



PROVIDER PRESS

Blue Cross and Blue Shield of Minnesota
and Blue Plus

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Provider Press is a quarterly newsletter available online at bluecrossmn.com. Issues are published in March, June, September and December.

Provider Service hours of operation

Provider Service hours of operation are as follows:

Monday through Thursday from 8:00 a.m. to 5:00 p.m.

Friday from 9:00 a.m. to 5:00 p.m.

Blood Lead Testing and Child and Teen Checkups: How the way you bill can make a big difference

Some Minnesota Health Care Programs (MHCP) enrollees have two health insurance coverage plans. If the secondary carrier (providing MHCP coverage) is not billed, then the health plan is unable to accurately report the C&TC and blood lead testing information to the Minnesota Department of Human Services. This affects the C&TC and blood lead testing rates for Blue Plus, your clinic and the county. Additionally, Blue Plus coverage provides reimbursement on the S0302 code which indicates that a complete C&TC screening was performed. This can result in additional reimbursement to your clinic.

When Blue Plus provides coverage to a Medical Assistance or MinnesotaCare member billed for C&TC screenings along with the primary carrier’s Explanation of Benefits (EOB), it enables proper data sharing and follow-up between the health plan, the Department of Human Services (DHS), children 11 and younger, and the county.

When enrollees have two health insurance coverage plans, one is referred to as the primary carrier who must be billed first, the other as the secondary carrier who must be billed with the claim and the primary carrier’s determination information *even if the primary carrier paid in full*. This also applies to blood lead testing if you provide the test at a time other than at the C&TC visit. In most cases, the

health plan providing the MHCP coverage will serve as the secondary carrier.

When billing for a C&TC, it is important that you bill the primary carrier all the components performed that are reimbursable under Blue Plus providing the MCHP coverage, even if you know the primary carrier will not pay on a particular code.

Dental Varnish: An easy, safe and effective way to prevent dental caries

Since early 2003, health care providers were eligible to receive reimbursement from Blue Plus for fluoride application provided to Minnesota Health Care Programs’ members. On January 1, 2007, a new code specific to the application of the dental varnish became available; it is D1206 (Topical fluoride varnish; therapeutic application for moderate to high caries risk patients). While D1203 is still a valid code, D1206 for the application of topical fluoride varnish is the preferred code to use.

If you would like to learn more about the on-line training available through the University of Minnesota, go to <http://www.meded.umn.edu/apps/pediatrics/FluorideVarnish/index.cfm>.

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Health brochures (FYI Section)

The US Committee for Refugees and Immigrants has recently posted 13 health brochures in Haitian Creole, Farsi, Spanish, Swahili, and Hmong on their website at www.refugees.org/hltoolkit.

All the brochures are available for download free of charge. The topics covered in the 13 brochures are as follows:

1. HIV/AIDS Prevention and Stigma
2. STDs
3. Cold & Flu
4. TB
5. Stop Smoking
6. Diabetes
7. Heart Disease
8. Obesity
9. Child Obesity
10. PAP Test, and Mammograms
11. Menstrual Cycle
12. Patients Rights
13. Emergency Room

These brochures are a great tool to help fill in communication gaps between the service provider and the patient. They are of course best utilized with verbal education, and should not be handed off without discussing the content with the patient. The 13 brochures are also available in ARABIC, VIETNAMESE, ENGLISH, SOMALI, KIRUNDI, RUSSIAN, KAREN, BURMESE, FRENCH, AMHARIC, and BOSNIAN.

Publications available online

The following is a list of Quick Points and bulletins published from December 2007 to February 2008 that are available online at bluecrossmn.com. As a reminder, bulletins are mailed to all participating providers affected by the information. Quick Points are only available on our website unless noted otherwise in the bottom left corner of the publication.

Quick Points

Number	Title
QP13-07	Billing during Intensive Service Days
QP14-07	SelectAccount N367 Remark Code for "pay the provider" payment capability
QP1-08	New Medicare Supplement plans announced

Bulletins

P31-07	Duplicate billing
P32-07	Children's therapeutic services and supports
P33-07	Notification of hospital discharge appeal rights
P34-07	Notification of SNFs, CORFs and Home Health Agencies Patient's Appeal Rights
P35-07	2008 HCPCS code update
P36-07	Additional claims to crossover from Medicare
P37-07	Update to BlueLink TPA guide
P1-08	Adjustment policy change to modifiers -24, -25 and -59
P2-08	Update to Attachment B: Definitions of Outpatient Health Service Categories
P3-08	Community Health Workers



Clinical Practice Guidelines

Blue Cross promotes the implementation of clinical practice guidelines and routinely notifies practitioners in appropriate specialties of updates.

