Rendering Provider Information Requirement

Beginning in December 2004, Excellus BlueCross BlueShield (Excellus BCBS) will require claim information to include a provider number for the rendering provider. The term “rendering provider” means the individual actually providing the service. For those providers who do not have an individual provider number, we will assign one. The rendering provider number must be included on claims for all lines of business.

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.

  As we noted in the March 2004 issue of Just the Facts, 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.

- 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.

Regional Differences

- For Utica Region providers, Excellus BCBS will assign an individual rendering provider number for those who belong to a group and do not have a separate tax identification number. You will receive this information from Excellus BCBS in the near future. The group number, if applicable, is the tax ID of the rendering provider’s group.

- For Central New York and CNY Southern Tier Region providers, the rendering provider number is the individual rendering provider’s Excellus BCBS assigned provider number. The group number, if applicable, is the number Excellus BCBS assigned to the rendering provider’s group.
Support Groups for Children with Serious Illness (and Parents, too)

In the last issue of this newsletter, we told you about three related support groups that have formed in the Utica area for families of children with a serious illness. The listing below includes some Web site addresses and telephone numbers of helpful organizations that parents can access for support groups. Please feel free to share this information with your patients.

Online Resources

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Information</th>
<th>Web Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic Alliance</td>
<td>(202) 966-5557</td>
<td><a href="http://www.geneticalliance.org">www.geneticalliance.org</a></td>
</tr>
<tr>
<td>National Association for People with Aids</td>
<td>(202) 898-0414</td>
<td><a href="http://www.napwa.org">www.napwa.org</a></td>
</tr>
<tr>
<td>Muscular Dystrophy Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Tay-Sachs &amp; Allied Disease Association Inc.</td>
<td>1 (800) 906-8723</td>
<td><a href="http://www.ntsad.org">www.ntsad.org</a></td>
</tr>
<tr>
<td>Cystic Fibrosis Foundation</td>
<td>1 (800) 344-4823</td>
<td><a href="http://www.cff.org">www.cff.org</a></td>
</tr>
<tr>
<td>The National Neurofibromatosis foundation</td>
<td></td>
<td><a href="http://www.nf.org">www.nf.org</a></td>
</tr>
<tr>
<td>PPG Parent Peer Group (affiliated with Tay-Sachs group) phone card to communicate with other as many as 400 families – no cost to family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kelley Communications – Hemophilia</td>
<td>1 (800) 249-7977</td>
<td><a href="http://www.kelleycom.com">www.kelleycom.com</a></td>
</tr>
<tr>
<td>Sickle Cell Disease Association of America, Inc.</td>
<td>1 (800) 421-8453</td>
<td><a href="http://www.sicklecelldisease.org">www.sicklecelldisease.org</a></td>
</tr>
<tr>
<td>Candlelighters Childhood Cancer Foundation</td>
<td>1 (800) 366-2223</td>
<td><a href="http://www.candlelighters.org">www.candlelighters.org</a></td>
</tr>
<tr>
<td>National Kidney Foundation</td>
<td>1 (800) 622-9010</td>
<td><a href="http://www.kidney.org">www.kidney.org</a></td>
</tr>
<tr>
<td>The Starbright Foundation</td>
<td></td>
<td><a href="http://www.starbright.org">www.starbright.org</a></td>
</tr>
</tbody>
</table>

PT/OT Reminder

Some health benefit programs require prior authorization for outpatient physical and/or occupational therapy. Excellus BCBS initially approves a maximum of nine visits for these therapies. If the practitioner feels that further visits are needed, after seven visits we require completion of an Update Request Form.

If a practitioner requests another authorization while an earlier authorization is still active (due to a different diagnosis or a different practitioner), we require completion of an Initial Authorization Form. When you call our referral intake line for the authorization, if the representative finds an authorization still open, he/she will fax or mail the Initial Authorization Form to you. The form is also available on our Web site at www.excellusbcbs.com.

Go to For Providers, click on Administration in the menu at the top, then on Print Forms in the menu along the bottom. Scroll all the way down to Other Forms/Guidelines. Both forms are there.

