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BRCA Testing & Myriad Genetic Laboratory Update for Empire HMO and POS Members

Effective February 1, 2017, Myriad Genetic Laboratories will no longer be an in-network laboratory for the following Empire BlueCross BlueShield (“Empire”) benefit plans:

- HMO (includes individual/group HMO and POS products, such as: HMO, Direct POS and DirectShare POS)
- Medicare Advantage HMO

As a result, Providers must start using alternate clinical networks for genetic laboratory services for their Empire HMO and POS patients by February 1, 2017. Using an in-network laboratory helps your patients ensure they are covered while maximizing their laboratory benefits and minimizing their out-of-pocket expenses.

LabCorp and Quest Diagnostics will continue as participating clinical genetic laboratory providers for Empire’s HMO and POS benefit plans.

- LabCorp’s BRCAssure® service provides a complete menu of BRCA genetic testing including:
  - Comprehensive BRCA1/2 analysis
  - Targeted BRCA1/2 mutation analysis
  - BRCA1/2 Ashkenazi Jewish profile

In addition, LabCorp’s team of genetic counselors are available to help your patients make informed healthcare decisions prior to testing, and to provide additional counseling when test results are received.

If you have specific questions regarding BRCA testing or other genetic testing performed by LabCorp, please contact LabCorp’s genetic coordinators at 800-345-4363. For general inquiries please call 1-888-LABCORP (522-2677) or visit www.LabCorp.com.

- Quest Diagnostics provides a complete menu of BRCA genetic testing, including:
  - GIVantage™ Hereditary Colon Cancer Panel
  - Qvantage™ Hereditary Women’s Health Cancer Panel
  - MYvantage™ Hereditary Comprehensive Cancer Panel

In addition to these more comprehensive panels, Quest Diagnostics offers a variety of more focused panels, including single gene assays allowing patients to customize their testing to meet specific patient needs. For help in selecting the most appropriate test or for assistance in interpreting results, please call a Quest Diagnostics genetic counselor at 866-GENE-INFO (866-4363-4636). For general inquiries in the Manhattan, Brooklyn and Staten Island area please call 1-800-631-1390, for all other locations call 1-800-631-1390 or visit www.QuestDiagnostics.com

A complete up-to-date list of in-network participating laboratories may be obtained online at empireblue.com > Providers & Facilities > Find a Doctor. It is important to check benefit plan details for coverage terms and conditions, including preauthorization requirements and coverage limits. If you or an Empire member you are treating have questions about coverage for genetic testing under the member’s benefit plan or this change, please contact the Member Services phone number on the back of the member ID card.
Reminder: Updated Fee Schedules for Commercial products

As communicated in the October edition of Network Update, effective January 1, 2017, Empire will update its HMO, EPO, PPO, and Indemnity fee schedules.

Although this update will result in an overall net increase of our physician network fees, the actual impact to any particular physician will depend on the codes most frequently billed by that physician.

Some highlights from the updated fee schedules are:
- Continued enhanced reimbursement of the Generic Chemotherapy In-office Drugs - J9000, J9045, J9070, J9190, J9206, J9250, J9260, J9265, J9360, J9370
- Increase in select E&M Codes – 99203, 99204, 99205, 99213, 99214, 99215

A sample fee schedule listing the most utilized codes will be available upon request.

You can request the information by:
- Email Empireps@empireblue.com
- Fax (888)-438-5205
- Phone (800)-552-6630 and follow the below prompts:
  - Option 1: Medical Providers
  - Option 4: Provider Updates and Other Information
  - Option 1: Participation and Credentialing Information
  - Enter your zip code

The complete updated fee schedule will be available on our Physician Online Services at empireblue.com upon their effective date of January 1, 2017.

Reminder: Individual and Small Group Fee Schedules for Commercial products

As communicated in the October edition of Network Update, effective January 1, 2017, Empire will be revising its fee schedules to support its individual and small group products, which are separate and apart from the HMO, PPO, EPO or Indemnity fee schedules. The below unilateral amendments vary based only on the provider's Network participation status as of January 1, 2017. Please review the applicable amendment which corresponds to your Network status as of January 1, 2017.

Please note that Empire is currently reassessing its Networks, and providers will receive a separate communication regarding any changes in their participation status, if applicable. Should you have any questions about your Network participation status or the applicable amendment, please contact your dedicated Network Management Consultant.

Pathway, Pathway Enhanced and Blue Priority Network Participating Providers
This unilateral amendment is applicable to Providers that as of January 1, 2017 are Network/Participating Providers in at least the following Networks: Pathway, Pathway Enhanced, and Blue Priority. Please click here to view the amendment.

Pathway and Pathway Enhanced Network Participating Providers but not in Blue Priority
This unilateral amendment is applicable to Providers that as of January 1, 2017 are Network/Participating Providers in at least the following Networks: Pathway and Pathway Enhanced; and are non-participating in the Blue Priority Network. Please click here to view the amendment.
Blue Priority Network Participating Providers but not in Pathway or Pathway Enhanced
This unilateral amendment is applicable to Providers that as of January 1, 2017 are Network/Participating Providers in at least the following Networks: Blue Priority, and are non-participating in the Pathway and Pathway Enhanced Networks. Please click here to view the amendment.

Again, should you have any questions about your Network participation status or the applicable amendment, please contact your dedicated Network Management Consultant.

Empire Professional Fee Schedule now available on the Availity Web Portal
Another new feature has been added to improve your experience on the Availity Web Portal. The new Professional Fee Schedule application is now available for Empire providers.

Use the Professional Fee Schedule application to retrieve contracted amounts for up to 50 procedure codes by taking just a few easy steps:
○ From the Availity Web Portal home page, select Payer Spaces; next choose Empire BlueCross BlueShield from the list of payer options. You’ll find the Professional Fee Schedule below the Applications tab.

Who has access to the Professional Fee Schedule application?
○ Your organization’s Availity Web Portal Administrator and Assistant have been granted automatic access to the Professional Fee Schedule application.
○ The Administrator and Assistant Administrator are responsible for assigning the Fee Schedule role to anyone else in your organization needing access.

Don’t know who your Availity Administrator is?
From the Availity home page select your Account and from the drop down menu choose “Who controls my access?” Your Administrator(s) will be listed along with their email address.

A new look is coming to provider communications
At Empire, we are committed to continuously improving the way we do business with our contracted provider community. In that respect, we have listened to your feedback and are pleased to announce that over the next few months a new look and feel is coming to Network Update and the Communications page on empireblue.com. The new design of Network Update will allow you to easily read and print individual articles that pertain to your practice.

While the Communications page may look a little different the next time you visit, we hope that the new design will allow you to more easily find the specific Empire communications that are important to you and your practice.

Empire ePASS® Weekly Webinars
This webinar provides a practical overview of how eligible providers can use the Electronic Patient Assessment Solution Suite (ePASS®) to access a supplemental clinical profile and complete a compliant medical SOAP Note for patients identified by Empire. (SOAP Note – or Subjective, Objective, Assessment, and Plan – is the standardized document format of a medical record.)

The webinar typically takes 30 minutes followed by time for questions.
Registration
We encourage you to register in advance by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend.

Webinar Dates
- Wednesday, December 7, 2016: 3:00 PM – 4:00 PM EST
- Wednesday, December 14, 2016: 3:00 PM – 4:00 PM EST
- Wednesday, December 21, 2016: 3:00 PM – 4:00 PM EST
- Wednesday, December 28, 2016: 3:00 PM – 4:00 PM EST

How to Join
The following information can be used to join all webinars scheduled in December 2016:
- Teleconference: Dial 1-888-850-4523 and enter access code: 108 607
- WebEx: Visit https://inovalon.webex.com and enter meeting number: 746 707 227
- Once you join the call, live support is available at any time by dialing *0

Medical chart reviews for members with plans on or off the exchange
Each year, Empire requests your assistance in our retrospective medical chart review programs. We continue to request members’ medical records to obtain information required by the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid Services (CMS).

We will continue our chart review program for those members who have purchased our individual and small group health insurance plans on or off the Health Insurance Marketplace (commonly referred to as the exchange). This particular effort is part of Empire’s compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased individual or small group health plans on or off the exchange. The members’ medical record documentation helps support this data requirement.

Empire engages Inovalon to conduct medical chart reviews for our exchange members
To assist with our ongoing medical chart review program for members enrolled in our individual and small group exchange plans, Empire is again collaborating with Inovalon – an independent company that provides secure, clinical documentation services – to contact providers on our behalf. Inovalon’s Web-based workflows help reduce time and improve efficiency and costs associated with record retrieval, coding and document management. Empire is working with Inovalon in retrieving and reviewing our members’ medical records.

