HIPAA

Claim Adjustment Reason Codes

Reference HealthCare News #231

On April 1, 2003, the BCBSND internal reason not allowed codes were replaced with the Claim Adjustment Reason codes. This was done to be consistent with the electronic 835 Transaction, which mandates the use of the Claim Adjustment Reason codes. BCBSND does not create or maintain this list. A list of the Claim Adjustment Reason codes can be found in the Implementation Guides on the Washington Publishing Company (WPC) web site, www.wpc-edi.com. Access the WPC web site for the most current codes.

A Claim Adjustment Group Code is one that identifies the general category of the payment adjustment. The following are examples of Claim Adjustment Group Codes:
- **CO** Contractual Obligations
- **CR** Correction and Reversals
- **OA** Other adjustments
- **PI** Payor Initiated Reductions
- **PR** Patient Responsibility

Some examples you might find on your payment listing:

- **PR1** - PR equals patient responsibility
  1 equals deductible amount
- **CO42** - CO equals contractual obligation
  42 equals charges exceed our fee schedule or maximum allowable amount

Refer to the web site for the most up-to-date information regarding the numerous claim adjustment reason codes at http://www.wpc-edi.com/codes/Codes.asp.

BCBSND 835 Version 4010A1 Remittances

BCBSND plans to discontinue the existing proprietary electronic payment remittances soon. Currently, BCBSND is testing the 4010A1 Electronic Remittance Advice (ERA) with institutional and professional providers. We are still seeking additional pilot providers to convert to the 835 transaction. If you want to continue receiving an electronic payment listing, you must convert to the 835 transaction.

If you want to receive an ERA (835 version 4010A1), you must do the following:

- Complete the proper request form found on Noridian Administrative Service’s (NAS) web site, www.nordianmedicare.com.
- Schedule a testing appointment with EDI by calling 1-800-967-7902.
HIPAA (cont.)

Medical Records and Psychotherapy Notes: What’s What?

HIPAA rules have led to some confusion over payor requests for medical records. Here is some clarification.

Privacy Rules allow a covered entity to disclose protected health information (PHI) for treatment, payment, or health care operations, as permitted by and in compliance with [45 CFR Section 164.506.] For health plans (e.g. BCBSND) and providers, “payment” means activities “to obtain payment for the provision of health care.” [45 CFR Section 164.501.] Mental health medical records have the same protection as any other medical record. If a provider refuses to submit the medical record, then the payor is not obligated to pay for the service. There should be enough information in the medical record to allow a third party payor to make a determination of medical necessity and appropriateness of the treatment.

There are different rules for psychotherapy notes. Psychotherapy notes are intended to allow a provider to keep personal information on a client that is not necessary for establishing medical appropriateness and necessity. Psychotherapy notes are a privilege, not a requirement. The Amended Privacy Rules Section 164.506 does NOT permit a covered entity (provider in this case) to disclose psychotherapy notes without an individual’s authorization. [45 CFR Section 164.506(a).] A “blanket” authorization, such as the one allowing the payor to review the medical record is not sufficient. Payors cannot make payment contingent on submission of the Psychotherapy Note. Psychotherapy notes should be kept separate from the medical record so that psychotherapy notes are not included when medical records are appropriately released.

HIPAA defines a psychotherapy note as: “… notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record.

Psychotherapy notes EXCLUDE medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.”

The “bottom line” is – when a payor requests a medical record for a legitimate purpose, it, or a summary of the information, should be made available. The medical record should contain enough information to justify the medical necessity and appropriateness of the treatment. In the intake note, there should be sufficient information to justify the diagnosis. The progress note should contain enough information that someone reading the note can determine that medical necessity and appropriate treatment was provided. Otherwise, the payor is not obligated to pay. Psychotherapy notes, on the other hand, should not be released without written authorization from the patient.

Countdown to HIPAA Compliance...

Update to HealthCare News #234

There are less than 5 days remaining until the October 16, 2003, compliance date for electronic transactions and code sets!

As a reminder, if you have not scheduled or begun HIPAA testing with EDI Support Services (EDISS), please do so immediately by calling 1-800-967-7902. Failure to schedule or begin testing may not allow you to electronically submit claims after the mandated October 16, 2003, deadline.

As you were made aware through previous communication, we no longer enhance, distribute or support MedTrac/DataTrac free billing software. If you are a direct submitter, you also need to have your vendor’s systems converted to the 4010A1 version by the HIPAA deadline.

We previously recommended several alternatives including:

- Installing our free HIPAA compliant billing software product called PC-ACE Pro32;
- Acquiring another HIPAA compliant billing software product from a vendor; or
- Outsourcing your claims submission to a clearinghouse or billing service.

For the latest updates on our HIPAA status and our potential contingency plans, please watch the EDI HIPAA List Serve or visit www.bcbsnd.com. If you are interested in signing up for the EDI HIPAA List Serve, visit http://www.noridianmedicare.com/provider/edi/hipaa.html.

If you have questions or need to schedule your testing appointment with EDISS, please contact us at 1-800-967-7902. You can also e-mail your questions to HIPAA EDI@noridian.com.
Medical Policy

Telemedicine

Effective Date: Update to current policy

Description

Telemedicine is the use of interactive video equipment to link practitioners and patients in different sites.

Policy/Criteria

1. To qualify as a professional service, actual visual contact (face to face) must be maintained between physician and patient. Provider to Provider consultations, such as telephone consultations, will not be reimbursed.