Professional Coding Seminar September 17 in Utica

Included in this newsletter is information (and a registration form) for a seminar presented by the Upstate New York Chapter of Professional Coders.
Medicare Blue PPO – Approved by CMS!
The Centers for Medicare & Medicaid Services (CMS) recently approved Medicare Blue PPO, our Medicare Advantage (Medicare+Choice) product, for marketing in Herkimer and Oneida counties. We are anticipating approval of the following counties before the end of 2004: Broome, Chemung, Madison, Onondaga, Oswego and Otsego.

It’s not too late to become part of our network! All you have to do is contact your Provider Relations Representative.

Please remember that, even though the member must live in one of the approved counties, the provider’s office does not have to be in an approved county in order to see these members. Medicare Blue PPO participating providers in any of the counties in the Excellus BCBS service area may provide services to any Medicare Blue PPO member, even if you are not located in one of the approved counties.

The member ID card has the words Medicare Blue PPO on it. The prefix is ZFM. There are prior authorization requirements for the following services:

- All facility inpatient admissions except emergencies
- Home care services
- DME
- Specific MRI/MRA/CT and PET scans (same as other products with this requirement)
- Organ transplants
- Behavioral health (inpatient, partial hospitalization, intensive outpatient)

ValuMed Plus Now Available in Many Excellus BCBS Counties
Excellus BCBS can now offer our safety net product, ValuMed Plus, throughout our entire Utica Region! This includes the following counties: Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Madison, Montgomery, Oneida and Otsego.

ValuMed Plus is also currently available in some counties in our other regions: Broome, Cayuga, Chemung, Jefferson, Onondaga, Oswego, Schuyler, St. Lawrence and Tioga. We have plans to expand the availability of this product to all counties in the Excellus BCBS service area.

ValuMed Plus is designed to help meet the needs of the working uninsured and unemployed who do not qualify for government-sponsored programs. New members with ValuMed Plus coverage must meet certain eligibility requirements determined by income and other factors.

Members are not required to select a PCP or get referrals to specialty care providers. A limited number of services require prior authorization, including organ transplants, home care outside our service area, and hospice care.

There is no deductible for benefits, but ValuMed Plus requires copays based on the type of service provided. Providers can identify members by a combination of product name (ValuMed Plus) and member ID prefix (ZFV) on the ID card.
**Introducing FourFront**

We recently mailed a communication that introduced *FourFront*, an innovative and consumer-driven version of our *BlueEPO* product. (As you may recall, *BlueEPO* is like our *BluePPO*, but does not include any out-of-network benefits.) We hope to begin enrolling members in *FourFront* in early fall 2004 (pending New York State Insurance Department approval).

*FourFront* members will use the same provider network as *BluePPO* and *BlueEPO*, and the provider fee schedule is the same as the schedule for services you provide to *BluePPO* and *BlueEPO* members. Member cost sharing includes a combination of copayment, coinsurance and deductible. While there is only one medical deductible (no separate deductibles for various types of services), the amount depends on the option selected by the employer group. Some deductible options are considerably higher than our other products.

The name *FourFront* hints at the unique EPO benefit design for diagnostic office visits and diagnostic lab and X-ray services.

**Diagnostic Office Visits**

- The first four diagnostic office visits in the benefit period have a low copayment. This copayment does not apply to the deductible.
- After the first four diagnostic visits, members are required to pay coinsurance and deductible.
- Preventive care is not considered a diagnostic office visit so is not counted in the first four.
- At the time of service, providers should always collect the office visit copay. On the fifth visit, the copay applies to the coinsurance/deductible.

**Diagnostic Lab and X-ray**

- The first $400 of diagnostic lab and X-ray services is covered in full.
- After this allowance is used, deductible and coinsurance apply.

There are no additional administration or utilization management requirements. UM requirements mirror those of *BluePPO*. Providers will identify *FourFront* members by the combination of product name (*FourFront*) and member ID prefix (ZFF) on the ID card.