Inovalon is using the following methods of collecting medical record information:
- Scanned or faxed medical records that providers’ offices send to Inovalon
- Onsite medical record reviews by trained clinical personnel
- Automated medical record retrieval using electronic health records (EHR) system interoperability through the provider’s EHR system

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon follows up with a phone call to request that the providers’ offices fax or mail the medical chart information. We ask that provider offices fax or mail the medical record information to Inovalon within 30 days.
In cases where Inovalon is requesting more than six medical records to review, an Inovalon reviewer calls the provider’s office and arranges a time convenient to visit the office onsite to collect the appropriate information. Before the onsite visit, Inovalon mails or faxes the provider’s office a letter to confirm the upcoming visit. The Inovalon medical record review
personnel coordinate all clinical facility communication, medical record data review scheduling, collection, and tracking – onsite or remotely.

To make it easier for providers, an automated, medical record data retrieval occurs through the provider’s EHR system. Upon receiving the provider group’s one-time authorization, Inovalon’s systems automatically retrieve targeted medical record data for quality and risk score accuracy from a centrally maintained repository from each EHR partner. The goal of this partnership is to both improve the medical record data extraction experience for Empire’s network-participating hospitals, clinics and physician offices. Empire and Inovalon are working together to identify facilities and providers’ offices for engagement.

**Appropriate coding helps provide comprehensive picture of patients’ health and services provided**

As the physician of our members who have health plans on and off the exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. When members visit your practice or office, we encourage you to document ALL of the members’ health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.

By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping Empire meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.

**Reminder about ICD-10 CM coding**

As you are aware, the ICD-10 CM coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, Empire uses ICD-10 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

We encourage you to follow the principles below for diagnostic coding to properly demonstrate medical necessity and complexity:

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.
- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider’s overall management or treatment of that patient in the remaining positions.

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

**Inovalon continues outreach efforts on Empire’s behalf to help identify members needing care**

At Empire, we are working to update health documentation for our members in the individual and small group markets who have purchased our health insurance plans on and off the exchange. Working with our providers, we engaged Inovalon to contact our members and encourage in-office visits with their physicians. Therefore, as a physician, you may receive letters throughout the year from Inovalon on our behalf. In 2017, we are continuing these efforts and want to help ensure you and your office staff are aware of these ongoing outreach efforts Inovalon is conducting on our behalf. The goal is to identify or help close gaps in care. We appreciate your cooperation should Inovalon contact your office or facility.
In the event our members do not visit their physicians, Inovalon also offers the option of a personal health visit that a medical professional from Inovalon conducts in members’ homes. The member may also opt to visit a retail clinic or other Inovalon location. We’ll continue to provide updates about the Inovalon engagement in upcoming editions of the Network Update.

If you have questions about the Inovalon effort and this ongoing outreach effort, we’ve compiled a list of questions and responses for your reference on empireblue.com.

**Reminder about completing SOAP Notes**

The SOAP Note – the standardized documentation format of a medical record – stands for Subjective, Objective, Assessment, and Plan. SOAP Notes are used with the Inovalon outreach efforts and are meant to be a supplement to providers’ usual documentation process. When submitting information to Inovalon, providers have the option of completing SOAP Notes electronically using Inovalon’s ePASS® Web-based tool or using a paper format. Here are some tips for completing SOAP Notes that we hope you find helpful.

- The exam date for the patient must match the exam date on the completed SOAP Note
- A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP Note
- The provider signature date should be the actual date the SOAP Note is signed
- All “mandatory” fields on the paper SOAP Note must be completed
- All “mandatory” fields on the paper SOAP Note must be completed to be eligible for incentive payment
- Incentives are only paid once for each patient for whom a health assessment was requested
- The exam date must always be in the current benefit year of when the member was targeted
  For example: A member targeted in 2016 must have an exam date in 2016. Also, all SOAP notes for 2016 must be submitted no later than February 15, 2017.

For additional information about SOAP notes, incentives, the medical record review process or the outreach effort, please refer to the frequently asked questions document available on empireblue.com

**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.

**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 www.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?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800-563-5909</td>
<td><a href="mailto:ECM-NY@Empireblue.com">ECM-NY@Empireblue.com</a></td>
<td>Monday–Friday, 8:30am to 9:00 pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saturday, 8:30am to 5:00pm</td>
</tr>
<tr>
<td>National (New York)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-855-239-0364</td>
<td></td>
<td>Monday – Friday, 8:00am to 8:00pm</td>
</tr>
<tr>
<td>Federal Employee Program</td>
<td>No email</td>
<td></td>
</tr>
<tr>
<td>800-711-2225</td>
<td></td>
<td>Monday – Friday, 8:00am to 7:00pm EST</td>
</tr>
</tbody>
</table>

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 the Provider website 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 Empire’s website at 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.

<table>
<thead>
<tr>
<th>To discuss UM Process and Authorizations</th>
<th>To Discuss Peer-to-Peer UM Denials w/Physicians</th>
<th>To Request UM Criteria</th>
<th>TTY/TDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-688-1019 Federal Employee</td>
<td>800-634-5605-Appeals Federal Employee</td>
<td></td>
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</tr>
</tbody>
</table>

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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.

Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

**HEDIS® 2016 Commercial Results Are In**

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) commercial data collection project for 2016. 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. The records that you provide to us directly affect the HEDIS results that are listed below.

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

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

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Further information regarding documentation guidelines can be found on empireblue.com > "Providers & Facilities" > Enter > Health and Wellness > Quality Improvement Standards > HEDIS > HEDIS 101 and HEDIS Physician Documentation Guidelines.

The following table shows some of our key measure rates across New York.
- Yellow boxes indicate rates that are above the national average.
- Bold indicates improvement in rate over the previous year.
- NA = Not Applicable - denominator too small
- Comprehensive Diabetes Care - Poor HbA1c Control (>9): Lower rate is good

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NY COMM HMO</th>
<th>NY COMM PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness of Care - Prevention and Screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>74.65</td>
<td>75.63</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Total</td>
<td>61.48</td>
<td>59.47</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition - Total</td>
<td>76.50</td>
<td>67.89</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity - Total</td>
<td><strong>68.58</strong></td>
<td>59.74</td>
</tr>
<tr>
<td>Childhood Immunization Status - Combo 2</td>
<td>78.51</td>
<td>69.83</td>
</tr>
<tr>
<td>Childhood Immunization Status - Combo 3</td>
<td>73.64</td>
<td>66.67</td>
</tr>
<tr>
<td>Childhood Immunization Status - Combo 10</td>
<td>42.98</td>
<td>38.44</td>
</tr>
<tr>
<td>Breast Cancer Screening Ages Total</td>
<td>68.71</td>
<td>68.64</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>52.76</td>
<td>60.39</td>
</tr>
<tr>
<td>Chlamydia Screening in Women – Total</td>
<td>56.31</td>
<td>62.15</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Respiratory Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Testing for Children With Pharyngitis</td>
<td>81.77</td>
<td>84.79</td>
</tr>
<tr>
<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td><strong>60.95</strong></td>
<td>58.09</td>
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<tr>
<td>Pharmacotherapy Management of COPD Exacerbation (Corticosteroid)</td>
<td>NA</td>
<td>79.50</td>
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<tr>
<td>Pharmacotherapy Management of COPD Exacerbation (Bronchodilator)</td>
<td>NA</td>
<td>82.61</td>
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<tr>
<td><strong>Effectiveness of Care - Cardiovascular</strong></td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>50.53</td>
<td>52.34</td>
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<tr>
<td>Persistence of Beta-Blocker Treatment after a Heart Attack</td>
<td>77.42</td>
<td>81.58</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Testing</td>
<td>87.69</td>
<td>91.48</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Poor HbA1c Control (&gt;9)*</td>
<td>31.16</td>
<td>30.17</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care HbA1c Good Control (&lt;8)</td>
<td>58.79</td>
<td>57.66</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exams</td>
<td>47.99</td>
<td>49.88</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Medical attention for nephropathy</td>
<td><strong>89.95</strong></td>
<td><strong>88.08</strong></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care Blood Pressure Control &lt;140/90</td>
<td>54.77</td>
<td>59.85</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Musculoskeletal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy</td>
<td><strong>80.80</strong></td>
<td><strong>86.78</strong></td>
</tr>
<tr>
<td>Imaging Studies for Low Back Pain</td>
<td>73.94</td>
<td>74.69</td>
</tr>
</tbody>
</table>
### Effectiveness of Care - Medication Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>HMO Rate</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td>82.43</td>
<td>84.56</td>
</tr>
</tbody>
</table>

### Access/Availability of Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>HMO Rate</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postpartum Care - Timeliness of Prenatal Care</td>
<td>88.46</td>
<td>89.55</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care - Postpartum Care</td>
<td>69.23</td>
<td>71.64</td>
</tr>
</tbody>
</table>

### Utilization and Relative Resource Use - Utilization

<table>
<thead>
<tr>
<th>Service Description</th>
<th>HMO Rate</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Child Visits in the First Fifteen Months of Life (6+ visits)</td>
<td>78.75</td>
<td>73.72</td>
</tr>
<tr>
<td>Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life</td>
<td>81.13</td>
<td>78.81</td>
</tr>
<tr>
<td>Adolescent Well Care Visits</td>
<td>58.59</td>
<td>51.66</td>
</tr>
</tbody>
</table>

In New York, many Commercial HMO and PPO rates improved and/or exceeded the national average.

