PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

August 2005

In This Issue

MA

Look for this symbol for all Medicare Advantage related information

BC

Look for this symbol for all BlueCard® related information

News

View Blue Shield's medical policy without login and password

Highmark Blue Shield no longer requires a login and password to look at its online medical policies. If you already have a medical policy login and password, you will no longer be prompted for them when you try to access Blue Shield's online medical policies.

Blue Shield's medical policies are available online in the Provider Resource Center at **www.highmarkblueshield.com**. An alphabetical, as well as a sectional index, is available on the Medical Policy page. You can search for a certain medical policy by entering a key word, policy number, or procedure code.

Medicare Advantage icon identifies FreedomBlue medical policy

MA

Highmark Blue Shield is introducing a new icon to help you determine if Blue Shield's medical policies apply to its Medicare Advantage PPO product, FreedomBlue℠.

FreedomBlue follows the national Medicare coverage decisions and the coverage decisions of HGSAdministrators, the Medicare Part B insurance carrier in Pennsylvania. When national or local Medicare coverage decisions are not available, Blue Shield's medical policy applies to FreedomBlue.

There are also instances when Blue Shield's claims processing or payment methodology will be applied to FreedomBlue claims. In those cases, the medical policy guidelines published in **PRN** apply to FreedomBlue.

Look for the new icon MA in this issue of **PRN**. The icon will point out which policy articles apply to FreedomBlue.

Read about national and local Medicare Advantage decisions in Medicare Report

To find out what national and local coverage decisions apply to FreedomBlue, refer to HGSAdministrators' newsletter, **Medicare Report**. It is available online at **www.hgsa.com**.

Attention PremierBlue Shield and Participating providers: Personal Choice claims processing transitioned to IBC

As of July 2, 2005, Highmark Blue Shield no longer processes claims for Independence Blue Cross (IBC) Personal Choice members. IBC now manages the processing of these claims.

During the past several years, Blue Shield had assisted IBC with processing claims for selected Personal Choice members. However, on July 2, 2005, processing of all Personal Choice medical/surgical claims was transitioned from Blue Shield's system to IBC's Managed Healthcare System.

Many of the changes involved in this conversion were invisible to you. However, please be aware of these important details:

- Within the five-county IBC region of Bucks, Chester, Delaware, Montgomery and Philadelphia counties, Highmark Blue Shield Participating providers are considered to be participating for this Personal Choice business.

- Outside of the five-county IBC region of Bucks, Chester, Delaware, Montgomery and Philadelphia counties, the eligible services performed by PremierBlue℠ Shield, Participating and Highmark Blue Shield-contracted ancillary providers are considered to be network services for this Personal Choice business.

- The member identification number alphabetical prefixes affected by this transition are QCA, QCB and QCM.
- In order to be routed correctly, electronic submissions of Personal Choice and Personal Choice 65 claims in HIPAA-compliant ANSI X12 837P format must include the NAIC code of 54704 in ISA-08. You should continue to use the NAIC code 54704 in GS-03. If you have questions about this billing change, please call (800) 992-0246.
- Please continue to send paper claims for Personal Choice and Personal Choice 65 members to:

  Personal Choice Claims
  PO Box 890016
  Camp Hill, Pa. 17089-0016

- Electronic remittance advices (835s) will be generated by IBC rather than Blue Shield for professional Personal Choice and Personal Choice 65 claims received on or after July 2, 2005. However, Blue Shield will continue to generate 835s for the Personal Choice business for professional claims with dates of service before Jan. 1, 2005.

  For dates of service from Jan. 1, 2005, to July 2, 2005, all professional claims received by Blue Shield or pending in Blue Shield's processing system will be forwarded to IBC. During the claims processing run-out period, you may receive 835s from both IBC and Highmark Blue Shield, depending upon the dates of service for the particular claims.
- IBC has also made changes in the content and envelope data of 835s. Please check with your vendor or clearinghouse to identify any changes that may be necessary for this transition.
- The Explanation of Benefits (EOB) also looks different.

If you have questions about this change, please contact your Provider Relations representative.