If you have any questions or did not receive a copy of the special *FourFront* communication, please contact Provider Service.

**Physician Recognition Dinner**

Many physicians at Cortland Memorial Hospital were recognized for reaching milestones in their years of service at the 13th Annual Physician Recognition Dinner. Additionally, Dr. Pat Hayes was named the 2004 Physician of the Year.

We would like to congratulate Dr. Hayes and the following physicians for their achievements, and thank them for working with Excellus BlueCross BlueShield to care for our communities.

**5-year Awards**
Dr. Polly Cator  
Dr. Lynn Cunningham  
Dr. Dieter Eppel  
Dr. James Kowalczyk  
Dr. Chris Moheimani  
Dr. Ann Robenstein  
Dr. Jack Sproul  
Dr. Clay Van Doren

**10-year Award**
Dr. Mihiri DeSilva

**15-year Awards**
Dr. Karl Gauss  
Dr. Sandy Holland

**20-year Awards**
Dr. Charlotte Hawkins  
Dr. Ho Woon Lee  
Dr. Dean Mitchell

**25-year Awards**
Dr. Kye Bang  
Dr. Andrew Chernow

**30-year Award**
Dr. Stu Gillim
Reminder: Southern Tier PR Administering ST Provider Contracts
Since June 1, 2004, the Provider Relations Representatives in the Central New York Southern Tier Region have been administering all provider contracts and amendments directly. We would like to remind you that contracts for CNY Southern Tier providers are no longer handled in the Syracuse office. Therefore, if you are a provider whose primary office is in Chemung, Schuyler, Steuben, Broome, Tioga or Chenango County, please contact your Provider Relations Representative if:

- You would like to receive an application or contract.
- You have a new provider joining a group.
- You have any questions or concerns regarding your contract.

Checklist for Safe Handling and Storage of Vaccines
The Centers for Disease Control and Prevention (CDC) urges providers to pay strict attention to storage and handling so that potency is not compromised by sudden changes in temperature.

According to the CDC, about 17 to 37 percent of providers expose vaccines to temperatures above or below recommended temperatures. In most cases, temperatures are too cold.

The following checklist may help you safeguard your vaccine supply.

- Have a designated person (and a backup) in charge of the handling and storage of vaccines.
- Keep a vaccine inventory log that documents:
  - vaccine name and number of doses received
  - date the vaccine was received
  - arrival condition of vaccine
  - vaccine manufacturer and lot number
  - vaccine expiration date
- Use a household or commercial style refrigerator that has a separate door for the freezer compartment. Do not use a dormitory-style refrigerator.
- Do not store food or drink in the refrigerator or freezer with the vaccines.
- Store the vaccines in the middle of the freezer or refrigerator, not in the doors.
- Stock and rotate your vaccine supply so that the newest vaccine of each type having the longest expiration date is placed behind the vaccine with the shortest expiration date.
- Check vaccine expiration dates and first use those that will expire soonest.
- Post a sign on the refrigerator door showing which vaccines should be stored in the refrigerator and which should be stored in the freezer.
- Always keep a thermometer in the refrigerator. The temperature should be maintained at 35-46°F (2-8°C).
- Always keep a thermometer in the freezer. The temperature should be maintained at +5°F (-15°C) or colder. Keep ice packs and other ice-filled containers in the freezer to help maintain cold temperatures in the event of a power interruption.
- Post a temperature log on the refrigerator door, for recording the refrigerator and freezer temperatures twice per day - at the start of the day and at closing time. This should include the name and number of the representative to call if the temperature goes out of range.
- Post a “Do Not Unplug” sign next to the refrigerator's electrical outlet.
- In the event of a refrigerator or freezer failure:
  - Immediately place the vaccines in a location with adequate refrigeration.
  - Mark affected vaccines, and separate them from undamaged vaccines.
  - Note the refrigerator and/or freezer temperature, and contact the vaccine manufacturer or state health department to determine how to handle affected vaccines.
  - Follow the manufacturer’s or health department’s instructions as to whether the affected vaccines can be used, and, if so, mark the vials with the revised expiration date provided.
Hypertension Treatment Guidelines

According to the American Heart Association’s 2004 statistical update on heart disease and stroke, one in four adults has high blood pressure. High blood pressure (BP) is defined as:

- systolic pressure of 140 mm Hg or higher, or
- diastolic pressure 90 mm Hg or higher, or
- taking antihypertensive medication.

