New York State Adds Copays to Family Health Plus

Effective September 1, 2005, Excellus BlueCross BlueShield (Excellus BCBS) and all other health plans that offer Family Health Plus (FHP) will begin applying copayments to certain services provided to most FHP members.

By law, providers cannot deny services (based on inability to pay) to FHP members who cannot pay the copayment. However, the member is liable for the copayment, and the provider may undertake collection procedures as necessary.

Copayments will not apply to the following members:
- under age 21
- pregnant (including tests to determine pregnancy)*
- permanent residents of nursing homes
- residents of community-based residential facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disability

*To prevent the copayment from being applied to a claim for a pregnant member, providers should include a secondary diagnosis of pregnancy on the claim.

Copays will also not apply to the following services:
- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Psychotropic drugs
- Tuberculosis drugs
- Prescription drugs for a resident of an Adult Care Facility licensed by the Department of Health

Vision Benefit
Also as of September 1, 2005, the FHP vision benefit no longer includes replacement of lost, damaged or destroyed eyeglasses. The following are covered once in any 24-month period:
- one eye exam, and
- either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary, and
- one pair of medically necessary occupational eyeglasses.

List of copays included
See the chart on page 3 for a list of the affected services and corresponding copayment amounts. Also included in this newsletter is a draft of the letter that the Department of Health is sending to all Family Health Plus members.
You asked Provider Service the question...

...We publish the answer – for everyone!

Q. Under what circumstances should our office refrain from submitting a Medicare primary claim for secondary payment to Excellus BCBS?

A. Many health plans have automatic crossover from Medicare. This means that after making payment, Medicare automatically forwards the claim to the secondary payer. If this has occurred, it will be noted on the EOMB from Medicare.

When your patient has coverage through another BlueCross BlueShield Plan (e.g., Empire BlueCross BlueShield), and you receive a Medicare EOMB indicating that the claim has been forwarded by Medicare to that other Plan, please DO NOT send the remaining claim balance to us as a BlueCard Host claim. Medicare has already filed the secondary balance to the correct Health Plan. Your BlueCard claim will only deny as a duplicate.

If the claim is for one of our members and Medicare forwarded the claim to us, if we need additional information (such as a copy of the actual EOMB), we will request it. In many instances, Medicare has already provided all the information necessary for us to process the claim.

Don’t forget – Just the Facts and the 2005 Participating Provider Manuals are on our Web site!

<table>
<thead>
<tr>
<th>Just the Facts</th>
<th>2005 Participating Provider Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider newsletters for the past two years are available at <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a>!</td>
<td>The Participating Provider Manual is available at <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a>!</td>
</tr>
<tr>
<td>• Click on For Providers.</td>
<td>• Click on For Providers.</td>
</tr>
<tr>
<td>• Go to the bottom of the page and click on News and Updates.</td>
<td>• Click on Administration at the top of the page.</td>
</tr>
<tr>
<td>• Look under Provider Newsletters.</td>
<td>• Click on Provider Manuals in the left column.</td>
</tr>
<tr>
<td>• Select Just the Facts for your region.</td>
<td>• The options for the regional manuals will appear under the Provider Manual heading.</td>
</tr>
<tr>
<td>• Select the month’s issue you would like to read.</td>
<td>• Select the region you need.</td>
</tr>
<tr>
<td></td>
<td>**If you do not have access to the Internet and need a paper copy of the Provider Manual,</td>
</tr>
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<td></td>
<td>please contact Provider Service.</td>
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</tbody>
</table>
## New York State Family Health Plus Copays Effective September 1, 2005

<table>
<thead>
<tr>
<th>Service or Supply</th>
<th>Copay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs</td>
<td></td>
</tr>
<tr>
<td>Per prescription and/or refill. No maximum. No copay for psychotropic drugs, tuberculosis drugs, prescription drugs for residents of an adult care facility licensed by the NYS Department of Health.</td>
<td>$3 generic $6 brand name</td>
</tr>
<tr>
<td>Covered over-the-counter drugs (OTC)</td>
<td>$0.50 each</td>
</tr>
<tr>
<td>Smoking cessation products, insulin, etc.</td>
<td></td>
</tr>
<tr>
<td>Clinic visits</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Per visit/ No maximum. No copay for emergency services, family planning/prenatal services, chemical dependence clinics, mental health clinics.</td>
<td></td>
</tr>
<tr>
<td>Physician visits</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Includes physician services for outpatient surgical procedures. Applies for ophthalmologist or podiatrist treating medical condition.</td>
<td></td>
</tr>
<tr>
<td>Dental service visits</td>
<td>$5 per visit up to a total of $25 per year</td>
</tr>
<tr>
<td>Lab tests</td>
<td>$0.50/test</td>
</tr>
<tr>
<td>No copay for pregnancy or prenatal tests or lab services related to emergencies.</td>
<td></td>
</tr>
<tr>
<td>Radiology services</td>
<td>$1/service</td>
</tr>
<tr>
<td>Includes diagnostic X-rays, ultrasound, nuclear medicine and radiation oncology services.</td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital stay</td>
<td>$25 per stay</td>
</tr>
<tr>
<td>Non-urgent/non-emergency ER visits</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Covered medical supplies</td>
<td>$1 per supply</td>
</tr>
<tr>
<td>• Diabetic supplies such as test strips, glucose monitor, lancets, syringes.</td>
<td></td>
</tr>
<tr>
<td>• Enteral formulas.</td>
<td></td>
</tr>
<tr>
<td>• Hearing aid batteries.</td>
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</table>

### Reminder to Specialists in Managed Care Networks

Please remember that when an individual specialist physician or a specialty group terminates participation in the Health Plan, the specialist or specialty group must notify affected members of the termination prior to the effective date of the termination. This has been a contract requirement for specialists in our managed care networks since July 1, 2003. This requirement is mandated by the National Committee for Quality Assurance, the accrediting agency for our managed care organization.

“Termination” includes termination of the contract between us and the physician or group for any reason, or any other situation in which the physician or group is no longer available to see an affected member. “Affected Members” shall refer to members who are receiving an ongoing course of treatment from the specialist physician or specialty group.
New Preauthorization Clinical Review Program

Excellus BlueCross BlueShield recently announced a new program for select, elective inpatient procedures requested on or after October 11, 2005. The program will apply to elective inpatient admissions for the procedures listed below for all health benefit programs that require preauthorization for inpatient admissions, including safety net and government programs. While these surgical procedures already require preauthorization for inpatient admissions, we now will review clinical indicators for these procedures more thoroughly and will, therefore, request more information before we authorize the procedure.

