



# PROVIDER News



## Mountain State Blue Cross Blue Shield Designates West Virginia Hospitals as Blue Distinction Centers for Cardiac Care®

Mountain State Blue Cross Blue Shield has designated five West Virginia hospitals as Blue Distinction Centers for Cardiac Care. These hospitals include Charleston Area Medical Center, Charleston; St. Joseph's Hospital, Parkersburg; St. Mary's Medical Center, Huntington; West Virginia University Hospital, Morgantown; and Wheeling Hospital Inc., Wheeling. To date, more than 400 facilities nationwide have received a Blue Distinction Center for Cardiac Care designation. However, this marks the first time that any West Virginia facility has received this prestigious honor.

The need for quality cardiac care is urgent: The American Heart Association estimates that this year alone, 1.2 million Americans will experience a first or recurrent heart attack.

Blue Distinction Centers for Cardiac Care demonstrate their commitment to quality care, resulting in better overall outcomes for cardiac patients. These five hospitals meet evidence-based clinical criteria, developed in collaboration with expert physicians' and medical organizations, including the American College of Cardiology (ACC) and the Society of Thoracic Surgeons (STS), and is subject to periodic re-evaluation as criteria continue to evolve.\*

"We are pleased to be able to designate these five hospitals as Blue Distinction Centers for Cardiac Care," said Fred Earley, MSBCBS President. "The commitment and quality of care demonstrated by these hospitals in treating patients with various cardiac health issues, is truly an example of the exceptional health care the citizens of West Virginia can feel confident in receiving right here in their own state."

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**April 2010**



“Blue Distinction puts a high value on research and evidence-based health and medical information,” says Allan Korn, MD, Blue Cross and Blue Shield Association Chief Medical Officer. “Blue Distinction Centers show our commitment to working with doctors and hospitals in communities across the country to identify leading institutions that meet clinically validated quality standards and deliver better overall outcomes in patient care.”

To be designated as a Blue Distinction Center for Cardiac Care, the five West Virginia hospitals met the selection criteria posted at [www.BCBS.com](http://www.BCBS.com) which includes:

- an established cardiac care program, performing required annual volumes for certain procedures (e.g. a minimum of 125 cardiac surgical procedures annually, including both CABG and/or valve surgery)
- appropriate experience of its cardiac team, including sub-specialty board certification for interventional cardiologists and cardiac surgeons
- an established acute care inpatient facility, including intensive care, emergency and a full range of cardiac services
- full facility accreditation by a CMS-deemed national accreditation organization
- low overall complication and mortality rates
- a comprehensive quality management program

Blue Distinction is a designation awarded by Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare. The designation is based on rigorous, evidence-based selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. Today, more than 1,600 Blue Distinction Center designations have been awarded to facilities nationwide, providing consumers with a framework for making informed decisions on where to go for specialty care in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery, and transplants.

Note: Designation as Blue Distinction Centers means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered under your policy at any facilities, please call your local Blue Cross and/or Blue Shield Plan.



## ***NIA To Provide Utilization Management Services***

Effective January 1, 2011, Mountain State will launch a radiology management program that is designed to improve quality and appropriateness of non-emergency imaging services delivered to our members.

National Imaging Associates, Inc. (NIA) will begin providing utilization management services for non-emergent, high-tech outpatient radiology services for Mountain State members enrolled in Mountain State commercial health plans, including Super Blue Plus PPO, Super Blue Plus Point of Service (POS), Steel and the West Virginia Small Business Plan (WVSBP). The requirements will be waived for Mountain State's Traditional Indemnity product, Bluecard and the Federal Employee (FEP) program.

Prior authorization will be required for the following outpatient radiology procedures for Mountain State members:

- MRI/MRA
- CT/CTA/CCTA
- PET
- Nuclear Cardiology
- Stress Echocardiography

We will be posting prior authorization guidelines on our Mountain State website at [www.msbcbs.com](http://www.msbcbs.com).

Key Provisions :

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- The ordering physician must obtain authorization.
- Failure to verify that affected services have been preauthorized may result in non-payment of your claim.

