Glad You Asked!

We are pleased to introduce our new Question and Answer column titled “Glad You Asked!” In each issue, we will answer questions that we have received from providers about various topics. These questions may be related to either institutional or professional services. The complexity and length of the response required will determine the number of questions answered. If you have specific questions that you would like to submit, please contact Provider Service at 1-800-368-2312. If you have questioned Provider Service regarding a particular issue and the information would be helpful to all providers, we will use those questions as well. Remember, we are unable to use any patient specific information and the topic may need to be generalized in order to be published.

Question: We are a smaller facility and do not have an MRI scanner. When an inpatient requires an MRI, we send them to a larger hospital for the scan but they return to our facility for the rest of their inpatient stay. How do I bill the MRI and the ambulance transport?

Response: The MRI charges should be included on your inpatient claim. These services are considered to be part of the DRG as the DRG payment includes diagnostic procedures. It is up to you as the billing hospital to reimburse the provider who performed the MRI. The ambulance transport to and from the hospital that provides the MRI is not a billable service by the ambulance provider. This is considered to be included in the DRG payment since it is considered part of the diagnostic service. You will need to contract with the ambulance provider for these types of transports.

Question: I bill services for a skilled nursing facility (SNF) and we provide outpatient physical, occupational, and speech therapy services. How should these services be billed?

Response: If these physical, occupational, and speech therapy services are being provided to patients who are not covered by BCBSND at an inpatient SNF level of care, they should be billed on the HCFA-1500 under the individual therapist’s provider number. These services should not be billed on a UB-92 under the SNF provider number. Remember, all of our outpatient therapy benefits, such as the physical therapy windows, apply to these services.
Medical Policy

Synagis

Revision to HealthCare News #190

Revisions are indicated in bold

With the approach of the Respiratory Syncytial Virus (RSV) season we would like to remind providers of our guidelines for Synagis (palivizumab).

Benefits will be allowed as a monthly injection during the RSV season. Benefits will be allowed for Synagis for:

1. children younger than 24 months with bronchopulmonary dysplasia
2. infants younger than 1 year with a history of premature birth (35 weeks gestation or less)

The first dose may be given in the outpatient clinic setting on the same day as discharge from the acute hospital, however, reimbursement will be for the drug and an administration fee. An office call should not be billed and will not be reimbursed, as the discharging physician will have already performed an evaluation and management service on the infant.

Synagis must be billed through physician services. The method by which the physician obtains the product is at the discretion of the physician, but only the physician (not the supplier) may bill BCBSND.

Coordination of claims with families of multiple births (such as twins, triplets, etc.) will be reviewed for reimbursement of the total number of vials used on the same day and the allowance will be prorated across the individual members’ claims. Claims should be submitted with the number of vials in the units field but milligrams administered must be submitted in the description field on claims submitted electronically or in Box 24, Section D on HCFA-1500 paper claims.

Coding

CPT
90378 – Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg each

Policy Reminder

UB-92 vs. HCFA-1500 Billing Methods

Reference HealthCare News #206 and #143

BCBSND participating providers are reminded of the directive issued by the Board of Directors published in HealthCare News #206 and #143. There has been no change in this policy since it was published in October 1995.

As a result of affiliations and mergers occurring at a number of health care organizations in North Dakota, BCBSND has identified the inappropriate financial potential for switching the type of claim form used to submit services with no substantial change in delivery of services. This policy also includes changes to a provider-based status. The intent of the policy is to prevent increased reimbursement for the same services simply because of a change in billing forms.

While certain medical services can be billed on either the HCFA-1500 or the UB-92 claim form, the BCBSND Board of Directors has determined that the method of billing such services must remain the same as it was prior to the organizational change unless a written approval is obtained. A written request for approval must be submitted to:

BCBSND
Provider Reimbursement
4510 13th Avenue SW
Fargo, North Dakota 58121

DVAC Coding Guidelines

DRG Validation Advisory Committee

The DVAC members have worked hard over the past year to create the following coding guidelines. These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation. Please refer to pages 3 and 4 for coding guidelines.
DVAC Coding Guideline: 
Postoperative Anemia

It is not unusual for anemia to be present following surgery, however it may or may not be considered a complication of surgery. A certain amount of blood loss is expected during surgery and can vary depending on the procedure. The physician’s documentation should support the anemia as a complication of surgery before assigning any complication codes (such as 998.11). All patients require care and observation following surgery. When the significance of the symptoms requires more than routine care or extends the length of stay, the coding of acute blood loss anemia (285.1) may be appropriate. The physician’s documentation should indicate the presence of blood loss anemia and that treatment and/or additional monitoring was required. Blood products (including autologous) given during surgery do not always indicate the presence of anemia, but can be given as a preventive measure to avoid anemia.

