Medical Policy

In this section	Page
A summary of Highmark Blue Shield medical policy guidelines	15.1
Medical care	15.1
 Evaluation and management services 	15.1
Medical decision making	15.2
Emergency medical and accident services	15.2
Emergency medical care requirements	15.2
Annual gynecological examinations and routine pap smears	15.3
Concurrent care	15.4
Establishing medical necessity for concurrent care	15.4
 Concurrent care payment guidelines 	15.4
Medical-medical concurrent care	15.4
 Medical-surgical concurrent care 	15.4
Inpatient preoperative and postoperative care	15.5
 Payment guidelines for inpatient preoperative care 	15.5
 Newborn care 	15.5
 Medical visits and associated services 	15.5
Consultation	15.8
 Consultation payment guidelines 	15.8
Surgery	15.8
 Multiple surgery guidelines 	15.8
 Removal of multiple skin lesions 	15.9
 Assistant surgery 	15.10
 Cosmetic surgery vs. reconstructive surgery 	15.10
 Mastectomy and reconstructive surgery 	15.10
 Mastectomy for fibrocystic breasts 	15.11
 Reconstructive surgery 	15.11
 Reconstructive surgery includes many procedures 	15.11
Breast prosthetics	15.12
Removal of cosmetic implants	15.12
Suction assisted lipectomy (SAL)	15.13
Team surgery	15.13
Co-surgery	15.13
Co-surgery vs. team surgery	15.14
Fracture care	15.14
Obstetrical delivery and associated services	15.14
■ Fetal testing	15.15
 Multiple birth guidelines 	15.15

Section 15

In this section	Page
 Fetal monitoring not covered same day as consultation 	15.16
Assisted fertilization	15.16
Assisted fertilization case management	15.17
Anesthesia	15.17
 Anesthesia services 	15.17
 Payment based on procedure, difficulty and unit values 	15.17
 Medical direction/supervision of anesthesia 	15.18
■ Coverage for CRNA services	15.18
Pain management services	15.18
Pathology	15.20
Clinical laboratory testing	15.20
 Surgical pathology guidelines 	15.20
Allergy testing	15.20
 Coverage threshold set per patient, per year 	15.21
Radiology/ultrasound	15.21
X-ray combination coding	15.21
■ Reinterpretation of X-ray	15.21
 Stress films and weight bearing X-rays 	15.21
Routine screening tests	15.21
Miscellaneous services	15.23
 Physician assistant services 	15.23
■ Obesity	15.23
 Non-covered services 	15.23
Physical therapy	15.23
Spinal Manipulation	15.23
■ Rhythm strip	15.24
 Resting ECG and stress testing 	15.24
Electrocardiogram reinterpretations	15.24
 Procedures of questionable current usefulness 	15.24
 Diagnostic studies with computer analysis or generation of automated data 	15.25
 Psychiatric/psychological services 	15.25
■ Chemotherapy	15.26
Miscellaneous reimbursement issues	15.26
■ Employment and supervision information	15.26
Criteria for employment of a licensed health care practitioner	15.27
 Purchased services 	15.27
■ "Status of patient" vs. "place of service"	15.28

A summary of Highmark Blue Shield medical policy guidelines

This section summarizes Highmark Blue Shield's policy guidelines for a number of services covered by our members' contracts. The services discussed in this section are those that generate the most questions among health care professionals and their staffs.

Please remember that an individual's coverage may vary in many ways, based on the terms of his or her contract. So, even though a particular service is listed in this section as one that we cover, it may not be covered under an individual member's contract.

Our guidelines are not intended to be practice guidelines

Highmark Blue Shield's medical policy guidelines are not intended to govern the practice of medicine. Rather, they reflect our policies regarding what services Highmark Blue Shield covers and the reimbursements we provide for those services.

A leader in medical policy development

Highmark Blue Shield is a leader in the development of current, sound medical policy guidelines. Our policies address hundreds of medical issues, including diagnostic and therapeutic procedures, and medical supplies and equipment.

The application of medical policy within our claims processing system assumes that health care costs are reimbursed as efficiently as possible. Two of the most important provisions in all Highmark Blue Shield contracts are a medical necessity clause and the exclusion of coverage for experimental procedures. Policy guidelines are established and maintained to address these provisions for a variety of procedures.

Highmark Blue Shield's policies are based on substantial professional input and reflect the current "state-of-the-art" within the medical community. We rely on a system of approximately 250 professional consultants (practicing physicians and other health care providers) for their expertise on issues within their given specialty. The Medical Programs staff maintains an extensive library of current medical information on hundreds of topics.

The results of our research may also be referred to the Medical Affairs Committee for consideration. This committee is responsible for helping the Corporation make determinations on the efficacy and appropriateness of new procedures, as well as to help the Corporation cover medically necessary and appropriate services within the terms of its member contracts. The Committee makes recommendations to the Board of Directors on issues referred to it for evaluation.

Each step in the development of our medical policy helps Highmark Blue Shield establish up-to-date guidelines that accurately reflect accepted medical practice and support our contractual agreements with our customers.

Medical care

Evaluation and management services

The evaluation and management (E/M) section of Highmark Blue Shield's *Procedure Terminology Manual* (*PTM*) includes definitions for various levels of medical care. These definitions serve simply as guidelines. It is the provider who ultimately must determine the level of care performed, based on the various components of the evaluation and management service. The key components in the selection of a level of E/M services are:

History

The levels of E/M services recognize four types of history that are defined as follows:

Problem focused

Chief complaint; brief history of present illness or problem.

Expanded problem focused

Chief complaint; brief history of present illness; problem pertinent system review.

Detailed

Chief complaint; extended history of present illness; extended system review; pertinent past, family and/or social history.

Comprehensive

Chief complaint; extended history of present illness; complete system review; complete past, family and social history.

Examination

The levels of E/M services recognize four types of examinations, defined as:

Problem focused

An examination that is limited to the affected body area or organ system.

Expanded problem focused

An examination of the affected body area or organ system and other symptomatic or related organ systems.

Detailed

An extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive

A complete single system specialty examination or a general multi-system examination.

Medical decision making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the:

- number of possible diagnoses and/or the number of management options that must be considered.
- amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed and analyzed; and,
- risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedures(s) and/or the possible management options.

Please refer to the PTM for a detailed explanation of each E/M code.

Emergency medical and accident services

Emergency medical care is defined by Highmark Blue Shield as medical care for the initial treatment of a sudden onset of a medical condition, manifesting itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably result in:

- Permanently placing the member's health in jeopardy.
- Causing other serious medical conditions.
- Causing serious impairment to bodily functions.
- Causing serious and permanent dysfunction of any bodily organ or part.

Emergency medical care requirements

To be considered an emergency, the patient's condition must meet these requirements:

■ **Severe symptoms must occur** – sufficiently severe enough to cause a person to seek immediate medical aid, regardless of the hour of the day or night.

- Severe symptoms must occur suddenly and unexpectedly. A chronic condition in which subacute symptoms have existed over a period of time but would not qualify as a medical emergency, unless symptoms suddenly became severe enough to require immediate medical aid.
- Immediate care is secured. If medical care is not secured immediately after the onset of symptoms, it is not considered a medical emergency. A telephone call to a doctor would not satisfy this requirement, if examination and treatment by a doctor in his or her office or in the outpatient department of a hospital are deferred until the next day.
- **Immediate care is required.** The illness or condition is diagnosed (or is indicated by symptoms), and the degree of severity of the condition must indicate that immediate medical care normally would be required.

Report emergency medical services with the appropriate evaluation and management code (92002-92014, 99058, 99201-99215, 99281-99285, or 99341-99350) with the ET (emergency services) modifier and a diagnosis code that reflects an emergency medical service.

