Recent Health Care Legislation Creates Positive Outcome for Young Adults

With the passage of legislation to assist in the reform of our country’s health care industry, President Barack Obama recently signed into law the Patient Protection and Affordable Care Act (“The Act”). The Act requires health plans and insurers that offer dependent coverage to make this coverage available until reaching the age of 26.

Even though Mountain State Blue Cross Blue Shield (MSBCBS) is not required under the Act to begin providing such enhanced coverage until the fall, effective June 1, 2010, our company is pleased to offer its affected members continued coverage for dependents to age 26 for all insured groups and direct pay contracts.

MSBCBS recognizes many dependents who are graduating in June would otherwise face a lapse in coverage until their group’s plan year begins. As a result, MSBCBS will continue coverage for all dependents that would have otherwise lost coverage in June 2010 or later.

Also because of this change, MSBCBS would like to announce that between now and September 30, 2010, members of insured groups have the opportunity to add dependents up to the age of 26. This also includes married dependents, however, not their spouses, nor their children. They may not be eligible if they have other employer provided coverage available to them. The new guideline eliminates all student and eligible dependent certification. If dependents are not added before September 30, 2010, they will be eligible to enroll at the beginning of the group’s plan year. The plan year coincides with the date their deductible begins, which is generally January 1, 2011. Direct Pay (non-group) members may apply to add the dependents on January 1, 2011.

MSBCBS is pleased to be able to offer this benefit to help young adults get access to the health care they need.
National Imaging Associates, Inc. to Provide Utilization Management Services

Effective January 1, 2011, National Imaging Associates, Inc. (NIA) will begin providing utilization management services for non-emergent, high-tech outpatient radiology services rendered to members enrolled in Mountain State commercial health plans, including Super Blue Plus PPO, Super Blue Select Point of Service (POS), Steel, West Virginia Small Business Plan (WVSBP) and HHIC Freedom Blue Medicare Advantage Plan. The requirements will be waived for Mountain State’s Traditional Indemnity product, Bluecard and the Federal Employee (FEP) program.

The NIA and Mountain State agreement is consistent with industry-wide efforts to coordinate the increasing utilization of these services and to ensure quality care for all Mountain State members. NIA is NCQA and URAC accredited and offers our participating providers a program that supports standard protocols and offers the expertise of peer physicians.

Effective January 1, 2011, prior authorization will be required for the following outpatient radiology procedures for Mountain State members:

- CT / CTA
- PET Scan
- MRI / MRA
- Nuclear Stress (MPI)
- CCTA
- Stress Echo
- Nuclear Cardiology

Prior Authorization guidelines will be posted on our website and at www.msbcbs.com.

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- The ordering physician must obtain authorization.
- Failure to verify that affected services have been preauthorized may result in non-payment of your claim.

We appreciate your support and we will be providing you with more specific information and details regarding the radiology management program. If you have any questions, please contact your Mountain State External Provider Relations Representative.

ICD-10 Transition Coming Oct. 1, 2013

The Department of Health and Human Services (HHS), as a part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, requires covered entities to use the International Classification of Diseases, 10th Revision (ICD-10) on HIPAA-covered transactions effective Oct. 1, 2013, for services performed on or after Oct. 1, 2013.

The newer ICD-10-CM codes are intended to be more complete and expandable. And, they provide greater information about the medical condition represented by the code. The relationship between the code sets is complicated by the fact that the new codes are longer and the structure is unlike the old.

Continued On Next Page
NAVINET UPDATE

New Design for Eligibility and Benefits Transaction
The Mountain State Blue Cross Blue Shield Eligibility and Benefits transaction has a brand new look. Effective June 26, 2010, you will see a number of new features including: streamlined patient search capability, easy-to-read results displayed to the user and simplified date selection using a new optional calendar icon. Simply select Eligibility and Benefits from your Transaction Menu from Plan Central. For more information on the new features go to ‘Customer Support’, scroll down to ‘Support Announcements’ and click on the ‘New Features’ link.

Electronic Transactions Via NaviNet
Electronic claim submission, claim inquiry submission, and authorization submission are some of the various transactions you can use via NaviNet. As we move more toward electronic transactions you are encouraged to use NaviNet at all of your office locations. If you have a billing agency that handles some of these transactions, they too can get NaviNet access. Please contact NaviNet Customer care at 1-888-482-8057 or your Provider Service Representative if additional offices need set up or additional training is required.

Issue Regarding Claim Inquiry Transaction
An issue was recently identified with the Claim Inquiry transaction. Providers have been unable to use the Claim Inquiry transaction to see some Medicare Advantage Blue Card claims. Please know that we are working on this issue as quickly as possible and apologize for the inconvenience.

ICD-10 Transition Coming Oct. 1, 2013 (Continued)

Here is a comparison of diagnosis codes between code sets:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 codes</td>
</tr>
<tr>
<td>Mostly numeric</td>
<td>Leading alpha</td>
</tr>
<tr>
<td>Minimum 3 positions</td>
<td>Minimum 3 characters</td>
</tr>
<tr>
<td>Maximum 5 positions</td>
<td>Maximum 7 characters</td>
</tr>
</tbody>
</table>

It is important to note that while ICD diagnosis and procedure codes are changing, CPT codes or HCPCS codes, which are used for professional claims pricing, are not. However, professional claims will use ICD-10-CM diagnosis codes to determine policy.

Mountain State Blue Cross Blue Shield is committed to sharing information about the upcoming migration to the ICD-10 code sets. Please watch for additional news and information about ICD-10-CM in future editions of the Provider News and on www.msbcbs.com.
Paper Claims Impacts Effective July 23, 2010; Electronic Claims Impacts Coming Later in 2010

Mountain State Blue Cross Blue Shield (MSBCBS) is in the process of making system modifications that will be necessary to comply with HIPAA Version 5010 transaction standards for electronic claims. Although the federal deadline is still two years away, MSBCBS and other insurers are already preparing for the change. While the HIPAA 5010 standards are for electronic claims transactions, certain refinements will also impact paper claims submission.

+Claims should be submitted electronically. However, we understand that there may be rare instances when it is necessary to submit a paper claim. If you submit a paper claim, please use the original, red CMS-1500 National Uniform Claim Committee (NUCC) issued version of the paper claim form. MSBCBS will not accept or process non-compliant versions or photocopies (black and white) of paper claims. If you are still submitting all of your claims on paper, we encourage you to begin submitting electronically. To learn about the many benefits of electronic claims submissions, call your Provider Relations representative for more information.

Note New Requirements for Paper Claims, Effective July 23, 2010

Effective with dates of service on or after July 23, 2010, MSBCBS will require the following information on all CMS-1500 (8/05) claim forms:

- The National Provider Identifier (NPI) number must be reported for the Billing Provider, Rendering Provider and Referring Provider. MSBCBS assigned Provider numbers will no longer be necessary.
- In certain circumstances, the Provider Taxonomy Code must be reported with the NPI. *In addition, when reporting the taxonomy code, a new three-character qualifier – PXC – must be used. (PXC replaces the currently required ZZ qualifier.)
- A physical street address must be reported for the Billing Provider and the Service Facility location. P.O. Boxes or lock boxes will not be accepted.
- The full nine digits of the ZIP+4 Code must be reported for the Billing Provider and the Service Facility Location. The use of zeros (0000) or spaces in place of the last four digits of the ZIP Code is not valid.

*When the billing or rendering provider’s NPI is associated with more than one MSBCBS contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider’s contractual business arrangements with MSBCBS.

Please be sure to share this important information about paper claims submission for your practice, including billing staff and vendors.

In addition to this MSBCBS supplied information, other information about the paper claim form and a reference instruction manual are available at www.nucc.org.

Changes to Electronic Claims Transactions Coming Later in 2010

MSBCBS is also working to meet HIPAA-mandated changes to Version 5010 standards for electronic claims transactions. These changes will impact 837I, 837P and 835 transactions, as well as NaviNet claims submission.
5010 Claim Submission testing with selected trading partners

MSBCBS is working to be ready to accept Version 5010 837I and 837P claim transactions and create 835 electronic remittance transactions by late summer 2010. MSBCBS and selected trading partners are preparing for the “early adopter” testing phase of the transition process, which is expected to take place in the third quarter of 2010. The Electronic Data Interchange (EDI) site within the MSBCBS Website www.msbcbs.com will provide ongoing information about the trading partners and software vendors that have been certified to submit Version 5010 837I and 837P claims to MSBCBS. At the conclusion of the “early adopter” testing phase, all other trading partners will have the opportunity to do their own claim submission testing, become certified and, as appropriate, move their claim submissions/their clients’ claim submissions into the production environment.

Version 5010 837P claim submission includes changes to the way certain information will be reported and accepted by MSBCBS. Here is a list of some notable changes; discuss these with your software vendor. Vendors can direct any questions they have to MSBCBS EDI Operations at 1-888-222-5950.

