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New York Provider News

September 2019 Empire Provider News

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Clinical Criteria and Prior Authorization updates for specialty pharmacy are available

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

Empire expands specialty pharmacy prior authorization list

Effective for dates of service on and after December 1, 2019, the following non-oncology specialty pharmacy codes from current clinical criteria will be included in our prior authorization review process.

Please note, inclusion of NDC code on your claim will shorten the claim processing time of drugs billed with a Not Otherwise Classified (NOC) code.

Empire’s prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Empire’s medical specialty drug review team. Oncology drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Clinical Criteria	HCPCS or CPT Code(s)	NDC Code(s)	Drug
ING-CC-0031	J3490	71879-0136-01	Yutiq™
ING-CC-0003	J3490 J3590 C9399	68982-0810-01 68982-0810-02 68982-0810-03 68982-0810-04 68982-0810-05 68982-0810-06	Cutaquig®
ING-CC-0003	J1599	69800-0250-01	Asceniv™

Clinical criteria updates for specialty pharmacy

Clinical criteria ING-CC-0061 addresses the use of gonadotropin releasing hormone analogs for the treatment of non-oncologic indications.

Effective for dates of service on and after December 1, 2019, the use of Zoladex for the treatment of endometriosis will be limited to 6 months.

To access the clinical criteria information please click here.

Clinical Criteria updates for specialty pharmacy are available

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

The following Clinical Criteria documents were endorsed at the June 20, 2019 Clinical Criteria meeting. To access the clinical criteria information please click here.

Empire's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Empire's medical specialty drug review team. Oncology drugs will be managed by AIM Specialty Health (AIM), a separate company.

Revised Clinical Criteria effective July 15, 2019

The following current clinical criteria were revised to expand medical necessity indications or criteria.

- ING-CC-0124 Keytruda (pembrolizumab)

Revised Clinical Criteria effective July 15, 2019

The following current clinical criteria were reviewed with no significant change to the medical necessity indications or criteria.

- ING-CC-0008 Subcutaneous Hormonal Implants
- ING-CC-0051 Enzyme Replacement Therapy for Gaucher Disease
- ING-CC-0076 Nulojix (belatacept)
- ING-CC-0077 Palynziq (pegvaliase-pqpz)

Revised Clinical Criteria effective September 1, 2019

The following new clinical criteria were revised to expand medical necessity indications or criteria. The table below will assist you in identifying the new document number for the clinical criteria that corresponds with the previous Clinical or Coverage Guideline.

Clinical or

Coverage Guideline	Clinical Criteria	Clinical Criteria Name	Drug(s)	HCPCS or CPT Code(s)
CG-DRUG-62	ING-CC-0103	Faslodex (fulvestrant)	Faslodex	J9395
DRUG.00062	ING-CC-0121	Gazyva (obinutuzumab)	Gazyva	J9301

Revised Clinical Criteria effective November 1, 2019

The following current clinical criteria were reviewed with no significant change to the medical necessity indications or criteria.

- ING-CC-0048 Spinraza (nusinersen)

Revised Clinical Criteria effective December 1, 2019

The following current clinical criteria were revised and might result in services that were previously covered but may now be found to be not medically necessary.

- ING-CC-0003 Immunoglobulins
- ING-CC-0031 Intravitreal Corticosteroid Implants
- ING-CC-0061 GnRH Analogs for the treatment of non-oncologic indications

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

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Access requirements for Behavioral Healthcare services

Published: Sep 1, 2019 - **Products & Programs** / Behavioral Health

Empire has been advising, via this publication and the Provider Manual, of the requirement that your practice provide the capability for a new patient appointment within a given timeframe. We annually conduct appointment access studies to assess how well practices are meeting this provision and a high percentage of Behavioral Health (BH) offices do not have timely access for new patients.

To be compliant, providers are expected to make best efforts to meet the following access standards:

- ***Initial Routine office visit*** – A new patient must be seen in the office by a designated BH Practitioner or another equivalent Practitioner in the practice within ten business days.

Explanation – This is a routine call for a new patient defined as a patient with non-urgent symptoms, which present no immediate distress and can wait to schedule an appointment without any adverse outcomes. It can be after the Practitioners intake assessment or a direct referral from a treating Practitioner.

Is your practice compliant?