#### Measures with rate increases that did not meet or exceed the National Average in the HMO line of business include:

- Weight Assessment & Counseling for Children/Adolescents – Counseling for Nutrition (3-11 yrs)
- Childhood Immunization Status – IPV, MMR, VZV, Pneumonia, Hep A, Combo 3, Combo 10
- Comprehensive Diabetes Care – Medical Attention for Nephropathy
- Disease Modifying Anti-Rheumatic Drug Therapy
- Metabolic Monitoring for Children & Adolescents on Antipsychotics (12-17 yrs)
- Adults’ Access to Preventive/Ambulatory Health Services – Total
- Children & Adolescents’ Access to PCP (12-24 months and 25 months – 6 yrs)

#### HMO Rates That Improved and Exceeded the National Average:

- Weight Assessment & Counseling for Children/Adolescents – Counseling for Physical Activity (Total)
- Childhood Immunization Status – Hep B, Influenza, Combo 2
- Antidepressant Medication Management – Effective Acute & Continuation Phases of Treatment
- Children & Adolescents’ Access to PCP (7-11 yrs)
- Initiation & Engagement of Alcohol & Other Drug Dependence Treatment – Initiation (Total)
- Adolescent Well-Care Visits

#### HMO Rates That Exceeded the National Average, but did not show improvement include:

- Weight Assessment & Counseling for Children/Adolescents – BMI (3-11 yrs)
- Immunizations for Adolescents – TDAP/Td
- Medication Management for People With Asthma (19-50 yrs) 75%
- Appropriate Treatment for Children with Upper Respiratory Infection
- Children & Adolescents’ Access to PCP (12-19 yrs)
- Well-Child Visits in the Third, Fourth, Fifth & Sixth Year of Life

#### HMO Measures that had rate decreases and have opportunities for improvement include:

- Adult BMI Assessment
- Weight Assessment/Counseling – BMI Total
- Weight Assessment/Counseling – Nutrition and Physical Activity Counseling (12-17 yrs)
- Human Papillomavirus Vaccine for Female Adolescents
- Cervical and Colorectal Cancer Screening
- Chlamydia Screening in Women – (16-20 yrs)
- Medication Management for People with Asthma
- Controlling High Blood Pressure
Measures with rate increases that did not meet or exceed the National Average in the PPO line of business include:
- Childhood Immunization Status – MMR, VZV
- Breast Cancer Screening
- Medication Management for People with Asthma
- Disease Modifying Anti-Rheumatic Drug Therapy
- FU Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phases
- Use of Multiple Concurrent Antipsychotics in Children & Adolescents Total
- Adults' Access to Preventive/Ambulatory Health Services Total

PPO Rates That Improved and Exceeded the National Average:
- Childhood Immunization Status – IPV, HIB, Hep B
- Human Papillomavirus Vaccine for Female Adolescents
- Colorectal Cancer Screening
- Chlamydia Screening in Women - Total
- Appropriate Testing for Children with Pharyngitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation (Corticosteroid & Bronchodilator)
- Comprehensive Diabetes Care – HbA1c Testing & Medical Attention for Nephropathy
- Follow Up After Hospitalization for Mental Illness (7 & 30 days)
- Metabolic Monitoring for Children & Adolescents on Antipsychotics
- Annual Monitoring for Patient on Persistent Medications Total
- Appropriate Treatment for Children with Upper Respiratory Infection
- Children’s and Adolescents’ Access to PCP
- Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (6-11 yrs)
- Well-Child Visits in the Third, Fourth, Fifth & Sixth Year of Life
- Adolescent Well-Care Visits

PPO Rates That Exceeded the National Average, but did not show improvement include:
- Adult BMI Assessment
- Weight Assessment & Counseling for Children & Adolescents – BMI, Nutrition & Physical Activity Total
- Childhood Immunization Status – DTAP, Pneumonia, Rotavirus, Combo 2
- Immunizations for Adolescents – Meningitis, TDAP/TD, Combo 1
- Cervical Cancer Screening
- BP Control <140/90
- Antidepressant Medication Management – Effective Acute & Continuation Phase Treatment

PPO Measures with rate decreases and have opportunities for improvement include:
- Adult BMI Assessment
- Weight Assessment and Counseling for Children/Adolescents – BMI & Physical Activity (12-17 yrs)
- Weight Assessment and Counseling for Children/Adolescents – Nutrition Counseling (3-11 yrs)
- Childhood Immunization Status – DTAP, PCV, Hep A, Rotavirus, Influenza, Combo 3, Combo 10
Immunizations for Adolescents – Meningitis, TDAP/TD, Combo 1

Controlling High BP

Comprehensive Diabetes Care - Poor HbA1c Control (>9) & HbA1c Good Control (<8)

Comprehensive Diabetes Care – Blood Pressure Control <140/90

Annual Monitoring Persistent Medications - Digoxin

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (13-17 yrs)

Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (12-17 yrs)

The HMO line of business noted significant rate improvements in several measures including Antidepressant Medication Management – Acute Phase (+8.34%) and Continuation Phase (+40.28%). There were improvements in all of the Childhood Immunization Status measures except HIB and Rotavirus, with the most significant improvements in Combo 2 (+12.85%), Combo 3 (+14.83%), and Combo 10 (+10.86%). Comprehensive Diabetes Care – Medical Attention for Nephropathy showed a significant improvement of 10.35%, as did Initiation of Alcohol and Other Drug Dependence Treatments for age 18+ (+9.15%).

The PPO line of business also experienced rate improvements in several measures including Childhood Immunization Status – MMR (+3.11%), HIB (+1.92%), Hep B (+1.12%), VZV (+2.85%) and Human Papillomavirus Vaccine for Female Adolescents (+31.91%). Colorectal Cancer Screening improved 11.30% along with Comprehensive Diabetes Care – HbA1c Testing (+6.21%) and Medical Attention for Nephropathy (+13.84%). Improvement was also noted in the behavioral health categories including Metabolic Monitoring for Children and Adolescents on Antipsychotics-Total (+7.80%), Use of Multiple Concurrent Antipsychotics in Children & Adolescents-Total (+153.03%), Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics-6-11 yrs (+63.39%) and Follow Up After Hospitalization for Mental Illness-7 days (+7.43%).

The HMO line of business also experienced significant rate decreases in several measures. Weight Assessment & Counseling for BMI for 3-11 year olds had a decrease of 5.86%, while counseling for BMI for 12-17 year olds decreased 28.38%, and the overall average dropped 16.60%. Counseling for nutrition for 12-17 year olds declined 9.39%, and counseling for physical activity in 12-17 year olds also decreased 7.93%. In addition, rates for preventive measures declined – Breast Cancer Screening (-3.93%), Cervical Cancer Screening (-9.30%), and Colorectal Cancer Screening (-23.38%). Follow Up after Hospitalization for Mental Illness-7 days decreased 20.91%, and follow up at 30 days dropped 16.37%. In addition, other substantial rate decreases were noted in Controlling High Blood Pressure (-23.08%), Timeliness of Prenatal Care (-7.85%), Postpartum Care (-15.16%), Comprehensive Diabetes Care – HbA1c control <8 (-10.18%), Eye Exams (-19.17%) and BP Control <140/90 (-22.91%). Significant rate decreases were also seen in Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (-22.57%), and for Engagement of Alcohol and Other Drug Dependence Treatments-combined ages (-11.23%).

PPO rates declined in several measures including Weight Assessment and Counseling for BMI-Total decreased 7.41%, counseling for nutrition decreased 8.52% and counseling for physical activity decreased by 8.72%. Decreased rates were also seen in the childhood immunization statuses including Influenza (-5.70%), Combo 2 (-5.90%), Combo 3 (-5.83%), Combo 10 (-14.14%), and in Immunizations for Adolescents including Meningitis (-7.43%) and Combo 1 (-5.86%). The rate for Controlling High Blood Pressure dropped 17.26%, and Comprehensive Diabetes Care-Blood Pressure Control <140/90 decreased 11.20%. In addition, declines were seen in Annual Monitoring of Persistent Medications – Digoxin (-14.34%), Initiation and Engagement of Alcohol and Other Drug Dependence Treatments in 13-17 year olds (-7.15%), and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – ages 12-17 (-14.91%).

The rate decreases may, in part, be related to changes in some of the technical specifications and our inability to rotate any measures this year. In addition, there was a significant decrease in the number of records received from provider’s offices.
this year and it may have had a significant impact on our rates. Without your records, we have no way of substantiating that appropriate care was provided. Your input is very important and plays an integral role in determining our rates.

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 again next HEDIS season.

