MOUNTAIN STATE Blue Cross Blue Shield
A HIGHMARK AFFILIATE

PROVIDER News

Mountain State Blue Cross Blue Shield Wins National Brand Excellence Award

For the fourth straight year, Mountain State Blue Cross Blue Shield (MSBCBS) has won a Brand Excellence Award of the Blue Cross and Blue Shield Association. MSBCBS was recognized in the Member Retention Category in its market share group.

The annual awards recognize Blue Cross and Blue Shield companies that excel in developing and enhancing the overall image of the Blue Cross and Blue Shield brands, some of the most recognized and trusted names in the world.

The Brand Excellence Award is one of the highest honors to be bestowed on a Blue Cross or Blue Shield Plan. The competition separates the Blue Plans into groups based on market share.

“This honor is a reflection of the hard work and commitment of our employees to providing superior service and products to meet the needs and expectations of our members,” said Fred Earley, President, MSBCBS.

The Blue Cross and Blue Shield Association will present the awards to the winners during its Board of Directors meetings on March 17.

The Blue Cross and Blue Shield Association began the Brand Excellence Award program in 1995. The winning companies are evaluated on five measures that represent brand excellence. Blue Cross and Blue Shield companies are recognized for exceptional performance in the following categories: 1) Enrollment growth - new members enrolled over the past year; 2) Membership recommendation - likelihood a Blue Cross and Blue Shield member would recommend their health plan; 3) Member retention - percentage of Blue Cross and Blue Shield members retained from previous year; 4) Brand extension - addition of products or services; 5) Provider satisfaction - favorable rating of overall performance.

Inside This Edition:

February 2010

Highmark Health Insurance Company (HHIC) will begin offering Commercial Coverage to Small Groups Based in Western and Central Pennsylvania Starting in July 2010

Effective July 1, 2010, western and central Pennsylvania-based group employers with 50 or fewer employees will be offered health coverage through Highmark's wholly owned subsidiary, Highmark Health Insurance Company (HHIC). This change is being made to continue offering viable health care coverage options for small employers in Pennsylvania.

What You Need to Know

This means that HHIC will now offer commercial insurance coverage, as well as the already-familiar Medicare Advantage products (FreedomBlue℠ PPO and FreedomBlue PFFS). Although the commercial insurance coverage will be offered to Pennsylvania-based groups, providers in West Virginia – especially near the border – are likely to see these members.

Please see the following details that you and your staff will need to know.

- The commercial products offered through HHIC will be similar to those offered through Highmark Blue Cross Blue Shield with similar product design, member cost sharing, networks, reimbursement, provider policies and procedures.
- As always, please ask members for their ID Card at each visit and report the information as noted on the ID Card. Also, continue to use NaviNet® to verify enrollment information, including eligibility and benefits. Verification of these benefits can be obtained through the BlueExchange(R) option.
- Claims for HHIC commercial products will be administered differently from the HHIC Medicare Advantage products.
    - FreedomBlue ID Cards will continue to have the "MA PPO suitcase" logo, and you will continue to submit claims as you currently do today.
    - HHIC commercial PPO product ID Cards will have the "PPO suitcase" logo. These claims will be processed via the BlueCard(R) Program, so you should file your claims as you currently do today for other host members and continue following the BlueCard guidelines for authorization and verification of benefits and dependent elegibility.
    - For those practices that use a billing vendor or service, please note that there are no impacts from the trading partner perspective. Just be sure you submit the commercial HHIC claims via the BlueCard Program.

Please watch for additional communication regarding the addition of commercial group coverage to the Highmark Health Insurance Company (HHIC), effective July 2010.

NAVINET UPDATE

REMINDERS: To assist in your use of NaviNet, please remember the following...

CLAIM LOG PURGE

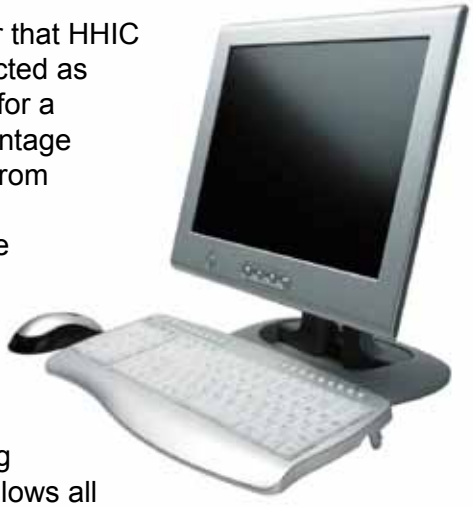
Effective January 18, 2010, NaviNet limited the claims retained in the claim log to those submitted in the last 18 months. Claims submitted through NaviNet that are older than 18 months were purged from the claim log and will now be retained in an archive file for 6 years. Access to the archived data will be available upon written notice request. Please see the Data Retention Policy link in the NaviNet Customer Support, under Policies and Agreements.

URGENT CARE COPAYS

Some group policies have separate urgent care co-pays in addition to the more commonly seen office visit, specialist and emergency room co-pays. These urgent care benefits will be listed in the members benefit links under the outpatient facility and/or professional services. The co-pay field only displays 3 co-pays. You must drill into the actual benefit links to find these additional copayments.

CLAIM SUBMISSION FOR UB OR 1500 SUBMITTERS – PAYER PAGE

Please be sure Mountain State Blue Cross Blue Shield (MSBCBS) or Highmark Health Insurance Company (HHIC) is the FINAL payer on the Payer Page when submitting claims electronically through NaviNet. MSBCBS (or HHIC) should never be listed as the primary payer 'A', with another carrier listed as payer 'B'.



Also remember that HHIC should be selected as the final payer for a Medicare Advantage PPO member from ANY plan for dates of service 1/1/2010 and after. This is for the Medicare Advantage network sharing program that allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other participating Blue MA PPO Plan as long as the member sees a contracted MA PPO provider.

