PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

October 2004

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BC

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News

Physical therapy benefit renamed physical medicine

In the past, Highmark Blue Shield has used the term "physical therapy" in its benefit contracts as a general reference to outpatient therapy and rehabilitation services. However, Blue Shield no longer intends to use the term "physical therapy" to describe a benefit under which services performed by a number of different health care provider types may be paid.

Specifically, Blue Shield is changing the language in its benefit contracts so that the benefit previously referred to as "physical therapy" will now be named "physical medicine." Blue Shield will also revise the definition of physical medicine to provide additional specificity regarding what services are covered under the benefit. This is being done so that members will not erroneously assume that the benefit refers to those services that can only be provided by licensed physical therapists. This change will be made to all of Highmark Blue Shield's direct-pay and group products, including CHIP, adultBasic and Special Care, as well as Agent Plan products that are wholly controlled by Blue Shield.

HIGHMARK® BLUE SHIELD

Some products continue to use term "physical therapy"

Since there are products over which Blue Shield does not have final approval of the language used to describe benefits, you will continue to see the existing terminology ("physical therapy") in reference to the member's benefit for some products.

Here are the products that will continue to use the term "physical therapy":

- the Federal Employee Program,
- Blue Shield's senior products: MedigapBlue, Signature 65 and 65 Special, and
- some Agent Plan business.

In products for which the terminology is changing, physical medicine services may be provided by any health care provider specialty licensed to perform the services as described within the definition of physical medicine and recognized as an eligible provider under Blue Shield's benefit plans. This includes, but is not limited to, physical therapists, doctors of chiropractic, doctors of osteopathic medicine and doctors of medicine.

This language change will have no impact on the scope of services covered by the benefit, nor will it change the manner in which benefit maximums or limits are applied, or the way that claims are adjudicated.

Physicians and suppliers needed to expand professional consultant network

Highmark Blue Shield is searching for health care professionals and other health care providers to expand its professional consultant network.

Blue Shield maintains an extensive network of physicians and other health care professionals, known as professional consultants.

Professional consultants are paid independent contractors who work with Blue Shield on a routine basis and are asked to provide their expertise for the many important issues related to medical policy, medical necessity determinations for specific claims, appeals and retrospective utilization reviews and reimbursement issues.

Becoming a professional consultant offers many rewards. Blue Shield offers a competitive compensation and the flexibility to tailor your consulting workload to your needs. It also gives you the chance to help ensure the quality and appropriateness of care received by Blue Shield members.

10/2004

Blue Shield's consultants play an important role in many of our key operations and serve as an important link to the health care community.

We have vacancies in the medical specialties of:

- Adult and pediatric critical care
- Allergy/immunology
- Anesthesiology
- Bariatric surgery
- Cardiology
- Colo-rectal surgery
- Endocrinology
- Gastroenterology
- Gynecology/endocrinology/infertility
- Infectious diseases
- Internal medicine
- Maternal/fetal medicine
- Neurological surgery
- Neurology
- Obstetrics and gynecology
- Occupational therapy
- Oncology
- Ophthalmology
- Orthopedic surgery
- Otolaryngology
- Otorhinolaryngology
- Pulmonary medicine
- Radiation oncology
- Radiology
- Rheumatology
- Speech/language pathology
- Speech/language pathology (pediatrics)

- Ultrasound
- Vascular surgery

We also have vacancies for ambulance services providers and durable medical equipment suppliers.

Professional consultant qualifications

To qualify as a professional consultant, physicians must:

- maintain active clinical practice,
- maintain appropriate board-certification for each specialty and/or sub-specialty for each designation as a professional consultant,
- maintain appropriate practice patterns and service utilization levels,
- be free of any findings of fraud or abuse, and
- be willing to provide medical opinions and input within the time frames required by Blue Shield.

To qualify as a professional consultant, suppliers must:

- maintain active links and current employment with a medical equipment dealer,
- maintain appropriate billing and supply utilization levels,
- be free of any findings of fraud or abuse, and
- be willing to supply expert opinions and input within the time frames required by Blue Shield.