NOTE: The changes below will occur when a provider begins to use Version 5010 for electronic claims submission (837) transactions:

- In all claim submission, full nine digits of the ZIP+4 Code must be reported for the Billing Provider and the Service Facility location. The use of zeros (0000) or spaces in place of the last four digits of the ZIP Code is not valid. Claims reporting ZIP Codes with fewer than 9 digits or reporting 0000 in the last four digits will be rejected.
- Claims containing either a P.O. Box or lock box in the Billing Provider address will reject.
- The NPI must be used for reporting and billing in the 837 transaction. When the billing provider’s NPI is associated with more than one MSBCBS-contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider’s contractual business arrangements with MSBCBS.
- The fields to support the reporting of Gender and Date of Birth for Other Insurance Insured have been removed.
- The Diagnosis Code field has been expanded to 12 occurrences per claim.
- For Assignment of Benefits, a new indicator of “W” is available to report “Not Applicable.”

The following are changes expected in transactions other than the 837:

- MSBCBS will use Version 5010 standardized acknowledgment transactions within the claim submission and editing process.
- The provider will no longer receive the current 997 (Functional Acknowledgement) transaction. It will be replaced by the 005010X231 999 transaction (Implementation Acknowledgement for Health Care Insurance).
- MSBCBS will no longer create a text-based, printable Claim Acknowledgement Report. All trading partners submitting 837 claim transactions in Version 5010 must be able to accept the 005010X214 277 Health Care Claim Acknowledgement (277CA) transaction.
- MSBCBS will provide more specific category codes (A6, A7, A8) in the 277 CA “Claims Acknowledgement” transaction in order to provide more detailed electronic claim responses.

Looking Ahead

- NaviNet Implementation of Version 5010β

NaviNet is preparing to test claim submission with MSBCBS during the fall of 2010 and expects to be ready to implement Version 5010 in the fourth quarter of 2010. As always, updated User Guides and NaviNet Release Notes will be available at the time of release to support providers in their use of the updated software.
implementation occurs, providers submitting their claims through NaviNet will notice screen changes and will experience the internal logic changes NaviNet has installed to support the requirements of Version 5010.

Important: References to NaviNet in this bulletin apply only to the implementation of Version 5010 requirements for NaviNet’s MSBCBS clients and do not apply to implementation for any other clients of that company, including other Blue Cross Blue Shield Plans.

- Transitioning Electronic Inquiry Transactions 270/271, 276/277 and 278 to Version 5010

MSBCBS is also planning toward the 2011 implementation of Version 5010 for electronic inquiry transactions 270/271, 276/277 and 278. Please watch MSBCBS’s provider newsletters, your mail, NaviNet and the MSBCBS website for more information.

Resources for Adopting the Changes Required by Version 5010

MSBCBS is developing a special HIPAA 5010 Library to assist providers in their own preparations for conversion to Version 5010. The library will be accessible under the HIPAA link on the Provider Resource Center via NaviNet or www.msbcbs.com. Please watch MSBCBS’s provider newsletters, your mail, and the Plan Central page of NaviNet for more information about the HIPAA 5010 Library.

Providers are reminded to consult the official Web sites of the Centers for Medicare & Medicaid Services, the Workgroup for Electronic Data Interchange and other national resources to stay apprised of the overall national 5010 implementation effort.

If you have specific questions regarding HIPAA mandated changes to Version 5010 transaction standards, please contact MSBCBS EDI Operations at 1-888-222-5950.

Mark Your Calendar for Our 2010 Provider Workshops

Mountain State Blue Cross Blue Shield wants you and your office staff to join us for our 2010 Provider Workshops.

Please mark your calendar now to attend one of the workshops which will be held across the state at the following locations. We will also be offering webinars if you are not available to attend one of the scheduled meetings below. More information regarding the webinars will be communicated in the upcoming Provider News.

Attending a workshop gives you the chance to speak with a Mountain State Representative, ask questions and gain valuable information for your practice.

Wednesday, September 15th - Wheeling WV - Oglebay Park
Wednesday, September 22nd - Beckley WV - Tamarack
Wednesday, September 29th - Parkersburg - Mountain State Corporate Office
Wednesday, October 13th - Morgantown - Lakeview Resort
Tuesday, October 19th – Holiday Inn Charleston House

Watch for more information regarding the meetings and registration details.
Effective April 1, 2010 – Easier Access to Pre-Certification/Pre-Authorization Information for Out-of-Area Blue Members

We are pleased to announce enhancements to the BlueCard Eligibility® Line. These changes will improve your experience in verifying eligibility and obtaining pre-certification/pre-authorization information for your out-of-area Blue patients. Please note the changes as follows.

If calling 1.800.676-BLUE (2583) to obtain pre-certification/pre-authorization only:

Effective April 1, 2010, when pre-certifications/pre-authorizations for a specific member are handled separately from eligibility verifications, your call will be routed directly to the area that handles pre-certifications/pre-authorizations. You will choose from four options regarding the type of service for which you are calling:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Durable medical equipment (DME)

Upon making your selection, you will be transferred to the appropriate area of the member’s Plan to service your specific request.

If calling 1.800.676-BLUE (2583) to obtain eligibility only or if you need both eligibility and pre-certification/pre-authorization:

Your call will be handled like it is today. You will select the option to obtain eligibility and pre-certification/pre-authorization information. First, your eligibility inquiry will be addressed. Then you will be transferred, as appropriate, to the pre-certification/pre-authorization area.

Important Reminders and Updates

Provider Manual Update
Please note that Chapter 15 of the Mountain State Blue Cross Blue Shield Provider Manual was recently updated. The updates to this chapter which deal with medical record documentation requirements from the Centers for Medicare/Medicaid Services, can be reviewed on our website at www.msbcbs.com.

Update to Claim Denial Process
If you receive a claim denial and additional information is needed to process your claim, please contact our Customer Service Department to receive a reference number. This new process has been implemented to allow our company to assist you in a more timely manner.

Member Identification Cards
Please make sure that upon each visit you are collecting the most current and accurate member identification card and insurance plan information from your patients covered by MSBCBS. We have identified a higher than normal volume of claim returns as a result of insufficient information. Collecting the up-to-date information will allow faster claims processing and payment.
As previously communicated by Special Bulletin and the Provider News, Mountain State has finalized the review of the changes made by the Centers for Medicare and Medicaid Services (CMS) to its 2010 RBRVS schedule. As the result of this review, Mountain State has concluded that adopting the changes would have a negative financial impact to the provider network. Consequently, Mountain State will not adopt the 2010 CMS RVUs for July 1, 2010 and the current Mountain State fee schedule (using CMS 2009 RBRVS) will continue in effect. If CMS did not have established RVUs, Mountain State may use 2008 INGENIX RVUs and the budget neutral factor to establish the allowance.

Mountain State will continue to use the 2009 CMS RBRVS values to include the West Virginia Geographic Practice Cost Index (GPCI) for all professional network providers in West Virginia and bordering counties.

Mountain State would like to provide an example regarding the RBRVS calculation for our commercial business using the CMS WV GPCI related to the RVU work, practice expense and malpractice components. The laboratory fee schedule which uses Ingenix RVUs is not subject to the application of the WV GPCLs.

The GPCI values for West Virginia are:
Work = 1.0
Practice Expense = 0.827
Malpractice = 1.353

The formula for 2009 physician fee schedule payment amount is as follows:
2009 Non-Facility Pricing Amount =
[(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Mountain State Market Factor

2009 Facility Pricing Amount = [(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Mountain State Market Factor

For more questions regarding this notice please contact your External Provider Relations Representative or visit the Mountain State Blue Cross Blue Shield website at www.msbcb.com.

**Code 93613 not subject to multiple surgery reductions**

Beginning Oct. 11, 2010, Mountain State Blue Cross Blue Shield will not apply multiple surgery reductions to code 93613 because it is an add-on code.

**Mountain State Continues to Recognize Consultation Services**

Even though CMS changed its payment guidelines for consultations effective January 1, 2010, Providers should continue to use and Mountain State will continue to process claims reporting consultation codes 99241-99255 for its commercial products. If, after review, Mountain State changes its payment guidelines for codes 99241-99255, those changes will be announced in a future edition of the Provider News.
2010 Lab Fee Schedule Update

Mountain State generally updates its Lab Fee Schedule after September (September 1, 2010). 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.

Reminder for Home Infusion Therapy Providers: Billing Multiple Infusion Therapies

Multiple infusion therapies apply to patients who require multiple concurrent infusion treatments, including, but not limited to, multiple antibiotics, hydration and chemotherapy. Mountain State will not reimburse separately for each therapy. Instead, the provider must bill and will be reimbursed for the most costly per diem that applies, plus the drug(s) administered. When billing for multiple therapies on the same claim, bill only for the most costly procedure. Do not report zero dollar charges for the remaining therapies. The only exception to this is aerosolized AIDS drug therapy. It is the only therapy that must be billed in conjunction with another mode of home IV therapy administration. It is also the only drug therapy that, while provided as part of a multiple-therapy treatment, can be billed as a separate service. Use procedure code S9061 to report aerosolized AIDS drug therapy.

