New York Provider News

July 2019 Empire Provider News

Medicaid:

Pharmacy Benefit Manager Change

Published: Jul 1, 2019 - **Products & Programs** / Pharmacy

Upon New York State Department of Health (DOH) approval, Empire HealthChoice HMO, Inc. will change the pharmacy benefit manager for some of its members on July 1, 2019.

Transferring prescriptions

- If your patient currently fills home delivery or specialty prescriptions through Express Scripts or Accredo, prescriptions with at least one refill will be transferred, with the exception of controlled substances, to the IngenioRx Home Delivery Pharmacy and IngenioRx Specialty Pharmacy.
- As your patients transition, new home delivery and specialty prescriptions will need to be sent to the following.
    - o For providers using ePrescribing there are no changes, simply select IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.
    - o For providers who do not use ePrescribing, you should send your new home delivery and specialty prescriptions to the following. *IngenioRx Home Delivery Pharmacy: Phone Number: (833) 203-1742* Fax number: (800) 378-0323 *IngenioRx Specialty Pharmacy:* Prescriber phone: (833) 262-1726 Prescriber fax: (833) 263-2871
- If your patient has an active prior authorization, that will transfer.
- Patients filling prescriptions at a retail pharmacy can continue using their same retail pharmacy, in most cases.
- If you want to check whether or not a specific patient has transitioned, Availity will display the member's information under the Patient Information section as part of the Eligibility and Benefits inquiry.

For more information

If you have immediate questions, you can contact the Provider Service phone number on the back of your patient's ID card or call the number you normally use for questions.

URL: https://providernews.empireblue.com/article/pharmacy-benefit-manager-change

Clinical criteria updates for specialty pharmacy

Published: Jul 1, 2019 - **Products & Programs** / Pharmacy

On December 1, 2018, Empire introduced the new clinical criteria page for injectable, infused or implanted drugs.

Effective for dates of service on and after August 1, 2019, the following new oncology clinical criteria will be included in our clinical criteria review process. The oncology drugs that require prior authorization will continue to require prior authorization notification with AIM.

Existing precertification requirements have not changed for the specific Clinical Criteria below. While there are no material changes, the document number and online location has changed. Go online to access the clinical criteria information. The table below will assist you in identifying the new document number for the clinical criteria that corresponds with the previous Clinical Guideline/Medical Policy.

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

Clinical Guideline	Clinical Criteria Document Number	Clinical Criteria Name	Drug	HCPCS Code
CG-DRUG-76	ING-CC-0089	Mozobil (plerixafor)	Mozobil	J2562

URL: https://providernews.empireblue.com/article/clinical-criteria-updates-for-specialty-pharmacy-23

Clinical Criteria coding updates for specialty pharmacy are available

Published: Jul 1, 2019 - **Products & Programs** / Pharmacy

As a result of coding updates in the claims system, the claim system edits for the clinical criteria 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 determination.

Effective May 1, 2019, we began implementing coding updates in the claims system for the following clinical criteria listed below which may result in not medically necessary determinations for certain services.

- ING-CC-0073 – Alpha-1 Proteinase Inhibitor Therapy

Go online to access the clinical criteria information.

URL: https://providernews.empireblue.com/article/clinical-criteria-coding-updates-for-specialty-pharmacy-are-available-2

Clinical Validation - Professional

Published: Jul 1, 2019 - **Administrative**

Effective with dates of service on or after 10/1/2019, we will update our audit process for claims with modifiers used to bypass claim edits by conducting modifier reviews through a pre-payment clinical validation review process. Claims with modifiers such as -25, -59, -57, LT/RT, and other anatomical modifiers will be part of this review process.

In accordance with published reimbursement policies which document proper usage and submission of modifiers, the clinical validation review process will evaluate the proper use of these modifiers in conjunction with the edits they are bypassing (such as National Correct Coding Initiative). Clinical analysts who are registered nurses and coders will review claims pended for validation, along with any related services, to determine whether it is appropriate for the modifier to bypass the edit.

If you believe a claim reimbursement decision should be reviewed, please follow the normal claims dispute process and include medical records that support the usage of the modifier applied when submitting claims for consideration.

URL: https://providernews.empireblue.com/article/clinical-validation-professional-3

Changes to timely filing requirements for Medicare Advantage

Published: Jul 1, 2019 - **Administrative**

Empire continues to look for ways to improve our processes and align with industry standards. With that in mind, it is also our goal to help providers receive their Empire payments quickly and efficiently. Timely receipt of medical claims for your patients, our members, helps our chronic condition care management programs work most effectively, and also plays a crucial role in our ability to share information to help you coordinate patient care. In an effort to simplify processes, improve efficiencies, and better support coordination of care, we are changing all professional agreements to adopt a common time frame for the submission of claims to us.

Effective September 1, 2019, we will amend the Medicare Advantage Attachment of your Empire Provider Agreement(s) to require the submission of all professional claims within ninety (90) days of the date of service. This means all claims **submitted on and after October 1, 2019,** will be subject to a ninety- (90) day timely filing requirement, and Empire will refuse payment if the claims you file to us are submitted more than ninety (90) days after the date of service.

Please note that all claims for commercial plans must continue to be submitted within 120 days of the date of service, and will be processed by Empire, in accordance with your Provider Agreement.