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

Products & Programs

Important Update: Delay of the transition of NOC oncology and biologic drugs to pre-service clinical review

Empire in partnership with AIM Specialty Health (“AIM”) planned an expansion of Pre-service Review to the medical necessity of coverage requests for all not otherwise classified “NOC” oncology and biologic drugs starting November 1, 2016. Empire is delaying this transition to pre-service review by AIM until further notice. Any medical necessity review of NOC oncolytic and biologic drugs will continue to be reviewed by Empire as they are today.

Empire will be expanding the Specialty Pharmacy Prior Authorization list

Listed below are specialty pharmacy codes from new or current Clinical UM Guidelines that will be added to our existing pre-service review process effective March 1, 2017.

Prior Authorization clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM®), a separate company administering the program on behalf of Empire.

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline number</th>
<th>DRUG code</th>
<th>Drug Names</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>J3590</td>
<td>Erelzi</td>
<td>New drug to existing Medical Policy</td>
</tr>
<tr>
<td>DRUG.00081</td>
<td>J3490, J3590</td>
<td>Exondys</td>
<td>New Medical Policy</td>
</tr>
</tbody>
</table>

Empire will be expanding the Specialty Pharmacy Level of Care Medication list.

Listed below are the specialty pharmacy codes from our new or current Medical Policies and Clinical UM Guidelines that will be added to our existing Level of Care review process using CG-DRUG-47 effective April 24, 2017.

Level of care pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health, (AIM), a separate company administering the program on behalf of Empire.
For more information, including a list of drugs that are reviewed for level of care, go to www.aimprovider.com/specialtyrx. You may also view our list of frequently asked questions at empireblue.com.

<table>
<thead>
<tr>
<th>Medical Policy</th>
<th>Drug Name(s)</th>
<th>Drug Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>Inflectra</td>
<td>Q5102</td>
</tr>
<tr>
<td>DRUG.00084</td>
<td>Actimmune</td>
<td>J9216</td>
</tr>
<tr>
<td>DRUG.00086</td>
<td>Increlex</td>
<td>J2170</td>
</tr>
<tr>
<td>CG-DRUG-43</td>
<td>Tysabri</td>
<td>J2323</td>
</tr>
</tbody>
</table>

#### Empire Tightens Prescription Refill Timing

In an effort to reduce medication waste and encourage medication dosage compliance, Empire is updating the system logic that determines the date on which a member can refill a prescription. This change will require members to refill their prescriptions closer to when their current supply ends; however, members should still have enough medication supply on hand to last until their next refill is allowed.

As always, it is important to prescribe medications with the appropriate quantity and directions so that the member has enough medication to last for the duration of each prescription fill. To provide clarity for the patient and the pharmacy, prescribers can take the following steps:

- If the dosage of a medication has changed since the initial prescription was written, a new prescription should be written for the patient, with the new directions clearly indicated.
- For as directed or as needed (PRN) prescriptions, try to be as clear as possible on your intentions for how long a prescription should last. For example, consider providing explicit directions such as: Use as directed for 15 days, or Take as needed for 30 days.
- Prescriptions for oral contraceptives should clearly indicate when a member is not taking the inactive tablets. The table below includes examples of how prescriptions for oral contraceptives should be written:

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 (1 pack)</td>
<td>If patient only taking active tabs, directions should be: 1 tab daily x 21 days, skip the last week and start new packet on day 22.</td>
</tr>
<tr>
<td>84 (3 packs)</td>
<td>If patient only taking active tabs, directions should be: 1 tab daily x 21 days, skip the last week and start new packet on day 22.</td>
</tr>
<tr>
<td>21 (1 pack)</td>
<td>1 tab daily</td>
</tr>
<tr>
<td>63 (3 packs)</td>
<td>1 tab daily</td>
</tr>
<tr>
<td>28 (1 pack)</td>
<td>If patient taking all tabs, directions should be: 1 tab daily x 28 days.</td>
</tr>
<tr>
<td>84 (3 packs)</td>
<td>If patient taking all tabs, directions should be: 1 tab daily x 28 days.</td>
</tr>
</tbody>
</table>

1 The new system logic for NY large groups and small groups requires that members use at least 75% of a prescription dispensed by Home Delivery (mail order) and 75% of a prescription dispensed by a retail pharmacy before a refill of the same medication is allowed.

2 Examples are for illustrative purposes only. The prescriber must determine which directions are most appropriate for the medication prescribed.
A better way to manage specialty drugs

As specialty drugs become more widely used, Empire is improving efficiency, access and costs while keeping members healthy. That’s why we created our Right Drug Right Channel (RDRC) program.

Our Right Drug Right Channel programs ensure:
- Better medication management - Members are reminded about refills and have access to support programs through the specialty pharmacy provider.
- Better cost management - By placing drugs under the appropriate benefit.
- Simplify access to medications - RDRC simplifies which benefit the drug falls under based on how the medication is administered.

Providers need to know certain self-administered medications will now be covered under the member’s pharmacy benefit and certain clinician administered medications will be covered under the member’s medical benefit. Providers can view the RDRC drug lists on anthem.com/pharmacyinformation.

If a member believes this change poses a hardship for them, he or she and/or the member’s doctor can ask us to keep covering the drug(s) under the member’s pharmacy benefit by submitting a request for an exception by calling us at the number on the member’s ID card.

Immunoglobulin Preferred Products

Empire has reviewed the immunoglobulin products through the P&T process and has selected two preferred drugs: Gamunex-C® and Octagam®. When prescribing these products, please consider the preferred drugs for initial therapy.

<table>
<thead>
<tr>
<th>Preferred Product</th>
<th>Non Preferred Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gamunex C®</td>
<td>Gammagard ®</td>
</tr>
<tr>
<td>Octagam®</td>
<td>Privigen®</td>
</tr>
</tbody>
</table>

Botulinum Toxin Agents Preferred Products

Empire has reviewed the botulinum toxin agents and has selected Xeomin® as the preferred agent. When prescribing a botulinum toxin, please consider Xeomin® for initial therapy.

<table>
<thead>
<tr>
<th>Product</th>
<th>Empire Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xeomin®</td>
<td>Preferred</td>
</tr>
<tr>
<td>Botox®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Myobloc®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Dysport®</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

*Preferred product for the following medical indications: upper limb spasticity, cervical dystonia and blepharospasm.
Hyaluronic Acid Preferred Products

Empire has reviewed the hyaluronic acid agents through the P&T process and has selected four preferred drugs: Synvisc-One®, Synvisc®, Monovisc® and Orthovisc®. Beginning September 1, 2016, an edit is in place requiring one of the preferred drugs below to be tried before a non-preferred drug. When prescribing these products, please consider the preferred agents below for patients needing hyaluronic acid therapy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Weekly Injections</th>
<th>Empire Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synvisc-One®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Synvisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Monovisc®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Orthovisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Euflexxa®</td>
<td>3</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Gel-One®</td>
<td>1</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Hyalgan®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Supartz®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

Report HCPCS code C9257 for Avastin Intravitreal Injection

Empire will now accept HCPCS code C9257 for physician reporting of Avastin for intravitreal injection. Physicians should no longer report codes J3490, J3590, J9035, or J9999 for Avastin used in intravitreal injections.

Empire has established a reimbursement allowance for code C9257, and will allow a maximum of 5 units per injection. Use of code C9257 will ensure that the appropriate reimbursement for this specific treatment is made. This reporting and reimbursement change impacts commercial Empire members only.

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;

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.
Important information about billing habilitative and rehabilitative services

In compliance with requirements of the Notice of Benefit and Payment Parameters for 2016 issued pursuant to the Affordable Care Act, Empire will apply separate and distinct benefit limits for habilitative and rehabilitative services for all individual and small group On-Exchange and Off-Exchange health plans beginning with dates of service on and after January 1, 2017. This means these plans will no longer have a combined visit limit for habilitative and rehabilitative services. Habilitative services help a person keep, learn, or improve skills and functioning for daily living which have not (but normally would have) developed. Rehabilitative services help a person keep, restore, or improve skills and functioning for daily living which have been lost or impaired after an illness or injury, such as a car accident or stroke.

Beginning with dates of service on and after January 1, 2017, the appropriate use of the modifier SZ is necessary when billing habilitative services to Empire. The SZ modifier was effective in 2014 and distinguishes between habilitative and rehabilitative services. Appropriate use of the modifier will help reduce claims issues and adjustments related to habilitative services.

Please review your current coding practices as it relates to the use of modifier SZ and the billing of habilitative and rehabilitative services.

Tips for Billing CPT Modifier 33

The modifier 33 was created to aid compliance with the Affordable Care Act (ACA) which prohibits member cost sharing for defined preventive services for non-grandfathered health plans. The appropriate use of modifier 33 reduces claim adjustments related to preventive services and your corresponding refunds to members.

Modifier 33 is applicable to CPT codes representing preventive care services. CPT codes not appended with modifier 33 will process under the member’s medical or preventive benefits, based on the diagnosis and CPT codes submitted.

Modifier 33 should be appended to codes represented for services described in the US Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) Guidelines.

The CPT® 2016 Professional Edition manual shares the following information regarding the billing of modifier 33, “When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.”

