Continuing Our Strategy to Better Serve Member and Provider Needs in 2003

Last year, we focused our provider strategy on the challenges facing the healthcare industry. Here are some highlights of our progress and a brief look at our plans for 2003.

Health management programs: Our heart failure, diabetes, and Blue Health Coach programs combine education, monitoring, and member self-management to improve members’ quality of life and understanding of their disease. Overall medical costs for our heart failure program members decreased by 10 percent for our commercial members and by 20 percent for our Blue Care® 65 members. Utilization has shifted from inpatient services to outpatient and home health services, and drug compliance has improved.

In 2003, we’ll continue to support these programs and begin developing programs for members with coronary artery disease, rare diseases, cancer, and joint diseases.

Physician and group incentives: In 2002, we rewarded physicians with nearly $16.5 million dollars for their PCP Incentive Program results. Participating physicians’ overall performance improved by approximately 8 percent over the prior year.

This year, we have introduced a Group Performance-Based Incentive Program (GPIP) for large group practices. In 2003, 75 percent of our providers, including specialists, will participate in performance-based programs.

Pharmacy cost-management initiatives: In 2002, we began sending PCPs quarterly prescription analysis reports and a pocket BCBSMA formulary. We also expanded our Quality Care Dosing program to provide consistency within classes of drugs. In 2003, we’ll work with pharmacies to support our pharmacy initiatives, including e-prescribing.

Administrative Simplification Efforts: In 2003, we plan to enhance our Web-based provider technology tools, pilot new technologies, and continue to improve existing applications. We will also continue working with our Professional, Institutional, Ancillary, and Billing Agency workgroups to streamline administrative processes.

Solicit Physician Input: In 2003, we’ll continue to work with our Physician Advisory Board and specialty committee meetings to advise us on policies and programs that affect our members and providers. We’re also planning a Physician Summit on Health Care this spring to begin discussing solutions to such complex issues as rising practice and malpractice costs, reimbursement issues, patient access, and quality care.

In This Issue

- Direct Contracts with Hospice Agencies ............2
- How to Bill for Early Maternity ..................2
- Outpatient Hospital Web Services .................2
- Medical Policy Updates .......3
- Medical Record Request ...3

New! Single Phone Number to Reach Provider Relations

To simplify your ability to reach someone who can help you, we have launched a new, easy-to-remember number to call your Provider Relations Manager for non-claims related issues: 1-800-316-BLUE (2583).

Please listen for the correct prompt. The single number replaces our previous region-based 800 numbers for all provider types.

Metro North Provider Relations Moves to Wakefield

At the end of November, our Metro North Provider Relations Managers moved to a new office in Wakefield. Their new address is:

401 Edgewater Place
Suite 570
Mail Stop 74-01
Wakefield, MA 01880
In December we began recontracting with hospice agencies. Under the new contract, BCBSMA reimburses hospice agencies directly for inpatient hospice services and inpatient respite services. This new process makes it easier for members and providers to access the hospice benefit, and is consistent with the process used by other plans in Massachusetts (including Medicare).

We hope that you will work closely with hospice agencies in your community that are contracted with BCBSMA to provide inpatient hospice and respite services and do business through your subcontracted relationships with these agencies.

You will no longer bill BCBSMA for these services. Effective April 1, 2003, BCBSMA will no longer pay hospitals and skilled nursing facilities directly for inpatient hospice and inpatient respite care.

Questions?
Call your Provider Relations Manager at 1-800-316-BLUE.

Home Health Providers:
How to Bill for Early Maternity Discharges and Post-natal Care

In December, we mailed an F.Y.I. alerting you that we added two new CPT codes for early maternity discharge visits to allow for additional reimbursement for these services. Previously, we reimbursed you for early maternity discharge visits under a single revenue code.

Please be sure to bill post-natal mother care assessment (99501) and newborn care assessment (99502) in conjunction with revenue code 551 (skilled nursing). Bill both the mother’s and baby’s assessment on the same claim form under the mother’s name. The total allowable reimbursement for early maternity discharge visits will be the sum of CPT code 99501 and 99502, minus any applicable member co-payments and/or deductibles. We require prior authorization for additional visits by either the mother or baby.

Please continue to bill early maternity discharge claims with the diagnosis code V242.

Billing for Federal Employee Program (FEP) Members
Although FEP members do not have early maternity discharge benefits, home health visits will be considered for payment with a doctor’s order. For FEP members, bill home health visits for mothers and babies on separate claims.

If you have any questions, please call your Provider Relations Manager, Denese Langevin, at 1-800-316-BLUE.

Attention Rehab Facilities: Change to Inpatient Co-pay

The 2003 co-payments for Blue Care®65 inpatient rehabilitation facility services are:

- Days 1-10: $0
- Days 11-90: $50 per day

Reimbursement for Outpatient Hospital Lab Services

For claims with dates of service on or after April 1, 2003, BCBSMA will change our reimbursement for chemistry test panel codes (also called multi-channel chemistry tests.) The new methodology will be consistent with Medicare. After this date, when you submit claims for two or more of the listed chemistry lab tests that cannot be rolled up into an organ or disease panel for the same member on the same date of service, our payment will be prorated.