Emergency accident care is defined by Highmark Blue Shield as the initial examination and non-surgical treatment performed in conjunction with a non-occupational injury.

Generally, Highmark Blue Shield pays only for the initial emergency accident visit, since follow-up care is not considered an emergency. Some groups, however, have separate coverage for follow-up care.

Report emergency accident services with the appropriate evaluation and management code (92002-92014, 99058, 99201-99215, 99281-99285, or 99341-99350) with the ET (emergency services) modifier and a diagnosis code that reflects an emergency accident service.

Highmark Blue Shield conducts extensive post-payment audits on claims for emergency services. We request refunds for payment of services that are:

- Not properly documented in the patient's medical records; or
- Do not meet the criteria for emergency services.

Annual gynecological examinations and routine pap smears

Payment will be made for one annual gynecological examination (G0101, S0610 or S0612) regardless of the patient's condition, and one routine Pap smear (G0123-G0145, G0141-G0148, P3000, P3001) per calendar year for all females.

A gynecological exam (code G0101, S0610 or S0612) may include, but is not limited to, these services: history, blood pressure and/or weight checks, physical examination of pelvis, genitalia, rectum, thyroid, breasts, axillae, abdomen, lymph nodes, heart and lungs.

When a physician performs a systemic physical examination that includes an annual gynecological examination, a medically-focused condition may be encountered. In some instances, treatment for a medically-focused condition may require more extensive medical evaluation, treatment and management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In those cases, the appropriate medical (E/M) codes (99201-99215, 99381-99397) may be reported in addition to the annual gynecological examination (code G0101, S0610 or S0612).

Concurrent care

Concurrent care is defined by Highmark Blue Shield as care provided to an inpatient of a hospital or skilled nursing facility simultaneously by more than one doctor during a specified period of time.

Such care is usually provided when:

- Two or more separate conditions required the services of two or more physicians.
- The severity of a single condition requires the services of two or more physicians for proper management of the patient.

Establishing medical necessity for concurrent care

The medical necessity for concurrent care is established on the basis of the patient's condition, as demonstrated by the reported diagnosis and other documentation. The necessity of each physician's particular skills is determined by considering the respective specialties and the diagnosis for which the services were provided.

In the event Highmark Blue Shield requires additional information to establish medical necessity, we may review hospital records. These records should:

- Document the primary doctor's request for the consultation to see the patient.
- Include sufficient documentation to indicate the seriousness of the patient's condition.

Concurrent care payment guidelines

Highmark Blue Shield applies the following payment guidelines to certain types of concurrent care:

Medical-medical concurrent care

- Under some circumstances concurrent care services are not required on a daily basis for the entire hospitalization.
- The admitting doctor is responsible for primary care and may be paid for medical care, unless the patient is transferred to the consultant.
- Highmark Blue Shield may pay for the concurrent treatment of two or more separate conditions by physicians not of the same specialty (recognized by Highmark Blue Shield).
- Highmark Blue Shield may not pay for the concurrent treatment of two or more separate conditions by physicians of the same specialty (recognized by Highmark Blue Shield).
- Highmark Blue Shield may not pay for the concurrent treatment of the same condition by physicians of the same specialty (recognized by Highmark Blue Shield).
- Highmark Blue Shield may not pay for the concurrent treatment of the same condition by physicians of different specialties (recognized by Highmark Blue Shield).

Medical-surgical concurrent care

- Highmark Blue Shield may pay for medical-surgical concurrent care for concurrent medical care provided by a physician who is not in charge of the case, and whose particular skills are required for the treatment of a serious condition that is not related to the surgical procedure performed.
- Based on documented evidence of meaningful service, Highmark Blue Shield may pay for concurrent medical care in cases where the patient has a history of a medical condition that may be aggravated by surgery, provided that:
 - a) The surgeon has requested a medical evaluation of the medical condition.
 - b) The complicating condition would be life threatening should an acute exacerbation occur.
- Payment for concurrent medical care to regulate postoperative fluid or electrolyte balance is limited to infants under two years of age or patients with a serious fluid or electrolyte problem.

Inpatient preoperative and postoperative care

Highmark Blue Shield's allowance for a definitive surgical procedure includes payment for the routine inhospital preoperative care and the routine postoperative care in or out of the hospital, when provided by a surgeon, his or her surgical associate or a surgical assistant.

One day of inpatient preoperative care is considered to be routine and is included in the payment to the operating surgeon for performing the operation.

Payment guidelines for inpatient preoperative care

The following guidelines apply to Highmark Blue Shield's payment of claims for inpatient preoperative care:

- Highmark Blue Shield may pay for all necessary preoperative medical care provided by a physician other than the operating surgeon, his or her surgical associate or a surgical assistant.
- If the surgeon, his or her surgical associate or a surgical assistant, renders two or more days care prior to the surgery, Highmark Blue Shield may pay for the days of care reported from the date of admission to the date of surgery. We also may pay even if there is a lapse of time between the last medical visit and the surgery.
- If the surgeon, his or her surgical associate, or a surgical assistant renders one day of care prior to definitive surgery, Highmark Blue Shield will not routinely pay for one day of care reported from the date of admission to the date of surgery. On an inquiry basis, we will pay only if unusual and extenuating circumstances are documented.

Generally, Highmark Blue Shield pays for medical care provided on days prior to and after those definitive surgical procedures with zero postoperative days. Medical care is not eligible for payment when it is provided on the same day as a definitive surgical procedure by the same physician, his or her associate, or a surgical assistant, for the same condition. However, when medical care is provided on the same day as a diagnostic surgical procedure, it is eligible for payment.

Newborn care

Highmark Blue Shield pays for routine inpatient care of a newborn for the following codes: 99221, 99222, 99231, 99232, 99238, 99239, 99431, 99433 and 99435. If other medical care codes are reported for routine care of a healthy newborn, the need for such care must be documented including codes 99223 and 99233.

If the physician who performs the delivery also provides routine care for the newborn after delivery, Highmark Blue Shield can pay for both services. Furthermore, when a physician other than the delivering physician reports both attendance at delivery and daily medical care of the newborn, both services are eligible for payment. The code for attendance at delivery is:

- Attendance at cesarean section, at risk neonate 99436
- Attendance at vaginal delivery, at risk neonate 99436

Medical visits and associated services

Highmark Blue Shield will not pay separately for services it considers an integral part of a doctor's medical or surgical care.

The services listed below are considered integral services:

- Administration of IV Innovar
- Amsler Grid Test

- Analysis of data from Swan-Ganz catheterization
- Anoscopy without biopsy (46600)
- Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (35400)
- Application of external fixation system (20690)
- Application of halo type appliance for maxillofacial fixation, includes removal (21100)
- Application of splint (29130-29131)
- Application of traction, suspension or corrective appliance (non-fracture care)
- Asthma education, non-physician provider, per session (S9441)
- Blood pressure check
- Blue field entoptoscopic exam
- Breast exam
- Brightness Acuity Test
- Canalith repositioning procedure (also known as, Epley maneuvers, Otolith repositioning) (S9092)
- Care plan oversight services (99374-99380)
- Catheter site inspection by physician
- Changing of tubes:
 - connecting tube
 - tracheostomy tube
 - tracheotomy tube (31502)
 - ureterostomy tube (50688)
- Chemical cauterization of granulation tissue (17250)
- Chemical pleurodesis, for example, for recurrent or persistent pneumothorax (32005)
- Corneal scrapings (65430)
- Corneal topography or computer-assisted photokeratoscopy (S0820)
- Dressing change (for other than burns) under anesthesia (other than local) (15852)
- Ear or pulse oximetry (94760-94762)
- Enterostomal therapy (S9474)
- Eye tonometry (92100)
- Foreskin manipulation including lysis of preputial adhesions and stretching (54450)
- Gastric saline load test (91060)
- Grenz ray therapy
- Hydrotubation of oviduct (tubal lavage), including materials (58350)
- Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic (S0395)
- Injection of corpora cavernosa with pharmacologic agent(s), for example, papaverine, phentolamine, etc. (54235)
- Injection of sinus tract (therapeutic) (20500)
- Insertion of pessary (57160)
- Irrigation and/or application of medicament for treatment of bacterial, parasitic or fungoid disease (57150)
- IV therapy for severe or intractable allergic disease in physician's office or institution with theophyllines, corticosteroids, antihistamines (excludes cost of the drug)
- Laryngoscopy, indirect or mirror, without biopsy (31505)
- Laser interferometry or retinometry
- Macroscopic examination of arthropod or parasite (87168, 87169)
- Magnified penile surface scanning (penoscopy)