This means that, while the hospital should continue to verify that the admission has been approved, the admitting physician’s office will need to make the preauthorization request and supply the clinical information to our organization.

This program is being established because surgical use rates, both overall and for these procedures, are above expected targets based on national benchmarks. The specific inpatient surgical procedures are as follows:

- Elective PTCA
- Open cholecystectomy
- Total hip replacement
- Total knee replacement
- Laminectomy
- Prostatectomy (non-cancerous)

It is not necessary to obtain preauthorization for these procedures when performed in an outpatient or office setting. Preauthorization is also not necessary for emergency procedures.

Over time, we may add to or remove procedures from this list, based on ongoing reviews and surgical trends.

Currently, the program is limited and the affected providers have been individually notified. A bulletin was sent out to all hospitals, neurosurgeons, orthopedic surgeons, general surgeons, urologists, thoracic surgeons and cardiologists. If you feel that this program applies to your practice and you did not receive the notification, or if you have any questions regarding the information, please contact your Provider Relations Representative.

Update to BlueExchange QuickLink Screens

As you are aware, BlueExchange functions for out-of-area members are available on both QuickLink and the Web. We have recently changed some of the QuickLink screens for the BlueExchange functions. The QuickLink main menu now includes an option for BlueExchange under F3. Previously BlueExchange transactions were done through the F2 function, Membership Verification screen.

In addition to the change on the QuickLink menu, the BlueExchange menu also has new, more concise transaction navigation. This includes changes to the function keys. The changes should be self-explanatory but, until you become accustomed to them, please read carefully the first few times you encounter the updated screens.

BlueExchange functions on the Web remain unchanged.
Updated Guidelines Available on our Web Site

We’ve recently updated the following Clinical Guidelines:

- Stroke Prevention
- Coronary Artery Disease: Secondary Prevention
- Preventive Health Services: Healthy Children to Age 18
- Preventive Care of Adults
- Smoking Cessation

The updated guidelines are available on our Web site at [www.excellusbcbs.com](http://www.excellusbcbs.com), along with many other clinical practice guidelines and materials.

Click For Providers, then on Patient Care. Select Clinical Practice Guidelines from the menu on the left. Scroll down to the guideline you need.

To have a paper copy of a guideline or other material mailed to you, please contact our Quality Management Department at (315) 671-7140.

Advance Care Planning Information Available on the Web

Please take the opportunity to encourage your patients to complete a Health Care Proxy form before they need it. While patients would prefer to think that they will never need a health care proxy, most are introduced to the idea upon an admission.

New York state law requires that patients be provided certain information prior to or upon admission to a health care facility, or within a reasonable time thereafter. This document requires serious thought and is too important to be rushed through at the time of admission. Another important consideration is that the law precludes health care facility staff and physicians from acting as agents, with certain exceptions. For more information about Health Care Proxy Laws in New York, visit the Department of Health Web site [www.health.state.ny.us/nysdoh/consumer/patient/hcproxy.htm](http://www.health.state.ny.us/nysdoh/consumer/patient/hcproxy.htm).

There, you will find a copy of The Health Care Proxy Law: A Guidebook for Health Care Professionals. This publication, prepared by The New York State Department of Health and The New York State Task Force on Life and the Law, includes a sample copy of a proxy form.

In addition to this information from the state, we provide information on our Web site [www.excellusbcbs.com](http://www.excellusbcbs.com). Click on For Members, then Print Forms at the bottom of the page, then follow the link to Advance Care Planning.

Availability of our Privacy Policy

At Excellus BlueCross BlueShield, we are committed to safeguarding our members’ protected health information (PHI). Our privacy policy outlines the many steps that we have taken to comply with federal and state laws, as well as guidelines of numerous accrediting agencies. The following are a few examples of information that can be found in our privacy policy:

- Our routine uses and disclosures of PHI
- Use of authorizations
- Access to PHI
- Internal protection of oral, written, and electronic PHI across the organization
- Protection of information disclosed to plan sponsors or employers

Our privacy policies are available on our Web site, [www.excellusbcbs.com](http://www.excellusbcbs.com).

At the bottom of the home page, click on Privacy Policy. This will bring you to the privacy policy page, which displays the Web site’s privacy policy. To view the complete Excellus BCBS privacy policy, click on the link in the left-hand column, Privacy Policy (PDF). Paper copies of our privacy policy are available from Provider Service.
Disease Management Program for PPO and EPO Members

Excellus BlueCross BlueShield is pleased to announce the availability of our standard disease management program for your BluePPO/EPO, BlueEPO Balance, BluePreferred PPO, Member Options, FourFront™, BASSETTplus PPO, and BluePPO HSA patients. This program is free to members and practitioners.

Beginning in September 2005, population-based program services will be introduced to our PPO members identified as having asthma, diabetes and/or heart disease.

All members identified as eligible for program enrollment are automatically enrolled but have the option to decline participation if they choose. In addition, groups for whom we provide administrative services only may choose not to participate in this program.

Members qualify for enrollment through a number of ways such as identification and risk evaluation using medical and pharmacy claims, physician referral, self-referral and referral from one of our Excel for Life Programs.

The program provides educational information to members and practitioners through activities such as educational newsletters, targeted reminder mailings regarding gaps in care, and nationally accepted evidence-based clinical guidelines with supporting patient education tools.

The level of intervention is based on the member’s level of illness risk.

High-risk patients are also eligible to receive one-on-one telephonic educational counseling with a nurse, through the Care Calls program, as well as case management services for medically complex members.

The focus of disease management is to enhance, not replace, the efforts of the physician. Working together, we can make a significant impact on health and improve the quality of life for our members with chronic illnesses.

Professional Coding Seminar Registration Included

Included in this newsletter is the registration form for the Sept. 15 seminar being hosted in Utica by the Upstate New York Chapter of Professional Coders. Seating is limited to 200, so get your registration in early!
Rendering Provider Identification Number Needed

During July, we sent rendering provider identification (RPI) numbers to all those participating providers who practice as part of a group. Each group should have received a list of everyone billing under the same tax ID number. We assigned a unique rendering provider ID to each name on the list.