We appreciate your support and we will be providing you with more specific information and details regarding the radiology management program. If you have any questions, please contact your assigned Provider Relations Representative.

# ***NAVINET UPDATE***

## **Electronic Claim Submission Via NaviNet**

If you are currently submitting paper claims for your office, please consider using the UB or 1500 Claim Submission transaction in NaviNet to expedite your claim. Electronic claim submission can save you time and money. No more forms to buy, no more postage to pay. The NaviNet claim submission transactions are easy to use and have edits to ensure mandatory fields have been completed. A copy feature can save you even more keying on subsequent claims for the same member. Our NaviNet transaction can be used by both facility and professional providers. Electronic submission is possible for primary, secondary or tertiary claims as well as local, Blue Card, FEP or Medicare Advantage/HHIC claims.

If you are interested in training on these transactions, please contact your Mountain State Provider Relations Representative, or call 304-234-7069.



## **Mountain State Blue Cross Blue Shield Contracting & Reimbursement Update...**

Mountain State has finalized the review of the changes made by the Centers for Medicare and Medicaid Services (CMS) to its 2010 RBRVS schedule. As the result of this review, Mountain State has concluded that adopting the changes would have a negative financial impact to the provider network. Consequently, Mountain State will not adopt the 2010 CMS RVUs for July 1, 2010 and the current Mountain State fee schedule (using CMS 2009 RBRVS) will continue in effect.

Mountain State will continue to use the 2009 CMS RBRVS values to include the West Virginia Geographic Practice Cost Index (GPCI) for all professional network providers in West Virginia and bordering counties.

Mountain State would like to provide an example regarding the RBRVS calculation for our commercial business using the CMS WV GPCI related to the RVU work, practice expense and malpractice components. The laboratory fee schedule which uses Ingenix RVUs is not subject to the application of the WV GPCIs.

The GPCI values for West Virginia are:

Work = 1.0

Practice Expense = 0.827

Malpractice = 1.353

The formula for 2009 physician fee schedule payment amount is as follows:

2009 Non-Facility Pricing Amount =

$[(\text{Work RVU} * \text{Work GPCI}) + (\text{Transitioned Non-Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Mountain State Market Factor}$

2009 Facility Pricing Amount =  $[(\text{Work RVU} * \text{Work GPCI}) + (\text{Transitioned Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Mountain State Market Factor}$

For more questions regarding this notice please contact your Provider Relations Representative or visit the Mountain State Blue Cross Blue Shield website at [www.msbcbs.com](http://www.msbcbs.com).

### ***A Note About Referring Members to Other Participating Providers***

There is an expectation by our members that when services are recommended by one provider to another provider, that the provider is participating in our network and would qualify for in-network benefit levels. It is our goal to provide the best coverage available to the members we both serve, so we are requesting that members are directed to a provider with an active participation agreement with Mountain State. If there is a question as to a provider's status with the network, please remember provider directories are located on our website [www.msbcbs.com](http://www.msbcbs.com). Your services and direction to members is of great value to all. But most importantly, it is the members who benefit by being referred only to participating providers.

Please share this information with appropriate staff and physicians.

### ***Reminder for home infusion therapy providers: how to bill for multiple infusion therapies***

When multiple infusion therapies are administered, Mountain State will not reimburse separately for each infusion therapy. Instead, you will be

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## Mountain State Blue Cross Blue Shield Contracting & Reimbursement Update Continued...

reimbursed for the most costly per diem that applies, plus the drug(s) administered. When billing for multiple therapies on the same claim, bill for only the most costly procedure. Do not report zero dollar charges for the remaining therapies.

Multiple infusion therapies are therapies that are administered to a patient who requires multiple concurrent infusion treatments including, but not limited to, multiple antibiotics, hydration, and chemotherapy.

There is one exception to this guideline— aerosolized AIDS drug therapy. You must bill this therapy in conjunction with another mode of home IV therapy administration. It is also the only drug therapy that, while provided as part of a multiple-therapy treatment, can be billed as a separate service. Use procedure code S9061 to report aerosolized AIDS drug therapy.

