# Medical Policy

## Medical Policies Available Online

Blue Cross Blue Shield of North Dakota (BCBSND) regularly develops and revises medical policies in response to rapidly changing medical technology. BCBSND is committed to updating the provider community as medical policies are adopted and/or revised. Benefit determinations are made based on the medical policy in effect at the time of service.

The following medical policies were reviewed by the Internal Medical Policy Committee on March 15, 2016. Medical policies are available online at www.BCBSND.com/web/providers/policies.

Revised medical policies (see policy for changes)
- Spinal Cord Stimulation
- Heart Transplant
- Actigraphy
- Implantable Bone-conduction and Bone-anchored Hearing Aids
- Noninvasive Prenatal Testing for Fetal Aneuploidies
- Hospice

Revised pharmacy policies (see policy for changes)
- Cosentyx
- Farydak
- Gleevec
- Oral Hepatitis C Agents
- Ibrance
- Inlyta
- Jakafi
- Kalydeco
- Lenvima
- Noxafil
- Tarceva
- Tykerb
- Drug Indications

## New Policies
- Identification of Microorganisms Using Nucleic Acid Probes
- Cryosurgical Ablation of Miscellaneous Solid Tumors
- Radiofrequency Ablation of Miscellaneous Solid tumors Excluding Liver
- Charged-particle (Proton or Helium Ion) Radiotherapy

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Coding and Billing

Outpatient Pre-Labor Monitoring Services

Note: This is an update to coding and billing notices published in HealthCare News volumes 228 (December 2002) and 288 (December 2007).

Blue Cross Blue Shield of North Dakota (BCBSND) reimburses outpatient pre-labor monitoring services on a uniform fee schedule rate. These rates can be found on the BCBSND Hospital Outpatient fee schedule. The following billing and claim submission requirements apply.

Billing instructions:
- Providers must bill for pre-labor monitoring services with revenue code 072X – Labor Room/Delivery (excluding revenue code 0723 - circumcision).
- Only one line of revenue code 072x per claim will be accepted.
- HCPCS will not be required on revenue code 072X.
- If a rated HCPCS is submitted on 072X, reimbursement will be the lesser of charges or fee schedule rate.
- Pre-labor monitoring services on revenue codes 072X (excluding revenue code 0723) and observation services on revenue code 0762 will not be accepted on the same claim. Claims will be returned to the provider if billed on the same claim.
- Additional nursing charges in the labor and/or delivery room are not separately billable.
- Fetal monitoring and fetal stress or non-stress tests must be billed with revenue code 0732 using the appropriate CPT®/HCPCS codes.
- Units must reflect the number of hours the patient was monitored to receive the appropriate reimbursement rate.

Claims submission:

The following are claims submission criteria for outpatient charges submitted for pre-labor monitoring. If a patient:

- Presents with early labor, is sent home and returns to deliver at a later date, a separate outpatient claim would be submitted.
- Presents with two distinct pre-labor monitoring encounters, separate claims should be submitted for each stay.
- Delivers while being monitored, there would be no separate outpatient charges or payment. The charges for the monitoring should be included in the inpatient delivery stay.
- Is continuously monitored over multiple days, one line should be billed on the claim with the units equaling the total number of hours for the monitoring.

Reimbursement will be the lesser of charges or the fee schedule rate. The rate will be based on the number of hours the patient is held for pre-labor monitoring. Separate rates have been established for 0-5 hours, 6-36 hours, and 37-48 hours. These rates are equal to the fee schedule amounts noted for the observation services on the BCBSND Hospital Outpatient fee schedule. Pre-labor monitoring stays greater than 48 hours will be reviewed on an individual basis. Other services will continue to be billed separately. When pre-labor room charges are present on a surgical claim, they will be included in the surgical roll-up methodology.

Family Therapy Coding

Family therapy is conducted with the child/adolescent, parents, and siblings in order to reduce symptomatology and integrate the child/adolescent's treatment goals into the family unit. Family members are assisted with identifying and maximizing the strengths they bring to the treatment process and with developing problem-solving techniques. Patterns of behavior and communication are assessed and addressed, as necessary. Family treatment should be part of a child/adolescent's treatment plan unless this modality is contraindicated for reasons of emotional or physical safety.