If the list you received did not include the name of the practitioner who owns the practice, that practitioner should continue to use the tax ID number as his or her RPI number when submitting claims.

The term “rendering provider” means the individual actually providing the service. **Excellus BCBS requires the RPI on all professional claims for all lines of business.** “Professional” claims are those submitted electronically in ANSI 837P format, or on a paper CMS-1500 claim form.

We will eventually start **denying claims that are submitted without the RPI**, so it is important that those who are not already doing this make the necessary changes now.

**Different Requirements for Electronic versus Paper Claims**

- **For paper claims**, please enter the individual rendering provider identification number (PIN#) in the lower left side of box 33 on the CMS-1500 (HCFA) form, and the group billing identification number (GRP#), if applicable, on the lower right side of the same box 33. In many cases, the group number, if applicable, is the tax ID of the rendering provider’s group.

  This information in box 33 is a “required” field according to the New York State Clean Claim Guidelines. A health insurer may reject as incomplete a claim submitted on a paper CMS-1500 claim form if the claim is missing information in required fields.

  Providers billing on paper using billing program software will need to contact your vendor to program this field to print the correct RPI number in field 33.

- **For electronic claims**, loop 2310B of the HIPAA-compliant ANSI 837P EDI transaction record must be populated with rendering provider number when it differs from the billing provider. **This may involve some programming changes for your software vendor.** We encourage you to contact your vendor as soon as possible so that the changes can be made.

We have established a temporary toll-free dedicated line to answer any questions you may have about this process. The number is 1 (877) 891-5597.

**Provider’s Right to Review Credentialing/Recredentialing Data**

Health care providers have the right to review the information that the Health Plan obtains to evaluate their credentialing applications, including that obtained from primary sources, such as the National Practitioner Data Bank and the New York State Office of Professional Conduct. Providers notified of a discrepancy between the information on the application and the information obtained by the Health Plan have the right to correct erroneous information. It is important to notify us in writing within 30 days of discovering erroneous information.

**AMA Supports CAQH**

The American Medical Association (AMA) recently issued a press release announcing its support for the Universal Credentialing Data Source (UCDS). The UCDS is a universal credentialing system developed by the Council for Affordable Quality Healthcare (CAQH). CAQH has based various system improvements on suggestions from the AMA. The complete press release can be viewed on the AMA Web site at the following address [http://www.ama-assn.org/ama/pub/category/15270.html](http://www.ama-assn.org/ama/pub/category/15270.html).

Most major payors in the Excellus BCBS regions participate with CAQH.
Update on Unique Subscriber Identification Numbers

As discussed in previous issues of this newsletter, we have given new ID numbers to all of our subscribers whose ID numbers were previously based on their social security numbers. This is to help protect the privacy and identity of our members.

The BlueCross BlueShield Association is requiring that all BlueCross BlueShield plans replace social security-based ID numbers by the end of 2005. During a transition period, claims are being accepted with either the old or new ID number. If you submit a claim for an Excellus BCBS member with the old ID, your remit will show the new number.

Because all BlueCross BlueShield plans may not yet have completed the changeover, your claims for a BlueCross BlueShield member from another plan (BlueCard) may not reflect a new ID number on the remit.

The BlueCross BlueShield Association did not require a specific format, so the number of positions may vary. The format for the new Excellus BlueCross BlueShield subscriber ID number is still nine positions, but it’s four numerals, one letter and four numerals (example: 1111A2222). This may not be the same format used by other BlueCross BlueShield plans, however. For example, the format for the ID number for New York State employees covered by the Empire Plan (prefix YLS) is also nine positions, but it is three numerals and one letter, followed by five more numerals (111A22222).

While the member identification number is required on all claims, the Health Plan does not require member social security numbers on claims, and members should not be required to provide that information when receiving services.

Please remember to always ask for the ID card. And don’t forget to include the three-digit alpha prefix on all claims for BlueCross BlueShield members.

Leave Field 17a on CMS-1500 Blank if Not Applicable

Please leave field 17a, I.D. NUMBER OF REFERRING PHYSICIAN, blank on claims where there is no referring physician. Do not put “not applicable” or “N/A” in this field as our optical character recognition (OCR) technology picks up the information and will recognize it as invalid. This can slow the processing of your claim.

So please remember, do not enter anything except a valid provider ID number in this field.

Practitioners May Discuss Any Treatment

The Health Plan does not place any limitations on communications between participating practitioners and our members regarding appropriate treatment alternatives, regardless of benefit coverage limitations. We do not penalize participating practitioners for discussing, with the patient or with us, what you believe to be care that is appropriate or medically necessary, or for making a report or complaint to a governmental body regarding the situation or our policies or practices.

Participating Provider Window Clings Available

At recent seminars, Excellus BlueCross BlueShield distributed participating provider window clings to display in your practice. If you did not receive a window cling or would like another, please let your Provider Relations Representative know. We’ll be happy to send you one.
Medical Policy/Protocol Update

To ensure that the development of corporate medical policies occurs through an open, collaborative process, we encourage our participating practitioners to become actively involved in medical policy development. Each month, draft policies are posted in the Provider section of our Web site (www.excellusbcbs.com) for participating practitioners’ review and comment. Click on For Providers, then Medical Policies. Next, click on Preview & Comment on Draft Policies located at the bottom of the menu on the left side under Medical Policies. The following policies are tentatively scheduled to be available for comment in August 2005:

- Genetic Testing for BRCA I and II Mutations
- Genetic Testing for Germline Mutations of the RET Proto Oncogene in Medullary Thyroid Carcinoma
- Immunizations
- PET for Non-oncologic Conditions
- Ultraviolet Light Therapy for Atopic Dermatitis

Corporate medical policies are used as a guide. Coverage decisions are made on a case-by-case basis and in accordance with the member’s contract. While a technology or service may be medically necessary, payment of benefits is subject to the member's eligibility on the date the service is rendered and the benefit/exclusion provisions in the member's contract. Before rendering care, providers should verify the member's eligibility for the service by calling the Provider Service Department of your local plan.