Erin Group and Significa use PremierBlue Shield network

On May 1, 2005, Erin Group Administrators, Inc. (Erin Group) and Significa Insurance Group, Inc. (Significa), wholly-owned subsidiaries of Blue Cross of Northeastern Pennsylvania, began to use the PremierBlue Shield network to provide services for their members.

As a contracted PremierBlue Shield participating provider, your practice will be considered "in network" for patients whose health coverage is through Erin Group or Significa. These patients will carry an Erin Group or Significa identification card.

Erin Group and Significa are responsible for the administration of these benefit plans; therefore, submit claims for these members directly to Erin Group or Significa, as appropriate. You can find the address for where to send your claims on the back of the member's identification card. Please direct your inquiries about benefits, eligibility or claim status to Erin Group or Significa.

Provider satisfaction increases with BlueCard claims handling

As a Blue Shield Plan, Highmark Blue Shield is proud of its 76-year service history in the health care industry. Because of Blue Shield's partnership with providers like you, more than 90 million members across the nation choose Blue Cross and/or Blue Shield as their health insurer. To build on its successful history, Blue Shield is focusing on your needs—by simplifying administrative processes and improving its service to you.

The Blue System holds focus groups, reviews satisfaction surveys and collects feedback from Blue Shield phone and field representatives who interact closely with providers. Blue Shield has used this research to deepen its customer focus, improve its service delivery with the BlueCard® program (out-of-area claims) and implement new technology to meet your changing needs.

Highmark Blue Shield is pleased to share the 2004 survey results in which you told it that it is improving your satisfaction with the BlueCard program. From 2003 to 2004, significant service delivery improvements in claims accuracy and resolution were noted:

- Claims accuracy improved 6 percent.
- Satisfaction with resolving problem claims increased 8 percent.
- Number of claims requiring follow-up decreased 10 percent.

Highmark Blue Shield is proud to be your single point of contact for BlueCard:

- claims,
- provider service, and
- provider education-related inquiries.

In 2005, Blue Shield is committed to further improve its service to you by:

- continuing to improve claims accuracy and claim resolution,
- improving claims timeliness,

- promoting internal education to guarantee excellent provider service experience, and
- improving the existing inter-Plan resolution process.

If you have questions about the BlueCard program or filing claims for out-of-area patients, please contact your Provider Relations representative.

You may also want to review the newly revised **BlueCard Provider Manual** available online in the Provider Resource Center through NaviNet or **www.highmarkblueshield.com**.

2005 survey coming soon

The 2005 BlueCard provider satisfaction survey will be conducted during September and October of this year. Your office could receive a call asking for your participation in this survey, which typically includes questions about your satisfaction in these areas: overall satisfaction, eligibility, claims handling, claims status, claims resolution, customer service, and education.

If your office is contacted, please direct the caller to the person with the most BlueCard experience. Thank you in advance for your participation.

Policy

Ziconotide eligible for chronic pain conditions

Highmark Blue Shield will cover ziconotide (Prialt®) if the member meets all of these criteria:

1. They must have a documented diagnosis of a chronic pain condition.
2. They must be under the supervision of a pain specialist, for example, neurologist, anesthesiologist.
3. They must have tried and failed at least three different oral opioid therapies, or have tried and failed intrathecal morphine therapy.

If ziconotide is prescribed for a diagnosis other than severe chronic pain, Blue Shield will consider it experimental or investigational. It will not be covered. A participating, preferred, or network provider can bill the member for the denied drug.

Blue Shield also considers the use of ziconotide in the following instances experimental or investigational because its safety, effectiveness and long-term product stability have not been proven:

- when it's used in combination with any other intrathecal medication,
- for the treatment of acute pain conditions.

Use code S0118 to report ziconotide.

Blue Shield determines coverage for ziconotide according to the individual or group customer benefits. Ziconotide is not reimbursable under the prescription drug benefit.

The Food and Drug Administration has approved ziconotide as an intrathecal infusion for the management of severe chronic pain in patients for whom intrathecal therapy is warranted, and who are intolerant or refractory to other treatment, such as systemic analgesics, adjunctive therapies, or intrathecal morphine.

Severe psychiatric symptoms and neurological impairment may occur during treatment with ziconotide. Patients with a pre-existing history of psychosis should not be treated with ziconotide. All patients should be monitored frequently for evidence of cognitive impairment, hallucinations, or changes in mood or consciousness.