URL: https://providernews.empireblue.com/article/access-requirements-for-behavioral-healthcare-services-2

Reminder: Changes to timely filing requirements for Medicare Advantage

Published: Sep 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.

As a reminder, 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/reminder-changes-to-timely-filing-requirements-for-medicare-advantage

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PCP after-hours access requirements

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

Empire has been advising via this publication and letters to your offices, of the requirementthatyour
practice provide continuation of care for our members outside of regular business hours. We have annually conducted after-hours access studies to assess how well practices are meeting this provision, and a high percentage of PCP offices do not have the basic messaging for our members for perceived emergency or urgent situations after regular office hours.

Tobecompliant,have your messagingoransweringserviceincludeappropriateinstructions.

Emergency situations
The compliant response for an *emergency* instructs the caller/patient to hang up and call 911 or go to ER or connects caller directly to the doctor.

Urgent situations
The compliant response for *urgent* would direct the caller to Urgent Care or ER, to call 911 or directly connect the caller to their doctor or the doctor on call.

Messaging that only gives callers the option of contacting their health care practitioner (via transfer, cell phone, pager, text, email, voicemail, etc.) or to get a call back for urgent questions or instructions is not complaint, as there is no direct connection to their health care practitioner.

Is your practice compliant?

URL: https://providernews.empireblue.com/article/pcp-after-hours-access-requirements-1

Empire launches Sydney on September 1; New app offers better digital health care support to members

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

Empire is working to deliver a new digital ecosystem that better supports our members. To that end, our new platform is designed to give our members a more personal, simplified experience. Empire is driving meaningful change through technology and Artificial Intelligence (AI) powered innovation to deliver an easier to use, more complete Web and mobile health care experience.

We're excited to announce the launch of **Sydney** – our new mobile app that runs on intelligence – as part of our digital strategy. Launching **September 1, 2019,** the new app replaces Empire Anywhere and provides the same services that members receive from Empire Anywhere, plus we'll phase in other features and new capabilities over time. In return, members will get a truly integrated mobile experience with even more personalized information to fit their unique needs. These changes will lead to a more personal experience, better engagement and improved health outcomes.

Beginning September 1, members enrolled in our commercial health benefit plans* (including those plans members purchase on or off the Health Insurance Marketplace) and Medicare health benefit plans will have with **Sydney** a personalized health assistant that connects questions to answers – and people to the right resources. It's all part of a more seamless digital experience, bringing together fully integrated benefit details, claims information, care finder tools, access to spending accounts and wellbeing programs. Members can download **Sydney** at the app stores starting September 1.

As part of our rollout efforts on September 1, Empire will also launch – using a phased approach – a digital solution called My Family Health Record (MyFHR). MyFHR offers several benefits for members and providers. Members will be better able to manage their own health, address care gaps, and have the ability to download electronic medical records (EMR) from one or more providers. With MyFHR, members will also have the ability to share EMR information with family, caregivers, and providers.

Watch for information on future enhancements to **Sydney** and MyFHR in upcoming editions of *Provider News*.

*Excludes Medicaid health benefit plans.

URL: https://providernews.empireblue.com/article/empire-launches-sydney-on-september-1-new-app-offers-better-digital-health-care-support-to-members

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Reminder about lab services for Suffolk County members

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

The Employee Health Plan of Suffolk County only provides coverage for lab services at a hospital based laboratory under limited circumstances,   All standard lab services should be directed to LabCorp. or Quest Labs which are a participating free standing laboratories. You can identify Suffolk County members by the prefix CDK or prefix SUF on the member identification card.

URL: https://providernews.empireblue.com/article/reminder-about-lab-services-for-suffolk-county-members

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Empire CRA Reporting Update: Risk Adjustment Data Validation (RADV) Audit happening now

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

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

The Centers for Medicare & Medicaid Services (CMS) is conducting a RADV Audit beginning **June 2019 through January 2020**. This audit is in accordance with the provisions of the Patient Protection and Affordable Care Act (PPACA) and its risk adjustment data validation standards.

For this audit, CMS will select a statistically valid sample of [Brand]'s members enrolled in an Affordable Care Act (ACA) compliant plan. Providers whose patients during the **benefit year 2018** were selected for this audit will receive requests and must provide copies of medical record(s)/chart(s). This audit is to verify that diagnosis codes, which have been submitted on claims and reported to CMS, are accurate, properly documented, and coded with accurate levels of specificity.

