New wellness initiatives for Federal Employee Program (FEP)

Beginning January 1, 2010, the BlueCross and BlueShield Service Benefit Plan will reward members of the Federal Employee Program (FEP) when they complete either the adult Blue Health Assessment or a child’s Body Mass Index (BMI) assessment. These programs are designed to encourage wellness and prevention, and aim to remove barriers to care. Incentives for completing the assessments include enhanced benefits.

- For adults who complete the Blue Health Assessment, our Health Risk Assessment through HealthPass, the copayment for their subsequent annual physical examination or an individual preventive counseling visit will be waived. A certificate entitling them to this visit can be presented to the physician at time of care.

- For children who complete a BMI assessment will receive a certificate to present at time of care. Co-payments of up to four nutritional counseling visits will be waived for children ages 5-17 whose BMI falls in the 85th percentile or higher, according to standards set by the Centers for Disease Control and Prevention (CDC).

Certificates for both programs will include the member’s name, contract identification number, effective date and expiration date.

Billing & Reimbursement

- Do not collect payment from a Service Benefit Plan member who presents a certificate. Reimbursement from HMSA for these visits will include the copayment.

Billing for post-op care

During the post-operative period for a major surgery (usually 90 days), the surgeon performs routine post-operative care. However, there may be times when a surgeon chooses to turn over the post-operative care to a patient’s internist. For example, a patient from a Neighbor Island may have surgery on Oahu and

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**Never Events and Hospital-Acquired Conditions policy clarification**

HMSA’s goal is to promote improved patient safety and quality care for our members. When a Never Event or Hospital-Acquired Condition is reported to us by a hospital, an HMSA nurse reviewer or medical director will discuss the case with the hospital’s utilization management staff, and individual patient issues and the hospital’s preventive policies and processes will be considered in the review.

If a reduction in payment is warranted, in most cases the reimbursement will be reduced to the non-complicated DRG for that condition. Members should be held harmless for the additional cost of the complication. Physician payments will not be affected except in the rare instances where one of the following three wrong surgery events occur:

- surgery performed on the wrong body part
- surgery performed on the wrong patient
- wrong surgical procedure performed on a patient

Some lines of business are operated under contracts that require specific Never Events/Hospital-Acquired Condition programs, such as QUEST and the Federal Employees Plan. HMSA is obligated to follow the requirements of those plans and will not pay facilities for complications in those cases.

In addition to the Never Events program, HMSA is also supporting a nationally acclaimed patient safety program led by the Johns Hopkins University Quality & Safety Research Group, which helps hospitals reduce the rate of bloodstream infections in intensive care units and teaches a comprehensive unit-based safety program (CUSP).

The “Hawaii on the CUSP: STOP BSI” program is a state-wide collaboration of all 17 Hawaii hospitals with ICUs that involves implementing evidence-based safety practices and improving teamwork among doctors, nurses and hospital leaders.

**Medical documentation – Use of templates**

When documenting care for patients, use of templates (via check boxes listed on a hard-copy record or electronic health record software) is acceptable. However, please take care to select or populate fields in accordance with the nature of the presenting problem. This should be used as the primary criterion of code selection.

Medical record documentation must contain up-to-date information and be pertinent to the patient’s chief complaint at the time of service. Only the level of service required to address the presenting problem should be billed to HMSA for reimbursement.

If, upon review, the documentation is determined to be insufficient to support the level of payment made, HMSA may require providers to return the amount that was overpaid for the service rendered.
receive post-operative care from their internist at home.

Because post-operative care is included in HMSA’s payment for the surgical package, the internist should not bill for office visits. The surgeon and the internist should reach an agreement about sharing HMSA’s payment for the surgery. The internist will then bill for post-operative care using the surgical procedure code and modifier code 55.

When filing claims using one or more of the relative modifiers (54, 55, 56), include information about the fee distribution in block 19 of the CMS 1500 claim form or in a comparable field for electronic submission. The two providers must come to an agreement on the fee split.

