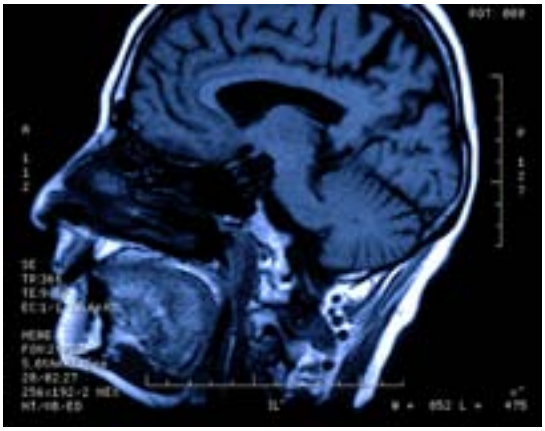
MOUNTAIN STATE Blue Cross Blue Shield
A HIGHMARK AFFILIATE

PROVIDER News

NIA Important Reminder: Continue to Verify Auth Requirements for Indemnity, FEP and BlueCard® Patients

Effective Jan. 1, 2011, National Imaging Associates, Inc. (NIA) began providing utilization management services for non-emergent, high-tech outpatient radiology services rendered to members enrolled in Mountain State commercial health plans, including SuperBlue® Plus PPO, SuperBlue Select Point of Service (POS), Steel, West Virginia Small Business Plan (WVSBP) and Highmark Health Insurance Company (HHIC) FreedomBlue℠ PPO Medicare Advantage Plan.

The NIA program requirements are waived for Mountain State's Traditional Indemnity product, BlueCard and the Federal Employees Health Benefits Program (FEP).



Providers are reminded, however, that it is important that you continue to verify with the members' benefits or home plan to determine if there are other authorization requirements.

Inside This Edition:

December 2010

Mountain State Implementing Electronic Requirements for NaviNet, EFT and Paperless EOB and Remittance Advice.

Implementing these requirements began Oct.1, 2010, and will continue throughout 2011. Mountain State will require network practitioners to enroll in NaviNet®, and receive paperless EOB statements and EFT. These electronic transactions provide enhanced protection of both member and practitioner data and provide you with faster reimbursement.

For providers who enroll in the EFT process, you will be required to receive a paperless EOB either by accessing NaviNet or by enrolling in the 835 HIPAA format as the means of receiving your EOB or Remittance advice. Beginning in March 2011 and upon enrollment the paper version will no longer be provided and mailed to you.

This conversion process is being conducted in three phases:

1. **Phase I:** Effective Oct. 1, 2010, all new assignment accounts and practitioners who are participating with Mountain State will be automatically enrolled in NaviNet, the free, easy, online solution linking physician offices with Mountain State and other health plans. These practitioners will also be required to receive EFT and paperless EOB statements.
2. **Phase II:** March 31, 2011, all practitioners currently enrolled with NaviNet will be required to receive EFT and paperless EOB statements.
3. **Phase III:** June 30, 2011, all practitioners doing business with Mountain State will be required to receive NaviNet, EFT and paperless EOB statements.

Initially, there will be four NaviNet transactions that will be mandated with this implementation. Those transactions are verification of benefits and eligibility, authorization submission, claims status inquiry and claims status investigations through the NaviNet portal.

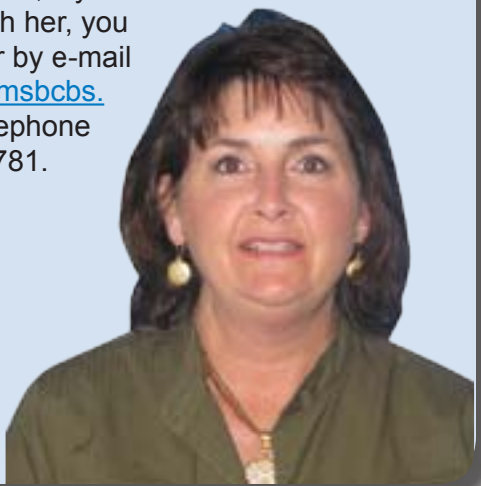
The Provider Relations Representatives will be conducting the necessary outreach to those providers who are not complying with the requirements. If you need access to or training for NaviNet, please contact your Provider Relations representative.

Introducing New Provider Relations Representative

Mountain State Blue Cross Blue Shield is pleased to introduce Kiz Metz as our new Provider Relations representative servicing the eastern panhandle and central regions of West Virginia. Ms. Metz will be working under the direction of Joyce Landers, Director of the Provider Relations Department.

Ms. Metz brings to Mountain State 30 years of experience working in the provider community and has served on the executive board of the Office Managers Association for 10 years, six of them as the state president.

Ms. Metz will be working out of the Parkersburg corporate office. She will be making her way into the provider areas soon. In the meantime, if you would like to talk with her, you can reach her by e-mail at kiz.metz@msbcbs.com or by telephone at 304-424-7781.



Kiz Metz

Partial ICD-9-CM and ICD-10 Code Freeze Takes Effect October 2011

The ICD-9-CM Coordination and Maintenance Committee is applying a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes before the Oct. 1, 2013, implementation of ICD-10.

The Centers for Medicare & Medicaid Services (CMS) proposed the code freeze in March 2010. It will become effective Oct. 1, 2011. Because of this code freeze, you will not have to keep pace with code updates while reworking your applications and systems for ICD-10-CM/PCS.

The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets will be made on Oct. 1, 2011.
- On Oct. 1, 2012, there will be only minimal, limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases.
- On Oct. 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM because it will no longer be used for reporting.
- On Oct. 1, 2014, regular updates to ICD-10 will resume, at which point only ICD-10 will be enhanced since ICD-9-CM will no longer be used.

During the code freeze, the ICD-9-CM Coordination and Maintenance Committee will continue to meet and follow their normal process to solicit comments twice a year. Any new code requests that are not determined to be essential updates will be evaluated for implementation once regular updates resume after Oct. 1, 2014.

What does the code freeze mean to me?

The freeze means you will not have to juggle making code and system updates for both ICD-9-CM and ICD-10-CM/PCS. You'll have more time to concentrate on becoming ICD-10 compliant. However, CMS has issued a reminder that the deadline for ICD-10 is fast approaching and it is firm. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is Oct. 1, 2013.

You can find current news and developments about the conversion to ICD-10-CM/PCS on the CMS website at www.cms.gov. Mountain State will also continue to share information about the upcoming migration to the ICD-10 code sets. Please watch for additional news and information about ICD-10 in future newsletters.

Don't Risk Rejected Claims; Upgrade to Version 005010 Now

Mountain State announced in the October 2010 **Provider News** that it was ready to accept and return Version 005010 claim transactions for claim submission, electronic remittance and claim acknowledgements; that is, transactions 837, 835, 999, 277CA. If you are not currently sending and receiving these Version 005010 transactions (through your Blue Cross Blue Shield trading partner), contact your trading partner to find out when you will be upgraded to Version 005010.

For those who have already been upgraded to Version 005010 for claim submission, electronic remittance and claim acknowledgements, you are halfway toward being compliant with the Version 005010 HIPAA mandate. To be in full compliance, you must also transition to using the Version 005010 format of the following transactions by Jan. 1, 2012:

- 270/271 — Health Care Eligibility Benefit Inquiry and Response
- 276/277 — Health Care Claim Status Request and Response
- 278 — Health Care Services Review — Request for Review and Response

Effective July 1, 2011, in compliance with the target date established by the Blue Cross and Blue Shield Association, Mountain State will support inquiry transactions 270/271, 276/277 and 278 in Version 005010 format. Throughout the remainder of the year, Mountain State will support both 005010 and 004010A1 formats for these transactions. Beginning Jan. 1, 2012, Mountain State will support only the 005010 format.

If you use NaviNet's® BlueExchange (Out of Area) transactions — BX Eligibility and Benefit Inquiry, BX Claim Status Inquiry, and BX Referral/Authorization Submission — 5010 versions of these transactions will be available during the fourth quarter of 2011.

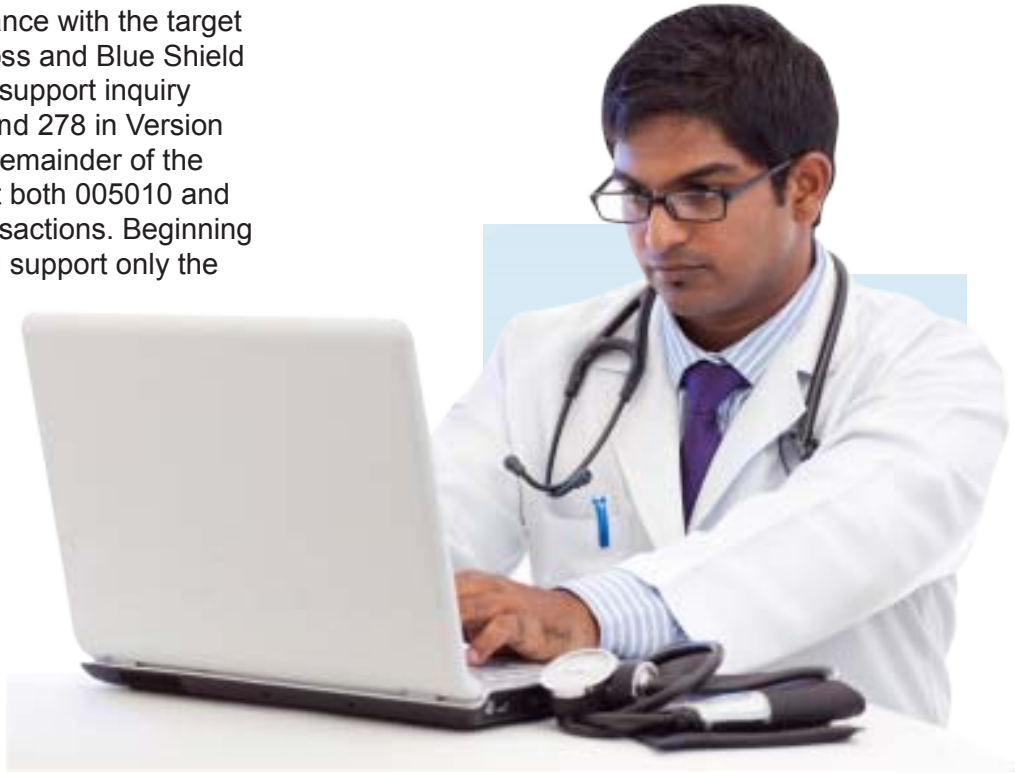
Compliance is critical

If you submit any transactions to Mountain State using 004010 formats after Jan. 1, 2012, they will be rejected. Only 005010-formatted transactions will be passed and accepted between HIPAA-covered entities, which include providers, clearinghouses and payers.

Questions?

If you have general questions about the changes being made by Mountain State to become Version 005010 compliant, please contact your Provider Relations representative. Questions specific to the Version 005010 authorization process or electronic claim transactions can be addressed to Mountain State's EDI Operations department at 800-992-0246.