2. Reimbursable services are those professional office or outpatient services such as Evaluation and Management services, psychiatric diagnostic interviews, individual psychotherapy services, diabetes education and speech therapy services listed in the book of Current Procedural Terminology (CPT®) of the American Medical Association. Only those services currently reimbursable in an office or outpatient setting will be allowed for payment. Reimbursement will be based on the current fee schedule in place at the time services are rendered.

3. All services provided must be medically appropriate and necessary. Documentation to support the service must be included in the clinical record.

4. Originating and distant sites of telemedicine services shall not be in the same facility or community, and the distant site shall be of a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialty services.

The term originating site means the location of an eligible member at the time the service is being provided via a telecommunications system.

The term distant site means the site where the practitioner providing the professional service is located.

5. A designated room with appropriate equipment, including camera(s), lighting, transmission and other needed electronics and the appropriate medical office amenities, shall be established in both the originating and the distant site. An on-site visit may be made to the originating telemedicine facility to address quality issues.

6. Reimbursement will be provided only to the consulting physician during the telemedicine session. No benefits will be available to a provider if his/her sole function is presentation of the patient to the consultant via telemedicine.

Reimbursement will be provided to the originating facility when HCPCS Q3014 (telehealth originating site facility fee) is billed. There will be no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Coding/Billing Information

Providers should use modifier GT to identify a service as being performed via telemedicine.

Institutional providers should use revenue code 510 when billing HCPCS Q3014.

CPT® Modifier GT – Via interactive audio and video telecommunications system

HCPCS Q3014 – Telehealth originating site facility fee

Source


Committee Review: Internal Medical Policy Committee 7/31/03 (Added speech therapy), 7/16/02

Medical Claims Review Advisory Committee 8/28/96, 10/8/96

Central Professional Services Committee 4/14/98, 10/24/96
**Medical Policy (cont.)**

**Cryoablation as Treatment for Renal Tumors**

*Effective Date: August 1, 2003*

**Description**

Cryoablation involves freezing and destroying diseased tissue. The current standard treatment for renal tumors today is either full or partial removal of the affected kidney (nephrectomy). The renal cryoablation procedure is less invasive.

**Policy/Criteria**

Benefits are not available for renal cryoablation as it is considered investigational based on review of the literature. Additional studies are needed to support long-term efficacy.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

**Coding/Billing Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT® 50542</td>
<td>Laparoscopy, surgical; ablation of renal mass lesion(s)</td>
</tr>
<tr>
<td>HCPCS S2090</td>
<td>Ablation, open, one or more renal tumor(s); cryosurgical</td>
</tr>
<tr>
<td>S2091</td>
<td>Ablation, percutaneous, one or more renal tumor(s); cryosurgical</td>
</tr>
</tbody>
</table>

**Source**


**Committee Review:** Internal Medical Policy Committee 7/31/03

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**Transcatheter Arterial Chemoembolization of the Liver**

*Effective Date: August 1, 2003*

**Description**

Transcatheter arterial chemoembolization (TACE) involves delivering chemotherapy drugs directly to the liver while also occluding arterial blood causing an infarct and subsequent necrosis of tumors to the infarcted region.

TACE requires hospitalization. A catheter is inserted via the femoral artery to the hepatic artery. An angiography of the liver vasculature is performed followed by injection of a viscous solution with chemotherapy. The solution occludes the artery, blocking the blood supply to the tumor area. The chemotherapy adds additional tumor cell destruction.

**Policy/Criteria**

Transcatheter arterial chemoembolization will be considered medically appropriate and necessary as a treatment for hepatocellular carcinoma.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

**Coding/Billing Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT® 37204</td>
<td>Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck</td>
</tr>
<tr>
<td>75894</td>
<td>Transcatheter therapy, embolization, any method, radiological supervision and interpretation</td>
</tr>
</tbody>
</table>

**Source**


**Plan Survey**


**Committee Review:** Internal Medical Policy Committee 7/31/2003 (Reversed previous policy Medical Memo #523)

Quality Committee 3/22/2002 (Determined Investigational)
Vacuum-Assisted Wound Closure or Negative Pressure Wound Therapy Pumps

Effective Date: August 1, 2003

Description

Vacuum-assisted closure is designed to promote the formation of granulation tissue in the wound bed either as an adjunct to surgical therapy, or as an alternative to surgery in a debilitated patient. Special foam dressing with an attached evacuation tube is inserted into the wound and covered with an adhesive drape to create an airtight seal. Negative pressure is then applied and the wound effluent is collected in a canister. Negative pressure may contribute to wound healing by removing excess interstitial fluid, increasing the vascularity of the wound, and/or creating beneficial mechanical forces that draw the edges of the wound closer together.

Policy/Criteria

Benefits will be allowed for vacuum-assisted wound closure when:

A complete wound therapy program specific to the type of wound* has been tried or has been considered and ruled out prior to application of negative pressure wound therapy; AND one of the following criteria has been met:

1. The patient has a chronic wound or ulcer (present for at least 30 days);
   a. Chronic Stage III or IV pressure ulcers
      i. Stage III - Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, the underlying fascia.
      ii. Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures such as tendon or joint capsules.
   b. Neuropathic ulcer (e.g., diabetic)
   c. Venous or arterial insufficiency ulcer
   d. Chronic ulcer of mixed etiology

2. The patient has complications of a surgically created wound (e.g., dehiscence) or a traumatic wound (e.g., preoperative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (e.g., patient has other conditions that will not allow healing times achievable with other topical wound treatments.)

*A wound therapy program must have been tried which included all of the following general measures:

- Documentation in the patient’s medical record of evaluation, care, and wound measurements by a licensed medical professional.
- Application of dressings to maintain a moist wound environment.
- Debridement of necrotic tissue if present.
- Evaluation of a provision for adequate nutritional status.