For example, if a patient’s PCP (Doctor A) plans to perform the post-operative care, but the surgeon (Doctor B) did the preoperative care and surgery, claims might be submitted with notes similar to those listed below.

- Dr. A's claim would list the CPT code for the surgical service (not an office visit) with modifier 55 indicating that he performed the post-operative care. In block 19, Dr. A may indicate a fee split agreement - Dr. B = 90%, Dr. A = 10%)

- Dr. B's claim would list the CPT code for the surgical service followed by modifier codes 54 and 56. In block 19, Dr. B may indicate a fee split agreement - Dr. A = 10%, Dr. B = 90%)

If this information is not found on the claim, the claim cannot be processed for the appropriate payment. Please see the Modifier Codes 54, 55, 56 entry in the Provider E-Library for more information.

Billing for initial maternity prenatal visit

HMSA’s private business plans pay for the initial prenatal visit outside the maternity global fee. HMSA defines the initial prenatal visit as the visit during which the physician or midwife initiates prenatal care, counsels the patient about risk factors and instructs patient about self-care. During that initial visit, the provider determines the patient’s due date and establishes a tentative schedule for future prenatal visits. Physicians are encouraged to bill separately for the initial visit by using the appropriate Evaluation and Management (E&M) code and indicating an appropriate ICD-9-CM diagnosis code from the code range of V22.0 to V22.1 (supervision of normal pregnancy) or V23.0 to V23.9 (supervision of high-risk pregnancy). Choosing a code from the above mentioned code ranges allows HMSA to gather accurate data on the number of women receiving appropriate prenatal care in the first trimester.

Detailed information on coding for the initial prenatal visit is in the Provider E-Library, Prenatal Visit – Initial. Also refer to the E-Library document, Maternity – Global Billing, to review details on how to bill for maternity services provided throughout a pregnancy.

Encourage members to contact HMSA’s The Good Pregnancy -- He Hapai Pono program by calling 952-4454 on Oahu or 1 (888) 400-2776 from the Neighbor Islands.
annual review of medical policies

The following policies have undergone annual review and have been updated:

- Durable Medical Equipment, Prosthetics and Orthotics
- Heart Transplant
- Home Phototherapy for Neonatal Jaundice
- Isolated Small Bowel Transplant
- Negative Pressure Wound Therapy (NPWT)
- Occupational Therapy (effective April 1, 2010)
- Photochemotherapy
- Photodynamic Therapy for Treatment of Actinic Keratoses and Other Skin Lesions
- Physical Therapy (effective April 1, 2010)
- Readmissions and Transfers

Please refer to the Provider E-Library to view the individual policies. Copies of the policies are available upon request.

provider input solicited for annual policy review – January

HMSA's medical directors welcome comments and suggestions from participating physicians regarding existing medical policies that are undergoing annual review.

Following is a list of policies for which HMSA is currently soliciting input. Comments are due by January 31, 2010. Physicians may comment by fax at 948-6340 (Oahu) or via e-mail to medical_policy@HMSA.com.

Physicians submitting comment should include supportive citation source material to assist HMSA's medical directors in evaluating the comment or proposed change.

- Botulinum Toxins
- Charged-Particle (Proton or Helium Ion) Radiation Therapy
- Cetuximab (Erbitux)
- Continuous Glucose Monitoring of Interstitial Fluid
- Cosmetic and Reconstructive Surgery and Services
- Erectile Dysfunction
- Esophageal pH Monitoring
- Observation Services
- Uterine Artery Embolization to Treat Fibroids
Policy News

Preimplantation Genetic Diagnosis – Effective April 1, 2010

This new policy is effective April 1, 2010, and requires precertification. The policy is available in the Provider E-Library.

Occupational and Physical Therapy – Effective April 1, 2010

Occupational Therapy – Federal Plan 87; Occupational Therapy – PPO, HMO, EUTF, HSTA; Physical Therapy – Federal Plan 87; and Physical Therapy – PPO, HMO, EUTF, HSTA will be revised effective April 1, 2010.