Family therapy codes should only be used when clinical necessity exists under the following conditions:

- Individual's (usually a dependent child) symptoms result from family stressors or dynamics or are worsened by the same, and therefore are expected to be reduced as a result of family therapy.
- The family therapy level of care is necessary in order to integrate the individual's treatment goals into the family unit.
- Family relationships are identified as problematic.
- Family dynamics are seen as a significant precipitant of symptoms and/or stabilization of family dynamics is instrumental to the individual patient's return to functioning/clinical improvement.
• The individual and the family (parent, parents, parents and siblings, etc.) are present for the session (pending unusual circumstances where child should be temporarily absent from a given session due to the child's best interest as determined by the therapist and parents).

The therapist should document family strengths, family issues to be resolved, specific type of family therapy used, length of treatment, etc.

Current Procedural Terminology (CPT®) procedure codes 90846 and 90847 are used to report services for family therapy. Family sessions are conducted face-to-face with family members, with patient present (90847), or without the patient present (90846). Family psychotherapy with patient present (90847) is frequently used in situations with dependent children. These are single unit codes identifying a “session.” Reviewing records, communicating with other providers, observing and interpreting patterns of behavior and communication between the patient and family members, and decision making regarding treatment including medication management is included.

Family therapy codes are not to be used:
• When the purpose of the visit is to explain the results of psychological testing. Such explanation is already reimbursed under the testing codes themselves.
• For taking a family history or for Evaluation and Management (E&M) counseling services.
• For seeing a parent alone in succession with seeing a child alone.

The CPT® codes eligible for payment by a Licensed Marriage and Family Therapist (LMFT) are:

90791 – Psychiatric diagnostic evaluation (no medical services) 90791 is a single unit service and regardless of the amount of time spent, the unit is always “one.”

90846 – Family psychotherapy, without the patient present. 90846 is a single unit service and regardless of the amount of time spent, the unit is always “one.”

90847 – Family psychotherapy (conjoint psychotherapy) (with patient present), 90847 is a single unit service and regardless of the amount of time spent, the unit is always “one.”

Any procedure codes other than 90791, 90846 or 90847 when billed by LMFTs will be non-covered as a member liable service.

New Institutional HCPCS Billing Codes Start on July 1

Blue Cross Blue Shield of North Dakota (BCBSND) has updated its coding for institutional providers for dates of service on or after July 1, 2016, to reflect standard Healthcare Common Procedure Coding System (HCPCS) manual nomenclature. These changes will impact psychiatric and substance abuse partial hospitalization and Intensive outpatient programs only. Coding for professional services will not be affected.

Here are some key points:
• For services rendered prior to July 1, 2016 providers should continue to use current coding.
• Effective July 1, these changes in coding will be required for dates of service of July 1, 2016, and thereafter.
• For members admitted prior to July 1, 2016, with episodes of care spanning into July, the claim will need to be split.

Claims with dates of service on or after July 1, 2016, submitted with the codes prior to July 1, 2016, will be deleted and returned.

Here is a crosswalk of the current codes to the new codes:

### Psychiatric

<table>
<thead>
<tr>
<th>Pre July 1st 2016</th>
<th>HCPCS CODES for dates of service through 6-30-2016</th>
<th>July 1 2016 and forward</th>
<th>HCPCS CODES for dates of service on or after 07-01-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization</td>
<td>912 S9480-22 – Intensive outpatient psychiatric services per diem. Modifier 22-Increased procedural services S9480(half day PHP)-Intensive outpatient psychiatric services per diem.</td>
<td>912</td>
<td>905 H0035 – Mental Health, partial hospitalization, less than 24 hrs., Half day partial program will no longer be a recognized service for dates of service after 6-30-2016.</td>
</tr>
</tbody>
</table>

| Intensive Outpatient Program | 905 H2020 – therapeutic behavioral services, per diem | 905 | 906 S9480 – Intensive outpatient psychiatric services per diem |

### Substance Abuse

<table>
<thead>
<tr>
<th>Pre July 1st 2016</th>
<th>HCPCS CODES for dates of service through 6-30-2016</th>
<th>July 1 2016 and forward</th>
<th>HCPCS CODES for dates of service on or after 07-01-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization</td>
<td>912 S9480-22-Intensive outpatient psychiatric services per diem. Modifier 22-Increased procedural services</td>
<td>912</td>
<td>S9475 ambulatory setting substance abuse treatment and or detox medically supervised mental and behavioral health services.</td>
</tr>
</tbody>
</table>

| Intensive Outpatient Program | 906 H2035-Alcohol and/or other drug treatment program, per hour | 906 | 906 H0015-Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) |
Psychiatric and Substance Abuse Services – Institutional
(Effective for dates of service of July 1, 2016, and beyond)

**Note:** This is an update to coding and billing notices published in HealthCare News volume 352 (March 2013).

Different levels of psychiatric and substance abuse services are provided by facilities with various types of licensure. These services are billed on the UB-04 using the facility’s National Provider Identifier (NPI).