- Manual, gross visual fields
- Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality (96902)
- Miller-Nadler Glare test
- Muscle testing (95831-95834, 95851-95852, 95875)
- Naso- or oro-gastric tube placement, necessitating physician's skill (43752, G0272)
- Nasopharyngolaryngoscopy (indirect)
- Nasopharyngoscopy (92511)
- Ophthalmodynamometry (92260)
- Otoscopy (no removal of foreign body)
- Phototherapy (for neonatal jaundice)
- Physician certification services for Medicare-covered services provided by a participating home health agency (patient not present) (G0180)
- Physician recertification services for Medicare-covered services provided by a participating home health agency (patient not present) (G0179)
- Physician supervision of a patient receiving Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities (G0182)
- Physician supervision of a patient receiving Medicare-approved services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities (G0181)
- Placement of nasogastric feeding tube
- Potential acuity testing (visual):
 - PAM (potential acuity meter)
 - Guyton Minkowski test
 - Visometer or retinometer
 - Macular integrity or electro-laser test
- Prolonged services (99354-99359)
- Prostatic massage
- Pulsed irrigation of fecal impaction (91123)
- Removal of cerumen (69210, G0268)
- Removal non-contraceptive pellets or capsules (FEP and special contracts only; Not covered under standard contracts)
- Rhinoscopy (no removal of foreign body)
- Schirmer test
- Screening test, visual acuity (99173)
- Slit lamp test (biomicroscopy, binocular microscopy and fluorescein staining) (92504)
- Special services (99050-99056)
- Starting of an IV (36000)
- Stat charges for laboratory services (\$3600, \$3601)
- Strapping of joint, including flexible, gel, and soft casts (29200-29280, 29520-29590)
- Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (99070)
- Telemetry
- Tuning fork test
- Venipuncture (36400-36410)
- Visual function screening, automated or semiautomated (99172)

These services are considered an integral part of a medical visit and are not covered as separate and distinct services.

Network providers cannot bill the patient for an integral service in addition to any payment received for the primary service, that is, the medical or surgical care.

Consultation

Consultation is defined by Highmark Blue Shield as a professional service performed by a second physician at the written or verbal request of the attending physician. A consultation includes:

- a history;
- examination of the patient;
- evaluation of tests, when applicable; and
- a written report filed with the patient's permanent record.

Consultation payment guidelines

Generally, payment for consultation is limited to one consultation per consultant during any one period of hospitalization. Highmark Blue Shield will, however, pay for medically necessary consultations, performed by physicians of different specialties, even though the consultations may be billed under a group provider number.

Surgery

Multiple surgery guidelines

Independent procedures are defined in Highmark Blue Shield's *PTM* as those services commonly performed with other more major (or primary) surgical procedures, and therefore, do not warrant additional payments beyond payment for the major service.

An independent procedure is eligible for separate reimbursement only when performed alone or when it is the highest-paying procedure of multiple surgical procedures.

Multiple surgical procedures other than independent procedures performed by the same doctor at the same time will be reimbursed as follows:

- 100 percent of the allowance for the primary (highest-paying) procedure;
- 50 percent of the allowance for each secondary procedure.

When multiple surgical procedures are performed as a result of trauma (such as emergency, life- or member-threatening situations) Highmark Blue Shield makes the reimbursement as follows:

- 100 percent of the allowance for the primary (highest-paying) procedure;
- 75 percent of the allowance for the second highest-paying procedure;
- 50 percent of the allowance for each additional surgical procedure thereafter.

To indicate trauma situations, add modifier WH to the procedure code.

Use combination codes, when possible

We encourage you to use combination codes when appropriate, including those specifying bilateral procedures. When we receive itemized charges for services that should be reported with a combination code, we will combine the charges and process the claim under the combination code.

If no single procedure code combines or lists the multiple surgical procedures for which you are requesting payment, please report each one separately, and itemize your charge for each. This will help us process your payment more quickly.

Removal of multiple skin lesions

Report claims for the removal of lesions using the codes appropriate to:

- the type of removal, as well as,
- the type and number of lesions.

For example, report 11300-11313 for shaving of dermal lesions; 11400-11446 for excision of benign lesions; 11600-11646 for excision of malignant lesions; 17000-17004 for chemosurgical, cryosurgical or electrosurgical destruction of benign or premalignant lesions, destruction by laser, or surgical curettement; and 17260-17286 for destruction of malignant lesion, any method.

Highmark Blue Shield processes claims for multiple procedures up to and including five at one session, according to multiple surgery guidelines.

Reporting guidelines for procedure codes 17000-17004 are specific to the terminology within the definitions of the codes. Report these codes in the following manner:

- Procedure code 17000 should only be reported once per session regardless of the number of lesions removed or the number of anatomical sites treated. Always report "1" as the service multiplier.
- Procedure code 17003 should be reported if more than one lesion is treated at one time. Report this code with a multiplier for each lesion in excess of one up to a maximum of 13. The appropriate multipliers to report with procedure code 17003 are 1 through 13.
- If more than 14 lesions are treated, only report code 17004. Reimbursement for procedure code 17004 includes an allowance for procedure codes 17000 and 17003 x 13. Always report code 17004 with a multiplier of 1.

Procedure code 17004 is an all inclusive code. It should not be billed with procedure codes 17000 and 17003.

Here are examples of how you should report codes 17000-17004:

- Removal of one lesion report procedure code 17000 x 1
- Removal of 2-14 lesions report procedure code 17000 x 1 and code 17003 x 1 to 13
- Removal 15 or more lesions report procedure code 17004 x 1

Removal procedures in excess of five at one session are paid at 10 percent of the reasonable charge, providing this amount does not exceed the billed charge.

If payment is questioned, our medical director or professional consultant will review claims reporting unusual circumstances or for more than five procedures.

Assistant surgery

The eligibility of an assistant surgeon's services is based on:

- The complexity and difficulty of the surgical procedure; and
- Whether or not the procedure routinely requires the services of an assistant surgeon.

An assistant surgeon must actively assist the operating surgeon in performing the covered surgery and must be able to complete the surgery in the event the surgeon is unable to continue.

Surgical assistance is not covered when performed by a professional provider who also performs and bills for another surgical procedure during the same operative session.

In addition, under certain contracts, Highmark Blue Shield will not pay for assistant surgery performed in a hospital where qualified residents or house staff are utilized for such assistance.

Highmark Blue Shield will pay a physician for assistant surgery performed by his or her employed physician assistant (PA). You must use modifier 80 and modifier AS to report assistant surgery performed by a PA.

Cosmetic surgery vs. reconstructive surgery

Cosmetic surgery is performed to improve a person's appearance and is generally ineligible for payment.

Reconstructive surgery is performed to improve or restore bodily function and is generally eligible for payment.