ELECTRONIC SUBMISSION

We have already had a volume of providers begin to use the NaviNet 1500 & UB claim submission transactions as a means to submit their claims electronically to MSBCBS. Congratulations! Remember that NaviNet is a free option to you as a network provider. For training on this transaction, please contact your external provider relations representative or Michelle Beihl at 304-234-7069.

WELCOME To Our Newest Group:

International Coal Groups (ICG)

Effective Date: 1/1/10
Number of employees: 2,637
Group location: 17 locations throughout WV, KY, OH, VA and IL
Product Type: PPO
Claims processing location: Parkersburg
Client Manager: Bonita Hess
Alpha Prefix: OAL

Electronic Claims UPDATE

Mandatory Facility Electronic Claim Submission

Mountain State Blue Cross Blue Shield would like to thank all of our facilities for their cooperation regarding the mandatory electronic submission of inpatient and outpatient bills that became effective January 1, 2010.

This requirement is expected to benefit providers and Mountain State through the reduction of administrative costs, allowing claims to process uninterrupted through our system, reducing errors of compliance on PHI, and increasing our ability to pay all claims without manual intervention and speeding payment.

Allscripts Now Submitting Electronic Claims to Highmark Health Insurance Company FreedomBlue

Allscripts is now able to submit electronic claims to NAIC code 71768 for Highmark Health Insurance Company (HHIC) FreedomBlue. If you are a professional provider who currently bills Mountain State Blue Cross Blue Shield through M. Transactions, Misys or Payerpath, you now have the ability to file your HHIC FreedomBlue claims electronically through Allscripts.

Guidelines Regarding Medicare Advantage Electronic Claim Submissions

As communicated in our last three issues of Provider News, please make sure you are billing the correct NAIC code for Mountain State and Medicare Advantage (MA) PPO for service dates January 1, 2010 and after.

West Virginia members covered under Highmark Health Insurance Company FreedomBlue, plan code 377, alpha prefix HQM (Medicare Advantage PPO) or HKP (Medicare Advantage Private Fee for Service) will still continue to be billed to 71768.

Other Blue Medicare Advantage PPO (MA PPO) plans that participate in reciprocal network sharing should be billed to NAIC code 71768. You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

MA | PPO
MEDICARE ADVANTAGE

The “MA” in the suitcase indicates a member who is covered under the MA PPO network sharing program.

NOTE: Use of this logo is not mandated until 2012. HHIC and some other Blue plans will be using the logo on ID cards in 2010. However, ID cards from several other Blue plans may not include the logo until 2012. Until the issuance of new ID cards by 2012, some ID cards may simply be worded as Medicare Advantage PPO.

Any other state’s Medicare Advantage member who is covered under a Medicare Advantage Private Fee for Service (PFFS) should continue to be billed to 54828. The only Medicare Advantage PFFS that should be billed to 71768 are West Virginia members PFFS alpha prefix HKP.

Claims billed to the incorrect NAIC code will reject on your 277CA report as A3>116, “CLAIM SUBMITTED TO THE INCORRECT PAYOR”. If this rejection is received, please file your claim electronically to the correct NAIC code.

Prepare now for the HIPAA 5010 Mandate

What does the HIPAA 5010 mandate mean to you? Are impacts from the 5010 mandate limited to the practice management vendors, billing centers, and clearinghouses for electronic claims? Do you have any policy or procedural changes affecting your provider's office operations?

There are a number of application and processing changes that providers and their practice management software vendor need to know about to become compliant with the HIPAA 5010 mandate.

Although Mountain State Blue Cross Blue Shield (MSBCBS) is committed to sharing information about many of these changes, you should contact your practice management software vendor to learn what you need to do to become compliant, how they plan to migrate to 5010, and how the 5010 mandate may impact your office operations.

The following items are a sampling of the impacts and changes being addressed as part of the HIPAA 5010 mandate:

- Reporting anesthesia services—the 837 Professional transaction is changing the way the surgery related to anesthesia services is reported. A new claim level segment has been created in the 2300 Claim Information loop, the Anesthesia Related Procedure "HI" segment, instead of the free form data element used in the current version of the electronic claim.

- ICD-10-CM code sets—conversion to Version 5010 accommodates the use of the International Classification of Diseases, Tenth Revision code sets, which are not supported by the current 4010A1 transaction set. Use of the actual ICD-10-CM codes will not occur until Oct. 1, 2013.

- 9-digit ZIP codes—providers must provide a full 9-digit ZIP code for billing provider and service facility locations on all claim submissions. When the full 9-digit ZIP code is required, spaces or zeroes are not valid in the last four digits of the ZIP code.

- Billing provider address—MSBCBS will reject electronic claims containing a PO Box or Lockbox as the billing provider address.

- MSBCBS-assigned provider numbers—MSBCBS will no longer consider these numbers during the electronic claim receipt and editing process.

- Implementation Acknowledgement for Health Care Insurance (999)—the 999 transaction replaces the current 997 (Functional Acknowledgement).

- Printable Claim Acknowledgement Report—Blue Shield will discontinue creating a text-based printable Claim Acknowledgement report.

  Those submitting electronic claims must be able to accept the 005010X214 277 Health Care Claim Acknowledgement (277CA) Transaction with implementation of the Version 5010 837 Claim transaction. If the practice management software is unable to process the new 277 Claim Acknowledgement along with the TA1 and 999 acknowledgements, providers could be faced with trying to interpret an EDI transaction or not receiving any information on accepted or rejected claims.

All providers who submit claims electronically are affected by these changes. MSBCBS encourages you to contact your practice management software vendor as soon as possible to discuss these electronic transaction changes so that your claim submission software is ready by Jan. 1, 2012.

If you have questions about the changes being made by MSBCBS to become 5010 compliant, contact your Provider Relations representative.

Watch for future newsletter articles and the NaviNet® Plan Central page for more information and updates about the transition to Version 005010 transactions.

