Use of Electronic Prescribing Systems Encouraged by HMSA

The Practitioner Quality and Service Recognition (PQSR) Program awards special bonuses to providers who have access to an electronic prescribing system. This bonus recognizes the overall efficiency of e-prescribing and is meant to encourage physicians to utilize this technology.

HMSA has extended its agreement with Allscripts® to continue supporting HMSA physicians with e-prescribing services through December 2008. Physicians who are looking for an e-prescribing system will be pleased to know that HMSA covers the costs of installation of hardware, software and training when a physician signs up with Allscripts TouchWorks Rx+. In the near future, TouchWorks Rx+ will be upgrading its e-prescribing system so electronic prescriptions can be transmitted over the Internet.

Allscripts has also agreed to extend a 40 percent discount off the list price for its Electronic Health Record system, which includes TouchWorks Base and TouchWorks Result, to participating HMSA physicians. TouchWorks Base is the workflow component that allows physicians to track scheduling and practice performance data, and also functions as an internal messaging and tasking application eliminating the “sticky notes” or paper phone message reminders. TouchWorks Result is the ambulatory clinical repository on the Web that gives quick and convenient access to test results and can automate the communication to the patient or other providers who may be providing care for the patient. By utilizing the Scan module, physicians can work toward significantly streamlining their paperwork in 60 to 90 days or less.

HMSA encourages physicians to review all options before selecting an e-prescribing system or an Electronic Health Record system.

If you would like more information on the services offered by Allscripts, please contact Scott Sumner, Senior Sales Executive – California, Allscripts Healthcare Solutions, (805) 432-6446, or email him at: scott.sumner@allscripts.com.

Increase claims processing efficiency for patients with dual coverage

Patients who are covered by more than one medical plan can be found in most physician practices. Although a patient should notify the practitioner and the affected medical insurance plans when changes to medical coverage occur, such notification does not always happen in a timely manner, resulting in claims rejections, incorrect reimbursements that may result in payment recovery requests, and claims processing delays.
To document changes to a patient’s medical coverage and submit the changes to HMSA in a timely manner, a Coordination of Benefits (COB) Subscriber Questionnaire is now available in the Provider E-Library. This form can be used by the physician’s office staff to expedite dual coverage changes.

When a patient informs the practitioner’s office staff that his or her medical coverage has changed, the staff can print out a copy of the form, ask the patient to complete and sign the form in the office, then either fax the information to HMSA at (808) 952-7987, or mail the completed form to:

Attn: 8th Flr – CA/Other Party Liability
HMSA
P.O. Box 860
Honolulu, HI 96808

HMSA will update its claims processing system with the changes indicated as soon as the information is received.

Submission of FEP claims

The Federal Employee Program (FEP) is a nationwide health insurance program administered through the Blue Cross and Blue Shield Association. The FEP membership card is identified by coverage codes 104 and 105 for Standard Option and 111 and 112 for Basic Option.

Claims submission should include the contract identification number exactly as shown on the membership card, which starts with “R” followed by eight digits. HMSA’s automated claims processing system recognizes a claim as an FEP claim when the contract identification number has a total of nine characters listed on the claim form.

Also, as a reminder, please send all FEP claims to:

HMSA – FEP
P.O. Box 1346
Honolulu, HI 96807-1346.

For information on eligibility, benefits and claims status, please contact HMSA – FEP at 948-6281 on Oahu or 1 (800) 966-6198 from the Neighbor Islands.

Proper inclusion of subscriber numbers on claims

Since HMSA’s claims system converted to the HIPAA compliant format, EDI claims without full subscriber numbers have resulted in claim denials. Incomplete subscriber numbers result when the full subscriber number, including the leading zeros, is not entered on a claim. For example, subscriber numbers from HMSA’s private business plans are comprised of 13 digits.

Excluding the leading zeros results in an incomplete subscriber number. A claim submitted with a subscriber number from one of HMSA’s private business plans that is less than 13 digits long may be directed for processing under another plan (e.g., FEP or QUEST), ultimately resulting in a denial.

