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Claim Adjustments

Institutional and Professional Claims

Currently, claim adjustment requests for institutional and professional claims will be accepted for reprocessing 180 days from the remittance date (payment listing) of BCBSND or other party responsible for the payment of claims. Requests for claim adjustments submitted after 180 days from the remittance date will not be accepted or reimbursed for claims processed on or after January 1, 2004.

Effective July 1, 2005, claim adjustment requests for institutional and professional claims will not be accepted or reimbursed for claims with a remittance date prior to January 1, 2004. Requests for claim adjustments submitted after 180 days from the remittance date will not be accepted or reimbursed for claims processed on or after January 1, 2004.

Claim adjustment requests submitted for claims with a remittance date on or after January 1, 2004, will continue to follow the current 180 day adjustment process.

Claim adjustment requests may include, but are not limited to, additions, deletions or changes to the following information:

- ICD-9-CM, CPT®, HCPCS
- Dollar amount(s)
- Unit(s) of service
- Modifier(s)
- Place of service
- Date of service
- Late charges

Important Reminders

A member must see a provider(s) that is part of their network to receive their highest level of benefits. If the member seeks services on their own (self-referred), from a provider(s) outside their network, the member will pay a higher cost share. Care must be directed by an in-network provider and communicated to BCBSND through an approved referral to receive the highest level of benefits from an out-of-network provider.

Summary of Benefit Plan Changes

Pending approval by the North Dakota Insurance Department, the following is a brief summary of the benefit plan changes effective July 1, 2005.

Mail Order Prescription Drug Benefits

Benefits have been added to include a mail order prescription drug option. This is an optional benefit for the member.

Outpatient Prescription Medications or Drugs

A $1,000 prescription drug coinsurance maximum per member per benefit period will be added to the outpatient prescription drug benefit. When this coinsurance maximum is met, 100% of the allowed charge will be paid for prescription drugs, less the co-payment amounts, during the remainder of the benefit period. This maximum applies to formulary drugs.

Diabetes Services/Education

The diabetes education lifetime maximum has been increased to a total of $1,000 per member for programs approved by BCBSND.

Fecal Occult Blood Testing

Benefits have been added to allow fecal occult blood testing for colorectal cancer screening for members age 50 and older, subject to a maximum benefit allowance of one test per benefit period.
Reimbursement

2005 BCBSND Ambulatory Surgery and Hospital Outpatient Fee Schedule Update

The 2005 BCBSND Ambulatory Surgery Center (ASC) and Hospital Outpatient Fee Schedules list an incorrect rate for CPT® code 41899 (Unlisted procedure, dentoalveolar structures). However, the rate in the BCBSND claims processing system is correct and claims have paid accurately. Please refer to the July 1, 2004, rate listed in the above fee schedules for the correct rate. Health Care News Bulletin #242 provides information on proper billing and coding instructions for 41899.

Clarification on Billing for BayRho-D

**Effective Date: Immediately**

BayRho-D is an injectable immune globulin obtained from human blood. The 2004 and 2005 expert editions of the HCPCS Level II book list BayRho-D under J2788 and J2792. Due to the large variance of pricing for the drugs listed under J2792, it was not rated by BCBSND; it was left as ‘by report’ for 2005. During the review of claims, it was noted BayRho-D does not match the description for J2792. Therefore, with clarification from the Blue Cross Blue Shield Association it was determined that BayRho-D should not be listed under J2792. For all future billing of BayRho-D, use the appropriate codes listed below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2788</td>
<td>Injection, Rho D immune globulin, human, minidose, 50 mcg</td>
</tr>
<tr>
<td>J2790</td>
<td>Injection, Rho D immune globulin, human, full dose, 300 mcg</td>
</tr>
</tbody>
</table>

BCBSND has established a reimbursement rate for J2790 and J2792. J2790 has also been removed from the Specialty Pharmacy list for 2005. The updated rates are available on the Injectables-Other Pharmacy Fee Schedule on the THOR bulletin board. If you are unable to view the Fee Schedule on THOR, please contact THOR Support Services at 1-800-544-8467.

Payment Listing

Changes to the 835 Remittance Advice/Paper Payment Listing

Currently, when requested medical information needed for claims processing has not been returned to BCBSND, the service is rejected with a group code of PR and a claim adjustment reason code of 17 on the payment listing. This exact group and adjustment reason code are also used when a member has not returned requested information to BCBSND. This has made it difficult for providers to determine if the information is needed from the member or the provider.