Appropriate Use of Modifier 59

The use of Modifier 59 indicates distinct procedural services given by the same provider on the same day. This modifier is intended to identify independent or distinct services which are not commonly performed together, but are appropriate to be billed separately under certain circumstances.

According to Mountain State Blue Cross Blue Shield Medical Policy, procedures are eligible for payment when provided under the following circumstances when reported with modifier 59.

- different operative session on same date of service
- different site or separate area of injury
- separate incision
- different body orifices
- bilateral surgical procedures

The Special Investigations Unit at Mountain State Blue Cross Blue Shield encounters the misuse of Modifier 59 quite often. Many providers and/or their staff members append this modifier to services that do not meet the criteria outlined for its appropriate use. Some examples of the misuse of modifier 59 include:

- Use of modifier 59 when services were performed on adjacent body regions or muscle groups that are connected to the primary site of treatment and/or are the result of the same injury.
- Constant or overuse of modifier 59 every time certain procedures are performed. Services requiring a 59 modifier are the exception, not the rule.
- Unbundling of services by using of modifier 59 to bypass system edits and receive payment for services that are considered integral to the primary procedure and would therefore not be considered a covered service.

The best way to ensure the appropriate use of modifier 59 is to make certain that you and your staff are familiar with CPT guidelines and Mountain State Blue Cross Blue Shield Medical Policies that affect your particular specialty or the services that you provide.

Changes to reporting requirements for anesthesia and moderate (conscious) sedation services, effective April 17, 2010

As mandated by HIPAA, all electronic data interchange transactions must be upgraded to Version 005010, effective Jan. 1, 2012. Although the federal deadline is two years away, Mountain State and other health insurers have already begun to implement system changes that will be necessary to meet HIPAA 005010 compliance.

Because of this, there will be some changes to anesthesia reporting requirements for electronic and paper claim forms, effective April 17, 2010.

Mountain State's anesthesia policy guidelines will remain the same. However, the manner in which you will report anesthesia services is changing for both electronic and paper claims.

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Mountain State Blue Cross Blue Shield

Contracting & Reimbursement Update...

2010 RBRVS Reimbursement Update

The annual 2010 RBRVS physician fee schedule update will be effective July 1, 2010. Mountain State is currently reviewing and analyzing the CMS changes. As Mountain State finalizes plans for the annual update we will provide an update to our provider community. The new CPT/HCPCS codes for 2010 were added effective January 1, 2010.

Walgreens (formerly Medmark) Program Update

The following drugs will be added to the mandatory Walgreens Injectable Drug program effective June 1, 2010.

Vivaglobin	90284
Vantas	J9225
Firmagon	J9155
Extavia	J1830
Copegus	J3490
CMV-IgIV (Immune Globulin)	90291
Forteo	J3110
HCG	J0725
Humira	J0135
IgIV (Immune Globulin)	90283
NPlate	J7192
Pegasys	S0145
PEG-Intron	S0146
Rebetol	J3490
Rhophylac, Rho (D)	J2791
Ribasphere	J3490
Soliris	J1300
AutoPlex-T	
Hyate C	
Proplex T	

The following drugs will be removed from the Specialty Drug program effective February 1, 2010, and will follow the standard method of reimbursement for drugs and biologicals.

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 long valid.

Please refer to the Mountain State web site for an updated list of drugs in the mandatory Specialty Drug program.

Changes to reporting requirements for anesthesia and moderate (conscious) sedation services, effective April 17, 2010 (Continued)

For the most efficient means of claims submission, submit your anesthesia services electronically.

Reporting changes for specific anesthesia services

When you use the national CPT anesthesia procedure codes (00100-01999) to report the administration of anesthesia, the surgical service performed must be included if you report “not otherwise specified” or “not otherwise classified” (NOC) anesthesia services. If you record the surgical HCPCS procedure code on all claims, your claims will be processed in a more timely manner.

Electronic claims

The ASC X12-5010 Health Care Claim: the Professional 837 transaction is changing the way health care professionals will report anesthesia

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Contracting & Reimbursement Update Continued...

Changes to reporting requirements for anesthesia and moderate (conscious) sedation services, effective April 17, 2010 (Continued)

services. A new claim level segment has been created in the 2300—Claim Information loop: HI – ANESTHESIA RELATED PROCEDURE.

When reporting the national CPT anesthesia procedure codes (00100-01999) to report the administration of anesthesia, if you report not otherwise specified or NOC anesthesia services, include an appropriate HCPCS procedure code for the surgery in the new Anesthesia Related Procedure HI segment. If the only suitable HCPCS procedure code for the surgery is an NOC, you must include a complete description of the service performed in the description element associated with the anesthesia procedure code (SV101-7). Mountain State will not accept the terminology of a national procedure code as a description of the service performed. To avoid claim rejections or delays, you must describe the actual service or surgery performed.

Examples of acceptable and unacceptable terminology are:
Acceptable: 31899 Excision of tracheal tumor – cervical
Unacceptable: 31899 Unlisted procedure, trachea, bronchi

Paper claims
If you report not otherwise specified or NOC anesthesia services, include an appropriate surgical HCPCS procedure code as the description of the actual service or surgery performed. If the only suitable surgical HCPCS procedure code is an NOC, you must include a complete description of the service performed. Mountain State will not accept the terminology of a national procedure code as a description of the service performed. To avoid claim rejections or delays, you must describe the actual service or surgery performed. This information should be reported in the shaded lines of block 24 in conjunction with ID Qualifier 7.

For example, if the surgical procedure is not an NOC surgical service, please report as follows:

24. A. DATES OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS	H. EPDST Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID #
08	15	09	08	15	09	20		00830	AA	1	2750	00	243		

In cases where the surgical procedure code is an NOC surgical service, please report as follows:

24. A. DATES OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS	H. EPDST Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID #
08	15	09	08	15	09	20		00320	QY	1	2750	00	243		
08	15	09	08	15	09	20		00320	QX	1	2750	00	243		

Note: Do not report start and stop times in the shaded area of block 24. Report only minutes in the Days or Units field (block 24 G)

<u>Reporting changes for moderate (conscious) sedation services</u>
When the same provider administers moderate sedation, also known as conscious sedation, for specified procedures, report the moderate sedation with procedure code 99143, 99144, or 99145.