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. 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, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange Information.
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 provider network representative.

HEDIS Spotlight: Respiratory Conditions

Asthma and Chronic Obstructive Pulmonary Disease (COPD) are major causes of morbidity, mortality, lower quality of life, and lost productivity including missed days from school or work. According to the Centers for Disease Control, 1 in 14 people have asthma or about 24 million Americans (roughly 7.4% of adults and 8.6% of children). Asthma causes almost 2 million emergency room visits each year; more than 14 million doctor visits; and 439,000 hospital stays. More than half of children and one-third of adults missed school or work due to their asthma. Each day, ten Americans die from asthma.¹ Many of these deaths are avoidable with proper treatment and care.

Since medication is vital to controlling asthma exacerbations, the National Commission for Quality Assurance (NCQA) requires health plans to review claims for medication management among members with persistent asthma, and contributes to health plan Accreditation levels and the Quality Rating System (QRS) measurement weight for Marketplace plans. The three measures are:

- Use of Appropriate Medications for People with Asthma (ASM): The percentage of members 5-85 years of age who were identified as having persistent asthma and who were appropriately prescribed medication.
- Medication Management for People with Asthma (MMA): The percentage of members 5-85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:
  - The percentage of members who remained on asthma controller medication for at least 50% of their treatment period.
  - The percentage of members who remained on asthma controller medication for at least 75% of their treatment period.
- Asthma Medication Ratio (AMR): The percentage of members 5-85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of .50 or greater.

COPD can also be managed by medication. However, it is important to distinguish diagnosis between asthma and COPD because of the differences in treatment, disease progression, and outcomes. According to the American Lung Association, COPD cost the U.S. $49.9 billion in 2010. Of that, $29.5 billion was spent on direct healthcare costs, $8 billion from indirect morbidity costs, and $12.4 were indirect mortality costs.² COPD is often misdiagnosed or undiagnosed until later in the disease. Almost 15.7 million Americans (6.4%) reported that they have been diagnosed with COPD. More than 50% of adults with low pulmonary function were not aware that they had COPD.³ In 2014, COPD was the third leading cause of death.

death in the U.S. Establishing a diagnosis of COPD requires spirometry testing, interpreted in the context of the patient's symptoms, smoking status, age, and comorbidities.4

The HEDIS measures related to COPD are:
- Use of Spirometry testing in the Assessment and diagnosis of COPD (SPR): The percentage of members 40 years of age and older with a new diagnosis of COPD, or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
- Pharmacotherapy Management of COPD Exacerbation (PCE): The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit and who were dispensed appropriate medications. Two rates are reported:
  - Dispensed a systemic corticosteroid (or evidence of an active prescription) within 14 days of the event.
  - Dispensed a bronchodilator (or evidence of an active prescription) within 30 days of the event.

Empire is helping
A consolidated Medication Review note may be sent to members and their providers when the following criteria are met:
- Member is less than 80% compliant on their asthma controller medication
- Member shows high utilization of short-acting beta agonist medication and not on an asthma controller (inhaled corticosteroid)
- Member has claim(s) for COPD medications including Atrovent, instead of more effective therapy (Spiriva)

What can you do?
- Use spirometry to diagnose and monitor treatment efficacy.
- Adopt a Patient Centered Planned Visit Model. Provide ongoing follow-up and care plans for patients throughout the year. Use every patient engagement/acute appointment to discuss concerns, compliance, and closing gaps in care.
- Educate your patients about their disease, possible consequences to their health and quality of life.
- Remind patients to take and refill controller medications. Discuss patient concerns that might interfere with adherence. Provide simple written instructions that are appropriate both culturally and in literacy level.
- Review proper inhaler use at each visit, encouraging patients to demonstrate. Work with your patients who have asthma to have a current written action plan and to use a peak flow meter to monitor control. Discuss patient's triggers and ways to avoid exposure to triggers.
- Code and document visits accurately.

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 Policy Effective 10-06-2016
- DRUG.00081 - Eteplirsen (Exondys 51™)

Revised Medical Policy Effective 10-04-2016
(The following policy was revised and had no significant changes to the policy position or criteria.)
- SURG.00055 - Cervical Total Disc Arthroplasty

Coding Updates

As a result of coding updates in the claims system, the claim system edits for the policy listed below will be revised. This will result in the review of claims for certain diagnoses before processing occurs to determine whether the service meets medical necessity criteria. As a result, these coding updates may result in a not medically necessary and/or investigational determination.

Effective March 18, 2017, we will be implementing coding updates in the claims system for the following policy listed below which may result in investigational/not medically necessary determinations for certain services.
- SURG.00023 - Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures

Review medical policy and clinical guidelines when referring services to a facility

In our December of 2010 Network Update, we reminded that you should review Empire’s on-line medical policies and clinical guidelines when referring members for services at a facility that are considered not medically necessary or investigational. Services which are determined to be not medically necessary are the liability of the rendering provider pursuant to Empire’s participating provider agreements unless a waiver is signed by the member satisfying certain criteria.
Effective March 18, 2017, we will be implementing coding updates in the claims system for the following policy and clinical guideline listed below which may result in investigational/not medically necessary determinations for certain services.

ANC.00007 - Cosmetic and Reconstructive Services: Skin Related
CG-SURG-12 - Penile Prosthesis Implantation

As a reminder, Empire’s medical policies and clinical guidelines are available online at empireblue.com. You may search by procedure code, diagnosis code, clinical guideline or medical policy number or name. Please be sure to review medical policy and clinical guidelines when referring services to a facility to ensure services are consistent with medical policy.

Update to Claims Processing Edits and Reimbursement Policies

Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU

Beginning with dates of service on or after March 1, 2017, we will be implementing the following code pair edits and have documented these edits in our future Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU reimbursement policies:

- CPT code 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar) will not be eligible for separate reimbursement when reported with CPT code 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Modifiers will not override this edit.
- CPT code 22614 (arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)) will not be eligible for separate reimbursement when reported with CPT codes 22600 (arthrodesis, posterior or posterolateral technique, single level; cervical below c2 segment), 22610 (arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)), 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)), 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar), and 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Modifiers will not override this edit.
- CPT codes 63081, 63082, 63085, 63086, 68087, and 63088 (vertebral corpectomies) will not be eligible for separate reimbursement when reported with CPT code 22558 (arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar). Modifiers will not override this edit.
- CPT code 82542 (column chromatography, includes mass spectrometry, if performed, non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen) will not be eligible for separate reimbursement when reported with CPT code 91065 (breath hydrogen or methane test). Modifiers will not override this edit.
- The Health Plan considers cervical and vaginal cytopathology to be incidental to evaluation and management (E/M) services. We currently deny CPT codes 88141-88155, 88165-88167, and 88174-88175 as incidental to preventive and problem oriented E/M services identified by such CPT codes as 99381-99397 and 99201-99215 when reported by the same provider for the same patient on the same date of service. Based on our current edit, we are adding HCPCS codes G0101, G0402, G0438, G0439, S0610 and S0612 (screening exams, preventive exams, and wellness exams) as additional support codes that cervical and vaginal cytopathology will not be eligible for separate reimbursement; modifiers will not override the edit.
- Taking guidance from the February 2016 CPT Assistant which states that train-of-four monitoring is bundled with the intraoperative neuromonitoring and should not be separately reported, we are adding an edit that CPT code 95937
(neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method) will not be eligible for separate reimbursement when reported with CPT codes 95940 (continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes), 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 room, per hour), and G0453 (continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes); modifiers will not over these edits.

Our current edit denies 76942 (ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental when reported with 76882 (ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific). Based on our interpretation of CPT guidelines that state “Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized. Use of ultrasound, without thorough evaluation of organ(s), or anatomic region, image documentation, and final, written report, is not separately reportable” we are updating our edit and will deny 76882 when reported with 76942; modifiers will not override the edit.

Claims Requiring Additional Documentation
There may be times when the Health Plan conducts claim reviews or audits either on a prepayment or post payment basis and the Health Plan or its designee may request documentation, most commonly in the form of patient medical records. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the patient’s plan of treatment or to confirm that charges were accurately reported in compliance with the Health Plan’s policies and procedures as well as general industry standard guidelines and regulations.

Effective for claims with dates of service on or after March 1, 2017, the Health Plan will have a new professional reimbursement policy titled Claims Requiring Additional Documentation. This policy documents the Health Plan’s guidelines for claims requiring additional documentation and the professional provider’s compliance for the provision of requested documentation. Please refer to the policy for further details.

Durable Medical Equipment
For claims processed on or after November 21, 2016, we updated our policy to reflect that the Health Plan will allow rental of two units per month for durable medical equipment (DME) that requires a back-up unit. These include items such as E0465 (home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)) and E0466 (home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)).

Frequency Editing
Based on changes in vial size available for J9047 (injection, Carfilzomib, 1 mg (Kypolis)), we have updated our maximum dosage amount to 150 units. This update will apply to claims with dates of service on or after July 15, 2016.