Institute for Clinical Systems Improvement (ICSI)

Clinical Practice Guidelines

Updated guidelines include:

- Preventive Services for Adults
- Preventive Services for Children and Adolescents
- Immunizations for Children, Adolescents and Adults

Guidelines reviewed in 2007 but not updated:

- Routine Prenatal Care
- Heart Failure in Adults

To obtain a copy of ICSI guidelines, visit www.icsi.org or contact Pam Dempsey via e-mail at Pamela_M_Dempsey@bluecrossmn.com, or via phone at (651) 662-7271 or 1-800-382-2000, ext. 27271 for more information.

Patient and Family Guidelines

ICSI has available sets of guidelines for patients and families. To view or print, visit www.icsi.org and For Patients and Families.

Blue Cross Needs Providers' Help in Assisting Pregnant Women

Blue Cross' Healthy Start® program offers prenatal education and support throughout a member's pregnancy. This program is offered to most commercial members and all Minnesota Health Care Programs (MHCP) members. Such members identified as having an at-risk pregnancy or who request to be enrolled in the program may receive the following services from a registered obstetrics nurse:

- Educational phone calls
- Pregnancy related educational materials
- Information about resources within Blue Cross and the community
- Answers to pregnancy related questions

Members are identified by claims and Minnesota Pregnancy Assessment Forms (MPAF) that are sent to Blue Cross. Blue Cross will reimburse the provider for each prenatal assessment form submitted. HCPCS billing code H1000 should be used to receive reimbursement. Providers should mail or fax the assessment forms to:

Blue Cross and Blue Shield of MN
Healthy Start, Mail Route W755
PO Box 64560
St Paul MN 55164-0560

Fax: (651) 662-7066

Providers with referrals to the prenatal support program or with questions can contact Blue Cross at (651) 662-1818 or 1-866-489-6948.



School Sports Physicals: An easy way to help ensure kids complete C&TC screenings

As you may know, the Minnesota State High School League’s (MSHSL) Sports Qualifying Physical Examination Clearance Form was revised in July 2006; you may download the form by going to <http://www.mshsl.org/mshsl/publications.asp#5>.

Blue Plus has reviewed the components required of the MSHSL Form and finds it to be a very comprehensive exam tool. However, there are just a few C&TC components that need to be added to make the sports physical exam count as a complete C&TC screening.

To make it easy for you, a documentation sheet that has the six components of a complete C&TC screening that are not on the MSHSL Form was created. Go to www.co.dakota.mn.us and enter “sports physical” in the search field to view the documentation sheet.

When performing a school sports physical, we ask that you also perform and document these 6 components in conjunction to the services listed on the MSHSL form

and attach the sheet to the MSHSL form. This will allow your clinic to bill the exam as a complete C&TC for Minnesota Health Care Programs (Medical Assistance and MinnesotaCare) enrollees. By doing so, this may result in increased reimbursement from Blue Plus.

New MN Law Requiring Electronic Health Care Transactions

Minnesota Statutes, section 62J.536, require all health care providers and group purchasers (payers, plans) to exchange eligibility inquiries and responses, claims, and remittance advices electronically, using a standard format, effective in 2009.

If you submit paper claims, receive electronic remittances, or use phone calls to obtain eligibility and benefit information for your patients, you should explore your options for electronic transactions and prepare to be in compliance by 2009. For more information regarding this requirement, visit the Administrative Uniformity Committee website at <http://www.health.state.mn.us/auc/index.html> or the Minnesota Department of Health’s Administrative Simplification website at <http://www.health.state.mn.us/asa/>.

Helpful phone numbers

BLUELINE (voice response unit)	(651) 662-5200 or 1-800-262-0820
Behavioral Health	1-800-469-1110
BlueCard member benefits or eligibility	1-800-676-BLUE (2583)
FEP (voice response unit)	(651) 662-5044 or 1-800-859-2128
FEP (behavioral health issues)	1-866-812-1580
ClearConnect	(651) 662-5742 or 1-866-251-6742
Provider Service	(651) 662-5000 or 1-800-262-0820

Please verify these numbers are correctly programmed into your office phones.