Ziconotide is not a substitute for opioids. If opiate withdrawal is required, the patient must be withdrawn slowly from opiates when initiating therapy.

Also applicable to FreedomBlue.

Proton beam radiation therapy coverage guidelines explained

Highmark Blue Shield considers proton beam radiation therapy an eligible service when it's performed to treat these conditions:

- chordomas and chondrosarcomas of the base of the skull and cervical spine (170.0, 170.2)
- intraocular melanomas (190.0-190.9)
- pituitary neoplasms (194.0-194.4)
- anomalies of the cerebrovascular system, for example, small arteriovenous malformation of the brain (747.81)
- central nervous system lesions (192.0-192.9)
- head and neck malignancies (142.0, 146.0-146.9, 147.0-147.9, 148.0-148.9, 160.0, 160.9, 171.0)

- malignant neoplasms of the prostate (185, 198.82)
- malignant neoplasms of the brain (191.0-191.9)

Blue Shield will deny all other applications or uses of proton beam radiation therapy as experimental or investigational. Blue Shield will not pay for the therapy in these instances because current medical literature does not conclusively verify proton beam radiation therapy's effect on health outcomes in other applications. A participating, preferred, or network health care professional can bill the member for the denied therapy.

Please use these codes, as appropriate, to report proton beam radiation therapy treatment delivery:

77520—proton beam treatment delivery; simple, without compensation

77522—proton beam treatment delivery; simple, with compensation

77523—proton beam treatment delivery; intermediate

77525—proton beam treatment delivery; complex

Proton beam radiation therapy, also called particulate radiation, delivers high dose radiation to a localized site. Proton beam radiation treatment is different from conventional electron beam radiation therapy because it uses protons rather than electron beams. It has several unique properties. Proton ions or particles slow down faster than photons. As they pass through tissue, they deposit more energy at precise depths as they slow down, culminating in a peak, called a Bragg peak. This method delivers the majority of radiation to the target site with minimal scatter, sparing surrounding or adjacent normal tissues.

MA Does not apply to FreedomBlue.

Enuresis alarm not covered

Highmark Blue Shield does not pay for enuresis (bed-wetting) alarms because they do not meet Blue Shield's definition of durable medical equipment (DME). A participating, preferred, or network provider can bill the member for the denied alarm.

Blue Shield defines DME as equipment that should:

- be able to withstand repeated use,
- be primarily and customarily used to serve a medical purpose,

- not be useful to a person in the absence of illness or injury,
- be appropriate for use in the home.

All requirements of the definition must be met before Blue Shield can consider an item as DME. Since an enuresis alarm does not primarily serve a medical purpose, it does not meet all the requirements for DME.

Blue Shield determines coverage for DME according to the individual or group customer benefits.

Use code S8270 to report an enuresis alarm.

An enuresis alarm is intended for use in the treatment of bed-wetting. The child wears the device at night to teach him or her to awaken when he or she needs to urinate. When the child begins to urinate, the sensor detects the moisture and triggers the alarm. The child awakens, sometimes with the help of the parent who is also awakened. The child then gets up to use the bathroom.

Also applicable to FreedomBlue.

Zoledronic covered for certain diagnoses

Zoledronic acid (Zometa®), a bisphosphonic acid and inhibitor of osteoclastic bone resorption, has been approved by the Food and Drug Administration (FDA) for the treatment of:

- hypercalcemia of malignancy (275.42)
- multiple myeloma (203.00-203.01)
- bone metastases from solid tumors in conjunction with standard anti-neoplastic therapy, including bone metastases from multiple myeloma, breast carcinoma, prostate carcinoma, and other solid tumors. (162.0-162.9, 170.0-170.9, 174.0-174.9, 175.0-175.9, 185, 189.0-189.9, 193, 195.0, 197.0, 198.0, 198.5, 198.81, 198.82)

  Note: Prostate cancer should have progressed after treatment with at least one hormonal therapy.

If zoledronic acid is used for a diagnosis other than those approved by the FDA, Highmark Blue Shield will deny it as experimental or investigational. It will not be covered. A participating, preferred, or network provider can bill the member for the denied drug.

Report zoledronic acid with code J3487.