We currently apply a frequency limit of one unit per date of service to CPT code 91065 (hydrogen or methane breath test). We consider this one test per challenge regardless of the number of samples collected; therefore, beginning with claims processed on or after November 21, 2016, modifiers will not override the frequency limit for CPT code 91065.

The Health Plan does not consider more than one unit to be applicable to HCPCS codes S9140 (diabetic management program follow-up visit non-MD provider) and S9141 (diabetic management program follow-up visit MD provider); therefore, beginning with dates of service on or after January 1, 2017, we will be applying a frequency limit of one per date of service; modifiers will not override this frequency limit.
Beginning with dates of service on or after March 1, 2017, we will be implementing the following frequency limits:

- The Health Plan considers HCPCS code(s) H0020 (alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)) and H0022 (alcohol and/or drug intervention service (planned facilitation)) to be “per day” services. Therefore, we will apply a frequency limit of one per date of service to HCPCS codes H0020 and H0022; modifiers will not override the frequency limit.
- The Health Plan will apply a frequency limit of one per date of service to CPT code 49185 (sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed). This limit is based on the Health Plan’s interpretation of CPT parenthetical instruction and the March 2016 CPT® Assistant Q&A which state “49185 may only be reported once per day for the treatment of multiple interconnected lesions via single access.” Modifiers will not override the frequency limit.
- Based on Center for Disease Control and Prevention (CDC) recommendation, we will apply a frequency limit of three per date of service to CPT codes 87491 (Chlamydia trachomatis, amplified probe technique) and 87591 (Neisseria gonorrhoeae, amplified probe technique).

Global Surgery and Modifier Rules
Taking guidance from the Centers for Medicare and Medicaid Services, beginning with dates of service on or after October 1, 2016, when modifier 55 (postoperative management only) is appended to a surgical procedure with zero post-operative days, the procedure will not be eligible for reimbursement.

Moderate (Conscious) Sedation, Bundled Services and Supplies, and Modifiers 59, XE, XP, XS, and XU
For dates of service on or after January 1, 2017, we will continue with the concept that moderate (conscious) sedation, identified by new CPT codes 99151, 99152, 99153, 99155, 99156, and 99157, is included with the reimbursement for certain Health Plan designated surgical, diagnostic, or therapeutic procedures and such sedation is not eligible for separate reimbursement when reported by the physician or other qualified health care professional performing one of the designated procedures. These designated procedures were previously listed in the deleted CPT Appendix G and are now identified in our “Codes that Include Moderate (Conscious) Sedation” list. Modifiers will not override the edits.

Modifiers 59, XE, XP, XS, and XU
Beginning with dates of service on or after March 1, 2017, modifiers will no longer override the following edits:

- Our current edit denies 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)) when reported with 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Based on CPT instruction that states to not report 22633 with 22612, modifiers will no longer override the edit.
- Our current edit denies 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure) when reported with 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar). The Health Plan considers this correct coding therefore modifiers will not override the denial.
- Our current edit denies CPT code 76942 (ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental to 76881 (ultrasound, extremity, nonvascular, real-time with image documentation; complete). We consider this to be correct coding therefore modifiers will not override the denial.
- We have a current edit that denies CPT code 42950 (pharyngoplasty (plastic or reconstructive operation on pharynx) as mutually exclusive to CPT code 15757 (free skin flap with microvascular anastomosis), when a free flap...
is used to reconstruct both a neck and tongue defect (after laryngectomy or glossectomy). We consider this to be correct coding therefore modifiers will not override the edit.

- Our edit denies CPT code 27275 (manipulation, hip joint, requiring general anesthesia) as incidental to procedures 27093 (injection procedure for hip arthrography; without anesthesia) and 27095 (injection procedure for hip arthrography; with anesthesia). We consider this correct coding therefore modifiers will not override the edits.

**Multiple Diagnostic Cardiovascular Procedures**
We are adding information to section B of our policy that our multiple diagnostic cardiovascular reimbursement rules are not applicable to procedures for which there are no RVUs assigned to the technical component of a code.

**Prolonged Services**
We have updated our Prolonged Services Diagnosis Coding list to include additional ICD-10-CM diagnosis codes that were effective October 1, 2016 and for which prolonged services are allowed-- E083211, E083212, E083213, E083219, E083311, E083312, E083313, E083319, E083411, E083412, E083413, E083419, I16, I160, I161, I169, O115, O165. In addition, we have removed the ICD-9-CM diagnosis codes, which are no longer valid for dates of service on or after October 1, 2015.

**Sleep Studies and Related Services & Supplies and Frequency Editing**
In our June 2016 Provider Network Update, we advised we would be implementing a one (1) per 60 days frequency limit to attended sleep studies represented by CPT codes 95807, 95808, 95810, 95811, 95782, and/or 95783 for dates of service on or after September 1, 2016. Upon further review, we have reconsidered our position and have removed this edit for dates of service on or after September 1, 2016.

**Telehealth and Modifier Rules**
We are updating our policies to reflect the addition of CPT modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system). Modifier 95 is effective January 1, 2017 and is an informational modifier to be used to identify services provided via telehealth for those codes that do not include telehealth in their description.

**Unit Frequency Maximums for Drugs and Biologic Substances**
We are adding information to our policy to document that modifiers will not override our unit frequency maximums for drugs and biologic substances.

**Review of reimbursement policies**
The following professional reimbursement policies received an annual review and may have word changes or clarifications however they do not have significant changes to the policy position or criteria:
- Co-Surgeon/Team Surgeon Services
- Documentation Guidelines for Adaptive Behavior Assessments and Treatment for Autism Spectrum Disorder
- Documentation Guidelines for Central Nervous System Assessments and Tests
- Documentation and Reporting Guidelines for Consultations
- Duplicate Reporting of Diagnostic Services Injectable Substances with Related Injection Services
- Multiple Diagnostic Imaging Procedures
- Once per Lifetime Procedures
- Physical and Manipulative Maintenance Services
- “Rule of Eight” Reporting Guidelines for Physical Medicine and Rehabilitation Services
- Three Dimensional Rendering of Imaging Studies
System Updates for 2017
As a reminder, our ClaimsXten (or other proprietary) editing software package will be updated quarterly in February, May, August and November of 2017. 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 Network Update and on Empire Provider Online Services.

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State & Federal updates

Attend December webinar to learn how to complete OptiNet assessments

All participating Medicare Advantage providers who provide imaging services must complete registration for AIM’s online registration tool, OptiNet. OptiNet will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services. Areas of assessment include facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

These data will be used to calculate site scores for providers who render imaging services for our individual Medicare Advantage members.

All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey by Jan. 1, 2017 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. This includes providers who have delegated risk arrangements and who may see Empire members outside of those risk arrangements.

Participating providers who have already completed the survey but scored less than 76 can use the online registration at any time to update their information and improve their score. All providers, including those who score less than 76, will receive individualized information they can use to improve their score.

Act now to avoid line-item claims denials

Providers are strongly encouraged to register and improve their scores as needed before the line-item denials for claims submitted for dates of service on or after Jan. 1, 2017 begins. Facilities billing on a UB-04 claim form will be excluded from line item denials at this time.

The provider registration is available online at www.aimspecialtyhealth.com/goweb.

- Select Empire MA from the drop down menu
- Only those providers who have completed the provider registration will be able to view their information online
- If you have questions or need help completing the registration, please call AIM Customer Service at 800-252-2021
To learn how to complete your survey, attend a webinar and find out how to:

- Access the OptiNet Assessment.
- Copy previously completed OptiNet Assessments to your Empire Medicare Advantage account.
- Complete a new AIM OptiNet registration.
- Interpret and improve your site score.

Choose one of the webinar sessions below to register:
If you would like an invite for this webinar sent to your calendar please contact ronald.younger@anthem.com.

Dec. 7, 2016, 4-5 p.m. ET
Dial 866-308-0254
Pass code 804 205 7402#
Smart Phone 1-Click Dial 866-308-0254, 8042057402#

Additional information is available at empireblue.com/medicareprovider under Important Medicare Advantage Updates.

Cardioverter Defibrillators -- confirm if authorization required for implants

When obtaining an authorization for a surgery that involves an implant, you must check the associated implant codes to determine if an authorization is also needed for the implant.

2017 Medicare Advantage individual benefits and formularies available

Summary of benefits, evidence of coverage and formularies for 2017 Individual Medicare Advantage plans can be found at empireblue.com/medicareprovider. A few notable benefit changes for 2017 are listed below. An overview of additional 2017 benefit changes will be available at empireblue.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at empireblue.com/medicareprovider for the latest Medicare Advantage information.

- Application of Copayments
  When member cost share is a copayment amount, members will be responsible for a copayment for each type of service rendered. If a member receives more than one type of service, the applicable copayment for each service will apply. Only one copayment will apply for each type of service rendered.
  As an example, if a member receives three X-rays in a Specialist Office on the same date of service, the member would be responsible for the one X-Ray copayment and one Specialist Office copayment.
  Please note: Certain places of service; including but not limited to, inpatient hospital, outpatient hospital, emergency room and urgent care will only assess one member copayment for each visit.