In the event your patients are selected for this RADV audit, please note that Empire is working with several vendors to collect the needed medical records and signature attestations (if applicable). Representatives from Empire or our vendors may reach out to

you to request the required medical records and signature attestations. We appreciate your assistance and patience during this process.

Be advised that Empire is **not** requesting copies of “psychotherapy notes” as defined by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, psychotherapy notes are defined as “notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual’s medical record. However, any data excluded from the definition of psychotherapy notes must be provided where applicable and pursuant to this request. The following list of items are not included in the definition of “Psychotherapy notes” and therefore, can be included pursuant to HIPAA:

- Medication prescription and monitoring
- Counseling session start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests; and
- Summary of the following:
    - o Diagnosis
    - o Functional status
    - o Treatment plan
    - o Symptoms
    - o Prognosis; and
    - o Progress to date

If you have any RADV audit questions/concerns, please contact Evelyn.Rey-Hipolito@anthem.com.

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

URL: https://providernews.empireblue.com/article/empire-cra-reporting-update-risk-adjustment-data-validation-radv-audit-happening-now

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Provider Transparency Update

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

A key goal of Empire's provider transparency initiatives is to improve quality while managing health care costs. One of the ways this is done is by giving certain providers ("Payment Innovation Providers") in Empire's various Payment Innovation Programs (*e.g., Enhanced Personal Health Care, Bundled Payments, Medical Home programs, etc.*) (the "Programs") quality, utilization and/or cost information about the health care providers ("Referral Providers") to whom the Payment Innovation Providers may refer their patients covered under the Programs. If a Referral Provider is higher quality and/or lower cost, this component of the Programs should result in their getting more referrals from Payment Innovation Providers. The converse should be true if Referral Providers are lower quality and/or higher cost.
Providing this type of data, including comparative cost information, to Payment Innovation Providers helps them make more informed decisions about managing health care costs and maintaining and improving quality of care. It also helps them succeed under the terms of the Programs.

Additionally, employers and group health plans (or their representatives or vendors) may also be given quality/cost/utilization information about Payment Innovation Providers and Referral Providers so that they can better understand how their health care dollars are being spent and how their health benefits plans are being administered. This will, among other things, give them the opportunity to educate their employees and plan members about the benefits of using higher quality and/or lower cost health care providers.

Empire will share data on which it relied in making these quality/cost/utilization evaluations upon request, and will discuss it with Referral Providers - including any opportunities for improvement. For questions or support, please refer to your local Network Management Representative or Care Consultant.

URL: https://providernews.empireblue.com/article/provider-transparency-update-17

Policy updates

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

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.

*Note: These updates may not apply to all ASO Accounts as some accounts may have non-standard benefits that apply.

Medical Policy Updates

Revised Medical Policy Effective 07-30-2019
(The following policy was revised to expand medical necessity indications or criteria.)

- MED.00129 - Gene Therapy for Spinal Muscular Atrophy

Clinical Guideline Updates

Archived Clinical Guideline Effective 10-01-2019
(The following guideline has been archived and has been replaced by AIM guidelines.)

- CG-MED-80 - Positron Emission Tomography (PET) and PET/CT Fusion

URL: https://providernews.empireblue.com/article/policy-updates-7

Coding Updates

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

As a result of coding updates in the claims system, the claim system edits for the policies and clinical guidelines 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 December 14, 2019 we will be implementing coding updates in the claims system for the following clinical guidelines listed below which may result in not medically necessary determinations for certain services.

- CG-SURG-101 - Ablative Techniques as a Treatment for Barrett's Esophagus

URL: https://providernews.empireblue.com/article/coding-updates-4

New Clinical Guideline: Pneumatic Compression Devices, effective December 1, 2019

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

Empire will implement the following clinical guideline effective December 1, 2019, to support the review for outpatient pneumatic compression devices post-op outpatient orthopedic procedures.

Visit empireblue.com/provider to view the summary of Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Lower Limbs **(CG-DME-46)**.

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

URL: https://providernews.empireblue.com/article/new-clinical-guideline-pneumatic-compression-devices-effective-december-1-2019-1

New Reimbursement Policy - Maternity Services and Multiple Delivery - Professional

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

Beginning with dates of service on or after December 1, 2019, Empire’s current Routine Obstetrics policy will be retired and will be replaced by the new Maternity Services policy and the new Multiple Delivery policy. The new Multiple Delivery policy has the same reimbursement guidelines and requirements as the current Routine Obstetrics policy. The new Maternity Services policy has the same reimbursement guidelines for global billing as the current Routine Obstetrics policy with an update to the postpartum period. The postpartum period for CPT code 59430 (Postpartum care only) will change from 45 days to a 90 day period.