If you are interested in finding out more about this exciting opportunity, and you specialize in one of the areas in which we have vacancies, please send a copy of your curriculum vitae (physicians) or resumé (suppliers) to:

Highmark Blue Shield
Attention: Professional Consultant Coordinator
Medical Policy
Senate Plaza, 3 North
PO Box 890089
Camp Hill, Pa. 17089

If your specialty is not listed and you are interested in becoming a professional consultant, please send us your curriculum vitae or resumé.

Blue Shield gives priority to HIPAA-compliant transactions

As of Oct. 1, 2004 Highmark Blue Shield gives priority treatment to the processing and payment of HIPAA-compliant transactions. Blue Shield began this priority handing of claims to encourage you, your billing services and clearinghouses to transition to HIPAA-compliant transactions and code sets.

Blue Shield now receives more than 93 percent of electronic claims in HIPAA-compliant 4010A1 formats.

Blue Shield began to offer priority treatment to HIPAA-compliant transactions because the Centers for Medicare and Medicaid Services modified its HIPAA contingency plan (Medlearn Matters No. MM2981) on July 1, 2004 to allow for priority handling of HIPAA-compliant Medicare transactions.

Blue Shield will process and pay non-compliant electronic transactions received after Oct. 1, 2004 with the same priority it assigns paper claims.

Remember, Blue Shield does not support and will not support ASCX12N version 4010 transactions.

If you have questions about how to submit your electronic claims, call EDI Operations at (800) 992-0246.

Correction

On Page 2 in the June 2004 **PRN**, the shading on the map used to illustrate Highmark Blue Shield's Central Region service area inadvertently omitted three counties. The Central Region also includes Berks, Lehigh and Northampton Counties, for a total of 21 counties.

Policy

Conscious sedation administered for endoscopic procedures by same provider not paid separately

Highmark Blue Shield does not pay separately for the administration of conscious sedation for endoscopic procedures when the same provider, regardless of specialty, performs the administration of the sedative and the endoscopic procedure.

Blue Shield includes the reimbursement for conscious sedation in the global allowance for diagnostic and uncomplicated therapeutic endoscopic procedures. A participating, preferred, or network provider cannot bill the member for the conscious sedation.

Guidelines for conscious sedation administered for other procedures

Blue Shield will not pay for conscious sedation when it's performed with any other surgical procedure by the same provider. In these instances, a participating, preferred, or network provider can bill the member for the conscious sedation.

Blue Shield will pay separately for conscious sedation when it's performed for any covered surgical procedure by a provider other than the operating surgeon, assistant surgeon, or attending professional.

Reporting guidelines for ovulation induction management explained

Ovulation induction management (cycle management) involves the medical management of the patient where medication is used to stimulate development of mature follicles within the ovaries.

Ovulation induction management may be performed as part of an assisted fertilization program or as a treatment for infertility outside of an assisted fertilization program. Report this service with an appropriate evaluation and management procedure code, provided there is patient and physician interaction and all of the components of the evaluation and management code have been met.

Highmark Blue Shield may consider ovulation induction management performed without a face-to-face patient and physician encounter, for example, conducted by telephone, an eligible service.

Use procedure code 58999 to report ovulation induction management services involving the interpretation or discussion of laboratory test results and clarification of medication dosage or instructions where there is no face-to-face contact between the physician and the patient. When you report code 58999, please provide a complete description of the service you performed by entering "ovulation induction management" in the narrative section of the electronic or paper claim.

Report code 58999 once for each cycle of ovulation induction management. Blue Shield will provide global reimbursement for each cycle of non face-to-face ovulation induction management, in accordance with the individual member's contract.

You should report other services performed within the ovulation induction management, for example, laboratory tests, ultrasound, etc., individually with the appropriate procedure code. Blue Shield will pay for these services in accordance with the individual member's contract.

Assisted fertilization services not eligible for reimbursement

Assisted fertilization services (including, but not limited to AI, IVF, GIFT, ZIFT or other techniques designed to result in fertilization) are generally excluded from Blue Shield standard medical-surgical contracts. They are not eligible for reimbursement. However, all medical, surgical, and diagnostic services performed to diagnose and treat infertility are normally covered unless the individual member's contract contains an exclusion for the diagnosis and treatment of infertility.