Each level of care requires specific billing and coding information, which determines appropriate reimbursement. The billing guidelines for these various levels are listed below.

To verify if preauthorization is required please contact Provider Services at 1-800-368-2312 or for FEP please call 1-800-548-4026.

Preauthorization can be obtained by submitting information through The Healthcare Online Resource (THOR), or by calling 1-800-825-6614.

### Psychiatric Services

<table>
<thead>
<tr>
<th>Facility Type of Service</th>
<th>Type of Bill</th>
<th>Revenue Code</th>
<th>Level</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>111</td>
<td>0114 Private</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0124 Semi-private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Treatment Center (RTC)</td>
<td>86X</td>
<td>1001</td>
<td>N/A</td>
<td>T2048</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>131</td>
<td>0912 Full Day</td>
<td>H0035</td>
<td></td>
</tr>
<tr>
<td></td>
<td>131</td>
<td>0912 Specialty Program</td>
<td>S9485</td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient Program (IOP)</td>
<td>131</td>
<td>0905</td>
<td>N/A</td>
<td>S9480</td>
</tr>
</tbody>
</table>

**Inpatient**

**Description:** Around-the-clock intensive psychiatric, medical, and nursing care including continuous observation and monitoring, acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others, daily monitoring of psychiatric medication effects and side effects, and a contained environment for specific treatments that could not be safely done in a non-monitored setting.

**Billing and coding:** Inpatient services are reimbursed an all-inclusive per diem that includes all medically necessary services used in a hospital treatment program such as room and board, lab, x-ray, all therapies including ECT, and services of social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dieticians, etc. These services should be billed using approved revenue codes. Services inherent to the treatment program should not be billed separately on the CMS-1500. Examples include but are not limited to group therapy or family counseling. Psychiatrists and psychologists may bill separately on the CMS-1500 for services outside of the treatment program that are medically appropriate and necessary, such as psychological testing, individual therapy for psychiatric diagnoses and hospital Evaluation and Management (E&M) services.

**Residential Treatment Centers (RTC)**

**Description:** 24-hour structured, medically supervised multidisciplinary treatment; skilled nursing involvement and psychiatrist/qualified physician supervision; to stabilize multidimensional risk that cannot be managed through existing community programs. RTC is not primarily for the purpose of maintaining long-term gains made in an earlier program, is not based on a preset number of days and is not a substitute for lack of available supportive living environment(s) in the community. Treatment is focused on stabilization and improvement of functioning and reintegration with family or significant others and is transitional in nature for the purpose of returning the individual to the community with subsequent continued ambulatory treatment services as needed.

**Billing and coding:** RTC services are reimbursed on a uniform per diem basis and payments are based on the lesser of charge or the per diem rate. The per diem rate includes all medically necessary services used in the RTC program, such as room and board, lab, all therapies and services of social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dieticians, etc. Services by psychologists and psychiatrist inherent to the treatment program, such as group therapy, should not be billed separately on the CMS-1500. Psychiatrists and psychologists may bill separately on the CMS-1500 for services outside of the treatment program that are medically appropriate and necessary, such as psychological testing, individual therapy for psychiatric diagnoses and E&M services. Group or family counseling cannot be billed in addition to the RTC stay. Services must be billed on the UB-04 with one line per date of service and a unit of 1.
Partial Hospitalization Program (PHP)

**Description:** Continuous, coordinated, time-limited structured, medically supervised multidisciplinary ambulatory treatment, including skilled nursing involvement and psychiatrist/qualified physician for individuals who can maintain personal safety with support systems in the community. PHPs may address one or both of two primary goals: acute crisis stabilization and/or acute symptom reduction.

**Billing and coding:** Partial hospitalization services are reimbursed the lesser of charges or an all-inclusive per diem payment that includes all medically necessary services used in the program. This includes all services and disciplines including therapies, social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dieticians, etc. Psychiatrists and psychologists may bill separately on the CMS-1500 for services outside of the treatment program that are medically appropriate and necessary, such as psychological testing, individual therapy for psychiatric diagnoses and E&M services. Group or family counseling cannot be billed in addition to the partial hospitalization stay. Services must be billed on the UB-04 with one line per date of service and a unit of 1. Reimbursement is age specific: Child (ages 0 through 12 years), Adolescent (ages 13 through 17 years) and Adult (ages 18 years and older).