For more information about this new policy, visit the Reimbursement Policy page at empireblue.com/provider.

URL: https://providernews.empireblue.com/article/new-reimbursement-policies-maternity-services-and-multiple-delivery-professional-3

New Reimbursement Policy - Intensity Modulated Radiation Therapy Planning and Delivery - Professional

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

Beginning with dates of service on or after December 1, 2019, Empire will implement a new professional reimbursement policy, Intensity Modulated Radiation Therapy Planning and Delivery. This policy applies limitations to the Intensity Modulated Radiation Therapy (IMRT) planning, delivery, development and field setting services.

For more information about this new policy, visit the **Reimbursement Policy** page at **empireblue.com/provider**.

Claim editing update for Excludes1 notes

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

Beginning with claims processed on and after September 29, 2019, we will be implementing revised claims edit logic tied to Excludes1 notes from ICD-10 coding guidelines. We recognize that the editing tied to Excludes1 notations found in ICD-10-CM, which was implemented in March 2019, contained some conflicts between Excludes1 and Excludes2 notes which caused a need for claims to be re-adjudicated. We have taken steps to modify the logic and remove such conflicts.

To help ensure the accurate processing of claims, use ICD-10-CM Coding Guidelines when selecting the most appropriate diagnosis for patient encounters. ICD-10-CM has two types of excludes notes; each type has a different definition for use but they are similar since they indicate that codes excluded from each other are independent of each other. One of the unique attributes of the ICD-10 code set and coding conventions is the concept of Excludes1 notes. An Excludes1 note indicates that the excluded code identified in the note should not be used at the same time as the code or code range listed above the Excludes1 note. These notes are located under the applicable section heading or specific ICD-10-CM code to which the note is applicable. When the note is located following a section heading, it applies to all codes in the section.

Remember to review diagnosis code(s) for any Excludes1 notes prior to submitting your claims to help ensure proper adjudication of your claims.

Some examples of Excludes1 scenarios in ICD-10-CM, where both diagnosis codes should not be billed together include:

- Reporting both M54.2 (cervicalgia) with M50.XX (cervicalgia due to intervertebral disc disorder)
    - 2 has an Excludes1 note for M50.XX
- Reporting both M54.5 (low back pain) with S39.012X (strain of muscle, fascia and tendon of lower back)

    - 5 has an Excludes1 note for S93.012X

- Reporting both M54.5 (low back pain) with M54.4X (lumbago with sciatica)

    - 5 has an Excludes1 note for M54.4X

- Reporting J03.XX (acute tonsillitis) with J02.XX (acute sore throat), J02.0 (streptococcal sore throat), J02.9 (sore throat NOS), J35.1 (hypertrophy of tonsils) or J36 (peritonsillar abscess)

    - XX has an Excludes1 note for J02.XX, J02.0, J02.9, J35.1 and J36

- Reporting N89 (other inflammatory disorders of the vagina) with R87.62 (abnormal results from vaginal cytological exam), D07.2 (vaginal intraepithelial neoplasia), R87.623 (HGSIL of vagina), N76.XX (inflammation of the vagina), N95.2 (senile [atrophic] vaginitis) or A59.00 (trichomonal leukorrhea)

    - N89 has an Excludes1 note for R87.62, D07.2, R87.623, N76.XX, N95.2, D07.2 and A59.00

Finally, if you believe an Excludes1 note denial should be reviewed, please follow the normal claims dispute process and include medical records that support the usage of the diagnosis combination when submitting claims for consideration.

URL: https://providernews.empireblue.com/article/claim-editing-update-for-excludes1-notes-1

Coming soon: electronic attachments

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

Category: Medicaid

As we prepare for the potential regulatory-proposed standards for electronic attachments, Empire will be implementing X12 275 electronic attachment transactions (version 5010) for claims.

Standard electronic attachments will bring value to you by eliminating the need for mailing paper records and reducing processing time overall.

Empire and Availity will pilot electronic data interchange batch electronic attachments with previously selected providers. Both solicited and unsolicited attachments will be included in our pilots.