Watch for future newsletter articles for more information and updates about the transition to HIPAA Version 005010 transactions.



Mountain State Expands Range of Numbers Possible in First Two Positions of UMI

To date, Mountain State has assigned each of its members a Unique Member Identifier, or UMI, to serve as his or her insurance identification number. This 12-digit identifier appears on the member's identification card and, in combination with the alphabetical prefix, is an important element in all claim and inquiry transactions.

Today, all valid UMIs begin with the numbers 10 or 11. Within the next year or so, Mountain State will run out of 12-position number combinations beginning with those two digits. To make sure that there will be enough UMI combinations available for the future, Mountain State is preparing to expand the range of numbers that can appear in the first two positions.

Beginning in January 2011, the numbers available to serve as UMIs will range from 100000000001 to 999999999001. Although your practice will not likely see UMIs beginning with numbers greater than 11 until much later next year, it is important to notify your vendor, clearinghouse or billing service about the change as soon as possible. If your practice management system includes hard-coded logic to accept only 10 or 11 in the first two positions of the UMI, some work may be necessary to accommodate the range expansion.

Valid Billing Provider NPI Required on All Claims

Correct reporting of the Billing Provider (National Provider Identifier [NPI]) on all claims submitted to Mountain State is not only necessary for claim processing but is also the key to accurate 1099 reporting.

Mountain State does not currently accept claims filed electronically through HIPAA transaction 837P if the Billing Provider is not recognized as a Billing Organization/Practice. Beginning in January 2011, Mountain State will reject claims submitted on the paper CMS-1500 (08/05) form when the NPI reported in block 33a (Billing Provider NPI) is not recognized as a Billing Organization/Practice.

You may report the Billing Provider as an individual only when the health care professional performing the services is an independent, unincorporated entity. In these cases, the Billing Provider is the individual whose Tax Identification Number (TIN) is used for IRS Form 1099 purposes.

To guarantee that your 1099 is correct, make certain that your biller or billing service is reporting the correct Billing Provider NPI on all claims.

As a reminder, after 1099s are issued in January 2011, Mountain State will not make changes to a 1099 if the claims were submitted with the performing provider incorrectly listed as the billing provider.

The Boeing Company Associates Receive New Identification Cards with New Alphabetical Prefixes

Blue Cross and Blue Shield of Illinois (BCBSIL) became the new health care benefits administrator for The Boeing Company on Jan. 1, 2011. Regence BlueShield of Washington previously administered benefits for these members.

BCBSIL issued new identification cards to The Boeing Company associates that include new alphabetical prefixes, BYR, BHP, BEM or BCU, as part of the member's identification number.

Here is a sample identification card:

As a provider who may service out-of-area Blue Plan members, please follow these guidelines to ensure claims are processed accurately and efficiently:

- Always ask members for their current identification card at each visit.
- The three-character alphabetical prefix at the beginning of the member's identification number is the key element used to identify and correctly route out-of-area members' claims. The alphabetical prefix identifies the Blue Plan to which the member belongs. It is critical for confirming membership and coverage.
- Verify that the information on the member's identification card is valid for the date of service.
- To verify current membership and coverage information for out-of-area members, use the BlueExchange transaction within NaviNet®, submit an electronic HIPAA 270 inquiry or call BlueCard Eligibility at 800-676-BLUE (2583).
- Be sure to enter the three-character alphabetical prefix, for example, BHP, along with the identification number from the member's identification card on the claim. If the alphabetical prefix or member identification number is missing or incorrect, your claim will be delayed.
- For more efficient claims processing, submit your claims electronically to Mountain State. If you must submit a paper claim, use the original, red CMS-1500 (08/05) claim version and mail it to:

Claims Processing
PO Box 7026
Wheeling, WV 26003

Movie Gallery Members' Coverage Terminated; Submit Claims before Feb. 28, 2011

As of Aug. 31, 2010, Blue Cross and Blue Shield of Alabama no longer administers health care benefits for members of Movie Gallery (alphabetical prefix MGA) due to the closing of their United States stores.

Submit Movie Gallery members' claims before Feb. 28, 2011

Blue Cross and Blue Shield of Alabama will continue to process all Movie Gallery claims for dates of service on or before Aug. 30, 2010, but you must submit those claims before Feb. 28, 2011.

Contracting/Reimbursement Update

2010 Lab Fee Schedule Update

As previously communicated, Mountain State is evaluating updates to its Lab Fee Schedule. Mountain State is currently analyzing the Medicare Fee Schedule, Ingenix RVUs and evaluation/ reduction of the Mountain State Market Conversion Factor used for laboratory services. As Mountain State finalizes plans for the update we will provide additional information to our provider community.

Updates to the MSBCBS and HHIC Walgreens Medical Injectable Drug Program

As communicated previously, the following drugs will be *added* to the mandatory Walgreens Injectable Drug program effective April 4, 2011.

- J1740 – Boniva (ibandronite sodium)
- J3110 – Forteo (teriparatide)
- J3488 – Reclast (zoledronic acid)
- *J3490 – Prolia (denosumab)

** **Note:** When drugs with NOC codes are assigned a specific HCPCS code, they will remain part of the Medical injectable Drug Program.*

Changes in the HCPCS codes made on January 1 or throughout the year for a mandatory drug should replace / be used when the prior HCPCS code is no longer valid.

Please refer to the Mountain State website for an updated list of drugs in the mandatory Walgreens Injectable Drug program.

West Virginia Small Business Plan (WVSBP) Update

Effective Jan. 1, 2011, Mountain State will update the WVSBP Hospital DRG rates with the PEIA allowable amounts.

Throughout calendar year 2011, using PEIA pricing for the West Virginia Small Business Plan (WVSBP), Mountain State Blue Cross Blue Shield will update all fee schedules within two months of receipt of the appropriate information from the PEIA. These fee schedules include RBRVS, DMEPOS, Clinical Lab, Drugs and Biologicals among others.

2011 New Code Update

As previously communicated, the new codes for 2011 will be adopted by Mountain State effective Jan. 1, 2011, utilizing the Centers of Medicare and Medicaid Services (CMS) Physician Fee Schedule fully implemented RVU and WV GPCI's for 2011. The complete annual review of the CMS RBRVS changes and update of the Mountain State fee schedule will be effective July 1, 2011. This timing allows Mountain State the opportunity to review and analyze the changes made by CMS. As Mountain State finalizes plans for the annual update we will provide information to our provider community.

For Highmark Health Insurance Company's (HHIC's) FreedomBlue PPO, the professional reimbursement will follow the CMS RBRVS physician fee schedule effective Jan. 1, 2011.

Mountain State Changes Payment Reduction for Certain Diagnostic Imaging Procedures in May 2011

Mountain State is changing the payment reduction for certain diagnostic imaging services when more than one service is performed for the same patient, during the same session, on the same service date.

Mountain State will change its payment reduction from 25 percent to 50 percent, similar to the July 2010 change implemented by the Centers for Medicare & Medicaid Services.

Mountain State's changed payment reduction will affect commercial products and FEP beginning May 23, 2011. In July 2010, Highmark Health Insurance Company (HHIC) increased payment reduction for its Medicare Advantage FreedomBlue℠ PPO.

These payment changes affect only the technical component of the diagnostic imaging services.

Medical Benefit Dental Fee Schedule Update

Mountain State will be updating the dental fee schedule for those procedures covered under a member's medical benefits on May 1, 2011. The revision of fees will result in increases and decreases to numerous codes.

An example of an increase is code D7955 (Repair of maxillofacial soft and/or hard tissue defect). Reimbursement for this code will increase from $631 to $1,692.

An example of a decrease is code D7220 (Removal of impacted tooth, soft tissue). Reimbursement for this code will decrease from $224 to $179.

Credentialing News

Recent Updates to Credentialing Policy and Procedure

Requirements for General Practitioners

General Practitioners without board certification must have the highest level of education and training verified from primary sources and must have an appropriate rotating internship, which includes pediatric training. General Practitioners are not considered “specialists” by the organization.

- General Practitioners (treating patients of all ages) - For a General Practitioner to be eligible to treat members under the age of 13, they must complete an average of 10 CME credit hours per year (30 CMEs over three years) in Pediatrics. General Practitioners who treat patients of all ages will be presented to the applicable Network Quality and Credentials Committee for review of their training, education and consideration into the network(s). Those practitioners who are eligible to see members under 13 years old will have no limitations listed in the provider directory.
- General Practitioners (treating patients 13 years of age and above) - No CMEs are required for General Practitioners who treat patients 13 years of age and older. General Practitioners who only treat patients 13 years of age and older and meet all of the other credentialing/recredentialing requirements do not need to be presented to the applicable Network Quality and Credentials Committee for review. Practitioners seeing members 13 years of age and older will be listed in the directory accordingly.

New Requirements
for Practitioners in Multiple Networks

Practitioners who are credentialing and recredentialing for both Mountain State Blue Cross Blue Shield PPO/POS networks and a Highmark network such as Keystone Health Plan West (KHPW) or PremierBlue℠ Shield will be held to the higher standard of credentialing requirements. For example, Board Certification will be required for Primary Care Physicians, Physician Specialists, Podiatrists and Dental Specialists (except Dental Anesthesiology). All applicable practitioners who are not board certified must meet one of the following exception criteria to be considered eligible for network participation.

- The exceptions for non-board-certified practitioners do not apply to Emergency Medicine practitioners; they must be board certified.
- Practitioners who have graduated from an accredited medical, osteopathic or podiatric medical school, or dental school, and have completed an accredited applicable residency or fellowship acceptable to the Highmark Network Quality and Credentials Committee in the specialty in which the practitioner practices; and completed training prior to December 31, 1987.
- The practitioner has not practiced for a sufficient length of time to complete board certification. Practitioners must have completed an approved, applicable residency or fellowship in the specialty in which he/she practices and complete the board certification within two (2) years of their initial eligibility.
- In the practitioner's practice, 50 percent or more of the organizational-credentialed practice's associates are board certified in the same specialty and the practitioner has completed an approved, applicable residency or fellowship in the specialty in which the practitioner is requesting to be credentialed.
- Rural practitioners must have greater than five years' experience in the specialty in which they practice and have completed an approved, applicable residency or fellowship in the specialty of practice.

Additional Stipulations

- Physicians in a Highmark network who practice in an emergency department and all physicians identified as working in a network-credentialed urgent care center* may be credentialed in Emergency Medicine if they meet one of the following criteria:

  1. Have current board certification in Emergency Medicine.

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New Requirements for Practitioners in Multiple Networks

(Continued from page 10)

2. Have completed the appropriate training in Emergency Medicine, Pediatrics, General Surgery, Internal Medicine or Family Practice and have current certification in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS).