Medmark’s Name to Change Effective 6/1/10

Medmark Inc., a subsidiary of Walgreen Co., will change its name to Walgreens Specialty Pharmacy, LLC, effective June 1, 2010. Medmark Inc. is Mountain State Blue Cross Blue Shield’s exclusive specialty pharmacy vendor, and the company recently notified Mountain State of the upcoming name change. Medmark Inc., which manages Mountain State’s Medical Injectable Drug and Retail Exclusivity Programs, reported that only its name is changing and all operations will be business as usual before and after June 1, 2010.

2010-2011 Seasonal Flu Shot to Include H1N1 Vaccine

In the aftermath of the 2009 H1N1 influenza pandemic — and in the face of potential new outbreaks expected in coming weeks — the Centers for Disease Control and Prevention (CDC) has reported that the 2010-2011 seasonal influenza vaccination will include protection against the H1N1 virus, along with safeguarding Americans against two seasonal flu strains. According to the CDC’s Web site, news of the availability of the trivalent vaccine was announced Feb. 23 at a meeting of the U.S. Food and Drug Administration’s Vaccines and Related Biological Products Advisory Committee (VRBPAC). The CDC notes that “the H1N1 virus recommended for inclusion in the 2010-2011 seasonal influenza vaccine is a pandemic 2009 H1N1 virus and is the same virus used in the 2009 H1N1 monovalent vaccine.”

ACIP Expands Immunization Recommendations for 2010-2011

To provide additional protection against the spread of the H1N1 and seasonal flu viruses, the CDC’s Advisory Committee on Immunization Practices (ACIP) voted Feb. 24 to expand its recommendation for annual influenza vaccination to include all people ages 6 months and older.

For more information, visit www.cdc.gov/media/pressrel/2010/r100224.htm. Also, check www.cdc.gov for H1N1 and seasonal flu updates.
Reminder: Report Address Changes to Mountain State

When you change your address (e.g., mailing, practice location, etc.) with the U.S. Postal Service, please also send a change of address to Mountain State. Due to new postal regulations, now it is more important than ever that Mountain State has correct provider information in its files. To ensure that you receive important notifications about policies, procedures and billing changes, please notify Mountain State of any address changes by composing a letter on the provider’s letterhead with the request.

Please be specific as to the type of address you are changing (e.g., main practice, practice, check or mailing). And, remember to always include your office hours even if they are not changing from the old practice address to the new practice location. This will ensure that Mountain State’s systems and provider directories are up to date. If you have questions about changing your address, please contact your Provider Relations representative.

Reminder: Walgreens (formerly Medmark) Injectable Drug Program Update

The following drugs were added to the mandatory Injectable Drug program effective February 1, 2010:

- Orencia J0129
- H. P. Acthar J0800
- Remicade J1745
- Lupron J1950, J9217
- Omnitrope J2941
- TEV-Tropin J2941
- Zorbtive J2941
- Trelstar Depot J3315
- Cimzia J3590
- Simponi J3590
- Theracy S J9031
- Tice BCG J9031
- Zoladex J9202
- Supprelin J9226

The following drugs were added to the mandatory Injectable Drug program effective June 1, 2010:

- Vivaglobin 90284
- Vantas J9225
- Firmagon J9155
- Extavia J1830

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

- 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
- Ribaspher J3490
- Soliris J1300
- AutoPlex-T
- Hyate C
- Proplex T

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.

Medicare Claims – Crossover Process

How do I submit Medicare primary/Blue Plan secondary claims?

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier. When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member’s ID card for additional verification. The member’s ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to Mountain State Blue Cross Blue Shield.

If the remittance indicates that the claim was not crossed over, submit the claim to Mountain State Blue Cross Blue Shield with the Medicare remittance advice. Electronic submitters should submit the claim electronically using the proper CAS codes.

For claim status inquiries, contact Mountain State Blue Cross Blue Shield. NaviNet enabled providers should check claim status via NaviNet.

What is Medicare crossover consolidation and how does it affect my claim processing?

To simplify and streamline claim submission, the Centers for Medicare and Medicaid Services (CMS) has now consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA). Under this program, the COBC will automatically forward most Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Blue Plans have now implemented the Medicare crossover consolidation process system-wide. You should be experiencing an increased level of “one-stop” billing for your Medicare primary claims.

This change may affect the timing of the secondary payment from the Blue Plan.

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14-30 business days for you to receive payment from the Blue Plan.

What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier, and haven’t received a response to your initial claim submission, don’t automatically submit another claim. Rather, you should:
• Review the automated resubmission cycle on your claim system.
• Wait 30 days.
• Check claims status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Who do I contact if I have questions?

If you have questions, please call Mountain State Blue Cross Blue Shield at 1-888-809-9121. For FEP Medicare claims, please call 1-800-535-5266.
Once again, the Blues On Call provider satisfaction survey is available online. Doctors are invited to complete a brief questionnaire by visiting:

https://www.msbcbs.com/blues_on_call.shtml

At the start of the survey, you will be asked for your name and the name of your practice. This information will only be used by Infogroup, the survey vendor, to make sure a paper survey is not mailed to your office later this fall. Your information will not be seen by Mountain State Blue Cross Blue Shield. All survey results will be seen by Mountain State in aggregate.

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.

We value your feedback and appreciate the time you spend completing the survey.

SMART® Registry release UPDATE for September 2010

The next release of the SMART Registry will be mailed to Mountain State Blue Cross Blue Shield providers in September 2010. The SMART Registry provides information to doctors on their patients with one or more of the chronic conditions managed by the Blues On CallSM Program.

New in 2010!

To protect PHI, all doctors with patients in the Blues On Call Program will now receive the SMART Registry on password protected encrypted CD rather than in binder format. In the past, you may have received a hard copy version of the SMART Registry. This new electronic version includes all of the information found in the print Registry with the added benefit of the filter and sort capabilities of the reports.

The CD includes a read-only PDF file of the entire SMART Registry as well as all supplemental materials; an Excel file of the Group Registry Reports with information that can be sorted and patient address file. The CD also includes reminder template letters directed toward patients with diabetes, asthma, CHD, HF, COPD and hypertension to alert members of a missing test or treatment or the need for an office visit. In addition, BOC has added an influenza vaccination reminder template letter.
SMART® Registry Continued...

If you have any questions about using the SMART Registry CD, please don’t hesitate to call the toll-free Blues On Call Physician Hotline at 1-888-777-9522. A Blues On Call Specialist (BOCs) will be happy to address any questions you may have to make sure you can get the most out of this valuable resource.

A BOC Specialist can work with you and your clinical office staff to sort the SMART Registry CD to provide the most important information for you. BOCs can also meet with you and your staff to review the SMART Registry reports and to help with making referrals to the Blues On Call Program.

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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:

Mountain State Provider News  
Post Office Box 1353  
Charleston, WV 25325  
or call  
Provider Relations  
Toll-Free 1-800-798-7768  
or email  
leah.worley@msbcbs.com

It is the policy of Mountain State Blue Cross Blue Shield to not discriminate against any employee or applicant for employment on the basis of the person's gender, race, color, age, religion, creed, ethnicity, national origin, disability, veteran status, marital status, sexual orientation, or any other category protected by applicable federal, state, or local law. This policy applies to all terms, conditions, and privileges of employment, including recruitment, hiring, training, orientation, placement and employee development, promotion, transfer, compensation, benefits, educational assistance, layoff and recall, social and recreational programs, employee facilities, and termination.

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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 V-2 (Concurrent Care)**
**Concurrent care guidelines changed.**
**Effective: July 1, 2010**

Mountain State Blue Cross Blue Shield defines concurrent care as care provided to an inpatient in a hospital, long-term acute care hospital, rehabilitation hospital, or skilled nursing facility, simultaneously by more than one physician during a specified period of time.

Such care is usually provided when:

- Two or more separate conditions require the services of two or more physicians.
- The severity of a single condition requires the services of two or more physicians for proper management of the patient.

The necessity of each physician’s particular skills is determined by considering the respective specialties and the diagnosis for which services were provided. If Mountain State Blue Cross Blue Shield requires additional information to establish medical necessity, hospital records may be requested for review.

These records should:

- Document the attending or ordering professional provider’s request for the consultant to see the patient, and
- Include sufficient documentation to indicate the medical necessity for each doctor’s professional services.

Concurrent care that does not meet Mountain State Blue Cross Blue Shield’s medical necessity criteria is not eligible for payment. 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.