Effective with the payment cycle for the week of August 1, 2005, if a service is being rejected because requested medical information has not been returned, the service will be rejected with the group code of OA and a claim adjustment reason code of 17. For those providers receiving the electronic 835, a remittance remark code of M125 will also be transmitted. This remark code will be sent in the 2110 loop, LQ segment. The LQ01 segment will contain the qualifier of HE (Claim Payment Remark Codes) and the LQ02 segment will contain the remark code of M125. For providers who receive a paper payment listing, only the group code of OA and claim adjustment reason code of 17 will be shown on the payment listing. The remark code will NOT show on the paper payment listing.

For electronic 835 providers using a vendor to retrieve and post the 835, please notify your vendor of this change so the appropriate system changes can be made if needed.
DVAC (DRG Validation Advisory Committee)

Member Position Opening
The DRG Validation Advisory Committee currently has openings for membership. This is an excellent opportunity to join DVAC if you are an experienced inpatient (DRG) coder or utilization review RN at a BCBSND participating healthcare facility.

Purpose:
The purpose of DVAC is to maintain an open forum to promote research and discussion of current coding guidelines, medical documentation to support coding for DRG reimbursement and current utilization review practices. Other issues include level of care, readmissions, and transfers. This committee promotes communication between payers and providers.

Membership:
To date, the membership has included representatives from BCBSND, NDQIO, and Worker’s Safety as well as large and small hospitals. Committee membership will remain a mixture of both payers and providers. The membership consists of experienced coding professionals or utilization review RNs. Member selection will be based on criteria such as coding/UR experience, current employment, credentials, and continuing education.

Operating Practices:
- The DVAC shall meet 4 times per year, at a minimum, and as necessary at the discretion of the committee.
- The individual DVAC members shall, at their own expense, keep current regarding ICD-9-CM coding practices and DRG classifications.
- The provider members of DVAC shall act in a manner that represents the entire provider community through agenda items brought forth to the Committee.
- Agenda items will be issue specific and kept in manageable proportions. Research and presentation will be assigned to members for each topic identified. (Ex. Coding Clinic, UHDDS guidelines, BCBSND policy, medical criteria, etc.)
- The members of DVAC will be reimbursed for mileage at the standard BCBSND rate for attending scheduled meetings.
- The provider members of DVAC serve 1, 2 or 3-year terms and may serve an unlimited number of terms upon re-application and re-appointment. This staggering of terms is determined necessary to provide a consistent retention of experienced versus new members and to provide an efficient process for continuation of work performed by this committee.
- All provider members are required to be employed by a participating provider of BCBSND in a coding or utilization review RN capacity. A change in employment status may result in removal from DVAC.

If you are interested in becoming a DVAC member and are currently employed in a utilization review or inpatient coding position, please complete a copy of the application included in this HealthCare News bulletin. Applications must be returned by July 20, 2005. Contact Deb Selland at 701-282-1879 for questions concerning the DRG Validation Advisory Committee.
Blue Cross Blue Shield of North Dakota
DRG Validation 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 or Utilization Review RN Positions: _________________

Total Years in the Health Care Industry: _____________________________________

Coding Designations/ Certifications Held: ________________________________

Training received/seminars attended within the last 3 years that would relate to DVAC:

Describe any facilitation or presentation skills/experience you have:

Why would you be a valuable member of the DRG Validation Advisory Committee?

Please return by July 20, 2005, to: Deb Unruh, Medical Review & Audit
Blue Cross Blue Shield of North Dakota
4510 13th Avenue S
Fargo, ND  58121-0001
Medical Policy

DRAFT Scanning Laser Technologies for Glaucoma Policy Available
A medical policy for Scanning Laser Technologies for Glaucoma is available for comment on our DRAFT medical policy web site www.bcbsnd.com/providers/draft_med_policy.html. Comments will be accepted for 30 days. Click on the link "Comment on this draft” to e-mail any comments to the BCBSND Medical Management Department.

We look forward to hearing from you.

Non-Formulary Medication

Physician Request for a Non-Formulary Medication - Approval Process
Update to HealthCare News # 246

A physician may submit a "Physician Request for a Non-Formulary Medication” form to request consideration for coverage of a non-formulary drug at the formulary level. Once this form is received and reviewed, the member and the provider will be notified of the decision. If the request is approved, the approval is valid for twelve months. If it is necessary for the member to continue on the approved drug beyond the initial twelve months, an additional request is required every twelve months. The member should contact the provider to submit the request prior to the expiration date. Requests will not be accepted prior to 60 days before the expiration date. Requests received more than 60 days prior to the expiration date will be returned to the provider.