The following new and updated medical policies have been reviewed and approved by the Corporate Medical Policy Committee, including practitioner representatives from Excellus BlueCross BlueShield, Central New York Region, Central New York Southern Tier Region, Utica Region, and Rochester Region.

Complete detailed policies are available on our Web site at www.excellusbcbs.com. Click on the For Providers menu option, then on View Our Medical Policies. Questions regarding medical policies may be directed to your Provider Relations Representative or to the Provider Service Department of your local health plan. Beginning in June 2005, we have added information regarding CMS coverage to our medical policies and protocols.

Medical policies are also located on the Web site for Excellus BlueCross BlueShield members at www.excellusbcbs.com. To access our policies, members need to click on For Members, followed by Health and Wellness, then Research Health Conditions and lastly View our Medical Policies.

Policies and protocols referenced in this newsletter are written for commercial contracts only. A brief description of CMS coverage has been provided in this newsletter for some Excellus BlueCross BlueShield medical policies/protocols that have a corresponding CMS coverage determination. Please refer to the Centers for Medicare & Medicaid Services (CMS) for more detailed information regarding medical policies or coverage determinations for Medicare contracts. Web sites for review of CMS policies are:


Please note: Although medical policies are effective on the date they are approved by the Medical Policy Committee, updates to the claims processing systems may not occur for up to 90 days in order to allow you to update your billing systems accordingly.

NEW POLICIES recently approved by Corporate Medical Policy Committee

Coronary Artery Computed Tomographic Angiography (Coronary CTA), a non-invasive imaging technique used to obtain detailed volumetric images of the coronary arteries has been proposed as an alternative to invasive coronary angiography. Its use for coronary artery evaluation is considered investigational at this time, as the clinical evidence remains insufficient to determine whether the diagnostic performance of coronary artery CTA is comparable to conventional coronary angiography.
In addition, the impact of the use of coronary CTA on clinical outcomes is uncertain. However, coronary CTA may be considered medically appropriate for the delineation of anomalous coronary arteries when conventional angiography has not provided the information needed for appropriate treatment.

Upstate Medicare’s local coverage determination Multislice or Multi-detector Computed tomographic Angiography of the Chest, provides coverage for diagnostic cardiac evaluation of patients with chest pain syndrome, symptomatic patients with known coronary artery disease (post-stent, post CABG), assessment of suspected congenital anomalies of coronary circulation or great vessels, assessment of symptomatic patients suspicious of pulmonary emboli or aortic dissection, and assessment of mediastinal or lung parenchymal lesions when critical to diagnosis.

CURRENT POLICIES recently updated by Corporate Medical Policy Committee

An End-diastolic Pneumatic Compression Device or circulator boot has been investigated as a technique to promote peripheral circulation by providing timed sequential compression. It has been proposed as a treatment for the complications associated with peripheral vascular disease such as stasis ulcers, dermatitis and osteomyelitis. End-diastolic pneumatic compression for the assistance of arterial and venous circulation in the lower extremities has not been proven to be effective in improving clinical outcomes and is considered investigational.

There is no specific national or local Medicare coverage determination addressing end-diastolic pneumatic compression devices.

Endoscopic Injection of Bulking Agents for Vesicoureteral Reflux, a minimally invasive alternative to ureteral implantation, is considered medically appropriate as an alternative to surgery for clinically severe vesicoureteral reflux (Grade II-IV) in children one year of age or older.

There is no specific national or local Medicare coverage determination addressing endoscopic injection of bulking agents for vesicoureteral reflux.

Optical Coherence Tomography (OCT) is a non-invasive diagnostic imaging technique analogous to ultrasound imaging except that light rather than sound waves are utilized to provide images of the retina. OCT is considered medically appropriate:

- In the evaluation of patients with retinal diseases; and
- As a method of detecting damage to the retinal nerve fiber layer due to glaucoma in high-risk patients where visual field results were inconclusive, reliable visual fields cannot be performed or a discrepancy exists between the clinical appearance of the optic nerve and visual field results.

Optical coherence tomography is addressed in Upstate Medicare’s local coverage determination (LCD), Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI). OCT is covered for the evaluation and treatment of patients with retinal disease and glaucoma following the guidelines outlined within Upstate Medicare’s LCD.

Transrectal Ultrasound (TRUS) is a diagnostic imaging procedure used in the diagnosis, staging and management of malignant diseases of the prostate, rectum and surrounding tissues. TRUS is considered medically appropriate for specific prostatic indications such guided-biopsy, cryoprobe or radioactive seed implant guidance; for the evaluation of azoospermia, ejaculatory/prostatic cysts, obstruction causing infertility or abscesses, evaluation of hematospermia or for the assessment of prostate volume when the size of the gland influences treatment selection. TRUS is also considered medically appropriate for colorectal indications such as staging of rectal carcinoma; evaluation of complex rectal masses, fistulae or abscesses; for the evaluation of fecal incontinence or for suspected rectovaginal endometriosis. TRUS is considered investigational as the sole means of diagnosing prostate cancer; for staging or screening of prostate cancer; and for monitoring the response of prostate or rectal cancer to treatment.

Upstate Medicare not only provides coverage of transrectal echography for the indications covered in our medical policy, but additionally covers the following: the clinical staging of prostate cancer, when
suspicion of prostatic disease is documented from the patient’s history, rectal examination or a PSA (prostatic-specific antigen) level of 4 ng/ml or above; and metastatic lesions of unknown origin, with a high PSA, which could have their origins in the prostate.

**CURRENT POLICIES recently updated with minimal changes**
The following policies required only minimal changes (e.g., updating of references, changing language to meet legal needs). **The coverage intent of the policies was not altered.** These policies were recently approved for updating by the Health Plan Medical Directors and are available on our Web site.

- Genetic Testing for Alzheimer’s Disease
- Genetic Testing for Inherited Susceptibility to Colorectal Cancer
- Transcatheter Closure Devices for Cardiac Defects and Patent Ductus Arteriosis
- Corneal Ultrasound Pachymetry
- Extracorporeal Photochemotherapy/Photopheresis
- Intradiscal Electrothermotherapy
- Liver Transplantation
- Lung Volume Reduction Surgery
- Pelvic Floor Electrical Stimulation
- Percutaneous Vertebroplasty/Kyphoplasty
- Scanning Laser Polarimetry
- Urethral Bulking Agents
- Vacuum Assisted Wound Therapy
- Water Induced Thermotherapy

**POLICIES scheduled to be deleted**
It has been determined that the nationally recognized criteria currently utilized in clinical reviews of radiological requests adequately address the Health Plan needs, therefore, the following policies are scheduled to be deleted.

