# PRN

## Policy Review & News

Important information about Pennsylvania Blue Shield
http://www.pablueshield.com

August 2002

## In This Issue



BC
**Look for this symbol for all BlueCard related information**

## News

### PremierBlue network renamed

Pennsylvania Blue Shield is renaming its PremierBlue preferred provider network. The network's new name is PremierBlue Shield.

The name change will not affect you in any way. You will see the new name, PremierBlue Shield, on all product information and related materials.

Blue Shield is changing the name of the network to align it with its fully-integrated health insurance products. The name change also satisfies standards of the Blue Cross and Blue Shield Association.

### Blue Shield to change high-cost technology payment policy

Pennsylvania Blue Shield is seeking approval from the Pennsylvania Insurance Department to replace its cost-based reimbursement with a standard fee schedule. Blue Shield will apply the new payment methodology to all freestanding providers of magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET) and radiation therapy services.

Blue Shield expects to implement the new fee schedule by fall 2002. The new fee schedule will impact only the technical component of MRI, CT, PET and radiation therapy procedures as part of the total component payment. Blue Shield anticipates a favorable impact on payments for these services.

PENNSYLVANIA BLUE SHIELD
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Blue Shield will send detailed information about this change to each provider it pays under the cost-based reimbursement policy.

In 1982, Blue Shield adopted a cost-based reimbursement policy for services involving technologically-advanced medical equipment costing $250,000 or more. Blue Shield has applied this cost-based payment method, which limits reimbursement for the technical portion of certain diagnostic procedures to the actual cost of providing the service, to MRI, CT, PET and radiation therapy. Blue Shield uses the cost-based methodology to calculate reimbursement levels for freestanding practices that bill the total component, both professional and technical. Cost-based reimbursement levels are provider specific—Blue Shield applies them to only UCR and PremierBlue Shield payments.

### Eastern Provider Relations office telephone number now toll free

Now you can call Pennsylvania Blue Shield's Eastern Provider Relations office for free.

The new telephone number for the Eastern Provider Relations office is (866) 362-6116.

## Policy

### Amplatzer device eligible for specific indications

Pennsylvania Blue Shield now pays for the implantation of the Amplatzer Septal Occluder device for closure of secundum atrial septal defects (ASD) for patients with:

- echocardiographic evidence of ostium secundum atrial septal defect, and
- clinical evidence of right ventricular volume overload, that is, 1.5:1 degree of left to right shunt or right ventricular enlargement.

Blue Shield will also pay for the implantation of an Amplatzer device for patients who have undergone a fenestrated fontan procedure who now require closure of the fenestration.

If the implantation of an Amplatzer device is reported for any other indication, Blue Shield will consider it not medically necessary. Blue Shield will deny the device as not covered. A participating, preferred or network health care professional cannot bill the member for the denied service.

Use procedure code 93799—unlisted cardiovascular service or procedure—to report the implantation of an Amplatzer device. Please include a complete description of the service when reporting code 93799.

### Biventricular pacemaker coverage outlined

Pennsylvania Blue Shield will pay for the insertion of a biventricular pacemaker as treatment for congestive heart failure in patients who meet all of these criteria:

- New York Heart Association Class III or IV,
- left ventricular ejection fraction < 35 percent,
- QRS duration of ≥ 150 milliseconds, and

- treatment with a stable pharmacological medical regimen prior to implant, including an ACE inhibitor or an angiotensin blocker, and a beta blocker or angiotensin receptor block, digoxin and diuretics.

If a biventricular pacemaker is inserted for other conditions, Blue Shield will deny it as not being medically necessary. It is not covered. A participating, preferred or network health care professional cannot bill the member for the denied service.

To report the implantation of a biventricular pacemaker, use code 93799—unlisted cardiovascular service or procedure. Remember to include a complete description of the service when reporting code 93799.

## CardioSeal eligible for ventricular septal defects

Pennsylvania Blue Shield now pays for the implantation of the CardioSeal Septal Occluder device for ventricular septal defects (VSD).

If the implantation of a CardioSeal device is reported for any other indication, Blue Shield will consider it not medically necessary. Therefore, the device is not covered. A participating, preferred or network health care professional cannot bill the member for the denied service.

Use procedure code 93799—unlisted cardiovascular service or procedure—to report the implantation of a CardioSeal device. Please include a complete description of the service you performed.

## Blue Shield to pay for growth hormone for Prader-Willi syndrome

Pennsylvania Blue Shield now pays for growth hormone for the treatment of Prader-Willi syndrome if it's a benefit of a member's contract.

Prader-Willi syndrome (759.81) is a genetic disorder characterized by a microdeletion in the long arm of chromosome 15. Clinically, the syndrome presents as a complex multisystem disorder characterized by excessive appetite, obesity, short stature, characteristic appearance, developmental disability and significant behavioral dysfunction. Test results for patients with Prader-Willi syndrome reveal growth hormone deficiency.