Specialty Programs provide services above and beyond those of standard partial hospitalization programs to achieve improved outcomes for specific disorders. In order to be reimbursed as a Specialty Program, the specialty applicant program must be approved by BCBSND, and the patient must meet medical necessity requirements for that level of care during the preauthorization process.

Specialty applicant programs are evaluated using the following criteria:

- Evidence that staff involved in the Specialty Program have a significantly higher level of expertise in treating the disorder than the standard partial hospitalization program. This evidence may include post-graduate courses or extensive workshops in the disorder or in a treatment protocol, staff publications in scholarly journals, certification of specialty training, etc.
- Evidence that the nature of patients being treated in the Specialty Program require treatment given by a higher level of expertise than the standard program, and require 7 or more hours of active treatment per visit five or more days per week.

To be granted Specialty Program status, the facility must provide documentation to support the additional service capabilities described above. Specialty Program status approval will be determined by the BCBSND Credentialing Committee. Services must be billed on the UB-04 with one line per date of service and a unit of 1.

Psychiatric Intensive Outpatient Program (IOP) will replace half day partial hospitalization (PHP), effective for dates of service on or after July 1, 2016.

Intensive Outpatient Program (IOP)

**Description:** Provides an intensive, coordinated, multi-disciplinary and time-limited treatment. This is an ambulatory treatment for individuals who are able to maintain personal safety with support systems in the community and are maintaining some ability to fulfill family, student, or work activities. An individual in psychiatric IOP has the ability to make age appropriate basic decisions for him/herself. An individual may be experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual. Clinical interventions may include individual, couples, family, and group psychotherapies along with medication management. This level of care may be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant immediately returned to a less structured outpatient setting.

**Billing and coding:** Psychiatric IOP is a facility-based level of care and is defined as a structured, short-term treatment modality more intensive than outpatient treatment but less intensive than partial hospitalization provided by an appropriately credentialed health care facility. It is a multi-disciplinary program of at least three (3) treatment hours per day at least three (3) times per week with an individualized treatment plan and length. Psychiatric IOP does not have a pre-determined program length. Psychiatric IOP does not require pre-authorization.

Psychiatric IOP is paid on the lesser of charge or a per diem rate. Psychotherapy services (individual, family and group) and pharmacologic management services completed by any provider type are considered to be included in the facility per diem payment. For reimbursement purposes, the facility must be licensed and credentialed for partial hospitalization services before being eligible to be credentialed for IOP. Participating facilities currently credentialed for partial hospitalization services must still be credentialed by Blue Cross Blue Shield of North Dakota (BCBSND) before being eligible to be reimbursed for psychiatric IOP services. The IOP Program must be reviewed and approved at the Program level. Services must be billed on the UB-04 with one line per date of service and a unit of 1.
### Substance Abuse Services

<table>
<thead>
<tr>
<th>Facility Type of Service</th>
<th>Type of Bill</th>
<th>Revenue Code</th>
<th>Level</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>111</td>
<td>0114 Private 0124 Semi-private</td>
<td>3.7 3.7-D 4 4-D</td>
<td>N/A</td>
</tr>
<tr>
<td>Residential Treatment Center (RTC) – Adolescent</td>
<td>86X</td>
<td>1002</td>
<td>3.1</td>
<td>H2036-52</td>
</tr>
<tr>
<td>Residential Treatment Center (RTC) – Adult</td>
<td>86X</td>
<td>1002</td>
<td>3.3</td>
<td>H2036-22</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>131</td>
<td>0912</td>
<td>2.5</td>
<td>S9475</td>
</tr>
<tr>
<td>Intensive Outpatient Program (IOP)</td>
<td>131</td>
<td>0906</td>
<td>2.1</td>
<td>H0015</td>
</tr>
</tbody>
</table>

### Billing and coding:
Inpatient services are reimbursed an all-inclusive per diem that includes all medically necessary services used in a hospital treatment program such as room and board, lab, x-ray, all therapies including ECT, and services of social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dieticians, etc. These services should be billed using traditional revenue codes. Services by psychiatrists and psychologists inherent to the treatment program, such as group therapy, should not be billed separately on the CMS-1500. Psychiatrists and psychologists may bill separately on the CMS-1500 for services outside of the treatment program that are medically appropriate and necessary, such as psychological testing, individual therapy for psychiatric diagnoses and hospital Evaluation and Management (E&M) services.

