# Network Update

**October 2017**

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Network Update
October 2017
Administrative updates

Electronic Member ID Cards

Empire BlueCross BlueShield (“Empire”) has a mobile app called Empire Anywhere that allows members to manage their benefits on their smart phones, including electronic copies of their ID cards. The Empire Anywhere mobile app allows members easy access to their ID card even when there is no internet connection.

Currently, members still receive hard copies of their ID cards, even if they utilize an electronic version. Starting in fall 2017, we will allow members the option to choose electronic cards only. If the member chooses this option, he/she will not receive a hard copy card. Members will continue to have the option of selecting a hard copy card if that is their preference.

We want to ensure a member’s request for electronic ID card meets a provider’s office needs. If presented with an electronic card, you may still obtain a copy of the ID card for your records.

Members that choose to use their mobile app will have the option to email or fax their ID Card from their phone, and providers can view (and print the card if needed) from the Availity Web Portal – NEW coming by January 1, 2018! Members are still required to have a copy of their card in one format or another, whether hard copy or electronic, in order for services to be rendered.

Empire members that will have this option

- Individual commercial members will have this option starting in fall 2017 for plans becoming effective on or after January 1, 2018. (This includes all plans on and off exchange.)
- Most Small Group members will have this option upon their group renewals starting in fall 2017 for plans becoming effective on or after January 1, 2018.
- Other membership including some Large Group, Federal Employee Program® (FEP®) and National Account members will have this option in late 2018
- Further expansion to additional members is scheduled for 2019 and beyond

Quick Reference Guide

- See our Electronic Member ID Cards – Quick Reference Guide for more details and information on:
  - Frequently Asked Questions
  - Details on provider options for obtaining a copy of an electronic Member ID card
  - Sample electronic Member ID cards

View our Quick Reference Guide online at empireblue.com > Providers & Facilities > Enter > Provider Home page, under the Self-Service and Support heading, select the link titled Electronic Member ID Cards – Quick Reference Guide.

Important Outreach to Opioid Use Disorder Providers about Medication Assisted Therapy

Opioid addiction rates and deaths from overdose continue in the United States at alarming rates. To help address this crisis, Empire urgently requests that you contact us if you are authorized to administer Medication Assisted Therapy (MAT). We want to be sure you are correctly listed in our provider directory and confirm you are accepting new patients. This will help ensure that those of our members who require treatment for opioid use disorder get the care they need when they need it.

Please respond immediately using any of the following:
Visually Enhanced ID Cards

Through recent market research and in an effort to further our continued commitment to our members, Empire will be introducing refreshed and visually enhanced Member ID Cards beginning in the fourth quarter of 2017.

The redesigned ID card directs members’ and provider’s attention to key information by enhancing the data with the use of color. No new information was added to the ID card; the enhancements include:

- Identification number has been replaced with Member ID for clarity and highlighted in blue for emphasis.
- Copays and other member specific information will be printed in blue.
- Member Service phone number has been enlarged and printed in blue.

Starting in September 2017 we will gradually issue the newly redesigned ID Cards to members in new groups as well as those that renew with benefit changes. Empire will not perform a mass reissue of ID cards to membership and, therefore, both the current ID card design and the new ID card design with blue accent will be present in the market.

Attention Electronic Claim Submitters: Request for Action

Empire values the relationship we have with our providers and we would like to share important information on submitting necessary electronic claim data for re-submissions. In an effort to reduce duplicate payments, or rejecting for additional information, please review the following reminder on how to submit a Corrected CMS-1500 Claim Submission:

Electronic claims need to contain the correct billing code to help identify when a claim is being submitted to correct or void a claim that has been previously processed.

- Enter the Claim Frequency Type code (billing code) 7 for a replacement/correction (2300 CLM05-3)
- Enter the Claim Frequency Type code (billing code) 8 to void a prior claim (2300 CLM05-3)
- Complete box 22 (Resubmission code) to include a 7 (the “replace” billing code) to notify us of a corrected or replacement claim, or insert an 8 (the “void” billing code) to let us know you are voiding a previously submitted claim
- Enter the ‘original’ claim number as the Original Ref. No., or if that information is not available, enter the DCN (Document Control Number). (2300 REF02)
New EDI Edits for 837 Institutional Claim Diagnosis Validation

Currently if an 837 Institutional claim is submitted the diagnosis codes are validated by the Statement Through date, regardless of the claim being Inpatient or Outpatient.

Beginning August 18, 2017 if the claim is for outpatient services, the diagnosis codes will be validated using the Statement From date instead of the Statement through date.

This change will involve the following submitted diagnoses:
- Principal diagnosis
- Admitting diagnosis
- Patient reason for visit
- External cause of injury
- Other diagnosis.

If you have any questions, please contact your local E-Solution service desk at 1-800-470-9630.

Integrated Medical and Behavioral Healthcare Reminders and Updates

In our ongoing efforts to encourage the coordination and integration of care between medical and behavioral health providers Empire continues to expand opportunities for primary care. Empire currently reimburses for screening and assessment for behavioral health and substance use through billing the following codes:
- G0396 /99408 - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
- G0397 / 99409 - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention, greater than 30 minutes
- G0442 - Annual alcohol misuse screening, 15 minutes ≤ G0443 - Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0443 - Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0444 - Annual depression screening, 15 minutes

In addition to screenings and assessments, Empire supports behavioral counseling for specific chronic conditions while in the primary care office. These services include:
- G0446 - Annual, face-to-face intensive behavioral therapy for cardiovascular disease, 15 minutes
- G0447 - Face-to-face behavioral counseling for obesity, 15 minutes
- G0473 - Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes

In January 2017 Empire initiated a medical/behavioral integration metric-based quality performance programs incentivizing behavioral health providers to engage in local care collaboratives with primary care. In this program, the behavioral health providers are measured on timely appointment and access for primary care referrals, engagement in behavioral health treatment, avoidable ER visits, and improvement on three highly co-morbid conditions (diabetes, hypertension and cardiac), among a few other metrics. Empire continues to expand this program.
Finally, effective December 1, 2017, Empire will begin to reimburse the new Psychiatric Care Collaborative codes (G0502, G0503 and G0504). These codes are reportable by primary care for their collaboration with a qualified behavioral health provider, such as a Psychiatrist, Licensed Clinical Social Worker, etc. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations. These codes are intended to represent the care and management for patients with behavioral health conditions that often require extensive discussion, information-sharing, and planning between a primary care physician and a specialist.

**Flu vaccine update**

Flucelvax® Quadrivalent is a new flu vaccine that was recommended by Advisory Committee Immunization Practices (ACIP) for the 2017/2018 flu season. CPT® Procedure Code, 90756 - Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use, is the code that was created to report this new vaccine. This code is effective January 1, 2018.

In the interim from August 1, 2017 to December 31, 2017, our recommendation is to report the currently active HCPCS Level II Code, Q2039 - Influenza virus vaccine, not otherwise specified, since it is the most specific code available during this timeframe that could be used to report this vaccine. As always, when using not otherwise specified codes, be sure to continue to include the appropriate NDC with your claim submission.

**Practice access after-hours**

Your contract with Empire requires that your practice provide continuation of care for our members outside of regular business hours. We will conduct after-hours access studies to assess how well practices are meeting this provision, and your practice may receive a call from North American Testing Organization, a vendor in California working on Empire’s behalf. To be compliant, please verify that your messaging or answering service includes appropriate urgent care instructions. The compliant response directs callers to Urgent Care, 911, the ER, or connects the call to the caller’s doctor or the doctor on call. In addition to these measures, but not in place of them, the messaging can give callers the option of contacting their health care practitioner (via transfer, cell phone, pager, etc.) or an opportunity to ask for a call back for urgent questions or instructions. Is your practice compliant?

**Out-of-area medical record retrieval**

Inovalon began sending medical records requests for out-of-area Blue Plan members in April 2017. Verscend will continue to send medical records requests through the end of 2017.

As a reminder, Verscend and Inovalon are the contracted vendors to gather medical records on behalf of Blue Cross and/or Blue Shield companies. Blue Plans utilize the vendors’ services to retrieve medical records for non-Empire Blue members or from providers in Empire’s Blue service area to support HEDIS®, risk adjustment and government required programs.