Some of the most frequently reported cosmetic/reconstructive surgical services are:

- Abdominal lipectomy (15831)
- Eyelid surgery:
 - Blepharoplasty (15820-15823)
 - Blepharoptosis (67900-67906)
- Breast surgery:
 - Reduction mammoplasty (19318)
 - Augmentation mammoplasty (19324-19325)
 - Mastectomy for gynecomastia (19140)
- Dermabrasion (15780-15787)
- Hair transplant (15775-15776)
- Otoplasty (69300)
- Rhinoplasty (30400-30450)
- Rhytidectomy (15824-15829)
- Scar revision

Mastectomy and reconstructive surgery

Mastectomy

Highmark Blue Shield contracts cover medically necessary services that are appropriate for the symptoms and diagnosis, or treatment of the member's condition, illness or injury. The services must also be in accordance with current standards of good medical care.

Mastectomy (19160-19240) is the removal of all or part of a breast. Mastectomies are typically performed as a treatment for cancer. However, mastectomies are also performed for the treatment of benign disease.

Mastectomy for fibrocystic breasts

Although fibrocystic breasts may not be considered a disease state, it is considered a condition or a "disorder."

There may be no symptoms, but for those women who do have symptoms, they range from mild to severe. Mastectomy is not the appropriate treatment for fibrocystic breasts in all cases. However, mastectomy for fibrocystic breasts may be indicated when the patient is symptomatic and has been unresponsive to conservative treatment and/or biopsy has been performed.

Symptoms of fibrocystic breasts include, but are not limited to: breast engorgement attended by pain and tenderness, generalized lumpiness or isolated mass or cyst. However, the presence of nipple discharge is rarely present in a fibrocystic breast.

Conservative treatment for fibrocystic breasts consists of, but is not limited to: support bras, avoiding trauma, avoiding caffeine, medication for pain, anti-inflammatory drugs, hormonal manipulation, use of vitamin E, use of diuretics and salt restrictions.

The type of mastectomy (subcutaneous, partial, modified or radical) and the timing of the surgery varies for each patient and is determined by the surgeon.

Reconstructive surgery

Reconstructive breast surgery is defined as those surgical procedures designed to restore the normal appearance of a breast following a mastectomy. Effective February 1, 1998, Act 51 of 1997 (Women's Health Security Act) requires coverage for reconstructive surgery and prosthetic devices incident to a mastectomy.

Act 51 of 1997 defines reconstructive surgery to include all surgery on the affected breast and surgery on the contralateral normal breast to re-establish symmetry between the two breasts or to alleviate functional impairment caused by the mastectomy.

Symmetry is defined as approximate equality in size and shape of the nondiseased breast with the diseased breast after definitive reconstruction surgery on the diseased or nondiseased breast has been performed.

Reconstructive surgery includes many procedures

The most common type of reconstructive surgery following mastectomy is the insertion of a silicone gel-filled or saline-filled breast implant. The implant can be inserted immediately at the time of the mastectomy (19340), or sometime afterward in conjunction with the previous use of a tissue expander (19342, 19357).

Other types of reconstruction on the diseased breast include, but are not limited to:

- Nipple or areola reconstruction (19350)
- Nipple tattooing (19499)
- Transverse rectus abdominis myocutaneous flap (TRAM) (19367-19369), latissimus dorsi flap (19361) or free flap (19364)

These procedures performed on the contralateral normal breast to provide symmetry with the reconstructed breast are also considered reconstructive procedures:

- Augmentation mammoplasty (19324, 19325)
- Reduction mammoplasty (19318)
- Mastopexy (19316)

Breast prosthetics

Act 51 of 1997 requires coverage for prosthetic devices incident to a mastectomy. The act defines prosthetics as the use of initial and subsequent artifical devices to replace the removed breast or portion of the breast.

Act 51 also requires coverage for a home health visit when a woman is discharged within 48 hours following her admission for a mastectomy. The home health visit should be billed as a hospital expense.

When the implantable breast prosthesis (L8600) is provided by the hospital, the charge should be billed as a hospital expense. When the physician incurs the cost of the implant, the charge should be billed to Highmark Blue Shield.

Charges for an implantable breast prosthesis will be denied as cosmetic when the implant is provided in conjunction with a cosmetic augmentation mammoplasty (19324-19325).

The following prosthetics are covered:

- Breast prosthesis, mastectomy bra (L8000)
- Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral (L8001)
- Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral (L8002)
- Breast prosthesis, mastectomy sleeve (L8010)
- Breast prosthesis, mastectomy form (L8020)
- Breast prosthesis, silicone or equal (L8030)
- Breast prosthesis, not otherwise specified (L8039)
- Adhesive skin support attachment for use with external breast prosthesis, each (A4280)
- External breast prosthesis garment, with mastectomy form, post mastectomy (L8015)
- Custom breast prosthesis, post mastectomy, molded to patient model (L8035)
- Implantable breast prosthesis, silicone or equal (L8600)
- Camisole, post-mastectomy (S8460)

Coverage for the services defined in Act 51 of 1997 are subject to any copayment, coinsurance or deductibles, and all other terms and conditions set forth in the patient's contract.

Removal of cosmetic implants

Implant removal covered for medical reasons

The removal of a cosmetic implant (such as, breast, synthetic hair, etc.) that has caused an infection or an allergic reaction in a patient is a covered service regardless of whether the original implant was eligible for payment. Claims for this service will be processed under the appropriate procedure code for the implant removal (such as, 19328 or 19330 – breast, 10121 – synthetic hair).

Cosmetic removals not covered

The removal of an intact mammary implant (19328) solely for cosmetic purposes (such as, to replace with a larger or smaller implant) is not covered.

Capsulectomy coverage outlined

When a periprosthetic capsulectomy (19371) or periprosthetic capsulotomy (19370) is reported, the allowance for the capsulectomy or capsulotomy includes the allowance for code 19328 (removal of the intact mammary implant). However, separate payment can be made for code 19330 (removal of mammary implant material) in addition to the capsulectomy or capsulotomy. Separate payment can also be made for the insertion of implant (19340, 19342) following capsulectomy or capsulotomy when the original breast implant procedure was reconstructive rather than cosmetic surgery.

Suction assisted lipectomy (SAL)

Suction assisted lipectomy claim guidelines:

- Suction assisted lipetomy done solely for cosmetic purposes is not eligible for payment.
- Suction assisted lipectomy performed as the sole method of treatment for an otherwise covered service (such as, removal of lipoma) is eligible for payment based on individual consideration.
- No separate or additional allowance should be made for suction assisted lipectomy when performed in conjunction with a covered surgical procedure.
- Suction assisted lipectomy performed on a prior date of service in preparation for a covered reconstructive procedure (such as, knee surgery) is eligible for payment based on individual consideration.

Team surgery

When more than two surgeons with different skills, and of generally different specialties, work together to carry out various procedures of a complicated surgery.

The individual procedure performed by each doctor on the surgical team will be considered on its own merit. Modifier 66 – surgical team, should be used to identify team surgery procedures. To be eligible for reimbursement, the component surgery billed by a member of the surgical team must be a covered service if performed alone.

Examples of surgical operations that could fall under the team surgery concept:

- Reattachment of limb, digit, etc.
- Organ transplants, such as a kidney transplant that could involve the services of a general surgeon, a urologist and/or a vascular surgeon to remove the diseased kidney (50340), to implant the donated kidney (50360-50365) and to transplant the ureters (50780).

Co-surgery

Co-surgery is recognized for certain procedures. It is defined as two surgeons of different specialties performing, either simultaneously or at separate times, portions of one or more surgical procedures during the same operative session. Because co-surgeons are performing portions of a procedure, the same procedure code describes the services performed by both surgeons.

Co-surgery is, therefore, eligible per procedure, not per operative session. This means that the performance of co-surgery at one procedure during an operative session for multiple procedures, does not qualify all procedures performed during that session as co-surgery. Only those procedures, in which the surgeon actually performs a portion of the procedure, will be considered co-surgery.