### Residential Treatment Centers (RTC)

#### Description
- **3.1 Clinically-Managed Low-Intensity Residential:** (Adults and Adolescents) 24-hour structure with available trained personnel; at least 5 hours of clinical service/week.
- **Level 3.1 supportive living may be provided in conjunction with level 2 programs when an individual’s multidimensional risk warrants the need for both levels.
- **3.3 Specific High Intensity Residential Services:** (Adults and Adolescents) 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community.
- **3.5 Clinically-Managed High-Intensity Residential:** (Adults) 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.
- **3.5 Clinically-Managed Medium-Intensity Residential:** (Adolescents) 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.

### Billing and coding:
Substance Abuse Residential Treatment Centers will continue to be reimbursed on a uniform per diem basis and payment will be based on the lesser of charge or the per diem amount. Substance abuse RTCs levels of care continue to be identified based on ASAM definitions and criteria.
The per diem rate includes all medically necessary services used in the RTC program, such as room and board, lab, all therapies and services of social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dieticians, etc. Services by psychologists and psychiatrist inherent to the treatment program, such as group therapy, should not be billed separately on the CMS-1500. Psychiatrists and psychologists may bill separately on the CMS-1500 for services outside of the treatment program that are medically appropriate and necessary, such as psychological testing, individual therapy for psychiatric diagnoses and hospital E&M services. Group or family counseling cannot be billed in addition to the RTC stay. Services must be billed on the UB-04 with one line per date of service and a unit of 1.

The per diem for ASAM Level 3.5 services will be a diminishing per diem rate methodology for care rendered at the same facility. A diminishing per diem rate methodology has different per diem amounts based on the length of stay of the episode of care. A minimum of 30 days between admissions will be required before starting a new reimbursement episode.

- **Days 1 through 21** – Services will be reimbursed at the full per diem amount.
- **Days 22 through 29** – Services will be reimbursed at 75 percent of the full per diem amount.
- **Days 30 through end of stay** – Services will be reimbursed at 50 percent of the full per diem amount.

The per diem for ASAM 3.1 will continue to be reimbursed on a uniform per diem basis and payment based on the lesser of charge or the per diem amount.

**Partial Hospitalization Program (PHP)**

**Description**

- **2.5 Partial Hospital Program**: 20 or more hours of service/week for multidimensional instability not requiring 24-hour care.

**Billing and coding**: Partial hospitalization is identified as ASAM 2.5 for adolescents and adults. Reimbursement for ASAM 2.5 corresponds to the "Full Day" description noted on the partial hospitalization fee schedule. Partial hospitalization services are reimbursed the lesser of charges or an all-inclusive per diem payment that includes all medically necessary services used in the program. This includes all services and disciplines normally used in the program, such as all therapies, social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dieticians, etc. Psychiatrists and psychologists may bill separately on the CMS-1500 for services outside of the treatment program that are medically appropriate and necessary, such as psychological testing, individual therapy for psychiatric diagnoses, hospital E/M services and lab services such as drug testing. Group or family counseling cannot be billed in addition to the partial hospitalization stay. Services must be billed on the UB-04 with one line per date of service and a unit of 1.

**Intensive Outpatient Program (IOP)**

**Description**

- **2.1 Intensive Outpatient**: 9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability

Substance Abuse IOP facility-based programs will be reimbursed a per diem rate. This per diem rate will apply to a structured ASAM Level 2.1 facility-based program in which the provider also offers ASAM II.5 services in order to facilitate individualized, coordinated delivery of service intensity as intended by ASAM. IOP is more intensive than outpatient but less intensive than partial hospitalization, these services must be billed on the UB-04. Payment will be based on the lesser of charge or the per diem amount. Services must be billed on the UB-04 with one line per date of service and a unit of 1.

If these services are an integral part of another program, they cannot be identified separately. If an independent practitioner with the appropriate licensure provides IOP, the services are submitted on the CMS-1500 using H2035 which is then reimbursed based on an hourly rate rather than the facility rate.

**Billing/Administration**

**IV Push and IV Infusion**

**Billing Requirements**

The Current Procedure Terminology (CPT®) manual provides guidance on billing for intravenous (IV) infusions and IV pushes. Drug compendia and labeling information provide information on standard preparation, handling, and administration of medications. An infusion is defined as requiring more than 15 minutes for safe and effective medication administration.