It is essential that providers include the correct number of digits on their claims to prevent claim denials.

Billing and Coding

✓ Immunization fee changes

The maximum allowable charges (MAC) for the following CPT codes have increased, effective June 1, 2005:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>New MAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90707</td>
<td>Measles, mumps and rubella vaccine (MMR), live, for subcutaneous use</td>
<td>$44.91</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella virus vaccine, live, for subcutaneous use</td>
<td>$75.01</td>
</tr>
</tbody>
</table>
The MACs for the following CPT codes will decrease, effective October 1, 2005:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>New MAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90702</td>
<td>Diphtheria and tetanus toxoids (DT) adsorbed for use in individuals younger than 7 years, for intramuscular use</td>
<td>$4.50</td>
</tr>
<tr>
<td>90718</td>
<td>Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular use</td>
<td>$9.00</td>
</tr>
</tbody>
</table>

The MACs for the following CPT codes have been established, effective July 2005:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>New Mac</th>
</tr>
</thead>
<tbody>
<tr>
<td>90714*</td>
<td>Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years of age or older, for intramuscular use</td>
<td>$19.35</td>
</tr>
<tr>
<td>90715**</td>
<td>Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals 7 years or older, for intramuscular use</td>
<td>$39.15</td>
</tr>
</tbody>
</table>

*A CPT code 90714 was previously assigned to the typhoid vaccine, but was deleted in 1999. The American Medical Association (AMA) reissued this code for DECAVAC, effective July 1, 2005.

**CPT code 90715 was established by the AMA in 2004, however, the drug BOOSTRIX was not FDA-approved until May 2005.

Maternal quadruple screening

Effective immediately, HMSA will cover maternal quadruple screening. For services before October 1, 2005, please submit claims using the following codes:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S3625</td>
<td>Maternal serum triple marker screen including alpha-fetoprotein (AFP), estriol, and human chorionic gonadotropin (hCG)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>86336</td>
<td>Inhibin A</td>
<td></td>
</tr>
</tbody>
</table>

A new HCPCS code will be available effective October 1, 2005. For services provided on or after October 1, 2005, please submit claims using the new maternal quadruple screening code:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S3626</td>
<td>Maternal serum quadruple marker screen including alpha-fetoprotein (AF), estriol, human chorionic gonadotropin (hcG), and inhibin A</td>
<td></td>
</tr>
</tbody>
</table>

Policy Updates

Botox injections

Botox injections to treat excessive drooling are considered investigational and will not be covered. Claims submitted for a Botox injection using HCPCS codes J0585 or J3490 with either diagnoses, 527.2, sialoadenitis, or 527.7, disturbance of salivary secretion (including sialorrhea), will be denied.
Pre-certification form available

An all-purpose HMSA Pre-certification Request Form is now available in the Provider E-Library. Please complete a copy of this form and submit it with the required documentation when requesting pre-certification for services requiring pre-certification.

We encourage providers to fax all requests and supporting documentation to facilitate the review process.

For services that require specific pre-certification forms, continue to use the more specific forms.

Velcade

Effective immediately, one of the criteria used to pre-certify Velcade has changed. A patient who has received at least one other type of treatment and shows evidence that the disease is progressing will now be considered as meeting that particular criteria. Previously, a patient was required to have undergone at least two types of treatments.

To view a complete policy online, please refer to HMSA’s Provider E-Library.

Well-baby care

HMSA covers well-baby visits once a newborn is discharged from the hospital. Should the newborn be discharged within 48 hours from birth, an additional well-baby visit is covered.

Coverage for the additional visit is intended to provide for services an infant would have received had the discharge occurred after the usual hospital length of stay after birth.

A decision for early discharge must be made by the attending physician in consultation with the mother.

This explanation is included in the well-baby care policy in the Provider E-Library.

