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QUESTIONS:
Contact your Professional Relations Representative, or the Professional Relations Hotline at 1.800432.3587, or in the Topeka area, 785.291.7060.

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Transcutaneous Electrical Nerve Stimulation (TENS)
Coverage under Federal Employee Program (FEP)

In the Blue Shield Report MAC-1-98, dated May 12, 1998, providers were advised that the rental of the TENS unit is no longer eligible for reimbursement. Reimbursement will be allowed only for the purchase of the four (4) lead TENS unit, subject to Maximum Allowable Payment (MAP). Claims for the two (2) lead TENS Unit will be denied as not medically necessary.

HOWEVER, please be advised that this guideline is NOT applicable to the Federal Employee Program (FEP). The following guidelines, as documented in the FEP Administrative Manual, are applicable to FEP.

Transcutaneous electrical nerve stimulation (TENS) is undertaken to relieve pain which is unresponsive to other standard pain therapies. Electrical stimulation is applied to nerves serving the painful limb or body region using one or more sets of two electrodes attached to the skin surface.

TENS is considered eligible for coverage under the FEP contract for treatment of acute postoperative pain and for treatment of severe and chronic pain that is refractory to all other standard pain therapies.
Benefits for TENS for FEP insureds are administered per the following guidelines:

A. Chronic Pain

1. Initial rental of the stimulator for a one week trial period.
2. After one week, continued rental or purchase of the stimulator should be justified by report of medical necessity (TENS form #15-3) and reviewed for Individual Consideration (IC).

B. Acute postoperative pain

1. Rental of the stimulator should be limited to a period of seven days or less
2. If the device is required for MORE than seven days, the claim should be reviewed for Individual Consideration (IC) to ascertain whether TENS is no longer being used for acute pain, but rather for chronic pain. In such cases, coverage should be provided for the treatment of chronic pain as described above.

Purchase CMN no longer needed for CPAP or Intermittent Assist System

The following guidelines should utilized when submitting for Continuous Positive Airway Pressure System (CPAP) and Intermittent Assist System with Continuous Positive Airway Pressure (i.e., BIPAP). The Certificate of Medical Necessity (CMN) form is no longer needed for the purchase of a CPAP or Intermittent Assist System, effective immediately.

A. CPAP is allowed for moderate to severe sleep apnea only. The physician’s summary of the sleep study must accompany the initial claim. Indications for CPAP would include significant hypoxemia (less than 87% oxygen saturation or significant daytime somnolence). The physician’s summary will serve as the certificate of medical necessity (CMN).

B. Sleep studies must extend over at least a six-hour period and should include information with the patient both off and on CPAP so that its effectiveness may be evaluated.

C. If allowed, CPAP should be rented for a three month trial period. At the end of three months, the provider should submit a claim for purchase if they wish to continue; first three-months rental will be applied to the purchase allowance.

Coverage for the Intermittent Assist System (i.e., BIPAP) will be reviewed on an Individual Consideration basis only. Indications for the Intermittent Assist System should include:

1. Patients with nocturnal hypoventilation, i.e., hypoventilation secondary to neuromuscular disease, kyphoscoliosis, post-polio syndrome, and amyotrophic lateral sclerosis.
2. Documented failure of CPAP. If CPAP is not tolerated and an Intermittent Assist System tried, a three month trial period is required to see if it can be tolerated before purchase. If after a month, documentation is received which supports its effectiveness, it could be purchased.

3. The following codes should be used for submitting charges for the CPAP and Intermittent Assist System:

   - **E0452** Intermittent assist device with continuous positive airway pressure device
   - **E0453** Therapeutic ventilator; suitable for use 12 hours or less per day
   - **E0601** Continuous positive pressure airway device
   - **K0193** Continuous positive pressure airway device, with humidifier
   - **K0194** Intermittent assist device with continuous positive airway pressure, with humidifier

   The following information is required for BCBSKS review:

   a. Physician's summary report
   b. Evaluation after initiation of unit

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**Button-G Tubes Guidelines**

When billing for Button-G tubes with kits, HCPCS code **E1399** should be billed. Please also include the invoice and item description with the claim, as there are different types of G tubes.

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**Pulse Oximeter Guidelines**

Benefits for the rental of a pulse oximeter machine, **S2200**, will be available when the following guidelines are met.

For Children:

1. Children needing oxygen therapy for cardiac or chronic lung disease, such as bronchopulmonary dysplasia or cystic fibrosis in the late stages.

2. Children with acute pulmonary infections receiving treatment at home. Diagnoses such as bronchopulmonary dysplasia or cystic fibrosis.
3. Need to document nocturnal hypoventilation. (Example: to establish the need for overnight supplemental oxygen in children with chronic pulmonary disease, cerebral palsy, etc.)

Specific documentation regarding the necessity for a pulse oximeter in the home setting should be included with the initial claim. Once pulse oximetry is started in the home setting, its usage should be reassessed every 30 days. The assessment, by the physician, should indicate that the care is being modified based on the use of the oximeter.

Rental of the pulse oximeter will be allowed if above guidelines are met. If these guides are not met, the claim(s) will be denied as not medically necessary.

For Adults:

The use of the pulse oximeter for adults in a home setting is not recommended by either a pulmonary or cardiology consultant.

Claim Lines and Narrative Descriptions

Codes requiring narratives should be placed only on lines 1 through 5 of the claim form. Narratives should not be placed on the 6th line as they will be cut off when BCBSKS prints the claim. The cut-off narrative will then cause the claim to be returned to the provider for a description.

Premier Blue Benefits

Premier Blue provides benefits for the following post-mastectomy bras, breast prostheses and surgical/radiation camisoles.

L8000 Post-mastectomy bra (Two are allowed per year.)

L8020 Breast prostheses, mastectomy form, other than silicone (Two are allowed per year for a unilateral mastectomy; four are allowed for a bilateral mastectomy.)

L8030 Breast prosthesis, mastectomy form, silicone or equal (Two are allowed per year for a unilateral mastectomy; four are allowed for a bilateral mastectomy.)

S0105 Post-mastectomy and/or post-radiation camisole (Up to five will be allowed per year.)
Corrections

PHYSICAL THERAPY AND OCCUPATIONAL GUIDELINES

Please note that in the Blue Shield Report S-26-99, August 6, 1999, under the Physical and Occupational Therapy Billing Guidelines, C. should read as follows:

C. Continue to bill 97002 or 97004 for re-evaluations.

HME BENEFITS

Please note that in the Blue Shield Report S-2-99, March 12, 1999, the correct code for the Cam Walker is L4360 (HME Benefits, page 2).

Please accept our apologies for any problems/confusion that this error may have caused.