- Magnetic Resonance Imaging (except MRI of the breast)
- Magnetic Resonance Angiography

**NEW PROTOCOLS recently approved by Corporate Protocol Committee**
The **Temporal Mandibular Joint (TMJ) Dysfunction** protocol outlines those services, related to TMJ that are eligible for coverage.

*There is no specific national or local CMS coverage determination for TMJ.*

**CURRENT PROTOCOLS recently updated by Corporate Protocol Committee**

**Air Ambulance Services** are considered medically necessary only if the patient’s medical condition is such that transportation by either basic or advanced life support land ambulance is not appropriate. Specific situations considered medically necessary are outlined within the protocol.

**Upstate Medicare provides coverage for fixed or rotary wing ambulance services when the beneficiary’s medical condition is such that ground transport is not appropriate; fixed or rotary wing ambulance services may also be necessary because the beneficiary’s condition requires rapid transport to a treatment facility and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility; or when the beneficiary is inaccessible by a land or water ambulance vehicle.**

**Land Ambulance Services** are provided in accordance with the New York State Mandate where coverage is provided for such ambulance services when a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in any of the following:

- placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- serious impairment to such person’s bodily function;
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.
The mandate does not require coverage of air ambulance services and the Mandate does not apply to ambulance transportation between hospitals or health care facilities.

*Upstate Medicare provides coverage for land ambulance based upon the patient’s physical condition and level of service required (e.g., basic life support, advanced life support).*

**Continuous Glucose Monitoring** systems are devices used by diabetic patients to supplement, not replace, blood glucose information obtained using standard fingerstick glucose meters and test strips. The routine use of continuous glucose monitoring systems (MiniMed system and Glucowatch) is considered not medically necessary as their effectiveness, in relation to the net health outcome of patients with diabetes, is not significantly greater than the established alternatives of glucose monitoring. However, the MiniMed CGMS device will be considered medically necessary in select patients on a one time testing basis for those patients that have difficulty controlling their diabetes and when treatment decisions will be based on the results of the testing, utilizing specific criteria:

- The patient must be insulin dependent and having frequent, unexplained hypoglycemic episodes; or
- The patient must be insulin dependent and having unexplained large fluctuations in the daily preprandial blood glucose levels and with diabetes not well controlled; or
- The patient must be insulin dependent and having episodes of ketoacidosis or hospitalizations for uncontrolled glucose levels; and
- The patient needs to have completed a comprehensive diabetic education program; and
- There is documented self monitoring of blood glucose at least 4 times per day by the patient; and
- The patient is compliant with recommended medical regimens.

*Upstate Medicare’s medical policy on continuous glucose monitoring addresses the MiniMed device only and allows the device on a one-time or occasional testing basis in those patients that have difficulty controlling their diabetes and only if they cannot control their diabetes or are having frequent hypoglycemic reactions.*

**Foot Care** is defined as the treatment or care of corns, calluses, trimming of nails and other preventive hygienic or maintenance procedures. Routine foot care is not covered. Foot care is eligible for coverage for patients with systemic conditions of sufficient degree to cause severe circulatory insufficiency and/or areas of desensitization in the feet or legs.

*Upstate Medicare’s local coverage determination states that Medicare generally does not cover routine foot care. However, payment may be made for routine foot care when the patient has a systemic disease of sufficient severity that performance of such services by a nonprofessional person would put the patient at risk (for example, a systemic condition that has resulted in severe circulatory embarrassment or areas of desensitization). Treatment of warts on foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body. Services normally considered routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infections.*

**Mycotic Nails** are caused by a fungus that produces a sponge-like growth on the nail. A confirmed diagnosis of fungal infection is necessary (positive culture or KOH) prior to treatment. Treatment of mycotic nails (including trimming and shaving of the nail) is limited to patients who have:

- vascular impairment or hazardous medical condition causing a severe circulatory embarrassment, and/or
- areas of desensitization in the feet or legs and pain/limitation of activity related to the thickened, dystrophic nails; or a compromised immune function (e.g., infection with human immunodeficiency virus – HIV).

*Upstate Medicare covers debridement by manual method or by electrical grinder as a modality used as part of a definitive antifungal treatment for onychomycosis. Treatment of mycotic nails is covered when there is clinical evidence of mycosis of the toenail and marked, significant limitations on ambulation or pain or secondary infection.*
CURRENT PROTOCOLS recently updated with minimal changes
The following protocols required only minimal changes (e.g., updating of references, changing language to meet legal needs). **The coverage intent of the protocols was not altered.** These protocols were recently approved for updating by the Health Plan Medical Directors and are available on our Web site.

- Cranial Orthotics
- Blepharoplasty
- Cryotherapy Devices
- Foot Orthotics
- Orthotics
- Opioid Addiction Treatment
- Nutritional Therapy
- Patients Lift/Seat Lift Chairs
- Treatment of Hirsutism
- Surgical Stockings
Hospital Billing Tips

Please take note of the following tips for billing hospital claims.

• The correct Type of Bill is critical for the accurate adjudication of the claim. Please complete the Type of Bill field beginning with the numeral 1 for services rendered in the hospital. The only exception to this involves facilities with a behavior health agreement for mental health services. Those facilities should submit behavioral health claims with type of bill code 761.

• Hospitals are encouraged to submit late charges, replacement or voided claims as adjustment requests. These are claims that have type of bill codes ending with 5, 6, 7 or 8. Use the Request for Adjustment form found on our Web site, or request a copy from Provider Service.

• When a claim is denied through No Fault, the hospital should remove all references to No Fault (for example, occurrence code 02) and rebill on paper with a copy of the denial. Complete the “No Fault, Workers’ Compensation and Medicare Exhausted Benefits Form” and send with the claim and the denial to the address on the form.

• When a claim is denied through Workers’ Compensation, remove all references to Workers’ Comp (for example, occurrence code 04) and rebill on paper with a copy of the denial. Complete the “No Fault, Workers’ Compensation and Medicare Exhausted Benefits Form” and send with the claim and the denial to the address on the form.