In addition, approximately 22 percent of American adults have “prehypertension.” Prehypertension, as defined by the Seventh Report of the Joint National Committee (JNC 7) on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, is a systolic pressure of 120-139 mm Hg, or a diastolic pressure of 80-89 mm Hg, or both.

Of those with high blood pressure:

- 30% are unaware they have it.
- 34% are on medication and have it controlled.
- 25% are on medication and are uncontrolled.
- 11% are not receiving pharmacotherapy.

In the Excellus BCBS service areas in New York State, hypertension is one of the top 10 reasons for an office visit. The Health Employer Data Information Set (HEDIS) performance measure for blood pressure control assesses whether BP was controlled (both systolic and diastolic BP < 140/90) among adults with diagnosed hypertension. The average HEDIS performance for controlling high blood pressure in the 2003 measurement year across all Health Plan regions was 67 percent. This is only one percent better than the national 90th percentile set at 66 percent. There is room for improvement.

The American Heart Association identifies lack of adherence to medication treatment plans as a primary obstacle to patients achieving BP control. Two-thirds of all Americans fail to take any or all of their prescribed medication.

During the 1990s, the Cardiovascular Health Study looked at control of BP levels to lower than 140/90 mm Hg and the use of various classes of antihypertensive medications in adults 65 years and older. Conclusions from this study show that while BP control improved, about half of the participants with hypertension had uncontrolled BP, and preferred medications were underused. The study also concluded that more widespread use of these medications is an important intervention to prevent the complications that result from hypertension. (Arch Intern Med. 2002;162:2325-2332). The updated treatment recommendations from JNC 7 indicate that the majority of patients will require two medications to reach BP goal, in addition to lifestyle modifications.

Considerable work remains to improve the early diagnosis, treatment, and management of hypertension. Excellus BCBS is in the process of developing interventions to help providers educate their patients regarding the seriousness of the diagnosis and the need for multiple medications to attain BP goal.

To view our most current clinical practice guideline for hypertension, visit our Web site at www.excellusbcbs.com. Click on For Providers, select Patient Care from the menu across the top of the screen, and then select Clinical Practice Guidelines from the menu to the left. Guidelines are alphabetized by disease.

For a copy of the JNC 7 guidelines reference card, go to the following Web site: www.nhlbi.nih.gov/guidelines/hypertension/jnc7card.htm.
**Getting Headaches over Hypertension?**

**Diagnosis Coding for this Common Disease**

Hypertension, as defined in the 19th Edition of Taber's Cyclopedia of Medical Dictionary, is:

1) greater than normal tension or tone; 2) in adults, a condition in which the blood pressure (BP) is higher than 140 mm Hg systolic or 90 mm Hg diastolic on three separate readings recorded several weeks apart.

Coding for hypertension can be difficult. The ICD-9-CM Index for hypertension is in the form of a table, with three separate columns to indicate whether the hypertension is malignant, benign, or unspecified. Some of the major subterms in the Index indicate whether the hypertension included heart or renal involvement, was a complication of pregnancy, was due to some other condition (i.e., brain tumor or renal disorder), or was secondary to some of those same conditions.

Coding for hypertension must be as specific as possible, and only a physician can indicate what type might be involved. Therefore, it is important for physicians to be familiar with the codes available and the terminology required.