In addition, the following required measures are specific to the type of wound:

Stage III or IV pressure ulcers

- Patient has been appropriately turned and positioned, and
- Patient has used a Medicare defined group 2 or 3 pressure reducing support surface (e.g., air fluidized bed, powered pressure reducing mattress or overlay) for pressure ulcers on the posterior trunk or pelvis, and
- Patient’s moisture and incontinence have been appropriately managed.

Neuropathic ulcers (e.g., diabetic)

- Patient has been on a comprehensive diabetic management program, and
- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

Venous insufficiency ulcers

- Compression bandages and/or garments have been consistently applied, and
- Leg elevation and ambulation have been encouraged.

Contraindications to vacuum-assisted wound closure devices include:

- Fistulas to organs or body cavity within the vicinity of the wound
- Presence in the wound of necrotic tissue with eschar present
- Untreated osteomyelitis within the vicinity of the wound
- Malignancy in the wound

Continued benefits require monthly documentation by a licensed medical professional of changes in the ulcer’s dimensions and characteristics. If no measurable degree of wound healing measured as wound exudate, length, width, or depth has occurred over the previous month or in the judgment of the treating physician that adequate wound healing has occurred, benefits will be discontinued.

Coverage beyond 4 months or for more than 1 pump will not be allowed. One pump can accommodate more than one wound if within close proximity.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.
**Medical Policy (cont.)**

**Coding/Billing Information**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0538</td>
<td>Negative pressure wound therapy electrical pump, stationary or portable</td>
</tr>
<tr>
<td>K0539</td>
<td>Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each</td>
</tr>
<tr>
<td>K0540</td>
<td>Canister set for negative pressure wound therapy electrical pump, stationary or portable, each</td>
</tr>
</tbody>
</table>

**Source**

CIGNA HealthCare Medicare Administration. Region D DMERC LMRP. Negative Pressure Wound Therapy Pumps. ID Number 11489. Revised 4/1/03.


**Committee Review:** Internal Medical Policy Committee Reviewed 7/31/2003

**Wireless Capsule Endoscopy**

**Effective Date:** October 1, 2003

**Description**

Wireless capsule endoscopy is performed using a disposable imaging capsule swallowed by the patient which allows for visualization of the small bowel mucosa. Peristalsis carries the capsule through the gastrointestinal tract where it is eliminated within 24 hours. The capsule contains a video-imaging camera, which transmits images to a receiving recorder device that the patient wears around the waist. The images are then downloaded onto a workstation for viewing and processing.

**Policy/Criteria**

Benefits will be allowed for wireless capsule endoscopy to investigate obscure gastrointestinal (GI) bleeding suspected of being of small bowel origin. Prior inconclusive upper and lower gastrointestinal endoscopic studies must be documented in the medical record. The medical record may be requested for review.

Obscure GI bleeding is defined as “recurrent or persistent iron-deficiency anemia, positive fecal occult blood test, or visible bleeding with no bleeding source found at original endoscopy.”

This test is not allowed for colorectal cancer screening or for confirming lesions or pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of treitz or distal to the ileocecal valve).

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

**Coding/Billing Information**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0262</td>
<td>Small intestinal imaging; intraluminal, from ligament of treitz to the ileocecal valve, includes physician interpretation and report</td>
</tr>
<tr>
<td>A4649</td>
<td>Surgical supply; miscellaneous</td>
</tr>
</tbody>
</table>

A specific code for the imaging capsule is not available. A4649 should be used to identify the capsule and a copy of the invoice for the capsule must be included.

**Source**


**Other Plan Survey**

**Committee Review:** Internal Medical Policy Committee 7/31/03

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**EDISS**

**Federal Holiday Schedule**

In conjunction with the following Federal holidays, providers will not be able to contact the Electronic Data Interchange Systems Services (EDISS) department located within Noridian Administrative Services (NAS) for phone support. However, transmission lines will be available.

Columbus Day ..................... Monday, October 13, 2003
Veterans Day ................... Tuesday, November 11, 2003
Martin Luther King Day....... Monday, January 19, 2004
Presidents Day .................. Monday, February 16, 2004
HealthCare News Issue #238

Medical Policy

Retinal Nerve Fiber Layer Analysis (RNFLA)

Update to HealthCare News #197

Effective Date: Documentation of current policy

Description

The scanning laser polarimeter is a confocal scanning laser ophthalmoscope with an integrated polarimeter, which measures nerve fiber layer thickness. Analysis of the image provides an accurate picture of glaucoma-induced tissue degeneration.

The laser coherence tomography produces high resolution longitudinal cross-sectional tomographs of ocular structures. It differentiates the anatomic layers of the retina and then measures retinal thickness.

The use of these new technologies is for screening patients for glaucoma. It is proposed that the sensitivity of the instrument allows for the diagnosis of glaucoma at an earlier stage of the disease.

Policy/Criteria

Benefits are not available for scanning laser polarimeter or laser coherence tomography for glaucoma screening or for diagnosing or monitoring disease progression. Evidence is insufficient to determine whether the procedure improves net health outcomes or is as beneficial as medical management or other procedures.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Coding/Billing Information

CPT® 92135 Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral

Source


Committee Review: Internal Medical Policy Committee 7/15/98, 3/15/00, 7/31/03

Deep Brain Stimulation

Effective Date: August 1, 2003

Description

Deep brain stimulation (DBS) is considered a treatment alternative for essential tremor and tremor associated with Parkinson’s disease. DBS involves the stereotactic placement of an electrode into the brain (i.e., thalamus, globus pallidus, or subthalamic nucleus) connected to a programmable stimulator. Noninvasive programming of the stimulator can be adjusted to the patient’s symptoms. Side effects of neurostimulation may consist of dysarthria, disequilibrium, or involuntary movements.