**Payment guidelines for concurrent care**

- The admitting physician should be primarily responsible for and paid for medical care unless the patient is transferred to the consultant or specialist.
- Mountain State Blue Cross Blue Shield may pay for concurrent care by physicians of different specialties.
- Mountain State Blue Cross Blue Shield may not pay for concurrent care by physicians of the same specialty (unless supported by medical record documentation).
- When two or more physicians of the same specialty submit claims for concurrent care, Mountain State Blue Cross Blue Shield will evaluate each claim based on the conditions that each physician was treating:

  For example:

  - A cardiologist and a general practitioner are treating a patient who has multiple conditions. Mountain State Blue Cross Blue Shield will
pay for concurrent medical care if the physicians are treating different conditions.

- Two cardiologists are treating a patient for the same condition, for example, myocardial infarction. Mountain State Blue Cross Blue Shield will not pay for concurrent care (unless supported by medical record documentation).

- Two cardiologists are treating a patient with multiple conditions, for example, the invasive cardiologist is treating the patient for their coronary artery disease and the electrophysiologist or cardiologist is treating the patient for an arrhythmia. Mountain State Blue Cross Blue Shield will pay for the concurrent care; however, it may request medical record documentation to support the medical necessity of the concurrent care.

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

**Astigmatism-correcting intraocular lens not covered.**

**Effective: August 2, 2010**

Mountain State Blue Cross Blue Shield does not consider an astigmatism-correcting intraocular lens (IOL), procedure code V2787—astigmatism correcting function of intraocular lens—, an eligible prosthetic device, since its purpose is to compensate for the imperfect curvature of the cornea.

If a member chooses to have an astigmatism-correcting IOL inserted after cataract surgery, Mountain State Blue Cross Blue Shield will deny the lens as non-covered. However, Mountain State Blue Cross Blue Shield will pay for the surgical procedure.

Mountain State Blue Cross Blue Shield will also deny any additional pre- and post-operative services beyond those typically provided in conjunction with a cataract extraction with insertion of a standard IOL as non-covered.

If you insert an astigmatism-correcting IOL in your office, you may bill code L8699 for the astigmatism-correcting IOL along with V2787 for the astigmatism-correcting function of the IOL.

Before the surgery, you must obtain a signed agreement from the patient. This agreement must specifically inform the patient that he or she is responsible for the entire cost of the astigmatism-correcting IOL and any additional pre- and post operative services beyond those typically provided in conjunction with a cataract extraction with insertion of a standard IOL. This documentation must be retained in the patient’s medical record and must be available upon request.

If you are a participating, preferred, or network provider and you do not get a signed agreement from the patient before surgery, you are responsible for the cost of the lens and any additional pre- and post operative services beyond those typically provided in conjunction with a cataract extraction with insertion of a standard IOL.

When the astigmatism-correcting IOL lens is inserted solely to compensate for the imperfect curvature of the cornea, that is, not for cataract surgery, Mountain State Blue Cross Blue Shield will deny the lens, the surgical procedure, and all pre- and post operative care as non-covered. A participating, preferred, or network provider may bill the member for the denied services.

**Medical Policy Bulletin R-60 (Image-Guided Target Localization and Image-Guided Radiation Therapy for Treatment Delivery)**

**Coverage expanded for intra-fraction target tracking during radiation therapy.**

**Effective: May 24, 2010**

Mountain State Blue Cross Blue Shield has expanded coverage for intra-fraction target tracking during radiation therapy. This procedure is now eligible for treating tumors of the prostate, esophagus, lung, liver, pancreas, and lymphomas of the thorax and abdomen. Tumors located in these anatomic areas are most susceptible to respiratory or internal organ motion.
Mountain State Blue Cross Blue Shield will deny intra-fraction target tracking as experimental or investigational when it’s used to treat tumors located at other anatomic sites. Recently published clinical literature does not document the effect of intra-fraction target tracking during radiation therapy on health outcomes, long-term results, and/or morbidities for other anatomic areas. A participating, preferred, or network provider may bill the member for the denied intra-fraction target tracking.

Often, the tumor target is a mobile soft tissue mass within the body. Patient repositioning based on bony landmarks alone can be subject to error. The size of a tumor or target volume can also vary daily because of an error in the patient setup, the internal motion of the tumor target or surrounding tissues, or a change in the tumor size.

Intra-fraction target tracking can be used to compensate for tumor target changes during the actual radiation treatment session. It is typically used in patients with tumors located near or within critical structures and/or in tissue that are significantly influenced by motion, such as lung or liver tumors. There are various methods for detecting inherent organ motion, including, but not limited to, breathing movement or respiratory gating, tumor tracking, organ motion dampening, or patient-directed methods, for example, active breath holding.

Examples of FDA-approved technology used to perform this procedure include, but are not limited to, the Calypso 4D Localization System, the ExacTrac Patient Positioning System, and the Instatrack System.

Use code 0197T—intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy, (e.g., 3D positional tracking, gating, 3D surface tracking, each fraction of treatment)—to report intra-fraction target tracking.

Medical Policy Bulletin Y-1 (Physical Medicine)
Two Constant attendance modalities performed at same time not paid
Effective: October 11, 2010

Effective Oct. 11, 2010, Mountain State Blue Cross Blue Shield will not pay separately for two constant-attendance physical therapy modalities performed at the same time, using one device.

When this occurs, report the code that represents the primary therapy. For instance, when electrical stimulation and ultrasound are performed together using a device such as the Sonicator, report the ultrasound code. It is not appropriate to report both modalities for the same 15-minute period of time.

Medical Policy Bulletin Z-24 (Miscellaneous Services)
Outpatient intravenous insulin treatment not covered.
Effective: April 5, 2010

As of April 5, 2010, Mountain State Blue Cross Blue Shield considers procedure code G9147—Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration—experimental or investigational. A participating, preferred, or network provider may bill the member for the non-covered OIVIT.

The term OIVIT refers to an outpatient regimen that integrates pulsatile or continuous intravenous infusion of insulin through any means guided by the results of measuring:

- respiratory quotient, and/or
- urine urea nitrogen (UUN), and/or
- arterial, venous, or capillary glucose, and/or
- potassium concentration

The disease management regimen must be performed in scheduled recurring periodic intermittent episodes.

Most commonly delivered in pulses (but sometimes as a more conventional drip solution), the insulin administration is an adjunct to the patient’s routine oral agent or insulin-based diabetic (or other disease) management regimen, typically performed on an intermittent basis (often weekly), and frequently performed chronically without duration limits.
OIVIT is also sometimes called Cellular Activation Therapy (CAT), Chronic Intermittent Intravenous Insulin Therapy (CIIT), Hepatic Activation Therapy (HAT), Intercellular Activation Therapy (iCAT), Metabolic Activation Therapy (MAT), Pulsatile Intravenous Insulin Treatment (PIVIT), Pulse Insulin Therapy (PIT), and Pulsatile Therapy (PT).

Report code G9147 on claims that you submit for non-covered OIVIT and any services compromising an OIVIT regimen.

Medical Policy Bulletin O-28 (Knee Orthosis)
More criteria added to knee orthosis coverage guidelines.
Effective: October 11, 2010

Mountain State Blue Cross Blue Shield is adding additional coverage criteria to its knee orthosis medical policy, O-28. These new requirements will take effect on Oct. 11, 2010.

A knee flexion contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 0 degrees extension or greater, that is, hyperextension, by passive range of motion. Zero degrees knee extension is when the femur and tibia are in alignment in a horizontal plane.

A knee extension contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 80 degrees flexion or greater by passive range of motion. A contracture is distinguished from the temporary loss of range of motion of a joint following injury, surgery, casting, or other immobilization.

Mountain State Blue Cross Blue Shield covers a knee orthosis with joints (procedure code L1810) or knee orthosis with condylar pads and joints with or without patellar control (procedure code L1820) for ambulatory patients who have weakness or deformity of the knee and require stabilization. If a knee orthosis with joints or a knee orthosis with condylar pads and joints with or without patellar control is provided for any other conditions, Mountain State Blue Cross Blue Shield will deny the knee orthosis as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied orthosis unless he or she has given advance written notice, informing the member that the orthosis 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 orthosis. The signed agreement should be maintained in the provider’s records.

Mountain State Blue Cross Blue Shield will cover a knee immobilizer without joints (procedure code L1830) or a knee orthosis with adjustable knee joints (procedure code L1832) if the patient has had recent injury to or a surgical procedure on the knee(s) and has one of these diagnoses:

- rheumatoid arthritis
- osteoarthritis
- meniscal cartilage derangement
- chondromalacia of patella
- knee ligamentous disruption
- rupture of tendon, nontraumatic - quadriceps tendon
- pathologic fracture of femur
- pathologic fracture of tibia or fibula
- aseptic necrosis of tibia or fibula
- stress fracture of tibia or fibula
- congenital deformity of knee
- fracture of femur - lower end
- fracture of patella
- fracture of tibia and/or fibula - upper end
- dislocation of knee
- sprains and strains of knee
- failed total knee arthroplasty

An L1832 knee orthosis is also covered for a patient who is ambulatory and has knee instability due to a condition specified by one of these diagnoses:
• rheumatoid arthritis
• osteoarthritis
• meniscal cartilage derangement
• chondromalacia of patella
• knee ligamentous disruption
• rupture of tendon, nontraumatic - quadriceps tendon
• pathologic fracture of femur
• pathologic fracture of tibia or fibula
• aseptic necrosis of tibia or fibula
• stress fracture of tibia or fibula
• congenital deformity of knee
• fracture of femur - lower end
• fracture of patella
• fracture of tibia and/or fibula - upper end
• dislocation of knee
• sprains and strains of knee
• failed total knee arthroplasty
• multiple sclerosis
• hemiplegia, unspecified
• infantile cerebral palsy, unspecified
• paraplegia of both lower limbs
• mononeuritis of lower limb, unspecified

A knee orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control (procedure codes L1843, L1845), is covered for a patient who is ambulatory and has knee instability due to a condition specified by one of the diagnoses listed for L1832.