URL: https://providernews.empireblue.com/article/changes-to-timely-filing-requirements-for-medicare-advantage-1

Make the move to the Availity EDI Gateway today

Published: Jul 1, 2019 - **Administrative**

If you currently submit claims directly to the Empire EDI Gateway, now is the time to make the move.
It is mandatory that, all trading partners must transition to the Availity EDI Gateway to avoid future disablement.

Do you already have an Availity User ID and Login? You can use the same login for your Empire EDI transactions.

- Log in to the Availity Portal and select Help & Training | Get Trained. In the Availity Learning Center, search the Catalog by key word “SONG” for live and on-demand resources created especially for you.

If you wish to become a direct a trading partner with Availity, the setup is easy.

- Use the Availity Welcome Application to begin the process of connecting to the Availity EDI Gateway for your Empire EDI transmissions.

Do you use a clearinghouse today?

- We encourage you to contact your clearinghouse to ensure they have made the move.

Need Assistance?
The Availity Quick Start Guide will assist you with any EDI connection questions you may have.

If you need additional assistance, contact Availity Client Services at 1-800-Availity (1-800-282-4548), Monday through Friday 8 a.m. to 7:30 p.m. Eastern Time.

URL: https://providernews.empireblue.com/article/make-the-move-to-the-availity-edi-gateway-today-3

CRA Reporting Update: 2019 Program Year Progression - What’s in it for you and your patients?

Published: Jul 1, 2019 - **Administrative**

Continuing our 2019 CRA reporting updates, Empire requests your assistance with respect to our CRA reporting processes.

As we reported in the May and June newsletters, we are completing our prospective and retrospective reviews for 2019. Prospectively, we intervene to encourage the participation of the members we have identified as appropriate for clinical assessments. Retrospectively, certified coders review medical charts to determine if there are diagnosis codes that have not been reported.

What's in it for you

- First, monthly you will receive lists of our members who are your patients to help you reach out to those who may have gaps in care, so they can come in for office visits earlier.
- Second, we've heard resoundingly from providers that participation in these programs helps them better evaluate their patients (who are our members) and, as a result, perform more strongly in population health management and gain sharing programs. Many cite that they ask different questions today that allow them to better manage their patients end to end.
- Finally, when you see Empire members and submit assessments, we pay incentives of $50 for a paper submission and $100 for an electronic submission. For additional details on how to earn these incentives and the options available, please contact our CRA Network Education Representative listed below.

What's in it for your patients

Empire has completed monthly postcard campaigns to members with Affordable Care Act (ACA) compliant coverage when we suspect a high risk condition with messaging to encourage the member to call his or her Primary Care Provider (PCP) and schedule an annual checkup. The goal is to get the members in to see their PCPs, so the PCPs have an overall picture of their patients' health and schedule any screenings that may be needed.

We will continue these monthly postcard mailings throughout all of 2019 to continue to encourage the members to be seen in your office, which supplements any patient outreach you may be doing as well.

If you have any questions regarding our reporting processes, please contact our CRA Network Education Representative: Alicia.Estrada@Empire.com.

URL: https://providernews.empireblue.com/article/empire-commercial-risk-adjustment-cra-reporting-update-2019-program-year-progression-whats-in-it-for-you-and-your-patients

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Empire Works to Simplify Payment Recovery Process for National Accounts Membership

Published: Jul 1, 2019 - **Administrative**

In our company's ongoing efforts to streamline and simplify our payment recovery process, we continue to consolidate our internal systems and will begin transitioning our National Accounts membership to a central system in 2019. While this is not a new process, we are transitioning the National Accounts membership to align with the payment recovery process across our other lines of business.

Currently, our recovery process for National Accounts membership is reflected in the EDI PLB segment on the electronic remittance advice (835). This segment will show the negative balance associated with the member account number. Monetary amounts are displayed at the time of the recovery adjustment.

As National Accounts membership transitions to the new system and claims are adjusted for recovery, the negative balances due to recovery are held for 49 days to allow ample time for you to review the requests, dispute the requests and/or send in a check payment. During this time, the negative balances due are reflected on paper remits ***only*** within the "Deferred Negative Balance" sections.

After 49 days, the negative balances due are reflected within the 835 as a corrected and reversed claim in PLB segments.

If you have any questions or concerns, please contact the E-Solutions Service Desk toll free at (800) 470-9630

URL: https://providernews.empireblue.com/article/empire-works-to-simplify-payment-recovery-process-for-national-accounts-membership

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Un-adopted clinical guidelines effective June 1, 2019

Published: Jul 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

(The following guidelines are no longer adopted.)

- CG-DME-07-Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD)
- CG-MED-70-Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule
- CG-MED-72-Hyperthermia for Cancer Therapy

- CG-SURG-24-Functional Endoscopic Sinus Surgery (FESS)
- CG-SURG-70-Gastric Electrical Stimulation
- CG-SURG-73-Balloon Sinus Ostial Dilation
- CG-SURG-76-Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
- CG-THER-RAD-04-Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors

URL: https://providernews.empireblue.com/article/un-adopted-clinical-guidelines-effective-june-1-2019-1

Updates to AIM Advanced Imaging Clinical Appropriateness Guidelines

Published: Jul 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

Effective for dates of service on and after September 28, 2019, the following updates will apply to the AIM Advanced Imaging Clinical Appropriateness Guidelines.

