PRN

Policy Review & News

Important information about Pennsylvania Blue Shield
www.pablueshield.com

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News

HIPAA privacy implementation date draws near

Note: This information is not a substitute for legal or other professional advice. It is for only informational purposes.

The federally mandated compliance date for the HIPAA Privacy Regulations is April 14, 2003.

The HIPAA Privacy Rule defines what information is protected under the law and under what conditions this information may be accessed or amended.

The final Standards for Privacy of Individually Identifiable Health Information, the Privacy Rule, were published on Aug. 14, 2002. The Privacy Rule creates national standards to protect individuals' personal health information. It also gives individuals increased access to their health information and records. As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Privacy Rule defines health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions electronically as being covered entities. These entities must comply with HIPAA. Most covered entities must comply with the Privacy Rule by April 14, 2003.

PENNSYLVANIA BLUE SHIELD
A HIGHMARK COMPANY

An Independent Licensee of the Blue Cross and Blue Shield Association

Here are some key areas of the Privacy Rule you should consider.

1. Adopt clear confidentiality procedures and policies.

   Review your current confidentiality policies and procedures to ensure compliance with the rules. Effective policies and procedures can help reduce administrative costs, simplify training, tighten security, and help troubleshooting by setting standards and guidelines for dealing with routine and emergency situations. Covered entities must have policies and procedures that reasonably limit access to and use of protected health information (PHI) to the minimum necessary given the job responsibilities of the work force and the nature of their business.

2. Develop and distribute a Notice of Privacy Practices.

   The Privacy Rule requires that health care providers with a direct treatment relationship with patients must make a good faith effort to obtain written acknowledgment from their patients that they received the provider's Notice of Privacy Practices (NPP). This NPP must describe all potential uses and disclosures of patient information and inform patients of their rights under the Privacy Rule. The patient must receive the NPP no later than the date of the first service delivery.

   In emergency treatment situations, you can provide and obtain the written acknowledgment as soon as possible after the emergency.

3. Establish a simple and consistent employee training program.

   Make sure all employees are adequately trained on privacy policies. Employees must receive updates, reminders and regular refresher training.

4. Determine when an accounting of disclosures may be required.

   Subject to certain exceptions, if an individual requests an accounting of disclosures of their PHI, they have the right to receive an accounting of those disclosures of PHI that have been made by the covered entity. Among other exceptions to the accounting right, individuals do not have the right to receive an accounting of disclosures made by the covered entity directly to the individual, as well as disclosures made to carry out treatment, payment or health care operations.

5. Review the HIPAA marketing definition and restrictions.

   All PHI used or disclosed for marketing purposes requires prior authorization from the individual, unless a few specific exceptions apply. The Privacy Rule defines marketing as "to make a communication about a product or service that encourages the recipients of the communication to purchase or use the product or service." The rule also describes, in detail, what is not considered marketing.

6. Review HIPAA restrictions concerning psychotherapy notes.

   With limited exceptions, a covered entity may not use or disclose psychotherapy notes to another covered entity for treatment, payment or health care operations without the individual's specific authorization.

7. Become familiar with the concept and requirements of a "limited data set."

   A limited data set is health information that contains no direct individual identifiers. The final rule permits disclosure without authorization of a limited data set for research, public health, and health care operations purposes. It also places conditions

on the disclosure of the limited data set. It requires the covered entity and the data set recipient to enter into a data use agreement. Covered entities do not need to include disclosures of PHI in limited data sets in any accounting of disclosures provided to the individual.

8. Become familiar with the phrase "incidental disclosures."

   An incidental disclosure is when PHI is disclosed merely by chance without intention of it occurring. Incidental disclosures are not violations of HIPAA if a covered entity has applied reasonable safeguards and minimum necessary standards to secure patient information, and to ensure that such incidental disclosures are made only for a valid purpose to those who have a need for it. To avoid incidental disclosure through oral communications, policies and procedures should include guidance concerning limitations on discussions of PHI in patient areas and public places. Covered entities are not required to include incidental disclosures in an accounting of disclosures provided to the individual.

9. Become familiar with the term "business associate."

   A business associate is an entity to which the covered entity discloses PHI so the entity can carry out, assist with, or perform a function or activity on behalf of the covered entity.