Co-surgery procedures must be reported with the primary modifier 62 – two surgeons. The co-surgery allowance for these procedures is 62.5 percent of the contract allowance, per surgeon per procedure. Multiple surgery guidelines are also applicable.

Payment may not be made to the same surgeon for assistant surgery and co-surgery procedures performed during the same operative session.

Co-surgery vs. team surgery

Co-surgery is not the same as team surgery, which is defined as more than two physicians, usually with different skills and of different specialties, working together to carry out various procedures of a complicated surgery.

Fracture care

Occasionally, the services of more than one physician are utilized in the treatment of a fracture – one physician for the initial treatment, and another for the follow-up care. In the event the initial patient contact is made by a physician who provides minimal treatment and diagnosis and then refers the patient to an orthopedist or surgeon for reduction or immobilization of the fracture, the services of the first physician are eligible for consideration as emergency accident care.

When one physician performs the initial reduction and/or immobilization and another physician performs the follow-up care, the "Sun Valley Rule" method of payment is applied – each physician receives the respective portion of the allowance he or she would have received if he or she had performed total care.

These payments include:

- Displaced fracture (a fracture that requires open or closed reduction), initial care two-thirds the allowance for total care
- Displaced fracture, follow-up care one-third the allowance for total care
- Undisplaced fracture (a fracture that does not require reduction but is usually treated by cast immobilization or splinting), initial care one-third the allowance for total care
- Undisplaced fracture, follow-up care two-thirds the allowance for total care

The Sun Valley Rule gets its name from the likelihood of fractures from skiing accidents, which occur away from the patient's home – such as in Sun Valley, Idaho.

Payment for application and removal of a cast for a fracture, when performed by the same physician, is included in the global allowance for the physician's overall fracture care. Therefore, it does not warrant separate payment. In addition, related follow-up medical care is also included in the allowance for the fracture care.

However, the removal of a cast is eligible for payment when performed by a provider other than the physician or his or her associate or partner who applied it.

Obstetrical delivery and associated services

These services are considered an integral part of a vaginal delivery (59400-59410), cesarean section (59510-59515) or delivery after previous cesarean delivery (59610-59622) and are not eligible as distinct and separate services:

- a) Induction of labor (for example, PEGGELL insertion, use of pitocin)
- b) Augmentation of labor, for example, use of pitocin
- c) Removal of shirodkar sutures prior to delivery
 - under anesthesia (except local) (59871)
 - under local anesthesia or without anesthesia

d) Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc. Highmark Blue Shield will pay separately for external version (59412).

- e) Suturing of episiotomy
- f) Fetal scalp blood sampling (59030)
- g) Fetal monitoring, including insertion of fetal oximetry sensor (0021T)

Fetal testing

Payment will be made for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (for example, oxytocin) and is generally administered intravenously. These tests are utilized to determine fetal status and viability.

Payment should be made for fetal non-stress testing (59025) once per day, regardless of the number of gestations.

Payment for obstetrical care (59400 and 59410) includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (for example, the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta (59414), as well as for antepartum care (59425, 59426) and/or postpartum care (59430), as appropriate.

Multiple birth guidelines

These guidelines apply to payment for multiple births:

- If infants are delivered by the same or different methods (vaginal or cesarean section), payment will be made for one delivery for each newborn.
- Anterpartum and postpartum care should be included with only one delivery code, that is, reimbursement will only be made for a single antepartum and postpartum period regardless of the number of newborns delivered.

Payment for delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate payment may be made for fetal monitoring to a physician other than the attending physician (code 59050 or 59051) when any one of the following criteria is met:

- For any high-risk pregnancy.
- For multiple gestation with complications.
- For any unusual or abnormal fetal heart rate findings.
- When there is a need for scalp pH.
- For fetal decelerations that are recurrent and of unknown etiology.
- When there are atypical fetal responses with maternal medical diseases.
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

Fetal monitoring not covered same day as consultation

When fetal monitoring (59050 or 59051) is provided on the same day as a consultation by the same health care professional, the fetal monitoring is not eligible for separate payment. When consultations are a benefit, the fetal monitoring is included in the allowance for the consultation.

Assisted fertilization

Infertility is the medically documented absence of, or diminished ability to conceive or induce conception. A couple is considered infertile if pregnancy does not occur over a one-year period of normal coital activity between a male and female partner without contraceptives. The cause of infertility can be a female or male factor, or a combination of both.

Assisted fertilization techniques enhance sperm-egg interaction. Management of the infertile couple with assisted fertilization is generally limited to those couples who do not respond to standard infertility treatments (such as, tuboplasty for the female, microsurgical reconstruction for the male).

Assisted fertilization techniques include, but are not limited to:

- Artificial insemination (AI)
- In vitro fertilization (IVF)
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)

Assisted fertilization is not covered, except for certain group programs. When assisted fertilization is a benefit, these procedures are covered services as part of the program.

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Code	Terminology
58321	Artificial insemination; intracervical (AI)
58322	Artificial insemination; intrauterine (AI)
58323	Sperm washing for artifical insemination
58970	Follicle puncture for oocyte retrieval, any method such as, laparoscopy, colposcopy
58974	Embryo transfer, intrauterine (IVF)
58976	Gamete, zygote, or embryo intrafallopian transfer, any method (GIFT, ZIFT)
58999	Ovulation induction (drug therapy and management, e.g., Pergonal injections)
76948	Ultrasonic guidance for aspiration of ova
84702	Gonadotropin, chorionic; quantitative (i.e., implantation monitoring - HCG assay)
89250	Culture and fertilization of oocyte(s)
89251	Culture and fertilization of oocyte(s); with co-culture of embryos
89252	Assisted oocyte fertilization microtechniques (any method) (e.g., Intracytoplasmic
	Sperm Injections, ICSI, sperm microinjection)
89253	Assisted embryo hatching, microtechniques (any method) (e.g., zona drilling)
89254	Oocyte identification from follicular fluid
89255	Preparation of embryos for transfer (any method)
89256	Preparation of cryopreserved embryos for transfer (includes thaw)
89257	Sperm identification from aspiration (other than seminal fluid)
89260	Sperm isolation: simple prep (e.g., sperm wash and swim-up) for insemination or
	diagnosis with semen analysis
89261	Sperm isolation: complex prep (e.g., per co gradient, albumin gradient) for
	insemination or diagnosis with semen analysis
89264	Sperm identification from testis tissue, fresh or cryopreserved
S4028	Microsurgical Epididymal Sperm Aspiration (MESA)

Assisted fertilization case management

When reported, assisted fertilization case management will be processed under the appropriate procedure codes for the services rendered. Assisted fertilization case management generally includes, but is not limited to, such services as a history and physical, daily visits, consultations for medication adjustment and counseling.

Although assisted fertilization is contractually excluded from standard coverage, payment can be made for evaluation of infertility and for managing the pregnancy and delivery, should the fertilization process be successful.

Anesthesia

Anesthesia services

These types of anesthesia qualify for payment as anesthesia services:

- Inhalation
- Regional
 - Spinal (low spinal, saddle block)
 - Epidural (caudal)
 - Nerve block (retrobulbar, brachial plexus block, etc.)
 - Field block
- Intravenous
- Rectal
- Conscious sedation

Local anesthesia, which is direct infiltration of the incision, wound or lesion, is not a covered service under most Highmark Blue Shield contracts.

Payment based on procedure, difficulty and unit values

Payment for anesthesia services is evaluated through the use of relative values. Basic unit values have been assigned to most surgical procedures and reflect the degree of difficulty for the anesthesia services, including the usual preoperative and postoperative care and evaluation. Therefore, it is not necessary to report basic unit values.