Public Programs Non-Covered Services

Providers are not allowed to bill a Minnesota Health Care Programs (MHCP) recipient unless the services are never covered by MHCP, and you have informed the recipient that they are liable for these charges prior to the services being rendered.

If MHCP covers the service but the recipient doesn't meet the coverage criteria, you are not allowed to bill or accept payment for those services.

To avoid confusion for the recipient, office procedures should be in place to inform the recipient of their liability for these services.

A waiver should be provided to the recipient for them to sign, authorizing that they understand the services are not covered under the health plan, and they will be responsible for the cost of the services. This waiver should include the date of the service, the non-covered service that you will be providing, the cost of the services, and any other pertinent information.

If you provide a non-covered service to a Public Programs member, a waiver must be signed, and a GA modifier should be submitted on the claim to indicate there is a waiver on file.

This article includes Blue Plus: Blue Advantage (PMAP, GA/GAMC, and Minnesota SeniorCare and Minnesota SeniorCare+), MinnesotaCare, SecureBlue, and CareBlue. South Country Health Alliance (SCHA): PMAP (MA/GA/GAMC), Minnesota SeniorCare+, MinnesotaCare, MSHO, and AbilityCare.

Change to provider adjustment requests

Do you need to change the provider number on your claim? If so, providers must submit a request to void the claim with the incorrect information. This is the current process for BlueCard® claims and is being expanded to include local business.

You may request a void by requesting a claim adjustment. You may request an adjustment through the web self-service site at www.providerhub.com, completing the Provider Inquiry/Appeal Form, or by calling provider service.

Once the claim has been voided, and the provider has verified that the claim was voided by accessing the provider web self service site or contacting provider services, the provider can resubmit the charges with the corrected provider information on a new claim. This process must be followed for changes to both individual and contracting provider numbers. A provider remit will be issued once the void has been completed.

Did your claim deny with an ANSI reduction remark code of 208? This reduction remark code indicates that the provider numbers, either contracting or individual, do not match. You will need to make the necessary corrections on the claim and resubmit the charges. The ANSI reduction remark code of 208 is not an adjustable remark code.



Clarification to eDispense provider bulletin P21-07

On October 11, 2007, provider bulletin P21-07 titled “eDispense Medicare Part D Vaccine Manager” was issued. Provider bulletins, contractually binding publications, are also used to distribute information that is not strictly related to contract compliance. Announcements of new products or major changes in how benefits are administered are two such examples of when Blue Cross and Blue Shield of Minnesota believes a bulletin might be warranted.

eDispense Part D Vaccine Manager is a web portal that provides physicians with real-time claims processing for in-office administered vaccines. This system also allows providers to electronically bill for Part D vaccine administration charges.

Physicians can submit claims for Part D vaccines and/or Part D vaccine administration in two ways, either electronically through the eDispense website or by using a CMS 1500 and following a paper claims process.

If you have enrolled with DSI (Part D electronic clearinghouse) to use their eDispense claims system, you can submit claims for vaccines and vaccine administration through their website. This website will also allow you to check member eligibility for various Part D vaccines, as well as to determine the applicable member co-pays, if any.

For more information on eDispense and

how to sign up to use that system, please visit: https://enroll.edispense.com/ws_enroll and click on the “Click here to Login to eDispense” bar to reach the site demo and/or more information sections of the site, or call DSI at 1-866-522-3386. You can also go to **bluecrossmn.com** and type eDispense in the search option.

If you have decided not to enroll in eDispense, you can use a CMS 1500 to submit claims for vaccines and administration. If you submit a paper claim, it must include:

- the NDC number for the vaccine
- Quantity
- Days supply—use 1

Paper claims for CareBlue or SecureBlue members can be submitted to:

BluePlus and the appropriate product name (CareBlue or SecureBlue)
P. O. Box 64813
St. Paul, MN 55164

For the regional products, MedicareBlue Rx or MedicareBlue PPO, please use the name of the product as the addressee when submitting the claim:

MedicareBlue Rx or MedicareBlue PPO
(whichever is appropriate)
P. O. Box 64813
St. Paul, MN 55164

If you have questions regarding claims submitted for the regional products, please call the member services number on the back of the member’s ID card.



April HCPCS update

There will be a first quarter HCPCS code update. A bulletin will be issued with details and the new codes before the April 1 effective date.