This approval process does not apply to FEP.

Requests may be mailed to:
Provider Service Department
Blue Cross Blue Shield of North Dakota
4510 13th Avenue S
Fargo, ND 58121-0001

Requests may be faxed to:
Provider Service Department
(701) 277-2132
**Question:** If a physician is excising several lesions in different areas and is doing an intermediate repair of these sites, how should the repair be coded?

**Response:** A simple repair is not reported separately when an excision is done; however, when layered closure is required and documented, the intermediate repair codes should be used. Layered closure involves one or more of the deeper layers of superficial fascia and subcutaneous tissue. Often more than one type of suture material is used. Absorbable suture material is usually used for the deeper tissue layers. This information must be documented in the medical record.

There are specific guidelines related to location and size that are used when billing the repair codes. The code definitions along with additional information noted in the repair section of CPT® 2005 (12001 – 13160) help explain the use of these codes.

Repair codes are not coded individually per lesion. According to CPT® 2005, repair is the “sum of lengths of repairs for each group of anatomic sites”. The lengths of all related sites based on the CPT® code definition are added together to equal a total length and the appropriate code is chosen based on that total length. Length is always measured in centimeters. If there are multiple wounds from the same indented category, add the lengths of each category (or anatomic site) together and report the total length for that category as one (1) code. Each series of indented codes in the repair section is specific to anatomic location, i.e. codes 12031 - 12037 correspond to all repairs for the areas of scalp, axillae, trunk and/or extremities (excluding hands and feet). Separate sites as identified by the indented code series are coded separately. For example:

A patient had 14 wounds repaired with layered closure. Three (3) are on the scalp and are 1.0 cm, .5 cm and .5 cm. Two (2) are on the hip and are 1.3 cm and 1.5cm. Two (2) are on the abdomen and are 2.1 cm and 1.6 cm. One (1) is on the leg and is 1.8 cm. One (1) is on the face and is .3 cm. Two (2) are on the ears and are .5 cm and .3 cm. Two (2) are on the neck and are 1.0 cm and .8 cm. One (1) is on the hand and is 1.0 cm.

<table>
<thead>
<tr>
<th>Location</th>
<th>Size</th>
<th>Total Length</th>
<th>Coding Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scalp (3)</td>
<td>1.0 cm, .5 cm, .5 cm</td>
<td>10.3 cm</td>
<td>The repair for the wounds on the scalp, hip, abdomen and leg are all grouped anatomically into the same indented code series. The sum of these lengths equals 10.3 cm. The code that represents this intermediate repair is 12034 (Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm).</td>
</tr>
<tr>
<td>Hip (2)</td>
<td>1.3 cm, 1.5 cm</td>
<td>2.8 cm</td>
<td>The repair for the wounds on the face and ears are also grouped anatomically per definition. The sum of these lengths equals 1.1 cm. The code that represents this intermediate repair is 12051 (Layer closure of wounds of face, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less).</td>
</tr>
<tr>
<td>Abdomen (2)</td>
<td>2.1 cm, 1.6 cm</td>
<td>3.7 cm</td>
<td>The last three repairs for the neck and hand are grouped into another anatomic category. The sum of these lengths equals 2.8 cm. The code that represents this intermediate repair is 12042 (Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm).</td>
</tr>
<tr>
<td>Leg (1)</td>
<td>1.0 cm</td>
<td>.8 cm</td>
<td>The repair for the wounds on the scalp, hip, abdomen and leg are all grouped anatomically into the same indented code series. The sum of these lengths equals 10.3 cm. The code that represents this intermediate repair is 12034 (Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm).</td>
</tr>
<tr>
<td>Face (1)</td>
<td>.3 cm</td>
<td>1.1 cm</td>
<td>The repair for the wounds on the face and ears are also grouped anatomically per definition. The sum of these lengths equals 1.1 cm. The code that represents this intermediate repair is 12051 (Layer closure of wounds of face, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less).</td>
</tr>
<tr>
<td>Ears (2)</td>
<td>.5 cm, .3 cm</td>
<td>1.8 cm</td>
<td>The last three repairs for the neck and hand are grouped into another anatomic category. The sum of these lengths equals 2.8 cm. The code that represents this intermediate repair is 12042 (Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm).</td>
</tr>
</tbody>
</table>

The three repair codes billed for this example would be 12034, 12042, and 12051. Since these procedures were done during the same outpatient operative session, they would be reimbursed at 100/50/50 for both the physician and the facility. The appropriate excision codes would also be billed.