Mountain State Blue Cross Blue Shield covers a knee orthosis, Swedish type, prefabricated (procedure code L1850) for a patient who is ambulatory and has knee instability due to genu recurvatum - hyperextended knee.

If you provide an L1832, L1843, L1845, or L1850 orthosis, please indicate in the patient's medical record that knee instability was documented by examination of the member and an objective description of joint laxity, for example, varus or valgus instability.

Mountain State Blue Cross Blue Shield will deny claims for L1832, L1843, L1845, or L1850 as not medically necessary when the patient does not meet the specific criteria listed, for example, if only pain or a subjective description of joint instability is documented.

A custom fabricated knee immobilizer without joints (L1834) is covered if both criteria 1 and 2 are met:

1. The coverage criteria for the prefabricated orthosis code L1830 are met (the patient has had a recent injury to or has had a surgical procedure on the knee(s), and they have a diagnosis listed; and

2. The general criterion for a custom fabricated orthosis is met.

If an L1834 orthosis is provided and both criteria 1 and 2 are not met, Mountain State Blue Cross Blue Shield will deny the orthosis as not medically necessary.

If an L1834 orthosis is provided and criterion 1 is met but criterion 2 is not, Mountain State Blue Cross Blue Shield will base its payment on the allowance for the least costly medically appropriate alternative, L1830.

A custom fabricated knee orthosis with an adjustable flexion and extension joint (L1844, L1846) is covered if both criteria 1 and 2 are met:

1. The coverage criteria for the prefabricated orthosis codes L1843 and L1845 are met (the patient is ambulatory and has knee instability because of a condition specified by one of the diagnoses listed; and
2. The general criterion for a custom fabricated orthosis is met.

If an L1844 or L1846 orthosis is provided and both criteria 1 and 2 are not met, Mountain State Blue Cross Blue Shield will deny the orthosis as not medically necessary.

If an L1844 or L1846 orthosis is provided and criterion 1 is met but criterion 2 is not, Mountain State Blue Cross Blue Shield will base its payment on the allowance for the least costly medically appropriate alternative, L1843 or L1845, respectively.

As of Jan. 1, 2010, elastic support garments do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices. Please use code A4466 to report devices that are not rigid or semi-rigid. Mountain State Blue Cross Blue Shield will deny code A4466 as a non-covered device. A participating, preferred, or network provider may bill the member for the noncovered elastic support garments.

Services that do not meet Mountain State Blue Cross Blue Shield’s medical necessity 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.


Autonomic nervous system function testing coverage criteria outlined.

Effective: October 11, 2010

Mountain State Blue Cross Blue Shield considers autonomic nervous system (ANS) function testing eligible to be performed one time to diagnose specific autonomic neuropathy or disease and to determine its degree of progression.

For patients with diagnosed autonomic disorders, the eligibility of repeated testing is governed by a change in clinical status or response to a therapeutic intervention. Mountain State Blue Cross Blue Shield will consider monitoring of disease progression with ANS function testing for coverage only when there has been a change in clinical status, or for evaluation of a patient’s response to directed treatment of a specific autonomic disorder.

Mountain State Blue Cross Blue Shield covers ANS function testing when it’s performed in an academic testing center or an accredited autonomic testing laboratory and when it’s used to:

- Diagnose the presence of progressive autonomic neuropathy and determine its severity and distribution.
- Diagnose suspected axonal neuropathy in symptomatic patients.
- Differentiate between benign and life-threatening autonomic disorders, for example, chronic idiopathic anhidrosis vs. adrenergic and cardiovagal failure, or syncope vs. peripheral autonomic failure.
- Diagnose distal small fiber neuropathy.
- Perform postural evaluation of tachycardia syndrome.
- Diagnose sympathetically maintained pain, for example, reflex sympathetic dystrophy, or causalgia.
- Monitor the course or progression of diagnosed autonomic failure. ANS testing is indicated initially to diagnose autonomic failure. Monitoring may be indicated when the autonomic deficits change in type, distribution, or severity.
- Evaluate the response of diagnosed autonomic failure to treatment, and determine whether the autonomic deficits have lessened in response to treatment.
- Aid in the evaluation of the differential diagnosis of recurrent syncope that poses a management problem or requires a tilt study and autonomic screening to evaluate the response to treatment.
Mountain State Blue Cross Blue Shield considers ANS not medically necessary:

- To screen patients without signs or symptoms of autonomic dysfunction, or to test for the sole purpose of monitoring disease intensity or treatment efficacy, that is, diabetes, renal disease.

- When performed in a physician’s office using noninvasive digital autonomic nervous system testing devices, for example, ANSAR ANX 3.0.

- For routine monitoring of the course or progression of diagnosed autonomic failure where there are no changes in type, distribution, or severity of deficits.

- Unless the results of the ANS function testing are to be used in clinical decision making and patient management.

If the ANS function testing does not meet the coverage 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 service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing a cost estimate. 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.

To report ANS function testing, please use procedure codes 95921, 95922, and/or 95923, as appropriate.

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**Medical Policy Bulletin O-24 (Ankle-Foot/Knee-Ankle-Foot Orthosis)**

*New ankle-foot or knee-ankle-foot orthosis policy Effective: October 11, 2010*

Mountain State Blue Cross Blue Shield’s new medical policy for ankle-foot or knee-ankle-foot orthosis, O-24, will become effective on Oct. 11, 2010.

**Ankle-foot orthoses not used during ambulation**

Mountain State Blue Cross Blue Shield will cover a static ankle-foot orthosis (procedure code L4396) if either all of criteria 1-4 or criterion 5 is met:

1. Plantar flexion contracture of the ankle (ICD-9-CM diagnosis code 718.47) with dorsiflexion on passive range of motion testing of at least 10 degrees, that is, a nonfixed contracture, and

2. Reasonable expectation of the ability to correct the contracture, and

3. Contracture is interfering or expected to interfere significantly with the patient’s functional abilities, and

4. The orthosis is used as a component of a therapy program that includes active stretching of the involved muscles and/or tendons.

The pneumococcal 7-valent conjugate vaccine licensed by the FDA in 2000 to prevent invasive pneumococcal disease and otitis media. The new vaccine extends the protection to six additional types of the disease causing bacteria.

The vaccine is administered in a four-dose schedule given at 2, 4, 6, and 12-15 months of age. The vaccine is available in single-dose, pre-filled syringes.

Mountain State Blue Cross Blue Shield will determine coverage for Prevnar 13 according to the member’s contract. Report Prevnar-13 vaccine with procedure code 90670—pneumococcal conjugate vaccine, 13 valent, for intramuscular use. Coverage will be based on the member’s benefit.

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**Medical Policy Bulletin I-8 (Immunizations)**

*FDA approves Prevnar 13; coverage based on member’s contract. Effective: February 24, 2010*

The U.S. Food and Drug Administration (FDA) approved Prevnar 13, a pneumococcal 13-valent conjugate vaccine for infants and children ages 6 weeks through 5 years, on Feb. 24, 2010.

Prevnar 13 will be the successor to Prevnar, the pneumococcal 7-valent conjugate vaccine licensed by the FDA in 2000 to prevent invasive pneumococcal disease and otitis media. The new vaccine extends the protection to six additional types of the disease causing bacteria.

The vaccine is administered in a four-dose schedule given at 2, 4, 6, and 12-15 months of age. The vaccine is available in single-dose, pre-filled syringes.
5. The patient has plantar fasciitis (ICD-9-CM diagnosis code 728.71).

If a static ankle-foot orthosis is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer. Those results must be documented in the patient’s medical record. There must also be documentation of an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home).

If the static ankle-foot orthosis is covered, Mountain State Blue Cross Blue Shield will cover a replacement interface (procedure code L4392) as long as the patient continues to meet Mountain State Blue Cross Blue Shield’s indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one per six months. Mountain State Blue Cross Blue Shield will deny additional interfaces as not medically necessary.

Ankle-foot orthoses and knee-ankle-foot orthoses used during ambulation

Mountain State Blue Cross Blue Shield covers ankle-foot orthoses, described by codes L1900, L1902-L1990, L2106-L2116, L4350, L4360, and L4386, for ambulatory patients with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally.