**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, and then select the Patient Care button along the top, and then View Our Medical Policies. At the bottom of the menu on the left side is a short list under Medical Policies. Click on Preview & Comment on Draft Policies. The following policies are tentatively scheduled to be available for comment in August 2004:

- Artificial Heart
- Biventricular Pacemaker
- Breast Duct Lavage
- Closure Devices for Cardiac Defects and Patent Ductus Arteriosus
- Excimer Laser for Psoriasis
- Low Density Lipoprotein
- Lung Volume Reduction Surgery
- PET for Non-oncologic Conditions
- Pulmonary Rehabilitation

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 any exclusion 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 Patient Care 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.

Policies and protocols referenced in this newsletter are written for commercial contracts only. Please refer to the Centers for Medicare and Medicaid Services (CMS) for medical policies pertaining to senior (Medicare) contracts. Web sites for review of CMS policies are:

- [http://cms.hhs.gov/manuals/06_cim/ci00.asp](http://cms.hhs.gov/manuals/06_cim/ci00.asp) for the Medicare Manual
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
There were none this reporting period.

CURRENT POLICIES recently updated by Corporate Medical Policy Committee

Allogeneic Stem Cell or Bone Marrow Transplant involves the infusion of stem cells obtained from a matched donor after a patient’s bone marrow has been eradicated by high dose chemotherapy or total body irradiation to destroy malignant cells. High dose chemotherapy with allogeneic stem cell support has been proven to be medically effective and is considered medically appropriate in certain conditions. This year’s update has provided coverage of an allogeneic stem cell transplant for selected patients with chronic lymphocytic leukemia where the disease is progressive and refractory to conventional treatment. Please refer to the medical policy for the specific indications of medical appropriateness.

Autologous Stem Cell or Bone Marrow Transplant involves the reinfusion of a patient’s own stem cells after his/her bone marrow has been eradicated by high dose chemotherapy or total body irradiation to destroy malignant cells. High dose chemotherapy with autologous stem cell support has been proven to be medically effective and is considered medically appropriate in certain conditions. Please refer to the medical policy for the specific indications of medical appropriateness.

Ambulatory Event Monitors are portable devices used to detect, record, store and/or electronically transmit electrocardiogram (EKG) data. There are two categories of AEM devices: continuous and intermittent. Ambulatory event monitors have been proven to be effective and, therefore, medically appropriate when used to:

- assess serious symptoms possibly related to rhythm disturbances;
- assess antiarrhythmic drug response in individuals in whom baseline frequency of arrhythmia has been well characterized as reproducible and of sufficient frequency to permit analysis;
- assess pacemaker or defibrillator device function and to assist in the programming of enhanced features for patients experiencing frequent symptoms of arrhythmia.

Ambulatory event monitoring has not been medically proven to be effective and is considered not medically necessary in all other situations, including but not limited to:

- assessment of patients’ risk for future cardiac events without symptoms of arrhythmia;
- measuring heart rate variability in the assessment of patients’ risk for future cardiac events without symptoms of arrhythmia; and
- monitoring patients for myocardial ischemia.

We have included home-based, real-time cardiac surveillance systems in this year’s update of the medical policy. These devices are considered not medically necessary, as peer-reviewed literature has not shown their incremental value in improving clinical outcomes over existing ambulatory event monitoring devices.

The Medically Induced Abortion policy addresses the use of methotrexate, mifepristone and misoprostol for the elective medical termination of pregnancy.

Pelvic Floor Electrical Stimulation for Urinary Incontinence is the application of electrical current to the pudendal nerve. This electrical stimulation causes reflex contraction of the pelvic floor musculature (detrusor/bladder muscle and levator ani muscle). Pelvic floor electrical stimulation continues to be considered not medically necessary for the treatment of urinary incontinence, because studies do not allow conclusions about the impact of this technology on outcomes.
Vacuum Assisted Wound Therapy is the controlled application of subatmospheric pressure to a wound. The technology has been used for chronic non-healing diabetic skin ulcers and decubitus ulcers, as well as burns, degloving injuries and dehisced surgical wounds. Vacuum assisted wound therapy is considered medically appropriate for the following indications, when specific criteria, outlined within the medical policy, are met:

- Chronic stage III or IV pressure ulcer, neuropathic (e.g., diabetic) ulcer, venous or arterial insufficiency ulcer, refractory to complete wound therapy program, or a chronic (present for at least 30 days) ulcer of mixed etiology; or
- Surgically created wounds (e.g., dehiscence), traumatic wounds or wounds refractory to standard wound regimens, where there is documentation of the medical necessity for improved formation of granulation tissue that cannot be achieved by other available topical wound treatments.

CURRENT POLICIES recently updated with minimal changes

The following policies only required minimal changes (e.g., updating of references, changing language to meet legal needs) to be updated. **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.

- Continuous Passive Motion
- External Counterpulsation
- Genetic Testing for Alzheimer's Disease
- Heart and Heart-Lung Transplant
- Home Automatic External Defibrillators (AED) and Wearable Defibrillator (WCD) Vests
- Papsure for Cervical Cancer Screening
- Prolotherapy
- Proton Beam Radiation
- Urethral Bulking Agents for Urinary Incontinence
- Water Induced Thermotherapy

NEW PROTOCOLS recently approved by Corporate Protocol Committee

There were none this reporting period.

CURRENT PROTOCOLS recently updated by Corporate Protocol Committee

Abdominoplasty, also referred to as a “tummy tuck,” is a surgical procedure that tightens a lax anterior abdominal wall caused by diastasis recti and removes excess fat and abdominal skin. A belt lipectomy combines an abdominoplasty with the circumferential excision of skin and fat for patients with circumferential trunk excess. Panniculectomy is the surgical resection of the overhanging “apron” of skin and fat in the lower abdominal area. The redundant skin folds are predisposed to areas of intertrigo, cellulitis, and/or panniculitis. A panniculectomy is considered medically appropriate when there is documentation of a significant functional impairment such as cellulitis/skin ulceration or skin abscesses that have been refractory to medical therapy for a period of at least 6 months. The criteria for panniculectomy apply regardless of the cause of the excess fatty tissue and/or redundant skin (e.g., redundant skin as a result of weight loss from diet/exercise programs or as a result of bariatric surgery). Abdominoplasty, “tummy tuck”, and belt lipectomy are not medically necessary as they are considered cosmetic in nature.

The **Cosmetic and Reconstructive Procedures** protocol defines cosmetic and reconstructive surgery and outlines the coverage and criteria for specific procedures. Procedures deemed cosmetic, as they are performed to reshape structures of the body to improve the patient’s appearance and self-esteem, are considered not medically necessary. Reconstructive surgery related to a congenital abnormality of a child, which has resulted in a functional deficit, is considered medically appropriate when supportive documentation is provided. Also, reconstructive surgery that is incidental to or following surgery resulting from accidental injury, infection or other disease of the part of the body involved, and that corrects a functional deficit, is considered medically appropriate when supportive documentation is provided.
A Cranial Orthotic consists of either a custom-molded helmet or band that can progressively mold the shape of the cranium. Cranial orthotics are considered medically appropriate when used to treat non-synostotic (positional) plagiocephaly in conditions where the axis of the skull has been rotated and also when used in the post-surgical treatment of synostotic plagiocephaly. In general, replacement helmets are not medically necessary but requests will be reviewed on an individual basis.

The Assisted Reproductive Technologies protocol is designed to outline NYS mandated coverage and benefit contract language.

Foot Orthotics are mechanical devices that are placed in a shoe to assist in restoring or maintaining normal alignment of the foot and to relieve stress from strained soft tissues, bony deformities and inflamed bursae. Foot orthotics are considered medically appropriate for specific conditions outlined within the protocol, but benefits will only be provided for patients whose subscriber contracts do not exclude foot orthotics.

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 or limitation of activity related to the thickened, dystrophic nails; or
- compromised immune function (e.g., infection with human immunodeficiency virus – HIV).

Orthotics are used to support, restore or protect body function. Orthotic devices are considered medically necessary when prescribed by a qualified provider for therapeutic support, protection or restoration of an impaired body part or when prescribed to improve the functioning of an impaired body part. Coverage for orthotics is contract specific.

