CALL TO ACTION

BCBS draft pharmacy policy is bad for Gastroenterologists

You’re comments can make a difference

The latest draft drug policies are available for review from BCBS and they will alter the way that we practice if approved. It is very important that you and your partners — whether members or not — respond to BCBS regarding the following.

Look through the immunomodulators section (specifically the requirement for a bottom-up approach), the hep c treatment recommendations (metavir score would require a liver bx to obtain) and a contraindication to interferon. While you are at it under the compounded medications the need for approval for domperidone in the state for motility disorders, including gastroparesis in those intolerant of reglan, and GI cocktail as well.

The comment period for Blue Cross is open now and you will need to respond to BCBS directly as these recommendations/policy changes could significantly affect all of our practices.

This is VERY IMPORTANT to respond to so please take the time to do so now and forward to all of your partners and nurse practitioners/PA’s for their review as well. View the Sept. 5 Provider News and find links to these policies on AGS’s website, www.alagastro.org.

IF you are not subscribed to BCBS newsletter you should do so, and have your practice administrators screen them regularly.

Robert Shaffer, MD | President
Deadline approaches for compliance with HIPAA-required Business Associate Agreements

The final deadline to revise noncompliant BAA’s is September 23, 2014

Notify your business associates.

As a covered entity, you should notify your BA’s of this requirement if you have not done so already. As mentioned above, BA’s will be subject to sanction for violations of these requirements.

What is a BA?

A BA is a person or entity that performs, on behalf of the physicians’ office, a function that is regulated by HIPAA that includes the use or disclosure of individually identifiable health information. A BA is also a person or entity that provides a myriad of services some of which are set forth below, that involve the use or disclosure of that health information. 45 C.F.R. § 160.103 provides, in part:

(1) Except as provided elsewhere** in this definition, business associate means, with respect to a covered entity, a person who:

(i) On behalf of such covered entity . . . , but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information (PHI) for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 C.F.R. § 3.20, billing, benefit management, practice management, and re-pricing; or

(ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in 45 C.F.R. § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity . . . where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person

(iii) A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate . . . .

(Emphasis added).

**Contractors are responsible for subcontractors.

Under the law, subcontractors should enter into BAA’s in the same manner that the covered entity is required to enter into a BAA. This requirement applies to subcontractors of BA’s that create, receive, transmit or maintain PHI in order to perform a function, activity or service that the BA has agreed upon in its agreement. Each subcontractor down the chain must enter into an agreement as far down as the delegation goes.

The information provided herein does not constitute legal advice. If you have questions concerning exactly how these provisions affect you and your situation, you should contact your own attorney experienced in this area of the law.

2014 CPT® and HCPCS coding update highlights

The 2014 Annual Coding Update was extensive again this year and incorporated over 1,900 revisions between the Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) guidelines. Over 500 new codes were added, over 1,100 were changed/revised, and over 200 were deleted. Major changes are included in the Surgery and Medicine Cardiovascular System, Surgery Digestive, Pathology, Psychiatry (evaluation and psychotherapy), and Nerve Conduction Studies sections. It is the responsibility of providers to be aware of the coding changes and rules and regulations associated with those changes.

Surgery

• The Digestive System subsection contains many changes to the esophagoscopy section. Existing codes were revised to be specific to flexible transoral esophagoscopy with new codes within each type created for rigid transoral, flexible transoral, and flexible transnasal esophagoscopies. The upper gastrointestinal endoscopy codes were revised as new “Esophagogastroduodenoscopy (EGD)” and Endoscopic Retrograde Cholangiopancreatography (ERCP) sections with introductory instructions. A number of new codes were created, and existing codes were updated throughout the sections to update the language.
**News Briefs**

**Secretin Improves Sensitivity of MRCP for Unexplained Pancreatitis**  

Magnetic resonance imaging with magnetic resonance cholangiopancreatography (MRCP) might be a useful alternative to endoscopic ultrasound (EUS) or endoscopic retrograde cholangiopancreatography (ERCP) in detecting occult malignancy and structural changes in patients with acute or acute, recurrent pancreatitis whose initial evaluation is negative. To assess whether administration of the hormone secretin improves the diagnostic accuracy of MRCP, investigators enrolled 258 patients with acute or acute, relapsing pancreatitis in an industry-funded, multicenter trial.

Patients were scheduled to undergo ERCP as part of their diagnostic evaluation. They first underwent MRCP both with and without secretin. Pancreatic duct images were read in a blinded fashion by three radiologists and two endoscopists. The final diagnosis was based on the ERCP findings but was augmented by other available imaging data as needed.

In 60% of patients, ≥1 pancreatic duct abnormality was observed at ERCP. The sensitivity and specificity of MRCP were 47% and 9%, respectively. With the addition of secretin, the sensitivity of MRCP increased to 66%, and specificity was 85%. Pancreas divisum was present in 25%. The ability to correctly identify a normal pancreatic duct at MRCP improved from 48% to 75% with secretin administration. No major adverse events occurred related to the secretin infusion, although transient nausea, abdominal pain, and flushing were attributed to infusion.

– *New England Journal of Medicine*

**Leaky gut – A source of non-AIDS complications in HIV-positive patients**

*Case Western Reserve University, www.twitter.com/casenews*

While HIV infection is no longer a fatal condition, scientists at Case Western Reserve University School of Medicine have discovered that bacterial products seep out of the colon, trigger inflammation throughout the body and set into motion the processes of cardiovascular, neurodegenerative, chronic kidney and metabolic diseases, and cancer. Their findings appear in an edition this summer of *PLOS Pathogens*.