- No copay benefit for diabetes retinal exam and HbA1c testing effective 1/1/2017
  Effective January 1, 2017, no copay will be required for HbA1c testing for individual and group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual retinal exam at no out-of-pocket cost.

Routine physical exams are covered in 2017

Empire Medicare Advantage (MA) plans will continue to supplement Medicare covered preventive services and offer coverage for routine physicals in 2017 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured,
which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

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

Additional details can be found at empireblue.com/medicareprovider under Important Medicare Advantage Updates.

**Dual Eligible Special Needs Plans – provider training required**

In 2017, Empire will offer Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors’ appointments. Some D-SNP plans may also include a card or catalog for purchasing over-the-counter items. Centers for Medicare & Medicaid Services regulations protect D-SNP members from balance billing.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans will receive notices in Q4 2016 that contain information for online training through self-paced training. Every provider contracted for our D-SNP plans is required to complete this annual training and click the attestation within the training site stating that they have completed the training. These attestations can be completed by individual providers or at the group level with one signature.

Additional information will be available at empireblue.com/medicareprovider under Important Medicare Advantage Updates.

**Claim adjustments may change member cost-share**

Empire reminds providers to please check the explanation of payments on claims. There are situations in which a claim may be adjusted and this may change a member’s cost-share. If you receive a claim adjustment from Empire, please ensure the member cost-share is still accurate. Basic member cost-share information is located on the front right-side of the member ID card but please note that not all cost shares are listed. If you have any questions about a member’s cost share, please call the number on the back of the member ID card.

**Verify injectable, infusion billable units approved via AIM**

Providers are to submit claims for medical injectable and infusion drugs in billable units for the Healthcare Common Procedure Coding System (HCPCS) code authorized. Providers can verify the amount of billable units approved for a case by using the member ID and authorization number provided. All claims submitted for more units than approved are subject to denial. To adjust the dose of an approved AIM authorization, please contact AIM for a new drug authorization request.

Claims are submitted in billable units per the HCPCS code. The billable units are calculated based on the HCPCS code administered and the dose associated with the code.
For example:
One (1) HCPCS unit of Rituxan represents 100mg of drug per HCPCS code J9310 (Rituxan) is administered at 1000mg for two doses
1000mg = 10 units (HCPCS code is 100mg)
Each dose of 1000mg is 10 billable units

Two doses = 20 billable units

AIM authorization details can be obtained via phone or the provider portal.
AIM phone number: 1-800-714-0040
AIM provider portal: www.providerportal.com
For AIM Provider portal support please contact AIM at 1-800-252-2021 option 2.

Note: An email address and the TIN for the facility/provider are needed to register for the site. Once registered, providers can view all AIM oncology drug approvals/denials by using the member information (name, ID#, Date of Birth).

For all other Part B injectable and infusion approvals/denials, inquiries will be answered via email at www.MASpecialtyPharm@Empire.com or via phone at 1-866-797-9884 option 5.

**HCPCS codes required for Rural Health Clinic claims**

All claims from Rural Health Clinics (RHC) with dates of service 04/01/16 and after must contain an appropriate HCPCS code for each service line along with a revenue code on their Medicare Advantage claims. This pertains to Contracted and Non-Contracted Providers. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans, including Dual Special Needs Plans, and Medicare-Medicaid Plans.

**Transitional Care Management Services eligibility**

A beneficiary is not eligible to receive TCM services until 30 days have passed since the beneficiary was discharged from an inpatient hospital setting. Empire determines the date of discharge based on the date the beneficiary received their discharge evaluation and management (E&M) visit. TCM services will be denied by Empire if the discharge E&M visit is not received before the TCM service.

These billing instructions apply to all individual Medicare Advantage plans, including Dual Special Needs Plans, and Medicare-Medicaid Plans.


**Avoid needless claims denials**

Tips for avoiding unnecessary claims denials, including:
- Services disallowed by utilization management
- Valid Clinical Laboratory Improvement Amendments number must be submitted
- Procedure not covered by diagnosis
- Inappropriate or missing modifier
- Duplicate claim
Clarification – Requesting Authorization for certain Arterial Duplex Imaging Procedures

As communicated in the April 2016 Network Update and Important Medicare Advantage Updates, Empire is collaborating with AIM Specialty Health to conduct medical necessity reviews for Vascular ultrasound management for our individual Medicare Advantage members.

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request clinical appropriateness review no later than 10 business days from the day the procedure is performed, and before you submit a claim.

Please note failure to contact AIM within the 10 day post service window for review will result in a denial of payment.

Impacted codes are as follows:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93925</td>
<td>DUP-SCAN LXTR ART/ARTL BPGS COMPL BI STUDY</td>
</tr>
<tr>
<td>93926</td>
<td>DUP-SCAN LXTR ART/ARTL BPGS UNI/LMTD STUDY</td>
</tr>
<tr>
<td>93930</td>
<td>DUP-SCAN UXTR ART/ARTL BPGS COMPL BI STUDY</td>
</tr>
<tr>
<td>93931</td>
<td>DUP-SCAN UXTR ART/ARTL BPGS UNI/LMTD STUDY</td>
</tr>
</tbody>
</table>

To submit your request, go to the AIM ProviderPortal www.aimspecialtyhealth.com. From the dropdown menu, select Empire Medicare Advantage. For additional assistance you may also call AIM toll free at 800-714-0040, Monday through Friday, 7 a.m. to 7 p.m. Central Time.

AIM clinical appropriateness guidelines for advanced imaging

Effective Feb. 18, 2017, the following changes to AIM Clinical Appropriateness Guidelines for Radiology and Cardiology will become effective:

- **Oncologic imaging (CT, MRI and PET)**
  - Enhanced criteria around surveillance following completion of therapy for colorectal cancer
  - Updated criteria for appropriate use of imaging studies in the management of prostate cancer and breast cancer
  - New guidelines for appropriate use of multiparametric MRI in the diagnosis of prostate cancer

- **Abdominal and pelvic imaging (CT and MRI)**
  - Updated criteria for appropriateness of imaging in inflammatory bowel disease
  - Guidelines for follow up of incidental liver lesions utilizing advanced imaging
  - Enhanced criteria for imaging in chronic abdominal pain and nephrolithiasis

Keep up with Medicare news

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

September reimbursement policy provider bulletin
Medicare Advantage reimbursement policies
Prior authorization requirement for Torisel
Prior Authorization changes to Interferon gamma-1b, Mecasermin, and Azacitidine
Prior authorization requirements for Doxil and Sustol
Providers must enroll with Medicare to be able to prescribe Part D beginning Feb. 1, 2016
Medicare notices and provider requirements
Clinical cumulative morphine equivalent dosing point of sale edit effective Jan. 1, 2017
Empire MediBlue HMO and PPO changing 2017 Medicare Advantage individual plans
Diabetic Supply Coverage for Individual Medicare Advantage Members

2017 FEP Benefit information available online
To view the 2017 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 2017. For questions please contact FEP Customer Service at 1-800-522-5566.

Are your patients with HIV virally suppressed?
With more care coordination programs focused on viral load suppression, it is important to make sure patients with HIV keep their follow-up appointments and complete a viral load screening at least every six months or twice in one calendar year.

Treating HIV infection to suppress viral loads in people living with HIV may reduce HIV transmission by 93.7%. Support people with HIV to stay in HIV care and encourage them to adhere to antiretroviral therapy (ART) for their personal health. Adherence to treatment also helps prevent transmission of HIV to their partners.

Regular testing helps identify any needs for changes in a patient’s medication regimen or helps determine if he or she is complying with treatment plans. The New York State Department of Health currently recommends that all patients living with HIV be treated with ART to reduce transmission of HIV in a strategy commonly known as “treatment as prevention.”

Reaching viral load suppression can help your patients live healthier longer lives and reduce the risk of transmitting the virus to others. For more information on viral load suppression and HIV treatment guidelines, please visit the New York State Department of Health AIDS Institute website at hivtrainingny.org.

Source: https://www.aids.gov/ http://www.hivguidelines.org/

PAVE Provider Breakfast Forums
Empire invites Medicaid providers and staff to PAVE provider breakfast forums. The forums are designed to offer information and resources for providing the highest quality patient care. The programs include updates on quality incentives and shared savings programs; New York State’s insurance affordability program, the Essential Plan; and Empire marketing and member programs. The forums are presented by the Provider Added Value and Experience Program (PAVE) and will be held in December 2016 at various Empire community service centers. PAVE drives collaboration between Empire and the Medicaid provider network, with a strong focus on education. For more information and to register to attend a forum, visit: http://empirebluepave.eventbrite.com
Update for AIM Reviews

Effective September 1, 2016, Empire BlueCross BlueShield HealthPlus began requiring clinical appropriateness review of radiation oncology, sleep medicine and cardiology services. Reviews will be managed by AIM Specialty Health® (AIM). For details, please visit the News and Announcements section on our provider website at: empireblue.com/nymedicaiddoc

Prior authorization required for elective one- and two-vessel Coronary Artery Bypass Graft

Effective January 1, 2017, Empire BlueCross BlueShield HealthPlus (Empire) will require prior authorization (PA) for elective one- and two-vessel Coronary Artery Bypass Graft (CABG). Elective one- and two-vessel Coronary Artery Bypass Graft (CABG) requests must be reviewed by Empire for PA for dates of service on and after January 1, 2017. Please refer to the Provider Self-Service tool for detailed authorization requirements.