** This credentialing requirement (for practitioners who work in an urgent care location) will become effective April 18, 2011.*

Physicians in the Mountain State commercial and HHIC FreedomBlue PPO (Medicare Advantage) networks who practice in an emergency department and all physicians identified as working in a network-credentialed urgent care center* may be credentialed in Emergency Medicine if they meet one of the following criteria:

- Have current board certification in Emergency Medicine.
- Have completed the appropriate training in Emergency Medicine, Pediatrics, General Surgery, Internal Medicine, Family Practice or General Practice ***and*** have current certification in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS) and Advanced Trauma Life Support (ATLS).

Cut and Save These Dates

2011 Mountain State Blue Cross Blue Shield Holiday Observances

Please make note that Mountain State Blue Cross Blue Shield will be observing the following holidays during 2011. These are the dates that our offices will be closed and the phone lines will be unavailable. We hope you have a safe and happy new year and look forward to working with you once again during this upcoming new year!

- **New Year's Day** (observed) - Friday, Dec. 31, 2010
- **Martin Luther King, Jr. Day** - Monday, Jan. 17, 2011
- **Good Friday** - Friday, April 22, 2011
- **Memorial Day** - Monday, May 30, 2011
- **Fourth of July** (observed) - Monday, July 4, 2011
- **Labor Day** - Monday, Sept. 5, 2011
- **Thanksgiving Day** - Thursday, Nov. 24, 2011
- **Friday after Thanksgiving** - Friday, Nov. 25, 2011
- **Day Before Christmas** (observed) - Friday, Dec. 23, 2011
- **Christmas Day** (observed) - Monday, Dec. 26, 2011
- **New Year's Day** (observed) - Monday, Jan. 2, 2012

Harrison County Physician Wins Blues On Call℠ Survey Raffle Prize

Congratulations to Alan Romine, DO, from Medpointe Family Medicine of Harrison County! Dr. Romine won the $100 luncheon gift certificate for completing and submitting the Mountain State Blue Cross Blue Shield, Blues On Call online provider survey this fall.

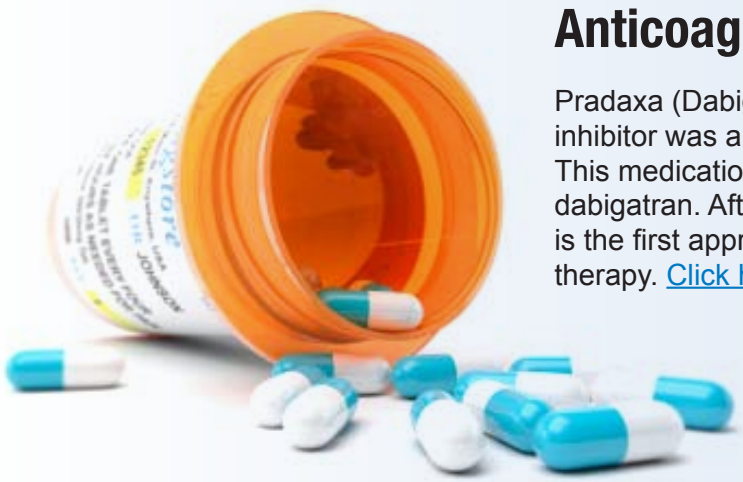
The Annual Provider Satisfaction Survey allows providers to give Blues On Call performance measures about program value for providers and to identify areas for improvement in Blues On Call services.

The Blues On Call program provides disease management and decision support to eligible Mountain State members. Health Coaches help members manage their condition, e.g., asthma, diabetes, heart failure, COPD and heart disease. Health Coaches are also available to help members facing important medical decisions.

If you have any questions about the Blues On Call program, or would like a Blues On Call Specialist to visit you to discuss the program, please call the toll-free Physician Hotline at 1-888-777-9522.

Alan Romine, DO, accepts the $100 Blues On Call Survey raffle prize from Jane Krupica, RN, BSN, a Blues On Call Specialist supporting Mountain State participating providers.

Mountain State Blues On Call℠ Information About the New Anticoagulant – Pradaxa (Dabigatran)



Pradaxa (Dabigatran), a new oral anticoagulant, thrombin inhibitor was approved for use by the FDA on Oct. 19, 2010. This medication is a prodrug of the direct thrombin inhibitor dabigatran. After many years of waiting, Pradaxa (Dabigatran) is the first approved alternative to Coumadin (Warfarin) therapy. Click here to learn more.

HHIC Clinical Quality Committees and Workgroups

The Highmark Health Insurance Company (HHIC) Clinical Quality Improvement (QI) Workgroups are responsible for supporting continuous improvement in the quality of health care received by HHIC FreedomBlue PPO members throughout West Virginia. The Clinical QI Workgroups comprise HHIC staff from key clinical departments. Practicing network physicians and specialists provide clinical input to the groups, which address topics in the following areas:

- Behavioral Health
- Chronic Conditions
- Preventive Health

The workgroups determine the preventive health and clinical practice guidelines adopted by HHIC and utilize the Total Quality Management (TQM) process to improve the plan's performance on important clinical measurements. The workgroup process involves:

a) Performance measurement and analysis;

b) Research of current literature;

c) Identification/prioritization of the barriers to clinical care;

d) Identification of opportunities for improvement;

e) Identification/prioritization of targeted interventions;

f) Implementation of interventions to improve clinical care; and

g) Re-measurement.

The activities of the Quality Improvement Workgroups are formally reviewed by a Clinical Advisory Committee that comprises the practicing network physician and specialist consultants who provide input to the workgroups.

Additionally, the HHIC Quality Improvement Committee (QIC) is a multidisciplinary committee dedicated to the continuous improvement of the quality and safety of clinical care and service provided by HHIC. The Clinical Advisory Committee reports to the QIC. The membership of the QIC is designed to provide representation for the key functional areas within HHIC, and attempts to represent participating network practitioners from a broad spectrum of specialties. Current physician representation on this committee includes PCPs and Specialists practicing in the areas of: Pediatrics, Internal Medicine, Family Practice, Psychiatry, Obstetrics/Gynecology, Pulmonology, Rheumatology and Cardiology.

If you are interested in providing feedback to the Clinical QI Workgroups or participating in one of the HHIC quality committees described above, please contact Shameena Webb at 412-544-2675, or e-mail her at shameena.webb@highmark.com.

Quality Management Program: Information for Your HHIC FreedomBlue℠ PPO Patients

The Highmark Health Insurance Company Quality Program has been designed to improve the quality, safety and equity of the clinical care and services provided to members. To do this, we continually review the aspects that affect member care and satisfaction and look for ways to improve them. We also work closely with the physician community in an effort to address both the clinical care and service members receive, as well as plan management to address the services provided by the organization (i.e., authorizations, claims handling, appeals, etc.). We also use member satisfaction surveys and other tools to get feedback on how we are doing. These results are used to guide the future clinical, service, network, member safety and equity quality-improvement activities.

For more information about the Quality Program, including information about program goals and a report on the progress toward meeting those goals, please write to:

Quality Management Department
c/o Charlene Trybus
Highmark Inc.
120 Fifth Ave.
Suite P1601
Pittsburgh, PA 15222

MEDICAL POLICY UPDATES

As an added enhancement to our Provider News, Mountain State Blue Cross Blue Shield communicates Medical Policy updates in each issue.

Our medical policies are also available online through NaviNet® or at www.msbcbs.com. An alphabetical, as well as a sectional, index is available on the Medical Policy page. You can search for a medical policy by entering a keyword, policy number or procedure code.

Recent updates or changes are as follows:

Place of Service Designation Added to More Medical Policies

Mountain State Blue Cross Blue Shield advised you in the August 2010 **Provider News** (see "Place of service designations added to some medical policies" on Page 20) that it would continue to add place of service indications to some of its medical policies.

Effective May 23, 2011, Mountain State Blue Cross Blue Shield will include place of service designations on these medical policies:

Policy number	Policy topic	Place of service
M-18*	Diagnostic Endocardial Electrical Stimulation vs. Ablation Procedures	Outpatient
S-67*	Cochlear Implantation	Inpatient Outpatient
S-75*	Extracorporeal Photopheresis	Outpatient
S-114*	Uterine Artery Embolization for Uterine Fibroids	Outpatient
S-153	Biventricular Pacemakers for the Treatment of Congestive Heart Failure	Inpatient
S-188	Alcohol Induced Septal Ablation	Inpatient

Note: For more information about policies annotated with an asterisk, please see the "Additional guidelines" section below.

Additional guidelines

Mountain State Blue Cross Blue Shield will consider each person's unique clinical circumstances with respect to requests for coverage of inpatient services that are typically performed in an outpatient setting.

In addition to the policies in the table at left, some of those circumstances are provided in these examples:

- Medical Policy M-18, Diagnostic Endocardial Electrical Stimulation (EES) vs. Ablation Procedures

Catheter ablation or endocardial electrical stimulation is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances including, but not limited to, current therapeutic anticoagulation therapy, presence of unstable angina, or symptomatic congestive heart failure.

- Medical Policy S-67, Cochlear Implantation

Cochlear implantation is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances including, but not limited to, pediatric patients requiring bilateral implantation.

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Medical Policy Bulletin: O-4 (Intraocular Lens {Pseudophakos})

Effective Date for Reporting Instructions for Astigmatism-Correcting IOL Changed to October 11, 2010

Effective: Oct. 11, 2010

In "Reporting instructions for astigmatism-correcting IOL to change Oct. 4, 2010" on Page 28 of the August 2010 **Provider News**, Mountain State Blue Cross Blue Shield issued an effective date of Oct. 4, 2010.

Mountain State Blue Cross Blue Shield has changed the effective date of October 4, 2010, to Oct. 11, 2010.

As of Oct. 11, 2010, do not report code L8699 for the astigmatism-correcting IOL. Instead, report code V2630, V2631 or V2632 for the astigmatism-correcting IOL along with V2787 for the astigmatism-correcting function of the IOL.

Medical Policy Bulletin: S-55 (Surgical Treatment of Varicose Veins)

Echosclerotherapy Fee Includes Needle Insertion, Injection and Ultrasound.

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield includes the reimbursement for the ultrasound in the fee for echosclerotherapy. Therefore, when you report code 76937, 76942 or 76998 in addition to code S2202, Mountain State Blue Cross Blue Shield will not make an additional allowance.

Beginning May 23, 2011, if you bill these services separately, Mountain State Blue Cross Blue Shield will deny them as not covered. A participating, preferred or network provider may not bill the member separately for these services.

You may report modifier 59 with the injection and/or ultrasound services to identify them as significant, separately identifiable services from the echosclerotherapy. When you report the 59 modifier, you must document in the patient's medical records that an injection and/or ultrasound service was provided independently.

Medical Policy Bulletin:

Mountain State Blue Cross Blue Shield Revises Oxygen Guidelines.

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield will consider oxygen and oxygen supplies medically necessary for appropriately selected patients only in cases when oxygen is prescribed by a physician and the following criteria are met:

- The patient has severe lung disease, defined as either:
  - a resting arterial oxygen partial pressure (PaO^2) below 55 mm Hg,
  - an oxygen saturation less than 90 percent, or
  - symptoms associated with oxygen deprivation, such as impairment of cognitive processes, restlessness or insomnia.