“The key observation is that virally suppressed HIV-positive patients have an important molecular and tissue defect – a leaky gut,” said senior author, Alan D. Levine, PhD, professor of medicine, pharmacology, pathology, molecular biology and microbiology, and pediatrics, Case Western Reserve University School of Medicine.

Levine and colleagues found that patients whose HIV was well controlled with antiretroviral medications still had weakened intestinal tight junctions.

Their findings provide a clear target for clinical intervention – repair the molecular and structural epithelial leakiness in the tight junctions of the colon.

---

**Coding update continued from page 2**

**Pathology and Laboratory**

• Ten new drug specific assay codes were added to the Therapeutic Drug Assays section.

• A new Tier 1 code was added to the Molecular Pathology section, and some additional revisions were made to the Tier 1 codes for HLA testing to clarify that typing of DRB3/4/5 regardless of level of resolution is treated as one locus and determination of the presence or absence of the DRB3/4/5 genes is included in the typing and not separately reported.

• Several new Category 1 Multianalyte Assays with Algorithmic Analyses (MAAA) codes were added.

• Chemistry, Microbiology, and Surgical Pathology had minimal revisions/additions.

**Medicine**

• A new vaccine code was created for the trivalent influenza vaccine Flubok, which is preservative and antibiotic free and derived from recombinant DNA and HA protein only. Some additional information on vaccine codes has been provided as well.

• Two new codes for percutaneous transcatheter closure of PDA and septal reduction, were added to the Cardiovascular subsection.

• The remaining subsections had several new codes added as well as some language revision.

NOTE: The above information is taken directly from American Medical Association (AMA) and BlueCross BlueShield Association resources (2014 CPT; 2014 CPT Changes – An Insider’s View; CPT and RBRVS 2014 Annual Symposium presentation notes; BlueCross BlueShield Association Coding News Backgrounder documents)
IBD patients: Consider giving infliximab a second try

BETHESDA, MD – Restarting infliximab therapy after a drug holiday is safe and effective for patients with inflammatory bowel disease (IBD), according to a new study in Clinical Gastroenterology and Hepatology, the official clinical practice journal of the American Gastroenterological Association.

“Our findings suggest that starting infliximab after a history of prior therapy can be very beneficial to patients,” said lead study author Filip Baert, MD, PhD, from the department of gastroenterology, University Hospitals Leuven in Belgium. “Most striking, response to infliximab can be regained in a subset of patients who previously had lost response to the treatment and failed several other treatments thereafter.”

Researchers conducted a retrospective single-center study to evaluate the efficacy of restarting infliximab in inflammatory bowel disease patients, both those suffering from Crohn’s disease and ulcerative colitis. The average duration of infliximab holiday was 15 months.

Patients who were in remission at the time infliximab was discontinued were the best candidates, with a 78 percent response rate at one year. In patients with a previous loss of response or an infusion reaction, the strategy was effective in 45 percent of patients at one year; while less than the other group, this may be enough in cases where the patient has failed other treatment options.

This study shows that starting pharmacologic monitoring (i.e., checking levels of medicine in the blood and antibodies to infliximab) early after restarting infliximab in inflammatory bowel disease patients can guide physicians to predict the long-term efficacy and safety of restarting this treatment. In clinical practice, these tests are not always readily available; however, measuring drug levels and antibodies early after restarting infliximab is very valuable and allows early optimization.

How safe is the strategy? Of the 128 patients re-treated, seven had severe infusion reactions, generally during the second or third induction dose. Unfortunately, premedication did not protect against all infusion reactions, but simultaneous immunomodulators did. Therefore, immunomodulator therapy should be strongly considered in these patients.

Patients may initially stop infliximab therapy due to loss of response, and, despite the current recommendations, patients sometimes will discontinue therapy for various reasons, including durable remission, pregnancy, safety or financial concerns.

“How clinicians understandably have been reluctant to rechallenge patients with infliximab given the fear of immediate or delayed hypersensitivity reactions with dose interruptions. This study provides the important message that restarting infliximab after a drug holiday is feasible,” added Dr. Baert.

Infliximab was the first anti–tumor necrosis factor (TNF) biologic for Crohn’s disease and still is used frequently for its efficacy in both Crohn’s and ulcerative colitis. Studies have shown that loss of response to infliximab is about 13 percent per patient-year of treatment.

For more information, visit the American Gastroenterologic Association website, www.gastro.org.

IBD patients: Consider giving infliximab a second try

Mark Your Calendars...

2015 Annual Meeting
June 12-14
The Marriott Grand Hotel
Point Clear, Ala.

2016 Annual Meeting
June 24-25
Hilton Sandestin Beach
Golf Resort & Spa
Destin, Fla.

2017 Annual Meeting
June 30 - July 2
Hilton Sandestin Beach
Golf Resort & Spa
Destin, Fla.

Calling all companies!

If you have a contact for a pharmaceutical, equipment, software, or other company offering an intriguing solution, please let us know. We are always looking for new and exciting companies to exhibit in our Annual Meeting Exhibit Show! Call Stephanie Fletcher at (334) 954-2506 or e-mail sfl etcher@masalink.org for more information.

IBD patients: Consider giving infliximab a second try