Once it has been established that the ultimate goal for the infertile patient is assisted fertilization, AI, IVF, GIFT, ZIFT, etc., Blue Shield considers all subsequent related diagnostic, medical, and surgical services part of the assisted fertilization program. These services are not covered when the member does not have an assisted fertilization benefit. A participating, preferred, or network provider can bill the member for the denied service.

Blue Shield does not cover Bilitec 2000

Highmark Blue Shield considers the Bilitec 2000 procedure experimental or investigational. Blue Shield will deny claims reporting this procedure. A participating, preferred, or network provider can bill the member for the denied procedure.

Blue Shield does not cover the Bilitec 2000 procedure because there is a lack of published peer-reviewed literature assessing its clinical utility. Additional studies are needed to determine the role of this procedure in evaluating patients with duodenogastroesophageal reflux.

To report the Bilitec 2000 procedure, use unlisted procedure code 91299. When you report code 91299, please provide a complete description of the service you performed in the narrative field of the electronic or paper claim.

The Bilitec 2000, a fiberoptic spectrophotometer, is used by a trained technician or health care professional to evaluate reflux disorders in the gastrointestinal tract. The evaluation is typically performed in an ambulatory setting independent of esophageal pH. The Bilitec 2000 is similar to other systems used for ambulatory esophageal pH monitoring.

Blue Shield pays separately for intraoperative monitoring

Highmark Blue Shield now pays separately for intraoperative monitoring procedures that are performed in conjunction with surgery and anesthesia.

Blue Shield no longer considers these monitoring procedures an integral part of the surgery or anesthesia service when they're performed by the same or different providers:

- ECG/EKG monitoring (93000-93010, 93040-93042)
- administration of fluids and/or blood (36430-36460)
- respiratory functions, for example, oxygen maintenance (94680-94750, 94770)
- monitoring heart-lung machine (99190, 99191, 99192)
- EEG monitoring (95999)
- heparin assays (85520)
- somatosensory evoked potential (95925)
- evoked response (ERA) audiometry (92585, 92586)
- brainstem auditory evoked response (BAER) recording (92585, 92586)
- intraoperative neurophysiology monitoring (95920)

Temporary tracheal occlusion for treatment of congenital diaphragmatic hernia no longer eligible

Highmark Blue Shield currently covers fetal surgery performed in-utero for certain conditions.

As of Jan. 17, 2005, Blue Shield will no longer provide coverage for temporary tracheal occlusion as a treatment for congenital diaphragmatic hernia. Recent randomized controlled trials have concluded that temporary tracheal occlusion does not positively impact fetal survival rates more than standard non-surgical treatment.

Blue Shield will continue to cover fetal surgery for these conditions:

- urinary tract obstruction
- congenital cystic adenomatoid malformation
- extralobar sequestration
- sacrococcygeal teratoma

Scientific evidence does not demonstrate the effectiveness of fetal surgery performed for other indications. Blue Shield considers fetal surgery for all other conditions, including myelomeningocele, aqueductal stenosis, and congenital diaphragmatic hernia experimental or investigational. A participating, preferred, or network provider can bill the member for the denied surgery.

Photodynamic therapy now eligible for Barrett's esophagus with high-grade dysplasia

Highmark Blue Shield will now pay for photodynamic therapy with Photofrin R, porfimer sodium, for patients with Barrett's esophagus with high-grade dysplasia.

Report ICD-9-CM diagnosis code 530.85 when you submit a claim for photodynamic therapy for patients with Barrett's esophagus with high-grade dysplasia.

Use procedure code J9600 to report the Photofrin R. Report code 96408, as appropriate, for the intravenous administration of the photosensitizing agent. Use code 43228 (esophagoscopy) in addition to 96570, 96571 (PDT), as appropriate, to report the second stage of the photodynamic therapy.