Signs and Symptoms
(It is important to consider the age and size of the patient when reviewing signs and symptoms)

- Low hemoglobin/hematocrit *
- Faintness
- Dizziness
- Thirst
- Sweating
- Weak/rapid pulse
- Rapid respiratory rate
- Orthostatic hypotension
- Pale
- Decreased blood pressure
- Fatigue
- Shortness of breath
*Comorbid conditions may affect the patient’s ability to tolerate a low hemoglobin

Treatment/Workup/Increased Length of Stay

- Transfusion
- Increased monitoring of hemoglobin/hematocrit
- Iron
- Volume expanders

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to blood loss anemia
- Clinical findings on examination
- Documentation of abnormal laboratory findings

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline: Postoperative Fever

It is estimated that between 25-50% of all patients will experience some temperature elevation following surgery. This is a normal physiologic response to surgery. The clinical examination and the physician’s documentation should substantiate whether the fever is a normal physiologic response to surgery versus a true postoperative fever. All patients require care and observation following surgery. The physician’s documentation should demonstrate that the fever was more than anticipated in the post surgical period, required more than routine care, or extended the length of stay. A code for postoperative fever should not be assigned when another diagnosis has been identified to account for the fever.

Signs and Symptoms

- Fever noted 24-48 hours following surgery
- Temperature 2-3 degrees above baseline
- Abnormal laboratory findings may include:
  - WBC
  - CRP
  - Differential with bandemia or left shift
- Unexplained confusion
- Increased heart rate

Treatment/Workup/Increased Length of Stay

- Cultures
- CBC with differential
- Analgesics
- Antibiotics (ordered due to fever rather than prophylactic use)
- Radiology
  - X-ray, CT scans, etc.
- Respiratory Therapy (ordered following identification of symptom)
  - CPT
  - Incentive Spirometry
  - Suctioning
  - Postural drainage
  - Nebulizer treatments
  - CPAP

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to fever
- Clinical findings on examination
- Documentation of abnormal laboratory findings

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
Blue Cross Blue Shield of North Dakota Coding Policy Advisory Committee (CPAC)

Blue Cross Blue Shield of North Dakota’s CPAC has completed its first 3 years of operation. Initial membership terms were 3 years in length in order to provide continuity within the committee. Three members were randomly selected to remain on the committee for an additional year beyond their initial 3 year term. As a result, there are 6 positions open on the committee.

**Purpose & Scope**

The CPAC shall serve in an advisory capacity to the Professional Billing and Reimbursement (PBR) and Institutional Billing and Reimbursement (IBR) teams at BCBSND in matters pertaining to the appropriate usage of CPT/HCPCS codes for billing professional and institutional services and procedures.

**Membership**

The provider members of CPAC shall be composed of 9 coding professionals with either physician or hospital coding experience. Experience and training will be of utmost importance in the selection process.

The BCBSND members of CPAC shall consist of 6 members – 1 from Reimbursement, 2 from Medical Review, 1 from Provider Service, 1 from Medical Management, and the Manager of Medical Review and Audit, who shall serve as Chair.

**Operating Practices**

- The CPAC shall meet 3 times per year, at a minimum, and as necessary at the discretion of the Chair.

- The individual CPAC members shall, at their own expense, keep current regarding CPT/HCPCS coding guidelines and reimbursement methodologies.

- The CPAC shall advise and make coding policy recommendations to BCBSND’s PBR and IBR teams. BCBSND reserves the right to accept or reject those recommendations.

- The provider members of CPAC shall act in a manner as to represent the entire provider community through the agenda items brought forth to the Committee and the development of their recommendation.

- The provider members of CPAC will be reimbursed for mileage at our standard rate for attending scheduled meetings.

- The provider members of CPAC will serve from 1-3 years in length and may serve an unlimited number of terms upon re-application and re-appointment.

- All provider members are required to be employed by a participating provider of BCBSND in a coding-related capacity. A change in employment status may result in removal from the committee.

Please complete a copy of the application found on page 7 if you are interested in becoming a member of the CPAC.