• When submitting for benefits after a primary insurer has paid, be sure to indicate the primary insurers’ remaining deductible or coinsurance by using Value Code fields, and include amounts. A1 (deductible) and A2 (coinsurance) are the two most common other insurance value codes. This is critical for claim submissions after Medicare has made primary payment. Value Code 08 (Medicare Lifetime Reserve Days coinsurance) and 09 (Medicare inpatient coinsurance days) are other common value codes that, when appropriate, must be included on the bill.

• When a member has exhausted Medicare benefits, the hospital should bill on paper with a copy of the denial. Complete the “No Fault, Workers’ Compensation and Medicare Exhausted Benefits Form” and send with the claim and the denial to the address on the form.
No Fault, Workers’ Compensation and Medicare Exhausted Benefits Form

Include this form when submitting a claim for benefits after No Fault, Workers’ Comp or Medicare has denied for exhausted benefits. **Use a separate form for each claim.** Also include a copy of the Explanation of Benefits from the primary carrier. Send the claim, accompanied by the form and EOB, directly to our OPL Department for adjudication. (See address below.)

If the claim is for an out-of-area BlueCross BlueShield member, we will process the claim through the BlueCard Program. If the Home Plan requests that the claim be handled directly at the Home Plan, we will coordinate the transfer of the claim, including the copy of the other insurer’s Explanation of Benefits.

Date Request Submitted: ________________

Hospital Name: __________________________ Provider #: __________________________

Contact Name: __________________________ Contact Phone #: __________________________

Patient Name: __________________________ Patient ID #, including Prefix: __________________________

Patient Account #: __________________________ Date of Service: __________________________

**Reason for Claim Submission:**

<table>
<thead>
<tr>
<th>Check</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Fault Benefits Exhausted</td>
</tr>
<tr>
<td></td>
<td>Workers’ Compensation Benefits Exhausted</td>
</tr>
<tr>
<td></td>
<td>Medicare Benefits Exhausted</td>
</tr>
<tr>
<td></td>
<td>No Fault or Workers’ Comp Partial Payment</td>
</tr>
</tbody>
</table>

Comments:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Mail completed form and attachments to:

Excellus BlueCross BlueShield
OPL Department
PO Box 4809
Syracuse, NY 13221-4809

*A nonprofit independent licensee of the BlueCross BlueShield Association*
Preview Web Site Changes Coming in October!

The provider area of our Web site will look a little different beginning in October. We need to make some changes so we can convert the site to new software. This software will help our site run more efficiently.

The changes should not cause you any difficulty finding or using the tools and features you’ve already been using but, just in case, we’re offering a preview of the screen changes on our Web site before we make them.

See a preview of what’s coming.

Visit us at www.excellusbcbs.com and go to the For Providers area. The link to “Preview Upcoming Web Changes” should answer any questions you may have.

We appreciate your patience through this minor face-lift!
Dear Family Health Plus Member:

A NEW STATE LAW HAS CHANGED FAMILY HEALTH PLUS ELIGIBILITY AND BENEFITS. IT IS IMPORTANT TO READ THIS LETTER TO UNDERSTAND HOW THE CHANGES MAY AFFECT YOU.

Starting [September 1, 2005], Family Health Plus members will be required to make co-payments for certain health and medical services. The Family Health Plus vision benefit will also change.

**CO-PAYMENTS**

Beginning [September 1, 2005], most Family Health Plus members will be responsible for making co-payments to their providers for the following covered Family Health Plus benefits:

- Brand Name Prescription Drugs
- Generic Prescription Drugs
- Clinic visits
- Physician visits
- Dental Service visits
- Lab tests
- Radiology Services (like diagnostic x-rays, ultrasound, nuclear medicine, and oncology services)
- Inpatient hospital stay
- Non-urgent emergency room visit
- Covered over-the-counter drugs (e.g., smoking cessation products, insulin)
- Covered medical supplies (e.g., diabetic supplies such as syringes, lancets, test strips, enteral formula)

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name Prescription Drugs</td>
<td>$6 for each prescription and each refill</td>
</tr>
<tr>
<td>Generic Prescription Drugs</td>
<td>$3 for each prescription and each refill</td>
</tr>
<tr>
<td>Clinic visits</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Physician visits</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Dental Service visits</td>
<td>$5 per visit up to a total of $25 per year</td>
</tr>
<tr>
<td>Lab tests</td>
<td>$0.50 per test</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>$1 per radiology service</td>
</tr>
<tr>
<td>Inpatient hospital stay</td>
<td>$25 per stay</td>
</tr>
<tr>
<td>Non-urgent emergency room visit</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Covered over-the-counter drugs</td>
<td>$0.50 per medication</td>
</tr>
<tr>
<td>Covered medical supplies</td>
<td>$1 per supply</td>
</tr>
</tbody>
</table>

Co-payments will **not** be applied to the following services:

- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Psychotropic drugs
- Tuberculosis drugs
- Prescription drugs for a resident of an Adult Care Facility licensed by the State Department of Health
You do not have to pay the co-payments if you are:
• Under age 21
• Pregnant
• A permanent resident of a nursing home
• A resident of community based residential facility licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disability
• Not able to pay the co-payment at any time and you tell the provider that you are unable to pay.

Family Health Plus members who cannot afford the co-payment may not be denied a service based on their inability to pay. Your provider cannot refuse to give you care or services because you are unable to pay. (However, you will still owe the unpaid co-pay amounts to the provider and the provider may ask you for payment later or send you a bill.)

VISION BENEFIT

Also as of [September 1, 2005], the Family Health Plus vision benefit will change to include in any twenty-four month period: 1) one eye exam; 2) either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary; and 3) one pair of medically necessary occupational eyeglasses. Replacement of lost, damaged or destroyed eyeglasses is no longer a covered benefit. Contact your health plan with any questions about this benefit change.

IMPORTANT CHANGE AFFECTING EMPLOYEES OF FEDERAL, STATE, OR COUNTY GOVERNMENTS, MUNICIPALITIES AND SCHOOL DISTRICTS

If you are eligible for employer-sponsored health benefits through your own or a family member’s employment with the Federal, State, or County government, a municipality or a school district, your Family Health Plus benefits will stop at the end of your benefit year. A change in State Law provides that individuals who have access to health care coverage through such employers are no longer eligible to enroll in Family Health Plus. Your coverage will terminate upon your next annual renewal date occurring after [September 1, 2005]. You will receive another notice before your Family Health Plus is terminated. You may wish to contact your employer to find out about enrolling in their plan, to avoid a gap in your health care coverage.