Brain Imaging Guideline contains updates to the following:
Infection, Multiple sclerosis and other white matter diseases, Movement disorders (Adult only), Neurocognitive disorders (Adult only), Trauma, Pituitary adenoma, Tumor, Hematoma or hemorrhage – intracranial or extracranial, Hydrocephalus/ventricular assessment, Pseudotumor cerebri, Spontaneous intracranial hypotension, Abnormality on neurologic exam, Ataxia, Dizziness or Vertigo, Headache, Hearing loss and Tinnitus.

Extremity Imaging Guideline contains updates to the following:
Congenital or developmental anomalies of the extremity (Pediatric only), Discoid meniscus (Pediatric only), Soft tissue infection, Osteomyelitis, Septic arthritis, Bursitis, Capitellar osteochondritis, Fracture, Patellar dislocation, patellar sleeve avulsion, Trauma complications, Bone lesions, Soft tissue mass – not otherwise specified, Lisfranc injury, Labral tear – hip, Labral tear – shoulder, Meniscal tear and ligament tear of the knee, Rotator cuff tear (Adult only), Avascular necrosis, Lipohemarthrosis (Pediatric only), Paget's disease – new multimodality indication and General Perioperative Imaging (including delayed hardware failure), not otherwise specified.

Spine Imaging Guideline contains updates to the following:

Multiple sclerosis or other white matter disease, Spinal infection, Cervical injury, Thoracic or lumbar injury, Paget's disease, Spontaneous (idiopathic) intracranial hypotension (SIH), Perioperative Imaging, including delayed hardware failure, not otherwise specified, Neck pain (cervical), Mid-back pain (thoracic)

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*SM 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: 877-430-2288, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

URL: https://providernews.empireblue.com/article/updates-to-aim-advanced-imaging-clinical-appropriateness-guidelines-6

Reimbursement Policy updates

Published: Jul 1, 2019 - **Policy Updates** / Reimbursement Policies

Modifier 79 reminder: Professional
A recent review of our claim trends has identified that many providers are not billing appropriately for modifier 79. According to Appendix A in the *CPT Professional Edition,* modifier 79 is used to indicate that a procedure or service is an "…*unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period*". If the current procedure or service does not fall within the postoperative period of a previously performed 0, (same day), 10 or 90 day postoperative period, by the same provider or a provider in the same group practice, please carefully consider the definition of modifier 79 when adding the modifier to a procedure or service.

Modifier 63 reminder: Professional

According to Appendix A of the CPT Professional Edition codebook, modifier 63 is only used when an invasive procedure is performed on neonates or infants up to a present body weight of 4 kg to indicate significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. Unless otherwise designated, this modifier should only be appended to the procedures/services identified in the modifier description. Additionally, based on the modifier description, modifier 63 is not valid for use with evaluation and management, anesthesia, radiology, pathology/laboratory, or medicine codes. Furthermore, many procedures performed on infants for correction of congenital abnormalities include additional difficulty or complexity that are inherent to the procedure and are identified by the code nomenclature and the CPT parenthetical "do not use modifier 63 in conjunction with…" These codes are also identified in Appendix F of the CPT Professional Edition codebook. Please note, incorrect reporting of modifier 63 may result in claim denials.

ICD-10-CM Coding Guidelines and Laterality: Professional
With the adoption of ICD-10-CM code set, we were introduced to diagnosis codes that now indicate the laterality of a condition. At present, diagnosis code descriptions indicate whether the condition is present on the left, right or exists bilaterally. A recent review of our claim denial trends has identified that many providers are not billing appropriately in regards to laterality. For specific guidance for reporting a diagnosis that designates a condition on the left and right versus a bilateral diagnosis refer to the *ICD-10-CM Official Guidelines for Coding and Reporting FY 2019***,** specifically, the General Coding Guidelines Section and the Chapter Specific Sections. Please carefully consider the information contained in the ICD-10-CM Coding Guidelines when trying to decide between reporting a condition using left diagnosis and right diagnosis codes versus a bilateral diagnosis code.

URL: https://providernews.empireblue.com/article/reimbursement-policy-updates-3

Empire Federal Employee Health Benefit Program® (FEP) PPO Members will now require prior approval for specific Specialty Drugs and Site of Care

Published: Jul 1, 2019 - **State & Federal** / Federal Employee Plan (FEP)

Effective July 1, 2019, Empire Federal Employee PPO members, *(ID numbers beginning with an, **'R'***), aged 18 and older, and not Medicare Primary, will now need to have Prior Approval for the following medications:

List of medications by name and code

Code	Procedure Description	CODE	Procedure Description
J0129	Abatacept injection **(Orencia)**	J1575	Injection, immune globulin/hyaluronidase **(HyQvia)**
J0490	Belimumab injection **(Benlysta)**	J1599	Injection, immune globulin **(Panzyga)**
J1459	Injection, immune globulin **(Privigen)**	J1602	Golimumab IV **(Simponi Aria)**
J1555	Injection, immune globulin **(Cuvitru)**	J1745	Infliximab not biosimilar **(Remicade)**
J1556	Injection, immune globulin **(Bivigam)**	J2323	Natalizumab injection **(Tysabri)**
J1557	Injection, immune globulin **(Gammaplex)**	J3380	Vedolizumab Injection **(Entyvio)**
J1559	Injection, immune globulin **(Hizentra)**	Q5103	Infliximab dyyb biosimilar **(Inflectra)**
J1561	Injection, immune globulin **(Gamunex-c/Gammaked)**	Q5104	Infliximab abda biosimilar **(Renflexis)**
J1566	Injection, immune globulin **(Carimune)**	Q5109	infliximab-qbtx, biosimilar **(Ixifi)**
J1568	Injection, immune globulin **(Octagam)**	J1569	Injection, immune globulin, (**Gammagard liquid**)
J1572	Injection, immune globulin , **(Flebogamma)**		

In addition to acquiring Prior Approval for the medication, the Outpatient Hospital Site of Care must also be approved. The Prior Approval process will identify members who meet the appropriate Empire site of care criteria and who can safely receive their medication in a location other than an outpatient hospital, including the home.
Effective January 1, 2020 failure to receive Prior Approval for these medications may result in non-coverage of the medication and facility services.