### Claims Submission Guidelines-Tips to Improve Provider Success

The following guidelines include information about how to justify reporting a gynecological exam and evaluation and management service on the same day, who should report hospital discharge day management codes, and suggestions for reporting time for constant attendance codes.

#### Gynecological exam and evaluation and management on the same day

To justify reporting a gynecological exam (G0101, S0610, S0612, or S0613) and an evaluation and management (E/M) service (99201-99215) on the same day, you must include sufficient documentation in the patient's records to support the appropriateness of performing both services.

Treatment for a medically-focused condition may require more extensive medical evaluation, treatment, and management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented E/M service. If the reported E/M service does not meet the component requirements, the second service will not be eligible for reimbursement. This pattern of reporting should not be a common occurrence in any practice.

#### When and who should report hospital discharge day management services (codes 99238 and 99239)

Hospital discharge day management services (codes 99238 and 99239) should be billed by the attending physician on the date of the actual visit with the patient even if the patient is discharged from the facility on a different calendar date. Only the attending physician should report discharge day management services. Physicians other than the attending physician should report subsequent hospital care (codes 99231-99233) for a final visit.

#### Constant attendance modalities 97032-97039

Constant attendance modalities (97032-97039) are those modalities that require direct one-on-one patient contact by the provider. These are time-based codes that include the time required to perform all aspects of the service, including pre-, -intra-, and post-service work.

When reporting time use either the start and stop time, for example, 2 p.m.–2:15 p.m., or the amount of time, for example, 15 minutes, spent to perform each service.

### Mountain State Continues to Recognize Consultation Services

Even though CMS changed its payment guidelines for consultations effective January 1, 2010, Providers should continue to use and Mountain State will continue to process claims reporting consultation codes 99241-99255 for its commercial products. If, after review, Mountain State changes its payment guidelines for codes 99241-99255, those changes will be announced in a future edition of the *Provider News*.

#### 2010 Lab Fee Schedule Update

Mountain State routinely updates its Lab Fee Schedule in September (September 1, 2010). Mountain State is currently analyzing the Medicare Fee Schedule, Ingenix RVUs, and evaluation/reduction of the Mountain State Market Conversion Factor used for laboratory services. As Mountain State finalizes plans for the update we will provide additional information to our provider community.

## ***Lowe's New Prior Certification for Specialty Drugs to be Administered by Care Continuum***

The Lowe's Companies, Inc. medical plan option will be utilizing Care Continuum, an independent utilization management company, on all primary Lowe's medical plan options, to perform the following services:

- Prior Certification of Specialty Drugs
- Specialty and Drug Claim Management

As of March 1, 2010, when caring for Lowe's medical plan members who require specialty drugs, begin following the steps below, in addition to all existing procedures:

- Contact Care Continuum at 866-240-4734 for prior certification of specialty drugs administered in your office or in the member's home. This number will also be listed on the member's insurance card. A list of drugs requiring prior certification can be found at: [www.carecontinuum.com/network/lowesspecialtydrug.htm](http://www.carecontinuum.com/network/lowesspecialtydrug.htm)
- When submitting a claim to Mountain State Blue Cross Blue Shield, include the National Drug Code (NDC) of the drug you are billing.

If you have a current patient and have not submitted a prior certification for the administration of a specialty drug in your office, clinic or in the patient's home, call Care Continuum to obtain prior certification. Please note the Lowe's medical plan requirement should follow mandatory prior certification guidelines. Failure to comply could result in financial penalties for the medical plan member.

Providers must submit appeals of adverse determinations either orally or in writing by contacting Care Continuum directly via the following:

Appeal Coordinator  
1700 Eastpoint Parkway Suite 50  
Louisville, Kentucky 40223  
Phone: 866-240-4734  
Fax: 877-540-6223

If you have any questions concerning this change contact Care Continuum at 866-240-4734.