Highmark Blue Shield determines payment for anesthesia services on the basic unit value, plus total time in minutes reported, plus eligible modifying units or modifying procedures reported, multiplied by the anesthesia conversion factor.

Highmark Blue Shield reimburses anesthesia services only when performed in conjunction with other covered services and performed by a physician other than the operating surgeon, the assistant surgeon or the attending physician.

Standby anesthesia implies "availability" of a physician (such as an anesthesiologist) with no actual physician involvement and no direct patient care. Consequently, standby anesthesia is not covered.

Medical direction/supervision of anesthesia

Medical direction or supervision of anesthesia is defined by Highmark Blue Shield as anesthesia direction, management or instruction by a provider who is physically present or immediately available in the operating suite. A provider rendering this service should not actually be concurrently administering anesthesia in another operating room.

For concurrent supervision, reimbursement is limited to no more than four anesthesia services performed concurrently. Highmark Blue Shield pays for medical direction of anesthesia as follows:

- When a provider such as an anesthesiologist medically directs a physician-in-training, for example, intern or resident, Highmark Blue Shield pays in the same manner as for the anesthesiologist's personal performance of the anesthesia service. In this instance, report modifier GC.
- When a provider such as an anesthesiologist medically directs a certified registered nurse anesthetist (CRNA), hired and paid by the anesthesiologist, Highmark Blue Shield pays in the same manner as for the anesthesiologist's personal performance of the anesthesia service.
 - Note: Two line items are required when reporting medical direction of a CRNA employee. Modifiers QK and QX, or QY and QX should be reported, as appropriate.
- When a provider such as an anesthesiologist medically directs a CRNA not employed by the anesthesiologist, Highmark Blue Shield pays up to 50 percent of the fee allowed for the anesthesiologist's personal performance of the anesthesia service. Modifier QK or QY should be reported, as appropriate.
- When a provider such as an anesthesiologist medically directs a CRNA who is directly billing his or her services on a fee-for-service basis, Highmark Blue Shield pays up to 50 percent of the allowance for the anesthesiologist's personal performance of the anesthesia services. Modifier QK or QY should be reported, as appropriate. In this instance, a CRNA who is directly billing his or her service on a fee-for-service basis may also be paid up to 50 percent of the anesthesia allowance. The CRNA should report modifier QX.

An anesthesiologist medically directing four or fewer anesthesia procedures can concurrently provide:

- Address an emergency of short duration in the immediate area;
- Administer an epidural or caudal anesthetic to ease labor pain;
- Provide periodic, rather than continuous, monitoring of an obstetrical patient;
- Receive patients entering the operating suite for the next surgery;
- Check or discharge patients in the recovery room; or
- Handle scheduling matters.

Coverage for CRNA services

Highmark Blue Shield recognizes covered services performed by a certified registered nurse anesthetist (CRNA), providing such services are within the scope of a CRNA's license, and are otherwise eligible for payment.

A CRNA employed by a health care facility or an anesthesiology group is not an eligible provider according to Act 209 of 1986. However, if a CRNA also wishes to simultaneously maintain a separate and independent practice, the CRNA can become an eligible provider with Highmark Blue Shield and can bill for services performed, but only within the independent practice.

Pain management services

Pain management techniques may be used to control pain both after surgery and in other situations. Here are Highmark Blue Shield's guidelines for the most commonly used pain management techniques:

Patient controlled analgesia (PCA) therapy involves self-administration of intravenous drugs through an infusion device. PCA for post-surgical pain control is considered routine postoperative pain management warranting no separate payment, regardless of who provides it.

When PCA is used for non-surgical pain management, such as for cancer, it is considered an integral part of a physician's medical care, and is not eligible for payment as a separate distinct service. A network provider cannot bill the patient separately for PCA in such cases.

There is no distinct procedure code for patient controlled analgesia.

Epidural analgesia (code 62318 or 62319, as appropriate) involves administering a narcotic drug through an epidural catheter. This type of analgesia is eligible as a separate and distinct service when used for postoperative management following major surgical procedures, such as total hip and knee replacement and major vascular surgery. Epidural analgesia includes the preoperative, intra-operative or postoperative insertion of an epidural catheter.

Payment also can be made for the insertion of an epidural catheter (code 62318 or 62319, as appropriate) for the treatment of a non-surgical condition.

Daily management of epidural drug administration (code 01996) for postoperative or non-surgical management is also eligible for separate payment after the day on which the catheter is inserted. Daily management reported on the same day as the catheter insertion is not covered. A network provider cannot bill the member for daily management on the same day as the catheter insertion.

Payment for the administration of epidural anesthesia for the relief of pain during labor and delivery is based on time and basic anesthesia units. The basic units are equated to those for either vaginal delivery or cesarean section (for example, 01960 or 01961).

The time spent providing continuous epidural anesthesia during labor and delivery includes:

- The *actual time* in attendance by the physician during placement of the epidural catheter.
- The *actual time* in attendance by the physician with the patient during the period of re-injection of the drugs into the epidural catheter.
- The *actual time* in attendance by the physician during delivery and perineal repair.

Don't report a separate code for epidural nerve blocks (for example, 01967, 62311) or for the insertion of an epidural catheter (code 62318 or 62319, as appropriate). In this instance, a network physician cannot bill the patient separately for the labor epidural.

A **nerve block** involves injecting an anesthetic agent into or around a given nerve.

For nerve blocks performed as anesthesia for a surgical or obstetrical service, report the appropriate surgical or obstetrical anesthesia procedure code. You may also report time units.

Nerve blocks administered as pain management *for a surgical condition* are eligible for payment. Nerve blocks administered as pain management *for obstetrical care* are considered routine pain management, regardless of who performs them, and are not eligible for separate payment.

Therapeutic nerve blocks for the treatment of a non-surgical or non-obstetrical condition (independent of any surgical or obstetrical procedure) are covered surgical services. Report procedure codes 62273-62282, 62310-62319, 64400-64450, 64470-64484, 64505-64530, as appropriate. Do not include time units, since therapeutic nerve blocks are considered to be surgical services.

Pathology

Clinical laboratory testing

- Highmark Blue Shield pays for clinical laboratory testing only when reported by the physician or independent clinical laboratory that actually performed the test. Clinical laboratory tests performed by a hospital laboratory that is not an independent laboratory, should be billed as a hospital expense.
- Independent laboratories may bill for tests performed by a reference laboratory when the independent laboratory has performed a majority of the tests.
- Physicians should only report charges for clinical laboratory tests performed in their offices. The
 independent laboratory should bill for any clinical studies referred to it by physicians.
- The **collection and handling of specimens** is a covered service under standard Highmark Blue Shield programs.

Surgical pathology guidelines

Procedure codes 88300-88309 designate surgical pathology studies. A **specimen** is defined as tissue or tissues submitted for individual and separate attention, requiring individual examination and pathologic diagnosis.

- Code 88300 represents any specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination.
- Code 88302 is used when gross and microscopic examination is performed on a specimen to confirm identification or absence of disease.
- Codes 88304-88309 represent all other specimens requiring gross and microscopic examination, and represent additional ascending levels of physician work.

Levels 88302 through 88309 are specifically defined by the assigned specimens.

Allergy testing

Here are Highmark Blue Shield's guidelines for its coverage of allergy testing:

- **Skin testing** Highmark Blue Shield will pay for up to 60 medically necessary skin tests per patient per year, regardless of the test method (for example, percutaneous, intracutaneous).
- In vitro testing Highmark Blue Shield will pay for up to 15 medically necessary in vitro tests, per patient per year, regardless of the type (i.e., RAST, FAST, multiple antigen simultaneous test, ELISA).
- **Combination testing** Highmark Blue Shield will not pay for both skin testing and in vitro testing for the same allergens.
- Medical necessity Highmark Blue Shield bases medical necessity for all allergy testing on the pertinent clinical findings. A "check-off' history sheet completed by the patient can supplement, but not replace, a history and physical examination. You should always perform a complete history and physical exam.
- **Documentation** The patient's medical record should indicate sufficient information, based on the clinical findings, to justify the medical necessity for allergy testing.