Examples of severe lung disease include, but are not limited to:

- chronic obstructive pulmonary disease,
- pulmonary fibrosis,
- cystic fibrosis,
- bronchiectasis,
- recurring congestive heart failure due to chronic cor pulmonale,
- chronic lung disease complicated by erythrocytosis (hematocrit >56 percent)

Or,

- The patient has cluster headaches, and other treatment has been tried and failed.

The physician's prescription must specify:

1. the diagnosis of the disease requiring use of oxygen,
2. oxygen concentration and flow rate,

(Continued on next page)

3. frequency of use (if there is an intermittent or leave in oxygen therapy, the order must include time limits and specific indications for initiating and terminating therapy),
4. method of delivery, and
5. duration of use (if the oxygen is prescribed for an indefinite basis, the physician must review the patient's care periodically to determine whether a medical need continues to exist).

Oxygen therapy should maintain adequate tissue and cell oxygenation while trying to avoid oxygen toxicity. Monitoring of the patient's condition should occur to ensure that the patient is receiving the proper mixtures of gases, mists and aerosols.

Mountain State Blue Cross Blue Shield considers oxygen therapy not medically necessary for these conditions:

- angina pectoris in the absence of hypoxemia
- breathlessness without evidence of hypoxemia
- severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities
- terminal illnesses that do not affect the lungs

Mountain State Blue Cross Blue Shield considers portable oxygen systems medically necessary only if the patient ambulates on a regular basis.

Oxygen and oxygen supplies that do not meet Mountain State Blue Cross Blue Shield's specific criteria will be considered not medically necessary. A participating, preferred or network provider may not bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement should be maintained in the provider's records.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Mountain State Blue Cross Blue Shield Covers CPAP and BiPAP Devices to Treat OSA.

Mountain State Blue Cross Blue Shield will cover a continuous positive airway pressure (CPAP) device (procedure code E0601) and BiPAP (procedure code E0470) as durable medical equipment when they're used in the treatment of obstructive sleep apnea (OSA) according to the following guidelines.

CPAP coverage guidelines

Mountain State Blue Cross Blue Shield covers a CPAP device for OSA when all of these criteria are met:

1. Sleep study results (attended or unattended):
   a. Apnea-Hypopnea Index (AHI) equal to or greater than 5 (also called the Respiratory Disturbance Index or RDI)
2. Results of CPAP Trial (at optimum CPAP pressure), that is, titration study:
   a. AHI less than 5, or for patients with AHI greater than 20, reduction in AHI is greater than 75 percent
   b. no oxygen desaturation less than 85 percent
   c. abolition of arrhythmia(s), for example, Type II second degree heart block or pause greater than three seconds or ventricular tachycardia at a rate greater than 140 per minute lasting greater than 15 complexes

You must certify on the claim that the documentation supporting a diagnosis of OSA (ICD-9-CM 327.23) is available.

Effective May 23, 2011, the patient's medical record must also document, through compliance chip information or other compliance monitoring mechanism, that the member has been compliantly using the device an average of four hours per 24-hour period and that he or she is benefiting from its use. New purchases or replacements of CPAP machines for members with an existing diagnosis of OSA do not need a compliance chip.

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When all the coverage criteria are met, Mountain State Blue Cross Blue Shield will pay for the rental of a CPAP device for the first three months from the original start date of therapy. After members have been using a CPAP device for three months, are found to be maintaining compliance with its use and are experiencing success in treatment, Mountain State Blue Cross Blue Shield will pay for the purchase of the device (after the expenses incurred for the first three months' rental have been applied to the purchase price).

If the coverage criteria are not met, Mountain State Blue Cross Blue Shield will deny the CPAP device as not medically necessary.

Arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a DME supplier. Mountain State Blue Cross Blue Shield does not consider a DME supplier a qualified provider or supplier of these tests. Mountain State Blue Cross Blue Shield does recognize the results of studies conducted by hospitals certified to perform such tests.

BiPAP coverage guidelines

Mountain State Blue Cross Blue Shield considers a BiPAP device (code E0470) medically necessary for those patients with OSA who meet the criteria, when a CPAP device (code E0601) has been tried and proven ineffective. Mountain State Blue Cross Blue Shield defines ineffective as documented failure to meet therapeutic goals using a CPAP device during the titration portion of a facility-based study or during home use despite optimal therapy, that is, proper mask selection and fitting and appropriate pressure settings.

If you bill for a BiPAP device (code E0470) and a CPAP has not been tried and proven ineffective, Blue Cross Blue Shield will base its payment on the allowance for the least costly medically appropriate alternative device at least as likely to produce an equivalent result, a CPAP device (code E0601).

When a BiPAP device with back-up rate is billed with code E0471 and the primary diagnosis is OSA, Blue Shield considers the device not medically necessary. However, Blue Cross Blue Shield will pay for E0470 or E0601 as a least costly medically appropriate alternative device at least as likely to produce an equivalent result.

A participating, preferred, or network provider may not bill the member for a device denied as not medically necessary unless he or she has given advance written notice, informing the member that the device may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the device. The signed agreement should be maintained in the provider's records.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Humidifiers Eligible Only for Covered CPAP or BiPAP

Either a heated humidifier (code E0562) or a non-heated humidifier (code E0561) is eligible for payment when it's used with a covered CPAP (code E0601) or BiPAP (code E0470) device. The humidifier must also be prescribed by the treating physician to meet the needs of the individual patient.

CPAP and BiPAP Procedure Codes and Medical Policy References

E0601 — continuous airway pressure (CPAP) device

Use procedure code E0601 to report an auto-titrating single-level CPAP device.

E0470 — respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

E0471 — respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

See Mountain State Medical Policy E-20, Continuous Positive Airway Pressure (CPAP) Device, for further information on CPAP devices used in the treatment of obstructive sleep apnea.

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See Mountain State Medical Policy E-34, Respiratory Assist Devices, for information on the use of respiratory assist devices, for example, BiPAP — E0470, E0471, used in treatment of diagnoses other than OSA.

See Mountain State Medical Policy Z-8, Sleep Disorder Services, for information on sleep studies, polysomnograms and treatment for sleep-related disorders.

Deep Brain Stimulation Coverage Guidelines Outlined

Mountain State Blue Cross Blue Shield considers unilateral or bilateral deep brain stimulation (DBS) of the thalamic ventralis intermedius nucleus eligible for the treatment of intractable tremors due to essential tremor or Parkinson's disease (PD), when all of the following criteria are met:

- diagnosis of essential tremor or idiopathic PD (with the presence of at least two cardinal PD features — tremor, rigidity, bradykinesia) that is not responding satisfactorily to drug therapy,
- marked disabling tremor of at least 3 or 4 on the Fahn-Tolosa-Marin Clinical Tremor Rating Scale (or equivalent scale), causing significant limitation in activities of daily living,
- no diagnosed dementia, severe depression, cerebral atrophy, or Hoehn and Yahr stage V PD,
- no focal lesion of the basal ganglia, for example, a space occupying lesion or lacunae, at the target site that would negate the result of thalamic stimulation,
- sufficient residual motor function in the upper extremity so that it is reasonable to expect an improvement following the surgery, and
- willingness and ability of the patient to cooperate during a conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.

Mountain State Blue Cross Blue Shield considers unilateral or bilateral DBS of the subthalamic nucleus or globus pallidus interna for the treatment of PD eligible when all of these criteria are met:

- diagnosis of advanced idiopathic PD as determined by the Hoehn and Yahr stage or a minimal score of 30 points on the Unified Parkinson's Disease Rating Scale part III motor subscale when off medication for 12 hours,
- PD (with the presence of at least two cardinal PD features — tremor, rigidity, bradykinesia) that is not responding satisfactorily to drug therapy,
- presence of disabling PD symptoms or medication side effects, for example, dyskinesias, motor fluctuations or disabling "off" periods, despite optimal medical therapy,
- no diagnosed dementia, severe depression, cerebral atrophy, or Hoehn and Yahr stage V PD,
- PD is Levodopa responsive with clearly defined "on" periods, and
- willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.

Mountain State Blue Cross Blue Shield also considers DBS eligible when it's used as a treatment for chronic intractable (drug refractory) primary dystonia, including generalized and/or segmental dystonia, hemidystonia and cervical dystonia (torticollis) in patients 7 years of age or older.

Mountain State Blue Cross Blue Shield considers DBS experimental or investigational when it's used for:

- other movement disorders including, but not limited to, multiple sclerosis, post-traumatic dyskinesia and tardive dyskinesia
- treatment of tremor from other causes such as trauma, degenerative disorders, metabolic disorders or infectious diseases
- other indications, including cluster headaches, refractory depression, obsessive or compulsive disorder and Tourette's syndrome

In this instance, a participating, preferred or network provider may bill the member for the denied DBS.

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Please use procedure codes 61863, 61864, 61867, 61868, 61885 or 61886, as appropriate, to report DBS.

DBS involves the delivery of continuous, high-frequency electrical impulses by electrode(s) that have been stereotactically implanted in the brain.

Medical Policy Bulletin: Z-75 (Posterior Tibial Nerve Stimulation)

Posterior Tibial Nerve Stimulation Considered Investigational for Urinary Dysfunction

Mountain State Blue Cross Blue Shield considers posterior tibial nerve stimulation (PTNS) experimental or investigational as a treatment for urinary dysfunction.

Mountain State Blue Cross Blue Shield does not cover PTNS because published data are inadequate to permit scientific conclusions regarding the long-term clinical safety and effectiveness of this procedure. A participating, preferred or network provider may bill the member for the denied PTNS.

Please use procedure code 64566 to report PTNS.

Urinary dysfunction includes, but is not limited to, urinary frequency, urgency, incontinence, nonobstructive retention and overactive bladder syndrome.

PTNS is an indirect external technique for stimulating the sacral plexus. This office-based type of electrical neuromodulation has been used for treating voiding dysfunction in patients who have failed behavioral and/or pharmacologic therapies. The principle behind PTNS is that stimulation of specific nerves of the pelvic floor through gentle electrical impulses can alter the activity of the bladder, disrupt the signals that lead to symptoms of urinary dysfunction, and improve voiding function and control.

Medical Policy Bulletin: E-1 (Durable Medical Equipment)

Rollabout Chairs and Transport Chairs Coverage Guidelines Explained

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield covers rollabout chairs and transport chairs when:

- a medical review determines that the patient's condition is such that there is a medical need for the chair, and
- the patient's physician prescribes a rollabout or transport chair instead of a wheelchair.