# Important Reminder

## Mountain State Blue Cross Blue Shield Observes Timely Filing Policy

As part of our commitment to our providers, MSBCBS strives to process claims as accurately and quickly as possible. This process includes timely claim submission. To ensure that claims are processed accurately and promptly, all providers are reminded of MSBCBS's Timely Filing\* policy:

Mountain State must receive all claims within 365 days of the last date of service or from the date of the primary payer payment. Mountain State has always enforced this Timely Filing policy and will continue to do so.

\* Timely Filing is a policy that indicates the period between the claim's last date of service or the payment/denial by the primary payer and the date by which MSBCBS must receive the claim.



## Mark Your Calendar for Our 2010 Provider Workshops

**Mountain State Blue Cross Blue Shield wants you and your office staff to join us for our 2010 Provider Workshops.**

Please mark your calendar now to attend one of the workshops which will be held across the state at the following locations. We will also be offering webinars if you are not available to attend one of the scheduled meetings below. More information regarding the webinars will be communicated in the upcoming Provider News.

Attending a workshop gives you the chance to speak with a Mountain State Representative, ask questions and gain valuable information for your practice.



- Wednesday, September 15th - Wheeling WV - Oglebay Park
- Wednesday, September 22nd - Beckley WV - Tamarack
- Wednesday, September 29th - Parkersburg - Mountain State Corporate Office
- Wednesday, October 13th - Morgantown - Lakeview Resort
- Tuesday, October 19th – Holiday Inn Charleston House

Watch for more information regarding the meetings and registration details.

## ***Electronic Funds Transfer (EFT) Payments are Increasing in the Provider Community***

Mountain State is excited to offer electronic funds transfers (EFT) or “direct” deposit”, to our network providers. A growing number of providers are signing up for EFT.

EFT offers faster availability of payments: Once you are set up your payments will be deposited directly into the checking account you assign.

We encourage you to consider taking advantage of EFT as a way to expedite cash flow and further streamline administrative functions for your practice.

If you are not utilizing other electronic connectivity functions such as electronic claims submission and the Navinet Provider Web Portal and you are interested in receiving more information on these valuable services please contact your Provider Relations Representative.



## **Participation in Healthways SilverSneakers® Fitness Program Shown to Lower Risk of Depression Among Older Adults**

*Study: Depression and Use of a Health Plan-Sponsored Physical Activity Program by Older Adults*

Depression affects between 5 and 10 percent of Medicare beneficiaries seen in primary care and is associated with decreased adherence to exercise, diet, and taking medication. This is the first study to examine the association between depression and participation in a health plan-sponsored physical activity program for Medicare beneficiaries in a non-research environment.



According to the study published in the American Journal of Preventive Medicine<sup>1</sup>, greater participation in the Healthways SilverSneakers® Fitness Program is associated with a lower risk of depression among

Medicare-eligible members.

The study, published in 2008, examined Medicare Advantage data gathered from 1998 through 2003 from nearly 5,000 SilverSneakers participants. Researchers assessed the association between depression and the likelihood of enrollment in SilverSneakers, patterns of program participation over two years, and the association between level of participation and risk of depression. A secondary assessment examined the association between participation dose and depression risk.

The major findings are as follows:

- Members with a history of depression were just as likely to participate in SilverSneakers as non-depressed members.



- For members without a diagnosis of depression in the first year of the program, those with two or more visits per week were less likely to be diagnosed with depression in the second year than members with less than two visits per week.

To obtain more information about this study, please visit [www.healthways.com](http://www.healthways.com) and enter *Depression and Use of a Health Plan-Sponsored Physical Activity Program by Older Adults* in the search field.

SilverSneakers is offered to Mountain State Blue Cross Blue Shield Medicare Supplement members of Medifil at no additional cost. To enroll in the program, members can simply bring their Medifil card to any of the following SilverSneakers locations in West Virginia, including Curves® for Women. For a complete list, members can visit us online at [www.silversneakers.com](http://www.silversneakers.com) or call the number on the back of their Medifil card.