Policy/Criteria

Benefits will be allowed for unilateral deep brain stimulation of the thalamus for patients with disabling, medically unresponsive tremor due to essential tremor or Parkinson’s disease. Disabling, medically unresponsive tremor requires that the tremor causes significant limitation in daily activities and that there is inadequate control on maximal dosage of medication for at least 3 months.

Benefits will be allowed for unilateral or bilateral deep brain stimulation of the globus pallidus or subthalamic nucleus in patients with Parkinson’s disease and:

- A good response to levodopa with clearly defined “on” periods; and
- A minimal score of 30 points on the Unified Parkinson Disease Rating Scale when the patient has been without medication for approximately 12 hours; and
- Motor complications not controlled by pharmacologic therapy.

Deep brain stimulation for other movement disorders, including but not limited to dystonia, multiple sclerosis and post-traumatic dyskinesia is not covered as it is considered investigational for these indications.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.
Medical Policy (cont.)

Coding/Billing Information

The CPT® coding for deep brain stimulation consists of a series of CPT® codes describing the various steps of the procedure: implantation of the electrodes, implantation of the pulse generator, intraoperative monitoring and programming of the electrodes, and postoperative neuroprogramming.

Implantation of Electrodes

CPT® 61862 Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)

Implantation of Pulse Generator

61885 Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886 with connection to two or more electrode arrays

Electronic Analysis

95970-95973 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of waveform, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements)

Source


Hayes, Inc. “Deep Brain Stimulation for Parkinson’s Disease and Essential Tremor”. Updated 2/6/03.

Committee Review: Internal Medical Policy Committee 7/31/03 (Approved)

Drug Indications

Effective Date: Documentation of current policy

Description

The USP DI is a collection of clinically relevant, established information about each drug. The first volume, Drug Information for the Health Care Professional, includes the Drug Information monographs. Manufacturers’ labeling of indicated uses approved by the U.S. Food and Drug Administration (FDA) or Health Canada’s Therapeutic Products Directorate are included. USP Advisory Panels include those off-label indications (i.e. not included in the labeling of any brand) which they believe represent reasonable, current prescribing practices based on their knowledge of the drug, the literature, and of current prescribing and utilization practices.

Drug Facts and Comparisons is a drug information compendium, guided by the Facts and Comparisons Editorial Advisory Panel comprised of nationally and internationally recognized clinicians, scientists, physicians, pharmacists and pharmacologists. Review of FDA-approved product labeling, biomedical journal articles and textbooks, and policies and recommendations from many authoritative and official groups form the base of evaluation of information for Drug Facts and Comparisons. Legitimate “unlabeled” uses and dosages are included when appropriate.

New uses for approved products that are not reflected in a product’s labeling are often discovered after marketing. Before a pharmaceutical manufacturer may include any new indications in the labeling for a particular drug, it must obtain the government’s approval for the uses. Such approval requires the completion of adequate and well-controlled clinical trials to document the drug’s safety and efficacy for the new uses. Manufacturers, in some cases, may not seek or obtain approval of new uses since there may not be sufficient economic incentive for the product sponsor to perform the necessary research or to make application to the regulatory agency.

Policy/Criteria

1. If a medical policy specific to a drug does not exist:

Either USP DI, volume I, Drug Information for the Health Care Professional or Drug Facts and Comparisons can be used as a reference to determine FDA approval of a drug or accepted, off-label indications. Benefits will be allowed for either accepted FDA approved indications or accepted off-label indications from either source.

2. No benefits will be allowed for unaccepted indications unless:

FDA approved antineoplastic agents may be allowed for an off-label, unaccepted diagnoses only if the physician is a member of an established protocol group and the member will be enrolled in an approved study/clinical trial.
Medical Policy (cont.)

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source

Medical Memo # 282
Committee Review: Internal Medical Policy Committee 7/31/03

Infertility

Update to HealthCare News #195

Effective Date: Documentation of current policy

Description

Infertility is the failure to conceive or inability to carry a pregnancy to a live birth after 12 months or more of regular sexual intercourse without any form of birth control. The following terms are used in the discussion of infertility:

Artificial Insemination - mechanical placement of semen containing viable spermatozoa into the vagina.

Assisted reproductive technology (ART) - all treatments or procedures that involve the handling of human eggs and sperm for the purpose of helping a woman become pregnant.

ART cycle - A process in which 1) an ART procedure is carried out, 2) a woman has undergone ovarian stimulation or monitoring with the intent of having an ART procedure, or 3) in the case of frozen embryos, embryos have been thawed with the intent of transferring them to a woman. A cycle begins when a woman begins taking fertility drugs or having her ovaries monitored.

Gamete Intrafallopian Transfer (GIFT) - An ART procedure that involves removing eggs from a woman’s ovary, combining them with sperm, and using a laparoscope to assist in placing the unfertilized eggs and sperm into the woman’s fallopian tube through small incisions in her abdomen.

In Vitro Fertilization (IVF) - An ART procedure that involves removing eggs from a woman’s ovaries and fertilizing them outside her body. The resulting embryos are then transferred into the woman’s uterus through the cervix.

Intracytoplasmic Sperm Injection (ICSI) - The injection of a single sperm into an egg. Used in cases of male infertility due to low amounts of weak sperm.