Both vendors are experienced health care analytics and services companies. They provide an efficient, centralized process, to coordinate medical record requests on behalf of Blue Cross and/or Blue Shield companies across the country and help reduce multiple requests for patient data.
As outlined in your contract, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Verscend in 2017 only and Inovalon beginning April 1, 2017, and later. Empire is working diligently to ensure this process is followed.

**Health Insurance Portability and Accountability Act (HIPAA)/Privacy**

Verscend and Inovalon are contractually bound to preserve the confidentiality of health plan members’ protected health information (PHI) obtained from medical records, in accordance with HIPAA regulations. Please note that patient-authorized information releases are not required in order for you to comply with these requests for medical records.

Providers are permitted to disclose protected health information to health plans without authorization from the patient when both the provider and health plan had a relationship with the patient and the information relates to the relationship [45 CFR 164.506(c)(4)]. For more information regarding privacy rule language, please visit [http://www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy).

If you have any questions, please do not hesitate to call the Provider Service number on the back of the member’s ID card.

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

**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.

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

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

The following tables compare our results from 2016 with those in 2017. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Empire. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile.

When you’re reviewing these results, we encourage you to focus on and address those performance areas of your own practice that may have room for improvement. Addressing those areas will help our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the quality of services provided.
## 2017 Empire HMO/POS
### CAHPS® Adult Member Satisfaction Survey Results and NCQA Quality Compass Percentile Achieved

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>2016</th>
<th>2017</th>
<th>Trend 2016 vs. 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rating of Physician</strong> 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>82%</td>
<td>87%</td>
<td>↑</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>84%</td>
<td>84%</td>
<td>=</td>
</tr>
<tr>
<td>Rating of All Health Care Provided in Past 12 Months</td>
<td>65%</td>
<td>70%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Getting Care Quickly</strong> 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for <em>urgent care</em> as soon as needed</td>
<td>78%</td>
<td>NA</td>
<td>---</td>
</tr>
<tr>
<td>Got appointment for <em>check-up or routine care</em> as soon as needed</td>
<td>75%</td>
<td>73%</td>
<td>↓</td>
</tr>
<tr>
<td>Got help or advice needed when calling doctor after regular office hours</td>
<td>61%</td>
<td>78%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Doctor’s Communication with Patients</strong> 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>97%</td>
<td>97%</td>
<td>=</td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>95%</td>
<td>96%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>96%</td>
<td>98%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>91%</td>
<td>94%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Shared Decision Making</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor discussed reasons to take a medicine?</td>
<td>93%</td>
<td>91%</td>
<td>↓</td>
</tr>
<tr>
<td>Doctor discussed reasons not to take a medicine?</td>
<td>65%</td>
<td>76%</td>
<td>↑</td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you?</td>
<td>75%</td>
<td>78%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Continuity of Care &amp; Health Promotion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did your personal doctor seem informed about care you received from other health providers?</td>
<td>78%</td>
<td>82%</td>
<td>↑</td>
</tr>
<tr>
<td>Did you and your doctor discuss ways to prevent illness?</td>
<td>73%</td>
<td>73%</td>
<td>=</td>
</tr>
</tbody>
</table>

1 = Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 = Percent responding “Usually” or “Always.”
3 = % responding “Yes”
4 = Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile. NA = Number of survey respondents too low to be valid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Improving Your Patients' Health Care Experience

Empire is committed to working with our network physicians to make our members' health care experience a positive one. Towards this end we wanted to share with you a document we discovered that was developed by the California Quality Cooperative. This resource outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

Visit empireblue.com > Enter > Health & Wellness > Tools & Resources > Guide to Improving the Patient Experience.

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

Products & Programs

AIM genetic testing program expands to include additional health plans

Effective with dates of service on and after January 1, 2018, Empire will expand the medical necessity review as a prior authorization of all genetic testing services to include Empire’ National Account and self-funded health plans with services medically managed by AIM Specialty Health® (AIM), a separate company. As a reminder, this program was effective for Empire fully-insured members on July 1, 2017.

The medical policies and codes reviewed for Empire plans managed by AIM include:

<table>
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<tr>
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<th>Medical Policy Title</th>
<th>Codes</th>
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<tr>
<td>GENE.00001</td>
<td>Genetic Testing for Cancer Susceptibility</td>
<td>81404, 81405, 81406, 81437, 81438, 81445, 81450, 81455, 81479, 0013U*, 0014U*</td>
</tr>
<tr>
<td>GENE.00002</td>
<td>Preimplantation Genetic Diagnosis Testing</td>
<td>89290, 89291</td>
</tr>
<tr>
<td>GENE.00003</td>
<td>Genetic Testing and Biochemical Markers for the Diagnosis of Alzheimer's Disease</td>
<td>81401, 81405, 81406, 83520, 84999, S3852</td>
</tr>
<tr>
<td>GENE.00004</td>
<td>Janus Kinase 2 (JAK2)V617F Gene Mutation Assay</td>
<td>81270, 81403</td>
</tr>
<tr>
<td>GENE.00005</td>
<td>BCR-ABL Mutation Analysis</td>
<td>81170, 81401</td>
</tr>
<tr>
<td>GENE.00006</td>
<td>Epidermal Growth Factor Receptor (EGFR) Testing</td>
<td>81235, 88365</td>
</tr>
<tr>
<td>GENE.00007</td>
<td>Cardiac Ion Channel Genetic Testing</td>
<td>81406, 81413, 81414, 81404, 81405, 81406, 81407, 81408, S3861</td>
</tr>
<tr>
<td>GENE.00008</td>
<td>Analysis of Fecal DNA for Colorectal Cancer Screening</td>
<td>81528, 81479</td>
</tr>
<tr>
<td>GENE.00009</td>
<td>Gene-Based Tests for Screening, Detection and Management of Prostate Cancer</td>
<td>81313, 81479, 81599, 0005U</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Code(s)</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GENE.00010</td>
<td>Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status</td>
<td>81225, 81479, 81381, 81226, 81400, 81401, 81227, 81350, 81355, G9143, 0015U*</td>
</tr>
<tr>
<td>GENE.00011</td>
<td>Gene Expression Profiling for Managing Breast Cancer Treatment</td>
<td>81519, 0008M, 81599, 84999, S3854, 0008M*</td>
</tr>
<tr>
<td>GENE.00012</td>
<td>Preconceptional or Prenatal Genetic Testing of a Parent or Prospective Parent</td>
<td>81200, 81209, 81220, 81221, 81222, 81223, 81224, 81241, 81242, 81251, 81252, 81253, 81254, 81255, 81256, 81257, 81260, 81290, 81330, 81401, 81412, S3841, S3842, S3844, S3845, S3846, S3849, S3853, 81403, 81404, 81405, 81406, S3800, 81479, 81415, 81416, 81417, 81425, 81426, 81427, 0012U*</td>
</tr>
<tr>
<td>GENE.00014</td>
<td>Analysis of KRAS Status</td>
<td>81275, 81276, 88363</td>
</tr>
<tr>
<td>GENE.00016</td>
<td>Gene Expression Profiling for Colorectal Cancer</td>
<td>81525, 81599, 84999</td>
</tr>
<tr>
<td>GENE.00017</td>
<td>Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)</td>
<td>81403, 81405, 81406, 81407, 81408, 81439, 81479, S3865, S3866</td>
</tr>
<tr>
<td>GENE.00018</td>
<td>Gene Expression Profiling for Cancers of Unknown Primary Site</td>
<td>81406, 81504, 81540, 81599</td>
</tr>
<tr>
<td>GENE.00019</td>
<td>BRAF Mutation Analysis</td>
<td>81210, 88363, 81406</td>
</tr>
<tr>
<td>GENE.00020</td>
<td>Gene Expression Profile Tests for Multiple Myeloma</td>
<td>81479, 81599</td>
</tr>
<tr>
<td>GENE.00021</td>
<td>Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies</td>
<td>81228, 81229, S3870, 81405</td>
</tr>
<tr>
<td>GENE.00022</td>
<td>In Vitro Companion Diagnostic Devices</td>
<td>Specific coding does not apply</td>
</tr>
<tr>
<td>GENE.00023</td>
<td>Gene Expression Profiling of Melanomas</td>
<td>81599, 84999</td>
</tr>
<tr>
<td>GENE.00024</td>
<td>DNA-Based Testing for Adolescent Idiopathic Scoliosis</td>
<td>0004M</td>
</tr>
<tr>
<td>GENE.00025</td>
<td>Molecular Profiling for the Evaluation of Malignant Tumors</td>
<td>81425, 81445, 81450, 81455, 81479, 81599, 88363, 0013U*, 0014U*</td>
</tr>
<tr>
<td>GENE.00026</td>
<td>Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy</td>
<td>81507, 0009M, 81420, 81479, 81599, 81422</td>
</tr>
<tr>
<td>GENE.00027</td>
<td>The Panexia™ Test for Oncologic Indications</td>
<td>81406, 81479</td>
</tr>
<tr>
<td>GENE.00028</td>
<td>Genetic Testing for Colorectal Cancer Susceptibility</td>
<td>81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81317, 81318, 81319, 81403, 81435, 81436, 81201, 81202, 81203, 81401, 81406</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Codes</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>GENE.00029</td>
<td>Genetic Testing for Breast and/or Ovarian Cancer Syndrome</td>
<td>81162, 81211, 81212, 81213, 81214, 81215, 81216, 81217, 81432, 81433, 81445, 81455</td>
</tr>
<tr>
<td>GENE.00030</td>
<td>Genetic Testing for Endocrine Gland Cancer Susceptibility</td>
<td>81404, 81405, S3840, 81445, 81455, 81479</td>
</tr>
<tr>
<td>GENE.00031</td>
<td>Genetic Testing for PTEN Hamartoma Tumor Syndrome</td>
<td>81321, 81322, 81323</td>
</tr>
<tr>
<td>GENE.00032</td>
<td>Molecular Marker Evaluation of Thyroid Nodules</td>
<td>81545, 81599</td>
</tr>
<tr>
<td>GENE.00033</td>
<td>Genetic Testing for Inherited Peripheral Neuropathies</td>
<td>81324, 81325, 81326, 81403, 81404, 81405, 81406, 81440, 81479</td>
</tr>
<tr>
<td>GENE.00034</td>
<td>SensiGene® Fetal RhD Genotyping Test</td>
<td>81403</td>
</tr>
<tr>
<td>GENE.00035</td>
<td>Genetic Testing for TP53 Mutations (Li-Fraumeni Syndrome)</td>
<td>81404, 81405, 81445, 81455</td>
</tr>
<tr>
<td>GENE.00036</td>
<td>Genetic Testing for Hereditary Pancreatitis</td>
<td>81222, 81223, 81224, 81401, 81404, 81479</td>
</tr>
<tr>
<td>GENE.00037</td>
<td>Genetic Testing for Macular Degeneration</td>
<td>81401, 81405, 81408, 81479, 81599</td>
</tr>
<tr>
<td>GENE.00038</td>
<td>Genetic Testing for Statin-Induced Myopathy</td>
<td>81400</td>
</tr>
<tr>
<td>GENE.00039</td>
<td>Genetic Testing for Frontotemporal Dementia (FTD)</td>
<td>81406, 81479</td>
</tr>
<tr>
<td>GENE.00040</td>
<td>Genetic Testing for CHARGE Syndrome</td>
<td>81403, 81407</td>
</tr>
<tr>
<td>GENE.00041</td>
<td>Short Tandem Repeat Analysis for Specimen Provenance Testing</td>
<td>81479, 0007U*</td>
</tr>
<tr>
<td>GENE.00042</td>
<td>Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome</td>
<td>81406</td>
</tr>
<tr>
<td>GENE.00043</td>
<td>Genetic Testing of an Individual's Genome for Inherited Diseases</td>
<td>81200, 81209, 81221, 81222, 81223, 81224, 81241, 81242, 81251, 81252, 81253, 81254, 81255, 81256, 81257, 81260, 81290, 8130, 81412, 81479, 81599, 81400, 81403, 81404, 81405, 81406, 81408, 81410, 81411, 81415, 81416, 81417, 81425, 81426, 81427, 81430, 81431, 81434, 81440, 81442, 81460, 81465, 81470, 81471, 81479, 81493, 81506, 81599, S3800, S3841, S3842, S3844, S3845, S3846, S3849, S3853, 0012U*</td>
</tr>
<tr>
<td>GENE.00044</td>
<td>Analysis of PIK3CA Status in Tumor Cells</td>
<td>81404</td>
</tr>
<tr>
<td>GENE.00045</td>
<td>Detection and Quantification of Tumor DNA Using Next Generation Sequencing in Lymphoid Cancers</td>
<td>81479, 81599</td>
</tr>
<tr>
<td>GENE.00046</td>
<td>Prothrombin G20210A (Factor II) Mutation Testing</td>
<td>81240</td>
</tr>
<tr>
<td>GENE.00047</td>
<td>Methylene tetrahydrofolate Reductase Mutation Testing</td>
<td>81291</td>
</tr>
</tbody>
</table>
Beginning January 1, 2018, please submit genetic testing prior authorization requests for these members to AIM using one of the following ways:
- Access AIM ProviderPortalSM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-877-430-2288, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

To learn more about genetic testing prior authorization, visit aimprovider.com/genetictesting/

For questions regarding prior authorization requirements, please contact the provider service number on the back of the member ID card.

Important information regarding post-service reviews using AIM Specialty Health®

Empire uses AIM Specialty Health® (AIM), a separate company, to administer pre-service clinical reviews for services noted below. AIM reviews requests in real time against evidence-based clinical guidelines and Empire medical policy.

Effective January 1, 2018 providers will be notified via letter or remit message when claims are submitted without the appropriate pre-service review by AIM. As a result, providers will need to obtain a post-service clinical review for the service via the AIM ProviderPortalSM.

To help prevent delays in claim processing and post-service reviews, ordering providers submit pre-service requests to AIM in one of the following ways:
- Access AIM ProviderPortalSM directly at www.providerportal.com, available 24/7 to process orders in real-time
- Access AIM via the Availity Web Portal at www.availity.com

As a reminder, AIM reviews the following services for clinical appropriateness:
- Advanced diagnostic imaging (e.g. CT, MRI/MRA)
- Cardiology tests and procedures (e.g. MPI, echocardiography, PCI, cardiac catheterization)
- Medical oncology treatments through the Cancer Care Quality Program
- Radiation oncology treatments (e.g. IMRT, brachytherapy)
- Sleep testing, treatment, and supplies
- Specialty pharmacy
- Genetic testing
- Musculoskeletal (e.g. spine and joint surgeries, pain management)

Services performed in an emergency or inpatient setting are excluded from AIM programs.

This update applies to local fully-insured Empire members, with services medically managed by AIM. It does not apply to BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, Federal Employee Program® (FEP®), members who are covered under a self-insured (ASO) benefit plan.

For more information, please contact the phone number of the back of the member ID card.
Update to coverage guideline for cervical cancer screening and human papillomavirus testing (CG-MED-53)

Effective January 1, 2018, the updated coverage guideline CG-MED-53 will apply to cervical cancer screening and human papillomavirus (HPV) testing.

- Cervical cancer screening with cytology, with or without HPV testing, for women under 21 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed (for example, organ transplant recipients or seropositive for the human immunodeficiency virus [HIV]).
- Cervical cancer screening with HPV testing, alone or in combination with cytology, for women younger than 30 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed.
- Cervical cancer screening with cytology with or without HPV testing, is considered medically necessary for women under 30 years of age who are chronically immunosuppressed.
- There is no change to the medical necessity criteria for cervical cancer screening with cytology without HPV testing for women ages 21 to 65 years.

This coverage guideline does not apply to Medicare Advantage and Medicare Supplement plans.

Empire expands specialty pharmacy prior authorization list

Effective for dates of service on and after January 1, 2018, the following specialty pharmacy codes from new or current medical policies or clinical UM guidelines will be included in our existing prior-authorization review process.