**Barboursville**  
Absolute Fitness

**Beckley**  
Bodyworks Health Fitness Rehabilitation

**Berkeley Springs**  
Rankin Physical Therapy

**Bluefield**  
Greater Bluefield Community Center  
Downtown Health & Wellness Center

**Charleston**  
YMCA of Kanawha Valley

**Charles Town**  
Gold's Gym – Charles Town

**Clarksburg/Bridgeport**  
Harrison County YMCA

**Cross Lanes**  
Tyler Mountain YMCA

**Elkins**  
Total Training Fitness Center

**Grafton**  
Tygart Valley Rehabilitation & Fitness Center

**Keyser**  
Lifestyle Fitness Center

**Lewisburg**  
Greenbrier Valley YMCA

**Madison**  
Southern Fitness

**Point Pleasant**  
Pleasant Valley Hospital Wellness Center

**Hico**  
Active Fitness Center

**Huntington**  
Huntington High YMCA

**Marietta, OH**  
Marietta Family YMCA

**Martinsburg**  
Berkeley 2000 Recreation Center

**Moorefield**  
Hardy County Health & Wellness Center

**Morgantown**  
Healthworks Rehab & Fitness  
Lakeview Fitness Center

**Oak Hill**  
Active Fitness Center

**Parkersburg**  
Family Fitness Center

**Princeton**  
Princeton Health and Fitness Center

**Ripley**  
Community Fitness Center

**Romney**  
Hampshire Wellness and Fitness

**Saint Albans**  
Active Sports Complex

**Scott Depot**  
Tri-County YMCA

**Spencer**  
The Fitness Complex of Roane General Hospital

**Summersville**  
Nicholas Fitness Center

**Terra Alta**  
Fit & Fabulous

**Weirton**  
Weirton Millsop Community Center

**Wheeling**  
Howard Long Wellness Center  
J.B. Chambers YMCA

Mountain State Medifil members who are not within 15 miles of their residence can enroll in SilverSneakers STEPS. This home-based exercise program provides Medifil members a free pedometer, tracking logs, and health-related educational material. Members can call 1-800-481-5502 to learn more about the program.

<sup>1</sup>Huong, N.Q., Koepsell, T., Unuetzer, J., Larson, E., & LoGerfo, J.P. (2008). *Depression and Use of a Health Plan-Sponsored Physical Activity Program by Older Adults*. *American Journal of Preventive Medicine*, 35(2), 111-117.  
[http://www.ajpm-online.net/article/S07493797\(08\)00381-4/abstract](http://www.ajpm-online.net/article/S07493797(08)00381-4/abstract).

# MEDICAL POLICY **UPDATES**

As an added enhancement to our Provider News, Mountain State Blue Cross Blue Shield communicates Medical Policy updates in each issue.

Our medical policies are also available online through NaviNet® or at [www.msbcbs.com](http://www.msbcbs.com). An alphabetical, as well as a sectional index, is available on the Medical Policy page. You can search for a medical policy by entering a key word, policy number or procedure code.

Recent updates or changes are as follows:

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## **Mountain State Blue Cross Blue Shield changes medical policy bulletin format, diagnosis codes moved to new subsection**

Mountain State Blue Cross Blue Shield is changing the format of its medical policy bulletins during 2010.

### All diagnosis codes move to new subsection

Mountain State Blue Cross Blue Shield's medical policy bulletins incorporated related ICD-9-CM diagnosis codes throughout the text in the "Indications and Limitations of Coverage" section.

Now, a new subsection, "Diagnosis Codes," has been added before the glossary on the medical policy bulletins. You can find all ICD-9-CM diagnosis codes that apply to the medical policy bulletin you are viewing in the new subsection. A hyperlink at the beginning of the medical policy bulletin will link to the new diagnosis code subsection.

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## **Medical Policy Bulletin S-198 ( Acellular Dermal Grafts for Reconstruction)**

### **Alloderm covered for post-mastectomy breast reconstruction**

**Effective: August 23, 2010**

Mountain State Blue Cross Blue Shield provides coverage for AlloDerm when it's used in conjunction with breast reconstruction following mastectomy (procedure codes 19357-19369).

