Annual Eye Exams Part of Diabetic Care

More than 47,000 HMSA members have been diagnosed with diabetes. Diabetic retinopathy is the leading cause of new cases of blindness among adults between the ages of 20 and 74. As with other diabetes-related medical conditions, the sooner diabetic retinopathy is diagnosed, the better the chance for successful treatment.

An annual comprehensive eye exam, including a dilated retinal exam (DRE), is recommended by the American Diabetes Association and the Hawaii State Practice Recommendations for Diabetes Mellitus for patients with the following:
- Type I diabetes, with exams beginning five years after onset.
- Type II diabetes, with exams beginning at the time of diagnosis.
Exams may be performed less often (once every two to three years) when advised by the patient's eye care physician.

Primary care physicians (PCPs) should refer patients with diabetes to an eye care specialist for a DRE every year. Results of a diabetic eye exam should be reported to the patient's PCP since coordination between practitioners will ensure the patient receives continued comprehensive diabetic care.

Programs like HMSA’s Practitioner Quality and Service Recognition (PQSR) Program and Health Plan Hawaii Quality and Performance (Q&P) Evaluation Program have provided physicians with data on screening rates and patient-specific information identifying patients who are due for a DRE. We believe this information is a valuable tool that can assist physicians in their treatment of patients with diabetes.

Pharmacy drug list of condition codes is available online

The condition code matrix has been updated with all the ICD-9-CM diagnosis codes effective Jan. 1, 2005, and is available online. This tool should assist physicians in looking up the ICD-9-CM diagnosis code needed on certain drug prescriptions. Please refer to the Provider E-Library and look in the CONDITION CODES section of the PHARMACY/FORMULARY for the updated matrix.

Essential information needed to pre-certify an oral drug

When an oral drug needs to be pre-certified, submit a Drug Review Request Form to HMSA for review. The form needs to be completed in full so the request can be processed in a timely manner. Often, Drug Review Request forms are received missing essential information, such as the member’s name, membership number, provider name, name of drug (including the strength, days supply, refill amount), and mail order or retail provider. Incomplete forms cause delays! Please
review your Drug Review Request Form for completeness before submitting it to HMSA.

Billing and Coding

✓ Additional CPT codes for debridement

Additional debridement codes for 2005, effective Jan. 1, 2005, are as follows.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11004</td>
<td>Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum</td>
</tr>
<tr>
<td>11005</td>
<td>Abdominal wall, with or without fascial closure</td>
</tr>
<tr>
<td>11006</td>
<td>External genitalia, perineum and abdominal wall, with or without fascial closure</td>
</tr>
</tbody>
</table>

When submitting claims using debridement codes, an operative report or other narrative documenting the extensive nature of the services being performed, must also be submitted. A claim submitted without a narrative report will be denied, as debridement is generally considered integral to wound or fracture repair.

✓ Correct use of modifier 57 and 25 associated with emergency room visits requiring surgery

Recent review of claims for E/M services provided in the emergency room indicates that these services are sometimes erroneously coded with a modifier 57, when associated with a minor surgery.

Use of modifier 57 to code an emergency room visit that determines the need for major surgery. Modifier 57 may be used when an emergency room visit:
- Is performed on the day before or on the day of a major surgery.
- Resulted in the initial decision to perform the surgery.

The major surgery must be performed on an urgent or emergent basis, as defined by HMSA, and the surgeon must not have seen the patient within the previous 30 days for the same condition.

A major surgical procedure is defined by HMSA as any procedure that is performed in an operating room, usually under general anesthesia, which has a 90-day postoperative period.

If the emergency room visit claim is submitted without modifier 57, only the major surgery associated with the visit will be considered for payment.

Use of modifier 25 to code an emergency room visit associated with minor surgery. When a separately identifiable emergency room visit is performed in association with a minor surgical procedure, modifier 25 should be appended to the visit. When a claim is received without modifier 25, only the surgery associated with the emergency room visit will be considered for payment.