Empire’s prior-authorization clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

The following clinical guidelines or medical policies will be effective January 1, 2018.

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline</th>
<th>Code</th>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00058</td>
<td>J3490, J3590</td>
<td>Haegarda</td>
<td>New Drug to Existing Policy</td>
</tr>
<tr>
<td>DRUG.00111</td>
<td>J3490, J3590</td>
<td>Tremfya</td>
<td>New Drug Policy</td>
</tr>
</tbody>
</table>

Empire expands specialty pharmacy level of care drug list

Effective for dates of service on and after January 1, 2018, the following specialty pharmacy codes from new or current medical policies or clinical UM guidelines will be included in our existing level of care prior authorization process.

Empire’s level of care 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.

Level of Care Prior Authorization drug list:
http://www.aimprovider.com/specialtyrx/pdf/ClinicalSiteofCareDrugList.pdf

View the level of care prior authorization clinical review FAQs for more information.
**Prior Authorization clinical review for skilled nursing home health services**

Effective with dates of service on and after January 1, 2018, Empire will review the skilled nursing home health services noted below for medical necessity. Medical necessity review will take place as a prior authorization and will apply to Empire’s fully insured health plans. You will be notified in advance of the expansion of this review to local self-funded groups at a later date.

Ordering and servicing providers may submit prior authorization requests by contacting the phone number on the back of the member ID card.

Please note, this program does not apply to the following plans: Medicare, Medicaid, National Accounts, and FEP. **CG-MED-23** is the clinical guideline that applies to home health services.

The following codes will be reviewed:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0550-0559</td>
<td>Skilled nursing (includes codes 0550, 0551, 0552, 0559)</td>
</tr>
<tr>
<td>0570-0579</td>
<td>Home health aide (includes codes 0570, 0571, 0572, 0579)</td>
</tr>
<tr>
<td>0580-0589</td>
<td>Home health, other visits (includes codes 0580, 0581, 0582, 0583, 0589)</td>
</tr>
<tr>
<td>0590-0599</td>
<td>Home health, units of service (includes codes 0590, 0599)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT/HCPS codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure</td>
</tr>
<tr>
<td>S9122</td>
<td>Home health aide or certified nurse assistant, providing care in the home, per hour</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care, in the home; by registered nurse, per hour.</td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care, in the home; by licensed practical nurse, per hour</td>
</tr>
<tr>
<td>T1001</td>
<td>Nursing assessment/evaluation</td>
</tr>
<tr>
<td>T1002</td>
<td>RN services, up to 15 minutes</td>
</tr>
<tr>
<td>T1003</td>
<td>LPN/LVN services, up to 15 minutes</td>
</tr>
<tr>
<td>T1004</td>
<td>Services of a qualified nursing aide, up to 15 minutes</td>
</tr>
<tr>
<td>T1021</td>
<td>Home health aide or certified nurse assistant, per visit</td>
</tr>
</tbody>
</table>
Reminder: Hyaluronan Injections in the Knee (CG-DRUG-29)

Clinical guideline CG-DRUG-29 addresses the use of intra-articular injections of hyaluronic. Effective for dates of service on and after December 1, 2017, intra-articular injections of hyaluronan are considered not medically necessary for the treatment of pain due to osteoarthritis of the knee and all other knee conditions.

The following codes will be subject to review under this clinical guideline:

<table>
<thead>
<tr>
<th>Hyaluronic Acid</th>
<th>Euflexxa</th>
<th>J7323</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyaluronic Acid</td>
<td>Gel-One</td>
<td>J7326</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Gel-Syn</td>
<td>J7328</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Genvisc</td>
<td>J7320</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Hyalgan</td>
<td>J7321</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Hymovis</td>
<td>J7322</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Monovisc</td>
<td>J7327</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Orthovisc</td>
<td>J7324</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Supartz</td>
<td>J7321</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Synvisc</td>
<td>J7325</td>
</tr>
<tr>
<td>Hyaluronic Acid</td>
<td>Synvisc-One</td>
<td>J7325</td>
</tr>
</tbody>
</table>

Please note, this initiative is not administered by AIM Specialty Health® (AIM).

For questions, please contact the provider service number on the back of the member ID card.

Empire adopts Milliman guideline for Inpatient Rehabilitation, Sub-Acute Rehabilitation, and Skilled Nursing Facility clinical reviews

Effective with dates of service on and after December 1, 2017, Empire will transition from using the Empire Clinical Guidelines CG-Rehab-09, CG-MED-31, and CG-MED-29 to using Milliman Care Guidelines (MCG) Recovery Facility Care guidelines for the review of prior authorization requests for inpatient rehabilitation and skilled nursing facility services. This change applies to commercial, FEP and National accounts. This change does not apply to Medicare or Medicaid plans at this time.

Providers should continue to call the phone number indicated on the back of the member ID card to request prior authorization review for these services. Additionally, you may initiate your request online at www.availity.com
For questions, please contact the provider service number on the back of the member ID card.

**Important upcoming changes to Empire Drug Lists (formularies) effective October 1, 2017**

Effective October 1, 2017, medications listed in the link below will be removed from the Empire National Drug List. These changes will apply to all commercial health plan (non-government plan) members that have the Empire National Drug List.

To ensure a smooth transition and to avoid disruption in care, please take time to switch your patients currently on the non-preferred drugs to an appropriate preferred drug. Thank you for your cooperation with this formulary change.

For a complete list of the medications removed from the National Drug List and their preferred alternatives, please go here.

If you have any questions, please contact the Provider Services phone number on the back of the member's ID card.

**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](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](http://www.anthem.com/pharmacyinformation). 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](https://www.caremark.com/portal/asset/z6500_drug_list807.pdf)
- Standard Option: [https://www.caremark.com/portal/asset/z6500_drug_list.pdf](https://www.caremark.com/portal/asset/z6500_drug_list.pdf)

This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at [www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies](http://www.fepblue.org).  

**Intensive In-Home Treatment Program**

Empire offers an in-home treatment option available in Manhattan, Bronx and limited parts of Queens for children, adolescents and young adults with serious mental health and substance use disorders. The New York Foundling, a non-profit organization providing services to New York City children and families, offers Functional Family Therapy through their PICOH Program, an evidence-based intervention for substance use and behavioral health disorders. The treatment is delivered in the member’s home and actively engages all family members in improving relationships and behaviors. More information about The Foundling’s PICOH Program may be obtained by calling them at 1-212-660-1380.
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 08-17-2017
(The following policy is new and determined to not have significant changes.)
- DRUG.00111 - Guselkumab (Tremfya™)

Revised Medical Policies Effective 08-17-2017
(The following policies were revised to expand medical necessity indications or criteria.)
- DRUG.00040 - Abatacept (Orencia®)
- DRUG.00055 - Denosumab (Prolia®, Xgeva®)
- DRUG.00058 - Pharmacotherapy for Hereditary Angioedema
- DRUG.00071 - Pembrolizumab (Keytruda®)
- DRUG.00082 - Daratumumab (DARZALEX™)
- DRUG.00099 - Cerliponase Alfa (Brineura™)
- DRUG.00107 - Avelumab (Bavencio®)
- GENE.00011 - Gene Expression Profiling for Managing Breast Cancer Treatment
- MED.00051 - Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- MED.00081 - Cognitive Rehabilitation
- RAD.00035 - Coronary Artery Imaging: Contrast-Enhanced CT Angiography, Fractional Flow Reserve derived from CT, Coronary MRA, and Cardiac MRI
- RAD.00066 - Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy
- SURG.00055 - Cervical Total Disc Arthroplasty
- SURG.00121 - Transcatheter Heart Valve Procedures