If AlloDerm is used for any other indications, including hernia repair, Mountain State Blue Cross Blue Shield considers it experimental or investigational. A participating, preferred, or network provider may bill the member for the denied AlloDerm.

Please use the not otherwise classified code 19499 when you report the incorporation of the AlloDerm tissue graft with breast reconstruction. If you report code 19499 in these instances, please include the terminology "placement of AlloDerm tissue graft" in the narrative section of the electronic or paper claim.

Mountain State Blue Cross Blue Shield considers acellular dermal material a prosthetic device. When a physician supplies AlloDerm, please report it with code Q4116—skin substitute, AlloDerm, per square centimeter. Mountain State Blue Cross Blue Shield determines coverage for prosthetics according to individual or group customer benefits.

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## **Medical Policy Bulletin I-8 (Immunizations) Fluzone High-Dose covered according to member's benefits**

**Effective: February 15, 2010**

The U.S. Food and Drug Administration (FDA) approved Fluzone High-Dose, an inactivated influenza virus vaccine, on Dec. 23, 2009. The vaccine is indicated for use in persons aged 65 years and older for the prevention of disease caused by influenza virus subtypes A and B. Fluzone High-Dose is administered as a single injection in the upper arm.

Mountain State Blue Cross Blue Cross Blue Shield will determine coverage for Fluzone High-Dose according to the member's benefits.

Report Fluzone High-Dose with procedure code 90662—influenza virus vaccine, split virus,

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preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use.

In clinical studies in which the product was compared with Fluzone in older persons, Fluzone High-Dose promoted an enhanced immune response. Non-serious adverse events occurred more frequently after vaccination with Fluzone High-Dose compared with Fluzone. The rate of serious adverse events was comparable between Fluzone High-Dose and Fluzone.

### **Medical Policy Bulletin L-85 (Genetic Testing for Warfarin Dose)**

#### **Genetic testing for warfarin dose considered investigational**

**Effective: April 5, 2010**

Mountain State Blue Cross Blue Cross Blue Shield considers genotyping to determine cytochrome p450 2C9 (CYP2C9) and vitamin K epoxide reductase subunit C1 (VKORC1) genetic polymorphisms for the purpose of managing the administration and dosing of warfarin, including use in guiding the initial warfarin dose to decrease time to stable International Normalized Ratio (INR) and reduce the risk of serious bleeding, experimental or investigational. Genetic testing for warfarin dose is not eligible for reimbursement. A participating, preferred, or network provider may bill the member for the denied tests.

Mountain State Blue Cross Blue Shield has decided not to cover genetic testing for warfarin dose because the impact of this testing on clinical outcomes is unknown. Prospective studies are needed to assess the benefits and potential risks in guiding drug selection and dose and adjustment.

Please use procedure code G9143—warfarin responsiveness testing by genetic technique using any method, any number of specimens—to report this testing.

Warfarin is administered for preventing and treating thromboembolic events in high-risk individuals. Warfarin dosing is a challenging process due to the narrow therapeutic window, variable response to dosing, and serious bleeding events in five percent or more of patients.

Patients are typically given a starting dose of 2–5 mg and monitored frequently with dose adjustments until a stable INR value (a standardized indicator of clotting time) between 2 and 3 is achieved. During this adjustment period, a patient is at high risk for bleeding.

Final, stable warfarin dose varies among individuals by more than an order of magnitude. Factors influencing stable dose include body mass index, age, interacting drugs, and indication for therapy. In addition, genetic variants of CYP2C9 and VKORC1 genes together account for a substantial proportion of inter-individual variability.

Using the results of CYP2C9 and VKORC1 genetic testing to predict a warfarin starting dose that approximates the individual patient's likely maintenance dose may benefit patients by decreasing the risk of serious bleeding events and the time to stable INR. Algorithms have also been developed that incorporate not only genetic variation but also other significant patient characteristics and clinical factors to predict the best starting dose.