To acquire Prior Approval please contact the Empire Federal Employee Program Utilization Management Department at 1-800-860-2156.

URL: https://providernews.empireblue.com/article/empire-federal-employee-health-benefit-program-fep-ppo-members-will-now-require-prior-approval-for-specific-specialty-drugs-and-site-of-care

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Medicare Advantage: Electronic claim payment reconsideration

Published: Jul 1, 2019 - **State & Federal** / Medicare

As currently outlined in your provider manual, providers can submit claim payment reconsiderations verbally, in writing or electronically. We are reaching out to notify you about some exciting new tools for electronic submission that will become available through the Availity Portal. In addition, the Medicare Advantage provider manual has been updated with new information regarding claim remediation tools through the Availity Portal.

Beginning June 17, 2019, providers will have the ability to submit claim reconsideration requests through the Availity Portal with more robust functionality. For you, this means an enhanced experience when:

- Filing a claim payment reconsideration.
- Sending supporting documentation.
- Checking the status of your claim payment reconsideration.
- Viewing your claim payment reconsideration history.

New Availity Portal functionality will include:

- Acknowledgement of submission at the time of submission.
- Notification when a reconsideration has been finalized by Empire BlueCross BlueShield.
- A worklist of open submissions to check a reconsideration status.

With the new electronic functionality, when a claim payment reconsideration is submitted through the Availity Portal, we will investigate the request and communicate an outcome through the Availity Portal. Once an outcome has been determined, the Availity Portal user

who submitted the claim payment reconsideration will receive notification through Availity informing the user the reconsideration review has been completed. If you are not satisfied with the reconsideration outcome, continue to follow the process to file a claim payment appeal, as outlined in your provider manual.

You can get a jump start on your training and be ready to go as soon as the tool is fully launched. To learn more about the claim payment dispute tool, register for a live webinar or view a previous recording:

- Log in to Availity at **http://www.availity.com**.
- Select Help & Training | Get Trained.
- Enter Appeals in the search field.
- Enroll in a course.

Providers who have questions as they begin to use the new functionality should contact Availity at **1-800-282-4548**.

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URL: https://providernews.empireblue.com/article/medicare-advantage-electronic-claim-payment-reconsideration

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Medicare Advantage: Sepsis diagnosis coding and billing reminder

Published: Jul 1, 2019 - **State & Federal** / Medicare

To help ensure compliance with the coding and billing of Sepsis, Empire BlueCross BlueShield reviews clinical information in the medical records submitted with the claim, including lab results, treatment and medical management. In order to conduct the review accurately and consistently, our review process for Sepsis applies ICD-10-CM coding and documentation guidelines, in addition to the updated and most recent Sepsis-3 clinical criteria published in the **Journal of the American Medical Association, February 2016**. At discharge, clinicians and facilities should apply the Sepsis-3 criteria when determining if their patient's clinical course supports the coding and billing of Sepsis. The claim may be subject to an adjustment in reimbursement when Sepsis is not supported based on the Sepsis-3 definition and criteria.

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URL: https://providernews.empireblue.com/article/medicare-advantage-sepsis-diagnosis-coding-and-billing-reminder

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Home health billing guidelines for contracted providers

Published: Jul 1, 2019 - **State & Federal** / Medicare

*This information is intended for home health agencies that **do not** submit their claims to MyNexus and are contracted with Empire BlueCross BlueShield (Empire) to be compensated based on the original Medicare Home Health Prospective Payment System. This information is not intended for home health agencies that are contracted to be compensated based on per visit rates.*

Below are some billing guidelines we recommend home health providers use when billing a Request for Anticipated Payment (RAP) and final claim to Empire. This information will assist home health providers in receiving the correct and timely payment according to Medicare guidelines and their contract.

- Empire should receive the final bill within 120 days after the start date of the episode or 60 days after the paid date of the RAP claim — whichever is greater. If the final bill is not received within this time frame, the RAP payment will be canceled/recouped — This is a Medicare billing requirement.
- Bill the full Medicare allowed amount for the episode as the billed charges. Do not bill only the expected additional payment on the final claim as the billed charges. When this happens, the Lesser of Logic term in your contract affects the final payment made for the services. If the billed charges are less than the final allowed, the payment will be reduced to only pay up to the billed charges. The billed charges on the final claim should be for at least the full Medicare allowed amount for the services rendered. This will allow the claim to process correctly according to Medicare guidelines.

- Example: RAP claim paid $500. The final claim is submitted with billed charges in the amount of $1,000. The Medicare allowed amount is $1,500. Since the billed charges on the final claim are only $1,000, Empire would only pay an additional $500 for the final allowed according to the Lesser of Logic term in the contract. If the provider would have

billed charges in the amount of at least $1,500, then an additional payment of $1,000 would have been paid.