Blue Shield determines coverage for zoledronic acid according to the individual or group customer benefits. Zoledronic acid is not reimbursable under the prescription drug benefit.

MA Does not apply to FreedomBlue.

How to report multiple imaging studies performed on the same day

Here is how Highmark Blue Shield determines payment for multiple X-ray studies when they're performed on the same day.

Multiple studies performed during the same imaging session

Highmark Blue Shield pays separately for diagnostic X-ray studies when multiple X-ray studies are performed during the same imaging session on the same day. However, when a combination code is available, you must report the appropriate combination code for the anatomic area(s) imaged.

For example, you should report code 73520—radiological study of bilateral hips, minimum of 2 views of each hip, including anteroposterior view of pelvis—when you image bilateral hips and pelvis.

Multiple studies of the same anatomic area performed during different times on the same day

Blue Shield pays for an X-ray study of the same anatomic area when it is performed during different imaging sessions on the same day. In these cases, report the procedure codes with modifier 59 to indicate different imaging sessions or patient encounters.

For example, when chest X-rays are performed during different sessions on the same day, such as in the morning and evening, Blue Shield will pay for each study. Modifier 59 must be reported with the appropriate chest X-ray procedure codes to indicate that the studies were taken during different imaging sessions on the same day.

If you do not report the procedure code with modifier 59, Blue Shield may deny the service. You should keep a separate interpretation or report in the patient's medical records that documents the medical necessity for each study.

MA Also applicable to FreedomBlue.

Separate charge not allowed for use of robotic surgical system

Highmark Blue Shield does not pay an additional allowance for the use of a robotic surgical system, procedure code S2900.

Blue Shield will deny code S2900 as not covered when it's reported as a separate charge. A participating, preferred, or network provider cannot bill the member for the denied charge because it does not represent the surgical procedure performed.

MA Also applicable to FreedomBlue.

Blue Shield allows pamidronate for FDA-approved indications

Highmark Blue Shield will cover pamidronate (Aredia®) for these FDA-approved indications:

- The treatment of moderate to severe hypercalcemia associated with malignancy (275.42), with or without bone metastases.
- The treatment of moderate to severe Paget's disease of the bone (731.0) (osteitis deformans) characterized by abnormal and accelerated bone metabolism.
- The treatment of osteolytic bone metastases of breast cancer and osteolytic lesions of multiple myeloma (174.0-174.9, 175.0-175.9, 198.5, 198.81, 203.00, 203.01) in conjunction with standard antineoplastic therapy.

If pamidronate is used to treat any other conditions, Blue Shield will deny it as experimental or investigational. It will not be covered. A participating, preferred, or network provider can bill the member for the denied drug.

Report pamidronate with code J2430.

Blue Shield determines coverage for pamidronate according to the individual or group customer benefits. Pamidronate is not reimbursable under the prescription drug benefit.

Pamidronate, a bone-resorption inhibitor, either directly blocks the dissolution of calcium phosphate in bone by its adherence to a chemical compound in the drug, or it inhibits osteoclast activity.

MA Does not apply to FreedomBlue.

LUNA considered experimental; PSN covered in certain cases

Highmark Blue Shield considers laparoscopic uterine nerve ablation (LUNA) experimental or investigational in the treatment of severe refractory dysmenorrhea and chronic disabling midline pelvic pain. There is not enough published data to prove the effectiveness of this procedure.

Because Blue Shield does not cover LUNA, it is not eligible for payment. A participating, preferred, or network provider can bill the member for the denied procedure.

Blue Shield will cover presacral neurectomy (PSN) when it's used to treat refractory dysmenorrhea and chronic disabling midline pelvic pain when conservative non-surgical treatment options have been tried and failed.

When PSN is performed in the absence of documented failure of non-surgical treatment options, or for lateral rather than midline pelvic pain, Blue Shield considers it not medically necessary. In such instances, PSN is not eligible for coverage. A participating, preferred, or network provider cannot bill the member for the denied procedure.

Use procedure code 58999 to report LUNA or PSN. When you report code 58999, please include a complete description of the procedure you performed in the narrative section of the electronic or paper claim.

LUNA and PSN involve the interruption of pelvic sensory fibers in order to reduce or eliminate chronic disabling midline pelvic pain and severe refractory dysmenorrhea in women who have failed more conservative attempts at treatment.