Moderate sedation performed by other than the operating surgeon, assistant surgeon, or attending professional should be reported with procedure code 99148, 99149, or 99150.

Mountain State Blue Cross Blue Shield
Contracting & Reimbursement Update Continued...

In both situations, report units, not minutes, for these codes. Remember, certification modifiers are not required.

CMS eliminates payment for consultation codes in 2010; Mountain State will continue to pay for consultations for commercial products

On Oct. 30, 2009, the Centers for Medicare & Medicaid Services (CMS) announced that it would stop paying for consultation codes 99241-99255 on Jan. 1, 2010. CMS will continue to recognize the telehealth consultation G codes (G0406-G0408, G0425-G0427).

Mountain State maintains payment guidelines for consultation codes for commercial products
Even though CMS is changing its payment guidelines for consultations, Mountain State will continue to process claims reporting consultation codes 99241-99255 for its commercial products.

Mountain State is reviewing the new CMS consultation payment guidelines. If Mountain State changes its payment guidelines for codes 99241-99255, it will announce those changes in a future edition of the *Provider News*.

How to Report Bilateral Procedures

Bilateral procedures are defined as services performed on paired organs or limbs, such as both feet, both hands, or both eyes. When you report procedures that were performed bilaterally, be sure the number of services correspond with the modifiers that you report. There are several ways to report bilateral procedures.

Right and left modifiers
If you report bilateral services on two lines of service, report an RT modifier on one line and an LT modifier on the second line. The number of services on each line should be 1.
Example
20610 RT $35.00 (01)
20610 LT $35.00 (01)

If you report a “50” modifier to indicate bilateral procedures, report only one line of service and indicate the number of services as "2".
Example
20610 50 $70.00 (02)

If you are reporting multiple services performed on the same side of the body, for example, right arm, right leg, you may follow either of these examples:
20610 RT $70.00 (02)
or
20610 RT $35.00 (01)
20610 RT 76 $35.00 (01)

In the second example above, you must report the 76 modifier on the second line that reports the same procedure code for correct payment to be made.

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Mountain State Blue Cross Blue Shield
Contracting & Reimbursement Update Continued...

How to Report Bilateral Procedures (Continued)

Here are some common examples of correct and incorrect reporting of bilateral procedures:

Correct reporting	Incorrect reporting
20610 RT $35.00 (01)	20610 RT $35.00 (01)
20610 LT $35.00 (01)	20610 50 LT $35.00 (01)*
*The “50” modifier on the second line should not be reported since itemized charges are being reported for “right” and “left”	

Correct reporting	Incorrect reporting
20610 50 $70.00 (02)*	20610 50 $70.00 (01)
*When reporting a “50” modifier, the number of services should always be “2”	

Correct reporting	Incorrect reporting
20610 LT knee $35.00 (01)	20610 LT knee $35.00 (01)
20610 LT 76 shoulder $35.00 (01)*	20610 LT shoulder $35.00 (01)
*For the claim to be processed correctly, a “76” modifier must be reported on the second line to indicate repeat services	

HHIC FreedomBlue PFFS and FreedomBlue PPO no longer reimburse consultation codes 99241-99255

On Oct. 30, 2009, the Centers for Medicare & Medicaid Services (CMS) announced that it would stop paying for consultation codes 99241-99255 on Jan. 1, 2010. CMS will continue to pay for telehealth consultation G codes (G0406-G0408, G0425-G0427).

HHIC’s Medicare Advantage products—FreedomBlue℠ PFFS and FreedomBlue PPO—will follow CMS’s consultation code payment guidelines.

Healthways SilverSneakers® Fitness Program Proven to Reduce Health Care Costs of Members with Diabetes

Groundbreaking study focuses on benefits for members with diabetes

Older adults with diabetes who are enrolled in the SilverSneakers Fitness Program are admitted to the hospital less often, have lower inpatient care costs, and have significant reductions in their overall health care costs after only a year of participation, according to a recent study published in *Diabetes Care*, the journal of the American Diabetes Association.[1]

The study, funded by the Centers for Disease Control and Prevention (CDC) and conducted by Group Health and the University of Washington, extends a January 2008 study that looked at nearly 5,000 SilverSneakers participants over a two-year period. Researchers examined whether the impact of SilverSneakers participation on health care costs and utilization also applies to older adults with chronic conditions such as diabetes.[2]

Study: Health Care Use and Costs Associated with Use of a Health Club Membership Benefit in Older Adults with Diabetes

The health care costs from SilverSneakers members with diabetes (study group) were compared to costs from diabetic members of the same age and gender who were not enrolled in SilverSneakers (control group).

Key conclusions include:

Lower total health care costs

• During the first year of the program, the study group generated $1,600 less per member in total health care costs than the control group. During the second year, continued reductions of $1,230 per member were seen for the study group compared to the control group.

Lower hospitalization rate

• Study group members had 29 percent fewer hospital admissions than control group members.
• Costs per member for inpatient care were similar for study and control group members.

Greater savings with more participation

• Participants who averaged two or more visits per week in the first year of the study had significantly lower costs in the second year than those members who visited the fitness center fewer than two times per week in year one.
• Members participating more frequently generated $2,141 less per member in total health care costs than members with less participation.

The study suggests that the health care cost reductions associated with participation in an exercise program for older adults in general also apply to older adults with diabetes. In fact, the impact on total health care cost is seen earlier and is three times greater in this higher risk group.

To obtain more information about this study, please visit **www.healthways.com**.