Revised Medical Policies Effective 09-27-2017
(The following policies were reviewed and had no significant changes to the policy position or criteria.)
- ADMIN.00002 - Preventive Health Guidelines
- ADMIN.00004 - Medical Necessity Criteria
- ADMIN.00005 - Investigational Criteria
- ADMIN.00007 - Immunizations
- ANC.00006 - Biomagnetic Therapy
- ANC.00007 - Cosmetic and Reconstructive Services: Skin Related
- BEH.00002 - Transcranial Magnetic Stimulation
- DME.00004 - Electrical Bone Growth Stimulation
- DME.00009 - Vacuum Assisted Wound Therapy in the Outpatient Setting
- DME.00024 - Transtympanic Micropressure for the Treatment of Ménière’s Disease
- DME.00027 - Ultrasound Bone Growth Stimulation
- DME.00030 - Altered Auditory Feedback (AAF) Devices for the Treatment of Stuttering
- DME.00036 - Ultraviolet Light Therapy Delivery Devices for Home Use
- DME.00037 - Cooling Devices and Combined Cooling/Heating Devices
- DME.00039 - Prefabricated Oral Appliances for the Treatment of Obstructive Sleep Apnea
- DRUG.00002 - Tumor Necrosis Factor Antagonists
- DRUG.00006 - Botulinum Toxin
- DRUG.00017 - Hyaluronan Injections in Joints Other than the Knee
- DRUG.00024 - Omalizumab (Xolair®)
- DRUG.00042 - Ustekinumab (Stelara®)
- DRUG.00064 - Enteral Carbipoda and Levodopa Intestinal Gel Suspension
- DRUG.00077 - Monoclonal Antibodies to Interleukin-17A
- DRUG.00080 - Monoclonal Antibodies for the Treatment of Eosinophilic Asthma
- DRUG.00087 - Asfotase Alfa (Strensiq™)
- DRUG.00091 - Naltrexone Implantable Pellets
- DRUG.00093 - Sebelipase alfa (KANUMA™)
- GENE.00021 - Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Abnormalities
- GENE.00022 - In Vitro Companion Diagnostic Devices
- GENE.00042 - Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome
- LAB.00016 - Fecal Analysis in the Diagnosis of Intestinal Disorders
- LAB.00027 - Selected Blood, Serum and Cellular Allergy and Toxicity Tests
- LAB.00031 - Advanced Lipoprotein Testing
- MED.00055 - Wearable Cardioverter Defibrillators
- MED.00090 - Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders
- MED.00098 - Hyperoxemic Reperfusion Therapy
- MED.00107 - Medical and Other Non-Behavioral Health Related Treatments for Autism Spectrum Disorders and Rett Syndrome
- MED.00109 - Corneal Collagen Cross-Linking
- MED.00112 - Autonomic Testing
- MED.00121 - Implantable Interstitial Glucose Sensors
- OR-PR.00005 - Upper Extremity Myoelectric Orthoses
- RAD.00019 - Magnetic Source Imaging and Magnetoencephalography
- RAD.00034 - Dynamic Spinal Visualization (Including Digital Motion X-ray and Cineradiography/ Videofluoroscopy)
- RAD.00042 - SPECT/CT Fusion Imaging
- RAD.00045 - Cerebral Perfusion Imaging using Computed Tomography
- RAD.00046 - Cerebral Perfusion Studies using Diffusion and Perfusion Magnetic Resonance Imaging
RAD.00063 - Magnetization-Prepared Rapid Acquisition Gradient Echo Magnetic Resonance Imaging (MPRAGE MRI)
SURG.00005 - Partial Left Venticulectomy
SURG.00014 - Cochlear Implants and Auditory Brainstem Implants
SURG.00020 - Bone-Anchored and Bone Conduction Hearing Aids
SURG.00026 - Deep Brain, Cortical, and Cerebellar Stimulation
SURG.00032 - Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
SURG.00048 - Panniculectomy and Abdominoplasty
SURG.00049 - Mandibular/ Maxillary (Orthognathic) Surgery
SURG.00051 - Hip Resurfacing
SURG.00054 - Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection
SURG.00056 - Percutaneous Neurolysis for Chronic Neck and Back Pain
SURG.00071 - Percutaneous and Endoscopic Spinal Surgery
SURG.00074 - Nasal Surgery for the Treatment of Obstructive Sleep Apnea (OSA) and Snoring
SURG.00076 - Nerve Graft after Prostatectomy
SURG.00077 - Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques
SURG.00084 - Implantable Middle Ear Hearing Aids
SURG.00086 - Treatment of Osteochondral Defects
SURG.00093 - Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques
SURG.00116 - High-Resolution Anoscopy Screening for Anal Intrathelial Neoplasia (AIN) and Squamous Cell Cancer of the Anus
SURG.00118 - Bronchial Thermoplasty
SURG.00125 - Radiofrequency and Pulsed Radiofrequency Treatment of Trigger Point Pain
SURG.00126 - Irreversible Electroporation (IRE)
SURG.00130 - Devices for Maintaining Sinus Ostial Patency Following Sinus Surgery
SURG.00133 - Alcohol Septal Ablation for Treatment of Hypertrophic Cardiomyopathy
SURG.00134 - Interspinous Process Fixation Devices
SURG.00141 - Doppler-Guided Transanal Hemorrhoidal Dearterialization

Revised Medical Policy Effective 10-14-2017
(The following policy was revised to expand medical necessity indications or criteria.)
  - SURG.00011 - Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting

Revised Medical Policy Effective 10-14-2017
(The following policy was reviewed and had no significant changes to the policy position or criteria.)
  - SURG.00085 - Mastectomy for Gynecomastia

Revised Medical Policies Effective 01-01-2018
(The policies below were revised and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)
  - DRUG.00015 - Prevention of Respiratory Syncytial Virus Infections
  - DRUG.00031 - Subcutaneous Hormone Replacement Implants
  - DRUG.00052 - Pertuzumab (Perjeta®)
  - DRUG.00095 - Ocrelizumab (Ocrevus™)
- DRUG.00103 - Abaloparotide (Tymlos™) Injection
- GENE.00041 - Genetic Testing to Confirm the Identity of Laboratory Specimens

**New Medical Policy Effective 01-01-2018**
(The policy below was created and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)
- LAB.00035 - Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis

**Revised Medical Policies Effective 01-20-2018**
(The policies below were revised and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)
- MED.00005 - Hyperbaric Oxygen Therapy (Systemic/Topical)
- SURG.00007 - Vagus Nerve Stimulation
- SURG.00010 - Treatments for Urinary Incontinence
- SURG.00023 - Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- SURG.00024 - Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- SURG.00055 - Cervical Total Disc Arthroplasty
- SURG.00122 - Venous Angioplasty with or without Stent Placement or Venous Stenting Alone
- SURG.00140 - Peripheral Nerve Blocks for Treatment of Neuropathic Pain
- SURG.00145 - Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)

**Clinical Guideline Updates**

**Revised Clinical Guideline Effective 08-17-2017**
(The following adopted guideline was reviewed and had no significant changes to the policy position or criteria.)
- CG-BEH-03 - Psychiatric Disorder Treatment

**Revised Clinical Guideline Effective 08-19-2017**
(The following adopted guideline was revised to expand medical necessity indications or criteria.)
- CG-SURG-27 - Sex Reassignment Surgery

**Clinical Guidelines Adopted Effective 09-01-2017**
(The following guidelines will be applied and might result in services that were previously covered but may now be found to be not medically necessary.)
- CG-DRUG-53 - Drug Dosage, Frequency, and Route of Administration
- CG-MED-55 - Level of Care: Advanced Radiologic Imaging

**Revised Clinical Guideline Effective 09-27-2017**
(The following adopted guideline was revised to expand medical necessity indications or criteria.)
- CG-DRUG-09 - Immune Globulin (Ig) Therapy

**Revised Clinical Guidelines Effective 09-27-2017**
(The following adopted guidelines were reviewed and had no significant changes to the policy position or criteria.)
- CG-BEH-02 - Adaptive Behavioral Treatment for Autism Spectrum Disorder
- CG-BEH-07 - Psychological Testing
Clinical Guideline Adopted Effective 12-01-2017
(The following guidelines will be applied for dates of service on or after 12-01-2017 and might result in services that were previously covered but may now be found to be not medically necessary.)
- CG-DRUG-29 - Hyaluronan Injections in the Knee

Revised Clinical Guidelines Effective 01-01-2018
(The following adopted guidelines were revised and might result in services that were previously covered but may now be found to be not medically necessary.)
- CG-DRUG-09 - Immune Globulin (Ig) Therapy
- CG-DRUG-11 - Infertility Drugs

Revised Clinical Guidelines Effective 01-20-2018
(The following adopted guidelines were revised and might result in services that were previously covered but may now be found to be not medically necessary.)
- CG-REHAB-08 - Private Duty Nursing in the Home Setting
- CG-SURG-27 - Sex Reassignment Surgery

Coding Updates
As a result of coding updates in the claims system, the claim system edits for the policies 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 January 20, 2018, 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.