MA Also applicable to FreedomBlue.

New immune globulin, VIGIV, eligible for payment

Highmark Blue Shield will provide coverage for the new immune globulin, Vaccinia Immune Globulin Intravenous (human) (VIGIV), in accordance with the member's contract and the Childhood Immunization Act for dependent children, as well as applicants or members and their spouses who are up to and including 20 years of age. For individuals outside this population, Blue Shield will base coverage for VIGIV on the member's contract.

VIGIV is the first intravenous human plasma-derived product available to treat certain rare complications of the smallpox vaccination.

Use code 90393 to report VIGIV.

MA Does not apply to FreedomBlue.

How to report speech evaluations and speech therapy

Report speech evaluations and speech therapy with these codes, as appropriate:

- 92506—evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
- 92507—treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
- 92508—treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals

These codes are not time-based codes. Do not report multiple services based on the amount of time spent with the patient. These codes represent therapy that requires face-to-face encounters with the patient. Report these codes once per session.

MA Also applicable to FreedomBlue.

Presbyopia-correcting intraocular lens not covered

Highmark Blue Shield does not cover a presbyopia-correcting (accommodating) intraocular lens (IOL), for example, CrystaLens.

If the patient chooses to have an accommodating IOL inserted after cataract surgery to avoid additional corrective lenses for a refractive error, Blue Shield will deny the IOL. Blue Shield's medical-surgical products do not provide coverage for lenses that correct a refractive error. However, Blue Shield will pay for the surgical procedure.

In this case, the participating, preferred, or network provider must obtain a signed agreement from the patient before surgery. By signing the agreement, the patient assumes responsibility for the entire cost of the accommodating IOL. You must retain the signed agreement in the patient's medical records. The agreement must be available if Blue Shield requests a copy.

If the participating, preferred, or network provider does not obtain a signed agreement before surgery, he or she will be liable for the cost of the accommodating IOL.

If an accommodating IOL is inserted only for the correction of refractive errors, that is, not for cataract surgery, Blue Shield will deny both the lens and the surgical procedure as not covered. A participating, preferred, or network provider can bill the member for the denied lens and surgery.

Use code L8699 to report an accommodating IOL. When you report code L8699, please include the term "accommodating intraocular lens" along with the brand name of the specific lens, in the narrative section of the electronic or paper claim.

Blue Shield determines coverage for prosthetics according to the individual or group customer benefits.

An accommodating IOL is an artificial lens used to correct the visual impairment of aphakia after cataract surgery. It is intended to restore a patient's ability to see objects far away and near, in most cases without the use of contacts or eyeglasses. An accommodating IOL can also be used solely to correct refractive errors.

MA Does not apply to FreedomBlue.

RSV treatment guidelines outlined

Highmark Blue Shield follows the American Academy of Pediatrics guidelines to determine coverage for RSV-IGIV (RespiGam™) and palivizumab (Synagis®). These immunizing agents protect infants and children with either chronic lung disease or prematurity against lower respiratory tract infection with respiratory syncytial virus (RSV).

You should begin prophylaxis with these agents at the onset of the RSV season and stop treatment at the end of the RSV season. Outbreaks usually start in October through December, and end during March through May. Regional differences may occur.

Typically, a total of 5 monthly dosages are given during the RSV winter season. Once a child qualifies for initiation of prophylaxis at the start of the RSV season, you should continue administration throughout the season. Do not stop treatment if the infant reaches 6 months or 12 months of age during the season.

Patients with more severe chronic lung disease may benefit from prophylaxis during a second RSV season if they continue to require medical therapy for respiratory or cardiac dysfunction.

Using the guidelines from the American Academy of Pediatrics, Blue Shield may consider monthly administration of immune prophylaxis for RSV with RSV-IGIV or palivizumab in these infants and children:

1. Infants and children younger than 2 years of age with chronic lung disease who have required medical therapy for their chronic lung disease within 6 months before the anticipated RSV season.