Additional procedures eligible for co-surgery

Highmark Blue Shield considers these additional procedures eligible for payment for co-surgery:

22325—open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; lumbar

35626—bypass graft, with other than vein; aortosubclavian or carotid

35646—bypass graft, with other than vein; aortobifemoral

35656—bypass graft, with other than vein; femoral-popliteal

35820—exploration for postoperative hemorrhage, thrombosis or infection; chest

44005—enterolysis (freeing intestinal adhesion) (separate procedure)

44310—ileostomy or jejunostomy, non-tube (separate procedure)

45110—proctectomy; complete, combined abdominoperineal, with colostomy

61500—craniectomy; with excision of tumor or other bone lesion of skull

62146—cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter

Note: Other Blue Shield medical policies may impact the eligibility of these procedures.

Blue Shield considers slings part of overhead expense

Beginning Jan. 1, 2005, Highmark Blue Shield will consider slings, code A4565, part of a provider's overhead expense.

Blue Shield will not pay separately for a sling. A participating, preferred, or network provider cannot bill the member for overhead expenses.

Ultraviolet light B therapy now eligible for pruritus of malignancy

Highmark Blue Shield now considers pruritus of malignancy a covered indication for ultraviolet light B (UVB) therapy.

Blue Shield determines coverage for UVB therapy according to the individual or group customer benefits program.

Sapala-Wood Micropouch Roux-en-Y gastric bypass not eligible

Highmark Blue Shield considers the Sapala-Wood Micropouch Roux-en-Y gastric bypass procedure experimental or investigational. Blue Shield will deny claims reporting this service. A participating, preferred, or network provider can bill the member for the denied surgery.

Blue Shield is not covering this procedure because there is a lack of long-term studies demonstrating its safety and effectiveness.

Use unlisted procedure code 43999 to report Sapala-Wood Micropouch Roux-en-Y gastric bypass. When you report code 43999, please provide a complete description of the service you performed in the narrative field of the electronic or paper claim.

Report number of vials, not mCi's, for certain radiopharmaceutical codes

The terminology for some radiopharmaceutical codes indicates a dosage of "per mCi," however, these radiopharmaceuticals are manufactured in single dose vials. For these radiopharmaceuticals, Highmark Blue Shield bases its reimbursement on the average wholesale price of each vial, not on the number of mCi's.

When you submit claims for these radiopharmaceuticals, please do not report the number of mCi's in the days or units field. You should indicate the number of vials in the days or units field so that you receive the correct reimbursement.

Here are the radiopharmaceutical codes that indicate a dosage of per mCi:

A9503—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m, Medronate, (MDP), up to 30 mCi

A9513—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m mebrofenin, per mCi

A9514—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m pyrophosphate, per mCi

A9515—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m pentetate, per mCi

A9517—supply of radiopharmaceutical therapeutic imaging agent, I-131 sodium iodide capsule, per mCi

A9519—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m macroaggregated albumin, per mCi

A9520—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m sulfur colloid, per mCi

A9522—supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per mCi

A9523—supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxean, per mCi

A9528—supply of radiopharmaceutical diagnostic agent, I-131 sodium iodide capsule, per millicurie

A9533—supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per millicurie

A9534—supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per millicurie

A9605—supply of therapeutic radiopharmaceutical, Samarium SM 153 Lexidronam, 50 mCi

Q3003—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m Bicisate, per unit dose

Q3005—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m Mertiatide, per mCi

Q3006—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m Gluceptate, per 5 mCi

Q3009—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m Oxidronate, per mCi

Q3010—supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m labeled red blood cells, per mCi

Q3012—supply of oral radiopharmaceutical diagnostic imaging agent, Cyanocobalamin Cobalt Co57, per 0.5 mCi

Intradiscal therapy codes S2370, S2371 deleted

On Oct. 1, 2004 Highmark Blue Shield deleted code S2370—intradiscal electrothermal therapy, single interspace—and code S2371—intradiscal electrothermal therapy; each additional interspace.

You can continue to use these codes, as appropriate, to report intradiscal therapy on or after Oct. 1, 2004:

0062T—percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level

0063T—percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; one or more additional levels (list separately in addition to 0062T for primary procedure)

Highmark Blue Shield considers intradiscal electrothermal annuloplasty (IDEA) or intradiscal electrothermal therapy (IDET) an experimental or investigational procedure. A participating, preferred, or network provider can bill the member for the denied IDEA or IDET.