10. Review your business associate contracts.

    Covered entities must enter into or amend written contracts with their business associates to obtain satisfactory assurances that the business associate will appropriately safeguard PHI, and to mitigate any harm caused by a known wrongful use or disclosure of patient information made by a business associate. Existing contracts must either be amended by April 14, 2004, or whenever they are renewed or modified, whichever is earlier. In situations in which the business relationship exists but no written contract is in place, health care professionals must enter into a formalized business associate agreement on or before April 14, 2003.

    The Office for Civil Rights (OCR) is responsible for implementing and enforcing the privacy regulation. You can view the complete regulation text for the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) on OCR's website at **www.hhs.gov/ocr/hipaa/finalreg.html**.

April 16 HIPAA testing deadline approaches

All covered entities must begin software and systems testing pertaining to the HIPAA compliant Electronic Health Care Transactions and Code Sets by April 16, 2003. This is a federally mandated date.

Covered entities include health plans, health care clearinghouses and those health care providers that conduct certain financial and administrative transactions in electronic form.

To assist its trading partners in this initiative, Pennsylvania Blue Shield is offering a voluntary trading partner testing program.

HIPAA trading partner testing with Blue Shield is not mandatory, but is highly recommended. Blue Shield is not requiring trading partners to become HIPAA certified.

Blue Shield has contracted with the Foresight Corporation to use their web-based HIPAA Validator™ product.

HIPAA Validator is a testing solution that performs:

- transactional syntax testing
- HIPAA data compliance testing
- Blue Shield business rules testing

Blue Shield offers free HIPAA Validator to its trading partners who have executed a new EDI trading partner agreement. This product is designed to make EDI HIPAA compliance testing fast, simple and secure by using a web-based validation environment. Testing partners will receive a detailed error analysis report or a notice of compliance validation.

You can complete Blue Shield's EDI trading partner agreement online through the "Sign-Up" link on the Provider Resource Center at **www.pablueshield.com/health/pbs-professionals/edi-services/signup.html**.

Blue Shield also offers these resources to help you with the testing program:

1. Updated **EDI Reference Guides**. The guides contain information specific to Blue Shield's business rules for EDI submissions. Use them as a supplement to the ASC X12N 4010 implementation guides. The free guides are available on the EDI pages of the Provider Resource Center at **www.pablueshield.com/health/pbs-professionals/edi-services/specification.html**.
2. Blue Shield trading partner testing support is available Monday through Friday, 7 a.m. to 6 p.m. EST, to assist with any HIPAA Validator testing questions. You can contact the Blue Shield Validator help desk by e-mail or telephone:

   E-mail: **hmhipaatst@highmark.com**

   Telephone: (866) 727-4941

EOB message informs of combined procedures

Pennsylvania Blue Shield combines certain procedures to a more appropriate "all encompassing" procedure code when it processes your claims. Blue Shield merges the services and charges together into one line on the claim.

For example, if you report codes 20605 and J3301 Blue Shield merges the codes and charges under code 20605. Blue Shield considers code J3301 part of code 20605.

When Blue Shield combines codes, it includes a message on your Explanation of Benefits. For example, "J1010—The charge for this procedure has been combined with the charge for other procedure codes reported on this claim. Amounts appearing on this line are not included in the totals line."

Do not resubmit claims for services that were combined—Blue Shield will reject your resubmission as a duplicate.

If you have questions about combined procedure codes, please call the appropriate Blue Shield customer service area:

Central region: (866) 731-8080

Eastern region: (866) 975-7290

Federal Employee Program: (866) 763-3608

1099 toll-free help line now available

If you have questions about your 1099-Misc tax form, call (866) 425-8275. The new toll-free automated telephone answering service became available in January.

The automated answering service offers many options to expedite your 1099-Misc questions. The options include fax back and voice message abilities. The automated answering service will also address your B Notice and IRS audit issues.

Pennsylvania Blue Shield will include the telephone number for the automated answering service on all 1099-Misc forms it issues.

Attention assignment accounts: identify performing provider on all SelectBlue claims

Since certain Central Pennsylvania members are now covered by the SelectBlue Point of Service program, remember to report the performing provider on your claims. If you do not report the performing provider, Pennsylvania Blue Shield may reject your claims.