Effective April 1, 2010, precertification will be required after the first eight visits per benefit period except for the Federal Plan 87 which still requires precertification after 10 visits per episode. A treatment authorization will have to be completed and sent to Landmark Healthcare. The maximum number of visits by diagnosis is no longer applicable.

FDA-approved Drugs Requiring Precertification – Effective April 1, 2010

• Belimumab (Benlysta)

Additional Codes that Do Not Meet Payment Determination Criteria

Effective January 1, 2010, the following codes will be added to the list of Codes That Do Not Meet Payment Determination Criteria: CPT Codes 74263, 75571, 84145, 86352 and 89387.

Effective April 1, 2010, CPT Code E0676 will be added to the list of Codes That do Not Meet Payment Determination Criteria.

Submit separate payments to HMSA

When submitting payment to HMSA for money returned by lines of business such as Senior Plan, BlueCard, Fed 80, EUTF, QUEST and/or FEP, please be sure to indicate for which entity the payment is being made. Bundled payments for multiple lines of business cannot be accepted. Submit a separate payment indicating which line of business the money is for so that HMSA Benefits Recovery can accurately record your information and the money returned.
New wellness initiatives for Federal Employee Program (FEP)

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• Providers will be required to refund the member if a copayment is collected in error.

• To ensure correct reimbursement the claim must be filed with the appropriate evaluation/management procedure code and diagnosis to reflect that the visit was primarily a routine/annual examination for adults or the appropriate medical nutrition therapy/nutritional counseling codes and diagnosis to reflect the visit was primarily a nutritional counseling visit for children.

• Providers may retain certificates; they are not required to be submitted with the claim.

• Childrens certificates entitle them to four visits. Sign and date the certificate at each visit to track usage.

For questions about the certificate program, please contact the Federal Employee Program Customer Service Center at 948-6281 or 1 (800) 966-6198 from the Neighbor Islands.

2010 Changes to the Federal Employee Program (FEP)

Effective January 1, 2010, the following Federal Employee Program (FEP) services will require prior approval for both Basic and Standard Option members:

• Outpatient intensity-modulated radiation therapy (IMRT)

• Hospice services

• Outpatient professional or outpatient facility care for mental health and substance abuse

As a reminder, precertification is required prior to admission for both Basic and Standard Option members.

Prior approval is required for the following surgical services if they are to be performed on an outpatient basis:

• Surgery for morbid obesity

• Surgical correction of congenital anomalies

• Outpatient surgery to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth

Any questions regarding benefit changes for 2010 and these new programs should be directed to the FEP Customer Service Center at 948-6281 or 1 (800) 966-6198 from Neighbor Islands.
Share Your E-mail Address with TriWest

TriWest Healthcare Alliance is developing a more effective means of communicating with providers by collecting provider e-mail addresses. The goal is to obtain provider e-mail addresses that will allow TriWest to communicate the right information to the right person at the right time.

For example, it will allow TriWest to inform you about:

- TRICARE program changes
- New TriWest processes, policies and/or resources to help you care for TRICARE beneficiaries
- Educational opportunities or events in your community

TriWest will not sell or distribute your e-mail address to other companies — with the exception of your local network representative. TriWest will not send spam e-mails as all communications will be information related to TRICARE and TriWest. Also, TriWest will not overload your e-mail account.

You can share your e-mail address(es) with TriWest by registering for the TRICARE eNews on our website via email at providerservices@triwest.com, by contacting your local representative at 948-5213, or by calling TriWest at 1 (888) TRIWEST (874-9378), or through the TRICARE Policy Manual at www.tricare.mil/.

REMINDER: CMS 1500 (08-05)

All claims must be filed via the new CMS 1500 (08-05) version. Any claims submitted on old CMS 1500 claims forms will be returned.