SilverSneakers is offered to Mountain State Blue Cross Blue Shield Medicare Supplement members of Medifil at no additional cost. To enroll in the program, members can **s**imply bring their Medifil card to any of the following SilverSneakers locations in West Virginia, including Curves® for Women. For a complete list, members can visit us online at **www.silversneakers.com** or call the number on the back of their Medifil card.

Barboursville
Absolute Fitness

Beckley
Bodyworks Health Fitness Rehabilitation

Berkeley Springs
Rankin Physical Therapy

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Healthways SilverSneakers® Fitness Program *Continued*

Bluefield
Greater Bluefield Community Center

Charleston
YMCA of Kanawha Valley

Charles Town
Gold's Gym – Charles Town

Clarksburg/Bridgeport
Harrison County YMCA

Cross Lanes
Tyler Mountain YMCA

Elkins
Total Training Center

Grafton
Tygart Valley Rehabilitation & Fitness Center

Keyser
Lifestyle Fitness Center

Lewisburg
Greenbrier Valley YMCA

Madison
Southern Fitness

Point Pleasant
Pleasant Valley Hospital Wellness Center

Hico
Active Fitness Center

Huntington
Huntington High YMCA

Marietta, OH
Marietta Family YMCA

Martinsburg
Berkeley 2000 Recreation Center

Moorefield
Hardy County Health & Wellness Center

Morgantown
Healthworks Rehab & Fitness
Lakeview Fitness Center

Oak Hill
Active Fitness Center

Parkersburg
Family Fitness Center

Princeton
Princeton Health and Fitness Center

Ripley
Community Fitness Center

Romney
Hampshire Wellness and Fitness

Saint Albans
Active Sports Complex

Scott Depot
Tri-County YMCA

Spencer
The Fitness Complex of Roane General Hospital

Summersville
Nicholas Fitness Center

Weirton
Weirton Millsop Community Center

Wheeling
Howard Long Wellness Center
J.B. Chambers YMCA

Mountain State Medifil members who are not within 15 miles of their residence can enroll in SilverSneakers STEPS. This home-based exercise program provides Medifil members a free pedometer, tracking logs, and health-related educational material. Members can call 1-800-481-5502 to learn more about the program.

[1] Huong, H.Q., Maciejewski, M.L., Gao, S., Lin, E, Williams, B., & LeGerfo, J.P. (2008). Health Care Use and Costs Associated with Use of a Health Club Membership Benefit in Older Adults with Diabetes. *Diabetes Care*, 31(8), 1562-1567. http://care.diabetesjournals.org/content/ vol31/issue8.
[2] http://www.cdc.gov/pcd/issues/2008/jan/07_0148.htm.

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 key word, policy number or procedure code.

Recent updates or changes are as follows:

Medical Policy Bulletin G-24 (Obesity)
Biliopancreatic diversion with duodenal switch now eligible for select criteria
Effective: January 1, 2010

Mountain State Blue Cross Blue Shield now covers biliopancreatic bypass with duodenal switch for members who meet all of the following patient selection criteria:

Adult Patient Selection Criteria

- The patient has a BMI of 50 kg/m2 or greater.
- The patient is at least 18 years old.
- The patient has received non-surgical treatment, for example, dietitian or nutritionist consultation, low calorie diet, exercise program, and behavior modification, and attempts at weight loss have failed.
- The patient must participate in and meet the criteria of a structured nutrition and exercise program. This includes dietitian or nutritionist consultation, low calorie diet, increased physical activity, behavioral modification, and/or pharmacologic therapy. These program requirements must be documented in the patient's medical record.

  The structured nutrition and exercise program must meet all of these criteria:

  a. The nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists.

  b. The nutrition and exercise program(s) must be for a total of six continuous months or longer.

  c. The nutritional and exercise program must occur within two years before the surgery.

  d. The patient's participation in a structured nutrition and exercise program must be documented in the medical record by an attending physician who supervised the patient's progress. A physician's summary letter is not sufficient documentation. Documentation should include medical records of the physician's on-going assessments of the patient's progress throughout the course of the nutrition and exercise program. For patients who participate in a structured nutrition and exercise program, medical records documenting the patient's participation and progress must be available for review.

- The patient must complete a psychological evaluation performed by a licensed mental health care professional and be recommended for bariatric surgery. The patient's medical record documentation should indicate that all psychosocial issues have been identified and addressed.
- Patient selection is a critical process requiring psychiatric evaluation and a multidisciplinary team approach. The member's understanding of the procedure and ability to participate and comply with life-long follow-up and the life-style changes, for example, changes in dietary habits, and beginning an exercise program, are necessary for the success of the procedure.

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If the patient does not meet all of the patient selection criteria for bariatric surgery, Mountain State Blue Cross Blue Shield will deny the procedure as not medically necessary. A participating, preferred or network provider may not bill the member for the denied surgery unless the provider has given advance written notice, informing the member that the surgery 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 surgery. The signed agreement should be maintained in the provider's records.

Report biliopancreatic diversion with duodenal switch with procedure code 43845 - gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)

Mountain State Blue Cross Blue Shield determines coverage for the surgical treatment of morbid obesity according to individual or group customer benefits.

Medical Policy Bulletin Z-24 (Miscellaneous Services)
Endoscopic radiofrequency ablation of the esophagus not covered
Effective: November 23, 2009

Mountain State Blue Cross Blue Shield considers endoscopic radiofrequency ablation of the esophagus experimental or investigational. A participating, preferred or network provider may bill the member for the noncovered service.

Mountain State Blue Cross Blue Shield does not cover endoscopic radiofrequency ablation of the esophagus because well-designed large population, multicenter, controlled clinical trials with long-term follow-up are needed before the role of this procedure in the treatment of Barrett's esophagus, precancerous, and cancerous conditions of the esophagus can be established.

Report endoscopic radiofrequency ablation of the esophagus with code 43499. When you report code 43499, please include the words "endoscopic radiofrequency ablation of the esophagus" in the narrative field of the electronic or paper claim.

