling for 12-17 year olds, and Medication Management for People with Asthma (19-50 years) who stayed on their asthma controller medication for at least 75% of their treatment period. Although the rate is below the national average, the largest rate increase in childhood immunizations was for influenza. In the commercial PPO line of business, there were also many improved scores that exceeded the national average, especially those in Pharmacotherapy Management of COPD (systemic corticosteroid), Persistence of Beta-Blocker after AMI, Pharmacotherapy Management of COPD (bronchodilator), and Adult BMI Assessment.

Although many rates were above the national average this year, in the HMO line of business, there are opportunities for improvement in the measures that experienced the most significant decreases in rates including: Follow Up Care for Children's ADHD Medication – Initiation, Initiation of Alcohol and Drug Dependency Treatment (age 18+), Initiation of Alcohol and Drug Dependency Treatment Total (Combined Ages), and Engagement of Alcohol and Drug Dependency Treatment (age 18+). In the PPO plan, the measures with the most significant rate decreases included Annual Monitoring of Persistent Medications – Digoxin, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Childhood Immunization Status – Influenza, and Postpartum Care. All of these rates except Avoidance of Antibiotic Treatment of Adults are above the national average.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project, and to demonstrate the exceptional care that you have provided to our members.
In an effort to improve our scores, you and your office staff can help facilitate the HEDIS process improvement by:

- Responding to our requests for medical records within five days
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care in the patient's medical record

Again, we thank you and your staff for demonstrating teamwork as we work together to improve the health of our members and your patients. We look forward to working with you next HEDIS season.

Survey says... Patients see room for improvement with physician care

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

The following tables compare our results from 2014 with those in 2015. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Empire. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country perform the CAHPS survey. Our goal is to achieve the 75th Percentile.

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

NCQA Quality Compass Percentile Legend 5	10th	25th	50th	75th	90th

Survey Question	2014	2015	Trend 2014 vs. 2015
Rating of Physician [1]			
Rating of Personal Doctor	86%	84%	↓
Rating of Specialist Seen Most Often	84%	89%	↑
Rating of All Health Care Provided in Past 12 Months	79%	81%	↑

Getting Care Quickly [2]			
Got appointment for *urgent care* as soon as needed	88%	97%	↑
Got appointment for *check-up or routine care* as soon as needed	82%	83%	↑
Got help or advice needed when calling doctor after regular office hours	DNA	80%	---
Doctor's Communication with Patients [2]			
How often personal doctor explained things understandably to you	97%	97%	=
How often personal doctor listened carefully to you	97%	96%	↓
How often personal doctor showed respect for what you had to say	97%	98%	↑
How often personal doctor spent enough time with you	93%	93%	=
Shared Decision Making			
Doctor discussed reasons to take a medicine? [3]	DNA	96%	---
Doctor discussed reasons not to take a medicine? [3]	DNA	80%	---
Doctor asked what you thought was best for you? [4]	DNA	78%	---
Continuity of Care & Health Promotion			
How often did your personal doctor seem informed about care you received from other health providers? [2]	79%	78%	↓
Did you and your doctor discuss ways to prevent illness? [4]	78%	78%	---

1 = Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 = Percent responding "Usually" or "Always."
3 =% responding "A lot" or "Some"
4 = % responding "Yes"
5 = Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.
DNA = Data Not Available
NA = Number of survey respondents too low to be valid.

Improving Your Patients' Health Care Experience

Empire is committed to working with our network physicians to make our members' health care experience a positive one. Towards this end we wanted to share with you a document we discovered that was developed by the California Quality

Cooperative. This resource outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

Simply go to empireblue.com > Providers & Facilities >Enter>Health & Wellness>Improving Your Patient's Care Experience.

"This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California."

We Believe in Continuous Improvement

Commitment to our members' health and their satisfaction with the care and services they receive is the basis for the Empire Quality Improvement Program. Annually, Empire prepares a quality program description that outlines the plan's clinical quality and service initiatives. We strive to support the patient-physician relationship, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of Empire's quality program and most current outcomes, visit us at empireblue.com.

Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Empire is available to offer assistance in these difficult moments with our Case Management Program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

CM Telephone Number	CM Email Address	CM Business Hours
1-800-563-5909	ECM-NY@Empireblue.com	Monday–Friday, 8:30am to 9:00 pm Saturday, 8:30am to 5:00pm
National (New York) 866-202-8727	NYCoreANAAtlanta@empireblue.com	Monday – Friday, 8:30am to 5:00pm
Federal Employee Program 800-711-2225	No email	Monday – Friday, 8:00am to 7:00pm EST

Coordination of Care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Empire would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Empire urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
   - Diagnosis
   - Treatment plan
   - Referrals
   - Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Empire has several tools available on empireblue.com including a Coordination of Care template and cover letters for both Behavioral Health and other Healthcare Practitioners.* In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.**

*Access to the forms and cover letters are available at empireblue.com>Providers & Facilities> Provider Home>Answers@Empire.

**Access to the Toolkit is available at empireblue.com>Providers & Facilities>Provider Home> Health and Wellness.

Important Information about Utilization Management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Empire's medical policies are available on empireblue.com.
You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. UM criteria are also available on the web. Just select "Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements" from the Provider home page at empireblue.com.

We work with providers to answer questions about the utilization management process and the authorization of care. Here's how the process works:

- Call us toll free from 8:30 a.m. - 5 p.m. Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8:00 a.m. – 7 p.m. Eastern.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID card.

To discuss UM Process and Authorizations	To Discuss Peer-to-Peer UM Denials w/Physicians	To Request UM Criteria	TTY/TDD
1-800-982-8089 OR 1-800-688-1019 Federal Employee Program Phone 1-800-522-5566 FAX 1-800 732-8318 (UM) FAX 1-877 606-3807 (ABD)	1-800-688-1019 Press 4 1-800-634-5605-Appeals Federal Employee Program Phone 1-800-522-5566	Call number on back of member's ID card Federal Employee Program Phone 1-800-522-5566 FAX 1-800 732-8318 (UM) FAX 1-877 606-3807 (ABD)	711 or TTY: 1-800-662-1220 TTY/HCO Voice: 1-800-421-1220 Voice

For language assistance, members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

Members' Rights and Responsibilities

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Empire has adopted a Members' Rights and Responsibilities statement.

It can be found on empireblue.com > Provider & Facilities > Enter> Health & Wellness> Quality Improvement and Standards> Member Rights & Responsibilities.

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 empireblue.com.

Medical Policy Updates

New Medical Policies Effective 03-01-2016
(The policy below was created and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

- THER-RAD.00011 - Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT)

Clinical Guideline Updates

Clinical Guidelines Adopted Effective 03-01-2016
(The following guidelines will be applied and might result in services that were previously covered but may now be found to be not medically necessary.)

- CG-SURG-44 - Coronary Angiography and Cardiac Catheterization in the Outpatient Setting
- CG-SURG-48 - Elective Percutaneous Coronary Interventions (PCI)
- CG-THER-RAD-01 - Fractionation and Radiation Therapy: Bone Metastases and Whole-Breast Irradiation Following Breast-Conserving Surgery
- CG-THER-RAD-02 - Special Radiation Physics Consult and Treatment Procedure

Professional Reimbursement Policy updates

Review of reimbursement policies
The following professional reimbursement policies received an annual review and may have word changes or clarifications, but do not have significant changes to the policy position or criteria:

- Co-Surgeon/Team Surgeon Services
- Documentation Guidelines for Central Nervous System Assessments and Tests
- Documentation and Reporting Guidelines for Consultations
- Documentation and Reporting Guidelines for Evaluation and Management
- Drug Screen Testing

- Injectable Substances with Related Injection Services
- Multiple Diagnostic Imaging Procedures
- Physical and Manipulative Maintenance Services
- Place of Service
- "Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services
- Sleep Studies and Related Bundled Services and Supplies

Anesthesia Services

CPT code 93355 (guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s)...), effective January 1, 2015, was added by the Centers for Medicare & Medicaid Services (CMS) to the National Correct Coding Initiative (NCCI) edit that denies 93355 when reported with an anesthesia service. 93355 is an NCCI column 2 (denied) code with a superscript of "0" therefore the denial will not be overridden by an override modifier. We are adding this code to section 6.c—Services Included/Excluded in the Global Reimbursement for Anesthesia—of the policy to document the current NCCI edit. Additional word changes and clarifications were also made without changes to the policy position or criteria.

Bundled Services and Supplies

Beginning with claims processed on or after November 16, 2015, we implemented an edit that Healthcare Common Procedure Coding System (HCPCS Level II) codes S0395 (casting), A4580 (cast supplies) and A4590 (special casting materials) are not eligible for separate reimbursement when reported with custom foot orthotics HCPCS codes L3000, L3010, L3020 and L3030. The Health Plan considers casting and cast supplies and materials to be mutually exclusive to the manufacture and provision of custom foot orthotics. Modifiers will not override this edit.