Please refer to the Provider E-Library online for guidelines to use when determining whether to use modifier 57 or 25.

✓ Additional codes not requiring pre-certification for Intensity Modulated Radiation Therapy (IMRT)

Pre-certification is not required for IMRT of the prostate, head and neck areas. The following ICD-9-CM codes were recently added to the list of diagnoses not requiring pre-certification.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>141.0-141.9</td>
<td>Malignant neoplasm of tongue</td>
</tr>
<tr>
<td>143.0-143.9</td>
<td>Malignant neoplasm of gum</td>
</tr>
<tr>
<td>161.0-161.9</td>
<td>Malignant neoplasm of larynx</td>
</tr>
<tr>
<td>196.0</td>
<td>Lymph nodes of head, face, and neck</td>
</tr>
</tbody>
</table>

Please refer to the Provider E-Library for a complete list of diagnoses and pre-certification information on IMRT.
 ✓ **Immunization fee MAC increase**

   The maximum allowable charge (MAC) for pneumococcal conjugate vaccine has increased, effective Nov. 23, 2004. The new MAC appears below.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>MAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90669</td>
<td>Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for IM use</td>
<td>74.03</td>
</tr>
</tbody>
</table>

**Correction**

EDI support staff phone number for the Neighbor Islands was erroneously reported in the November Provider Update. The correct phone number is 1 (800) 377-4672.

**Policy Changes**

 ✓ **Oxycodone controlled release (OxyContin) quantity limit increase**

   Effective March 1, 2005, prescriptions for OxyContin brand and generic will be increased to no more than 90 tablets a month for patients taking the drug three times a day. Currently, only 60 tablets may be dispensed. Pre-certification is required when a physician needs to prescribe quantities greater than the limitation.

 ✓ **New policy on biological therapeutics and biopharmaceuticals**

   HMSA has a new policy that applies to a newly released biological, when no medical policy for the specific biological exists.

   Effective Jan. 1, 2005, pre-certification is required for all new biological therapeutics for the first year from the date of release and may require continued pre-certification after the first year. Physicians will be notified if pre-certification is required after the first year.

   The Food and Drug Administration (FDA) has recently approved a new drug, Tarceva (Erlotinib). This drug requires pre-certification under HMSA’s new medical policy on biologicals.

   Please refer to the medical policies available online in the MEDICAL section of the Provider E-Library.

 ✓ **Enbrel policy updated**

   Effective January 15, 2005, pre-certification is required for the drug Enbrel. This policy has been updated online to include information about pre-certification procedures. Please refer to the Provider E-Library to review the updated information.

 ✓ **Cox-2 Inhibitors**

   Changes will be made to the criteria used to determine whether a patient will receive additional benefit coverage for selected Cox-2 inhibitors. These changes are effective March 1, 2005. Patients must meet one or more of the following criteria:

   - Is 60 years of age or older
   - Is expected to require continuous, ongoing treatment for at least six months for a chronic disease
   - Has a history of gastrointestinal ulcer and/or upper gastrointestinal bleeding
   - Is on concomitant anticoagulant therapy, chronic oral glucocorticoid therapy, or misoprostol, PPI, H2 antagonist or Arthrotec
   - At least two prescription NSAIDs were found ineffective or not well tolerated after the patient has undergone an adequate course of treatment. An adequate course of treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of NSAID therapy.

   The FDA warns that caution should be exercised when using Cox-2 medications by persons with known heart disease and those at high risk for development of heart disease.

   For detailed information, please refer to the medical policies available online in the MEDICAL section of the Provider E-Library.

 ✓ **Cosmetic surgery pre-certification**

   Pre-certification requests for cosmetic surgery usually include photos and/or slides as part of the documentation. HMSA generally does not return supporting documentation. However, when a practitioner wants photos and/or slides returned, the practitioner should indicate such on the pre-certification request.
Speech therapy benefits for Federal Plan 87

In the November 2004 Provider Update, speech therapy benefits were outlined for HMSA's private medical plans. Further clarification is required regarding speech therapy benefits for Federal Plan 87 members. Federal Plan 87 provides for medically appropriate speech therapy up to a maximum of 25 visits per year.