SelectBlue members must select a primary care physician (PCP). Members may select either an assignment account or an individual provider (either a member of an assignment account or a solo practitioner) as their PCP.

When members see their selected PCP for services, the PCP receives the highest level of reimbursement for the services. Look at your patient's identification card to find their PCP.

How to identify the performing provider

If your practice bills as an assignment account, and the member has chosen a provider in your account as their PCP, you must report the specific provider who performed the service. You must identify the performing provider for each service line item reported on the claim.

If you submit paper claims, follow these guidelines:

- 1500A claim form: report the assignment account's identification number, including the alphabetical prefix, in block 31. You must also identify the performing provider, including their alphabetical prefix, in block 24H. Remember to do this for each line item on the claim, even if the same provider has performed all reported services.
- CMS 1500-series claim form: report the assignment account's identification number, including the alphabetical prefix, in block 33. You must also identify the performing provider, including their alphabetical prefix, in block 24K. Remember to do this for each line item on the claim, even if the same provider has performed all reported services.

If you bill electronically, you must report the assignment account's identification number in the billing provider number field. You must also identify the health care provider who personally performed the service at the line level. Do not report the alphabetical prefix for either the billing provider or performing provider on electronic claims.

Blue Shield improves claims processing for continuous rental items

Pennsylvania Blue Shield has modified its processing systems so that it can quickly process claims for continuous rental items, in particular, codes E0194, E0431, E0434, E0439, E0445, E0450, E0454, E0460, E0461, E1390, K0533, and K0534.* All current referral and authorization processes for these procedure codes still apply.

Blue Shield considers these items "continuous rental." Providers retain ownership of continuous rental items and are responsible for their maintenance, service and repair.

** Medical equipment represented by these procedure codes is subject to Blue Shield's medical policy and member benefit requirements.*

Policy

Wireless capsule endoscopy eligible for obscure digestive bleeding

Pennsylvania Blue Shield now pays for wireless capsule endoscopy for obscure digestive bleeding.

Wireless capsule endoscopy is indicated for the diagnosis of occult gastrointestinal bleeding (562.02, 562.03, 569.86, 578.1, 578.9, 792.1), the site of which has not previously been identified by upper gastrointestinal endoscopy, colonoscopy, push enteroscopy, nuclear imaging, or radiological procedures. It is especially helpful in the diagnosis of angiodysplasias of the gastrointestinal tract (569.85).

If wireless capsule endoscopy is reported for any other indication, Blue Shield will consider it not medically necessary. A participating, preferred or network health care professional cannot bill the member for the denied service.

Wireless capsule endoscopy is limited to those patients who have undergone complete gastrointestinal studies, that is, barium enema, stool specimen, upper gastrointestinal endoscopy, and colonoscopy, and these tests fail to reveal a source of bleeding. The patient's medical records must indicate that the member has continuing GI blood loss and anemia secondary to the bleeding.

Use procedure code G0262—small intestine imaging; intraluminal, from ligament of Treitz to the ileo-cecal valve, including interpretation and report—to report wireless capsule endoscopy.

Blue Shield pays for cryosurgical ablation of small renal tumors

Pennsylvania Blue Shield's Board of Directors recently approved coverage for cryosurgical ablation of renal tumors.

Blue Shield now pays for renal cryosurgery when it's used to treat renal tumors less than 4 cm.

Use codes 50220-50240, 50542, as appropriate, to report cryosurgical ablation of renal tumors.

Middle ear implants eligible under certain contracts

Pennsylvania Blue Shield now pays for the insertion of middle ear devices, for example, Vibrant Soundbridge, for members with moderate to severe sensorineural hearing loss.

The middle ear implant, which is considered a hearing device, must be a benefit of the member's contract. Blue Shield determines coverage for hearing devices according to the individual or group member benefits.

If the middle ear implant is not covered by the member's contract, a participating, preferred or network provider can bill the member for the denied implant.

Report the insertion of the middle ear implant with procedure code 69799. Always include a complete description of the service you performed when you report code 69799.