For dates of service on or after January 1, 2016, new CPT codes 99415 and 99416 (prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision...(list separately in addition to code for outpatient evaluation and management service)) are being added to Section 1 of our policy as an always bundled service. The Health Plan considers this service to be part of the overall care of the patient and not eligible for reimbursement.

Beginning with dates of service on or after March 1, 2016, Current Procedural Terminology (CPT®) code 95940 (continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes) will not be eligible for separate reimbursement when reported with CPT code 95941(continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating, per hour). The Health Plan considers 95940 to be an overlapping/mutually exclusive service when reported with 95941 during the same patient encounter on the same date of service. Modifiers will not override this edit; therefore this information is included in our Modifiers 59 and XE, XP, XS, and XU professional reimbursement policy.

Claim Editing Overview

For claims processed on or after November 16, 2015, we implemented an edit to our "Procedure to Diagnosis Rule" that urinary system CPT code 50590 (lithotripsy, extracorporeal shock wave), which signifies a procedure to break up a stone or stone in the urinary system, will not be eligible for reimbursement when reported with any orthopedic diagnosis.

Documentation and Reporting Guidelines for Adaptive Behavior Assessments and Treatments for Autism Spectrum Disorder

We are posting a new policy effective December 1, 2015 that outlines the Health Plan's documentation and reporting guidelines for adaptive behavior assessments and treatments for autism spectrum disorder.

Duplicate Reporting of Diagnostic Services

The Duplicate Reporting of Diagnostic Services policy is being updated December 1, 2015 to document our current edit that when one provider reports a global procedure and a different provider reports the same procedure with a professional (26) or technical (TC) component modifier for the same patient on the same date of service, the first charge approved by Empire will be eligible for reimbursement and subsequent charges processed will be considered duplicate services and will not be eligible for separate reimbursement. This information is also included in our Claim Editing Overview and Laboratory & Venipuncture reimbursement policies.

Frequency Editing

By definition, HCPCS codes S9123 (nursing care, in the home; by registered nurse, per hour) and/or S9124 (Nursing care, in the home; by licensed practical nurse, per hour) are reported on a once per hour basis. Since a day consists of 24 hours, the maximum number of reported hours/units would be 24 per date of service for a code that includes "per hour" in the definition. Therefore, for claims processed on or after November 16, 2015 we implemented a frequency maximum of 24 hours/units per date of service for HCPCS codes S9123 and/or S9124.

In addition, we added J2505 (injection, pegfilgrastim, 6 mg (Neulasta)) to our code table to support our current frequency limit of 1 per date of service.

Beginning with dates of service on or after March 1, 2016, we will apply a frequency limit of one unit per 60 days for CPT codes 11720 (Debridement of nail(s) by any method(s); 1 to 5) and/or 11721 (Debridement of nail(s) by any method(s); 6 or more). This frequency limit is in agreement with the Centers for Medicare & Medicaid Services (CMS) 60-day limitation for these codes. This edit will use claim lines processed in history that have previous, current, and subsequent dates of service to accumulate and apply this frequency limit.

Effective for dates of service on or after March 1, 2016, we are adding frequency limits to the drugs listed in the table below. These limits are based on FDA approval and/or manufacturers' dosage guidelines. Unless otherwise noted, these maximums are per date of service.

HCPCS Drug Codes	Description	Unit Frequency
J0129	Orencia, 10 mg	100 per date of service
J0585	Botox / Botox cosmetic, 1 unit	400 per date of service
J0586	Dysport, 5 units	200 per date of service
J0717	Cimzia, 1 mg	400 per date of service
J0897	Prolia/Xgeva, 1 mg	120 per date of service
J1453	Fosaprepitant (Emend), 1 mg	150 per date of service
J1750	Iron dextran, 50 mg	20 per date of service
J2353	Octreotide, depot form for intramuscular injection, (Sandostatin, depot) 1 mg	40 per date of service
J2357	Injection, omalizumab, 5 mg (Xolair)	90 per 14 days
J2469	Injection, palonosetron HCl, 25 mcg (Aloxi)	10 per date of service
J2507	Pegloticase (Krystexxa), 1 mg	8 per date of service
J3489	Zoledronic acid, 1 mg	5 per date of service
J7312	Dexamethasone, intravitreal implant (Ozurdex), 0.1 mg	14 per 90 days
J7325	Hyaluronan or derivative (Synvisc or Synvisc-One), 1	96 per date of service