Mountain State Blue Cross Blue Shield limits coverage to rollabout chairs that have casters of at least 5 inches in diameter and are specifically designed to meet the needs of ill, injured or otherwise impaired individuals. Mountain State Blue Cross Blue Shield does not cover the wide range of chairs with smaller casters found in general use in homes, offices, and institutions for purposes not related to the care or treatment of ill or injured persons. Examples of rollabout chairs include, but are not limited to, Geriatric Chair, Glideabout Chair, Lumex Chair Table and Mobile Geriatric Chair.

Use codes E1031, E1035, E1036, E1038 or E1039, as appropriate, to report rollabout chairs.

Mountain State Blue Cross Blue Shield covers a customized pediatric stroller (procedure code E1037) as medically necessary for a child who is non-ambulatory when either of the following conditions apply:

- the child requires more support than is available in a standard pediatric wheelchair, or
- the child is too small to safely use a standard pediatric wheelchair.

Mountain State Blue Cross Blue Shield does not cover standard strollers that are not specially adapted because they are not primarily medical in nature and do not meet Mountain State Blue Cross Blue Shield's definition of durable medical equipment.

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If a rollabout chair, transport chair or stroller does not meet Mountain State Blue Cross Blue Shield's medical necessity criteria, Mountain State Blue Cross Blue Shield will deny it as not medically necessary. A participating, preferred or network provider may not bill the member for the denied chair unless he or she has given advance written notice, informing the member that the chair may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the chair. The signed agreement should be maintained in the provider's records

If two or more chairs (rollabout, transport and stroller) are rented or purchased, Mountain State Blue Cross Blue Shield considers the additional chairs a matter of convenience for the member and his or her family. Mountain State Blue Cross Blue Shield will not cover the chairs unless there is a change in the member's physical condition that makes a different mobility device medically necessary.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Rollabout chairs may be called by other names such as "transport" or mobile geriatric chairs (geri-chairs). Rollabout chairs and transport chairs are particularly useful for persons who are unable to self-propel a manual wheelchair or operate a POV or power wheelchair, and who have a caregiver who is willing and able to operate the transport chair or rollabout chair.

Dorsal Column Stimulation Eligible for Chronic Intractable Neurogenic Trunk and Limb Pain

Mountain State Blue Cross Blue Shield considers dorsal column stimulation, also known as spinal cord stimulation, eligible for the relief of chronic intractable neurogenic pain of the trunk and/or limbs when all of the following conditions have been met:

- there is documented pathology, or an objective basis for the pain
- dorsal column stimulation is being used as a late or last resort when other treatment modalities (pharmacological, surgical, physical or psychological therapies) have been tried and did not prove satisfactory, cannot be tolerated or are contraindicated
- a minimum three-day trial of percutaneous spinal stimulation has resulted in a significant pain reduction of 50 percent or more
- there is no evidence of existing untreated drug addiction (per American Society of Addiction Medicine guidelines)
- the patient has undergone careful physical and psychological evaluations before implantation
- the patient has been evaluated by a pain management specialist prior to implantation
- all the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training and follow-up of the patient must be available

Mountain State Blue Cross Blue Shield considers the use of spinal cord stimulation for conditions other than chronic intractable neurogenic pain of the trunk and/or limbs, for example, chronic stable refractory angina or peripheral ischemia, experimental or investigational. It is not eligible for payment because the medical effectiveness of such therapy has not been established. A participating, preferred or network provider may bill the member for the denied service.

Please use procedure code 63650, 63655 or 63685, as appropriate, to report dorsal column stimulation.

Dorsal column stimulation involves the surgical implantation or percutaneous insertion of neurostimulator electrodes near the spinal cord for the delivery of low-voltage electrical stimulation to block the sensation of pain.

Medical Policy Bulletin: S-54 (Implantation of Subcutaneous Intravascular Catheter)

Reporting Guidelines for Subcutaneous Catheter Maintenance Revised

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield will pay for subcutaneous catheter maintenance as a distinct and separate service on a day in which no other services are provided.

Do not report procedure code 96523 — irrigation of implanted venous access device for drug delivery systems — if any other services are provided on the same day.

Use code 96523 to report irrigation of implanted venous access devices for drug delivery systems.

Medical Policy Bulletin: E-1 (Durable Medical Equipment)

Oscillatory Devices and Conventional Percussors, Eligible Conditions Explained

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield covers oscillatory devices and conventional percussors for mobilizing secretions in patients with the following pulmonary conditions that limit the ability to expectorate secretions:

- cystic fibrosis (ICD-9 - CM diagnosis codes 277.00 – 277.09)
- chronic bronchitis (ICD – 9-CM diagnosis codes 491.0 – 491.1, 491.20 – 491.21, 491.8 – 491.9)
- bronchiecstasis (ICD-9-CM diagnosis codes 494.0, 494.1)
- congenital bronchiectasis (ICD-9-CM diagnosis code 748.61)
- immotile cilia syndrome
- asthma (ICD-9-CM diagnosis codes 493.00 – 493.92)
- organ or tissue replaced by transplant, lung (ICD-9-CM diagnosis code V42.6)

If an oscillatory device or a conventional percussor is provided for any other conditions, Mountain State Blue Cross Blue Shield will deny it as not medically necessary. A participating, preferred or network provider may not bill the member for the denied device unless he or she has given advance written notice, informing the member that the device may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the device. The signed agreement should be maintained in the provider's records.

Oscillatory devices, for example, Flutter, In-Exsufflator and Percussionaire, are alternatives to conventional percussors.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Medical Policy Bulletin: S-114 (Uterine Artery Embolization for Uterine Fibroids)

Medical Necessity Criteria for Uterine Artery Embolization or Fibroid Embolization Clarified

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield considers uterine artery embolization or fibroid embolization (procedure code 37210) medically necessary for the treatment of uterine fibroids (ICD-9-CM diagnosis codes 218.0-218.9) when the patient has persistence of one or more symptoms directly attributed to uterine fibroids, that is, excessive menstrual bleeding (menorrhagia), bulk-related pelvic pain, pressure or discomfort, urinary symptoms referable to compression of the ureter or bladder, and/or dyspareunia, and is unresponsive to conservative treatment, for example, hormonal therapy, D&C, analgesics, endometrial ablation, etc.

If the uterine artery embolization or fibroid embolization does not meet Mountain State Blue Cross Blue Shield's medical necessity criteria, Mountain State Blue Cross Blue Shield will deny the procedure as not medically necessary. A participating, preferred or network provider may not

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bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement should be maintained in the provider's records.

Medical Policy Bulletin: E-1 (Durable Medical Equipment)

Comfort or Convenience Items Not Covered

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield will consider the following items to be comfort or convenience items since they are not primarily medical in nature:

- total hip chair
- posture support chair
- corner chair
- feeder seats
- carrie seats
- floor sitters
- Versa Form chairs
- adjustable high chair
- backrests
- safety car seats
- standard feeder seats
- standard high chairs
- Lumex Ortho-Biotic High Back Rockers
- Lumex Ortho-Biotic Recliners
- Maddapult Assisto-Seat
- zero gravity chair

This is not an all-inclusive list. For more information on non-covered durable medical equipment, please review Mountain State Medical Policy E-1, Durable Medical Equipment.

Because these items do not meet Mountain State Blue Cross Blue Shield's definition of durable medical equipment, Mountain State Blue Cross Blue Shield will deny them as not covered. A participating, preferred or network provider may bill the member for the denied service.

Use code E1399 — durable medical equipment, miscellaneous — to report these items. When you report code E1399, please provide a complete description of the item you provided in the narrative section of the electronic or paper claim.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Implanted Peripheral Nerve Stimulation Covered for Treating Chronic Intractable Neurogenic Pain

Mountain State Blue Cross Blue Shield considers peripheral nerve stimulation eligible for the treatment of chronic intractable neurogenic pain when all of the following criteria are met:

- the chronic intractable neurogenic pain is refractory to other methods of treatment, for example, analgesics, physical therapy, local injection, surgery,
- there is objective evidence of nerve injury or disease pathology, for example, electromyography,
- there is no psychological contraindication to peripheral nerve stimulation,
- there is no addiction to drugs (per American Society of Addiction Medicine guidelines), and
- a trial of transcutaneous stimulation was successful (resulting in at least a 50 percent reduction in pain).

Mountain State Blue Cross Blue Shield considers the use of peripheral nerve stimulation for post-herpetic neuralgia and for all other indications experimental or investigational. A participating, preferred or network provider may bill the member for the denied peripheral nerve stimulation.

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Please use procedure codes 64575 and 64590, as appropriate, to report peripheral nerve stimulation.

Peripheral nerve stimulation involves the implantation of electrodes around a selected peripheral nerve. Electrical impulses are provided by a generator to block the sensation of pain.

Medical Policy Bulletin: S-153 (Biventricular Pacemakers for the Treatment of Congestive Heart Failure)

Biventricular Pacemakers for Treating Congestive Heart Failure Covered for Certain Indications

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield considers the insertion of a biventricular pacemaker medically necessary as a treatment of congestive heart failure in patients who meet all of these criteria:

- New York Heart Association Class III or IV,
- left ventricular ejection fraction ≤ 35 percent,
- QRS duration of ≥ 120 msec, and
- patients treated with an optimal pharmacological medical regimen before implant, which may include the following, unless contraindicated:
- angiotensin-converting enzyme inhibitor
- angiotensin receptor blocker
- beta blocker
- digoxin
- diuretics

If the insertion of a biventricular pacemaker for congestive heart failure is reported for any other indication, including Class I and II heart failure, Mountain State Blue Cross Blue Shield will deny it as experimental or investigational. A participating, preferred or network provider may bill the member for the denied pacemaker.

A biventricular pacemaker is used for the treatment of congestive heart failure. It consists of a pulse generator that is implanted in the chest and connected to the heart by three wires (leads) that deliver electrical impulses. One wire is placed in the upper right heart chamber and the others are placed in each of the two lower chambers, where they simultaneously stimulate both the left and right ventricles.

Medical Policy Bulletin: E-1 (Durable Medical Equipment)

Walkers Covered for Impaired Ambulation Caused by Medical Condition

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield covers walkers (procedure codes E0130-E0149) if:

- the member has a medical condition impairing ambulation and there is a potential for ambulation, and
- there is a need for greater stability and security than provided by a cane or crutches.

If the above criteria are not met, Mountain State Blue Cross Blue Shield will deny the walker as not medically necessary. A participating, preferred or network provider may not bill the member for the denied walker unless he or she has given advance written notice, informing the member that the walker may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the walker. The signed agreement should be maintained in the provider's records

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Report Codes 94774-94777 Only Once Every 30 Days.

The procedure code descriptions for 94774-94777, pediatric home apnea monitoring event recording, specify a "per 30-day period of time." Therefore, when you submit home apnea monitoring services with codes 94774-94777, bill these only once every 30 days.

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If you report codes 94774-94777 more than once every 30 days, Mountain State Blue Cross Blue Shield will deny the excessive services as not covered. A participating, preferred or network provider may not bill the member for the denied commode.