How to report the application of stress for stress films and weight bearing radiographic studies

Procedure code 76006 represents the manual application of stress performed by the health care professional for joint radiography, including the contralateral joint, if indicated.

Report code 76006 with the appropriate procedure code for the conventional X-ray study performed. Pennsylvania Blue Shield will deny code 76006 when it is not reported with the appropriate conventional X-ray code. A participating, preferred or network provider cannot bill the member for the denied service in this situation.

Blue Shield does not pay an additional allowance for stress films or weight-bearing radiological studies when performed in conjunction with conventional X-ray studies of the same anatomic area, for example, spine, hip, knee, ankle. When both conventional X-ray studies and stress films or weight bearing studies are reported and billed separately, Blue Shield will combine the charges under the appropriate procedure code for the conventional X-ray study performed. If only stress films or weight bearing X-rays are reported, Blue Shield will process the service under the appropriate code for a limited X-ray of the anatomic area.

Blue Shield's requirements for intensity modulated radiation therapy

Pennsylvania Blue Shield considers intensity modulated radiation therapy (IMRT) appropriate for treating tumors in various anatomic areas when sparing the surrounding normal organs and/or tissue is essential and the patient has *at least one* of these conditions:

- Critical organs and/or tissue adjacent to, but outside the planned treatment volume are sufficiently close and require IMRT to ensure safety and morbidity reduction.
- An immediately adjacent volume has been irradiated and abutting portals must be established with high precision.
- Gross tumor volume margins are concave or convex and in close proximity to critical structures that must be protected to avoid unacceptable morbidity.
- Non-IMRT techniques would increase the probability of grade 2 or grade 3 radiation toxicity in greater than 15 percent of radiated similar cases.
- The volume of interest is in such location that its parameters can only be defined by MRI or CT.
- The tumor tissue lies in areas associated with target motion caused by cardiac and pulmonary cycles, and the IMRT is necessary to protect adjacent normal tissues.

The decision to use IMRT requires a clear understanding of accepted clinical practices that consider the risks and benefits of such therapy when compared to conventional and 3-D conformal treatment. You should not use IMRT as a substitute for conventional radiation therapy methods.

You should document the reason you chose IMRT over other radiation therapy methods in each patient's medical record by including this information:

- the prescription, defining the goals and requirements of the treatment plan, including the specific dose constraints for the target(s) and nearby critical structures;
- a statement by the treating health care professional documenting the medical necessity for performing IMRT on the patient in question, rather than performing conventional or 3-dimensional treatment planning and delivery;
- a signed IMRT inverse plan that meets prescribed dose constraints for the planning target volume and surrounding normal tissue using either dynamic multi-leaf collimator or segmented multi-leaf collimator (average number of "steps" required to meet IMRT delivery is five) to achieve IMRT delivery;
- the target verification methodology that must include:
  - documentation of the clinical treatment volume and the planning target volume
  - documentation of immobilization and patient positioning
  - means of dose verification and secondary means of verification;
- an independent check of the monitor units generated by the IMRT treatment plan, prior to the patient's first treatment;
- fluence distributions re-computed in a phantom; and

- plan to account for structures moving in and out of high and low dose regions created by respiration. Voluntary breath holding is not considered appropriate and the solution for movement can best be accomplished with gating technology.

For reimbursement purposes, the treating physician, for example, radiation oncologist, must be on site during treatment in the event his or her assistance is required to care for the patient.

Use code 77418 to report IMRT treatment delivery.

Report IMRT planning (code 77301) once for each treatment volume during a course of therapy. If code 77301 is reported more than once for the same tumor, you must document the medical necessity for the additional service in the patient's medical record. These records must be available for review upon request.

Blue Shield considers simultaneous or planned sequential treatment of multiple targets within a region a single treatment plan, for example, when multiple lesions of the brain or prostate and seminal vesicles are treated. Report code 77301 using the date that the plan was approved by the radiation oncologist or physicist.

If the following services are reported on the same day as IMRT treatment planning (code 77301), they are not eligible for separate payment. A participating, preferred or network provider cannot bill the member for these services in this instance.