- DRUG.00028 – Intravitreal Treatment for Retinal Vascular Conditions
- SURG.00023 - Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- SURG.00085 – Mastectomy for Gynecomastia
- SURG.00086 - Reduction Mammoplasty
Professional Reimbursement Policy updates

Update to Claims Processing Edits and Reimbursement Policies
On October 1, 2017, unless otherwise noted, we will be updating the following new and/or revised reimbursement policies for our commercial products. Reimbursement policies may be reviewed via Empire Online Provider Services accessible through Availity at www.availity.com. Once signed on to the Availity site, select Payer Spaces > Empire > Resources > Provider Portal (Empire). Once on the Empire Provider Services page, choose the link for Reimbursement Policies located under Claim Processing Edits. The updates below identify if the article pertains to professional or facility provider billing. The updates below identify if the article pertains to professional or facility provider billing.

Bundled Services and Supplies
For dates of service on or after December 1, 2017 we will begin to reimburse the Psychiatric Care Collaborative Management Healthcare Common Procedure Coding System (HCPCS Level II) codes G0502, G0503, and G0504. These codes describe behavioral health care coordination that is directed by the primary care team and are reported by primary care providers for their collaboration with a qualified behavioral health provider, such as a Psychiatrist, Licensed Clinical Social Worker, etc. Please see additional information under the article titled “Integrated Medical and Behavioral Healthcare Reminders and Updates.”

In accordance with Section 1 of our policy (always bundled services) which indicates HCPCS G codes for CMS programs are considered always bundled services, effective with dates of service January 1, 2018, HCPCS codes G9143 (warfarin responsiveness testing), G9147 (Outpatient Intravenous Insulin Treatment (OIVIT)), G9156 (evaluation for wheelchair requiring face-to-face visit with physician), and G9157 (transesophageal doppler used for cardiac monitoring) will not be eligible for reimbursement.

Bundled Services and Supplies and Modifiers 59, XE, XP, XS, & XU
The Health Plan considers the use of technology used to assist in the performance of a procedure to be part of the surgical procedure. Therefore, beginning with dates of service on or after January 1, 2018, ultrasonic guidance (Current Procedural Terminology (CPT®) code 76942) will not be eligible for separate reimbursement when reported with trigger point injection services (CPT codes 20552 and 20553); modifiers will not override this edit.

Claim Editing Overview: Professional and Technical Components
As a reminder, a global diagnostic procedure code includes reimbursement for both the professional (26) and technical components (TC). Therefore, according to our policy, when both components are performed by the same provider, the appropriate code must be reported as a global service without the 26/TC modifiers. This will ensure proper reimbursement for the global diagnostic procedure performed.

Effective with dates of service on or after January 1, 2018, we will be updating our policy to indicate that when the professional and the technical component of a global diagnostic procedure are performed by the same provider or an associate provider in the same practice for the same patient, the service must be reported as a global procedure.

Durable Medical Equipment
On October 1, 2017 we are updating the Continuous Rental section of our policy to indicate that pressure/automatic positive airway pressure (CPAP/APAP) devices, bi-level positive airway pressure (BPAP) devices, and corresponding humidifiers will be designated as continuous rental items. As a reminder, continuous rental items reported with durable medical equipment (DME) purchase modifiers will not be eligible for reimbursement.
Frequency Editing

Beginning with claims processed on or after November 18, 2017, for Healthcare Common Procedure Code System (HCPCS) code G0249 (provision of test materials and equipment for home INR monitoring ... includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests) we are revising our current frequency limit of 3 units per 90 days to 3 units per 84 days.

Multiple Surgery Reimbursement

For claims processed on or after November 18, 2017, the Health Plan will apply multiple surgical rules to HCPCS surgical “S” codes that are eligible for reimbursement. Please refer to our Multiple Surgery and Bilateral Processing Reimbursement Policy for details on our multiple surgical rules.

Physical and Manipulative Maintenance Services

As of October 1, 2017, we are retiring our Physical and Manipulative Maintenance Services Reimbursement Policy, however, these physical and manipulative maintenance services should continue to be reported with HCPCS code S8990. As a reminder, providers are encouraged to continue to verify benefits for their members.

Routine Obstetrical Services

According to our policy, evaluation and management (E/M) services are included in the reimbursement for global obstetrical care when reported with a normal pregnancy and/or delivery diagnosis. Beginning with dates of service on or after October 1, 2017, ICD-10 is deleting antenatal screening code Z36 and replacing Z36 with more specific codes for antenatal screening—Z36.1, Z36.2, Z36.3, Z36.4, Z36.5, Z36.81, Z36.82, Z36.83, Z36.84, Z36.85, Z36.86, Z36.87, Z36.88, Z36.89, Z36.8A, and Z36.9. As part of our policy maintenance, based on the ICD-10 changes, we are updating our policy to include these expanded antenatal screening diagnosis codes and delete Z36. Please refer to our policy for further information.

Telehealth Services

Our Telehealth Services Reimbursement Policy received a review and has some minor language updates and clarifications; however, the updates do not change the policy position or criteria.

Coding Tip: Annual Wellness Visits

The Centers for Medicare & Medicaid Services (CMS) developed two codes to describe annual wellness visits (AWV)—G0438 (annual wellness visit, initial visit), which is used to report an initial wellness visit after the first twelve months of Medicare coverage, and G0439 (annual wellness visit, subsequent visit), which is used to report subsequent AWVs. Based on the description of these codes and in agreement with CMS guidelines, G0438 is to be reported only once per patient for the initial AWV and all subsequent AWVs are to be reported with HCPCS code G0439 regardless of the provider, provider group, or provider location.

Coding Tip: Procedure Unbundling

When two or more procedure codes are used to describe a service when a single, more comprehensive procedure code exists that more accurately describes the complete service performed, the comprehensive code that most accurately describes the documented service should be reported. Reporting the most comprehensive code will decrease denials and ensure proper adjudication of the procedure performed.

Reminder

As a reminder, in accordance with our Three Dimensional (3D) Radiology Services and Bundled Services and Supplies Reimbursement Policies, 3D rendering services (76376 and 76377) are not eligible for reimbursement.
Frequency Editing
HCPCS code A9276 (sensor; invasive, disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply) will have a unit limit of 1 per three (3) days of service for claims processed on and after January 1, 2018. Modifiers will not override this frequency limit edit.
For more information visit empireblue.com > Click on the link for Reimbursement Policies under “Learn More”.

Bundled Services and Supplies Code List
Beginning with claims processed on and after November 18, 2017, we have updated the Bundled Services and Supplies Section 1 code list to reflect that transitional care codes 99495 and 99496 are eligible for separate reimbursement.

Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate Transitional Care Management (TCM) code. For 99496, the face-to-face visit must occur within 7 calendar days of the date discharge and medical decision making must be high complexity. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge and medical decision making must be of at least moderate complexity.

Only one provider may report these services and only once per patient within 30 days of discharge.

Facility Reimbursement Policy Updates

Readmission Policy
As communicated in our June 2017 edition of Network Update, the Readmission Policy posted on empireblue.com went into effect September 1, 2017. This policy will not supersede any individual facility contract provisions or state or federal guidelines. To view Empire’s Facility Reimbursement Policies visit empireblue.com > Click on the link for Reimbursement Policies under “Learn More” > Facility Reimbursement Policies > Readmissions.

Clinic Policy
In October 2016, a notification was made regarding new Facility Reimbursement Policy updates that Empire had posted on empireblue.com. The policy will be effective November 1, 2017 and outlines the procedure for processing and clinic charges being billed by Facilities. To view Empire’s Facility Reimbursement Policies visit empireblue.com > Click on the link for Reimbursement Policies under “Learn More” > Facility Reimbursement Policies > Clinic Charges.