Assist at surgery using robotics

Per Chapter 11 (surgical services section) of the Blue Cross and Blue Shield of Minnesota Provider Policy and Procedure Manual, assistant at surgery services may be allowed if the following criteria are met:

- The surgical assistant is a licensed physician, nurse practitioner (NP), registered nurse first assistant (RNFA), or physician assistant (PA).
- The surgical assistant's services are medically necessary. Generally, we follow the list that CMS has furnished to Medicare carriers, for approved codes.
- The appropriate modifier (-80 or -AS) must be appended to the surgical procedure.

When a robot is used in conjunction with a surgery, an assist-at-surgery service may be billed for the qualified practitioner (MD, RNFA, NP, or PA) assisting by operating the machine (robot). The appropriate surgical code and modifier would be billed. However, separately billed charges for surgical robotics (S2900) will not be allowed.

Adjustment policy change reminder

The bulletin P1-08 "Adjustment policy change to modifiers -24, -25 and -59" was issued January 14, 2008. We would like to remind you that effective April 14, 2008, an appeal must be requested to add modifiers -24, -25 or -59 to a procedure code. The appeal request will require medical documentation, such as office notes

and/or operative notes, for review and possible reconsideration. The Provider Inquiry/Appeal Form was updated to refer to the Provider Policy and Procedure Manual for instructions on which modifiers must be appealed with documentation.

Important Appeal Review Information

- It will be necessary to send documentation with your claim when using modifiers -24, -25 or -59 beginning April 14, 2008. Documentation should support the modifier used.
- Remember that two different ICD-9-CM codes alone does not justify adding modifier -25. The documentation must support each service billed.
- Adding a modifier just because the service was denied is not appropriate.

Important Miscellaneous Facts

- It is only appropriate to report modifiers -24, -25 and -57 on evaluation and management procedure codes.
- Never report modifier -59, -76 or -77 on an evaluation and management code.
- Report modifiers -54 and -55 on the evaluation and management code only.
- For additional information on modifiers refer to Chapter 11 of the Blue Cross and Blue Shield of Minnesota Provider Policy and Procedure manual online at bluecrossmn.com.



Blue Cross and Blue Shield of Minnesota's medical and behavioral health policies are available for your use and review on the Blue Cross website: bluecrossmn.com. Information on policies is updated monthly following the Medical Policy Committee meeting and the Behavioral Health Policy Committee meeting. Policies with changes will be identified as "new" on the website. The following listing is a brief summary of medical and behavioral health policies that have been developed or revised since November 2007. If you have any additional questions regarding medical or behavioral health policy issues, you may call provider service at (651) 662-5200 or 1-800-262-0820 for assistance.

MEDICAL POLICY ACTIVITY

Policies Developed

Scintimammography (Breast-Specific Gamma Imaging)

- Accepted medical practice to evaluate breast masses/lesions when the results of conventional imaging procedures (for example, mammography and/or ultrasound) are indeterminate or inconclusive.
- Prior authorization – no

Artificial Cervical Intervertebral Disc

- Investigative
- Prior authorization – not applicable

Dermatoscopy

- Not medically necessary / incidental to office visit
- Prior authorization – not applicable

Genetic Testing for Familial Alzheimer's Disease

- Investigative
- Prior authorization – not applicable

Policies Revised

Surgery for Morbid Obesity

- A second type of adjustable gastric band (the REALIZE Band) has been added to the list of procedures considered to be accepted medical practice. Prior authorization is recommended.
- Sclerosing endotherapy of the stoma for weight regain following previous weight loss surgery is considered investigative. Prior authorization – not applicable

Wireless Capsule Endoscopy (Patency Capsule)

- Use of the *patency capsule* prior to wireless capsule endoscopy is considered not medically necessary.
- Prior authorization – not applicable

MRI-Guided Focused Ultrasound Ablation of Uterine Fibroids and Other Tumors

- Use of this procedure to treat uterine fibroids remains investigative.
- Use of this procedure to treat any other tumors (such as, breast, brain, or prostate) is considered investigative.
- Prior authorization – not applicable.



