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Communication and Care Coordination

Optimal coordination of care requires communication between care providers to ensure quality health care services. Specialists are responsible for keeping the primary care physician (PCP) informed about any care a mutual patient is receiving under his/her specialty care.

Please promptly share with the PCP any diagnoses, consultation reports or treatment notes, diagnostic reports, treatment plans, medications prescribed or changed, and any other pertinent information. If applicable, concurrent care management reports should also be provided.

Please contact your Provider Relations and Contracting account specialist with any questions you may have.

Medical Services Protocol Updates Now on Our Website

Medical protocols that have recently undergone an annual review are now available online. Seven new protocols have been added. The effective date of these changes is January 1, 2014, unless otherwise noted.

To view the protocols and cover letters, go to Policies & Guidelines > Medical Protocols or bsneny.com/medical-protocols.

- Please note that some of the protocol updates may not pertain to the members to whom you provide care.
- If you need assistance obtaining specific protocol updates, please contact Provider Service.

Spirometry Testing

The signs and symptoms of asthma and chronic obstructive pulmonary disease (COPD) are similar; spirometry testing is important in determining a differential diagnosis.

If you suspect, or are uncertain if a patient has COPD:
- Order spirometry testing
- Educate and assist in smoking cessation, when applicable

Our disease management program offers dedicated nurse health coaches to educate patients about managing their chronic condition.

To enroll your patient in our disease management program, call 1-877-878-8785, option 2.

Mental Illness

Mental illness remains a stigma in our society and many patients do not share signs and symptoms during an office visit. It's important to discuss this subject with your patients.

Try questions such as:
1. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
2. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
4. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor’s office or shopping?

By asking questions, you will help your patient become aware of underlying issues and talk about these problems.

Helpful references:
cdc.gov/mentalhealth/
ahrq.gov/professionals/clinicians-providers/ehclibrary/mentalhealth/

Updated Drug Therapy Guidelines

Updated drug therapy guidelines are available on our provider website. Go to Policies & Guidelines > Drug Therapy Guidelines or bsneny.com/drug-therapy-guidelines.

These updates are a result of the annual review and quarterly new drug evaluations by our Pharmacy and Therapeutics Committee.

The BlueShield of Northeastern New York Exclusive Formulary will be effective January 1, 2014 for Exchange products and small groups. Available for review on our website now, it is a list of drugs to help guide physicians and pharmacists to select the medication that provides the appropriate treatment for the best price.
Radiation Safety Awareness Program

The Radiation Safety Awareness Program is designed to increase physician and patient awareness of the risks of radiation exposure from medical testing and improve clinical safety. This is a collaborative effort with National Imaging Associates (NIA), our radiology benefits manager.

NIA will provide patient exposure level information to:
- assist in medical decision making
- reduce unnecessary imaging

Ordering physicians will receive patient-specific details about cumulative radiation exposure above a level identified as increasing the risk of associated complications, such as cancer. We hope that you will discuss this information with your patient to determine the benefits versus the risks of potential imaging studies. For example, in some cases, imaging may not be necessary in the acute phase of injury.

The program also promotes coordination of care between primary care physicians, radiologists, and other specialists by making previous radiology study information available to the ordering physician. You can also have a coordination of care peer discussion with an NIA physician/radiologist.

How is my patient identified?

NIA reviews BlueShield of Northeastern New York radiology claims on a monthly basis for analysis of member exposure levels.

How am I notified if my patient is identified at risk?

Notifications will be over the phone or online at the time a requested radiology procedure is reviewed for preauthorization. An alert letter is also sent via fax or mail. The level of radiation exposure does not affect the preauthorization process or final outcome for requested imaging studies.

How can I use this information in managing my patient?

- Explain the risks/benefits of the radiology study being considered.
- It helps you answer these questions:
  - Is this radiation study the best one to perform?
  - Can other tests such as ultrasound, endoscopy, or labs be used instead?
- Awareness of the patient’s imaging history.

How is radiation exposure measured?

Radiation exposure is measured in milliSieverts (mSv). Radiation effective dose is the amount of radiation received by the patient. This varies depending on various factors such as distance from source, exposure time, overall body and organ size, and location and nature of tissue exposed.

Studies suggest an increased risk of developing cancer at radiation effective dose estimates of 50 mSv or greater. Radiation exposure is cumulative over a lifetime. Reaching an effective radiation dose level of 50 mSv is not uncommon in patients who receive multiple CT scans, cardiac and/or nuclear imaging studies.

An interactive radiation exposure calculator tool that you may find helpful as a patient education tool is available on our website.

Where can I get more information?

- Our provider website Patient Safety page at bsneny.com
- NIA website, radmd.com
- Peer discussion with an NIA physician at 1-888-642-7649
- Health Care Quality Improvement Department at 1-877-878-8785, option 3
Medical Record Documentation Standards

To improve the quality and completeness of medical record documentation and care, the Medical Record Documentation Standards for primary care are reviewed annually and revised as necessary to reflect current national standards and/or recommendations by the New York State Department of Health (NYSDOH) and the Centers for Medicaid & Medicare Services (CMS). The established Documentation Standards were reviewed in June 2013 and no changes or additions were made for 2014.

The Medical Record Documentation Standards are available on our provider website, bsneny.com.

Documentation Tips Regarding Pediatric Well Care:

• Assessment and documentation of body mass index (BMI) percentile for children and adolescents is required by the NYSDOH and BlueShield of Northeastern New York.

• Copies of BMI-for-age percentile charts are available on our provider website.

• When documenting BMI/BMI percentile, the height and weight of the child must also be documented for the same measurement year.

• Beginning in January 2011, pediatric records were evaluated and scored for the inclusion of documentation of required anticipatory guidance components of an adolescent well care visit beginning at age 12. This was a change from the previous age of 14 based on recommendations from the American Academy of Pediatrics.

• For offices that use and include Adolescent Questionnaires in the medical record, the health care professional reviewing the questionnaire with the patient should sign or initial the document. This constitutes compliant documentation.

• If the Adolescent Questionnaire is not used or retained, documentation that the anticipatory guidance topics have been assessed or discussed is necessary. A statement such as “assessed for signs and symptoms of depression,” “discussed sexual activity, tobacco, alcohol, drug use, nutrition, physical activity,” is adequate. A general statement such as “anticipatory guidance given” is not acceptable documentation as it does not indicate the topics discussed.

Another acceptable option is a checklist method that indicates the topics discussed, e.g.:  
- Nutrition  
- Physical activity  
- Risk behaviors/sexual activity  
- Depression  
- Tobacco use  
- Substance use/Alcohol use

A convenient sticker-type checklist charting tool for both adult care and pediatrics can be printed from our provider website. Simply apply to existing chart documents.

A statement regarding limiting of screen/computer time only is not considered compliant documentation for an assessment of the physical activity component. Documentation may include a statement regarding screen time but should also include a date and at least one of the following:

- Discussion of current physical activity behaviors (exercise routine, participation in sports, exam for sports participation)
- Checklist as noted above
- Counseling or referral for physical activity
- Documentation that patient received educational materials on physical activity
- Anticipatory guidance for physical activity

Additional Documentation Tips:

Assessment and documentation of adult BMI should also include height and weight in the same measurement year.

While a signed Health Care proxy in the medical record is preferable, for adults 18 years and over, a statement in the medical record by the physician or practitioner concerning discussion of a Health Care Proxy (HCP) and/or Advanced Directive is acceptable documentation and meets the established documentation standard.

Documentation of adult immunization information should include a date. A statement of “up to date” is not considered acceptable documentation.

Patient demographic data is recommended to include documentation of employer, work telephone, emergency contact and marital status information as applicable. These elements are frequently not documented and indicate a need for improvement.

Culturally competent care can be addressed simply by documentation of language spoken, race, ethnicity, culture, use of an interpreter, or any communication or cultural issue considered in the patient’s care.
Prompt Notification of Changes in Practice

All providers are contractually obligated to promptly notify BlueShield of Northeastern New York, in writing, if there are any changes to their practice. Changes include, but are not limited to: participation status (retirement, moving out of area), telephone number, business address, office hours, or any change that may materially impair the ability of the participating provider to carry out the duties and obligations of his/her agreement. We use the information that your practice provides to populate directories and other member service information. If the information that we have regarding your practice status is not accurate, our members may not be able to obtain the necessary services in an expeditious manner.

Please refer to your Participating Provider Agreement (Section 2.6: Notification) for more information. You should submit written notification of changes in practice to:

BlueShield of Northeastern New York
Provider Enrollment Department
257 West Genesee Street
Buffalo, NY 14202-2657

You may also fax the notification to the Provider Enrollment Department at 1-716-887-2056.

Medical News: Osteoarthritis of the Knee

Last spring, the American Academy of Orthopedic Surgeons (AAOS) updated their clinical practice guideline Treatment of Symptomatic Osteoarthritis of the Knee.

One of the common procedural treatments, hyaluronan injections, previously found inconclusive as a recommended treatment (2008 practice guideline), has now been updated to a strong position of “not recommended.”

The guideline is available at:

aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf

Accurately Reporting Access to and Availability of Participating Physicians

We have been notified by the New York State Department of Health (NYSDOH) that some of our plan providers have not satisfied the Department’s requirements regarding Member Access and Availability. Providing members access to care is not only important to the NYSDOH but to our plan as well. It is imperative that we provide the most accurate information regarding participating providers to our members. We depend on you to promptly notify us of restrictions in your practice.

In accordance with Section 2.4.2 of the Participating Physician Agreement:

Participating Physician shall not close his or her panel to new patients and/or referrals, as applicable, except on thirty (30) days prior written notice to BlueShield of Northeastern New York, provided that, in such event, Participating Physician shall not accept new patients or referrals of persons who are covered by or enrolled in any other entities that provide, arrange or pay for health care services.

Participating Physician acknowledges and agrees that any closure of his or her panel shall not apply to any of Participating Physician’s existing or prior patients who become Covered Persons. Participating Physician further agrees to provide BlueShield written notice prior to opening his or her panel to new patients or referrals, as applicable.
Provider Administrative Policies

Provider Administrative policies are reviewed annually and updated as necessary. For your convenience, the following administrative policies are available on our provider website at bsny.com.

This information can also be found in the Provider and Facility Reference Manual, Section 11:

Provider Practice Policies:

- Access to Care
- Information Exchange Policy for Primary Medical Home/Specialists/Facilities
- Medical Record Review
- Medical Record Retention
- Medical Record Transfer for Primary Medical Home/Specialists
- Medical Record Documentation Standards
- Patient Confidentiality in Physician’s Office

The following important policy updates may be pertinent to your office practice:

Access to Care Policy

This policy ensures that our members have timely accessibility to health care and behavioral health services. The clarifications listed below were made in accordance with applicable regulatory requirements.

Primary, Specialist and OB-GYN Care Providers

- After Hours Access including emergent life threatening and urgent conditions in new and established patients: Practitioner should employ a 24-hour, 7-days-a-week “on-call” telephone resource that includes: access to a “live voice” via an answering service, an answering service with the option to page the practitioner, an advice nurse with access to the practitioner, access to the practitioner auto-pager, or an answering machine/voice mail system with appropriate after-hours instructions for patients.

The patient should either receive an immediate response or be instructed on how to obtain services after hours and on weekends. Answering machine/voicemail instructions should include an anticipated timeframe during which the patient could expect a return call. Patient calls cannot be routinely referred to an emergency room.

Behavioral Health Care Providers: Behavioral Health Practitioners include Psychiatrists, Psychologists, Social Workers, Community Mental Health Centers and Chemical Dependency Treatment Centers.

- After Hours Access including emergent life threatening and urgent conditions in new and established patients: Practitioner should employ a 24-hour, 7-days-a-week “on-call” telephone resource that includes: access to a “live voice” via an answering service, an answering service with the option to page the practitioner, access to the practitioner auto-pager, or an answering machine/voice mail system with appropriate after-hours instructions for patients on how to obtain services.

Instructions may include referral to a community 24-hour crisis services hotline. Emergent patient calls may be referred to an emergency room or to a community 24-hour crisis services hotline.

Adherence to this policy is monitored during provider onsite review, after-hours audits, as well as member complaint evaluations and member satisfaction surveys.

Medical Record Retention Policy

The following policy clarifications were added to the policy.

All participating practitioners and facilities, including behavioral health practitioners, are required to maintain medical and billing records for all covered persons receiving covered services in accordance with the terms and conditions of such participating practitioner’s/facility’s participation agreement with the health plan, including, but not limited to, the terms provided below.

Records must be maintained as follows:

1. For covered persons (other than covered persons enrolled in Medicare Advantage or Medicaid Prepaid Coverage Plans or children’s health program agreements between the health plan and the Centers for Medicare and Medicaid Services (CMS) (collectively, the "Medicare Contract"), for no less than:

   (a) seven (7) years following termination,

   (b) four (4) years past the age of majority, or

   (c) seven (7) years past the date of service, whichever is longer.

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Provider administrative policies
Continued from page 6

2. For covered persons enrolled in a Medicare Contract, for no less than ten (10) years following conclusion or termination of the applicable Medicare Contract or from the date of completion of any audit by CMS, the U.S. Department of Health and Human Services and/or the Comptroller General, whichever is later, unless

   (a) CMS has determined that there is a special need to retain a particular record or group of records for a longer period and notifies the health plan and/or participating practitioner/facility at least thirty (30) days prior to the normal disposition date,

   (b) CMS determines that there is a reasonable possibility of fraud or similar fault by the health plan or the participating practitioner/facility, in which case the retention period may be extended for six (6) years from the date of any resulting final resolution of the termination, dispute or fraud or similar fault, or

   (c) CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit Health Plan and/or the participating practitioner/facility at any time.

3. The time period required pursuant to applicable law.

For questions or requests for paper copies, contact the Health Care Quality Improvement Department at 1-877-878-8785, option 3, or go to our website, click “Contact us” and submit your question or comment.

You may also write to us at:

BlueShield of Northeastern New York
PO Box 80
Buffalo NY, 14240

Falls Prevention in Older Adults

The Falls Prevention in Older Adults program helps decrease falls among the Medicare population by identifying at-risk members, raising awareness, and promoting falls risk assessments/management as a part of routine care by primary care providers.

Falls are a leading cause of hospitalizations and loss of independence in older adults. Factors influencing their risk include: mobility issues and inactivity, chronic health conditions, vision problems, multiple medications, and home and environmental hazards. These factors are more prevalent in the older population.

The program includes:

- Promotion of physician best practices through the adoption of the 2010 American Geriatric Society Guidelines for Prevention of Falls in Older Adults.
- Early assessment and intervention by the physician to include a multi-factor assessments.
- Discussions between physician and patient regarding problems with gait, strength, or balance.
- Encouragement for the use of standardized strength and balance assessment tools by physician such as the “Get Up and Go” test.
- Education for members and family caregivers about ways to identify and reduce the risk of a fall.
- Member “medication safety” education.
- Care transitions and home care services that include assistance with medication reconciliation and a home safety assessment.

Your patient(s) may receive a Falls Prevention educational mailing that includes the following materials:

- A specially designed “Medication Safety” bag for the patient to bring their medications to an office visit for review and reconciliation.
- A Falls Prevention brochure with helpful tips on how to decrease the incidence of a fall.
- A falls risk self-assessment with instructions to complete and bring to their next office visit with you.
- A wallet card to list their current medications.

“Medication Safety” bags and or falls risk self-assessments for patient distribution will be mailed to your office upon request. Call the Health Care Quality Improvement Department at 1-877-878-8785, option 3.

A summary and link to the 2010 Clinical Practice Guideline for the Prevention of Falls in Older Persons developed by the American and British Geriatric Societies, is available on our provider website.
Timely Health Information Exchange Improves Care

Timely information exchange during transitions in health care is an essential component in providing safe, coordinated, cost-effective patient care. In 2013, our Healthcare Quality Improvement Department conducted the following quality initiatives to identify opportunities for improvement in continuity and coordination of care.

The 2013 Behavioral Health and PCP surveys measured information exchange between urgent care centers, specialists, behavioral health, and primary care providers. The results identified an opportunity for improvements in rate, timeliness, and process for information exchange between all provider types measured.

Information Exchange

1. **Primary care** providers reported that:
   - Behavioral health specialists need to improve sharing information about the initial consult, medication changes, and annual updates.
   - For emergency care, six in ten PCPs report receiving communication about ER visits.
   - Urgent Care Centers continue to need improvement in communicating with PCPs.
   - Specialists are strong in communicating the initial consult with primary care providers. About eight in ten PCPs report receiving communication of medication, condition, or treatment changes, as well as the annual updates from the specialist.
   - Regular use of electronic medical records (EMR) by PCPs has significantly increased and more are planning to adopt them in the future.
   - Health Information Exchange is slow but trending upward in the last three years.

2. **Behavioral health** providers reported that:
   - The sharing of clinical information between PCPs and behavioral health (BH) specialists has shown improvement in 2013 but is still low. Sharing of medical history between PCPs and BH providers has significant room for improvement.
   - The survey indicated that BH specialists continue to have low usage of new technologies, with the majority not planning to adopt EMR, Health Information Exchange, or e-prescribing.

3. Based on focused medical record review, communication of specialty care (dermatology and orthopedic) to the PCP occurred as follows:
   - 21 percent of the dermatologists communicated with the PCP. Of the 21 percent who communicated, 100 percent of the consult reports were received by the PCP within 30 days. PCP review of the consult reports happened 57 percent of the time.
   - 41 percent of the orthopedics communicated with the PCP. Of the 41 percent who communicated, 98 percent of the consult reports were received by the PCP within 30 days. PCP review of the consult reports happened 69 percent of the time.

To help improve care coordination, we initiated a Physician Support Line for PCPs treating behavioral health conditions. The support line is a free service offered through our behavioral health vendor, Health Integrated. It is designed to assist you in identifying and treating behavioral health conditions by providing information and education on:
   - psychiatric treatments
   - psychiatric medications

This assistance is provided by a board certified psychiatrist. The provider survey indicates that less that 10 percent have used it. If you haven’t used it yet, we suggest that you take advantage of it when next appropriate.

You may access the Physician Behavioral Health Support Line Monday–Friday between 9 a.m. to 7 p.m. via fax at (813) 960-2492, telephone (toll free) at 1-866-390-0943, or via email at: providerconsult@healthintegrated.com.

Emergency Room Use

- We monitor emergency room visits in an effort to address the concerning increase in emergency room use and to assist PCPs with effective patient management. The goal is to increase provider awareness of members with high ER use.

PCP and member-focused interventions were implemented to improve performance.

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**Timely Health Information**

*Continued from page 8*

**What you can do to improve communications**

1. Advise your patients on the importance of information sharing in receiving quality care. Ask them if there are other practitioners that need to know about their health information.

2. Participate in your local health information exchange, HIXNY, including e-prescribing.

3. Encourage patients to sign consent for real-time electronic access to their medical information through the regional health information exchanges.

4. Conduct an internal review of your information sharing system.
   - Do you have a process for ensuring timely communication of pertinent health information to other health care providers?
   - What is your process for reviewing and incorporating incoming information into your patient’s record/plan of care? This includes health information communicated to you by a shared electronic record system.
   - Do you monitor your performance for gaps and act on opportunities for improvement?

5. Review the following Information Exchange Policy:

**Information Exchange Policy for Primary Medical Home/Specialists/Facilities**

This information exchange policy is established to ensure our practitioners and facilities have the necessary health care information to provide truly coordinated quality health care services for our members. All practitioners, including behavioral health and facilities providing health and behavioral care services to our members, must ensure timely exchange of pertinent medical information. (Consent may be addressed with member by the office privacy policy or by separate consent to share information.)

*Time frames for this exchange shall be within thirty (30) calendar days of initial assessment; annually if concurrent care continues for more than 12 months, or more frequently if the member’s clinical condition or treatment changes significantly and within seven (7) calendar days of a medication change.* These guidelines are supported by NYSMHL 42 CFR Part 2, CMS, and NCQA standards.

Those affected by the policy are primary medical home, specialists, pertinent ancillary practitioners, health care and home care facilities, surgical and diagnostic centers.

**Minimum Information to be exchanged**

1. **Primary Medical Home:** The primary medical home is required to provide the specialist with pertinent medical information. This should include but is not limited to:
   - Office notes
   - Discharge summaries
   - A formal letter summarizing medical history
   - Diagnostic test reports
   - Other pertinent consult reports and information

2. **Specialist:** The specialist is required to provide the member’s pertinent medical information to the primary medical home in order to promote optimal coordination of care, regardless of the member’s referral method. This should include but is not limited to:
   - Diagnosis
   - Consultation report or treatment notes
   - Diagnostic reports
   - Plan of treatment
   - Medications prescribed or medication changes
   - Other pertinent consult reports and information
   - Concurrent care management reports, when applicable

3. **Facility (including Urgent Care Centers):** Facilities involved in the member’s care are required to provide the primary medical home:
   - Discharge summaries
   - Diagnostic reports
   - Emergency room summaries/reports/notes
   - Concurrent care management reports (e.g., home care, skilled, rehabilitation)

4. **Behavioral Health Specialist:** Exchange of information may be to another behavioral health practitioner and/or the member’s primary medical home with an appropriate signed consent from the member.
   - Diagnosis
   - Medications prescribed or medication changes
   - Any significant risk status or issues
   - Stress-related factors
   - Treatment recommendations
   - Frequency of treatment
   - Significant coordination of care issues/medical compliance
### Code Categorization Updates

Effective January 1, 2014, to be consistent with Medicare classification, the following codes will be categorized as durable medical equipment (DME). The codes were previously categorized as orthotic and prosthetic.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0485</td>
<td>Oral Device/Appliance Used To Reduce Upper Airway Collapsibility, Adjustable Or Non-Adjustable, Prefabricated, Includes Fitting And Adjustment</td>
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<tr>
<td>E0486</td>
<td>Oral Device/Appliance Used To Reduce Upper Airway Collapsibility, Adjustable Or Non-Adjustable, Prefabricated, Includes Fitting And Adjustment</td>
</tr>
<tr>
<td>E0617</td>
<td>External Defibrillator With Integrated Electrocardiogram Analysis</td>
</tr>
<tr>
<td>E0765</td>
<td>FDA Approved Nerve Stimulator, With Replaceable Batteries, For Treatment Of Nausea And Vomiting</td>
</tr>
<tr>
<td>E1634</td>
<td>Peritoneal Dialysis Clamps, Each</td>
</tr>
<tr>
<td>E1800</td>
<td>Dynamic Adjustable Elbow Extension/Flexion Device, Includes Soft Interface Material</td>
</tr>
<tr>
<td>E1801</td>
<td>Static Progressive Stretch Elbow Device, Extension And/Or Flexion, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories</td>
</tr>
<tr>
<td>E1805</td>
<td>Dynamic Adjustable Wrist Extension/Flexion Device, Includes Soft Interface Material</td>
</tr>
<tr>
<td>E1806</td>
<td>Static Progressive Stretch Wrist Device, Flexion And/Or Extension, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories</td>
</tr>
<tr>
<td>E1810</td>
<td>Dynamic Adjustable Knee Extension/Flexion Device, Includes Soft Interface Material</td>
</tr>
<tr>
<td>E1811</td>
<td>Static Progressive Stretch Knee Device, Extension And/Or Flexion, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories</td>
</tr>
<tr>
<td>E1815</td>
<td>Dynamic Adjustable Ankle Extension/Flexion Device, Includes Soft Interface Material</td>
</tr>
<tr>
<td>E1816</td>
<td>Static Progressive Stretch Ankle Device, Flexion And/Or Extension, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories</td>
</tr>
<tr>
<td>E1818</td>
<td>Static Progressive Stretch Forearm Pronation/Supination Device, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories</td>
</tr>
<tr>
<td>E1820</td>
<td>Replacement Soft Interface Material, Dynamic Adjustable Extension/Flexion Device</td>
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<tr>
<td>E1821</td>
<td>Replacement Soft Interface Material/Cuffs For Bi-Directional Static Progressive Stretch Device</td>
</tr>
<tr>
<td>E1825</td>
<td>Dynamic Adjustable Finger Extension/Flexion Device, Includes Soft Interface Material</td>
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<tr>
<td>E1830</td>
<td>Dynamic Adjustable Toe Extension/Flexion Device, Includes Soft Interface Material</td>
</tr>
<tr>
<td>E1831</td>
<td>Static Progressive Stretch Toe Device, Extension And/Or Flexion, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories</td>
</tr>
<tr>
<td>E1840</td>
<td>Dynamic Adjustable Shoulder Flexion/Abduction/Rotation Device, Includes Soft Interface Material Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material</td>
</tr>
<tr>
<td>E1902</td>
<td>Communication Board, Non-Electronic Augmentative Or Alternative Communication Device</td>
</tr>
<tr>
<td>S8262</td>
<td>Mandibular orthopedic repositioning device, each</td>
</tr>
</tbody>
</table>
Billing for Titration

When billing for continuous positive airway pressure (CPAP) titration, please use modifiers KR and RR (example: E0601 RR KR).

A one-month rental is allowed for this service and is not applied toward the capped rental period of the respiratory equipment.

Billing for the CPAP rental and CPAP titration can be within the same month, but not for the same date of service.

Code & Comment Search Tool for Providers

The Code & Comment tool provides procedure code coverage information, including preauthorization requirements and potential medical protocols that may apply.

Code & Comment is available as a “Quick Link” on our secure website. Once selected, a pop-up window will appear. Once you type in a procedure code and select a code type, the coverage information will be returned. A key is also available to explain the abbreviations used in the results.

Medicare Crossover Claims Electronic Billing

Our electronic claims vendor, Administrative Services of Kansas (ASK), implemented new edits to ensure Medicare coordination of benefit (COB) claims have sufficient time to process. This process will help to stop duplicate claims that result in unnecessary work and inaccurate claims processing. Edit logic and codes will be posted in the near future on the ASK website.

- A MA18 or N89 on the Medicare remittance advice indicates that the claim has automatically crossed to the secondary payer.
  - Claims with these remark codes should not be filed with the secondary payer prior to 30 days from the date of Medicare remittance advice.
- The payer remittance advice contains all of the information needed by the subsequent payer(s) to accurately process the claim.
- All primary processing information must be included on a secondary claim.
- The following claim types will be excluded from this editing:
  - Veterans’ administration claims
  - Claims with a “GY” modifier

In some instances, practice management software will automatically produce a secondary claim (either electronic or paper) upon posting the primary payment. This could result in duplicate claims that will be rejected due to the new edits. If your software automatically produces a secondary claim, please contact your vendor or billing service to review the secondary process.

We encourage you to sign up for the email notifications at ask-edi.com.

Did you miss us?

Prior editions of the 2011-13 Vital Signs Practitioner Newsletter are still available on the Provider site at bsneny.com.
Visit the BlueShield of Northeastern New York Provider Website  
bsneny.com

**Telephone Directory**

**Provider Service**  
1-800-444-4552 or (518) 220-5620  
(Managed Care and Indemnity)  
1-877-327-1395 (Government Programs)

**Provider Relations and Contracting**  
(518) 220-5601

**Utilization Management**  
1-800-422-7333 or (518) 220-4650

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**We Want to Hear from You!**

Was something you read not clear?  
Do you have an idea for making this newsletter more useful?  
Want to tell us what’s on your mind?  
Your feedback is important and will help us improve our service to you.

Please email your questions, comments or suggestions to:  
NENYPracNewsletter@bsneny.com

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**Note about website links**
Links provided in this newsletter to content on the BlueShield of Northeastern New York website and third party websites are valid and working at the time of publication.