In review of these services, physicians should reference the InterQual Procedures criteria for CABG.

Please use one of the following methods to request PA:
- Call Provider Services: 1-800-450-8753
- Fax: 1-800-964-3627
- Visit the Web: www.empireblue.com/nymedicaiddoc

If you have questions about this communication or need assistance with any other item, call Provider Services at 1-800-450-8753.

Prior authorization requirements for injectable/infusible drugs: Istodax (Romidepsin), Ixempra (Ixabepilone), Doxil (Doxorubicin), Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb)

Effective February 1, 2017, Empire BlueCross BlueShield HealthPlus will require prior authorization (PA) for Istodax (Romidepsin), Ixempra (Ixabepilone), Doxil (Doxorubicin), Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb).

This notice applies to the injectable/infusible drugs listed and billed with J codes under the member's medical benefits and not pharmacy benefits.

For more information on PA requirements, please refer to the provider self-service tool by going to www.empireblue.com/nymedicaiddoc, selecting Precertification & Claims and then Precertification Lookup Tool from the menu.

Please use one of the following methods to request Precertification:
- Phone: 1-800-450-8753
- Fax: 1-800-964-3627
- Visit the Web: www.empireblue.com/nymedicaiddoc

If you have questions about this communication or need assistance with any other item, please call Provider Services at 1-800-450-8753.

Provider Website Survey

Empire BlueCross BlueShield HealthPlus relies on your feedback to improve and strengthen our processes and operations. Our Provider Website Survey is a new tool to evaluate the effectiveness of our Medicaid provider website. Input about your
experience with our website is essential to our goal of efficient and effective provider resources. We will use your survey responses to better understand your experiences and continue to improve our site. Providing exceptional service to providers who serve our members is one of our strongest commitments.

Thank you in advance for taking the time to complete this brief survey. To access the survey, go to https://www.surveymonkey.com/r/7PHY5BL.

### Updated medical policies

On May 5, 2016, the Medical Policy and Technology Assessment committee (MPTAC) approved the following medical policies applicable to Empire BlueCross BlueShield HealthPlus (Empire). These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the listing below. Note: Existing precertification requirements have not changed.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Policy number</th>
<th>Medical policy</th>
<th>Medical policy (new/revised)</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00082</td>
<td>Daratumumab (DARZALEX™)</td>
<td>New</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00083</td>
<td>Elotuzumab (Empliciti™)</td>
<td>New</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00084</td>
<td>Interferon gamma-1b (Actimmune®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00085</td>
<td>Ixabepilone (Ixempra®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00086</td>
<td>Mecasermin (Increlex®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>GENE.00045</td>
<td>Detection and quantification of tumor DNA using next generation sequencing in lymphoid cancers</td>
<td>New</td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>SURG.00143</td>
<td>SpaceOAR® system</td>
<td>New</td>
</tr>
<tr>
<td>May 12, 2016</td>
<td>DRUG.00028</td>
<td>Intravitreal treatment for retinal vascular conditions</td>
<td>Revised</td>
</tr>
<tr>
<td>May 12, 2016</td>
<td>DRUG.00063</td>
<td>Ofatumumab (Arzerra®)</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00076</td>
<td>Blinatumomab (Blinicyto®)</td>
<td>Revised</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00077</td>
<td>Monoclonal antibodies to interleukin-17A</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>MED.00119</td>
<td>High intensity focused ultrasound (HIFU) for oncologic indications</td>
<td>Revised</td>
</tr>
</tbody>
</table>

The medical policies were made publicly available on the Empire provider website on the effective date listed above. To search for specific policies, visit empireblue.com/nymedicaiddoc.

### Updated Clinical UM Guidelines

On May 5, 2016, the MPTAC approved the following Clinical UM Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the Clinical UM Guidelines adopted by the Medical Operations committee for the Government Business Division on July 21, 2016. Note: Existing precertification requirements have not changed.
These clinical guidelines were made publicly available on the Empire provider website on the effective date listed above. To see the full UM Guidelines, visit empireblue.com/nymedicaiddoc.

### Reimbursement Policy Updates

**Policy Reminder: Claims Timely Filing**  
(Policy 06-050, originally effective 07/01/2013)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:
- 90 days for participating providers and facilities  
- 15 months for nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

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<table>
<thead>
<tr>
<th>Effective date</th>
<th>Clinical UM guideline number</th>
<th>Guideline title</th>
<th>New/revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 28, 2016</td>
<td>CG-DME-39</td>
<td>Dynamic low-load prolonged-duration stretch devices</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-48</td>
<td>Azacitidine (Vidaza®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-49</td>
<td>Doxorubicin hydrochloride liposome injection</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-50</td>
<td>Paclitaxel, protein-bound (Abraxane®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-51</td>
<td>Romidepsin (Istodax®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-52</td>
<td>Temsirolimus (Torisel®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-53</td>
<td>Drug dosage, frequency and route of administration</td>
<td>New</td>
</tr>
<tr>
<td>June 13, 2016</td>
<td>CG-SURG-55</td>
<td>Intracardiac electrophysiological studies (EPS) and catheter ablation</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-15</td>
<td>Gonadotropin releasing hormone analogs</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-34</td>
<td>Docetaxel (Docefrez™, Taxotere®)</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-SURG-27</td>
<td>Sex reassignment surgery</td>
<td>Revised</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>CG-SURG-44</td>
<td>Coronary angiography in the outpatient setting</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-THER-RAD-01</td>
<td>Fractionation and radiation therapy in the treatment of specified cancers</td>
<td>Revised</td>
</tr>
</tbody>
</table>
For additional information, refer to the Claims Timely Filing reimbursement policy at http://www.empireblue.com/nymedicaiddoc.

Policy Update: Modifier Usage
(Policy 06-006, effective 08/01/16)
Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, Empire BlueCross BlueShield HealthPlus will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at www.empireblue.com/nymedicaiddoc.

Policy Reminder Split-Care Surgical Modifiers
(Policy 11-005, effective 08/01/16)
Reimbursement of surgical codes appended with “split-care modifiers” is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:
- Modifier 54 (surgical care only): 80%

Empire BlueCross Blue Shield HealthPlus does not recognize Modifier 55 and Modifier 56.

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at www.empireblue.com/nymedicaiddoc.

Initiation and Engagement or IET – The Facts

Initiation and engagement of alcohol and other drug dependence treatment or IET is a HEDIS®/QARR (Quality Assurance Reporting Requirement) measure that gauges how a plan performs with linking members recently diagnosed with Substance Use Disorder or treatment. The IET eligible population is defined as members who are 13 years and older and newly diagnosed with Substance Use Disorder in any place of service. A member is considered newly diagnosed if they have not received treatment for substance use disorder within the past 60 days.

To fully pass the measure, two phases must be completed:
- Initiation: The expectation is for the member to have a follow-up substance use disorder treatment visit within 14 days of the new substance use disorder diagnosis.
- Engagement: Two additional substance use disorder treatment visits within 30 days of the Initiation visit are expected to fully meet the measure.
Note:
- If the Initiation phase is failed, then the Engagement phase is automatically failed.
- Detoxification does not qualify as a follow-up visit.
- All of the visits must be documented with substance use disorder code.
- These codes may include but are not limited to diagnoses of Substance Use Disorder ranging from Cannabis, Alcohol, Opioid, Sedative/Hypnotics/Anxiolytics, Cocaine, Stimulants, Hallucinogens and Inhalants to name a few.
  Please note that Nicotine dependence is entirely excluded from this measure..

Empire BlueCross BlueShield HealthPlus can provide you with training to better understand this measure as well as referral resources to help assure successful implementation of the IET Measure.

- Please call our Information Referral Specialist who is assigned to our Behavioral Health Outpatient Unit at Empire BlueCross BlueShield HealthPlus: (212) 563-5570 x64431
- The Office of Alcoholism and Substance Abuse Services (OASAS) [https://www.oasas.ny.gov/providerdirectory/](https://www.oasas.ny.gov/providerdirectory/) has a Provider Directory that will give you resources in your area.
- The Substance Abuse and Mental Health Service Administration (SAMHSA) will assist with treatment locations, by using the following link: [https://findtreatment.samhsa.gov/locator](https://findtreatment.samhsa.gov/locator)

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