Zygote Intrafallopian Transfer (ZIFT) - An ART procedure in which eggs are collected from a woman’s ovaries and fertilized outside her body. A laparoscope is then used to assist in placing the resulting zygote (fertilized egg) into the woman’s fallopian tube through small incisions in her abdomen.

Policy/Criteria

For those benefit plans that allow benefits for infertility services:

When previous voluntary sterilization or sterilization reversal has not been performed on either partner, benefits are available for medical services, supplies and drugs related to infertility, artificial insemination and assisted reproductive technologies (ART) such as in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and intracytoplasmic sperm injection (ICSI) (not an inclusive list) and will accumulate toward a lifetime dollar maximum according to the terms of the benefit plan.

In addition, benefits for artificial insemination (AI) or intrauterine insemination (IUI) procedures are limited to 6 cycles per patient per lifetime, or per pregnancy. The 6 cycle limit can be renewed if successful pregnancy is attained and dollars remain under the benefit maximum. Pregnancy must be confirmed by a live birth, an ultrasound, or by a miscarriage documented by a pathology report.

Any cycle billed using artificial insemination and/or prescription drugs will be applied to the 6 cycle maximum. If the patient abandons a treatment regimen before the cycle is complete, the partial cycle may be counted as one of the 6 eligible cycles or the patient may assume all charges for that cycle in order to preserve benefits for 6 complete cycles.

Prior approval is required for ART (e.g. IVF, GIFT, ZIFT, ICSI, etc).

The following criteria must be met:

- The patient must be a Member and be covered by the benefit plan;
- The patient must have at least a 2 year history of unexplained infertility, OR the infertility must be associated with 1 or more of the following conditions:
  - Endometriosis
  - Fetal exposure to diethylstilbestrol (DES)
  - Blocked or surgically removed fallopian tubes that are not a result of voluntary sterilization.
  - Abnormal male factors contributing to the infertility

Cryopreservation of embryos only (see exclusions below) will be allowed for 6 months when prior approval has been obtained for assisted reproductive technology.
Medical Policy (cont.)

Benefits are not available for donor eggs including any donor treatment & retrieval costs, donor sperm, cryopreservation or storage of unfertilized sperm or eggs, surrogate pregnancy & delivery; gestational carrier pregnancy & delivery; preimplantation genetic diagnosis testing, or multi fetal pregnancy reduction.

The Federal Employees Program (FEP) does not allow benefits for ART or AI.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source
HealthCare News Issue #195

American Society for Reproductive Medicine


Committee Review: Internal Medical Policy Committee 5/25/1999
Internal Medical Policy Committee 7/31/2003 (Reformatted and Added exclusion for preimplantation genetic diagnosis testing)

Reduction Mammoplasty

Effective Date: Documentation of current policy

Description
Female breast hypertrophy is used to describe an increase in the volume and weight of breast tissue in excess of the normal proportion. A variety of surgical procedures have been utilized to reduce the excess weight of the breast. All of these procedures produce permanent scars that the patient must accept in exchange for a better-positioned and proportioned breast.

The diagnosis of female breast hypertrophy involves a comparison of overall body stature with breast size as determined by nipple position and an estimate of excess breast tissue weight. There is a wide variation in female breast size and a transition from normal breast size to symptomatic breast hypertrophy. Schnur¹ has provided a logarithmic chart comparison of body surface area and excess breast tissue removed at surgery that allows separation of symptomatic women from those seeking a change in appearance.

Policy/Criteria

Written prior approval is required except for Federal Employee Program (FEP) members.

The written request must include:
• a summary of the history of the patient
• height and weight
• estimation of breast tissue to be removed

Prior approval will be based on both of the following criteria:

1. Reduction mammoplasty is considered reconstructive when female breast hypertrophy results in the following significant clinical manifestations:
   • Interrigo
   • Neck and shoulder pain
   • Strap mark indentations
   • Lordotic posture and postural backache
   • Reduction of physical activities

2. The amount of tissue removed is equal to or greater than 500 grams per breast. If removal of 500 grams per breast is not medically appropriate based on the woman’s body surface area, then the amount removed must place the patient at or above the 22nd percentile based on the Schnur Index.
   • In the case of asymmetrical breasts, the combined grams of tissue removed from both breasts must be equal or greater than 2 times the Schnur index for one breast.
   • Benefits for reduction mammoplasty following contralateral mastectomy will be allowed as part of a reconstructive sequence to achieve symmetry. Prior approval is not necessary nor is a minimum number of grams required.

If prior approval is not obtained prior to the procedure being performed or the amount of breast tissue actually removed does not meet criteria, no benefits will be available. Charges for professional and institutional services submitted will be provider liable. No margin of error is allowed for presurgical misestimation. Retrospective review of the pathology report will be performed to determine actual grams removed.

Inpatient admission for reduction mammoplasty will only be allowed with prior approval or as a result of complications meeting medical necessity guidelines.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Coding/Billing Information
CPT® 19318 Reduction mammoplasty

If prior approval is requested but medical criteria is not met, the written response from the company will serve as a denial of a noncovered service (cosmetic). A claim does not need to be submitted.
Medical Policy (cont.)

Source
3. Plastic Surgeon Consultants


Magnetic Resonance Angiography

Update to HealthCare News #144

The performance of a Magnetic Resonance Imaging study and Magnetic Resonance Angiography service for the same body area on the same date of service will require clinical documentation in the medical record to support the individual studies.

Post pay audits may be performed to review the medical appropriateness and necessity of the two studies.