### **Medical Policy Bulletin S-28 (Cosmetic Surgery vs. Reconstructive Surgery)**

#### **Mountain State Blue Cross Blue Shield revises coverage criteria for mastectomy for gynecomastia**

**Effective: August 23, 2010**

Effective August 23, 2010, Mountain State Blue Cross Blue Shield will be archiving medical policy B-36 (Surgery for Gynecomastia). At that time, the revised medical necessity criteria for these services will be documented on medical policy S-28 (Cosmetic Surgery vs. Reconstructive Surgery).

Mountain State Blue Cross Blue Cross Blue Shield defines cosmetic surgery as surgery performed to improve an individual's appearance. Cosmetic surgery is generally not eligible for payment. However, cosmetic surgery may be eligible when it's performed to correct a condition resulting from an accident. Mountain State Blue Cross Blue Shield determines coverage for cosmetic services according to individual or group customer benefits.

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Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Reconstructive surgery is generally eligible for payment.

The American Society of Plastic Surgeons' classification system of gynecomastia is as follows:

- Grade I: Small breast enlargement with localized button of tissue around the areola
- Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest
- Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy
- Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

Mountain State Blue Cross Blue Shield considers mastectomy for gynecomastia as reconstructive when:

1. The patient meets the criteria for Grades II, III, or IV, and
2. The body mass index (BMI):
  - for boys 16, 17, and 18, whose BMI is less than the seventy-fifth percentile for age, that is, a BMI of 22.7 for age 16, and BMI of 23.4 for age 17, and BMI of 24.1 for age 18
  - is less than 25 for men over age 18, and
3. Pathologic gynecomastia, for example, hypogonadism, endocrine disorders, metabolic disorders, neoplasms, and male breast cancer, and pharmacologic gynecomastia, that is, gynecomastia induced by pharmacological agents, including but not limited to, cimetidine, digitalis, methadone, marijuana, clomiphene, chemotherapeutic agents, anti-retroviral agents, herbal remedies, cholopromazine, and anabolic steroids, have been excluded.

If these three criteria are not met, you must document in the patient's medical record that the tissue is primarily breast tissue, by pathology report, and not just adipose (fatty) tissue.

Gynecomastia in patients younger than 16 years of age generally will resolve on its own. Therefore, mastectomy for gynecomastia is not indicated for these patients. In this instance, Mountain State Blue Cross Blue Shield considers it cosmetic.

Use procedure code 19300 to report mastectomy for gynecomastia.

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### **Medical Policy Bulletin S-196 (Saturation Biopsy for Diagnosis and Staging of Prostate Cancer) Saturation biopsy for diagnosis and staging of prostate cancer not covered Effective: August 23, 2010**

Effective Aug. 23, 2010, Mountain State Blue Cross Blue Shield considers saturation biopsy, taking 20 or more core tissue samples at one time, experimental or investigational in the diagnosis, staging, and management of prostate cancer—it is not covered.

A participating, preferred, or network provider may bill the member for the non-covered saturation biopsy.

Report saturation biopsy with procedure code 55706—biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance. You may also use one of these procedure codes to report saturation biopsy:

G0416—surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens

G0417—surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens

G0418—surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens

G0419—surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens

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Saturation biopsy involves obtaining at least 20 biopsy tissue cores from the prostate in a systematic manner. The use of saturation biopsy has been proposed for use in the initial diagnosis or repeat biopsy, staging, and management of patients with prostate cancer.

### **Medical Policy Bulletin R-15 (Selective Internal Radiation Therapy {SIRT})**

#### **Selective internal radiation therapy covered for treating certain liver cancers**

**Effective: March 15, 2010**

Mountain State Blue Cross Blue Shield now covers selective internal radiation therapy (SIRT) for the treatment of unresectable hepatocellular cancer and unresectable metastatic liver tumors from primary colorectal cancer.

This includes unresectable or medically inoperable primary or secondary liver malignancies that are not typically amenable to ablation therapy only, for example, tumors greater than five centimeters in size. The tumor burden should be liver dominant, but not necessarily exclusive to the liver. Patients should demonstrate that the procedure will allow them to benefit from such therapy such as an Eastern Cooperative Oncology Group performance status of 0 or 1, or Karnofsky Performance Status of 70 or more. Also, the patient should have a life expectancy of at least three months.