Background
On January 1, 1998, the American Medical Association deleted chemistry test panel codes from the CPT Manual and introduced organ and disease panel codes in their place. With this change, BCBSMA changed its system to appropriately pay for full organ and disease panels, as called for under the update. However, we did not update our system to continue discounting payment for multiple clinical chemistry tests, as we had done prior to January 1, 1998. Rather, BCBSMA began to pay each such code billed at 100 percent of the fee schedule amount.

This resulted in an unintended increase in outpatient lab payments to hospitals and is inconsistent with Medicare’s handling of this fee coding.
Thanks to your valuable feedback, BCBSMA and other Blue Cross and Blue Shield Plans nationally have improved our medical records management process—particularly for out-of-area and BlueCard® Program claims.

### Specific Medical Records Requests

A new one-page form will accompany requests for medical records we need for claims adjudication. It lists specific information that reviewers need to process your claim. Please return this form with only the requested portions of the record. This eliminates the need for you to send the entire medical record. For certain audit and utilization review purposes, however, we will still require records for multiple members.

#### Expedited Processing

We have made internal changes to expedite claims processing. This means that you will be paid promptly for services provided to our members and members from other Blue Cross and Blue Shield Plans.

#### Better Tracking and Improved Claims Turnaround Time

Our medical records coordinators have implemented new tracking procedures to better coordinate the medical records request process. Our medical records procedures and policies comply with national, state and HIPAA medical record privacy standards. For more information about when patient authorization is and is not needed under HIPAA’s privacy rules, see our Fact Sheet on Understanding HIPAA’s Privacy Rule. You can obtain this document by calling our Fax-on-Demand system at 1-888-633-7654 and requesting document 832.

### Medical Records Request Process Simplified

#### Ultrasound, 007

- Added coverage for Intravascular Ultrasound for coronary vessels. Effective 10/01/02.

#### CT Scan, 009

- Clarified Blue Care®65 and Medex® coverage criteria in accordance with CMS guidelines. Effective 10/15/02.

#### Bone Densitometry, 34

- Clarified coverage criteria for bone densitometry in accordance with CMS guidelines. Effective 12/01/02.

#### Infertility, 086

- Clarified coverage exclusion for serum anti-sperm antibody testing.

#### IVF, 086

- Added coverage for sperm penetration assay. Effective 10/01/02.

#### Magnetic Resonance, 106

- Added coverage criteria for Breast MRI. Effective 4/03. Clarified coverage criteria for magnetic resonance imaging for Blue Care®65 and Medex® in accordance with CMS guidelines. Effective 10/15/02.

#### Mammography and Scintimammography, 125

- Added coverage for computer assisted detection (CAD) for lesion detection, mammography. Effective 04/01/03.

#### SPECT, 330

- Clarified coverage criteria for SPECT for cardiovascular imaging, diagnosis of abnormal EKG covered for Blue Care®65, only.

#### Endometrial Ablation and Uterine Artery Embolization 331

- Added coverage for uterine artery embolization for treatment of fibroids. Effective 03/01/03.

#### Flow Cytometry for Cell Analysis, 341

- Added coverage for cell cycle or DNA analysis for all Plans for partial hydatiform mole. Effective 1/01/03. This diagnosis and others for this procedure are covered for Blue Care®65.

#### Monoclonal Antibody Imaging for Cancer and Other Disorders, 378

- Added coverage for monoclonal antibody imaging in patients with diagnosed ovarian cancer for Blue Care®65 only. Effective 10/01/02.

#### Corneal Topography, Endothelial Microscopy, and Retinal Nerve Fiber Analysis, 391

- Added coverage for retinal nerve fiber analysis (RNFA) also known as SCODI, for diagnosis or management of glaucoma. Indications will include background diabetic retinopathy (362.01) and cystoid macular degeneration (362.53.) Effective 01/01/03.

#### Medical Technology Assessment Non-covered Services, 400

- CPT code 82523, collagen cross-links, is non-covered for all plans. Effective 03/01/03. Added 2003 non-covered CPT and HCPCS codes. Effective 01/01/03.
Partnering With Our Providers to Keep Our Members Healthy

At Your Service

■ Hospital providers:
  • For claims-related questions, call Provider Services at 1-800-451-8123 (hours: 8:30 a.m. to 4:30 p.m., M - F).
  • For all other questions, call your Provider Relations representative at 1-800-316-BLUE (2583).

■ Ancillary providers:
  • For claims-related benefit and eligibility questions, call Ancillary Provider Services at 1-800-451-8124.
  • For all other questions, call Ancillary Provider Relations at 1-800-316-BLUE (2583).

■ All providers:
  • To access BCBSMA’s medical policies and administrative tools, call Fax-on-Demand at 1-888-633-7654. Request document 411 for a list of all available documents.

Blue Focus is published quarterly for BCBSMA hospitals and institutional ancillary providers. Submit letters and suggestions for future articles to:
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