HCPCS Drug Codes	Description	Unit Frequency
	mg	
J9031	BCG (intravesical) per instillation (Theracys/Tice Bcg)	1 per date of service
J9047	Carfilzomib (Kyprolis), 1 mg	60 per date of service
J9202	Goserelin acetate implant (Zoladex), per 3.6 mg	3 per date of service
J9217	Leuprolide acetate (for depot suspension), 7.5 mg (Lupron Depot, Eligard)	6 per date of service
J9395	Fulvestrant (Faslodex), 25 mg	20 per date of service

Modifier Rules

For claims processed on or after November 16, 2015, we implemented an edit that when orthotic and prosthetic items (HCPCS codes L0112-L9900) are reported with rental modifiers KI, KR, LL, NR, and RR, the items will be denied for invalid use of modifier. Because orthotic and prosthetic items are used only by the patient they are prescribed for and are not reusable by any other patient, these items are considered always purchased items and are not eligible for reimbursement when reported as rental items.

Once per Lifetime

We are posting a new policy effective for dates of service on or after December 1, 2015 that documents the Health Plan's once per lifetime procedures guidelines. Once per lifetime procedures are those procedures that may, clinically, anatomically, per code description, or based on coding instructions, be performed once per lifetime on an individual patient by a physician(s) or other qualified healthcare provider(s).

Place of Service

The Health Plan considers the provision of radiopharmaceuticals to be included under the facility's reimbursement as part of the technical portion of diagnostic imaging or treatment services when provided in a facility setting. Therefore, beginning with claims processed on or after November 16, 2015 when HCPCS code A9606 (radium RA-223 dichloride, therapeutic, per microcurie) is reported by a professional provider with a facility setting place of service, A9606 will not be eligible for reimbursement.

Significant Edits

We have updated our Significant Edits posting to reflect the 2015 analysis of claims data for significant edits. We define a significant edit as: A code pair edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial of payment for a particular CPT code or HCPCS code more than two-hundred and fifty (250) times per year in the Health Plan's service area.

System Updates for 2016

As a reminder, our ClaimsXten editing software package will be updated quarterly in February, May, August and November of 2016. These upgrades will:

- reflect the addition of new and revised CPT/HCPCS codes and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- include assistant surgeon eligibility in accordance with the policy
- include edits associated with reimbursement policies including, but not limited to, preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

Notice of reimbursement policy modifications due to these updates will continue to be published in the Empire Network Update and on empireblue.com.

Coding Tip: Radiation Treatment Delivery and IGRT

Effective January 1, 2015, the American Medical Association (AMA) with input from the American Society for Therapeutic Radiology and Oncology (ASTRO) released CPT code 77387 for guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed (IGRT). According to the CPT Radiation Management and Treatment Table, the professional component (modifier -26) of 77387 is not bundled into treatment delivery codes 77371, 77372, 77373, 77385, and 77386. Therefore, beginning with dates of service on or after January 1, 2016, the professional component of IGRT (77387) will be eligible for separate reimbursement when reported with treatment delivery codes 77371, 77372, 77373 (stereotactic radiation treatment delivery), 77385, and 77386 (intensity modulated radiation treatment delivery).

Correct Coding Reminder: Manifestation Diagnosis Codes

Per ICD-10 guidelines, a manifestation diagnosis code is not eligible as the only diagnosis billed on a claim or claim line (example: E13.39 - Other specified diabetes mellitus with other diabetic ophthalmic complication, should be the first/primary diagnosis code with manifestation diagnosis code H42 - Glaucoma in diseases classified elsewhere, reported as the 2nd diagnosis). When the only diagnosis on the claim line is a manifestation code the claim line will not be reimbursed due to correct coding guidelines

Correct Coding Reminder: Neonatal and/or Pediatric Critical or Intensive Care Per Day Codes

Per CPT guidelines, Neonatal or Pediatric Critical Care codes 99468-99476 and Initial and Continuing Intensive care codes 99477-99480 “may be reported by a single individual and only once per day, per patient in a given facility”.

Correct Coding Reminder: Oral Appliances E0485 and E0486

The code descriptions for HCPCS codes E0485 (oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment) and E0486 (Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment) include fitting and adjustment, which would require face-to-face contact with the patient. When a provider has not directly provided face-to-face fitting and adjustment services to the patient, E0485 and E0486 are not to be reported. The provider should report their provision of an oral appliance with the appropriate code that reflects the actual oral appliance provided.