Medical Policy Bulletin G-24 (Obesity)
Bariatric surgery patient selection criteria explained for adults on structured nutrition and exercise program
Effective: June 14, 2010

Mountain State Blue Cross Blue Shield requires an adult bariatric patient to participate in and meet the criteria of a structured nutrition and exercise program. This includes dietitian or nutritionist consultation, low calorie diet, increased physical activity, behavioral modification, and/or pharmacologic therapy. This information must be included in the patient's medical record.

This structured nutrition and exercise program must meet all of these criteria:

1. The nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists.

2. Effective June 14, 2010**,** the nutrition and exercise program must include a total of six visits or more during a period of six consecutive months.

3. The nutrition and exercise program must occur within two years before the surgery.

4. The patient's participation in a structured nutrition and exercise program must be documented in the medical record by an attending physician who supervised the patient's progress.

   A physician's summary letter is not sufficient documentation. Documentation should include medical records of the physician's on-going assessments of the patient's progress throughout the course of the nutrition and exercise program. For patients who participate in a structured nutrition and exercise program, medical records documenting the patient's participation and progress must be available for review.

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Medical Policy Bulletin R-9 (Oncologic Applications of PET Scanning)
Mountain State Blue Cross Blue Shield covers PET scans for advanced testicular germ cell tumors
Effective: December 14, 2009

Mountain State Blue Cross Blue Shield has expanded coverage of PET scans to include advanced testicular germ cell tumors (diagnosis codes 186.0, 186.9, 236.4) to assess for viable tumor or to differentiate between fibrosis and/or necrosis. The following criteria must be met:

- the patient has a CT-documented residual mass after chemotherapy treatment
- the patient has normal or elevated serum markers

The interval between the PET scan for this indication and the completion of the chemotherapy treatment is usually no less than six weeks.

Mountain State Blue Cross Blue Shield considers PET scans performed for the diagnosis, staging, or monitoring of testicular cancer not medically necessary. In this case, the PET scan is not eligible for payment. A participating, preferred, or network provider may not 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 as 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 I-78 (Intravitreal Implants)
Ozurdex™ covered for treating macular edema after branch retinal or central retinal occlusion
Effective: June 18, 2009

On June 18, 2009, the United States Food and Drug Administration approved Ozurdex™ (dexamethasone intravitreal implant) 0.7 mg for the treatment of macular edema following branch retinal vein occlusion (diagnosis code 362.36) or central retinal vein occlusion (diagnosis code 362.35).

Mountain State Blue Cross Blue Shield considers the use of Ozurdex™ for any other indication experimental or investigational. In these instances, it is not covered. A participating, preferred, or network provider may bill the member for the denied service.

Report procedure code J3490 for Ozurdex™. When you report J3490, provide the name of the drug and dosage in the narrative field of the electronic or paper claim.

Mountain State Blue Cross Blue Shield determines coverage for Ozurdex™ according to individual or group customer benefits. Ozurdex™ is not covered under the prescription drug benefit.

Ozurdex™ dexamethasone intravitreal implant employs the Novadur™ solid polymer drug delivery system, which is proprietary to Allergan, Inc. Ozurdex™ implant is injectable and biodegradable. Each implant comes preloaded in a specially designed, single-use applicator. Ozurdex™ is administered as an in-office procedure by retinal specialists.

Medical Policy Bulletin G-24 (Obesity)
Certain bariatric surgical procedures eligible for adolescents
Effective: January 1, 2010

Mountain State Blue Cross Blue Shield now covers vertical banded gastroplasty and gastric stapling (open), laparoscopic or open Roux-en-Y gastric bypass and biliopancreatic bypass with duodenal switch for adolescent members with a BMI of 50 kg/m2 or greater who meet all of the following patient selection criteria.

Adolescent patient selection criteria
Vertical banded gastroplasty and gastric stapling (open), laparoscopic or open Roux-en-Y gastric bypass and biliopancreatic bypass with duodenal switch are covered for members under the age of 18 years when they meet all of these patient selection criteria:

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- Attainment or near-attainment of physiologic or skeletal maturity at approximately age 13 in girls and 15 for boys. (The patient has attained Tanner 4 pubertal development and final or near-final adult height, for example, greater than 95 percent of adult stature).
- The patient is morbidly obese (defined as a BMI of greater than 50), or severely obese (defined as a BMI of greater than 40) with these serious comorbidities:
    - Life threatening cardiopulmonary problems such as severe obstructive sleep apnea, Pickwickian syndrome, obesity related cardiomyopathy, pulmonary hypertension, documented coronary artery disease
    - Pseudomotor cerebri
    - Type II Diabetes
- The patient has received non-surgical treatment, for example, dietitian or nutritionist consultation, low calorie diet, exercise program, and behavior modification, and attempts at weight loss have failed.
- The patient must participate in and meet the criteria of a structured nutrition and exercise program. This includes dietitian or nutritionist consultation, low calorie diet, increased physical activity, behavioral modification, and/or pharmacologic therapy. These program requirements must be documented in the patient's medical record. This structured nutrition and exercise program must meet all of the following criteria:
    a. The nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists.
    b. The nutrition and exercise program(s) must include a total of six visits or more during a period of six consecutive months.
    c. The nutrition and exercise program must occur within two years before surgery.
    d. The patient's participation in a structured nutrition and exercise program must be documented in the medical record by an attending physician who supervised the patient's progress. A physician's summary letter is not sufficient documentation. Documentation should include medical records of the physician's on-going assessments of the patient's progress throughout the course of the nutrition and exercise program. For patients who participate in a structured nutrition and exercise program, medical records documenting the patient's participation and progress must be available for review.
- The patient must complete a psychological evaluation performed by a licensed mental health care professional and be recommended for bariatric surgery. The patient's medical record documentation should indicate that all psychosocial issues have been identified and addressed.
- The patient must be able to show decisional capacity and maturity in the psychological evaluation and provide informed assent for surgical management.
- The patient must be capable and willing to adhere to nutritional guidelines postoperatively.
- The patient must have a supportive and committed family environment.
- Patient selection is a critical process requiring psychiatric evaluation and a multidisciplinary team approach. The member's understanding of the procedure and ability to participate and comply with life-long follow-up and the life-style changes, for example, changes in dietary habits, and beginning an exercise program, are necessary to the success of the procedure.