- CT guidance for replacement of radiation therapy fields (code 76370)
- coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction (code 76375)
- simulation-aided field setting (codes 77280, 77285, 77290, 77295)
- teletherapy, isodose planning (codes 77305, 77310, 77315)

IMRT is an advanced form of three-dimensional conformal radiation therapy (3-D CRT) that uses radiation beams of varying intensities to produce dose distributions that conform more precisely to the treatment area than is possible with standard 3-D CRT. When a tumor is not well separated from surrounding healthy tissues and/or organs at risk, for example, when a tumor wraps itself around an organ, there may be no combination of radiation beams of the same intensity that will safely separate the tumor from the healthy organ or tissue. Instead of treating the patient with a single, large, uniform beam, IMRT uses many very small beams of varying radiation intensities. This treatment method delivers the appropriate dose of radiation to a tumor while protecting or sparing the adjacent healthy tissues and/or organs.

Blue Shield requires specific information for cosmetic surgery

Pennsylvania Blue Shield reviews all potential cosmetic procedures to determine if they are performed for cosmetic or reconstructive purposes. You can avoid delays in the preauthorization or claims processing of potentially cosmetic procedures by submitting the appropriate documentation with your preauthorization request or claim.

Documentation requirements for potential cosmetic surgeries

- Abdominal lipectomy (15831)
  - History of present illness (HPI) and history and physical report
  - Preoperative photographs—one full-body photograph of the patient standing straight and one photograph of the abdominal fold lifted up to document any reported skin changes, for example, dermatitis, ulceration
- Blepharoplasty (15820-15823) and blepharoptosis (67900-67906)
  - Automated visual field study including interpretation and report
  - Preoperative photographs—one full-frontal view with patient looking directly at the camera and one view each of the eyes only looking upward and downward
- Breast surgery—augmentation mammoplasty (19324-19325) and reduction mammoplasty (19318)
  - HPI and history and physical report
  - Patient's height
  - Preoperative photograph
  - Date of previous surgery, if applicable
- Breast surgery—gynecomastia—(19140)
  - HPI and history and physical report
  - Preoperative photograph
  - Breast surgery—nipple tattooing
  - HPI and history and physical report
  - Date of previous surgery, if applicable
- Breast surgery—removal of implant(s) (19328, 19330) and insertion of implant(s) (19340, 19342)
  - HPI and history and physical report
  - Date of previous surgery, if applicable
- Dermabrasion (15780-15787) and hair transplant (15775-15776)
  - HPI and history and physical report
- Otoplasty (69300)
  - HPI and history and physical report
  - Preoperative photographs

- Repair of bilobe ear
  - HPI and history and physical report
  - Preoperative photograph
- Rhinoplasty (30400-30450)
  - HPI and history and physical report
  - Preoperative photographs—one frontal view, one profile, one view with head held back
  - Date of previous surgery, if applicable
  - If an accident, name and location of treating health care professional at the time of the accident and emergency room or office records, including X-ray or X-ray report, if available
- Rhytidectomy (15824-15829)
  - HPI and history and physical report
  - Preoperative photograph
- Scar revision
  - HPI and history and physical report
  - Preoperative photograph
- Suction assisted lipectomy (15876-15879)
  - HPI and history and physical report
  - Preoperative photograph

Cosmetic surgery is performed to improve an individual's appearance. It is generally not eligible for payment under Blue Shield contracts. However, cosmetic surgery is eligible when performed to correct a condition resulting from an accident.

Reconstructive surgery is performed to improve or restore functional impairment resulting from a disease, injury, or congenital birth defect. Usually, Blue Shield pays for reconstructive surgery.

Speculoscopy considered investigational

Pennsylvania Blue Shield considers speculoscopy, for example, PapSure, an investigational procedure.

There is insufficient scientific evidence to support the use of speculoscopy in the triage of low grade atypical pap smears or for routine screening for cervical cancer. The clinical role of speculoscopy as a screening device remains undefined.

Use procedure code 0031T to report speculoscopy. To report speculoscopy with directed sampling, use code 0032T.

Speculoscopy is a technology used to enhance conventional cervical cytological screening. Its purpose is to reduce false-negative pap smear results. Speculoscopy has also been used as a triage method to identify which patients with low grade atypical pap smears need further evaluation by colposcopy and biopsy. Speculoscopy uses a chemoluminescent light to illuminate the cervix to aid naked-eye or minimally magnified visualization of acetowhite changes on the cervix.