State & Federal Programs

Medicare Advantage

Prior authorizations required for new group-sponsored MA membership
Beginning Jan. 1, 2018, Empire will expand the types of benefits available to new group-sponsored Medicare Advantage membership. Some services for these new group-sponsored Medicare Advantage members also will have new utilization management and prior authorization requirements.
Medicare Advantage members with alpha prefixe YGZ are group-sponsored Medicare Advantage members who are eligible for additional services and may require additional utilization management and prior authorizations. Additional information is available at empireblue.com/medicareprovider at Important Medicare Advantage Updates.
Current utilization management and prior authorization requirements for group-sponsored Medicare Advantage membership will not change Jan. 1, 2018 for group-sponsored Medicare Advantage members with the following alpha prefixes: JQB, JQF, VGD, WSP, XDK, XKJ, YGJ, YLR, YLV, YRA and YRE.

Detailed prior authorization requirements are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. As always, you may confirm member benefits via the Availity web portal or by calling the number on the back of the member ID card. Any updates regarding effective dates or other changes will be posted to Important Medicare Advantage Updates.

New group-sponsored MA membership – Delta retirees

Beginning Jan. 1, 2018, many Delta airline retirees will become members of a Medicare Advantage LPPO. We appreciate your care for these new group-sponsored Medicare Advantage members.

It is important to always call and confirm eligibility and benefits before providing care to ensure coverage and accurate copayment/coinsurance collection. Providers can confirm member eligibility and benefit information through the Availity Web Portal at availity.com.

Liability assignment for eye refraction and self-administered drugs

Empire would like to clarify liability assignment related to Statutorily Non-Covered Services of Eye Refraction (procedure code 92015) and Self-Administered Drug (procedure code A9270) when the service is denied on Medicare Advantage individual and group-sponsored claims.

For the liability assessment to be assigned appropriately, we require that the G modifier(s) be submitted on the claim form and the Notice of Denial of Medical Coverage letter be obtained prior to the service rendered.

When the Notice of Denial of Medical Coverage letter is obtained, please submit both the GX and GY modifier on the claim. This billing process is different from traditional Medicare, which only requires a GY modifier be appended to the procedure code.

The Centers for Medicare & Medicaid Services considers Empire Medicare Advantage contracted providers as plan “agents;” therefore related CMS regulations must be followed. Due to this, a GY modifier only submitted on the claim form will not ensure the correct liability assignment for the denied service.

Please refer to the FAQ for Non-Covered Services at empireblue.com/medicareprovider for additional details.

Improve Medicare Advantage members’ medication adherence with 90-day prescriptions

To help improve medication adherence among Empire individual and group-sponsored Medicare Advantage members, Empire will fax providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins to promote the use of 90-day prescriptions. Ninety-day prescriptions help improve the adherence of our Medicare Advantage members by having them travel to their pharmacy less often. When medically appropriate, we request that you convert the member’s prescription to a 90-day supply to improve patient adherence and outcomes without compromising the quality of care. Please note that we do not intend to transfer these prescriptions to a mail-order or specialty pharmacy. The member will obtain the 90-day supply medication at the same pharmacy where he or she previously obtained the 30-day supply prescription.
Help ensure Medicare Part D members receive a Comprehensive Medication Review

The Centers for Medicare & Medicaid Services require that plans with Medicare Part D benefits offer a Comprehensive Medication Review as part of the Medication Therapy Management (MTM) program. A CMR is offered to members who have three or more chronic diseases and who are receiving eight or more maintenance medications. Empire employs SinfoniaRx to contact our qualifying individual and group-sponsored Medicare Part D members to complete the interactive consultation. The CMR consists of a consultation followed by a written medication summary to help educate and support provider recommendations for medication adherence. Please ask these members if they have received a letter or postcard inviting them to participate in a Medication Review.

Include NPI on surgical procedure UB04 bills

In October 2017 Empire will edit for operating provider NPI when a surgical procedure code is billed for members having an individual Medicare Advantage or MMP plan. A surgical procedure code is a code within the range of 10021-69990 but excluding 10035, 10036, 15780-15783, 15786-15789, 15792, 15793, 20527, 20550-20553, 20555, 20612, 20615, 29581-29584, 36406, 36410, 36415, 36416, 44705, 47531, 47532, 50430, 50431, 59425, 59426, 59430, 62302-62305, 62320-62327, 62367-62370, 69209, 69210. When a surgical procedure code is billed the operating provider’s NPI must be billed in box 77 on the facility UB04 CMS 1450 claim form for outpatient services. If a surgical procedure code is billed without an operating provider NPI the claim will be denied for missing NPI.

Critical Access Hospitals (CAH) Reimbursed at Medicare Rate

Effective May 26, 2017, Empire began using a rate database, sourced from CMS-published Medicare hospital cost reports, of CAH inpatient, swing bed and outpatient rates to price claims from non-contracted CAHs for individual Medicare Advantage and MMP members. Consequently, Empire usually will not need a Medicare Administrative Contractor (MAC) rate letter to process claims from non-contracted CAHs for individual Medicare Advantage and MMP members. However, Empire will require a MAC rate letter in the situations noted below. We look forward to handling your claims in a more-timely manner with this process change.

Empire still will require a MAC rate letter or additional information from CAHs in the following situations.

- Non-contracted CAHs must submit a MAC rate letter for claims for Medicare Advantage group-sponsored members.
- Contracted CAHs compensated using Medicare rates must continue to submit MAC rate letters to their Empire network managers as required by contract.
- All CAHs should update Empire regarding a change in status in Method (from I to II or II to I). Note that Method II reimbursement applies to contracted CAHs only if specified in contract.

MA members to receive gift cards for diabetic retinal eye exams

To encourage individual and group-sponsored Medicare Advantage members to receive screening for diabetic retinal disease, eligible members in Empire Medicare Advantage HMO and Special Needs Plans will receive Visionary Rewards, an offer for a $50 VISA gift card for completing a retinal or dilated eye exam in 2017. The goal of the incentive is to improve HEDIS/Star measure (CDC-DRE) and improve member health outcomes while reducing cost of care through early detection and improving member satisfaction.
Empire collaborates with Call9 for SNF bedside emergency care

Empire is collaborating with Call9, now operating in Skilled Nursing Facilities in the New York City area. Call9 delivers bedside emergency care to nursing home patients via their on-site Clinical Care Specialists (CCSs) who are connected to remote Emergency Physicians via Call9 Inc.’s technology platform.

When a nursing home patient suffers an acute event, the Call9 CCS is at the patient's bedside within moments with bedside labs, EKG, telemetry and real-time ultrasound. The CCS will then tap the Call9 Inc. app where they're connected to a remote Emergency Physician who can see the patient, the CCS and all the patient's vitals streaming in real-time to their laptop. The doctor can then direct care through the Call9 CCS.

Use more than token charge for medication reconciliation quality reimbursement

Empire Medicare Advantage is using measurement code 1111F as part of a medication reconciliation quality program for Medicare Advantage members. Since this code is typically a measurement code, please bill more than the token charge to receive reimbursement for the quality program.

Additional information is available here.

Network Delegation for Home Health Care Services

Empire will delegate its provider network for Home Health Care Services for most of our Medicare Advantage individual products to myNEXUS in 2018.

We want to ensure the transition is as seamless as possible for our members. If you are not currently contracted with myNEXUS and wish to continue providing Home Health Care services to Empire Medicare Advantage individual members, please contact myNEXUS using one of the options below:

- To stay current with delegation dates and learn more, visit the myNEXUS Contracting Homepage at https://www.mynexuscare.com/contracting/
- By Email: contracting@mynexuscare.com
- By phone: (844) 411-9622

Keep up with Medicare news

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

- Medication Reconciliation Post-Discharge (MRP): billing codes for reimbursement

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Medicaid

Important notice for Empire BlueCross BlueShield HealthPlus (Empire) providers

Fresenius dialysis facilities will no longer be participating Empire providers as of September 1, 2017. Empire members receiving care at a Fresenius dialysis facility will be notified of this network change. Providers are asked to support members' transitions of care to participating dialysis facilities.