Nutritional Therapy involves the assessment of the person’s overall nutritional status followed by the assignment of individualized diet, therapy and/or specialized nutrition therapies to treat a chronic illness or condition. Nutritional therapy is medically appropriate for chronic conditions/diseases in which dietary adjustment has a therapeutic role. Examples of these diseases are outlined within the policy.

Patient Lifts or similar transfer devices are devices that enable movement and positioning of an immobilized patient. Seat Lift Chairs have a motorized mechanism that when activated, lift the body from a sitting to a standing position. They provide assistance to patients who are able to ambulate once they are in a standing position. Patient lifts and seat lift chairs are considered durable medical equipment and are eligible for coverage in specific situations outlined within the protocol. Ceiling lifts have been addressed with this year’s update. Ceiling lifts are devices that incorporate a lift or walking sling that is mounted on tracks and installed into the ceiling of the home/facility to allow for transfer of a patient. Ceiling lifts are ineligible for coverage because the devices don’t meet the criteria for durable medical equipment.

Treatment of Hirsutism is considered not medically necessary.

Surgical Stockings or graduated compression stockings are custom-made or custom-fitted support for the lower extremities. Surgical stockings (e.g., Jobst, Sigvaris, and Circaid) are eligible for coverage as a prosthetic/orthotic for the following indications:

- Venous insufficiency
- Varicose veins
- Phlebitis/Thrombophlebitis
- DVT prophylaxis during pregnancy and postpartum
- Orthostatic hypotension
- Ulceration due to chronic venous insufficiency
- Lymphedema
(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 7 CEUs toward continuing education requirements.

Fall 2004 Training Conference
September 17, 2004
Holiday Inn
Burrstone Road
Utica, NY 13502

Agenda

<table>
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<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>8:30 – 9:00 a.m.</td>
<td>Registration and Meet the Vendors</td>
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| 9:00 – 10:00 a.m.| Jeff Flood, Regional Vice President of Communications for Excellus BlueCross BlueShield (Excellus BCBS)  
**Topic:** Current legislative issues affecting the health care industry |
| 10:00 – 10:15 a.m.| Break/vendors                                                        |
| 10:15 – 11:15 a.m.| Flora Allen, Director of Special Investigations for Excellus BCBS  
**Topic:** Fraud Investigation; Coding Issues – Resolution and Recovery |
| 11:15 – 12:00 noon| Lunch with the Vendors                                               |
| 12:00 – 1:00 p.m.| Andy Salvatore, RN, EMR Analyst, Slocum-Dickson Medical Group  
**Topic:** Demonstration and Utilization of Electronic Medical Records |
| 1:00 – 1:15 p.m. | Break                                                                |
| 1:15 – 2:15 p.m. | Donna Silsbee, PhD, RHIA, CTR, CCS and Professor at SUNY Institute of Technology at Utica  
**Topic:** Preparation for the changes from ICD-9 coding to ICD-10 and how these new codes will be structured |
| 2:15 – 2:30 p.m. | Break                                                                |
| 2:30 – 3:30 p.m. | Lorraine Kane, MS, RHIA and Professor at SUNY Institute of Technology  
**Topic:** Information related to the anticipated new CPT changes as well as how to query those difficult coding situations |
| 3:30 – 4:30 p.m. | Roundtable with Question and Answer period                          |

See reverse side for registration information.
Registration Fees:
Members: $62.00
Non-Members: $69.00
Students: $49.00

Payable to Upstate NY Chapter of Professional Coders

10% discount for organizations sending three or more participants!

REGISTRATIONS WILL NOT BE PROCESSED WITHOUT PAYMENT.
Deadline for Registration is September 10, 2004.

For directions, please visit our Web site at http://upstate.lc.aapc.com, select News Archive, and then click directly on Directions.

Registration fee includes:
- Five presentations
- All materials
- Exhibits
- Continental breakfast, luncheon, afternoon snack

Registration Form
“Fall into Coding” Conference September 17, 2004

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

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