Here are the descriptions for codes 94774-94777:

- 94774 — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, physician review, interpretation and preparation of a report
- 94775 — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitor attachment only (includes hook-up, initiation of recording and disconnection)
- 94776 — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitoring, download of information, receipt of transmission(s) and analyses by computer only
- 94777 — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; physician review, interpretation and preparation of report only

Phrenic Nerve Stimulation Coverage Guidelines Outlined

Mountain State Blue Cross Blue Shield considers percutaneous or open implantation of a phrenic nerve stimulator (phrenic pacing) eligible when the following criteria are met:

- for treatment of chronic ventilator or respiratory insufficiency requiring mechanical ventilation due to either:
- lesions/injury of the spinal cord at or above the C-3 vertebral level, or
- central alveolar hypoventilation, either primary or secondary to a brain stem disorder
- the phrenic nerve is viable and intact, and
- diaphragmatic function is sufficient to accommodate chronic stimulation.

Mountain State Blue Cross Blue Shield considers the use of phrenic nerve stimulation for all other indications experimental or investigational. In these instances, it is not eligible for payment. A participating, preferred or network provider may bill the member for the denied service.

Please use procedure code 64560 or 64577, as appropriate, to report phrenic nerve stimulation.

Phrenic nerve stimulation is intended to be an alternative option in the management of patients with chronic respiratory insufficiency who are dependent upon a mechanical ventilator.

Medical Policy Bulletin: E-1 (Durable Medical Equipment)

Commodes Covered for Bed- or Room-Confined Patients

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield will cover a commode — stationary or mobile, that is, chair-on-wheels — if the patient is confined to a bed or room.

The term “room confined” means that the patient’s condition is such that leaving the room is medically contraindicated. The accessibility of bathroom facilities generally would not be a factor in this determination. Confinement of a patient to his or her home in a case where there are no toilet facilities in the home may be equated to room confinement. Mountain State Blue Cross Blue Shield may also pay for a commode if a patient’s medical condition confines him or her to a floor of his or her home and there is no bathroom located on that floor.

If Mountain State Blue Cross Blue Shield’s medical necessity criteria are not met, Mountain State Blue Cross Blue Shield will deny the commode as not medically necessary. A participating, preferred or network provider may not bill the member for the denied commode unless he or she has given advance written notice, informing the member that the commode may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume

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financial responsibility, before receiving the commode.
The signed agreement should be maintained in the provider's records

Use codes E0163, E0165 or E0168 to report stationary or mobile commodes.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Medical Policy Bulletin: E-1 (Durable Medical Equipment)

Crutch Substitute Covered after Below-the-Knee Injury or Surgery.

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield will cover a crutch substitute, lower leg platform, with or without wheels, if it's determined to be medically necessary following below-the-knee injury or surgery.

When a crutch substitute, lower leg platform, is provided to a member who has not sustained an injury below the knee or had surgery below the knee, Mountain State Blue Cross Blue Shield will deny the device as not medically necessary. A participating, preferred or network provider may not bill the member for the denied device unless he or she has given advance written notice, informing the member that the device may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the device. The signed agreement should be maintained in the provider's records

Use code E0118 to report a crutch substitute, lower leg platform, with or without wheels, each.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Medical Policy Bulletin: S-112 (Co-Surgery)

Procedure Codes 21936, 22551, 22552, 32900, 50715, 60270, 62121 Eligible for Co-Surgery

Mountain State Blue Cross Blue Shield considers these additional procedure codes eligible for payment for co-surgery:

- 21936 — radical resection of tumor (e.g., malignant neoplasm), soft tissue of back or flank; 5 cm or greater
- 22551 — arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
- 22552 — arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
- 32900 — resection of ribs, extrapleural, all stages
- 50715 — ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis
- 60270 — thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
- 62121 — craniotomy with repair of encephalocele, skull base

Remember, other Mountain State Blue Cross Blue Shield medical policies may affect the eligibility of these codes.

Transcutaneous Electrical Nerve Stimulation Coverage Guidelines Explained

Mountain State Blue Cross Blue Shield considers transcutaneous electrical nerve stimulation (TENS) an eligible service when it is used for the treatment of chronic intractable pain and as a means of assessing the need for continued treatment with an implanted electrical nerve stimulator.

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Mountain State Blue Cross Blue Shield considers the use of TENS for conditions other than chronic intractable pain or for treatment of acute pain, that is, postoperative pain, experimental or investigational. It is not eligible for payment. A participating, preferred or network provider may bill the member for the denied service.

Please use procedure code 64550 to report TENS.

TENS, a non-invasive electrical stimulation technique, is applied to the surface of the skin to provide relief of chronic intractable pain due to peripheral nerve disease or injury.

Coverage for Semi-Electric Hospital Beds, Total Electric Hospital Beds and Heavy-Duty Hospital Beds to Change

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield is changing the way it determines coverage for hospital beds.

Here are the new coverage criteria:

Semi-electric and total electric hospital beds

Mountain State Blue Cross Blue Shield considers a semi-electric hospital bed covered if the patient:

- meets the requirement for a standard hospital bed, that is, the patient requires positioning of the body not feasible in an ordinary bed or attachments are required which cannot be used on an ordinary bed
- has a condition that requires frequent and/or immediate change in their body position, that is, no delay in change can be tolerated
- is capable of operating the bed's controls (exceptions may be made in cases of spinal cord disease or injury and brain-damaged patients)

Mountain State Blue Cross Blue Shield will not cover a total electric hospital bed because it considers the height adjustment feature a convenience feature. Mountain State Blue Cross Blue Shield will pay for a total electric bed as the least costly medically appropriate alternative for the comparable semi-electric bed.

A semi-electric bed has a manual height adjustment and electric head and leg elevation adjustments. Report code E0260, E0261, E0294, E0295 or E0329, as appropriate, for a semi-electric hospital bed.

A total electric bed has an electric height adjustment and electric head and leg elevation adjustments. Report code E0265, E0266, E0296 or E0297, as appropriate, for a total electric hospital bed.

Heavy-duty hospital beds

Mountain State Blue Cross Blue Shield covers a heavy-duty extra-wide hospital bed (codes E0301, E0303) if the patient meets one of the criteria for a fixed-height hospital bed and the patient's weight is more than 350 pounds, but does not exceed 600 pounds.

Mountain State Blue Cross Blue Shield covers an extra-heavy-duty hospital bed (codes E0302, E0304) if the patient meets one of the criteria for a hospital bed and the patient's weight exceeds 600 pounds.

If a hospital bed does not meet Mountain State Blue Cross Blue Shield's medical necessity criteria, Mountain State Blue Cross Blue Shield will consider it not medically necessary. A participating, preferred or network provider may not bill the member for the denied bed unless he or she has given advance written notice, informing the member that the bed may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the bed. The signed agreement should be maintained in the provider's records.

For more information on hospital beds and related accessories, including a list of eligible conditions for semi-electric beds, please review Mountain State Medical Policy Bulletin E-12, Beds — Accessories and Related Items.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Home Apnea Monitors Covered for Certain Infants

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield considers the rental of a home cardiorespiratory monitor, for example, apnea monitor, SIDS monitor, medically necessary for infants:

- who have experienced an apparent life-threatening event (Mountain State Blue Cross Blue Shield defines an apparent life-threatening event as an episode characterized by some combination of apnea, color change, marked change in muscle tone, choking or gagging),
- with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise,
- with neurologic or metabolic disorders affecting respiratory control, or
- with chronic lung disease, for example, bronchopulmonary dysplasia, particularly those requiring supplemental oxygen, continuous positive airway pressure or mechanical ventilation.

Effective May 23, 2011, Mountain State Blue Cross Blue Shield will also consider the rental of a home cardiorespiratory monitor medically necessary when it's used in the treatment of premature infants who are at high risk of recurrent episodes of apnea, bradycardia and hypoxemia after hospital discharge. The use of home cardiorespiratory monitoring in this population should be limited to approximately 43 weeks' postmenstrual age or after the cessation of extreme episodes, whichever comes last.

Use code E0618 or E0619, as appropriate, to report an apnea monitor.

If the above criteria are not met, Mountain State Blue Cross Blue Shield will consider the monitor and related supplies not medically necessary. A participating, preferred or network provider may not bill the member for the denied monitor and supplies unless he or she has given advance written notice, informing the member that the monitor and supplies may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the monitor and supplies. The signed agreement should be maintained in the provider's records.

Refer to Mountain State Medical Policy E-3, Home Apnea Monitors, for more information.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Medical Policy Bulletin: A-2 (Administration of Anesthesia for Surgical and Nonsurgical Procedures, Same Provider)

Clarification: Anesthesia Administered by Operating Surgeon Not Covered.

Mountain State Blue Cross Blue Shield will cover anesthesia administered for eligible services when it's ordered by the attending professional provider and performed by a health care professional other than the operating surgeon, assistant surgeon or attending professional provider.

When anesthesia is reported by the operating surgeon, assistant surgeon or attending professional provider, Mountain State Blue Cross Blue Shield will deny it as not covered. A participating, preferred or network provider may bill the member for the non-covered anesthesia service.

Exception: anesthesia for eligible oral surgery procedures not performed inpatient covered

An exception to this would be anesthesia administered by the operating surgeon, assistant surgeon or attending professional provider for covered oral surgical procedures. Mountain State Blue Cross Blue Shield will pay for this anesthesia in addition to the oral surgery when it's performed in any place of service other than inpatient.

For more information, please review Mountain State Medical Policy A-2, Administration of Anesthesia for Surgical and Nonsurgical Procedures, Same Provider.

Medical Policy Bulletin: M-7 (Electronystagmography (ENG) and Videonystagmography (VNG) Services)

Coverage Guidelines for Electronystagmography and Videonystagmography Clarified

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield pays for electronystagmography (ENG) and videonystagmography (VNG) services when they're used to evaluate persons with symptoms of vestibular disorders (dizziness, vertigo, disequilibrium or imbalance). If ENG or VNG is reported for any other conditions, Mountain State Blue Cross Blue Shield considers it not medically necessary.

Vestibular disorders include the following covered conditions:

- Meniere's disease: ICD-9-CM diagnosis codes 386.00 – 386.04
- other and unspecified peripheral vertigo: ICD-9-CM diagnosis codes 386.10 – 386.19
- vertigo of central origin: ICD-9-CM diagnosis code 386.2
- labyrinthitis: ICD-9-CM diagnosis codes 386.30 – 386.35
- labyrinthine fistula: ICD-9-CM diagnosis codes 386.40 – 386.48
- labyrinthine dysfunction: ICD-9-CM diagnosis codes 386.50 – 386.58
- other disorders of labyrinth: ICD-9-CM diagnosis codes 386.8 – 386.9
- dizziness and giddiness: ICD-9-CM diagnosis code 780.4

A participating, preferred or network provider may not bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement should be maintained in the provider's records.