Mountain State Blue Cross Blue Shield considers all other indications and uses of SIRT experimental or investigational because there is no published scientific literature providing evidence on the potential impact of this treatment modality on survival or the quality of life for other applications. Randomized controlled trials are needed to determine the clinical utility of this treatment for other indications. In cases where Mountain State Blue Cross Blue Shield considers SIRT experimental or investigational, it is not covered. A participating, preferred, or network provider may bill the member for the non-covered SIRT.

Report SIRT with procedure code S2095—transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres.

SIRT is the targeted delivery of small beads (microspheres) impregnated with a radioactive source, for example, yttrium-90 (<sup>90</sup>Y), into the liver to destroy liver tumors. This technique provides a mechanism by which a very high radiation dose can be delivered to tumors within the liver. Once trapped within the tumor, these microspheres destroy the tumor, with limited concurrent damage to normal, healthy liver tissue.

### **Medical Policy Bulletin S-75 (Extracorporeal Photophoresis)**

#### **Extracorporeal photophoresis coverage guidelines explained**

**Effective: August 23, 2010**

Mountain State Blue Cross Blue Shield covers extracorporeal photophoresis when it's performed for these indications:

- palliative treatment of skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy (ICD-9-CM diagnosis codes 202.10-202.18, 202.20-202.28, 202.70-202.78)
- patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment (ICD-9-CM diagnosis codes 996.83, 996.85, V42.1, V42.81, V42.82)
- patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment (ICD-9-CM diagnosis codes 279.50-279.53, 710.0, 710.1, 714.0-714.9)

Mountain State Blue Cross Blue Shield considers extracorporeal photophoresis not medically necessary if it's performed for any other indications. A participating, preferred, or network provider may not bill the member for the denied service unless he or she has given advanced written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility before receiving the service. The signed agreement should be maintained in the provider's records.

*Continued On Next Page*

Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the patient's white blood cells. The drug is typically administered into the white blood cells after they have been removed from the patient, but the drug can alternatively be administered directly to the patient before the white blood cells are withdrawn. After UVA light exposure, the treated white blood cells are re-infused into the patient.

A cycle of extracorporeal photopheresis consists of treatment on two consecutive days, once a month. If there is no response to the treatment within six to eight months, the treatment is stopped.

Report each day of the two-day cycle with code 36522.

**Medical Policy Bulletin S-28 (Cosmetic Surgery vs. Reconstructive Surgery)**

**Canthopexy considered reconstructive surgery when performed for specific conditions**

**Effective: August 23, 2010**

Mountain State Blue Cross Blue Shield considers medial or lateral canthopexy reconstructive surgery when it's performed for these conditions:

- Bell's palsy
- dermatochalasis
- documentation of epiphora and poor closure of the lids
- entropion
- extropion
- mucous membrane changes
- presence of corneal or conjunctival staining

If canthopexy is performed for any other conditions, Mountain State Blue Cross Blue Shield considers it cosmetic surgery.

Because cosmetic surgery is performed to improve an individual's appearance, Mountain State Blue Cross Blue Shield usually does not pay for it. Cosmetic surgery may be covered when it's performed to correct a condition resulting from an accident. Mountain State Blue Cross Blue Shield determines coverage for cosmetic services according to individual or group customer benefits. A participating, preferred, or network provider may bill the member for the denied surgery.

Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Reconstructive surgery is generally eligible for payment.

Please use procedure code 21280 to report medial canthopexy. To report lateral canthopexy, use code 21282.

Canthopexy is a surgical procedure designed to tighten the lower eyelid by shortening supporting structures at the lateral canthus (lateral canthal tendon or lateral retinaculum).

Mountain State's Provider News is designed to serve providers by offering information that will make submitting claims and treating our subscribers easier. We want to know what you would like to see in upcoming issues of this newsletter. Do you have a question that needs to be answered that you think other providers would be interested in? Are there issues or problems not addressed in this publication? If so, let us know. Send your questions and concerns to:

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