If the patient does not meet all of the patient selection criteria for bariatric surgery, 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 surgery unless the provider has given advance written notice, informing the member that the surgery 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 surgery. The signed agreement should be maintained in the provider's records.

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Note: The United States Food and Drug Administration (FDA) has not approved the adjustable gastric band for patients less than 18 years of age. The FDA premarket approval for the LAP-BAND System indicates it is for use only in severly obese adult patients. (The clinical study that was submitted to the FDA for approval of the LAP-BAND was restricted to adults, ages 18-55 years.).

How to report bariatric surgical procedures

- Report vertical banded gastroplasty or gastric stapling (open) with one of these procedure codes:

  43842 - Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty

  43843 - Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty.

- Report open Roux-en-Y gastric bypass with procedure code 43846 - gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy.

- Report laparoscopic Roux-en-Y gastric bypass with procedure code 43644 - laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less).

- Report biliopancreatic diversion with duodenal switch with procedure code 43845 - gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch).

Mountain State Blue Cross Blue Shield determines coverage for the surgical treatment of morbid obesity according to the individual or group customer benefits.

Medical Policy Bulletin I-8 (Immunizations)
Mountain State Blue Cross Blue Shield covers Cervarix® vaccine according to member's benefits
Effective: October 19, 2009

The United States Food and Drug Administration approved Cervarix® (Bivalent Human Papillomavirus [Types 16 and 18] Recombinant Vaccine). Cervarix® prevents cervical cancer and precancerous lesions caused by human papillomavirus types 16 and 18.

The vaccine is approved for use in girls and women ages 10 years through 25 years. Cervarix® is administered in three separate shots, with the initial dose being followed by two additional shots at one and six months.

Mountain State Blue Cross Blue Shield will determine coverage for Cervarix® according to the member's contract.

Report Cervarix® vaccine with procedure code 90650-human papillomavirus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use.

Medical Policy Bulletin S-151 (Transmyocardial (Laser) Revascularization (TMR)
Transmyocardial revascularization eligibility explained
Effective: June 14, 2009

Mountain State Blue Cross Blue Shield considers transmyocardial (laser) revascularization (TMR) eligible for these conditions:

- intermediate coronary syndrome (diagnosis code 411.1)
- angina decubitus (diagnosis code 413.0)
- prinzmetal angina (diagnosis code 413.1)
- other and unspecified angina pectoris (diagnosis code 413.9)

If TMR is reported for any other indications, Mountain State Blue Cross Blue Shield considers it not medically necessary; therefore, it is not covered. A participating, preferred or network provider may not bill the member for the denied service unless the provider has given advance

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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.

TMR can be performed as a stand-alone procedure in patients with ischemic myocardium who are not candidates for other types of revascularization procedures, such as coronary artery bypass grafting (CABG) or percutaneous transluminal coronary angioplasty (PTCA) due to anatomical features within their coronary circulation. TMR as a stand-alone therapy is eligible as a last resort for patients with severe (Canadian Cardiovascular Society classification classes III or IV) angina (stable or unstable), which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. The angina must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectory, or coronary bypass.

In addition, patients must have:

- an ejection fraction of 25 percent or greater
- areas of viable ischemic myocardium (as demonstrated by diagnostic study) that are not capable of being revascularized by direct coronary intervention
- been stabilized or have had maximal efforts to stabilize acute conditions such as severe ventricular arrhythmias, decompensated congestive heart failure, or acute myocardial infarction

TMR can also be performed in conjunction with CABG in patients with areas of ischemic myocardium that cannot be treated with bypass grafting. TMR performed as an adjunct to CABG is an eligible service.

Use procedure 33140 to report TMR as a stand-alone procedure. In addition, use procedure code 33141 to report TMR performed in conjunction with CABG.

Medical Policy Bulletin I-11 (Botulinum Toxin (Chemodenervation))
Dysport™ coverage guidelines outlined
Effective: January 1, 2010

Dysport™ (abobotulinum toxin A), an acetycholine release inhibitor and a neuromuscular blocking agent, is indicated for the treatment of adults with cervical dystonia (diagnosis code 333.83) to reduce the severity of abnormal head position and neck pain in both toxin-naïve and previously treated patients.

The potency units of Dysport™ are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products; therefore, units of biological activity cannot be compared to or converted into units of any other botulinum toxin products assessed with any other specific assay method.

Mountain State Blue Cross Blue Shield considers the use of Dysport™ for any other diagnosis not medically necessary. It would not be covered in these instances. A participating, preferred, or network provider may not bill the member for the denied drug unless the provider has given advance written notice, informing the member that the drug 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 drug. The signed agreement should be maintained in the provider's records.

Report Dysport™ with procedure code J0586-injection, abobotulinum toxin A, 5 units.

Mountain State Blue Cross Blue Shield determines coverage for Dysport™ according to the individual or group customer benefits.

Medical Policy Bulletin S-112 (Co-Surgery)
Code 27886 eligible for co-surgery
Effective: January 1, 2010

Mountain State Blue Cross Blue Shield now considers the following additional code eligible for payment for co-surgery:

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27886 – amputation, leg, through tibia and fibula; re-amputation

Remember, other Mountain State Blue Cross Blue Shield medical policies may affect the eligibility of code 27886.