Attachment types

- Solicited attachments: The provider sends a claim and the payer determines there is not enough information to process the claim. The payer will then send the provider a request for additional information (currently done via letter). The provider can then send the solicited attachment transaction, with the documentation requested, to process the claim.
- Unsolicited attachment: When the provider knows that the payer requires additional information to process the claim, the provider will then send the X12 837 claim with the Paper Work Included segment tracking number. Then, the provider will send the X12 275 attachment transaction with the additional information and include the tracking number that was sent on the claim for matching.

What you can do
As we prepare for this change, you can help now by having conversations with your clearinghouse and/or electronic healthcare records vendor to determine their ability to set up the X12 275 attachment transaction capabilities.

In addition, you should be on the lookout for additional information and details about working with Empire and Availity to send attachments via electronic batch.

NYE-NU-0144-19 July 2019
501704MUPENMUB

URL: https://providernews.empireblue.com/article/coming-soon-electronic-attachments-3

Prior authorization changes

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

Category: Medicaid

Effective December 1, 2019, prior authorization (PA) requirements are changing for the codes listed below. The listed codes will require PA by Empire BlueCross BlueShield HealthPlus for Medicaid Managed Care members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, 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 are being added to the following:

- Lower extremity prosthesis — shank foot system with vertical loading pylon (L5987)
- Gait trainer, pediatric size — anterior support, includes all accessories and components (E8002)
- Wheelchair, pediatric size — tilt-in-space, folding, adjustable, without seating system (E1234)
- Wheelchair, pediatric size — tilt-in-space, rigid, adjustable, without seating system (E1233)
- Transport chair, pediatric size (E1037)
- Multi-positional patient transfer system with integrated seat, operated by care giver (E1035)
- Wheelchair accessory — ventilator tray, gimbaled (E1030)
- Water circulating heat pad with pump (E0217)

To request PA, you may use one of the following methods:

- Web: https://www.availity.com
- Fax: 1-800-964-3627
- Phone: 1-800-450-8753

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal (**https://www.availity.com**). Providers who are unable to access Availity may call us at **1-800-450-8753** for PA requirements.

NYE-NU-0149-19 July 2019

Evaluation and management services - over-coded services

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

Category: Medicaid

In an ongoing effort to ensure accurate claims processing and payment, Empire BlueCross BlueShield HealthPlus (Empire) is taking additional steps to verify the accuracy of payments made to providers. Beginning on October 27, 2019, Empire will assess selected claims for evaluation and management (E&M) services using an automated analytic solution to ensure payments are aligned with national industry coding standards.
Providers should report E&M services in accordance with the American Medical Association CPT manual and CMS guidelines for billing E&M service codes (**Documentation Guidelines for Evaluation and Management**).

The level of service for E&M service codes is based primarily on the documented key factors, medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem and face-to-face interaction are considered contributing factors. The appropriate E&M level code should reflect and not exceed what is needed to manage the member’s condition(s).

Claims will be selected from providers who, based on a risk adjusted analysis, code a higher level E&M services compared to their peers with similar risk-adjusted members. Individual claims will be identified as over-coded based on a claim specific risk adjusted analysis. If a claim is determined to be over-coded, it will be reimbursed at the fee schedule rate for the appropriate level of E&M for the condition(s) identified. Providers whose coding patterns improve are eligible to be removed from the program.

If providers have medical record documentation to support reimbursement for the originally submitted E&M service, those medical records should be submitted for consideration.

If you have questions, contact your local Provider Relations representative or call Provider Services toll free at **1-800-450-8753**.

NYE-NU-0150-19 July 2019

URL: https://providernews.empireblue.com/article/evaluation-and-management-services-over-coded-services

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Clinical Criteria updates

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

Category: Medicaid

On March 29, 2019, April 12, 2019 and May 1, 2019, the Pharmacy and Therapeutic (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Empire BlueCross and BlueShield. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider website, and the effective dates will be reflected in the ***Clinical Criteria Q2 update***. Visit ***Clinical Criteria*** to search for specific policies.

For questions or additional information, use this **email**.

NYE-NU-0153-19 July 2019
501734MUPENMUB

URL: https://providernews.empireblue.com/article/clinical-criteria-updates-11

MCG Care Guidelines update and customizations

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

Category: Medicaid

The upgrade to the 23rd edition of the MCG Care Guidelines for Empire BlueCross BlueShield HealthPlus (Empire) has changed from May 24, 2019, to September 5, 2019. In addition, Empire has customized some of the MCG Criteria.