All participating dialysis facility information may be found in the online directory. Visit http://ebcbshp.prismisp.com or contact Provider Services at 1-800-450-8753 for more information. Empire case managers are available to assist with the transition.

If you have questions or know of members needing assistance during this transition, please call Provider Services at 1-800-450-8753. We will be happy to help you. Thank you for the care you provide our members!

Effective November 1, 2017 - prior authorization for genetic testing required

Effective for dates of service on or after November 1, 2017, Empire HealthPlus will transition the medical necessity review of all genetic testing services to AIM Specialty Health® (AIM). Additionally, all genetic testing will now require prior authorization.

Beginning November 1, 2017, please submit genetic testing prior authorization requests to AIM via one of the following ways:

- ProviderPortal℠ is the fastest, easiest way to contact AIM. An online application, ProviderPortal is available 24/7 to process orders in real time and is the fastest and most convenient way to request authorization or check on the status of your previous orders. Go to https://providerportal.com to begin. Registration is required.
- Call the AIM Contact Center toll-free number at 1-800-554-0580, Monday through Friday, 8:30 a.m. to 7 p.m. ET.
- Fax requests will not be accepted for the services reviewed by AIM.

Providers should verify that the necessary prior authorization has been obtained in advance of rendering the services. Failure to do so may result in nonpayment of your claim.

For further questions regarding prior authorization requirements, please contact the Provider Services number on the back of your patient's ID card or your local Network Relations consultant or call Provider Services at 1-800-450-8753.

Access to Disease Management - helping you care for patients with chronic health care needs

Empire HealthPlus Disease Management programs are designed to assist PCPs and specialists in managing the care of Medicaid Managed Care members with chronic health care needs. Members are provided with care management and education by a team of highly qualified disease management professionals whose goal is to create a system of coordinated health care interventions and communications for enrolled members.

Case managers provide support to members with:

- Behavioral health conditions
- Diabetes
- Heart conditions
- Pulmonary conditions
- Substance use disorder
Additionally, in order to improve condition-specific outcomes, case managers use motivational interviewing to identify and address health risks such as tobacco use and obesity. Licensed nurse case managers are available Monday through Friday from 8:30 a.m. to 5:30 p.m., and our confidential voicemail is available 24/7. To contact our Disease Management team, call 1-888-830-4300.

**Hemophilia factor injections to require prior authorization**

Effective October 1, 2017, Empire HealthPlus requires prior authorization (PA) for hemophilia factor injections for Medicaid Managed Care members when provided in the outpatient setting. Federal and state law as well as state contract language including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:
- J7175 — injection of factor x (human), 1 international unit (IU)
- J7179 — injection of von willebrand factor (recombinant), vonvendi, 1 IU
- J7202 — injection of factor ix (albumin fusion protein, recombinant), idelvion, 1 IU
- J7207 — injection of factor viii, (antihemophilic factor, recombinant), pegylated, 1 IU
- J7209 — injection of factor viii, (antihemophilic factor, recombinant), nuwiq, 1 IU

To request PA, you may use one of the following methods:
- Phone: 1-800-450-8753
- Fax: 1-800-964-3627
- Web: Interactive Care Reviewer tool via https://www.availity.com

For detailed PA requirements, please refer to our provider website (www.empireblue.com/nymedicaid > Precertification & Claims > Precertification Lookup Tool) or call Provider Services at 1-800-450-8753.

**Medicaid Reimbursement Policy Updates**

**Modifier 62: Co-Surgeons**
*(Policy 06-027, effective 12/15/17)*

Empire HealthPlus allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62. Each surgeon must bill the same procedure code(s) with Modifier 62. Reimbursement to each surgeon is based on 62.5% of the applicable fee schedule or contracted/negotiated rate. Co-surgeons must be from different specialties and performing surgical services during the same operative session.

For more information, please refer to Modifier 62: Co-Surgeons Reimbursement Policy at www.empireblue.com/nymedicaid.

**Transportation Services: Ambulance and Nonemergent Transport**
*(Policy 07-036, effective 01/01/2018)*

Empire HealthPlus allows reimbursement for medical transport to and from covered services or other services. This policy provides reimbursement guidelines for nonemergent medical transport services, ambulance services and transportation modifiers.

Empire transportation services for emergency and nonemergency are provided through a state vendor.
For additional information, please refer to the Transportation Services: Ambulance and Nonemergent Transport reimbursement policy at www.empireblue.com/nymedicaiddoc > Precertification & Claims > Medicaid Reimbursement Policies. Due to the complex nature of transportation services, Empire recommends that providers also review state guidelines for coverage requirements.

**Medicaid Medical Policy update**

On May 4, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Medical Policies applicable to Empire BlueCross BlueShield HealthPlus (Empire). These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The Medical Policies were made publicly available on the Empire provider website on the effective date listed below. Visit www.empireblue.com/medicalpolicies/search.html to search for specific policies.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Medical Policy number</th>
<th>Medical Policy title</th>
<th>New or revised</th>
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<tr>
<td>5/18/2017</td>
<td>DRUG.00099</td>
<td>Cerliponase Alfa (Brineura™)</td>
<td>New</td>
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<td>5/18/2017</td>
<td>DRUG.00107</td>
<td>Avelumab (Bavencio®)</td>
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<td>5/18/2017</td>
<td>DRUG.00109</td>
<td>Durvalumab (IMFINZI™)</td>
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<td>6/28/2017</td>
<td>MED.00121</td>
<td>Implantable Interstitial Glucose Sensors</td>
<td>New</td>
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<td>6/28/2017</td>
<td>MED.00122</td>
<td>Wilderness Programs</td>
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<td>Spectral Analysis of Prostate Tissue by Fluorescence Spectroscopy</td>
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<td>DME.00040</td>
<td>Automated Insulin Delivery Devices</td>
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<td>DRUG.00002</td>
<td>Tumor Necrosis Factor Antagonists</td>
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<td>Bevacizumab (Avastin®) for Non-Ophthalmologic Indications</td>
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### Effective date | Medical Policy number | Medical Policy title | New or revised
---|---|---|---
6/28/2017 | DRUG.00062 | Obinutuzumab (Gazyva®) | Revised
5/18/2017 | DRUG.00066 | Antihemophilic Factors and Clotting Factors | Revised
5/18/2017 | DRUG.00071 | Pembrolizumab (Keytruda®) | Revised
5/18/2017 | DRUG.00075 | Nivolumab (Opdivo®) | Revised
5/18/2017 | DRUG.00083 | Elotuzumab (Empliciti™) | Revised
5/18/2017 | DRUG.00088 | Atezolizumab (Tecentriq®) | Revised
5/18/2017 | DRUG.00104 | Nusinersen (SPINRAZA™) | Revised
5/18/2017 | GENE.00032 | Molecular Marker Evaluation of Thyroid Nodules | Revised
5/18/2017 | GENE.00035 | Genetic Testing for TP53 Mutations | Revised
6/28/2017 | SURG.00121 | Transcatheter Heart Valves | Revised
5/18/2017 | THER-RAD. 00004 | External Beam Intraoperative Radiation Therapy | Revised
5/18/2017 | TRANS.00024 | Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome | Revised

### Federal Employee Program

**FEP® launches new automated telephone system**

As mentioned in the August newsletter, Empire Blue Cross Blue Shield Federal Employee Program has moved to a new automated telephone system on September 14th. The FEP Customer Service telephone numbers will not change. This new and improved telephone system incorporates voice recognition features as well as touch tone options. You will be able to speak responses or enter responses using corresponding options on your telephone keypad. The system is more intuitive and will prompt for missing or incompatible information. Please listen carefully to the messages as many of our menu options have changed.

A Quick Reference Guide has been created to help you navigate the system and familiarize yourself with the capabilities. When the system is available, you can obtain a copy of the Quick Reference Guide by saying More Choices or Pressing 6 in the Main Menu then Saying IVR Quick Reference or Pressing 2 in the More Choices Menu.