2. Infants born at 32 weeks of gestation or earlier without chronic lung disease or who do not meet the criteria in item No. 1 according to this schedule:

    - Infants born at 28 weeks of gestation or earlier are candidates for prophylaxis during their first RSV season, whenever that occurs during the first 12 months of life, or

    - Infants born at 29 to 32 weeks of gestation are candidates for prophylaxis up to 6 months of age. Thirty-two weeks gestation refers to an infant born on or before the thirty-second week of gestation.

3. Infants born between 32 weeks and 35 weeks of gestation, that is, between 32 weeks, 1 day and 35 weeks, 0 days, and are younger than 6 months at the start of the RSV season, with at least two or more of these high-risk factors:

    - child care attendance

    - school-aged siblings

    - exposure to environmental air pollutants

    - congenital abnormalities of the airways

    - severe neuromuscular disease

Blue Shield may consider monthly administration of immune prophylaxis with only palivizumab (not RespiGam) medically necessary for children who are 24 months of age or younger with hemodynamically significant cyanotic and acyanotic heart disease.

Decisions regarding prophylaxis with palivizumab in children with congenital heart disease should be based on the degree of physiologic cardiovascular compromise. Infants younger than 12 months of age with congenital heart disease who are most likely to benefit from immunoprophylaxis include those:

- who are receiving medication to control congestive heart failure,

- with moderate to severe pulmonary hypertension, or

- with cyanotic heart disease.

For children with heart disease meeting the American Academy of Pediatrics criteria for palivizumab and any one of the conditions described in the above three bullets, Blue Shield may consider an additional postoperative dose of palivizumab medically necessary after a surgical procedure requiring cardiopulmonary bypass.

Blue Shield does not consider immune prophylaxis medically necessary for infants and children with hemodynamically insignificant heart disease, including, but not limited to, secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, or patent ductus arteriosus. A participating, preferred, or network provider cannot bill the member for the denied service.

Blue Shield considers other indications for immune prophylaxis for RSV experimental or investigational, including, but not limited to:

- adults with any diagnosis,
- patients undergoing stem-cell transplantation,
- immunocompromised children or children with cystic fibrosis, not otherwise addressed by the criteria on Pages 13-15.

A participating, preferred, or network provider can bill the member for the denied service.

Also applicable to FreedomBlue.

Bilateral procedures performed on different days require supporting documentation

When a health care professional has determined that a patient requires a bilateral blepharoplasty, bilateral blepharoptosis repair or a bilateral brow ptosis repair, Highmark Blue Shield expects that the procedures will be performed on the same date of service.

If you perform bilateral procedures on different days, Blue Shield requires you to submit medical documentation to support the medical necessity of performing these procedures on different dates of service.

Also applicable to FreedomBlue.

New and established patient defined

Evaluation and management services include office or other outpatient visits, emergency department visits, hospital visits, and consultations.

There are two subcategories of office or other outpatient visits: new patient and established patient.

To avoid differing interpretations and to increase the consistency of reporting by health care professionals of different specialties, Highmark Blue Shield has defined new and established patients.

Here are Blue Shield's definitions of new and established patients:

- A new patient is one who has not received any professional services from a health care professional or other health care professional of the same specialty in the same group practice, within the past three years.
- An established patient is one who has received professional services from a health care professional or other health care professional of the same specialty in the same group practice, within the past three years.

For purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a health care professional and reported by a specific procedure code.

Use these codes, as appropriate, to report office or outpatient evaluation and management services:

- 99201-99205 for new patients
- 99211-99215 for established patients

If you are on call for or covering for another health care professional and you treat one of his or her established patients, do not classify this patient as a new patient. Please report this encounter with an appropriate established visit code.

MA Also applicable to FreedomBlue.

Implantation of intrastromal corneal ring segments for keratoconus considered investigational

Highmark Blue Shield considers implantation of intrastromal corneal ring segments, for example, INTACS, experimental or investigational for the treatment of keratoconus (371.60-371.62). Blue Shield will deny claims reporting this procedure. A participating, preferred, or network provider can bill the member for the denied service.

Blue Shield does not cover implantation of intrastromal corneal ring segments, for example, INTACS, for the treatment of keratoconus because there are inadequate data to permit scientific conclusions. Long-term outcomes also need to be evaluated.

To report implantation of intrastromal corneal ring segments use procedure code 0099T.