Customizations to the 23rd edition of the MCG Care Guidelines:
Effective September 5, 2019, the following customizations will be implemented:

- **Left Atrial Appendage Closure, Percutaneous (W0157)** — customized to refer to SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- **Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156)** — customized to refer to Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria, guidance and/or examples for the following:

- Clinical indications for admission:

- Aggressive hydration needs that cannot be managed in an infusion center
- Prolonged marrow suppression

- Regimens that cannot be managed outpatient

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations **online** by selecting **Customizations to MCG Care Guidelines 23rd Edition (Publish date November 1, 2019)**.

For questions, contact Provider Services at **1-800-450-8753**.

NYE-NU-0154-19 August 2019

URL: https://providernews.empireblue.com/article/mcg-care-guidelines-update-and-customizations

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Ensuring quality of care when prescribing antipsychotic medications to children and adolescents

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

Category: **Medicaid**

Children and adolescents may be prescribed antipsychotic medications by psychiatrists, neurologists, pediatricians or providers in other specialties for various mental health diagnoses ranging from mood disorders to autism. Some commonly prescribed antipsychotics include: risperidone, aripiprazole, quetiapine, lurasidone, haloperidol, olanzapine and chlorpromazine. The National Committee for Quality Assurance (NCQA) has developed three quality HEDIS® measures related to the prescribing of antipsychotics to children and adolescents.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP):

- This measures the percentage of children and adolescents ages 1 to 17 years old who are prescribed an antipsychotic medication during the measurement year and have documentation of psychosocial care provided as first-line treatment.
- Empire BlueCross BlueShield HealthPlus (Empire) conducts outreach to the parents and guardians of those dependent members. The case manager inquires if the member has received therapeutic services in the 30 days since being prescribed this new antipsychotic medication. If the member isn't connected to therapeutic services, the case manager will assist the parent or guardian with referrals for outpatient behavioral health services.
- Providers are encouraged to address psychosocial care and link members to therapeutic services. If the prescriber is also providing these services, the provider is encouraged to send a claim with CPT code [**XXXX**].

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM):

- Children and adolescents taking antipsychotic medication are recommended to have at least [annual] health screenings and blood tests that include a cholesterol test (LDL) and a glucose test or HbA1c.
- The behavioral health case manager from Empire reaches out to a member's parents/guardians by phone and mail to provide education on the importance and purpose of having these regular health screenings. The case manager also offers assistance to parents in scheduling these health screenings.
- Prescribers are encouraged to monitor HbA1c and LDL at least once a year.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC):

- This measures the percentage of children and adolescents 1 to 17 years of age who are on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
- These individuals should be assessed and monitored closely by a psychiatric professional such as a psychiatric nurse practitioner or psychiatrist.

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

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URL: https://providernews.empireblue.com/article/ensuring-quality-of-care-when-prescribing-antipsychotic-medications-to-children-and-adolescents

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Provider satisfaction survey

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Category: Medicaid

We need your help!
Empire BlueCross BlueShield HealthPlus (Empire) is conducting a provider satisfaction survey to ascertain your opinions on the services we offer you as a participating provider. We will randomly select a number of provider offices to take part in this process. If you are selected, you will receive a questionnaire in the mail from SPH Analytics, an independent research firm conducting the survey on behalf of Empire.

When you receive the survey, we would greatly appreciate you taking the time to complete it in its entirety. The survey should take about 15 minutes to complete, and your answers will greatly help us to assess and improve the services we provide.

By participating in the survey, you will provide us with valuable information about how well we are serving you and any areas in which our health plan needs improvement.

Thank you in advance for your help; we greatly appreciate you!

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Coming soon: electronic attachments

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Category: Medicare

As we prepare for the potential regulatory-proposed standards for electronic attachments, Empire BlueCross BlueShield (Empire) will be implementing X12 275 electronic attachment transactions (version 5010) for claims.

Standard electronic attachments will bring value to you by eliminating the need for mailing paper records and reducing processing time overall.

Empire and Availity will pilot electronic data interchange batch electronic attachments with previously selected providers. Both solicited and unsolicited attachments will be included in our pilots.