Medical Policy Bulletin: S-55 (Surgical Treatment of Varicose Veins)

Subfascial Endoscopic Perforator Surgery Eligible for Treating Symptomatic Varicose Veins

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield covers subfascial endoscopic perforator surgery (SEPS) for the treatment of symptomatic varicose veins (ICD-9-CM diagnosis codes 454.0 – 454.8) with evidence of at least one of the following:

- severe, persistent leg aching, burning, itching, cramping and/or swelling interfering with activities of daily living that fails to respond to conservative treatment
- ulceration secondary to venous stasis that fails to respond to conservative treatment
- hemorrhage or recurrent bleeding episodes from ruptured superficial varicosity
- recurrent superficial thrombophlebitis that fails to respond to conservative treatment

There should also be documented Doppler evaluation and/or Duplex ultrasonography of the incompetent perforator vein, and the vein should be located on the medial aspect of the calf being treated.

Effective May 23, 2011, if SEPS is reported for any other condition, including the treatment of non-symptomatic varicose veins, Mountain State Blue Cross Blue Shield considers it cosmetic. A participating, preferred or network provider may bill the member for the denied service.

Use code 37500 — vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS) — to report this service.

Medical Policy Bulletin: S-55 (Surgical Treatment of Varicose Veins)

Sclerotherapy Includes Sclerosing Agent

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield includes the reimbursement for the sclerosing agent in its fee for sclerotherapy. Therefore, when you report code J3490 in addition to code 36470 or 36471, Mountain State Blue Cross Blue Shield will not make an additional allowance.

You may report modifier 59 — distinct procedural service — with code J3490 to identify it as a significant, separately identifiable service from the sclerotherapy. When you report modifier 59, you must include documentation in the patient's medical records that an injection was provided independently.

When you report code J3490, please include the name of the drug in the narrative section of the electronic or paper claim.

High Frequency Chest Wall Oscillation Devices Eligible Only For Specific Diagnoses

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield will begin to cover high-frequency chest wall oscillation devices, for example, ABI vest, for members who meet criterion 1, 2 or 3, and criterion 4:

1. The member has a diagnosis of cystic fibrosis.
2. The member has a diagnosis of bronchiectasis, which has been confirmed by a high-resolution, spiral or standard CT scan, and is characterized by:
   a. daily productive cough for at least six continuous months, or
   b. frequent, that is, more than two per year, exacerbations requiring antibiotic therapy.

   Chronic bronchitis and chronic obstructive pulmonary disease in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.
3. The member has one of these neuromuscular disease diagnoses:
   - post-polio
   - acid maltase deficiency
   - anterior horn cell diseases
   - Multiple Sclerosis
   - quadriplegia
   - hereditary muscular dystrophy
   - myotonic disorders
   - other myopathies
   - paralysis of the diaphragm
4. There must be well-documented failure of standard treatments to adequately mobilize retained secretions.

If all of the criteria are not met, Mountain State Blue Cross Blue Shield will deny the high-frequency chest wall oscillation device as not medically necessary.

It is not medically necessary for a member to use both a high-frequency chest wall oscillation device (code E0483) and a mechanical in-exsufflation device (code E0482). If the member meets the criteria for the high-frequency chest wall oscillation device (code E0483) and a mechanical in-exsufflation device (code E0482) is also billed, Mountain State Blue Cross Blue Shield will deny the mechanical in-exsufflation device (code E0482) as not medically necessary.

Mountain State Blue Cross Blue Shield will cover replacement supplies, codes A7025 and A7026, used with member-owned equipment, if the member meets the criteria for the base device, code E0483. If these criteria are not met, Mountain State Blue Cross Blue Shield will deny the replacement supplies as not medically necessary.

A participating, preferred or network provider may not bill the member for the denied device or supplies unless he or she has given advance written notice, informing the member that the device or supplies may be deemed not medically necessary and providing an estimate of the cost.

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The member must agree in writing to assume financial responsibility, before receiving the device or supplies. The signed agreement should be maintained in the provider's records.

Medical Policy Bulletin: S-55 (Surgical Treatment of Varicose Veins)

Clinical Criteria for Surgical Treatment of Varicose Veins Explained

Effective: May 23, 2011

Mountain State Blue Cross Blue Shield covers the surgical treatment of symptomatic varicose veins (ICD-9-CM diagnosis codes 454.0 – 454.8) with evidence of at least one of the following:

- severe, persistent leg aching, burning, itching, cramping and/or swelling interfering with activities of daily living that fails to respond to conservative treatment
- ulceration secondary to venous stasis that fails to respond to conservative treatment
- hemorrhage or recurrent bleeding episodes from ruptured superficial varicosity
- recurrent superficial thrombophlebitis that fails to respond to conservative treatment
- varicosities at least 5 mm in size for those patients being treated with sclerotherapy

Surgical treatment of varicose veins on the contralateral extremity is eligible only if that leg is also symptomatic.

Failed conservative treatments must include at least three months of conservative treatment that includes all of the following:

- compression hose providing at least 30 mm Hg pressure,
- leg elevation above heart level as often as possible, and,
- walking or exercising regularly as often as possible.

If treatment of varicose veins is reported for conditions other than symptomatic varicose veins, Mountain State Blue Cross Blue Shield considers the treatment cosmetic. This includes the treatment of non-symptomatic varicose veins. A participating, preferred or network provider may bill the member for the denied services.

Limited sclerotherapy may be necessary during the routine surgical postoperative period to achieve a better and more complete surgical result. Sclerotherapy performed by the surgeon, his or her associate, or the assistant surgeon during the postoperative period following vein ligation and stripping procedure is part of the global surgical allowance. A participating, preferred or network provider may not bill the member separately for these services.

Procedure codes for reporting surgical treatment of varicose veins

Use one of the following procedure codes to report surgical treatment of varicose veins:

- 36470 — injection of sclerosing solution; single vein
- 36471 — injection of sclerosing solution; multiple veins, same leg
- 36475 — endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
- 36476 — endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
- 36478 — endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
- 36479 — endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

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- 37500 — vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
- 37700 — ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
- 37718 — ligation, division and stripping, short saphenous vein
- 37722 — ligation, division and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
- 37735 — ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
- 37760 — ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open one leg
- 37761 — ligation of perforator veins(s), subfascial, open, including ultrasound guidance, when performed, one leg
- 37765 — stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
- 37766 — stab phlebectomy of varicose veins, one extremity; more than 20 incisions
- 37780 — ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
- 37785 — ligation, division and/or excision of varicose vein cluster(s), one leg
- S2202 — echosclerotherapy

Medical Policy Bulletin: E-47 (Non-Powered Negative Pressure Wound Therapy System)

New Non-Powered Negative Pressure Wound Therapy System Coverage Guidelines Outlined

Mountain State Blue Cross Blue Shield considers a non-powered negative pressure wound therapy (NPWT) system, for example, Smart Negative Pressure (SNaP®) Wound Care System, and related supplies covered for the following conditions:

1. The patient has a chronic, that is, being present for at least 30 days, diabetic ulcer or venous ulcer of the lower extremity, other than pressure ulcer.
2. A wound therapy program as described, as applicable to the type of wound, should have been tried or considered and ruled out before application of a non-powered NPWT system.
   a. For all ulcers or wounds, the wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out, before application of a non-powered NPWT system:
      - 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, and
      - evaluation of and provision for adequate nutritional status.
   b. For diabetic ulcers:
      - the patient has been on a comprehensive diabetic management program, and
      - reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
   c. For venous insufficiency ulcers:
      - compression bandages and/or garments have been consistently applied, and
      - leg elevation and ambulation have been encouraged.

Currently, the available non-powered NPWT dressing is 15x15cm in size. Allowing for the suggested 1cm overlap on each border to create a good seal, 13x13cm is currently the maximum diameter for the wound being treated with this system.

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The non-powered NPWT system, for example, SNaP Wound Care System, is currently indicated for removal of small amounts of exudate.

If Mountain State coverage criteria are not met, Mountain State Blue Cross Blue Shield will deny the non-powered NPWT system and related supplies as not medically necessary.

The non-powered NPWT system must be prescribed by a physician who is actively involved in the wound care management of the patient.

A health care professional must be licensed to assess wounds and/or administer wound care within the state where the member is receiving the non-powered NPWT system. A licensed health care professional may be a physician, physician's assistant, registered nurse, licensed practical nurse or physical therapist.

Once a patient is placed on a non-powered NPWT system and supplies, for coverage to continue, a licensed health care professional must, on a regular basis:

a. directly assess the wound(s) being treated with the non-powered NPWT system, and

b. at least monthly, document changes in the ulcer's dimensions and characteristics.

The health care professional must also record wound measurements consistently and regularly in the patient's medical records. This documentation is necessary for Mountain State Blue Cross Blue Shield to establish the medical necessity of the device and to determine continual coverage for an eligible non-powered NPWT system.

Mountain State Blue Cross Blue Shield will deny a non-powered NPWT system and supplies at any time as not medically necessary, if one or more of the following are present:

- actively infected wounds
- inadequately drained wounds
- inadequately debrided wounds
- exposed blood vessels, anastomotic sites, organs, tendons or nerves
- wound containing malignancy
- fistulas
- osteomyelitis
- actively bleeding wounds

Supplies

Mountain State Blue Cross Blue Shield limits supplies for non-powered NPWT to:

- cartridge (code E1399) — 10 cartridges per wound per month (additional cartridges per month must be supported by documentation evidencing the volume of drainage of exudates)
- dressings (code A4649) — 10 dressings per wound per month (additional dressings per month must be supported by documentation in the patient's medical record.) The record must be available upon Mountain State Blue Cross Blue Shield's request.
- one strap (code E1399) per episode of treatment

Mountain State Blue Cross Blue Shield will deny requests for amounts greater than the stated limits as not medically necessary.

Mountain State Blue Cross Blue Shield will deny the non-powered NPWT system and supplies as not medically necessary with any of the following, whichever occurs first:

- adequate wound healing has occurred to the degree that non-powered NPWT may be discontinued, in the judgment of the treating health care professional, or
- any measurable degree of wound healing has failed to occur over the prior month as documented in the patient's records, or
- four months (including the time non-powered NPWT was applied in an inpatient setting before discharge to the home) have elapsed using a non-powered NPWT device in the treatment of any wound.

Mountain State Blue Cross Blue Shield will give individual consideration to requests for coverage beyond four months. It will base its decision on additional documentation. This additional documentation must address the initial condition

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of the wound including measurements, efforts to address all aspects of wound care, subsequent monthly wound measurements, and what changes in wound therapy are being applied to effect wound healing. This information must be updated with each subsequent request for additional months of use of non-powered NPWT.

If the non-powered NPWT system and related supplies do not meet Mountain State Blue Cross Blue Shield's medical necessity guidelines, Mountain State Blue Cross Blue Shield will consider it not medically necessary. A participating, preferred or network provider may not bill the member for the denied non-powered NPWT system unless he or she has given advance written notice, informing the member that the system may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the non-powered NPWT system. The signed agreement should be maintained in the provider's records.