Intrastromal corneal ring segments consist of micro-thin methylmethacrylate inserts of variable thickness that are implanted on the perimeter of the cornea. They are used in refractive surgery to correct mild myopia, and as a treatment of keratoconus.

MA Also applicable to FreedomBlue.

Ventavis eligible for primary and secondary hypertension

Highmark Blue Shield will cover treatment with inhalation administration of iloprost (Ventavis®) for patients who meet these criteria:

- Primary pulmonary hypertension (416.0) and New York Heart Association (NYHA) Class III or Class IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy.
- Secondary pulmonary hypertension (416.8) related to collagen vascular disease, congenital systemic-to-pulmonary shunt, portal hypertension, Human Immunodeficiency Virus (HIV) infection, drugs and toxins, and appetite suppressants; and persistent pulmonary hypertension of the newborn and NYHA Class III or Class IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy.

Blue Shield considers the use of Ventavis for any other diagnosis not medically necessary. It is not covered. A participating, preferred, or network provider cannot bill the member for the denied therapy.

Blue Shield determines coverage for Ventavis according to the individual or group customer benefits. Blue Shield will not pay for Ventavis under the prescription drug benefit.

Ventavis is formulated for inhalation only through the Prodose® adaptive aerosol delivery system (K0730).

Use code Q4080 to report Ventavis.

Ventavis has not been studied in children under the age of 18.

MA Also applicable to FreedomBlue.

Attendance at labor coverage guidelines clarified

Highmark Blue Shield will not pay for attendance at labor. Attendance at labor is considered part of the global delivery fee. It is not eligible as a distinct and separate service. A participating, preferred, or network provider cannot bill the member for the denied service.

Use code 59899 to report attendance at labor. When you report code 59899, please include the term “attendance at labor” in the narrative section of the electronic or paper claim.

MA Also applicable to FreedomBlue.

PRN

Remicade eligible for additional indications

Highmark Blue Shield now allows coverage for Remicade® (infliximab) for these additional indications:

- Ankylosing spondylitis (720.0)—for the reduction of signs and symptoms in patients with active ankylosing spondylitis.
- Maintenance therapy in fistulizing Crohn's disease (569.81)—for the reduction in the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in patients with fistulizing Crohn's disease.
- Psoriatic arthritis (696.0)—for the reduction of signs and symptoms in patients:
  - with active articular disease defined as five or more swollen and tender joints and either C-reactive protein levels of at least 15 mg/l or morning stiffness lasting 45 minutes or longer, and
  - who have active plaque psoriasis with at least one target lesion no less than 2 centimeters in diameter, and
  - who have tried and experienced an inadequate response to at least one disease modifying antirheumatic drug (DMARD).

Blue Shield determines coverage for Remicade according to the individual or group customer benefits. Remicade is not reimbursable under the prescription drug benefit.

MA Does not apply to FreedomBlue.

How to report routine colonoscopy

When a screening colonoscopy is performed on an asymptomatic patient, use one of these codes to report the procedure:

G0105—colorectal cancer screening; colonoscopy on individual at high risk

G0121—colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.

If you report colonoscopy codes other than G0105 or G0121 when you perform colorectal screening, your claim may be denied in error.

Highmark Blue Shield will determine coverage for a screening colonoscopy according to the individual member's preventive benefits.

MA Does not apply to FreedomBlue.

Blue Shield covers Boostrix vaccine

Highmark Blue Shield now provides coverage for the new vaccine, Boostrix®.

Blue Shield will determine coverage for Boostrix according to the member's contract and the Childhood Immunization Act for dependent children as well as applicants or members and their spouses who are up to and including 20 years of age. For individuals outside this population, Blue Shield will base coverage on the member's contract.

Report the Boostrix vaccine with code 90715.

Boostrix is a combination tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine, adsorbed (Tdap). Boostrix is given as a single dose to individuals aged 10 to 18 years, thereby adding a pertussis component to the routine tetanus/diphtheria booster currently administered to teens.

MA Does not apply to FreedomBlue.

Include modifier 57 with visits that result in surgery decision

Highmark Blue Shield may pay for an evaluation and management service that results in the initial decision to perform surgery.

If a decision to perform surgery is made at the time of the visit, whether on the day before or on the day of the surgery, report modifier 57 with the evaluation and management service.