Questions or comments on these new medical policies?

We want to know what you think about our new medical policy changes. Send us an e-mail with any questions or comments that you may have on the new medical policies discussed in this edition of **PRN**.

Write to us at **medicalpolicy@highmark.com**.

Codes

New codes and modifier available October 1

These new codes and modifier became available Oct. 1, 2004:

Code	Terminology
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion
S0109	Methadone, oral, 5 mg
S0166	Injection, olanzapine, 2.5 mg
S0167	Injection, apomorphine hydrochloride, 1 mg
S0168	Injection, azacitidine, 100 mg
S0515	Scleral lens, liquid bandage device, per lens
S2215	Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection of implant material into and along the muscle of the lower esophageal sphincter for treatment of gastroesophageal reflux disease
S8093	Computed tomographic angiography, coronary arteries, with contrast material(s)
S9097	Home visit for wound care

Modifier	Terminology
SS	Home infusion services provided in the infusion suite of the IV therapy provider

2004 PTM for Ancillary Providers change

Please make this change to your 2004 **PTM for Ancillary Providers** manual:

Page	Code	Terminology	Action
18	S9363	Home infusion therapy, anti-spasmodic therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Revise terminology. Effective Oct. 1, 2004.

Patient News - Information about your patients who are Highmark Blue Shield customers

Central and Eastern Region

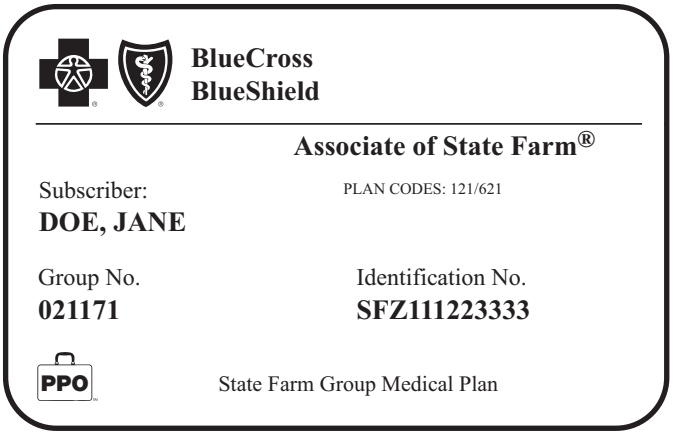
Blue Cross and Blue Shield of Illinois to process PPO claims for State Farm Insurance Group Medical Plan

Blue Cross and Blue Shield of Illinois (BCBSIL) will begin to administer the State Farm Insurance Companies' Group Medical PPO Plan on Jan. 1, 2005. The Group Medical Plan is only offered to State Farm employees, agents, employees of agents, and retirees. It is not offered to the general public.

BCBSIL's administration of the State Farm Group Medical Plan does not include medical policies that are sold as a line of business by State Farm agents.

As with any Blue Cross and Blue Shield policy, the identification card is key. All State Farm Group Medical Plan members will be issued a BCBSIL card with the standard BlueCard PPO suitcase logo. The identification number on the card will not be the member's Social Security number. BCBSIL will assign an alternate identification number to these members. Look for alphabetical prefix **SFZ** before the identification number to identify these members.

Here is a sample of the new identification card:



Need to change your provider information?

Fax the information to us!

You can fax us changes about your practice information, such as the information listed on the coupon below.

The fax number is (866) 731-2896. You may also continue to send information by completing the coupon below.

Coupon for changes to provider information

Please clip and mail this coupon, leaving the **PRN** mailing label attached to the reverse side, to:

Highmark Blue Shield
Provider Data Services
PO Box 898842
Camp Hill, Pa. 17089-8842

Name _____ Provider ID number _____

Electronic media claims source number _____

Please make the following changes to my provider records:

Practice name _____

Practice address _____

Mailing address _____

Telephone number ( ) _____ Fax number ( ) _____

E-mail address _____

Tax ID number _____

Specialty _____

Provider's signature _____ Date signed _____

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Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the Current Procedural Terminology, as contained in CPT-2004, Copyright 2003, by the American Medical Association. **PRN** includes CPT descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.

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