Pre-certification requirements for 65C Plus

HMSA's Medicare-based 65C Plus plan requires pre-certification for custom wheelchairs only. The 65C Plus plan follows Medicare coverage guidelines.

Referral to nonparticipating providers

HMSA encourages members to seek services from HMSA participating providers in order to receive the best benefits possible from their HMSA medical plan.

When physicians refer HMSA patients to nonparticipating providers, patients generally incur greater out-of-pocket expense. While participating providers agree to accept the eligible charge for covered services, nonparticipating providers generally do not, which may result in the member being responsible for any difference between the actual charge and the eligible charge.

HMSA recommends that participating providers refer members to other participating providers.

HMO referral update

HMSA HMO referrals should be made through HHIN. This is the preferred way since the information entered on HHIN is directly processed in our system and ensures a more timely response.

When a provider is unable to use HHIN, HMSA has updated the HPH/HMO Referral Form that can be used to complete and send by fax or mail. Please refer to it online in the Provider E-Library under the FORMS section when making an HMO referral.

65C Plus Changes

Incentive payments for physician in shortage areas (HPSA and PSA)

HMSA's 65C Plus physicians who render covered HMSA 65C Plus services in a geographically designated Health Professional Shortage Area (HPSA) may be entitled to a 10 percent incentive payment. The incentive amount is calculated on the amount actually paid by HMSA's 65C Plus, not the approved amount. The HPSA incentive is allowed only when the physician actually renders the service in a geographically designated area.

Effective Jan. 1, 2005, there will be an additional payment to physicians in counties where there is a scarcity of physicians (Physician Scarcity Area—PSA). (See http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pdf for information related to HPSA and PSA payments.)

Centers for Medicare & Medicaid Services (CMS) has created a user-friendly Web page for the provider community that addresses the changes to the HPSA bonus payment program and describes the new PSA bonus payment program. The new procedures are effective for claims submitted with dates of service on and after Jan. 1, 2005 and can be found at http://www.cms.hhs.gov/providers/bonuspayment.

Medicare has provided for quarterly automatic payments (and does not require the billing of the modifiers) for HPSA and PSA services rendered in specific zip code areas effective Jan. 1, 2005. HMSA 65C Plus providers must continue to bill the appropriate modifiers in order to receive the HPSA and PSA bonus payments (QB/QU for HPSA and AR for PSA bonus payments). HMSA will provide these bonus payments on a calendar year basis because of the limited number of 65C Plus contracting providers eligible for these payments.
EDI update

HMSA has enhanced the information available through EDI 270/271 Eligibility and Benefit Inquiry Transactions. Technical information about the updates is available online at www.hmsa.com/about/issues/hipaa/provider.asp. Click on the link to the HMSA Trading Partner Manual for more information.

Reminder

New pre-certification fax numbers are in effect.

HMO referrals
Oahu.............................. 944-5602
Neighbor Islands.......... 1 (800) 965-4672

Medical pre-certification......944-5611
Facility admission face sheets/census.........................944-5611
Oral drug pre-certification.....944-5618

Internet Reminder

The Provider E-Library contains the most complete and up-to-date HMSA provider reference material available. Our Internet site www.HMSA.com/portal/provider is updated as new information becomes available and is the best source for the most current provider information.

HMSA encourages you to bookmark the Provider Resource Center home page, or add it to your list of Internet favorites.

Enclosures

We have also included a CD for physicians receiving this mailing. The CD includes:

- An updated list of changes to the HMSA formulary effective Jan. 1, 2005. Please include it with your pharmacy reference material.

Clinical Practice Guidelines and formulary changes will be reflected online as of the effective date of the changes.

The Provider E-Library is also available on HHIN on the information page.

If you have questions about information in this Provider Update, please call a Provider Teleservice Representative at 948-6330 on Oahu or 1 (800) 790-4672 from the Neighbor Islands.