Positron Emission Tomography (PET)

Effective immediately, PET scans for cervical cancer must meet additional criteria listed in the pre-certification section.

Several ICD-9-CM codes have been added to the list of codes in the Covered Codes section of the policy.

The previously mentioned changes and the complete policy are available online in the Provider E-Library.

Home infusion for pain management

Changes to the policy for home infusion therapy for pain management were made recently. The changes include:

- Duration for approved therapy treatment will vary based on a patient’s response and the documented medical criteria presented.
- Documentation submitted must show a patient’s failure to respond to maximal doses and co-analgesics administered through other routes before intraspinal pain management would be considered.

These changes are effective immediately. To review the complete policy on home pain management therapy, please refer to our Provider E-Library.

Erectile dysfunction

Effective immediately, CPT code 37788, penile revascularization, artery, with or without vein graft, will not be covered since it is not considered part of the current standard of treatment and is no longer utilized.

For a copy of the complete policy, please refer to HMSA’s Provider E-Library online.

Home phototherapy for neonatal jaundice

Effective October 15, 2005, home phototherapy for the treatment of neonatal jaundice will be covered, provided the following criteria are met:

- The infant must be at least 38 weeks (gestational age).
- The total serum bilirubin at discharge or post-discharge follow up must fall within the levels listed in the table included in the policy.
- The infant has no risk factors.

The home nursing care is limited to the evaluation of the infant and does not include the setting up or retrieval of the phototherapy unit or instruction of caregiver on the use of the unit.
The treating physician is responsible for ensuring that the caregiver receives proper instructions on the use of home phototherapy in accordance with the American Academy of Pediatrics guidelines.

If the infant is discharged at less than 24 hours of age, the infant must be re-evaluated by a qualified healthcare professional by the time he or she reaches 48 hours of age and a total serum bilirubin level must be measured when jaundice is present.

In addition, total serum bilirubin levels must be monitored at least daily and phototherapy must be discontinued once the total serum bilirubin level has fallen below the age-specific range listed in the table included in the policy.

Should the total bilirubin level exceed the age-specific range listed in the policy's table, or should the bilirubin levels continue to increase at a rate where exceeding the age specific range can be predicted or when the infant's health status deteriorates in any way, the infant should be re-admitted.

Pre-certification for this treatment is not required when the above criteria are met.

The policy will be available for review in the Provider E-Library, as the effective date nears.

✓ Home intravenous therapy

Policies on home intravenous therapy have been reviewed and updated. The policies affected are as follows:

- Home anti-infective therapy
- Home enteral nutrition therapy
- Home inotropic infusion therapy
- Home IV hydration therapy for hyperemesis gravidarum
- Home pain management therapy
- Home prolonged IV hydration therapy for adults and adolescents
- Home total parenteral nutrition therapy

Please review these policies online in the Provider E-Library.

**Reminders**

**Lactation counseling**

Lactation counseling is not covered by HMSA. A claim submitted for an office visit or consultation for the sole purpose of providing lactation counseling will be denied.

Breastfeeding problems in newborns should be addressed by the pediatrician as part of a well-baby visit. Nursing mothers suffering from cracked or bleeding nipples, or mastitis, should see their primary care physician for treatment.

**Medical records**

HMSA participating physicians are required to establish and maintain medical records in accordance with generally accepted medical practices. When HMSA reviews copies of a patient's medical record during the medical or payment review process, the medical record should provide a clear picture of the services rendered to a patient, and documentation must support the coding used when billing for these services. If medical appropriateness cannot be determined because documentation is illegible, the review may result in a denial of services and HMSA may recover payment.

HMSA also conducts routine medical record reviews as part of its Quality Improvement Program. Such reviews are conducted to assess a practitioner's performance in providing quality healthcare services to HMSA members. Medical records should reflect the level of quality service that physicians provide when treating patients.

Please review our medical record guidelines located in the Provider E-Library, under MEDICAL RECORDS for detailed information.