Attachment types

- Solicited attachments: The provider sends a claim and the payer determines there is not enough information to process the claim. The payer will then send the provider a request for additional information (currently done via letter). The provider can then send the solicited attachment transaction, with the documentation requested, to process the claim.
- Unsolicited attachment: When the provider knows that the payer requires additional information to process the claim, the provider will then send the X12 837 claim with the Paper Work Included segment tracking number. Then, the provider will send the X12 275 attachment transaction with the additional information and include the tracking number that was sent on the claim for matching.

What you can do

As we prepare for this change, you can help now by having conversations with your clearinghouse and/or electronic healthcare records vendor to determine their ability to set up the X12 275 attachment transaction capabilities.

In addition, you should be on the lookout for additional information and details about working with Empire and Availity to send attachments via electronic batch.

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URL: https://providernews.empireblue.com/article/coming-soon-electronic-attachments-4

Changes to PA requirements

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Category: Medicare

Beginning **December 1, 2019**, prior authorization (PA) requirements will change some codes covered by Empire BlueCross BlueShield (Empire) for Medicare Advantage members. Federal and state law, state contract language and CMS guidelines (including definitions and specific contract provisions and exclusions) take precedence over these rules and must be considered first when determining coverage. Empire will deny claims that are noncompliant with the new rules.

PA requirements will be added to the following:

- **T1019** — Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
- **C9740** — Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
- **E0953** — Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware
- **E1031** — Rollabout chair, any and all types with castors 5 inches or greater
- **E1090** — High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- **E1130** — Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests

- **E1140** — Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- **E1260** — Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- **E1285** — Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest
- **E1290** — Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- **E2207** — Wheelchair accessory, crutch and cane holder
- **E2378** — Power wheelchair component, actuator, replacement only
- **K0039** — Leg strap, H style

Not all PA requirements are listed here. Detailed prior authorization requirements are available to contracted providers by accessing the Provider Self-Service Tool at **https://www.availity.com.** Contracted and noncontracted providers who are unable to access the Availity Portal may call the number on the back of your patient's Empire ID card for PA requirements.

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Pharmacy benefit manager change to IngenioRx

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Category: Medicare

Effective January 1, 2020, IngenioRx will become our new pharmacy benefit manager (PBM) and will start managing prescription coverage for your Medicare Advantage individual and group retiree plan patients. IngenioRx PBM services will include handling your patients' prescriptions for mail order and specialty pharmacy medications.

Transferring prescriptions

We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using Express Scripts Mail Order Pharmacy. Members will receive instructions for initializing IngenioRx Home Delivery Pharmacy later this year. For patients receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Most patients will be able to fill their prescriptions at their same retail pharmacy outlet. If your patient's pharmacy will not be available, we will notify your patient by letter and include a list of three alternative pharmacies near his or her home.

Prescriptions for controlled substances currently being filled at Express Scripts Mail Order Pharmacy or Accredo cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

For providers	Then
Who use ePrescribing	There are no changes — Simply select IngenioRx.
Who do not use ePrescribing	You should send your mail order and specialty prescriptions to IngenioRx. IngenioRx will begin accepting prescriptions January 1, 2020. Please consider the days' supply of the prescription when making these requests. **IngenioRx Mail Order Pharmacy new prescriptions:** Phone: 1-833-203-1742 Fax: 1-800-378-0323 **IngenioRx Specialty Pharmacy:** Prescriber phone: 1-833-262-1726 Prescriber fax: 1-833-263-2871

You can confirm whether your patient has transitioned to IngenioRx through the Availity Portal.
Your patient's PBM information can be located in the *Patient Information* section of their patient profile as part of the eligibility and benefits inquiry.

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.

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Customizations to the 23rd edition of the MCG Care Guidelines

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Category: Medicare

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria and guidance on the following:

- Clinical indications for admission; examples will also be added for:
- Aggressive hydration needs that cannot be managed in an infusion center.
- Prolonged marrow suppression.
- Regimens that cannot be managed outpatient; examples will also be added.

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations **online** by selecting **Customizations to MCG Care Guidelines 23rd Edition**.

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URL: https://providernews.empireblue.com/article/customizations-to-the-23rd-edition-of-the-mcg-care-guidelines-1

Keep up with Medicare news

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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
- Bill Medicare Part D for shingles or tetanus vaccination claims

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URL: https://providernews.empireblue.com/article/keep-up-with-medicare-news-79