Endoluminal Radiofrequency and Laser Ablation for Treatment of Varicose Veins/Venous Insufficiency

- Endoluminal radiofrequency ablation or laser ablation of the *greater, small or accessory saphenous veins* is considered accepted medical practice for the treatment of varicose veins when the procedure is used as an alternative to saphenous vein ligation and stripping in patients with documented symptomatic saphenofemoral or saphenopopliteal reflux.
- Prior authorization – no

Policies Reviewed with No Changes

CT Colonography (Virtual Colonoscopy) as a Screening Test for Colorectal Cancer

- Investigative; specific indications will be considered for coverage on an exception basis.
- Prior authorization – not applicable

Occlusion of Uterine Arteries as Treatment for Uterine Fibroids

- Accepted medical practice; repeat embolization is considered investigative.
- Laparoscopic occlusion is considered investigative.
- Prior authorization – no

Vagus Nerve Stimulation (Treatment of Epileptic Seizures)

- Accepted medical practice for treatment of medically refractory partial onset epileptic seizures.
- Prior authorization is recommended.

Treatment for Severe Primary Insulin-Like Growth Factor 1 (IGF-1 Deficiency

- Accepted medical practice when specific criteria are met.
- Prior authorization is recommended.

Policies Inactivated*

None

BEHAVIORAL HEALTH POLICY ACTIVITY

Policies Revised

Cognitive Behavioral Therapy for Depressive Disorder

- Accepted medical practice with the following added to the policy: Some improvement in clinical symptoms should be discernible within twelve weeks of treatment initiation. Reassessment and modification of a treatment plan is recommended if noticeable symptom improvement is lacking.
- Prior authorization – no

Continuous Performance Tests

- Not medically necessary as a screening tool or the sole diagnostic tool for attention deficit hyperactivity disorder but may be included by some practitioners as part of a comprehensive evaluation.
- Prior authorization – no



Policies Reviewed with No Changes

Altered Auditory Feedback

- Investigative to include both treatment and devices for stuttering.
- Prior authorization – not applicable

Anesthesia-Assisted Opioid Withdrawal

- Investigative due to lack of better outcomes when compared to use of routine withdrawal protocols as well as known cases of death resulting from this procedure.
- Prior authorization – not applicable

Treatment of Depressive Disorders with Botulinum Toxin (Botox) Type A

- Investigative
- Prior authorization – not applicable

Dialectical Behavior Therapy for Borderline Personality

- Accepted medical practice when it is defined as containing the five categories of core functional components and must include the following four basic modes of treatment: Structured group therapy or psychoeducation; Individual psychotherapy; Telephone contact; Therapist consultation meetings.
- Prior authorization – no

Naltrexone for Alcohol Dependence

- Accepted medical practice
- Prior authorization – no

Neurofeedback/EEG Biofeedback

- Investigative including use of computers and computer software for the purpose of neurofeedback/biofeedback training to treat a mental health or substance-related condition or disorder.
- Prior authorization – no

Pfeiffer Treatment Center Metallothionein Protein (mt) Assessment and Treatment Protocol

- Investigative
- Prior authorization – no

Policies Inactivated*

- Attention Deficit/Hyperactivity Disorder (Children and Adolescents)
- Attention Deficit/Hyperactivity Disorder (Adults)
- Anorexia Nervosa
- Bulimia Nervosa

Policies may be inactivated for any of the following reasons: 1) requests for coverage are no longer received for a particular therapy or procedure, 2) a particular therapy or procedure has become accepted medical practice, or 3) a particular therapy or procedure is already addressed in the subscriber contracts. Refer to the Blue Cross and Blue Shield of Minnesota website at blucrossmn.com to view the medical and behavioral health policies.



Coding edit decisions

Several edits have been reviewed. The code edits and decisions are listed below.

CODE and EDITS:	DECISION/ACTIONS:
G0268 denied as incidental to 92556 or 92557	Edit upheld
30115 denied as incidental to 31255	Edit upheld
69210 denied as incidental to 92256 or 92557	Edit upheld
90760 denied incidental to 90774	Edit reversed 10/29/2007 – code 90774 will now deny incidental to 90760
94760 and all E/Ms	Edit added 10/29/2007 – code 94760 denies as incidental to all E/M codes
97802 denied mutually to 90760	Edit upheld
97804 denied incidental to 99241	Edit upheld

PROVIDER PRESS is posted on our website quarterly for business office staff of multispecialty clinics, physicians, public health agencies, DME providers, chiropractors, podiatrists, physical therapists, occupational therapists, optometrists and behavioral health professionals/providers. Direct inquiries to:

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*Information in Provider Press is a general outline.
 Provider and member contracts determine benefits.*



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