Coverage threshold set per patient, per year

It is Highmark Blue Shield's position that, based on these sources, it is rarely medically necessary to exceed 15 in vitro or 60 skin tests per patient per year. In most instances, you'll need fewer than these established maximums to thoroughly evaluate the patient.

Therefore, Highmark Blue Shield will not pay for allergy tests in excess of the established upper limits, except in extraordinary circumstances. When submitting documentation to Highmark Blue Shield to establish the need for tests in excess of these limits, include:

- A copy of the patient's history and physical examination report, including the completed allergen "check-off" sheet, if available;
- A copy of the test results;
- Any other pertinent documentation.

Radiology/ultrasound

X-ray combination coding

Report multiple diagnostic radiological studies of the same general anatomic area performed at the same time under a combination code where available. For example:

Separate charges reported for codes 72100 (radiologic examination, spine, lumbosacral; 2 or 3 views) and 72120 (radiologic examination, spine, lumbosacral, bending views only, minimum of four views) should be reported under code 72114 (radiologic examination, spine, lumbosacral; complete, including bending views).

Reinterpretation of X-ray

Highmark Blue Shield pays for only one interpretation of any given X-ray. When reporting the professional component of an X-ray, the health care professional must perform a complete interpretation of the X-ray that includes a detailed written report of the results for the patient's records.

A re-interpretation of that same X-ray by another physician is not eligible for payment as a distinct and separate service.

Stress films and weight bearing X-rays

Highmark Blue Shield does not provide separate payment for stress films or weight bearing X-ray studies when performed in conjunction with conventional X-ray studies of the same body area, for example, spine, hip, knee, ankle. When you perform stress films or weight bearing X-rays, report the appropriate procedure code for the conventional X-ray of the anatomic area studied.

When you perform the manual application of stress for joint radiography, report only code 76006-manual application of stress performed by a physician for joint radiography, including contra lateral joint if indicated. Highmark Blue Shield will not pay for this service unless it's reported with the appropriate code for the conventional X-ray study for which it is performed. Highmark Blue Shield will deny code 76006 when it's reported alone.

Routine screening tests

Coverage for routine screening tests or services for asymptomatic patients varies according to the terms of the individual Highmark Blue Shield contract.

Here are the codes you should report for asymptomatic patients:

Code	Terminology		
G0102	Prostate cancer screening; digital rectal examination		
G0103	Prostate cancer screening; prostate specific antigen test (PSA), total		
G0104	Colorectal cancer screening; flexible sigmoidoscopy		
G0106	Colorectal cancer screening; screening sigmoidoscopy, barium enema		
G0107	Colorectal cancer screening; fecal occult blood test one - three simultaneous determiniations		
G0120	Colorectal cancer screening; screening colonoscopy, barium enema		
G0122	Colorectal cancer screening; barium enema		
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision		
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician		
<u>Code</u>	<u>Terminology</u>		
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision		
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision		
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening using cell selection and review under physician supervision		
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision		
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening		
G0202	Screening mammography, producing direct digital image, bilateral, all views		
P3000	Screening Papanicolauo smear, cervical or vaginal, up to three smears, by a technician under physician supervision		
P3001	Screening Papanicolauo smear, cervical or vaginal, up to three smears, requiring interpretation by a physician		
S0601	Screening proctoscopy		
S0605	Digital rectal examination, annual		
76092	Screening mammography, bilateral (two view film study of each breast)		

Miscellaneous services

Physician assistant services

Highmark Blue Shield covers licensed physician assistant (PA) services when the PA is employed by and is acting under the direct, personal supervision of a physician

• Highmark Blue Shield cannot pay a PA directly. Instead, we pay either the participating, preferred or network doctor or the patient (for services provided by a non-participating doctor). We pay the same amount as we would for services personally performed by the reporting physician.

Obesity

Claims reporting services performed in conjunction with a diagnosis of "obesity" are not eligible for payment.

Obesity is an increase in body weight beyond the limitation of skeletal and physical requirements, as a result of excessive accumulation of fat in the body. In general, 20 percent to 30 percent above the "ideal" bodyweight, according to standard life insurance tables, constitutes obesity. Morbid obesity is further defined as a condition of consistent and uncontrollable weight gain that is characterized by a weight which is at least 100 pounds or 100 percent over ideal weight, or a body mass index (BMI) of at least 40 or a BMI of 35 with comorbidities, for example, hypertension, cardiovascular heart disease, dyslipidemia, diabetes mellitus type II, sleep apnea.

BMI is a method used to quantitatively evaluate body fat by reflecting the presence of excess adipose tissue. BMI is calculated by dividing measured bodyweight in kilograms by the patient's height in meters squared. The normal BMI is 20-25 kg/m2.

Claims reporting surgical services (for example, gastric stapling and gastric bypass surgery) for the treatment of "morbid obesity" are generally eligible for payment under standard Highmark Blue Shield contracts.

Non-covered services

Highmark Blue Shield provides benefits according to the terms of the individual member's Highmark Blue Shield contract. Services that are specifically excluded under the contract may be billed to the patient.

Examples of services that are not covered under most Highmark Blue Shield contracts:

- Artificial insemination;
- Corneal microsurgery for the correction of myopia or hyperopia;
- In vitro fertilization:
- Routine neonatal circumcision.

Physical therapy

Physical therapy is a covered service when performed with the expectation of restoring the patient's level of function that has been lost or reduced by injury or illness.

However, physical therapy is not eligible when performed repetitively to maintain a level of function.

Spinal Manipulation

Manipulation therapy is a covered service when performed with the expectation of restoring the patient's level of function that has been lost or reduced by injury or illness.

However, manipulation therapy is not eligible when performed repetitively to maintain a level of function.

Rhythm strip

A rhythm strip is considered an inherent part of the following studies and does not warrant separate payment in addition to that study:

- Echocardiogram;
- Electrocardiogram;
- Master two-step;
- Stress test (cardiac or pulmonary).

Consequently, when a rhythm strip is reported in conjunction with any of these tests, Highmark Blue Shield will pay only for the appropriate study (for example, 93000, 93015).

Resting ECG and stress testing

A resting ECG is an inherent part of cardiac stress testing and does not warrant separate payment in addition to that for the stress test.

Consequently, when you report a resting ECG in conjunction with a cardiac stress test, Highmark Blue Shield will pay only for the cardiac stress test.

Separate payment can be made for a resting EKG when there is evidence that the EKG was performed independent of the stress test, that is, at a different time of the day.

Electrocardiogram reinterpretations

An attending or admitting physician who interprets an ECG will not be reimbursed in non-emergency cases when the ECG is interpreted by another physician, such as a staff physician, whose duties include the interpretation of ECGs.

In non-emergency cases, Highmark Blue Shield views reinterpretation of an ECG as integral to the attending or admitting physician's medical care. Therefore, a network provider cannot bill the patient separately for these reinterpretations.

However, if the patient's condition requires immediate interpretation of the ECG (emergency treatment), Highmark Blue Shield can pay the attending or admitting physician as well as the hospital-staff physician who also interprets the ECG.

Report emergency ECG interpretations by adding modifier "YC" to the appropriate ECG procedure code.

Procedures of questionable current usefulness

Procedures of questionable current usefulness (POQCU) are procedures that are no longer routinely paid by Highmark Blue Shield.