Mountain State Blue Cross Blue Shield covers knee-ankle-foot orthoses, described by codes L2000-L2038, L2126-L2136, and L4370, for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

Ankle-foot orthoses and knee-ankle-foot orthoses that are molded-to-patient-model, or custom-fabricated, are covered for ambulatory patients when the basic coverage criteria previously listed as 1-5 and one of the following criteria are met:

- The patient could not be fitted with a prefabricated ankle-foot orthosis.
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than six months).
- There is a need to control the knee, ankle, or foot in more than one plane.
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury.
- The patient has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

If the specific criteria for a molded-to-patient-model or custom-fabricated orthosis are not met, but the criteria for a prefabricated, custom fitted orthosis are met, Mountain State Blue Cross Blue Shield will base its payment on the allowance for the least costly medically appropriate alternative.

Mountain State Blue Cross Blue Shield covers the replacement of a complete orthosis or component of an orthosis due to loss, significant change in the patient’s condition, or irreparable accidental damage if the device is still medically necessary. The reason for the replacement must be documented in the supplier’s record.

Please refer to Mountain State Medical Policy E-15, Diabetic Services and Supplies, for more information about diabetic orthosis.

Reasons for noncoverage

Mountain State Blue Cross Blue Shield will deny as not medically necessary:

- A static ankle-foot orthosis and replacement interface if the contracture is fixed.
- A static ankle-foot orthosis and replacement interface for a patient with a foot drop but without an ankle flexion contracture.
- A component of a static ankle-foot orthotic that is used to address positioning of the knee or hip because the effectiveness of this type of component is not established.

Mountain State Blue Cross Blue Shield does not cover a static ankle-foot orthosis and replacement interface (procedure code L4392) when it is used solely for the prevention or treatment of a heel pressure ulcer because for these indications it is not
used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body, that is, does not meet Mountain State Blue Cross Blue Shield’s definition of a brace. A participating, preferred or network provider may bill the member for the non-covered orthosis.

A foot drop splint or recumbent positioning device (procedure code L4398) or replacement interface (procedure code L4394) is not reimbursable. Mountain State Blue Cross Blue Shield will deny a foot drop splint or recumbent positioning device and replacement interface as not medically necessary for a patient with foot drop who is nonambulatory because there are other more appropriate treatment modalities.

Mountain State Blue Cross Blue Shield does not cover a foot drop splint or recumbent positioning device (procedure code L4398) and replacement interface (procedure code L4394) when it is used solely for the prevention or treatment of a pressure ulcer because for these indications it is not used to support a weak or deformed body member, or to restrict or eliminate motion in a diseased or injured part of the body, that is, it does not meet Mountain State Blue Cross Blue Shield’s definition of a brace. A participating, preferred or network provider may bill the member for the non-covered device.

If the basic coverage criteria for an ankle-foot orthosis or knee-ankle-foot orthosis are not met, Mountain State Blue Cross Blue Shield will deny the orthosis as not medically necessary.

Mountain State Blue Cross Blue Shield will deny additions to ankle-foot orthoses and knee-ankle-foot orthoses (procedure codes L2180-L2550, L2750-L2768, L2780-L2830) as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

If the patient’s medical record does not include an explanation of the medical necessity of excess quantities of supplies (those greater than a replacement interface limited to a maximum of one per six months), Mountain State Blue Cross Blue Shield will deny the excess quantities as not medically necessary.

For Mountain State Blue Cross Blue Shield to consider an item for coverage under the brace benefit category, it must be a rigid or semi-rigid device, which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It must provide support and counterforce, that is, a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support, on the limb or body part that it is being used to brace. Mountain State Blue Cross Blue Shield does not cover items that do not meet its definition of a brace. A participating, preferred or network provider may bill the member for the non-covered device.

When products are used solely to treat edema or ulcers or to prevent an ulcer of the lower extremity, code them based on the patient’s condition. For example, when walking boots are used as a brace for the treatment of orthopedic conditions, report them with codes L4360 and L4386. However, if walking boots are used only for the prevention or treatment of a lower extremity ulcer or edema reduction, report them with code A9283—foot pressure off loading/supportive device, any type, each.

When you use code A9283, you cannot bill separately by using the additions to the orthotics codes. Report code A9270—non-covered item or service—for replacement liners for devices billed with A9283. A participating, preferred or network provider may bill the member for the non-covered device.

Elastic support garments do not meet Mountain State Blue Cross Blue Shield’s statutory definition of a brace because they are not rigid or semi-rigid devices; therefore, Mountain State Blue Cross Blue Shield will deny code A4466 as not covered. A participating, preferred or network provider may bill the member for the non-covered non-covered elastic support garments.

Mountain State Blue Cross Blue Shield does not cover foot pressure off-loading or supportive device (procedure code A9283) because there is no benefit category for these items. A participating, preferred or network provider may bill the member for the non-covered device.

Continued On Next Page
Socks (procedure codes L2840, L2850) used in conjunction with orthoses are not covered. A participating, preferred or network provider may bill the member for the non-covered socks.

Mountain State Blue Cross Blue Shield does not cover replacement components, for example, soft interfaces, (procedure codes L4392, L4394), that are provided on a routine basis, without regard to whether the original item is worn out. A participating, preferred or network provider may bill the member for the non-covered replacement components.

Services that do not meet Mountain State Blue Cross Blue Shield's medical necessity 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.

**Medical Policy Bulletin B-54 (Orthotics)**
*This medical policy will be archived with the implementation of medical policy O-24.*
**Effective: October 11, 2010**

Due to the October 11, 2010 implementation of new medical policy O-24, medical policy B-54 will be archived on that same date. At that time, please see new medical policy O-24 for services addressed in B-54.

**Medical Policy Bulletin M-18 (Diagnostic Electrical Stimulation (EES) vs. Ablation Procedures)**
*How to report operative ablation, including the MAZE procedure.*
**Effective: October 11, 2010**

Operative ablation is an eligible surgical service that may be used to eliminate arterioventricular conduction defects (ICD-9-CM diagnosis codes 426.0, 426.10-426.13).

Use code 33250, 33251, or 33261 to report operative ablation.

The MAZE procedure is also eligible for reimbursement when it’s used to block reentrant impulses that are responsible for atrial fibrillation or flutter (ICD-9-CM diagnosis codes 427.31, 427.32).

Use code 33254, 33255, 33256, 33257, 33258, or 33259 to report the MAZE procedure.

When you perform the endoscopic approach for the MAZE procedure, report it with code 33265 or 33266.

Mountain State Blue Cross Blue Shield will determine eligibility of the MAZE procedure on an individual consideration basis. Medical records must indicate that the patient did not respond to other medical treatments or those treatments were contraindicated.

If operative ablation, including the MAZE procedure, does not meet Mountain State Blue Cross Blue Shield's medical necessity guidelines it 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.

For additional information on operative ablation, see Mountain State Medical Policy M-18, Diagnostic Endocardial Electrical Stimulation (EES) vs. Ablation Procedures.

**Medical Policy Bulletin Y-21 (Cognitive Rehabilitation)**
*Cognitive rehabilitation must meet specific criteria.*
**Effective: October 11, 2010**

Effective Oct. 11, 2010, Mountain State Blue Cross Blue Shield considers cognitive rehabilitation medically necessary for the rehabilitation of traumatic and acquired brain injury caused by brain hemorrhage, cerebral thrombosis, concussion, fractured skull, encephalopathy, and anoxic brain damage.

*Continued On Next Page*
Cognitive rehabilitation services must also meet all of these criteria:

- The services must be ordered by the attending physician and be part of a written plan of care.

- The service is so complex that it can only be performed by a qualified licensed professional.

- The patient is capable of actively participating in the program and capable, by mental status, of demonstrating responsiveness to verbal or visual stimuli and be able to follow commands and process and retain information.

- The individual’s mental and physical condition before the injury indicates there is significant potential for improvement, for example, a complete recovery of pre-injury memory, language or reasoning skills is not required, but there must be a reasonable expectation of improvement that is of practical value to the individual, measured against the individual’s condition at the start of the rehabilitation program, and the individual must have no lasting or major treatment impediment that prevents progress, such as severe dementia.

- The patient is expected to show measurable functional improvement within a predetermined timeframe (depending on the underlying diagnosis or medical condition) from the start of cognitive rehabilitation therapy. Goals and expected timeframes should be addressed before the onset of treatment.

- The attending physician should review the treatment plan periodically to assess the continued need for participation and document objective evidence of the patient’s progress.

- Neuropsychological testing has been performed and neuropsychological results will be used in treatment planning and redirecting rehabilitation strategies.

If cognitive rehabilitation services do not meet these criteria, Mountain State Blue Cross Blue Shield will consider them experimental or investigational. A participating, preferred, or network provider may bill the member for the denied cognitive rehabilitation service.