Please contact your Provider Relations representative with any questions.

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URL: https://providernews.empireblue.com/article/home-health-billing-guidelines-for-contracted-providers-3

Medical Policies and Clinical Utilization Management Guidelines update

Published: Jul 1, 2019 - **State & Federal** / Medicare

Category: Medicare Advantage

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. The Medical Policies and Clinical UM Guidelines below are followed in the absence of Medicare guidance.

Please share this notice with other members of your practice and office staff.

To view a guideline, visit **https://www11.empireblue.com/ny_search.html**.

Updates:

- **MED.00110 — Growth Factors, Silver-Based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting** was revised to add bioengineered autologous skin-derived products (for example, SkinTE) as investigational and not medically necessary.
- **MED.00126 — Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders** was revised to add nasal nitric oxide as investigational and not medically necessary in the diagnosis and monitoring of asthma and other respiratory disorders.

- **SURG.00037 — Treatment of Varicose Veins (Lower Extremities)** was revised to replace “non-surgical management” with “conservative therapy” in the medically necessary criteria and to add sclerotherapy used in conjunction with a balloon catheter (for example, KAVS procedure) as investigational and not medically necessary.
- **TRANS.00035 — Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases (Previous title: Mesenchymal Stem Cell Therapy For Orthopedic Indications)** was revised to expand the scope to address non-FDA-approved uses of mesenchymal stem cell therapy; the position statement has been revised to the following: “Mesenchymal stem cell therapy is considered INV & NMN for the treatment of joint and ligament disorders caused by injury or degeneration as well as autoimmune, inflammatory and degenerative diseases.”
- The following **AIM Specialty Healthâ updates** took effect on January 24, 2019: Advanced Imaging (imaging of the heart and imaging of the head and neck), Arterial Ultrasound and Joint Surgery.

Medical Policies

On January 24, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Empire BlueCross BlueShield (Empire).

Publish date	***Medical Policy* #**	***Medical Policy* title**	**New or revised**
2/27/2019	LAB.00036	Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus	New
2/27/2019	SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
1/31/2019	DRUG.00088	Atezolizumab (Tecentriq®)	Revised
2/27/2019	MED.00126	Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders	Revised
2/27/2019	MED.00110	Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting	Revised
2/27/2019	TRANS.00035	Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament	

Disorders, Autoimmune, Inflammatory and Degenerative Diseases *Previous title: Mesenchymal Stem Cell Therapy For Orthopedic Indications*	Revised		
1/31/2019	OR-PR.00003	Microprocessor Controlled Lower-Limb Prosthesis	Revised
1/31/2019	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
2/27/2019	SURG.00037	Treatment of Varicose Veins (Lower Extremities)	Revised

Clinical UM Guidelines

On January 24, 2019, the MPTAC approved the following *Clinical UM Guidelines* applicable to Empire. These guidelines were adopted by the medical operations committee for Medicare Advantage members on March 28, 2019.

Publish date	***Clinical UM Guideline* #**	***Clinical UM Guideline* title**	**New or revised**
1/31/2019	CG-ANC-07	Inpatient Interfacility Transfers	New
1/31/2019	CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	Revised
1/31/2019	CG-DRUG-99	Elotuzumab (Empliciti™)	Revised
1/31/2019	CG-LAB-09	Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain	Revised
1/31/2019	CG-REHAB-02	Outpatient Cardiac Rehabilitation	Revised
1/31/2019	CG-SURG-27	Sex Reassignment Surgery	Revised
1/31/2019	CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Revised
2/27/2019	CG-DRUG-106	Brentuximab Vedotin (Adcetris®)	Revised
2/27/2019	CG-GENE-05	Genetic Testing for DMD Mutations (Duchenne or Becker Muscular Dystrophy)	New
2/27/2019	CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	Revised
2/27/2019	CG-SURG-77	Refractive Surgery	Revised

2/27/2019	CG-SURG-92	Paraesophageal Hernia Repair	New
2/27/2019	CG-SURG-93	Angiographic Evaluation and Endovascular Intervention for Dialysis Access Circuit Dysfunction	New
3/21/2019	CG-SURG-94	Keratoprosthesis	New
3/21/2019	CG-SURG-95	Sacral Nerve Stimulation and Percutaneous Tibial Nerve Stimulation for Urinary and Fecal Incontinence; Urinary Retention	New
3/21/2019	CG-SURG-96	Intraocular Telescope	New

EBSCRNU-0028-19

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URL: https://providernews.empireblue.com/article/medical-policies-and-clinical-utilization-management-guidelines-update-13

Keep up with Medicare news

Published: Jul 1, 2019 - **State & Federal** / Medicare

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

- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- Group Retiree members and National Access Plus]

EBSCRNU-0034-19

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URL: https://providernews.empireblue.com/article/keep-up-with-medicare-news-69

New service types added to Availity

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

Enhancements have been made to the Availity Portal that will now allow you to access more service types when using the Eligibility and Benefits Inquiry tool and will also allow us to share even more valuable information with you electronically.

You may have already noticed new additions to service types, including:

- Medically related transportation.
- Long-term care.

- Acupuncture.
- Respite care.
- Dermatology.
- Sleep study therapy (found under diagnostic medical).
- Allergy testing.