A POQCU is classified as:

- 1) a procedure of unproved value or of dubious current efficacy;
- 2) redundant when performed in conjunction with other procedures; or
- 3) unlikely to yield information of value in the patient's treatment course.

If you provide information to Highmark Blue Shield that satisfactorily documents the medical necessity of a POQCU, we will pay for the procedure.

Highmark Blue Shield reviews all claims for a POQCU on an individual basis. Some examples of POQCU include:

<u>Code</u>	Procedure
27080	coccygectomy
44680	intestinal plication
61490	craniotomy for lobotomy

The PTM identifies all POOCUs.

Diagnostic studies with computer analysis or generation of automated data

Highmark Blue Shield will not pay a separate charge for computer analysis or generation of automated data performed in conjunction with a diagnostic medical study. These are considered to be an integral part of the diagnostic study and are not covered as separate and distinct services.

Psychiatric/psychological services

Generally, individual psychotherapy (codes 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845, 90875, 90876) and a psychiatric or psychological visit are not performed on the same day. In those cases where individual psychotherapy and a psychiatric or psychological visit are reported on the same day, Highmark Blue Shield will make payment for only one service.

Individual psychotherapy codes with medical evaluation and management (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827 and 90829) include pharmacologic management (90862, M0064) and evaluation and management (99201-99350). Therefore, pharmacologic management and E/M services should not be reported separately on the same day as a psychotherapy service by the same provider or mental health professional group. The single exception is that an initial consultation and psychotherapy may be reported on the same day of service, if it is medically indicated.

It is only in exceptional cases that multiple visits or multiple psychotherapy sessions (same modality) are necessary on the same day. Therefore, when multiple visits or psychotherapy sessions are reported to Highmark Blue Shield, payment will be made for only one visit or psychotherapy session. However, payment may be made for psychiatric/psychological treatment consisting of different modalities (for example, family or group vs. individual psychotherapy) when performed on the same day. Additionally, payment may be made for psychological testing/central nervous system assessments/tests (codes 96100, 96105, 96111-96117) and psychiatric or psychological treatment (for example, visit or psychotherapy) when performed on the same day.

A comprehensive or interval history of a patient's complaint or illness (codes 90801, 90802), when used to assist in psychiatric diagnosis and treatment planning, is an eligible service regardless of the source of information. When the patient is comatose or withdrawn and uncommunicative due to a mental disorder, a history may be obtained by interviewing the patient's family and close associates. However, family counseling (90846, 90887) is not reimbursable as part of the physician's personal services to the patient. Family counseling is generally not eligible for reimbursement.

Family psychotherapy (code 90847) primarily involves the physician's treatment of the patient's condition, and not the treatment of each family member's problems. Therefore, this code represents a complete family session, payable only for the patient. These codes should not be used for other family members involved in family psychotherapy.

As with all other professional services, Highmark Blue Shield pays for psychiatric or psychological services in accordance with the individual member's contract. Therefore, the guidelines explained above are applicable when those services are covered under the member's contract.

Chemotherapy

Coverage for chemotherapy services is generally provided in any place of service when:

- The treatment is administered by or under the supervision of a doctor for treatment of a malignant disease; and
- FDA-approved antineoplastic agents are used.

In addition, payment may be made for drugs administered as part of a rescue form, or antidote for, severe toxic reactions to the antineoplastic agent. For example, leucovorin given as an antidote following high-dose methotrexate therapy is covered.

Payment may be made for oral antiemetic drugs (Q0163-Q0181) when used as full replacement for intravenous antiemetic drugs as part of a cancer thermotherapeutic regimen.

- Procedure codes Q0166 and Q0180 should not exceed a 24-hour dosage regimen.
- The remaining codes should not exceed a 48-hour dosage regimen.

When drugs are administered in an outpatient or inpatient hospital setting, the drug is a hospital expense.

However, payment can be made for the administration of the antineoplastic drug when the physician personally administers the drug, or when he supervises an employee who is performing the administration.

Eligible methods of administration include intravenous, intra-arterial, intramuscular, intracavitary and oral routes.

- When multiple drugs are given by the same route of administration, during the same session, only one administration fee will be reimbursed.
- When multiple drugs are given by **different** routes of administration, each route can be paid.

Miscellaneous reimbursement issues

Employment and supervision information

Under Highmark Blue Shield's standard contracts, the services of a non-licensed person are not eligible for payment, regardless of employment or supervision status.

Highmark Blue Shield recognizes services performed by these providers, duly licensed and acting within the authority of their licenses:

- Audiologists
- Certain certified registered nurses
- Clinical laboratories
- Dentists

- Doctors of chiropractic
- Doctors of medicine
- Doctors of osteopathy
- Nurse midwives
- Optometrists
- Physical therapists
- Podiatrists
- Psychologists
- Speech pathologists, and
- Teachers of the hearing impaired

In some instances, Highmark Blue Shield will pay for covered services performed under the personal supervision of an eligible provider by a licensed health care practitioner in his or her employment.

"Personal supervision" means that the provider must be in the immediate vicinity so he or she can personally assist in the procedure or take over the patient's care if necessary. Availability of the provider by telephone or radio contact does not constitute direct personal supervision.

Certain diagnostic tests have been identified that have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include holter monitoring (93224, 93230, 93235), cardiac event monitoring (93268, G0004), and sleep studies (95807-95811). These procedures are performed under the physician's overall management and control, but the physician is not present for the duration of the test.

Criteria for employment of a licensed health care practitioner

Highmark Blue Shield recognizes an employment relationship between a provider and a licensed health care practitioner – and therefore pays for covered services – only if all of the following criteria are met:

- The employer has the power to hire and fire.
- The employer has the power to direct the work done by the health care practitioner, and has ultimate responsibility for the manner of his or her performance.
- The employer pays wages and fringe benefits, and establishes the level of compensation.
- The employer is personally responsible for withholding federal income tax and social security contributions and is personally responsible for making contributions for the health care practitioner under the Pennsylvania Unemployment Compensation Act, and is personally responsible for insuring the health care practitioner's liability under the Pennsylvania Workers' Compensation Act.
- There is no compensation received by any hospital for the services of the health care practitioner during the period of employment under the employer.

Purchased services

Purchased services are defined by Highmark Blue Shield as services reported by one physician, but actually performed by another physician, independent contractor or entity, such as an independent physiological laboratory (IPL), or other business corporation. Highmark Blue Shield defines an "independent contractor" as a physician who performs a professional service for another physician, but who is neither an employee nor a partner of the "purchasing" physician.

These services, usually radiological or diagnostic medical procedures, involve the technical and professional components of diagnostic studies performed by different entities (two physicians or a physician and an independent contractor, an IPL or other business corporation).

You may report the total procedure when the technical component is purchased. However, it is not acceptable to report a purchased professional component, either independently or as part of the total service.

Here are some examples of various billing arrangements:

- 1. An acceptable arrangement: A physician purchases the technical component of a diagnostic service from another physician, IPL or other entity. He then interprets the results of the test and reports the total procedure.
- 2. An unacceptable arrangement: A physician purchases both the technical and professional components of a diagnostic service from another physician, IPL or other entity. The physician then reports the total service, but has not actually performed any professional service for the patient.
- **3. An unacceptable arrangement:** A physician owns specialized equipment and performs only the technical portion of the test. The physician purchases a professional interpretation from another specialist and then reports the total service. Since the reporting physician has not performed any professional service for the patient, this billing arrangement is unacceptable.

"Status of patient" vs. "place of service"

Highmark Blue Shield classifies services performed on one of its members as "inpatient" or "outpatient," based on the status of the patient – not on the place where the service was performed. When a member who is an inpatient in a hospital is taken outside of that hospital to receive services (for example, to a mobile MRI or CT unit or to a physician's office) and then is returned to the hospital without being discharged, these services are considered inpatient.