Documentation requirements

Documentation of the history, previous treatment regimens (if applicable) and current wound management for which a non-powered NPWT system is being billed must be present in the patient's medical record and be available on request. This documentation must include elements such as length of sessions of use, dressing types and frequency of change, and changes in wound conditions, including precise measurements, quantity of exudates, presence of granulation and necrotic tissue, and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.).

Documentation of wound evaluation and treatment, recorded in the patient's medical record, must indicate regular evaluation and treatment of the patient's wounds. Documentation of quantitative measurements of wound characteristics, including wound length and width (surface area), depth and amount of wound exudate (drainage), indicating progress of healing must be entered at least monthly. This documentation must be available upon Mountain State Blue Cross Blue Shield's request.

How to report non-powered NPWT: Procedure Codes and ICD-9-CM Diagnosis Codes

Report the following procedure codes when you bill for the SNaP Wound Care System:

SNaP Wound Care System cartridge: E1399

SNaP Wound Care System dressing: A4649

SNaP Wound Care System strap: E1399

When you report code E1399 or A4649, please include the term "SNaP Wound Care System cartridge," "SNaP Wound Care System dressing" or "SNaP Wound Care System strap," as appropriate, in the narrative section of the electronic or paper claim.

- For diabetic ulcer of lower extremity, other than pressure ulcer, report 249.00-249.91, 250.00-250.93 or 648.00-648.04. When you report ICD-9-CM diagnosis codes 249.00-249.91, 250.00-250.93 or 648.00-648.04, you must also report one of these ICD-9-CM diagnosis codes: 707.10, 707.11, 707.12, 707.13, 707.14, 707.15 or 707.19.
- For venous ulcer of lower extremity, other than pressure ulcer, report 454.0, 454.2, 459.31 or 459.81. When you report ICD-9-CM diagnosis code 459.31 or 459.81, please also report ICD-9-CM diagnosis codes 707.10, 707.11, 707.12, 707.13, 707.14, 707.15 or 707.19.

Description

The purpose of the non-powered NPWT system is to promote wound healing.

The non-powered NPWT system is a portable NPWT device indicated for patients who would benefit from a suction device particularly as the device may promote wound healing. It is also indicated for removal of small amounts of exudate from chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, ulcers, for example, diabetic or pressure, and surgically closed incisions and flaps. According to the manufacturer's information, it provides the same level of negative pressure therapy as competitive technologies, but requires no electric or battery power, and is a fully disposable off-the-shelf system.

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Wound healing is defined as improvement occurring in either surface area or depth of the wound. Lack of improvement of a wound is defined as a lack of progress in quantitative measurements of wound characteristics including wound length and width (surface area) or depth measured serially and documented over a specified time interval.

The SNaP Wound Care System is comprised of three main components: the SNaP Wound Care System Cartridge, the SNaP Wound Care System Dressing and the SNaP Wound Care System Strap.

The SNaP Wound Care System Cartridge acts as the negative pressure source and exudate canister. It weighs less than three ounces, has a capacity of 60cc for wound exudate, is fully disposable and operates silently. The SNaP Wound Care System Cartridge is powered by technology that maintains constant negative pressure in the chamber. It is available in three models, each capable of creating a preset negative pressure level (-75, -100 and -125 mmHg) that cannot be changed.

The SNaP Wound Care System Dressing comprises a proprietary thin hydrocolloid that provides a strong seal while protecting the patient's periwound skin, and includes an integrated check-valve that prevents reflux of exudate to the wound. It is easily connected to the SNaP Wound Care System Cartridge with integrated cut-to -length tubing.

The SNaP Wound Care System Strap attaches the SNaP Wound Care System Cartridge to the leg for maximum patient mobility, and allows for the system to be completely hidden under normal clothing. The SNaP Wound Care System Strap is available in small, medium and large sizes.

Please review Mountain State Medical Policy E-31, Negative Pressure Wound Therapy Pumps/Vacuum Assisted Closure of Chronic Wounds, for more information about powered NPWT devices.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

Medical Policy Bulletin: V-60 (Special Services)

Select Special Services Not Eligible for Separate Reimbursement

Mountain State Blue Cross Blue Shield will include the allowance for select special services in the basic service that is performed on the same date. Therefore, if any of the services listed below are reported with a basic service or independently, Mountain State Blue Cross Blue Shield will deny them as not covered. In this instance, a participating, preferred or network provider may not bill the member separately for these services.

The following codes describe the specific circumstance under which a basic service is performed. These codes do not represent separately identifiable services.

99050 — services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.

99051 — service(s) provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to basic service.

99053 — service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service.

99056 — service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service.

99058 — service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.

99060 — service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.

If you bill an evaluation and management (E/M) service procedure code and a special services code (99050, 99051, 99053, 99056, 99058 or 99060), do not append modifier 25 to the E/M procedure code. Codes 99050, 99051, 99053, 99056, 99058 and 99060 do not describe separately identifiable services, but rather adjunctive services or the circumstances during which the basic service was rendered.

MA Medicare Advantage MEDICAL POLICY UPDATES

Medical Policy Bulletin: N-197 (Coverage of Kidney Disease Patient Education Services)

Coverage for Kidney Disease Patient Education Services

Effective: April 18, 2011

Medicare Advantage products will provide coverage for kidney disease education (KDE) services for members diagnosed with Stage IV chronic kidney disease - CKD (severe decrease in GFR; GFR value of 15-29 ml/min/1.73 m2), who have received a referral from the physician managing the member's kidney condition. KDE services should be tailored to meet the needs of the individual member involved, designed to provide members opportunities to actively participate in the choice of therapy and provide comprehensive information regarding:

- Management of comorbidities, including for the purpose of delaying the need for dialysis;
- Prevention of uremic complications; and
- Each option for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-facility, dialysis access options, and transplantation);

Payment will be made for KDE services that meet the following conditions:

- No more than six sessions of KDE services are provided in a member's lifetime,
- Sessions billed in increments of one hour (In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than one hour, still constitutes one session.),
- Sessions furnished either individually or in a group setting of two to 20 individuals (who need not all be members of the Plan), and
- Furnished, upon the referral of the physician managing the member's kidney condition, by a qualified person, meaning a:

1. physician, physician's assistant, nurse practitioner or clinical nurse specialist;

Reasons of noncoverage

KDE services provided for conditions other than chronic kidney disease, Stage IV (severe) will be considered not medically necessary. A provider cannot bill the member for the denied service unless the provider has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, in advance of receiving the service. The signed agreement, in the form of a Pre-Service Denial Notice, should be maintained in the provider's records.

Claims reporting more than six KDE sessions will be denied.

Payment will not be made for a professional claim and institutional claim for KDE services when both are reported on the same date of service.

Qualified persons that provide KDE services must develop outcomes assessments that are designed to measure the member's knowledge about CKD and its treatment. The assessment must be administered to the member during a KDE session and be made available upon request.

KDE reporting guidelines

Here are the procedure and diagnosis codes you should use to report KDE services:

- G0420 — Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour

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- G0421 — Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour
- ICD-9-CM diagnosis code 585.4 – Chronic kidney disease, Stage IV (severe)

MA

Medical Policy Bulletin: O-17 (Therapeutic Shoes for Persons with Diabetes)

Medicare Advantage Revises Coverage Criteria for Therapeutic Shoes for Persons with Diabetes

Effective: April 18, 2011

Medicare Advantage revised the coverage criteria for therapeutic shoes for persons with diabetes. Medicare Advantage will cover therapeutic shoes, inserts and/or modifications to therapeutic shoes if all of these criteria are met:

1. **The patient has diabetes mellitus (ICD-9-CM diagnosis codes 249.00-250.93), and**
2. **The certifying physician has documented in the patient's medical record one or more of the following conditions:**
   a. previous amputation of the other foot, or part of either foot,
   b. history of previous foot ulceration of either foot,
   c. history of pre-ulcerative calluses of either foot,
   d. peripheral neuropathy with evidence of callus formation of either foot,
   e. foot deformity of either foot, or
   f. poor circulation in either foot, and
3. **The certifying physician has certified that indications (1) and (2) are met and that he or she is treating the patient under a comprehensive plan of care for their diabetes and that the patient needs diabetic shoes.**

The following additional criteria are effective April 18, 2011:

In order to meet criterion No. 2, the certifying physician must either:

- Personally document one or more of criteria a–f in the medical record of an in-person visit within six months before delivery of the shoes or inserts and before or on the same day as signing the certification statement, or
- Obtain, initial or sign, date (before or on the same day as signing the certification statement) and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician's assistant, nurse practitioner or clinical nurse specialist that is within six months before delivery of the shoes or inserts, and that documents one or more of criteria a–f.

The requirement that the in-person visit(s) be within six months before delivery of the shoes or inserts is effective for claims with dates of service on or after April 18, 2011.

The certifying physician must:

- have an in-person visit with the patient during which diabetes management is addressed within six months before delivery of the shoes or inserts, and
- sign the certification statement on or after the date of the in-person visit and within three months before the delivery of the shoes or inserts.

4. **The supplier must conduct and document an in-person evaluation of the patient before selecting the specific items that will be provided.**
5. **At the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient.**

If criteria Nos. 1-5 are not met, Medicare Advantage will deny the therapeutic shoes, inserts and/or modifications as not covered. When codes for therapeutic shoes are billed without a KX modifier, Medicare Advantage will deny them as not covered. The provider may bill the member for the non-covered item.

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The certification statement is not sufficient to meet the requirement for documentation in the medical record.

Depending on the items ordered, both the evaluation and delivery could occur on the same day if the supplier had both a sufficient array of sizes and types of shoes or inserts and adequate equipment on site to provide the items that meet the beneficiary's needs. Both components of the visit (criteria Nos. 4 and 5) must be clearly documented.

There must be an in-person visit with the prescribing physician within six months before delivery of the shoes or inserts.

The only products that may be billed using code A5512 are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor website.

There are two categories of products that are billed with code A5513:

- Inserts that are custom fabricated by a manufacturer or central fabrication facility and then sent to someone other than the patient. These items may be billed with code A5513 only if they are listed on the PDAC website.
- Inserts that are custom fabricated from raw materials that are dispensed directly to the patient by the entity that fabricated the insert. These items do not have to be listed on the PDAC website to be billed with code A5513. However, the supplier must provide a list of the materials that were used and a description of the custom fabrication process on request.

If an insert is not included in one of these categories of items, it must be billed with code A5510 or A9270 (non-covered item).

Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Review can be found on the PDAC website or by contacting the PDAC.

For additional information, see Medicare Advantage Medical Policy O-17, Therapeutic Shoes for Persons with Diabetes.

PROVIDER News

Mountain State's *Provider News* is designed to serve providers by offering information that will make submitting claims and treating our subscribers easier. We want to know what you would like to see in upcoming issues of this newsletter. Do you have a question that needs to be answered that you think other providers would be interested in? Are there issues or problems not addressed in this publication? If so, let us know. Send your questions and concerns to:

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