Drug Formulary

Additions

Effective October 1, 2003

• GENERIC PRODUCTS ADDED

Brand-name products (in parentheses) are non-formulary and listed for reference only

omeprazole delayed-release capsules (Prilosec) rimantadine tablets (Flumadine)

• GENERIC PRODUCTS ADDED

Brand-name products (in parentheses) are also on formulary

brimonidine ophthalmic solution, 0.2% (ALPHAGAN) calcitriol oral solution, 1 mcg/mL (ROCALTROL) dihydroergotamine injection, 1 mg/mL (D.H.E. 45) ganciclovir capsule, 250mg & 500mg (CYTOVENE) levonorgestrel/ethinyloestradiol tablets - Aviane(ALESSE) lidocaine/prilocaine cream, 2.5%/2.5% (EMLA) lithium carbonate extended-release tablets, 450 mg (ESKALITH CR)

• BRAND-NAME PRODUCTS ADDED

ALINIA (nitazoxanide oral suspension) COPEGUS (ribavirin tablets) EMEND (aprepitant capsules & therapy pack) EPIVIR HBV (lamivudine tablets & oral solution) FUZEON (enfuvirtide injection) HEPERSA (adefovir tablets)

PEGASYS (peginterferon alfa-2a injection) PROSCAR (finasteride tablets) SINGULAR (montelukast oral granules) TEQUIN (gatifloxacin tablets) VAGIFEM (estradiol vaginal tablets) VELCADE (bortezomib injection)

• Other Additions

VFEND (voriconazole tablets) – requires prior authorization

ACTIMMUNE (interferon Gamma –1b) – requires prior authorization

Deletions

• BRAND-NAME PRODUCTS REMOVED

Generics remain
Effective October 1, 2003

AMOXIL (amoxicillin oral suspension, 200mg/5ml & 400mg/5ml)
AUGMENTIN BID formulations (amoxicillin/potassium clavulanate, 500 & 875 mg tablets, 200 mg & 400 mg chew tablets, 200 mg/5 mL & 400 mg/5 mL oral suspension)

• ALL VERSIONS, BRAND-NAME AND/OR GENERIC, REMOVED FROM FORMULARY

Effective October 1, 2003
cefixime tablets & oral suspension (SUPRAX) cimetidine tablets, 200 mg (TAGAMET)

• ALL VERSIONS, BRAND-NAME AND/OR GENERIC, REMOVED FROM FORMULARY

Effective October 1, 2004
candesartan tablets (ATACAND) candesartan/hydrochlorothiazide tablets (ATACAND HCT) furazolidone tablets and liquid (FUROXONE) moxifloxacin tablets (AVELOX) nystatin vaginal tablets sodium phosphates monobasic/dibasic tablets (VISICOL)

• ALL VERSIONS, BRAND-NAME AND/OR GENERIC, REMOVED FROM FORMULARY

Effective November 1, 2003 for new prescriptions Effective January 1, 2004 for current users lansoprazole capsules & suspension (PREVACID)

• OTHER REMOVALS

Effective January 1, 2004
cephalexin tablets, generic cephalaxin capsules & suspension remain

COMPAZINE syrup (prochlorperazine syrup), generic tablets & suppositories remain

• NON-PAYABLE

Effective November 1, 2003 for new prescriptions Effective January 1, 2004 for current users tegaserod tablets (ZELNORM)
Coding and Billing

Oxygen Contents

The appropriate coding and billing should be selected according to the code description for oxygen contents codes listed below. When a member receives oxygen contents for more than one month, a separate claim for each monthly increment is required. Codes that state, “one month’s supply equals one unit” are based on a monthly allowance. The contents should only be billed once a month, not daily or weekly. The submission of multiple claims within the same month for the same member is inappropriate. It is also inappropriate to submit multiple units for a single service date or service dates that span one month of time. Medical record documentation should support the services rendered.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>One month’s supply =</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0441</td>
<td>Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)</td>
<td>1 unit</td>
</tr>
<tr>
<td>E0442</td>
<td>Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned)</td>
<td>1 unit</td>
</tr>
<tr>
<td>E0443</td>
<td>Portable oxygen contents, gaseous (for use only with portable liquid systems when no stationary gas or liquid system is used)</td>
<td>1 unit</td>
</tr>
<tr>
<td>E0444</td>
<td>Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used)</td>
<td>1 unit</td>
</tr>
<tr>
<td>S8120</td>
<td>Oxygen contents, gaseous, 1 unit = 1 cu ft (This is a new code that is effective 10/01/03. Units are equal to cubic feet of oxygen.)</td>
<td></td>
</tr>
<tr>
<td>S8121</td>
<td>Oxygen contents, liquid, 1 unit = 1 lb (This is a new code that is effective 10/01/03. Units are equal to pounds of oxygen.)</td>
<td></td>
</tr>
</tbody>
</table>

New Product

Basic Blue 80

Effective October 1, 2003, Blue Cross Blue Shield of North Dakota (BCBSND) is offering a new 80/20 product, Basic Blue 80, that does not require a network affiliation. The Basic Blue 80 benefits are similar to the existing Basic Blue product; however, coinsurance will be 80/20. The existing Basic Blue product name will change to Basic Blue 70 to indicate the 70/30 coinsurance product.

It is also critical for confirming membership and coverage. We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff. Once you’ve identified the alpha prefix, pick up the phone and call the BlueCard Eligibility® line at 1-800-676-BLUE (2583) to verify the patient’s eligibility and coverage.

An operator will ask you for the alpha prefix and will connect you directly to the appropriate membership and coverage unit at the patient’s Blue Cross and Blue Shield Plan. If you can’t find an alpha prefix on the ID card, this may indicate the claims are handled outside the BlueCard Program. Check the back of the patient’s ID card for instructions or a telephone number for how to file these claims. If that information is not available, call BCBSND’s Provider Service at 1-800-368-2312 (toll free) or 282-1090 (local).