**Medical Policy Bulletin O-31 (Myoelectric Prosthesis for the Upper Limb and i-Limb Hand Prosthesis)**

**Myoelectric prosthesis for the hand and upper limb covered for certain conditions.**

**Effective: June 28, 2010**

Mountain State Blue Cross Blue Shield may consider myoelectric upper arm prosthetic components and myoelectric hand prostheses medically necessary when all of the following conditions are met:

- The patient has an amputation or missing limb at the wrist or above (forearm, elbow, etc.), and

- Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the individual in performing activities of daily living, and

- Evaluation indicates that a myoelectric prosthesis meets the functional needs of the individual in performing activities of daily living and that the patient has demonstrated sufficient physiological and cognitive function to allow effective operation of a myoelectric prosthetic device, and

- The patient must be able to tolerate the weight of the upper extremity myoelectric prosthesis, and

- The patient retains sufficient microvolt threshold in the residual limb to allow proper function of the prosthesis, and

- The member does not function in an environment that would inhibit function of the prosthesis, that is, a wet environment or a situation involving electrical discharges that would affect the prosthesis, and
• The patient is free of comorbidities (neuromuscular disease, etc.) that could interfere with the function of the prosthesis.

Because of expected normal growth and development, pediatric upper extremity amputees typically require upper extremity prosthesis replacement or refitting at 18 month intervals.

This is not the first type of prosthesis that the upper extremity amputee should be prescribed after upper extremity amputation. A minimum of a six month period of successful daily use and compliance with conventional upper extremity prosthesis is required before consideration of a myoelectric upper extremity prosthesis.

Mountain State Blue Cross Blue Shield will pay for the myoelectric upper limb prosthesis only if there is sufficient documentation in the patient’s medical record showing functional need for it. This information must be retained in the physician’s or prosthetist’s files, and must be available upon request.

Mountain State Blue Cross Blue Shield considers myoelectric prostheses and myoelectric hand prostheses contraindicated in these cases, and will deny them as not medically necessary:

• Patients that routinely lift heavy items.

• Patients that have environmental exposure to dirt, dust, grease, water, and solvents.

• Patients with upper extremity residual limb neuromas or phantom pain exacerbated by upper extremity prosthesis use.

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 prosthesis 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 covers polishing and resurfacing (code V2624) of an eye prosthesis twice per year.

Mountain State Blue Cross Blue Shield pays for one enlargement (code V2625) or reduction (code V2626) of the eye prosthesis. Additional enlargements or reductions are rarely medically necessary—Mountain State Blue Cross Blue Shield covers these services only when information in the medical record supports the medical necessity. The documentation must be available upon request.

Mountain State Blue Cross Blue Shield’s replacement of an ocular prosthesis is governed by Medicare’s five year reasonable useful lifetime rule. Mountain State Blue Cross Blue Shield will pay for the replacement of a prosthesis or prosthetic component before five years if the prosthesis is irreparably damaged, lost, or stolen.
Replacement of an ocular prosthesis because of loss or irreparable damage may be reimbursed without a physician’s order when Mountain State Blue Cross Blue Shield determines that the prosthesis as originally ordered still fills the patient’s medical needs.

Mountain State Blue Cross Blue Shield does not pay separately for trial scleral cover shells—they are included in the allowance for scleral cover shells, V2627.

You must include the RT and LT modifiers when you report procedure codes L9900, V2623, V2624, V2625, V2626, V2627, V2628, and V2629. When you provide bilateral ocular prostheses and you use the same code for the two prostheses, report both on the same line on the claim with the RT and LT modifier and indicate two units of service.

Medical Policy Bulletin M-7 (Electronystagmography (ENG) and Videonystagmography (VNG) Services)
Report one code (92540) for basic vestibular function test.
Effective: October 11, 2010

Procedure code 92540, basic vestibular evaluation, now includes the spontaneous nystagmus test, with gaze and fixation nystagmus, with recording (92541), the positional nystagmus test, minimum of four positions, with recording (92542), the optokinetic nystagmus test, bidirectional, foveal and peripheral stimulation, with recording (92544), and the oscillating tracking test, with recording (92545). Therefore, when you perform a basic vestibular evaluation, report only code 92540.

If code 92540 is reported with procedure code 92541, 92542, 92544, or 92545, Mountain State Blue Cross Blue Shield will pay for just code 92540.

Medical Policy Bulletin D-6 (Dental Services)
Dental extractions may be considered medically necessary when performed in places of service other than office
Effective: October 11, 2010

In most situations, dental extractions, for example, wisdom teeth, can be safely performed in an office setting. However, there may be rare circumstances where the procedure needs to be performed in an ambulatory surgery center or a hospital outpatient setting. In those instances, when there are oral surgery benefits under the member’s benefit plan, Mountain State Blue Cross Blue Shield may consider dental extractions medically necessary when they are performed in a hospital outpatient or ambulatory surgery facility.

For Mountain State Blue Cross Blue Shield to consider coverage for dental extractions in a hospital outpatient or an ambulatory surgery facility, the requesting physician or the patient’s primary care physician must have documentation in the patient’s medical record that supports the necessity of performing such extractions in these settings. The physician must provide substantiating documentation of such necessity as follows:

- Individuals with significant cognitive impairment or significant emotional conditions who have difficulty understanding what is expected in a dental treatment situation and have difficulty cooperating or following instruction. These individuals may require sedation and a higher level of monitoring.

- Individuals with complex medical problems under current medical management that increases the probability of complications (such as, but not limited to, severe hypertension and cardiac or respiratory disease) who require intra- and peri-operative monitoring.

Medical Policy Bulletin B-37 (Outpatient Settings for Dental Procedures)
This medical policy will be archived with the implementation of revised medical policy D-6.
Effective: October 11, 2010

Due to the October 11, 2010 implementation of the revised medical policy D-6, medical policy B-37 will be archived on that same date. At that time, please see revised medical policy D-6 for services addressed in B-37.

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HHIC Medical Policy Bulletin S-170
(Infrared Coagulation of Hemorrhoids)
Coverage Guidelines on Infrared Coagulation of Hemorrhoids
Effective: October 11, 2010

Effective October 11, 2010, Medicare Advantage considers infrared coagulation (IRC) medically necessary as an outpatient or office procedure only when used for treating symptomatic Grade I and Grade II internal hemorrhoids (455.2) that do not respond adequately to conservative treatment. Services that do not meet the medical necessity criteria 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.

Use procedure code 46930 - destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency) to report this service.

Do not append CPT Modifier 58 to procedure code 46930 to describe IRC services.

An accepted practice is to treat one quadrant per session, but only one service is reimbursed per 90-day global period, regardless of the number of treatment sessions. When multiple IRC fails to adequately manage the problem, another method of treatment with proven high success rates such as rubber band ligation or injection sclerotherapy is appropriate.

Hemorrhoids are symptomatic abnormalities of the fibrovascular cushions within the anal canal. The three cardinal locations for these cushions are left lateral, right antero-lateral, and right postero-lateral quadrants. Symptoms include pain, bleeding, and prolapse. Internal hemorrhoids are located above the dentate line, while external hemorrhoids are located below it. Internal hemorrhoids are graded according to these symptoms:

- Grade I - Prominent hemorrhoids without prolapse
- Grade II - Prolapse with Valsalva that is spontaneously reduced
- Grade III - Prolapse with Valsalva requiring manual reduction
- Grade IV - Chronic prolapse with ineffective manual reduction

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More criteria added to Medicare Advantage knee orthosis coverage guidelines

Effective: January 1, 2010

HHIC is adding additional coverage criteria to its knee orthosis medical policy, O-28, for its Medicare Advantage products. These new requirements took effect on January 1, 2010.

A knee flexion contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 0 degrees extension or greater, that is, hyperextension, by passive range of motion. Zero degrees knee extension is when the femur and tibia are in alignment in a horizontal plane.

A knee extension contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 80 degrees flexion or greater by passive range of motion. A contracture is distinguished from the temporary loss of range of motion of a joint following injury, surgery, casting, or other immobilization.

HHIC covers a knee orthosis with joints (procedure code L1810) or knee orthosis with condylar pads and joints with or without patellar control (procedure code L1820) for ambulatory patients who have weakness or deformity of the knee and require stabilization. If a knee orthosis with joints or a knee orthosis with condylar pads and joints with or without patellar control is provided for any other conditions, HHIC will deny the knee orthosis as not medically necessary. A provider may not bill the member for the denied orthosis unless he or she has given advance written notice, informing the member that the orthosis 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 orthosis. The signed agreement, in the form of a Pre-Service Denial Notice, should be maintained in the provider’s records.