For more information about these changes to your Family Health Plus benefits and applicable co-payments, call the Medicaid Helpline at 1-877-873-7283 between 8:30 am and 5:00 pm, or your Family Health Plus plan.

If you wish, you can have a meeting (conference) to talk about this action, or you can ask for a "State Fair Hearing." To learn how to do this, please read the sheet that says "RIGHT TO A CONFERENCE OR FAIR HEARING."

Sincerely,

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management
# Fall into Coding

**Presented by the Upstate New York Chapter of Professional Coders**

All certified professional coders and other interested individuals are invited!
Attendees will receive 8 CEUs toward continuing education requirements.

**September 15, 2005**

**Radisson Hotel – Utica Centre**

**200 Genesee Street**

**Utica, NY 13502**

## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:15 - 8:00 a.m.</td>
<td>Registration, Continental Breakfast and Meet the Vendors</td>
</tr>
<tr>
<td>8:00 – 8:15 a.m.</td>
<td>Introduction and announcements, Kathy Dunn, RN, CPC President, Upstate New York Local Chapter of the AAPC</td>
</tr>
<tr>
<td>8:15 – 8:30 a.m.</td>
<td>Opening remarks by Dr. Frank Dubeck, CMO and VP for Excellus BCBS, Utica Region: <em>The Winds of Change - Washington’s wishes for an IT revolution in Health Care, and the implications for coders</em></td>
</tr>
</tbody>
</table>
| 8:30 – 9:30 a.m.    | Flora Allen, Director of Special Investigations for Excellus BCBS  
**Topic:** A Case Study - “I think my employer is committing fraud . . . what do I do?” |
| 9:30 – 10:15 a.m.   | Cindy Hummel, Regional President, Excellus BCBS, Utica Region  
**Topic:** Current legislative issues affecting the health care industry |
| 10:15 – 10:30 a.m.  | Break and Refreshments                                                                                                                     |
| 10:30 – 11:45 a.m.  | Terrence Johnson, JD, CPC, CCP and Vice President of CPC Solutions in Chicago; and author of “Viewpoint” in AAPC monthly publication, *Coding Edge*  
**Topic:** Compliance and Health Care Regulatory Concerns |
| 11:45 – 12:30 p.m.  | Hazel Miller, former Sr. Representative for Empire Medicare, LPN, CPC  
**Topic:** Modifier 25 with E&M Coding, and Medicare Part A |
| 12:30 – 1:30 p.m.   | Lunch and Vendor Network Opportunity                                                                                               |
| 1:30 – 2:45 p.m.    | Terry Leone, President of Catamount Assoc., CPC, CIC, CMBS  
**Topic:** A Complete Guide Through Radiology Coding |
| 2:45 – 3:15 p.m.    | Chuck Spinelli, President of Spinelli Consulting  
**Topic:** Internet Crime and Health Care |
| 3:15 – 3:30 p.m.    | Break and Refreshments                                                                                                                 |
| 3:30 – 4:45 p.m.    | Donna Silsbee, PhD, RHIA, CTR, CCS and Professor at SUNY Institute of Technology at Utica  
**Topic:** ICD-10-CM / ICD-10-PCS Update |
| 4:45 – 5:00 p.m.    | Closing Remarks and Certificates                                                                                                          |

*See reverse side for registration information.*
REGISTRATIONS WILL NOT BE PROCESSED WITHOUT PAYMENT.
Deadline for registration is September 10, 2005.

For directions, please visit our Web site http://uticanewyork.lc.aapc.com and click on News Archive, then click directly on Directions. Please note the absence of “www” in the Web site address.

The Radisson is offering reserved room rates at a conference discount of $90.00 per night. Overnight parking is $6.00. Please contact (315) 797-8010 for reservations, or visit their Web site at www.radisson.com/uticany.

Registration is $99.00 all inclusive. Payable to Upstate NY Chapter of Professional Coders

Registration fee includes:
• Seven presentations
• All materials
• Exhibits
• Continental breakfast, luncheon, afternoon snack

We have lots of door prizes and giveaways planned again for this year's event!

Registration Form
“Fall into Coding” Conference September 15, 2005

Name__________________________________________________________

Title__________________________________________________________

Address____________________________________________________________________

City____________________________________________________________________

State___________________________ Zip ________________________

Phone #________________________ Fax _________________________

E-mail___________________________________________________________

Amount enclosed_________________________________________________

Please return this form with payment to:
Upstate New York Chapter of Professional Coders
PO Box 96
New York Mills, NY 13417

____Please check if you require special accommodations in order to participate fully in this program.

Describe special needs:____________________________________________________________________

Please be advised on the following information specific to this seminar:

➢ Seating for this seminar is limited to 200.
➢ Confirmation of your registration will be via the e-mail address you have provided. If you need to be contacted by other means, please note that in the space provided for the e-mail information.
➢ Refund requests must be submitted, in writing, no later than 15 days from the date of the seminar.
➢ As a courtesy to our speakers, certificates will be distributed at the close of the seminar. If you need to leave early, please indicate on the registration form, or advise one of the chapter members (who will be clearly identified at the conference) no later than 1:00 p.m. on the day of the conference.

We look forward to seeing you there!
CLINICAL UPDATES: Erectile Dysfunction (ED) Drugs
Viagra® (sildenafil), Cialis® (tadalafil) and Levitra® (vardenafil) have been the subject of news recently including:

Reports of Blindness:
The FDA has received a total of 48 reports of a rare type of blindness (Non-Arteritic Anterior Ischemic Optic Neuropathy or NAION) in men using Viagra (43 reports), Cialis (4 reports) and Levitra (1 report). NAION is considered one of the most common causes of sudden vision loss in older Americans, and reports estimate there are from 1,000 to 6,000 cases a year. Risk factors include diabetes and heart disease, two of the leading causes of impotence. There is not yet clear evidence that Viagra, Levitra® and Cialis® are the causative agents in these cases. The FDA is conducting an investigation. (Source: Associated Press, 5/27/05)

Discontinuing Coverage for Sex Offenders:
It was recently discovered that government funded health care has paid for ED drugs for convicted sex offenders. This discovery has led New York State and others to discontinue payment for ED drugs for all patients on government funded health care until a process is established to identify sex offenders within this population.