MA Also applicable to FreedomBlue.

Decavac eligible for coverage

Highmark Blue Shield now provides coverage for the new vaccine, Decavac™. Blue Shield will determine coverage for Decavac in accordance with the member's contract and the Childhood Immunization Act for dependent children as well as applicants or members and their spouses who are up to and including 20 years of age. For individuals outside this population, Blue Shield will base coverage on the member's contract.

Decavac, a Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, is administered intramuscularly to individuals 7 years or older.

If you administered Decavac on or after July 1, 2005, please report it with code 90714.

MA Does not apply to FreedomBlue.

Blue Shield reimburses new FDA-approved drugs at 95 percent of AWP

Highmark Blue Shield will set its UCR and PremierBlue Shield reimbursement at 95 percent of the average wholesale price (AWP) for all new therapeutic injections and chemotherapy drugs approved by the Food and Drug Administration (FDA) on or after Jan. 1, 2005.

These reimbursement rates will remain in effect for one year from the date the drug is first approved by the FDA. After the one-year introductory period expires, Blue Shield will price the drug or biological at 85 percent of the AWP.

Here are new drugs that Blue Shield will price at 95 percent of the AWP for one year.

Drug	FDA approval date	Effective date	Revision date
Ammonul (sodium phenylacetate and sodium benzoate)	Feb. 18, 2005	Feb. 18, 2005	Feb. 18, 2006
Symlin (pramlintide acetate)	March 18, 2005	March 18, 2005	March 18, 2006
Nexium IV (esomeprazole sodium)	April 1, 2005	April 1, 2005	April 1, 2006

Does not apply to FreedomBlue.

Blue Shield covers Oncotype DX assay for certain breast cancer patients

Highmark Blue Shield now provides coverage for the Oncotype DX Recurrence Score Assay for predicting recurrence of breast cancer for patients who meet these criteria:

- women newly diagnosed with Stage I or II breast cancer, and
- node negative receptor positive.

Oncotype DX has only been validated in patients treated with tamoxifen.

Use code 89240—unlisted miscellaneous pathology test—to report this testing. When you report code 89240, please provide a complete description of the service you performed in the narrative field of the electronic or paper claim.

Also applicable to FreedomBlue.

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 in this edition of **PRN**.

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

Codes

New codes, G0375 and G0376, now available

Here are two new procedure codes and the date they became available.

Code	Terminology	Effective date
G0375	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	March 22, 2005
G0376	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	March 22, 2005

Patient News

New identification cards for ALF members replace SSN with other identifier

On April 1, 2005, Excellus BlueCross BlueShield of Rochester issued new identification cards to Snyder of Berlin members whose identification numbers carry an ALF alphabetical prefix. The new identification cards have a 12-character identification number—the three character ALF alphabetical prefix followed by four numbers, then a letter, followed by four more numbers, for example, ALF1234M5678.

The new identification cards replace Snyder of Berlin members' former cards that contained their Social Security number (SSN).

Report correct identification number for services requiring authorization

All services for Snyder of Berlin members that require managed care authorization after April 1, 2005 must have those authorizations submitted and approved under the member's new identification number. This will ensure proper processing of these services for the higher level of payment.

Services that are affected include those that require precertification of a series of therapies or visits.

Here are examples of how to report these services.

Current record in system		**New record with new identification number**	
ALF123456789		ALF8201M3456	
Patient	Sam Jones	Patient	Sam Jones
Provider	SM1234567	Provider	SM1234567
Code/modifier	9894000	Code/modifier	9894000
Start date	03012005	Start date	04012005
End date	08302005	End date	08302005
Total approved treatments	10	Total approved treatments	8

The original (current) record was for services provided March 1, 2005 through August 30, 2005. Because these services were performed before April 1, 2005, they were reported with the member's SSN based identification number.

The new record is for the remaining services that would be performed April 1, 2005 through Aug. 30, 2005. Those services should be reported with the member's new identification number.

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 (800) 236-8641. 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 _____

PRN

Contents

Vol. 2005, No. 4

News

Policy

Codes

Patient News

Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the Current Procedural Terminology, as contained in CPT-2005, Copyright 2004, 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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PRN
Policy Review & News

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