Once the patient receives care, submit the claim to BCBSND. Include the patient’s complete identification number, which incorporates the three-character alpha prefix. Some alpha prefixes are assigned to specific accounts, not plans. Incorrect or missing alpha prefixes and identification numbers delay claims processing.

If you are interested in facilitating quicker payments, take the easy route and call BlueCard Eligibility® at 1.800.676.BLUE (2583).

BlueCard

Easy Access to Membership and Coverage Information by Calling 1-800-676-BLUE

Not sure what to do when a patient hands you an identification card from another Blue Cross and Blue Shield Plan? First, verify with the patient that this is the most current ID card. Then look for the three-character alpha prefix that precedes the identification number on the ID card. The alpha prefix identifies whether the patient is a member of the BlueCard Program and the member’s Blue Cross and Blue Shield Plan or national account.
**Glad You Asked!**

**Question:** Does Blue Cross Blue Shield of North Dakota recognize revenue code 637, self-administrable drugs?

**Response:** Revenue code 637, self-administrable drugs, is a legitimate revenue code; however, the categorization of pharmacy as self-administrable drugs relates to a specific Medicare regulation. BCBSND does not recognize self-administrable drugs as a separate category and does not require they be separately identified. Therefore, revenue code 637 should not be billed on claims where BCBSND is the primary payer.

Pharmacy should continue to be billed using the other appropriate pharmacy revenue codes, including revenue code 636 (Drugs Requiring Detailed Coding) for all pharmacy identified by specific HCPCS. Please see the article in HealthCare News #231 regarding specific billing instructions for take-home medications.

**Question:** A claim was submitted for debridement performed by physical therapy. We used revenue code 420 and HCPCS 16020. This claim was returned. Why?

**Response:** Prior to 2001, there were no specific codes to identify debridement when performed by a physical therapist; therefore, revenue code 42X had been set up to allow the CPT® codes 16020, 16025, and 16030 to be billed. In January 2001, two new codes were created specific to the Physical Medicine and Rehabilitation category of CPT®. These codes are specific to debridement services performed by a therapist and are more accurate in describing the service performed. The 2 codes are:

- **97601 –** Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
- **97602 –** Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

The creation of these specific codes changed the edits for revenue code 42X. Revenue code 42X will no longer allow the surgical debridement codes.

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**OCR (Optical Character Recognition)**

**Tips for Submitting Paper Claims**

All providers are encouraged to submit their claims electronically. If you are interested in pursuing electronic submission of claims, please contact EDI Services at 1-866-849-7246. If EMC is not an option, paper claims must be submitted according to the following guidelines. This will ensure timely and accurate processing of claims through the OCR system. We appreciate your cooperation and support.

Use red HCFA-1500 claim forms, version 12/90. HCFA-1491 claim forms and carbon copies of HCFA-1500 claim forms produce unclear images and increase the chance of inaccurate data entry. Photocopies of claims are not acceptable through the OCR system.

Print claims in a 10-12 pitch or 10-12 point font, using a dark black printer ribbon or black ink jet or laser print. Dark blue or light black printer ribbons and handwriting are often too light to be read correctly by the OCR equipment. If you need to manually correct information, write the corrections clearly with dark ink (no red ink) and cross out the unneeded or incorrect information.

Avoid the use of red pen, glitter pens, markers, and blue or green highlighters. The OCR equipment drops all red print when processing and any information written in red will “drop out” and be missed.

Align the claim form so that all information is contained within the appropriate box. Poorly aligned data may be read incorrectly or missed entirely, resulting in incorrect processing of the claim.

The following tips will ensure prompt and accurate OCR translation of your HCFA-1500 claims.

**Item 1a should contain the patient’s benefit plan number.** Submit the alpha prefix and patient’s benefit plan number that is in effect at the time services are rendered.

**Item 3 should contain the patient’s birth date and sex.** The patient’s birth date should be shown in the MMDDCCYY format. Enter an “X” in the appropriate box designating the sex of the patient.
Item 4 should contain the subscriber’s name. The name should be shown as LAST name, FIRST name, MIDDLE INITIAL with spaces between. For example, “Jane A. Doe” should be shown as “Doe Jane A”. Item 4 can contain “SAME” when the patient is the same as the insured.

Item 6 should contain the patient’s relationship to the insured. Enter an “X” in the appropriate box designating the patient’s relationship to the insured.

Item 21 for OCR imaged claims should include no more than four ICD-9-CM diagnosis codes in order of priority (1,2,3,4) using the degree of specificity. When submitting only two diagnosis codes the second diagnosis code must be shown in item 21 diagnosis code position #2. “E” codes are not allowed as the primary diagnosis. Descriptions of the ICD-9-CM codes should not be included. (Non-OCR claims can have up to eight diagnosis codes).

Item 24a must include a date of service for each detail line. If “From” and “To” dates are the same for a detail line, show date (MMDDYY) in the “From” column.