Note, although there is an extensive list of available benefit types available when submitting an eligibility and benefits request, these types do vary by payer.

Here are some important points to remember when selecting service types:

- The benefit/service type field is populated with the last benefit type you selected. If you don’t see a specific benefit in the results, submit a new request and select the specific benefit type/service code.
- You have the ability to inquire about 50 patients at one time using the Add Multiple Patients feature.

NYE-NU-0139-19

URL: https://providernews.empireblue.com/article/new-service-types-added-to-availity-1

Electronic claim payment reconsideration

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

Currently, providers can submit claim payment reconsideration requests verbally, in writing or electronically. We are reaching out to notify you about some exciting, new tools for electronic submission of Medicaid claims that will become available through the Availity Portal. You should soon see changes in your provider manual that will outline this new information.

Beginning June 17, 2019, providers will have the ability to submit claim reconsideration requests through the Availity Portal with more robust functionality. This means an enhanced experience when:

- Filing a claim payment reconsideration request.
- Sending supporting documentation.
- Checking the status of a claim payment reconsideration.
- Viewing your claim payment reconsideration history.

New Availity Portal functionality will include:

- Immediate acknowledgement of submission.
- Notification when a reconsideration has been finalized by Empire BlueCross BlueShield HealthPlus.
- A worklist of open submissions to check a reconsideration status.

With the new electronic functionality, when a claim payment reconsideration request is submitted via the Availity Portal, we will investigate the request and communicate an outcome through the Availity Portal. Once an outcome has been determined, the Availity Portal user who submitted the claims payment reconsideration request will receive notification informing them that the reconsideration review has been completed. If the user is not satisfied with the reconsideration outcome, they should continue to follow the existing process to file a claim payment appeal as outlined in the provider manual.

To register for a webinar or access a recorded webinar:

Log in to the Availity Portal at **https://www.availity.com** > Select Help & Training > Select Get Trained.
From the Availity Learning Center, enroll using one of the following methods:

- Select the Dashboard drop-down arrow > Select Catalog > Select Sessions > Select the date of the webinar > Select the webinar title > Select Enroll.
- While in the Catalog, select the Search button > Enter the webinar title > Select Enroll.

Providers who have questions as they begin to use the new functionality should contact Availity at **1-800-282-4548**.

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URL: https://providernews.empireblue.com/article/electronic-claim-payment-reconsideration-12

Trauma-informed care

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

As part of the Empire BlueCross BlueShield HealthPlus effort to improve mental health treatment for members, we are working with providers on a new initiative for trauma-informed care (TIC). TIC is an evidence-based practice that helps educate, inform and guide treatment options for those impacted by trauma. When implementing TIC, organizations can assess and treat trauma more effectively. TIC providers and facilities can improve members' lives and improve health outcomes.

The training includes:

- A brief overview.
- Principles of TIC.
- Agency self-assessment.
- How to assess for trauma.
- Treatment and intervention options.

If you have questions or would like more information on this topic, please contact Stephen Elsis at **steve.elsis@empireblue.com**.

NYE-NU-0138-19

URL: https://providernews.empireblue.com/article/trauma-informed-care

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Sepsis diagnosis coding and billing reminder

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Category: Medicaid

To help ensure compliance with the coding and billing of Sepsis, Empire BlueCross BlueShield HealthPlus reviews clinical information in the medical records submitted with the claim, including lab results, treatment and medical management. In order to conduct the review accurately and consistently, our review process for Sepsis applies ICD-10-CM coding and documentation guidelines, in addition to the updated and most recent Sepsis-3 clinical criteria published in the **Journal of the American Medical Association, February 2016**. At discharge, clinicians and facilities should apply the Sepsis-3 criteria when determining if their patient's clinical course supports the coding and billing of Sepsis. The claim may be subject to an adjustment in reimbursement when Sepsis is not supported based on the Sepsis-3 definition and criteria.

NYE-NU-0127-19

URL: https://providernews.empireblue.com/article/sepsis-diagnosis-coding-and-billing-reminder-3

Unspecified diagnosis code update

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

Empire BlueCross BlueShield HealthPlus (Empire) previously communicated that as of **July 1, 2018**, we now require unspecified diagnosis codes to be used only when an established diagnosis code does not exist to describe the diagnosis for our members. Our goal is to align with ICD-10-CM requirements, using more specific diagnosis codes when available and appropriate. This includes codes that ICD-10-CM provides with laterality specifying whether the condition occurs on the left, right or is bilateral. The target effective date has been delayed for implementing the corresponding code edit. However, providers are encouraged to ensure their billing staff is aware of the required specificity in reporting ICD-10-CM diagnosis codes to prevent future denials.

Empire will be sending out a follow-up article to inform providers of when to expect this requirement to go live and any additional details for the changes made.

