

WellChoice News

N E W J E R S E Y

In This Issue

Page

Administrative news

- NPI contingency period ending..... 2
- Flumist medical policy update..... 3
- Out-of-network providers 3

Quality initiatives

- Medical management overview 3
- Medical management criteria/Medical Director availability 3

Policy updates

- Medical policy and clinical updates 4

A letter from the Medical Director

If you're like me, you appreciate reminders that help keep you aware of upcoming events affecting your patients and your practice. I hope this issue is a useful tool that provides timely information for the busy days ahead.

January 25, 2008 will be here before we know it. The date marks the end of our contingency period for implementing the National Provider Identifier (NPI). Don't forget to register NPIs with us before that deadline to ensure uninterrupted access to online claims, eligibility and secure message information.

Now a reminder for your patients: Flu season is approaching and they need vaccinations. With that in mind, this issue has an update on the Flumist medical policy. It's good news for members with preventive services coverage.

Here is one of the most important things we'd like you to remember: We're committed to assist you in any way we can. Please call or visit us online at wellchoicenj.com at your convenience.

John F. Whitney, MD
Senior Medical Director

Administrative news

NPI contingency period ending

Beginning January 26, 2008, WellChoice will accept NPI only on HIPAA-covered electronic transactions. Failure to submit NPI only on these transactions will result in rejected claim submissions.

Important claim submission tips:

To ensure accurate claims payments when using Loop 2310B, Rendering Provider Name when submitting an NPI:

For services rendered in the physician's office: If services were rendered at an address that is different than the address used in loop 2010AA, Billing Provider Name, please provide the address of where the services were performed in loop 2310D, Service Facility Location Address.

Example #1 — Provider's physical address where services were rendered is different than the billing address

[Professional Provider's Billing Address]
LOOP 2010AA — BILLING PROVIDER NAME
NM1*85*1*JOHN*DOE****XX*1234567890~
N3*123 SOME STREET~
N4*CITY*STATE*ZIP CODE~

[Provider's physical address]
LOOP 2310D - SERVICE FACILITY LOCATION
NM1*77*2*OFFSITE CLINIC****XX*29876
54321~
N3*OFFSITE CLINIC ADDRESS LINE 1~
N4*CITY*STATE*ZIP CODE~

For services rendered in a hospital or other non-office setting: If the address in loop 2010AA the Billing Provider Name is *different* from the office address where the patient is primarily seen, please provide the address of this office in loop 2010AA Billing Provider Name. The office address where the patient is primarily seen *must* be present on the claim to ensure accurate claim payments.

Example #2 — Services rendered at a hospital

[Professional Provider's Billing Address]
— Name, NPI and Address of the individual physician
LOOP 2010AA — BILLING PROVIDER NAME
NM1*85*1*JOHN*DOE****XX*1234567890~
N3*123 SOME STREET~
N4*CITY*STATE*ZIP CODE~

[Services Rendered Address if different from Provider's Billing Address]
LOOP 2310D — SERVICE FACILITY LOCATION
NM1*FA*2*SOME HOSPITAL ****XX*29876
54321~
N3*HOSPITAL ADDRESS LINE 1~
N4*CITY*STATE*ZIP CODE~

Please be sure to provide the address of where the services were performed in loop 2310D Service Facility Location Address. Note remittances and checks will be sent to the billing address on the WellChoice Corporate Provider File even if this differs from the billing address noted on the claim.

Clarification on Entity Type Qualifiers:

There are two Entity Type qualifiers available for use in 837 Implementation Guides. Entity Type 1 denotes a person, e.g. individual provider. Entity Type 2 denotes a non-person entity, e.g. facility or organization. Please use the appropriate qualifier in the billing and rendering provider loops when submitting your 837 claims.

If you have both an entity type 1 NPI (individual) and an entity type 2 NPI (non-individual), please ensure you bill us with the correct NPI in the billing and rendering fields. In this scenario, entity type 1 should be noted in either the billing or rendering location. If you are billing with a type 2 NPI, then this needs to be noted in the billing location (not the rendering location).

Refer to the 837 Implementation Guide appropriate to your type of claim for more information.

Please contact the EDI helpdesk at **(866) 889-7322** if you any questions.

Make sure to verify all demographic information:

In order for WellChoice to process your claims submissions accurately and quickly, it's imperative that your claims information match what is listed in our Corporate Provider File (CPF). Fax any changes to Provider Registry at **(518) 367-3103**

NPI contingency period reminder:

As a reminder, WellChoice strongly recommends that all providers submit both their NPI and WellChoice Provider Identification Number (WPIN) on claims during our contingency period which ends on January 25, 2008. This will help ensure that we cross walk the NPI to the appropriate WPIN before we implement NPI Only on January 26, 2008.

Flumist medical policy update

Good news! WellChoice has changed its Medical Policy regarding Flumist to promote effective vaccination for your patients. Effective August 23, 2007, for members with preventive services coverage, Flumist will be covered when used in accordance with the guidelines of the Advisory Committee on Immunization Practices.

As we approach flu season, please remind your patients to get vaccinated.

- Influenza viruses can cause disease among any age group, but infection rates are highest among children.
- Rates of serious illness and death are highest among:
 - people aged 65 years or older
 - children under age two
 - people of any age who have medical conditions that could increase their risk of influenza-related complications.

Out-of-network providers

WellChoice is committed to giving our members access to the highest quality of care in the most cost-efficient manner. We encourage members to receive care in participating facilities to help them manage their out-of-pocket expenses.

You can help, too, by ensuring that all non-emergency care for WellChoice members is provided by participating network providers. The only exception is when you have obtained a written acknowledgment from the member (Covered Person), prior to the provision of service, indicating that the member was advised that no coverage — or only out-of-network coverage — would be available from WellChoice, and that the member agreed to be financially responsible for the additional costs related to those services.

Please log on to wellchoicenj.com and use the “Find a Doctor” search to find network providers.

Quality initiatives

Medical management overview

WellChoice is committed to quality and to providing our members with access to quality medical care and services. The Medical Management department shares this commitment by:

- Making utilization management decisions based on nationally recognized clinical guidelines, existence of coverage, the provider of these services and the setting in which the services will be delivered.
- not rewarding our medical staff — or other people who perform medical management functions — for denials of coverage for medical care and services
- having no financial incentives to encourage decisions that could result in underutilization.

Medical Director availability/ Medical management criteria

For information on Medical Director Availability, to discuss UM decisions, and to learn how to request our Medical Management evidence-based criteria, please visit our website at wellchoicenj.com. To request a printed copy of the criteria, please contact our Medical Management department at **800-441-2411**, Monday-Friday 8:30 a.m. – 5 p.m. Eastern time.

Medical policy and clinical guideline updates

These updates provide a brief description of new and/or revised WellChoice medical policies and clinical guidelines that will take effect on **November 15, 2007**, for all claims processed on and after November 15, 2007, regardless of date of service. Previously processed claims will not be reprocessed as a result of the changes. If there is any inconsistency or conflict between the brief description provided below and the actual policy or guideline, the policy or guideline will govern.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and Clinical Guidelines (and Medical Policy takes precedence over clinical guidelines) and must be considered first in determining eligibility for coverage. The member must be eligible for coverage and membership must be active at the time services are rendered. This document supplements previous Medical Policy Updates. Please place this update with your Sourcebook for future reference. The medical policy and clinical guideline details can be found on our website at www.wellchoicenj.com.

Claim Edits and Validation — To facilitate correct coding and claim submissions, validation is performed between procedure codes and the member's age and/or gender, between the diagnosis code and the member's age and/or gender.

Appropriate procedure and diagnosis codes should be reported according to the member's age and/or gender. For example, a diagnosis or a procedure related to the prostate should not be reported for a female member. A diagnosis or procedure related to an infant or newborn should not be reported on a claim for an adolescent or an adult. Diagnoses codes for the fetus/neonate should not be reported on the mother's claim.

Acne Rosacea (17106, 17107, 17108, 30120, 96920, 96921, 96922) — Laser and surgical treatment is medically necessary for members with severe and refractory forms of rosacea, unresponsive to standard medical therapy. Standard medical therapy includes an adequate trial of topical agents and/or oral agents (antibiotics). Documentation that the member has undergone and received inadequate results with conservative management, as well as preoperative photos documenting the clinical skin changes that are to be treated, are required.

Acupuncture — Evaluation and Management (E&M) visits related to acupuncture will be allowed only when reported for those diagnoses for which acupuncture is medically necessary. These are nausea and vomiting associated with surgery, chemotherapy, or pregnancy, in the absence of pacemaker, automatic implantable cardioverter-defibrillator (AICD), or bleeding disorders (same dxs for payment of acupuncture). Acupuncture is also considered medically necessary for treatment of painful chronic osteoarthritis of the

knee or hip when there is no other metabolic, infectious or inflammatory cause of the arthritis, the member does not have a pacemaker or AICD or a bleeding disorder, there are no plans for total joint replacement and the pain significantly affects daily activity and function.

Aerosolized Anti-Infective Therapy for Sinusitis — Tobramycin (J7685) is not medically necessary for sinusitis.

Auditory Brain Stem Implants (S2235, 92640) — An auditory brain stem implant is considered medically necessary in members 12 years of age or older with neurofibromatosis type 2, who are deaf due to bilateral resection of neurofibromas of the auditory nerve. Upgrades of existing components for next generation devices are considered medically necessary for members in whom response to existing components is inadequate to the point of interfering with the activities of daily living, or when components are no longer functional. Upgrades of an existing, functional external system to achieve aesthetic improvement, such as smaller profile components, or a switch from a body-worn, external sound processor to a behind-the-ear (BTE) model, are not considered medically necessary.

Chemical Peels (15788-15789, 15792-15793, 17340, 17360) — Chemical peels are considered medically necessary for active acne when the member has failed a trial of topical retinoid treatment, topical and oral antibiotic therapy. Dermal peels are considered medically necessary for members with 10 or more actinic keratoses or other pre-malignant skin lesions that have failed topical retinoid treatment, topical chemotherapeutic agents and cryotherapy. Chemical peels, either epidermal or dermal, are not medically necessary when used to treat photo-aged skin, wrinkles,

acne scarring or uneven epidermal pigmentation.

Cranial Nerve Procedures (15840-25845, 64716, 64732-64742, 64864-64865, 64866-64870 and 69955) — Claims reporting the above procedures will be reviewed to determine if the procedures are done to correct a significant functional impairment or to treat congenital or acquired facial palsy which has resulted in a significantly altered appearance.

Collagen Injections or Implants (11950, 11951, 11952, 11954) — Collagen injections or implants may be medically necessary in members with a significant physical functional impairment where the treatment can be reasonably expected to improve physical functional impairment.

Cryoablation for Plantar Fasciitis (64640) — Cryoablation for plantar fasciitis and plantar fibroma is considered investigational.

Dermabrasion (15780-15783, 15786, 15787) — Dermabrasion is considered medically necessary for members with malignant neoplasms of the skin, carcinoma in situ of the skin and actinic keratosis. Dermabrasion for all other diagnoses is considered not medically necessary. Note that CPT 15783 is also medically necessary for malignant neoplasms, and encounters for radiotherapy.

DME — Services limited by month were previously calculated based on a 28 day time period. This calculation will now be based on a calendar month. For example, respiratory assist device (E0470) was limited to one in 28 days. Code E0740 will now be limited to one in a calendar month.

When available, reimbursement for a DME item will be made at the allowed amount of the least costly alternative.

Claims for rental charges received following reimbursement of a claim for the purchase of the same item will be denied. Maintenance charges are not reimbursed when submitted for rental items. Maintenance of capped rental items will be limited to once in a six month period.

Manual wheelchair accessory codes should not be reported with power wheelchairs. Power wheelchair accessory codes should not be reported with manual wheelchairs.

Prosthesis codes should be consistent with the member's functional level as defined by CMS. For example, code L5930 (high activity knee control frame) is medically necessary only for members classified as functional level 4.

It is not necessary to use sterile or distilled water with a nebulizer and charges will be denied.

Drug infusion catheter supplies (A4221) will not be reimbursed separately when infusion set codes (A4230 or A4231) have been reimbursed within the same calendar month.

Unit Limitations:

- a. Tubing (A7010) is limited to 100 feet within a 58 day period.
- b. Skin barrier is limited to one reimbursement of either code (A5120 or A4369) within a one month period.
- c. Electrical stimulator supplies (A4595) is limited to one per month when TENS (E0720) is reported within the same period.
- d. One drainage bag (A4358 or A5112) will be allowed in a one month period.

Electrical Stimulation (E0745)

— Functional electrical stimulation and threshold electrical stimulations are considered investigational as a treatment for curvature of the spine.

Electrical Stimulation of Urinary Incontinence (97014, G0283) —

Treatment of urinary incontinence with electrical stimulation is considered investigational when reported for members with detrusor instability, intrinsic (urethral) sphincter deficiency [ISD], disorders of the urethra, stress incontinence, female, urinary incontinence and urinary frequency .

Facial Plastic Surgery (21083, 21087, 21172, 21175, 21179, 21180, 21235, 21256 and 21270) — Facial plastic surgery may be considered not medically necessary when done for familial jaw or chin deformities, or weak chin, or to remove excess fat or skin from under the chin. Claims reporting these procedures will be reviewed for medical necessity.

Genitalia Procedures (Male and Female) (54360, 54440, 56800, 56805, 56810, 57291, 57292, 57335)

— Procedures intended to address the sequelae of significant trauma, injury or disease performed on either male or female genitalia, in the absence of a functional impairment, may be considered medically necessary. Procedures intended to improve the appearance or enhance the sexual performance of either male or female genitalia, are considered not medically necessary.

Heating/Cooling Devices — The use of active or passive devices that combine cooling and heating is considered investigational for all indications, including, but not limited to the use of the VitalWrap™ system. This includes the use of active or passive cooling devices (e.g., CryoCuff®) in the postoperative care of members undergoing musculoskeletal surgery. Other applications of active and passive cooling devices are investigational.

Hyperthermia for Cancer (77600, 77610, 77615) — Claims reporting hyperthermia in conjunction with radiation therapy will be reviewed for medical necessity. Hyperthermia is medically necessary for members with primary or metastatic cutaneous or subcutaneous superficial tumors (e.g., superficial recurrent melanoma, chest wall recurrence of breast cancer, and cervical lymph node metastases from head and neck cancer). Treatment should be limited to twice weekly treatments for five weeks (i.e., 10-12 total treatments).

Incident To Services — Consistent with CMS, procedures designated as 'Incident To' will not be reimbursed separately when reported in the hospital inpatient or out patient settings.

Keloid and Scar Revision — Treatment of keloids and scar revision is medically necessary when the keloid or scar results in a significant physical functional impairment and the treatment can be reasonably expected to improve physical functional impairment.

L-Poly-L-lactic acid (S0196) (Sculptra™) — Injections of L-Poly-L-lactic acid may be considered medically necessary when used to restore appearance after treatment for a disease, injury or congenital abnormality.

Metabolite Markers — Code 82657 (enzyme activity in blood cells) is considered investigational when used in the diagnosis of ulcerative colitis and regional enteritis.

Pectus Excavatum or Carinatum (21740, 21742, 21743) — Surgical repair of significant Pectus Excavatum (PE) or Carinatum with either an open or a minimally invasive approach (e.g., Nuss procedure) with or without thoracoscopy may be medically necessary when related to an accidental injury, disease, trauma, or treatment of a disease or congenital defect. In general, the available literature investigating significant objective functional limitations associated with the presence of pectus excavatum (PE) or significantly improved objective functional outcomes as a result of corrective surgery provides inadequate or conflicting data, which does not convincingly support surgical repair of PE on functional grounds. Moreover, there is no evidence that the presence of PE limits life expectancy or the ability to perform any sort of occupation.

Pulse Oximetry (Overnight in the Home) (94762) — Home pulse oximetry is medically necessary as an overnight screening test for sleep apnea, only where nocturnal hypoxemia is suspected to be a causative factor in unexplained right heart failure, unexplained polycythemia, unexplained pulmonary hypertension; or cardiac arrhythmias occurring only during sleep (or increased during sleep). Overnight pulse oximetry may also be medically necessary in members with suspected nocturnal hypoxemia due to a condition unrelated to sleep apnea. Claims reporting overnight pulse oximetry will be reviewed for medical necessity. All other indications will be considered not medically necessary.

Otoplasty (69300) — Otoplasty is considered medically necessary when performed for a correctable congenital malformation, trauma, surgery, infection, or other process that is causing hearing loss of at least 15 decibels or to facilitate the use of a hearing aid. The surgery should reasonably expect to improve physical functional impairment. Otoplasty may be allowed when performed to restore a significantly abnormal external ear or auditory canal related to trauma, tumor, surgery, infection, or congenital malformation or congenital absence of the external ear. Claims reporting otoplasty will be reviewed for medical necessity.

Rhytidectomy (15824, 15828) — Rhytidectomy will be considered medically necessary in the treatment of significant burns or other significant facial trauma.

Separate Procedures — Procedure codes designated as separate procedures in the AMA CPT book should only be reported when done independently. Separate procedures will be denied as incidental when reported with a related, more extensive procedure.

Supplies Used by the Provider During Treatment — Please remember that all supplies used by the provider during treatment will be considered a component of the normal office overhead and are not reimbursed separately. Please note that supplies used during treatment in the ambulatory surgical center, hospital inpatient or outpatient settings are considered facility charges and are not reimbursed to the provider.

Tatooning (11920, 11921, 11922) — Tatooning is considered medically necessary for members with malignant neoplasms, carcinoma in situ and when undergoing radiotherapy. All other indications are considered not medically necessary.

Transcatheter Arterial Chemoembolization (TACE) (37204, 75894) — Transcatheter arterial chemoembolization (TACE) is considered medically necessary for the following conditions:

- a. as palliative treatment for members with neuroendocrine tumors (e.g., carcinoid tumors, pancreatic islet cell tumors) with hepatic metastases when systemic therapy has failed to control symptoms such as carcinoid syndrome (e.g., debilitating flushing, wheezing, and diarrhea), symptoms

from non-carcinoid neuroendocrine tumors (e.g., hypoglycemia, severe diabetes, Zollinger-Ellison Syndrome), or symptoms due to hepatic tumor bulk (e.g., pain).

- b. as a primary treatment for surgically unresectable primary hepatocellular carcinoma (HCC) when the member has preserved liver function defined as Childs-Turcotte-Pugh class A or B, has 3 or fewer encapsulated nodules that are less than 4 cm in diameter, has no evidence of extra-hepatic metastases, has no evidence of severe renal function impairment and has no evidence of portal hypertension.
- c. as a palliative treatment for hepatocellular carcinoma when there are significant symptoms related to tumor bulk (e.g., pain).
- d. as a palliative treatment for symptoms related to tumor bulk (e.g., pain).

Claims reporting TACE for diagnoses of hypoglycemia, pancreatic secretion (e.g., glucagon, gastrin) and for members awaiting organ transplants will be reviewed for medical necessity according to the criteria above.

Trigger Point Injections — Dry needling (insertion of a needle without injection of medication) is considered not medically necessary for all indications.

Corrections to the winter 2006 newsletter

Carcinoembryonic Antigen (CEA) (82378) — Measurements of carcinoembryonic antigen (CEA) are considered medically necessary in patients with gastrointestinal malignancies, such as esophagus, stomach, small intestine, colon, rectum, anus.

Glucose Monitoring — codes S1030 and S1031 were included incorrectly as interstitial monitoring.

Hemoglobin A1c Testing — CPT code 83037 is not intended to report a glycosylated hemoglobin (A1c) test that is obtained in the member's home by the member or family. Rather, code 83037 is intended to report rapid result testing for HbA1c levels to assist the physician in management of glycemic control while the physician is present with the member. Code 83037 is reported for testing and interpretation of results during a member encounter using a device cleared by the FDA for home use. Code 83037 will be allowed.

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