Item 24b must include a valid two-digit place of service. Valid place of service codes are:

03 – School
04 – Homeless Shelter
11 – Office
12 – Home
13 – Assisted Living Facility (Effective 10-1-03)
14 – Group Home (Effective 10-1-03)
15 – Mobile Unit
20 – Urgent Care Facility
21 – Inpatient Hospital
22 – Outpatient Hospital
23 – Emergency Room – Hospital
24 – Ambulatory Surgical Center
25 – Birthing Center
26 – Military Treatment Facility
31 – Skilled Nursing Facility
32 – Nursing Facility
33 – Custodial Care Facility
34 – Hospice
41 – Ambulance – Land
42 – Ambulance – Air or Water
49 – Independent Clinic (Effective 10-1-03)
50 – Federally Qualified Health Center
51 – Inpatient Psychiatric Facility
52 – Psychiatric Facility Partial Hospitalization
53 – Community Mental Health Center
54 – Intermediate Care Facility/Mentally Retarded
55 – Residential Substance Abuse Treatment Facility
56 – Psychiatric Residential Treatment Center
57 – Non-residential Substance Abuse Treatment Facility (Effective 10-1-03)
60 – Mass Immunization Center
61 – Comprehensive Inpatient Rehabilitation Facility
62 – Comprehensive Outpatient Rehabilitation Facility
63 – End Stage Renal Disease Treatment Facility
71 – State or Local Public Health Clinic
72 – Rural Health Clinic
81 – Independent Laboratory
99 – Other Unlisted Facility

Item 24d “CPT/HCPCS” should include only CPT or HCPCS codes. Descriptions of the CPT or HCPCS codes should not be included. The descriptions for “Unlisted” procedure codes should be included in item 19.

Item 24d “MODIFIER” should include two alpha, numeric or alpha-numeric characters per modifier when applicable. Spacing in the box will allow up to three modifiers per CPT/HCPCS code.

Item 24e this field identifies the ICD-9-CD diagnosis code reference number. This field allows digits 1 through 4 and is meant to reference the applicable ICD-9-CM diagnosis code(s) identified in item 21.

Item 24f should include the billed amount for that line item. The dollar amount should be to the left of the broken line and the cent amount (even if 00) should be to the right of the broken line. If one detail line is billing for two services at $15 each, item 24g should show “2” and item 24f should show “30 00”. Do not include a dollar sign ($).

Item 24g should include days (if greater than 1), units or minutes for that line item. When multiple services are provided, enter the actual number provided. For anesthesia, show the time in minutes. For example, 2 hours and 30 minutes should be billed as 150 in item 24g. Specific psychiatric and substance abuse procedure codes require the time in hours and minutes. For example, to record 1 hour and 10 minutes for procedure code 90801, the time would be reported as “110”. Please reference HealthCare News #208 for specific information on submitting units for psychiatric and substance abuse procedure codes.

Item 24k must include the performing provider’s abbreviated last name and PIN (Provider Identification Number) on each detail line item. The first three characters of the performing provider's last name and PIN, must be shown in item 24k, respectively. For example, Dr. Johnson with a PIN as 123456 should be billed as “Joh123456” in item 24k.

Item 28 should include the billed amount for that claim. The dollar amount should be to the left of the broken line and the cent amount should be to the right of the broken line. Do not enter “continued” and do not include charges from another page in the total charges. The HCFA-1500 claim form is designed for only six detail lines of information.

If you are interested in pursuing electronic submission of claims, please contact EDI Services at 1-866-849-7246.
**Health Insurance Claim Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSURED’S I.D. NUMBER</td>
<td>YQA123456789</td>
</tr>
<tr>
<td>INSURED’S NAME</td>
<td>Insuredlast, First M.</td>
</tr>
<tr>
<td>INSURED’S ADDRESS</td>
<td>Any Street</td>
</tr>
<tr>
<td>CITY</td>
<td>Anytown</td>
</tr>
<tr>
<td>STATE</td>
<td>ND</td>
</tr>
<tr>
<td>ZIP CODE</td>
<td>99999</td>
</tr>
<tr>
<td>TELEPHONE</td>
<td>(999) 999-9999</td>
</tr>
<tr>
<td>INSURED’S POLICY GROUP OR F.E.N. NUMBER</td>
<td></td>
</tr>
<tr>
<td>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER</td>
<td>Doe, PhD</td>
</tr>
<tr>
<td>SIGNATURE DATE</td>
<td>05/15/99</td>
</tr>
<tr>
<td>SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>MEDICAL AIDS</td>
<td></td>
</tr>
<tr>
<td>CHAMPAG</td>
<td></td>
</tr>
<tr>
<td>CHAMPAG GROUP</td>
<td></td>
</tr>
<tr>
<td>FECA</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
<tr>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>Referring Physician</td>
</tr>
<tr>
<td>I.D. NUMBER OF REFERRING PHYSICIAN</td>
<td>D12345</td>
</tr>
<tr>
<td>DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</td>
<td>04/15/99</td>
</tr>
<tr>
<td>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE</td>
<td></td>
</tr>
<tr>
<td>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE</td>
<td></td>
</tr>
<tr>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td>OUTSIDE LAB</td>
<td></td>
</tr>
<tr>
<td>MEDICARE RESUBMISSION CODE</td>
<td></td>
</tr>
<tr>
<td>ORIGINAL REF. NO.</td>
<td></td>
</tr>
<tr>
<td>PRIOR AUTHORIZATION NUMBER</td>
<td></td>
</tr>
<tr>
<td>TOTAL CHARGE</td>
<td>180.00</td>
</tr>
<tr>
<td>AMOUNT PAID</td>
<td>5.00</td>
</tr>
<tr>
<td>BALANCE DUE</td>
<td>5.00</td>
</tr>
<tr>
<td>SIGNATURE</td>
<td>Doe, PhD</td>
</tr>
<tr>
<td>DATE</td>
<td>05/15/99</td>
</tr>
</tbody>
</table>

**HealthCare Center**
Any Street, Box 123
Anytown, ND 99999

**PLEASE PRINT OR TYPE**

**APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/98**

**APPROVED OMB-0938-0089 FORM HCPA-1500 (12-90), FORM IRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPAG)