HIPAA Implementation Extension Critical to Avoid Service Disruptions, Unnecessary Costs

Issue: In August 2000, the Department of Health and Human Services (HHS) finalized the first of a series of regulations implementing the administrative simplification provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These rules set out complex, technical requirements to standardize electronic transactions and virtually all codes used by you, health plans and drug stores by October 2002.

Position: Blue Cross and Blue Shield Plans strongly support simplifying administration of our health care system for physicians, hospitals, consumers and others. However, the health care system undoubtedly faces a massive task in implementing the standard transaction and code sets. This task is much more complex and costly than Y2K and is compounded by the fact that the requirements are still evolving and there are many unanswered questions.

Implementation of HIPAA standard transactions and code sets should be extended for two years (October 2004) for a number of reasons, some of which are outlined in this article.

Rushed implementation risks national disruption of services and payment
Without time for health plans and professionals to thoroughly test the new transactions, payments to you and consumers would be seriously disrupted. Service problems would include delayed or inaccurate payments and increased difficulty in resolving consumer and provider inquiries quickly.

This task is much more complex and costly than Y2K and is compounded by the fact that the requirements are still evolving and there are many unanswered questions.

Staggered release of rules drives up costs unnecessarily
Originally, it was intended that the entire package of the administrative simplification rules would be released for implementation at the same time. This would have allowed for all changes to be coordinated as part of one comprehensive upgrade to systems and business processes.

However, the current schedule is for a staggered release of the regulations over an indefinite period.

All industry stakeholders will be forced to continually revisit and rework systems, policies, and procedures as each of the rules are released. This will undermine efficient planning and budgeting and drive multiple system upgrades.

Even so-called “final” rules are expected to change
While the clock is already ticking (with less than 20 months left) numerous critical issues remain unresolved and we expect HHS to make significant changes in the next few months. For example, the prescription drug codes released last year are widely expected to essentially be replaced in the near future.

Compliance costs are much higher than anticipated
There is growing evidence that implementation costs for HIPAA will far exceed those for Y2K. The October 2002 deadline precludes making HIPAA changes as part of the normal systems replacement, consolidation, and upgrade cycle.

As a result, many entities will be forced to waste millions of dollars making older systems compliant—even those slated for replace-
Procedures Allowing Surgical Assist: Thank You for Your Comments

Based on physician input and medical director review, we have decided to continue to allow a surgical assist for the following procedure codes:

- 23550, 24538, 25800, 27030, 27766, 27792
- 31040, 31800, 31601, 38570, 38571, 38572, 38740
- 42420, 43280, 43652, 43653, 44200, 44202, 47562, 47563, 47564, 47570, 49650, 49651
- 50546, 57550, 58550, 58551, 58672, 58673

This information supercedes the CPT Surgery Guidelines Report as well as any prior special mailings that you’ve received regarding the Assistant Surgeon List. Please file this notice in your manual.

Keep in mind, you may appeal any claim that is denied for a procedure that does not normally allow for an assist-at-surgery if you feel that an assistant surgeon was medically necessary for that procedure.

If you believe we’ve paid or denied a claim in error, submit a Reconsideration Request Form. Be sure to attach a copy of the claim in question and any necessary supporting documentation.

The Assistant Surgeon List is subject to change. However, future changes to this list will be sent to your office (30-days prior to implementation) for your review and comments.

Quick Reminders Re: Office Copays

✓ If a copay applies, the amount is shown on the patient’s I.D. card.
✓ The copay may be collected while the patient is in the office.
✓ The copay amount is also itemized on your remittance advice.
✓ The copay amount could be different, depending on coverage. Taking a copy of the front and back of the I.D. card assists in correct matching for coverage.

We have a variety of office copay coverages. The following are the standard codes that an office copay may apply to:

- 99201 - 99215

Contract information such as amount of copay, deductible and coinsurance is available by calling GABBI, our automated voice response unit, at 1-800-635-0579.

Bulletin Board

Update, in combination with the Policies and Procedures manual, is published by the Professional & Provider Relations Dept. to provide participating and preferred providers with amendments to their agreements with BCBSNE.

Non-participating providers receive the same information as a service to persons covered by BCBSNE.

Reprint only with permission.

Please address comments about the newsletter to:

Update Editor Heidi Woodard
P.O. Box 3248
Omaha, NE 68180-0001
heidi.woodard@bcbsne.com
(402) 390-1872

Senior Vice President, Managed Care Networks & Organized Delivery Systems
Steven A. Lorenzen

Director, Professional & Provider Relations
Charles Dabney

Circulation Tamara Ketcham

Metabolic Lab Panels

CPT 80053 comprehensive metabolic panel consists of the components of CPT 80048 basic metabolic panel plus the components of CPT 80076 hepatic function panel.

For claims processed on and after May 15, 2001, when you bill for both 80048 and 80076, our claims system will bundle these two codes into 80053 for payment.
“Moe” Represents BCBSNE

Morris (Moe) Mellion, M.D., chief medical officer of BCBSNE, is working with the International Standards Organization (ISO) to establish more credible standards for evaluating health plans across the country.

Through his work with the national Blue Cross and Blue Shield Association, Dr. Mellion represented Blue Plans at the ISO International Technical Agreement Workshop in Detroit.

The American Society for Quality Division and the Automotive Industry Action Group sponsored the workshop to develop guidelines for implementing ISO 9000 Quality Management Systems for the health care industry.

The International Standards Organization, based in Geneva, Switzerland, is a highly respected international body that develops consensus standards for numerous fields. More than 16 countries were represented at the workshop seeking to reach an agreement on the Quality Management Systems — Guidelines for Process Improvements in Health Care Organizations.

Selected Surgical Precert Requirements Discontinued

We are very pleased to announce that effective May 1, 2001, the required precertification for selected surgical procedures for the HMO/POS products will be discontinued.

There are several reasons behind the decision, but chief among them is that over the last several years, the number of surgical procedures (which are approved during precertification) continues to rise. The most recent calculations show that 99 percent of all procedures precertified are approved.

Elimination of selected surgical precertification will reduce your office administrative expenses, as well as speed the future process for surgical scheduling between you and your patients.

Please note that this article supersedes the information published in your manual.
About 20 years ago, data indicated that clinicians too frequently failed to intervene with their patients who smoke. Unfortunately, recent studies confirm that this picture has not changed markedly over the past two decades. One study reported that only 15 percent of smokers who saw a physician last year were offered assistance with quitting and only 3 percent were given a follow-up appointment to address this topic.

In our last Update, we published information that outlined the problem. Now, we’d like to offer some simple steps that you can take to fight the battle against tobacco.

**Tobacco Cessation Guidelines**

*Treating Tobacco Use and Dependence* (a Public Health Service-sponsored Clinical Practice Guideline) reflects new, effective clinical treatments for clinical treatment of tobacco dependence. These treatments promise to enhance the rates of successful tobacco cessation.

The key recommendations of the guideline, based on literature review and expert panel opinion, follow:

* **Tobacco dependence is a chronic condition that often requires repeated intervention.**

However, effective treatments exist that can produce long-term or even permanent abstinence.

* **Because effective tobacco dependence treatments are available, patients who use tobacco should be offered at least one of these treatments.**
  * Patients unwilling to try to quit tobacco use should be provided a brief intervention designed to increase their motivation to quit.

  **It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.**

  Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.

  **There is a strong relation between the intensity of tobacco dependence counseling and its effectiveness.** Treatments involving person-to-person contact are consistently effective, and their effectiveness increases with treatment intensity.

  Numerous effective drug treatments for smoking cessation now exist. *Except in the presence of contraindications, these should be considered with patients attempting to quit smoking.*

  * Bupropion SR *
  * Nicotine gum *
  * Nicotine inhaler *
  * Nicotine nasal spray *
  * Nicotine patch *

  * Not covered by BCBSNE

Two second-line drug treatments were identified as effective and may be considered by clinicians if the treatments listed above are ineffective.

  * Clonidine
  * Nortriptyline

If you’d like to learn more about effective treatments for tobacco dependence, please visit: [www.surgeongeneral.gov/tobacco/tobaqrg.htm](http://www.surgeongeneral.gov/tobacco/tobaqrg.htm)
The BCBS Federal Employees Plan (FEP), a national PPO administered in Nebraska by BCBSNE, has a quantity limits program managed nationally for the following drugs:

- Non-sedating antihistamines, such as Allegra, Claritin and Zyrtec
- Proton Pump Inhibitors, such as Aciphex, Prilosec, Prevacid and Protonix
- Flu products, such as Tamiflu and Relenza
- Migraine agents, such as Amerge, Imitrex, Maxalt and Zomig
- Sonata
- Stadol
- Trovan
- Zyvox

The allowances for these medications are based on FDA recommendations, as well as clinical studies and manufacturer guidelines.

A phone call from the prescribing physician's office is all that is required to determine quantity allowance. Information about the program is available at the FEP website, www.fepblue.org, or by calling the FEP Retail Pharmacy Program at 1-800-624-5060.

FEP members can be identified by their unique I.D. numbers that begin with the letter "R" and cards that display the wording, "Federal Employees Program."

Currently, BCBSNE has a quantity limitation program only for exceptionally large quantities of migraine medications. (Refer to December 2000 Update, page 7, for a complete listing or search the December 2000 issue online at www.bcbsne.com/Update.)

Eliminating local codes may have important implications for home health, long term care, and certain mental health services. Nationally, there are many companies that use a multitude of local codes. Fortunately, BCBSNE uses very few local codes and has already begun converting them to national code sets. This transition should provide little, if any, impact on our members and health care professionals.

Local codes are now used to recognize and pay for new technologies. It is unclear how new technologies will be adopted into the system when local codes are no longer allowed.

The majority of information published in this article was obtained from the Blue Cross and Blue Shield Association.
Inside your April Update...

HIPAA Implementation Extension Critical to Avoid Service Disruptions, Unnecessary Costs........................................1

Bulletin Board........................................................................................................2
  Procedures Allowing Surgical Assist
  Quick Reminders Re: Office Copays
  Metabolic Laboratory Panels

“Moe” Represents BCBSNE..................................................................................3

Selected Surgical Precert Requirements Discontinued..............................3

Smoking Cessation: Part 2..................................................................................4

FEP Drug Quantity Allowances.........................................................................5

Be sure to check us out online at www.bcbsne.com/Update