NYE-NU-0134-19

URL: https://providernews.empireblue.com/article/unspecified-diagnosis-code-update

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Coding Spotlight: Hypertension, A providers' guide for coding

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

ICD-10-CM coding for hypertension

ICD-10-CM hypertension coding highlights:

- Hypertensive crisis can involve hypertensive urgency or emergency.
- Hypertension can occur with heart disease, chronic kidney disease (CKD) or both.
- ICD-10-CM classifies hypertension by type as essential or primary (categories I10-I13) and secondary (category I15).1
- Categories I10-I13 classify primary hypertension according to a hierarchy of the disease from its vascular origin (I10) to the involvement of the heart (I11), CKD (I12), or heart and CKD combined (I13).1

Hypertension categories:

Code	Description
I10	Essential (primary) hypertension
I11.0	Hypertensive heart disease with heart failure
I11.9	Hypertensive heart disease without heart failure
I12.0	Hypertensive CKD with stage 5 CKD or end-stage renal disease (ERSD)
I12.9	Hypertensive CKD with stage 1 through stage 4 CKD or unspecified CKD
I13.0	Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD or unspecified CKD
I13.10	Hypertensive heart and CKD without heart failure with stage 1 through stage 4 CKD or unspecified CKD
I13.11	Hypertensive heart and CKD without heart failure with stage 5 CKD or ERSD
I13.2	Hypertensive heart and CKD with heart failure and with stage 5 CKD or ERSD
I15.-	Secondary hypertension
I16.-	Hypertensive crisis

Hypertensive heart disease

ICD-10-CM presumes a causal relationship between hypertension and heart involvement and classifies hypertension and heart conditions to category I11 (hypertensive heart disease) because the two conditions are linked by the term “with” in the *Alphabetic Index of ICD-10-CM*. These conditions should be coded as related even in the absence of provider documentation linking them. Code first I11.0 (hypertensive heart disease with heart failure) as instructed by the note at category I50 (heart failure). If the provider specifically documents different causes for the hypertension and the heart condition, the heart condition (I50.-, II51.4 to I51.9) and hypertension are coded separately.1

Category I11 is subdivided to indicate whether heart failure is present. However, an additional code from category I50 is required to specify the type of heart failure, if known.

Documentation may vary, but coding instructions remain the same. For example:

- Congestive heart failure due to hypertension: I11.0 + I50.9
- Hypertensive heart disease with congestive heart failure: I11.0 + I50.9
- Congestive heart failure with hypertension: I11.0 + I50.9

Other heart conditions that have an assumed causal connection to hypertensive heart disease:

Code	Description
I51.4	Myocarditis, unspecified
I51.5	Myocardial degeneration
I51.7	Cardiomegaly
I51.81	Takotsubo syndrome
I51.89	Other ill-defined heart diseases
I51.9	Heart disease, unspecified

Hypertension and CKD
When the diagnostic statement includes both hypertension and CKD, ICD-10-CM assumes there is a cause-and-effect relationship. A code from category I12 (hypertensive CKD) is assigned because the two conditions are linked by the term “with” in the *Alphabetic Index of ICD-10-CM*. These conditions should be coded as related even in the absence of provider documentation linking them, unless the documentation clearly states the conditions are unrelated.1

A fourth character is used with category I12 to indicate the stage of the CKD. The appropriate code from category N18 should be used as a secondary code to identify the stage of CKD.

Hypertensive heart and CKD
Combination category I13 codes are assigned for hypertensive heart and CKD when there is hypertension with both heart and kidney involvement. If heart failure is present, an additional code from category I50 is assigned to identify the type of heart failure.1

The appropriate code from category N18 (CKD) should be used as secondary code with a code from category I13 to identify the stage of CKD.

Hypertensive cerebrovascular disease
For hypertensive cerebrovascular disease, first the appropriate code from categories I60 to I69 is assigned followed by the hypertension code.

Hypertensive retinopathy

Subcategory H35.0 (background retinopathy and retinal vascular changes) should be used with a code from category I10 to I15 (hypertensive disease to include the systemic hypertension).2

Hypertension, secondary
Two codes are required — one to identify the underlying etiology and one from category I15 to identify the hypertension. For example:

- Hypertension due to systemic lupus erythematosus: M32.10 + I15.8
- Acromegaly with secondary hypertension seen for hypertension management: I15.2 + E22.0

Hypertension, transient
Code R03.0 (elevated blood pressure reading without diagnosis of hypertension) is assigned unless the patient has an established diagnosis of hypertension. For transient hypertension of pregnancy, code O13.- (gestational [pregnancy-induced] hypertension without significant proteinuria) or O14.- (pre-eclampsia).

Hypertensive crisis
A code from category I16 (hypertensive crisis) is assigned for any documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Report two codes, at a minimum, for hypertensive crisis. The crisis code is reported in addition to the underlying hypertension code (I10 to I15).1

- Hypertensive urgency: I16.0
- Hypertensive emergency: I16.1
- Hypertensive crisis, unspecified: I16.9

Pulmonary hypertension
Pulmonary hypertension is classified to category I27 (other pulmonary heart diseases). For secondary pulmonary hypertension (I27.1, I27.2-), any associated conditions or adverse effect of drugs or toxins should be coded.2

More coding tips
Blood pressure and medication management should be assessed at every encounter involving a hypertensive patient. Clarity is important in documenting hypertension. Ensure that the diagnosis is captured by noting it in the medical record documentation:

- Specify a pregnant patient with hypertension as having a pre-existing, gestational, pre-eclampsic or eclampsic hypertension.
- Document and code the smoking status of a patient with hypertension:

- Current smoker: F17.
- Personal history of tobacco dependence: Z87.891
- Tobacco use: Z72.0
- Exposure to environmental tobacco smoke: Z57.31

- Document any causal relationship between hypertension and background retinopathy or other condition in which the hypertension caused vascular changes and organ damage.

HEDIS Quality Measures for hypertension
The Controlling High Blood Pressure (CBP) measure looks at a sample of members ages 18 to 85 years of age who have a diagnosis of hypertension and whose blood pressure (BP) is regularly monitored and controlled.3

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

Record your efforts
Document blood pressure and diagnosis of hypertension. Patients whose BP is adequately controlled include patients ages 18 to 59 with less than 140/90 mm Hg.

Both systolic and diastolic values must be below the stated value. The most recent BP measurement during the year counts toward compliance.

What does not count?

- A BP measurement taken on the same day or one day before the test or procedure (fasting blood tests not included).
- Patient reported BP measurements.
- A BP measurement taken on the same day as a diagnostic test or procedure that requires a change in diet or medication regimen. For example:

- Procedures that require a change in diet or medication regimen: colonoscopy, dialysis, infusions, chemotherapy, nebulizer treatment with albuterol and injection of lidocaine prior to mole removal

- Procedures (low-intensity or preventive) that would not disqualify the BP reading:

Codes to identify hypertension

ICD-10-CM	CPT Category II codes4
I10	3074F: systolic BP <130 3075F: systolic BP 130 to 139 3077F: systolic BP ≥140 3078F: diastolic BP <80 3079F: diastolic BP 80 to 89 3080F: diastolic BP ≥90

Strategies for success

- Improve the accuracy of BP measurements performed by your clinical staff by:

- Providing training materials from the American Heart Association.
- Conducting BP competency tests to validate the education of each clinical staff member.
- Making a variety of cuff sizes available.

- Instruct your office staff to recheck BPs for all patients with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits; have your staff record the recheck in the patient's medical records.
- Educate your patients (and their spouses, caregivers or guardians) about the elements of a healthy lifestyle, such as:

- Heart-healthy eating and low-salt diet.
- Smoking cessation and avoiding secondhand smoke.
- Adding regular exercise to daily activities.
- Home BP monitoring.
- Ideal body mass index.
- The importance of taking all prescribed medications as directed.

- Remember to include the applicable Category II reporting codes on the claim form to help reduce the burden of HEDIS medical record review.

Resources

1 “ICD-10-CM Expert for Physicians. The complete official code set,” Optum360, LLC (2019).2 Elsevier, “ICD-10-CM/PCS Coding, Theory and Practice — 2019/2020 Edition.”3 “HEDIS Measures and Technical Resources,” NCQA, accessed April 15, 2019, https://www.ncqa.org/hedis/measures.4 “CPT 2019 Professional Edition,” American Medical Association (2019).5 “HCPCS Level II,” American Medical Association (2019).

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URL: https://providernews.empireblue.com/article/coding-spotlight-hypertension-a-providers-guide-for-coding

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Health Homes - a valuable provider of community-based care coordination

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Category: Medicaid

Empire BlueCross BlueShield HealthPlus provides community-based care coordination through Health Homes and
their care management partners. Eligible Medicaid Managed Care members are assigned a dedicated care manager who will set up an in-person meeting with the member to:

- Review their health, work, housing, nutrition and transportation needs.
- Complete all the necessary forms.
- Explain how care managers work with the member and help link them to services in the community.

Health Homes are a covered Medicaid benefit, which means that there is no additional cost to our members. To enroll, members simply need to meet with a Health Homes care manager.

Community-based care coordination services offered through Health Homes include:

- Support coordinating care amongst all of a member's providers.
- Working with the health plan to find the most suitable providers.
- Helping a member meet their recovery goals.
- Educating a member about employment or training opportunities.
- Coordinating medical appointments and accompanying a member on visits.
- Identifying services such as transportation and crisis prevention/intervention.
- Navigating the health care and social service systems with the member.
- Assisting a member with applying for benefits like food stamps, stable housing and other benefits.
- Educating a member on how to stay healthy and out of the emergency room and/or hospital.
- Serving as a point of contact for a member's health care.

As always, we are committed to ensuring members receive quality health care — in the right place, at the right time.

If you have questions regarding Health Homes, contact Monique Benitez at **1-646-532-8837** or Samantha Bicanic at **1-646-477-9831**.

NYE-NU-0136-19

URL: https://providernews.empireblue.com/article/health-homes-a-valuable-provider-of-community-based-care-coordination

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Reimbursement Policy Update: Multiple Radiology Payment Reduction (Policy 12-002)

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Category: Medicaid

There is a change regarding reimbursement for diagnostic imaging.

Currently, the global, professional component and technical component of diagnostic imaging procedures are reimbursed at 100% of the contracted/negotiated rate for each professional component and technical component service with the highest payment. Reimbursement of subsequent services is based on:

- 95% of the professional component.
- 60% of the technical component.

However, effective October 1, 2019, Empire BlueCross BlueShield HealthPlus will reimburse for diagnostic imaging procedures based on the following:

- 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure
- 60% for the second and additional services

NYE-NU-0140-19

URL: https://providernews.empireblue.com/article/reimbursement-policy-update-multiple-radiology-payment-reduction-policy-12-002

Pharmacy benefit manager change

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

Go online to learn more about the Pharmacy benefit manager change.

URL: https://providernews.empireblue.com/article/pharmacy-benefit-manager-change-1

New York City Department of Health advisory: HIV outbreak risk factors are present in New York City

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

Click here to read more about the New York City Department of Health advisory.

URL: https://providernews.empireblue.com/article/new-york-city-department-of-health-advisory-hiv-outbreak-risk-factors-are-present-in-new-york-city

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