Treatment of Pulmonary Arterial Hypertension (PAH)
The FDA has approved sildenafil for the treatment of PAH. Pfizer will market sildenafil as Revatio® for PAH and Viagra for erectile dysfunction. Revatio was found to increase the six-minute walk distance in a trial of 277 subjects and is available in a 20mg tablet given three times daily. There was no evidence that higher doses (up to 80mg TID) provided any additional benefit.

(Source: www.FDA.gov/cder)

NEW DRUG APPROVALS:
The FDA has recently approved several drug reformulations, as well as new indications for existing drugs:

Reformulations:
- Asmanex - oral inhalation powder version of mometasone (active ingredient in Nasonex) for first-line maintenance treatment of asthma as prophylactic therapy in patients at least 12 years old.
- Focalin XR - extended release capsule formulation of Focalin (dexmethylphenidate HCl) for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in adults, adolescents, and children.
- Fosamax-D - new 70mg Fosamax also contains 2800 IU (or 400 IU per day) of Vitamin D (cholecalciferol, Vit D3).
- Proquin XR - once daily extended-release formulation of ciprofloxacin for the treatment of uncomplicated urinary tract infection.
- Revatio - 20mg dose of sildenafil for treatment of pulmonary arterial hypertension.
- Tramadol ODT - formulation of tramadol that dissolves in the mouth.
- Triglide - fenofibrate formulation, which doesn’t require the patient to take it with food.
- Zemplar - oral formulation of paricalcitol used for treatment and prevention of secondary hyperparathyroidism.

New Indications:
- Pegasys - approved for the treatment of chronic Hepatitis B. Treatment is for 48 weeks.
- Remicade - approved for psoriatic arthritis.
- Requip - approved for restless leg syndrome.
New Warnings

Recall on Children’s Tylenol Meltaways, Softchews and Junior Tylenol Meltaways® - McNeil
Specially Pharmaceuticals has announced a nationwide recall on the above products due to concerns about product labeling and packaging which may lead to improper dosing, including overdose. Some of the blister cavities contain two tablets, while others contain one tablet. The labeling states “each dose” provides 80mg of acetaminophen, which may lead people to believe that the two tablet blister provides 80mg, when in fact each tablet provides 80mg. Revised labeling will state that “each tablet provides 80mg of acetaminophen.”

Novantrone® (Mitoxantrone) Linked to Cardiotoxicity and Acute Myelogenous Leukemia (AML) - The FDA and Serono, Inc. recommend evaluation of cardiac function and blood cell counts as part of the risk/benefit assessment prior to each dose of Novantrone. Post marketing reports have shown that Novantrone is associated with a risk of cardiotoxicity at any time during treatment. Mitoxantrone should not be administered in patients who demonstrate a significant decrease in left ventricular ejection fraction (LVEF) of less than 50 percent, or who have reached a cumulative lifetime dose of 140 mg/m.

The FDA notes that mitoxantrone generally should not be administered in patients with neutrophil counts less than 1,500 cells/mm. (Source: www.FDA.gov)

Sustiva® (efavirenz) Potential Risk of Fetal Harm: The FDA has changed the classification of Sustiva (used for treatment of HIV) from pregnancy category C to D to avoid potential risk of fetal harm, particularly in the first trimester. The change was based on four retrospective reports of neural tube defects, including three cases of meningomyelocele and one of Dandy Walker Syndrome. The FDA recommends that women of childbearing age have a pregnancy test prior to initiation of Sustiva and that pregnancy be avoided during treatment through a combination of barrier and an additional form of contraception. (Source: www.FDA.gov)

More than 75 Percent of on-line Canadian Pharmacies are Not Legitimate
An FDA study of 11,000 pharmaceutical internet sites found that most sites claiming to be Canadian did not actually sell drugs, but referred visitors to about 1,000 on line stores. Only 214 of these stores were identified as being legitimately connected to a business or individual in Canada. Over 86 percent of the sites were hosted by companies located in the U.S. Nearly 15 percent of these sites were located in other countries such as Australia, Czech Republic, El Salvador, Germany, Mexico, and Vietnam. Most of the fraudulent sites were only accessible through clicking on links in “spam” email. Two-thirds of the sites stated no prescription was required. While fraudulent pharmacy sites abound, roughly 80 percent of all drugs imported into the U.S. from Canada come from approximately 30 Canadian pharmacies that have met health and safety requirements set by the Canadian Internet Pharmacy Association (CIPA). In the U.S., the Verified Internet Pharmacy Practice Sites (VIPPS) program certifies 15 pharmacies. An important safety reminder for your patients is that any legitimate U.S. or Canadian Internet pharmacy will require a written prescription. (Source: FDA commissioned report conducted by Cyveillance)

DID YOU KNOW?

U.S. consumers could save $8.8 billion a year (11 percent of total drug expenditures) if generic medications were substituted for their brand name counterparts. A study of 10,000 households published in the Annals of Internal Medicine of showed 56 percent of all outpatient drugs prescribed were available generically, but 39 percent could have been dispensed generically and were not.

Generics represent 53 percent of the total prescriptions dispensed in the U.S., but only 12 percent of all of the dollars spent on prescription drugs. New York State law requires pharmacists to substitute the brand name drug with a generic drug if there is an A-rated generic available and the prescribing physician does not write Dispense as Written (DAW) on the prescription.

Rx Facts Editor: Mona Chitre, PharmD, CGP; contributing authors: Coreen Montagna, Pharm. D. and Joel Owerbach, Pharm. D. of FLRx Pharmacy Management. Rx Facts is a service provided at no cost to practicing health care practitioners. Grants or funding are not solicited for this service from the pharmaceutical industry. Providers are directed to specific reference sources or drug package inserts for detailed information on drug dosing and monitoring. Copyright © 2005 by FLRx. All rights reserved. Comments or questions are welcome by fax: 1-877-812-5306 or phone: 1-877-777-2737 - email: mona.chitre@FLRx.com