HHIC will cover a knee immobilizer without joints (procedure code L1830) or a knee orthosis with adjustable knee joints (procedure code L1832) if the patient has had recent injury to or a surgical procedure on the knee(s) and has one of these diagnoses:

- rheumatoid arthritis
- osteoarthritis
- meniscal cartilage derangement
- chondromalacia of patella
- knee ligamentous disruption
- rupture of tendon, nontraumatic - quadriceps tendon
- pathologic fracture of femur
- pathologic fracture of tibia or fibula
- aseptic necrosis of tibia or fibula
- stress fracture of tibia or fibula
- congenital deformity of knee
- fracture of femur - lower end
- fracture of patella
- fracture of tibia and/or fibula - upper end
- dislocation of knee
- sprains and strains of knee
- failed total knee arthroplasty
- multiple sclerosis
- hemiplegia, unspecified
- infantile cerebral palsy, unspecified
- paraplegia of both lower limbs
- mononeuritis of lower limb, unspecified

An L1832 knee orthosis is also covered for a patient who is ambulatory and has knee instability due to a condition specified by one of these diagnoses:

- rheumatoid arthritis
- osteoarthritis
- meniscal cartilage derangement
- chondromalacia of patella
- knee ligamentous disruption
- rupture of tendon, nontraumatic - quadriceps tendon
- pathologic fracture of femur
- pathologic fracture of tibia or fibula
- aseptic necrosis of tibia or fibula
- stress fracture of tibia or fibula
- congenital deformity of knee
- fracture of femur - lower end
- fracture of patella
- fracture of tibia and/or fibula - upper end
- dislocation of knee
- sprains and strains of knee
- failed total knee arthroplasty
- multiple sclerosis
- hemiplegia, unspecified
- infantile cerebral palsy, unspecified
- paraplegia of both lower limbs
- mononeuritis of lower limb, unspecified

A knee orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control (procedure codes L1843, L1845),
is covered for a patient who is ambulatory and has knee instability due to a condition specified by one of the diagnoses listed for L1832.

HHIC covers a knee orthosis, Swedish type, prefabricated (procedure code L1850) for a patient who is ambulatory and has knee instability due to genu recurvatum - hyperextended knee.

If you provide an L1832, L1843, L1845, or L1850 orthosis, please indicate in the patient’s medical record that knee instability was documented by examination of the member and include an objective description of joint laxity, for example, varus or valgus instability.

HHIC will deny claims for L1832, L1843, L1845, or L1850 as not medically necessary when the patient does not meet the specific diagnosis criteria listed, for example, if only pain or a subjective description of joint instability is documented.

A custom fabricated knee immobilizer without joints (L1834) is covered if both criteria 1 and 2 are met:

1. The coverage criteria for the prefabricated orthosis code L1830 are met (the patient has had a recent injury to or has had a surgical procedure on the knee(s), and they have a diagnosis listed); and

2. The general criterion for a custom fabricated orthosis is met.

If an L1834 orthosis is provided and both criteria 1 and 2 are not met, HHIC will deny the orthosis as not medically necessary.

If an L1834 orthosis is provided and criterion 1 is met but criterion 2 is not, HHIC will base its payment on the allowance for the least costly medically appropriate alternative, L1830.

A custom fabricated knee orthosis with an adjustable flexion and extension joint (L1844, L1846) is covered if both criteria 1 and 2 are met:

1. The coverage criteria for the prefabricated orthosis codes L1843 and L1845 are met (the patient is ambulatory and has knee instability because of a condition specified by one of the diagnoses); and

2. The general criterion for a custom fabricated orthosis is met.

If an L1844 or L1846 orthosis is provided and both criteria 1 and 2 are not met, HHIC will deny the orthosis as not medically necessary.

If an L1844 or L1846 orthosis is provided and criterion 1 is met but criterion 2 is not, HHIC will base its payment on the allowance for the least costly medically appropriate alternative, L1843 or L1845, respectively.

Elastic support garments do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices. Please use code A4466 to report devices that are not rigid or semi-rigid. HHIC will deny code A4466 as a non-covered device. The provider may bill the member for the non-covered elastic support garments.

Services that do not meet HHIC’s medical necessity criteria will be considered not medically necessary. A 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, in the form of a Pre-Service Denial Notice, should be maintained in the provider’s record.

**HHIC Medical Policy Bulletin N-1 (Cardiac Rehabilitation Programs)**

**Cardiac rehabilitation services reporting guidelines outlined for Medicare Advantage Effective: October 11, 2010**

Beginning Oct. 11, 2010, HHIC’s Medicare Advantage products cover cardiac rehabilitation services, codes 93797 and 93798 for these conditions:

- an acute myocardial infarction within the preceding 12 months (ICD-9-CM diagnosis codes 410.00-410.92, 412)
- coronary artery bypass surgery (ICD-9-CM diagnosis code V45.81)
**PROVIDER News**

- current stable angina pectoris (ICD-9-CM diagnosis codes 413.9, 414.00-414.07)
- heart valve repair or replacement (ICD-9-CM diagnosis codes V42.2, V43.3, V45.00)
- percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting (ICD-9-CM diagnosis code V45.82)
- heart or heart-lung transplant (ICD-9-CM diagnosis code V42.1)

Cardiac rehabilitation programs must include these components:

- physician-prescribed exercise each day cardiac rehabilitation items and services are furnished,
- cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to the patients’ individual needs,
- psychosocial assessment,
- outcomes assessment, and
- an individualized treatment plan detailing how components are used for each patient.

Cardiac rehabilitation program sessions are limited to a maximum of two one-hour sessions, per day, for up to 36 over the course of 36 weeks, with an optional additional 36 sessions over an extended period of time, if approved. You may report a maximum of two one-hour sessions per day.

In order to report one session of cardiac rehabilitation services in a day, the duration of treatment must be at least 31 minutes. Two sessions of cardiac rehabilitation services may only be reported in the same day if the duration of treatment is at least 91 minutes. If several shorter periods of cardiac rehabilitation services are furnished on the same date of service, the minutes of service during those periods must be added together for reporting in one-hour increments.

If cardiac rehabilitation services are provided for any other conditions not listed above, or that exceed the frequency guideline, HHIC will deny them as not medically necessary. A 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, in the form of a Pre-Service Denial Notice, should be maintained in the provider’s records.

**HHIC Medical Policy Bulletin N-1 (Cardiac Rehabilitation Programs)**

**Intensive cardiac rehabilitation services Medicare Advantage coverage guidelines explained**

**Effective: October 11, 2010**

On Oct. 11, 2010, HHIC’s Medicare Advantage products will cover cardiac rehabilitation services, codes G0422 and G0423, for these conditions:

- an acute myocardial infarction within the preceding 12 months (ICD-9-CM diagnosis codes 410.00-410.92, 412)
- coronary artery bypass surgery (ICD-9-CM diagnosis code V45.81)
- current stable angina pectoris (ICD-9-CM diagnosis codes 413.9, 414.00, 414.07)
- heart valve repair or replacement (ICD-9-CM diagnosis codes V42.2, V43.3, V45.00)
- percutaneous transluminal coronary angioplasty or coronary stenting (ICD-9-CM diagnosis code V45.82)
- heart or heart-lung transplant (ICD-9-CM diagnosis code V42.1)

Cardiac rehabilitation programs must include the following components:

- physician-prescribed exercise each day cardiac rehabilitation items and services are furnished,
- cardiac risk factor modification, including education, counseling, and behavioral
intervention at least once during the program, tailored to patients’ individual needs,

- psychosocial assessment,
- outcomes assessment, and
- an individualized treatment plan detailing how components are used for each patient

**Cardiac rehabilitation reporting requirements**

Intensive cardiac rehabilitation program sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

In order to report one session of cardiac rehabilitation services in a day, the duration of treatment must be at least 31 minutes. Additional sessions of intensive cardiac rehabilitation services beyond the first session may only be reported in the same day if the duration of treatment is 31 minutes or greater beyond the hour increment. For example, in order to report six sessions of intensive cardiac rehabilitation services on the same date of service, the first five sessions would account for 60 minutes each and the sixth session would account for at least 31 minutes. If several shorter periods of intensive cardiac rehabilitation services are furnished on the same date of service, the minutes of service during those periods must be added together for reporting in one-hour increments.

If cardiac rehabilitation services are provided for conditions not listed, or that exceed the frequency guideline, HHIC will deny them as not medically necessary. A 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 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 record.

Procedure code J9035 injection, bevacizumab, 10 mg describes the chemotherapeutic dose and must not be submitted for intraocular use. Intraocular use requires compounding to constitute the 1.25 mg dose. When bevacizumab is used for intraocular use, report procedure code J3590, unclassified biologics for this service.

**HHIC Medical Policy Bulletin I-100**

**Avastin® Coverage for Intraocular Use**

**Effective: October 11, 2010**

Effective October 11, 2010, bevacizumab (Avastin) for intraocular use will be eligible for coverage for the following ICD-9-Cm (diagnosis) codes:

- 362.01-362.07
- 362.15
- 362.16
- 362.29
- 362.30
- 362.35
- 362.36
- 362.52
- 362.53
- 362.83
- 362.84
- 364.42
- 365.63
- 365.89

Bevacizumab for intraocular use will be denied as not medically necessary when reported with a diagnosis code listed. 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 record.