Push technique describes a method of administering a medication directly into a vein using a syringe. The time during which this administration is given is usually 15 minutes or less, but may be longer. An IV push, for coding purposes, is defined as either an injection during which the health care professional is continuously present or an infusion of 15 minutes or less. Further defined, if the nurse performs a drug administration service (safely delivered in less than 15 minutes) but is continuously present for 20 minutes to perform that service, it is still considered to be an IV push.

Blue Cross Blue Shield of North Dakota (BCBSND) expects medication administration and its subsequent billing of CPT® codes to be consistent with the drug administration instructions. For those infrequent circumstances during which the medication is provided over a period greater than what is considered reasonable, the medical record should reflect that increased time as necessary according to the patient condition or risk involved.
Billing for Anesthesia Services

Blue Cross Blue Shield of North Dakota’s (BCBSND) would like to clarify the billing requirements for anesthesia services.

Anesthesia billing information can be found on the BCBSND anesthesia fee schedule. Fee schedules are reviewed and updated each year in July to reflect current reimbursement. All participating (par) providers receive this fee schedule annually.

Here are some other tips for submitting claims for anesthesia services:

- Anesthesia services are submitted on a CMS 1500 claim form.
- Report total anesthesia time as minutes in the units field.
- BCBSND will convert the minutes billed into 15-minute time units. These time units will be added to the procedure’s base units to determine reimbursement.
- BCBSND used the base units as published in the most recent copy of the American Society of Anesthesiologists (ASA) Relative Value Guide.
- Anesthesia services must be submitted according to the descriptive terms and identifying codes used to report medical services and procedures performed as set forth by the American Medical Association (AMA) Current Procedure Terminology (CPT®) and applicable time units.
- The appropriate modifier must be attached to the anesthesia CPT® code indicating who is providing the anesthesia service.
- Reimbursement for CPT® code 01967 (labor epidural) is calculated using set time units of five plus base units multiplied by the appropriate anesthesia conversion factor. This is not a time based code.
- Anesthesia documentation must reflect the correct information in order to support the anesthesia services/codes billed (i.e. provider, start time, stop time, total time, etc.).

Provider Webinars

Blue Cross Blue Shield of North Dakota (BCBSND) hosts regular webinars for providers. For more information on how to register, please review the “Upcoming Webinars” on the Provider Webinars page of the BCBSND website: www.BCBSND.com/web/providers/provider-webinars.

Trends Identified by Provider Audit and SIU

May webinar (Registration open now through May 18)

When: Thursday, May 19, 2016
12:15 – 1 p.m. Central

Topic: Provide information regarding common concerns identified in the Provider Audit and Special Investigations Unit (SIU) areas and tips to help prevent these findings.

Audience: Billing and coding staff, providers who code their own claims and business office staff.

Agenda:
- Documentation concerns
- Coding concerns
- Prevention tips

New Institutional Billing Codes for Behavioral Health

June webinar (Registration available May 19 – June 15)

When: Thursday, June 16, 2016
12:15 – 1 p.m. Central

Topic: Coding for institutional providers for dates of service on or after July 1, 2016. This impacts psychiatric and substance abuse partial hospital and intensive outpatient programs.

Audience: Providers who submit claims for psychiatric or substance abuse Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP) services using the Healthcare Common Procedure Coding System (HCPCS).

Agenda:
- What is changing?
- History and rationale
- New code requirement crosswalk
- Claims submission
- Questions
Welcome to THOR (The Healthcare Online Resource)

THOR is a self-service website that allows providers, payers and other professionals secure access 24/7 to information regarding claims, patients and a wide range of electronic services to help do business faster, more accurately and at less cost. Register online at www.bcbsnd.com/providers.

THOR provides secure access to the following functions and more:

- Submit professional claims online and receive payment information within seconds.
- View claim status and submit claim adjustments.
- Correct claims electronically in a real-time environment.
- Verify eligibility, benefits and coverage information.
- Check deductible and out-of-pocket status.
- Create, update and view referrals and admission notifications.
- Receive your weekly remittances electronically.

E-Services offered: Bulletin Board, Chiropractic Fee Schedule, Claim Inquiry, Claim Adjustment, Claim Correction, Electronic Payment Listing, Membership, Injectables/Other Pharmacy Fee Schedule, Physician Payment Schedule, Preauthorization and Referral, Provider Data Exchange, Real Time Claims Submission and Provider Directory.

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