Blue Shield implements new guidelines for wound management

On Jan. 1, 2003, Pennsylvania Blue Shield implemented new wound management guidelines. Here are the new guidelines for electrical stimulation and electromagnetic stimulation.

Electrical stimulation

Electrical stimulation for the treatment of wounds is the application of electrical current through electrodes placed directly on the skin in close proximity to the wound.

Blue Shield will pay for electrical stimulation (G0281) for the management of the following types of chronic ulcers when it is used as adjunctive therapy after there are no measurable signs of healing for at least 30 days of treatment with conventional wound treatments:

- arterial ulcers
- diabetic ulcers
- pressure ulcers (Stage III or Stage IV)
- venous stasis ulcers

Blue Shield does not pay for electrical stimulation when it's used as an initial treatment modality.

Blue Shield will not pay for continued treatment if measurable signs of healing have not been demonstrated within any 30 day period of treatment. Measurable signs of improved healing include a decrease in wound size either in surface area or volume, decrease in amount of exudates, and decrease in amount of necrotic tissue. If electrical stimulation is being used, the treating health care professional must evaluate the wounds at least once a month.

Blue Shield will deny all other uses of electrical stimulation for the treatment of chronic ulcers as not being medically necessary. This includes code G0282 that references all other stimulation not described in code G0281. A participating, preferred or network provider cannot bill the member for the denied service.

Blue Shield will not pay for electrical stimulation for wound healing in the home setting. Blue Shield does not consider unsupervised use of electrical stimulation by patients in the home as medically reasonable or necessary.

Electromagnetic stimulation

Blue Shield will not pay for electromagnetic stimulation (G0295) since it considers it not medically necessary. A participating, preferred or network provider cannot bill the member for the denied service.

Conventional or standard therapy for chronic wounds involves local wound care as well as systemic measures.

Standard wound care includes:

- optimization of nutritional status,
- debridement by any means to remove devitalized tissue,
- maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, and

- necessary treatment to resolve any infection.

Standard wound care, based on the specific type of wound, includes frequent repositioning of a patient with pressure ulcers (usually every 2 hours); off-loading of pressure and good glucose control for diabetic ulcers; establishment of adequate circulation for arterial ulcers; and the use of a compression system for patients with venous ulcers. There are other therapeutic modalities that may apply to certain patients depending on their type of wound.

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

2002 PTM changes

Please make these changes to your 2002 Pennsylvania Blue Shield **Procedure Terminology Manual (PTM)**.

Page	Code	Terminology	Action
367	S8945	Physical medicine treatment (constant attendance by provider) to one area, initial 30 minutes, each visit; phonophoresis	Delete. Effective 4/1/03.
369	S8990	Physical or manipulative therapy performed for maintenance rather than restoration	Add. Effective 4/1/03.
426	S5108	Home care, training to home care client, per 15 minutes	Add. Effective 4/1/03.
426	S5109	Home care, training to home care client, per session	Add. Effective 4/1/03.
435	S9524	Nursing services related to home IV therapy, per diem	Delete. Effective 4/1/03.

Change to 2002 PTM for Ancillary Providers

Page	Code	Terminology	Action
17	S9524	Nursing services related to home IV therapy, per diem	Delete. Effective 4/1/03.

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

Central and Eastern Region

Plumbers Union Local 690 members now have home and office visit coverage

Plumbers Union Local 690 members and their dependents now have coverage for unlimited home and office visits, per year, under Pennsylvania Blue Shield traditional medical-surgical benefits. Coverage for home and office visits became available Jan. 1, 2003.

Blue Shield pays for these home and office visits at 100 percent UCR. There is a 25 percent coinsurance. There is no copayment or deductible.

Concurrent processing simplifies billing for ClassicBlue Traditional

You can report all professional services you provide to ClassicBlue Traditional members on one claim form and send it either electronically or on a 1500 claim form to Pennsylvania Blue Shield. Blue Shield does not require you to submit a major medical claim form for ClassicBlue Traditional members.

The major medical claim form is not necessary for ClassicBlue Traditional members because Blue Shield introduced concurrent major medical processing for ClassicBlue.