**Professional Claims**

**Paper Claim Submission**

To ensure the imaging accuracy of claims, it is important that the space directly above form locator 1 (HCFA-1500 form) is left blank. This is the space used by Blue Cross Blue Shield of North Dakota to place the assigned claim number.

The print alignment and print quality are also contributing factors to the imaging accuracy of the claim. Please verify the alignment of the claim form in your printer and that the print is dark and legible.

**HIPAA**

**Professional Paper Payment Listing**

*Effective November 1, 2002.*

Minor changes will be made to the paper payment listings for professional claims. See page 6 for an example of the Professional Payment Listing. These changes are being made to accommodate the changes coming for the electronic 835 (Health Care Claim Payment/Advice) mandated by HIPAA.

The patient account number will be moved and displayed directly below the subscriber’s name. The column currently titled Provider Account Number will be replaced with Line Item Control Number. Nothing will be displayed in this column until our system has been converted to support the 835 transaction and the field is received in the 837 format (Health Care Claim Transaction). The full patient name will now be displayed, instead of only the patient’s first name.

In the near future, the BCBSND internal rejects will be replaced with the Claim Adjustment Reason codes. This is being done to be consistent with the electronic 835 transaction, which mandates the use of the Claim Adjustment Reason codes. The Claim Adjustment Reason codes can be found on the Washington Publishing Company website, [www.wpc-edi.com](http://www.wpc-edi.com).

Changes will be made to the paper payment listings for Dental and Institutional claims in the future. A HealthCare News article will be published before the changes are implemented.
## PAYMENT LISTINGS

### PAYMENTS

**DATE** 09/03/02  
**PAGE** 1

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*This procedure code has been changed from what was originally submitted on the claim.*

*Blue Cross Blue Shield of North Dakota Participating Physicians have agreed by contract to accept the Plan allowance as payment in full for covered services. They will not bill the amount shown in this column.*

*Non-covered charges are the responsibility of the patient and are to be paid directly to the physician.*
Blue Cross Blue Shield of North Dakota
Coding Policy Advisory Committee
Application for Committee Appointment

Name: ________________________________

Employer Name: ________________________________

Employer Address: ________________________________

Phone Number: ________________________________

E-mail Address: ________________________________

Position Held: ________________________________

Number of Years in Current Position: ________________________________

Number of Years in Coding Positions: ________________________________

Total Years in the Health Care Industry: ________________________________

Coding Designations/Certifications Held: ________________________________

__________________________________________________________________________________________________________________________ ...

CPT/HCPCS coding training received/seminars attended within the last 3 years:

__________________________________________________________________________________________________________________________ ...

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Describe any facilitation or presentation skills/experience you have:

__________________________________________________________________________________________________________________________ ...

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Why would you be a valuable member of the Coding Policy Advisory Committee?

__________________________________________________________________________________________________________________________ ...

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Please return by November 22, 2002, to: Dawn Rude, Reimbursement
Blue Cross Blue Shield of North Dakota
4510 13th Avenue SW
Fargo, ND 58121-0001
**Drug Formulary**

**Administrative Actions:**

The following drugs were automatically added to the Formulary when available:

- Amoxicillin & Potassium Clavulanate 200mg & 400mg chew tabs
- Amoxicillin & Potassium Clavulanate 500mg & 875mg tabs
- Amoxicillin & Potassium Clavulanate 200 & 400mg/5ml suspension
- Viread Tab 300mg
- Prednisolone Sodium Phosphate Liquid 6.7mg/5ml
- Enpresse-28 tab
- Potia-28 tab
- Lisinopril 2.5,5,10,20,30 & 40mg
- Lisinopril/HCTZ 10-12.5,20-12.5,20-25mg
- Fenofibrate 134 & 200mg caps
- Misoprostol 100 & 200mcg
- Prochlorperazine Maleate 2.5 & 5mg supp
- Bromocriptine 2.5mg tab
- Heparin Sodium (porcine) inj. 20000units/ml
- Tretinoin Gel 0.01%
- Finevin Cream 20% (Azelaic Acid Cream)
- Desonide lotion 0.05%
- Clindamycin Lotion 1%
- Cyclosporine 25mg and 100mg caps

The following BRAND name drugs were removed from the Formulary when the equivalent generic drug was available:

- AMOXIL 875mg
- CLEOCIN 150 & 300mg caps
- PEDIAFRED Liquid 6.7mg/5ml
- ZESTRIL all strengths
- ZESTORETIC all strengths
- CYTOTEC 100 & 200mcg tabs
- AZELEX Cream 20%

Additions to the Formulary effective October 1, 2002:

- Mirtazapine (REMERON standard tablet)
- Griseofulvin (GRIFULVIN V tablet and suspension)

Deletions from the Formulary effective January 1, 2003:

- CEFTIN tablets – generics remain
- CLEOCIN 75mg capsule – generic capsules and
- CLEOCIN suspension remain
- Gatifloxacin (TEQUIN)
- Iodoquinol (YODOXIN)
- ZANTAC Efferdose and Granules
- COMPAZINE Supp. – generics remain
- Metoclopramide Intensol
- Balsalazide (COLAZAL)
- Methenamine Hippurate (HIPREX and UREX)
- Bethanechol (URECHOLINE)
- ORACIT
Influenza Vaccine

Reference: HealthCare News #215

With the approach of the flu season, we would like to remind providers of our billing guidelines for the flu vaccine. BCBSND will not accept roster billing. A HCFA-1500 claim form must be submitted for each patient.

The vaccine should be submitted with the appropriate CPT code for the product used. The administration of the flu vaccine must be billed with CPT Code 90471 or G0008.

The Average Wholesale Price (AWP) for the vaccine was updated as of October 1, 2002.

If an Evaluation and Management (E&M) code is submitted in addition to the administration code, the administration will be considered included in the reimbursement for the E&M.

Vaccine
90657 – 90660

Administration
90471 or G0008

Additional Bundled Procedures

Effective for Services on and after November 1, 2002

Reference: HealthCare News #220 and #224

As noted in our April 2002 HealthCare News, component and comprehensive code pairs were listed that would generally be considered incorrect to bill together on the same day unless the component code was done as a separate procedure. When done separately, it should be identified with an appropriate modifier. If an appropriate modifier is not used, the professional system will automatically deny the component code. Although the same guidelines apply, services in the institutional system will be reviewed on a post-pay basis.

Listed below are additional code combinations that will be implemented November 1, 2002. This listing includes additional radiology and lab procedures. Remember, any coding combinations that include E&M services (the codes that identify professional services billed on the HCFA-1500 such as office calls, consults, hospital care days, etc.) are specific to services billed to the professional system on the HCFA-1500 and will not be applied to institutional claims. It is also important to keep in mind that any medical policy that may pertain to these codes will take precedence – examples of this may relate to specific coverage based on medical criteria, diagnoses, etc. There may be other established medical policy related to incidental procedures that will also remain in effect; that is, these are additions to our existing policies. Any specific Benefit Plan language related to exclusions, maximums or other specified coverage also will apply.

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Line Of Business Codes

Reference HealthCare News #225.

Updates are indicated in bold.

The following codes correspond with those found on your weekly payment listing under the column Type.

03 Federal Employee Program
06 Banner Health Systems/LHS
10 Comprehensive Health Association of North Dakota (CHAND)
11 Comprehensive Health Association of North Dakota (CHAND) Medicare Extended
13 FEP Basic Option
33 FEP POS
36 Medicare Extended
40 Hospital Medical Indemnity
43 Basic Non-Group
44 North Dakota Public Employees Retirement System (NDPERS)
45 Basic Group
46 Alternate Finance Groups
47 Alternate Finance Groups Medicare Extended
49 Catholic Health Corporation
56 First Choice (F-M Homebuilders)
59 Caring Foundation
60 Preferred Provider Organization Groups
63 SelectChoice
64 NDPERS Exclusive Provider Organization
66 Medicare Supplement Plan F Select
70 Medicare Standardization
72 Basin Electric (Electramed)
73 North American Coal
77 BlueChoice
81 Montana Dakota Utilities (MDU)
82 North American Coal Texas BlueChoice
83 BlueCard PPO
84 US Bank
85 Women’s Way
87 Healthy Steps
88 Dakota Growers Pasta
89 Sunrise Television Corp.
90 ITS (ECR Claims)
91 Altru Health Systems
92 AltruChoice
93 The Dakotas Health Plan
94 Classic Blue
95 AltruCare
96 Community First Bank
98 ITS (Host Claim)

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Provider Service Department
Blue Cross Blue Shield of North Dakota
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Fargo, ND 58121-0001