Medical Policy Bulletin I-18 (Treatment of Pulmonary Hypertension)
Mountain State Blue Cross Blue Shield covers Tyvaso inhalation solution for specific conditions
Effective: January 1, 2010

Tyvaso (treprostinil) a prostacyclin analogue, is indicated to increase walk distance in patients with WHO Group I pulmonary arterial hypertension and New York Heart Association (NYHA) Class III symptoms. The patient must meet these criteria:

1. Primary pulmonary hypertension (diagnosis code 416.0) and NYHA Class III symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy.
2. Secondary pulmonary hypertension (diagnosis code 416.8) related to collagen vascular disease, congenital systemic-to-pulmonary shunt, portal hypertension, Human Immunodeficiency Virus (HIV) infection, drugs and toxins, and appetite suppressants; and persistent pulmonary hypertension of the newborn and NYHA Class III or Class IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy.

Tyvaso has not been studied in children under the age of 18.

Tyvaso is intended for oral inhalation using the Tyvaso Inhalation System. Tyvaso is dosed in 4 separate, equally spaced treatment sessions per day, during waking hours.

Mountain State Blue Cross Blue Shield considers the use of Tyvaso for any other diagnosis not medically necessary. It is not covered. A participating, preferred, or network provider may not bill the member for the denied drug unless the provider has given advance written notice, informing the member that the drug 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 drug. The signed agreement should be maintained in the provider's records.

Report Tyvaso with procedure code J7699. When you report code J7699, provide the name of the drug and dosage in the narrative field of the electronic or paper claim.

Mountain State Blue Cross Blue Shield determines coverage for Tyvaso according to the individual or group customer benefits.

Medical Policy Bulletin Z-13 (Emergency Medical Care)
Emergency department services reporting guidelines explained

Mountain State Blue Cross Blue Shield defines an emergency department as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day to be considered an emergency department.

Mountain State Blue Cross Blue Shield defines emergency medical care as the initial treatment of a medical condition manifesting itself with sudden onset of symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

- placing the member or, with respect to a pregnant woman, the health of the woman or her unborn child's health in jeopardy,
- causing other serious medical consequences,
- causing serious impairment to bodily functions, or,
- causing serious dysfunction of any bodily organ or part.

Codes 99281, 99282, 99283, 99284, and 99285 are for reporting evaluation and management services provided in the emergency department. These codes should be reported with the ET modifier —

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emergency services—if the diagnosis code reflects an emergency medical service.

Each code's terminology specifies key components that must be documented and supported within the patient's clinical record. This documentation is necessary for Mountain State Blue Cross Blue Shield to determine payment eligibility for the reported code. When you include this documentation in the clinical record, it must clearly reflect the focus of the patient's history and examination (problem focused, expanded, detailed, or comprehensive) and the complexity (straightforward, low, moderate, or high) of the medical decision making. Please remember, the level of the evaluation and management service reported on the claim is dependent on these key components and the requirements increase as the patient's clinical status becomes more complex.

Code	Terminology
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: • A problem focused history; • A problem focused examination; and • Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: • An expanded problem focused history; • An expanded problem focused examination; and • Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: • An expanded problem focused history; • An expanded problem focused examination; and • Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: • A detailed history; • A detailed examination; and • Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: • A comprehensive history; • A comprehensive examination; and • Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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Emergency department service codes different from evaluation and management visit codes

Emergency department service codes (99281-99285) are different in nature as compared to typical evaluation and management visit codes:

- there is no distinction between a new and established patient,
- time is not a descriptive component,
- many different physicians staff emergency departments, and,
- previous information about a patient may not be readily available to physicians in the emergency department.

Time is not considered when determining the level of code to use for emergency department service codes because it is difficult to provide accurate estimates of time spent with patients in an emergency department. These services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over extended periods of time. The nature of the presenting problem and the key components provided are the factors that support which level of code to report. Always include details about the key components you provided and the nature of the patient's presenting problem in their clinical record. The requirements of the level of the emergency department service codes increase as the patient's clinical status becomes more complex.

For more information about emergency department services, please review Mountain State Blue Cross Blue Shield Medical Policy Z-13, Emergency Medical Care.

MA Medicare Advantage MEDICAL POLICY UPDATES

Medical Policy Bulletin
HHIC will no longer reimburse consultation codes 99241-99255
Effective: January 1, 2010

As of Jan. 1, 2010, the Centers for Medicare & Medicaid Services (CMS) no longer recognizes CPT consultation codes 99241-99245 and 99251-99255 for inpatient facility and office or outpatient settings where consultation codes were previously billed for services in various settings. CMS will continue to recognize telehealth consultation G codes (G0406-G0408, G0425-G0427).

HHIC will follow CMS consultation code payment guidelines.

For services provided on or after Jan. 1, 2010, you should code a patient evaluation and management (E/M) visit with an E/M code that represents where the visit occurs and that identifies the complexity of the visit performed.

If you bill for a consultation service after Jan. 1, 2010, HHIC will deny your claim with this message: "The reported code is not payable under Medicare guidelines. Reimbursement can be considered under a more appropriate code." Submit your claim with an appropriate E/M code.

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A physician or qualified non-physician practitioner (NPP) who performs an initial evaluation in the inpatient hospital or nursing facility setting may bill an initial hospital care visit code (code 99221-99223) or nursing facility care visit code (99304 – 99306), where appropriate.

The admitting or attending physician who oversees the patient's care should append modifier "-AI," defined as "Principal Physician of Record" in addition to the E/M code. This modifier identifies the physician who oversees the patient's care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient should bill only the E/M code for the complexity level performed.

Follow-up visits by a physician in the facility setting should be billed as subsequent hospital care visits for hospital inpatients and subsequent nursing facility care visits for patients in nursing facilities.

In the office or other outpatient setting where an evaluation is performed, physicians and qualified NPPs should report codes 99201-99215 depending on the complexity of the visit and whether the patient is a new or established patient to that physician.

In all cases, bill the available code that most appropriately describes the level of the services provided.

You can find more information about Medicare's elimination of consultation codes, by reading 2009 transmittal number 1875 at **http://www.cms.hhs.gov/Transmittals/2009 Trans**.

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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