When you submit your claims for ClassicBlue Traditional members, Blue Shield will process all the services under the member's basic coverage. If there is remaining liability, the services will automatically roll over to the member's major medical coverage.

Blue Shield pays UCR program allowances directly to the participating provider. If you are a participating provider, do not bill the member when you perform services. Instead, please wait for your Explanation of Benefits (EOB) so you will know the amount Blue Shield has paid under both types of coverage. You will also find out if the member owes you a balance. Participating providers may not collect more than the UCR allowance for covered services.

ClassicBlue Traditional is an indemnity program that offers basic medical-surgical, hospital and major medical coverage in one benefit package. Blue Shield has included the member's major medical benefit with the traditional benefits.

You can identify Pennsylvania Blue Shield ClassicBlue Traditional members with the concurrent major medical processing by looking for plan code 378 on their identification card.

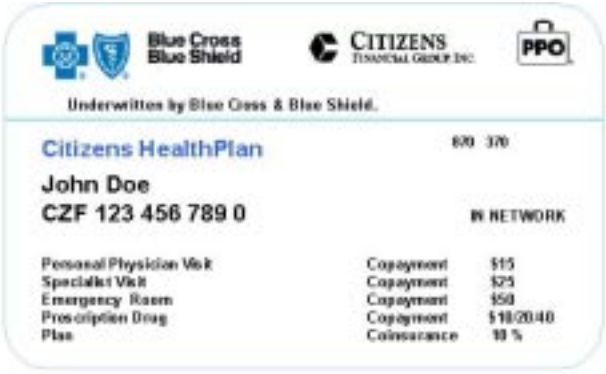
Citizens Financial Group's control plan and alphabetical prefix change

On Jan. 1, 2003, Blue Cross and Blue Shield of Rhode Island began to administer the Citizens HealthPlan for all Citizens Financial Group active and retired employees.

This national BlueCard PPO coverage has no in-network deductible and provides reimbursement for most in-network services at 90 percent.

There is a $250 individual and $750 family deductible for services performed out of network.

You can recognize these members by the alphabetical prefix **CZF** preceding their identification number. Here is a sample of the new identification card.



You can submit claims for Citizens Financial Group's employees either electronically or on a 1500A claim form.

Send 1500A claim forms to:

Pennsylvania Blue Shield
PO Box 890062
Camp Hill, Pa. 17089-0062

Out-of-area HMO patients may seek care from Blue Shield participating providers

When outside their local service area, Blue Cross Blue Shield HMO members affiliated with other Blue Cross Blue Shield Plans may seek care from a Pennsylvania Blue Shield participating provider in these circumstances:

- follow-up care initiated at the member's home HMO plan
- urgent care
- care that was authorized by the member's home HMO plan

Emergency services generally do not require authorization from the member's home HMO plan.

If you treat one of these members, please remember that you must verify their eligibility.

How to identify out-of-area HMO members

You can identify Blue Cross Blue Shield HMO members from other Blue Plans by the empty-suitcase logo and three-character alphabetical prefix preceding the member's identification number on their identification card.

Call BlueCard *Eligibility* at (800) 676-BLUE (2583) to verify the member's eligibility. Give the operator the member's three-character alphabetical prefix that appears on his or her identification card.

BlueCard claims

Handle claims for these members as you do for Pennsylvania Blue Shield members and Blue Cross Blue Shield traditional patients from other Blue Plans.

- When the member receives care, do not ask for full payment up front. You may request payment for out-of-pocket expenses such as an office visit copayment.
- Submit claims for Blue Cross Blue Shield HMO members affiliated with other Blue Plans through the BlueCard program.
- Submit the member's claim with the member's complete identification number, including the alphabetical prefix, to Pennsylvania Blue Shield. You can submit these claims electronically or on a paper 1500A claim form.

  Send 1500A claim forms to:

  Pennsylvania Blue Shield
  PO Box 890062
  Camp Hill, Pa. 17089-0062
- If the services are approved for payment by the member's home HMO plan (subject to the member's eligibility and benefits), you will receive direct reimbursement from Pennsylvania Blue Shield.

Notes

Notes

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:

Pennsylvania 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

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