## Home-based, real-time cardiac surveillance monitoring now covered

Pennsylvania Blue Shield will pay for home-based, real-time cardiac surveillance monitoring for patients who have demonstrated a need for cardiac monitoring and who:

- require monitoring for known, non-life-threatening arrhythmias, such as atrial fibrillation, other supra-ventricular arrhythmias, evaluation of various bradyarrhythmias and intermittent bundle branch block,
- are recovering from coronary artery bypass graft surgery or valve replacement surgery who have had documented atrial arrhythmias,
- have symptomatic underlying structural disease,
- do not have structural heart disease but who have recurrent severe symptoms, that is, recurrent syncope, in whom all testing is negative and an implantable event recorder is contemplated, or

- have uncontrolled atrial fibrillation post-pneumonectomy.

Home-based, real-time cardiac surveillance monitoring is eligible for these conditions or diagnoses:

- atrioventricular block, complete (426.0)
- atrioventricular block, other and unspecified (426.10-426.13)
- left bundle branch hemiblock (426.2)
- other left bundle branch block (426.3)
- right bundle branch block (426.4)
- bundle branch block, other and unspecified (426.50-426.54)
- other heart block (426.6)
- anomalous atrioventricular excitation (426.7)
- other specified conduction disorders (426.81, 426.89)
- conduction disorder, unspecified (426.9)
- paroxysmal supraventricular tachycardia (427.0)
- atrial fibrillation (427.31)
- atrial flutter (427.32)
- supraventricular premature beats (427.61)
- sinoatrial node dysfunction (427.81)
- syncope and collapse (780.2)

Home-based, real-time cardiac surveillance monitoring is performed by means of an automatically activated device. The device does not require patient intervention to either capture or transmit an arrhythmia when it occurs. This device provides an analysis and report of 24 hours of monitoring, similar to Holter studies. Therefore, the simultaneous use of cardiac surveillance, Holter monitoring, and/or event monitoring would not be medically necessary.

To report home-based, real-time cardiac surveillance monitoring, use code 93799—unlisted cardiovascular service or procedure—with the description “ECG arrhythmia detection and alarm system.” You should also identify what component of the monitoring was performed, that is, technical, professional or total component.

## How to report intracoronary brachytherapy

Now you can report intracoronary brachytherapy treatment delivery services with one of these procedure codes:

77781—remote afterloading high intensity brachytherapy; 1-4 source positions or catheters

77782—remote afterloading high intensity brachytherapy; 5-8 source positions or catheters

77783—remote afterloading high intensity brachytherapy; 9-12 source positions or catheters

77784—remote afterloading high intensity brachytherapy; over 12 source positions or catheters

Use code 92974—transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy—to report the placement of the radiation delivery device for intracoronary brachytherapy.

Pennsylvania Blue Shield pays for intracoronary brachytherapy, using gamma or beta radioactive ribbons, to treat or manage in-stent restenosis in native coronary vessels. It must be performed with FDA-approved devices and radioactive materials.

Blue Shield considers intracoronary brachytherapy investigational in other applications when it is performed:

- as an adjunct to PTCA (with or without stenting) in the management of an initial lesion (de novo) to prevent restenosis,
- using any other radioactive source (for example, an alpha energy source such as helium ions), or
- using radioactive stents or catheter balloons filled with liquid radioactive material.

The long-term efficacy of intracoronary brachytherapy in the management of initial (de novo) lesions, with or without stent, or any other use has not been established.

## PET imaging of the breast coverage guidelines explained

Beginning Oct. 1, 2002, Pennsylvania Blue Shield will pay for positron emission tomography (PET) imaging of the breast when it's used as an adjunct to other imaging modalities. Blue Shield will pay for PET imaging of the breast when it's used to:

- stage patients with distant metastasis,
- restage patients with locoregional recurrence or metastasis, or
- monitor tumor response to treatment in patients with locally advanced and metastatic breast cancer when a change in therapy is contemplated.

The referring physician must document that one of the above conditions has been met. This documentation must be filed in the patient's records.

Blue Shield will not pay for PET breast imaging when it's used to diagnose breast cancer or stage axillary lymph nodes. In these instances, a participating, preferred or network health care professional cannot bill the member for the denied PET breast imaging service.

### How to report PET imaging of the breast

Report PET imaging of the breast with the appropriate procedure code:

G0252—PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes), not covered by Medicare

You should also report code G0252 to Blue Shield when you perform PET imaging of the breast for the initial diagnosis of breast cancer and/or surgical planning for breast cancer, for example, initial staging of lymph nodes. Blue Shield does not pay for PET imaging of the breast for this indication. A participating, preferred or network health care professional cannot bill the member for the denied service in this instance.

G0253—PET imaging for breast cancer, full and partial ring PET scanners only, detection of local regional recurrence or distant metastasis, i.e., staging/restaging after or prior to course of treatment

G0254—PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment

In all situations, you must report the appropriate HCPCS procedure code that accurately describes the procedure performed. If you report the wrong code, Blue Shield could deny your claim or pay it incorrectly.

## Dermatomal somatosensory evoked potential studies may be eligible for payment

Pennsylvania Blue Shield may pay for dermatomal somatosensory evoked potential (DSEP) studies if it determines they're medically necessary.

Use code 95999 to report DSEP studies. Remember to include a complete description of the service you performed.

A DSEP study is not the same as a conventional somatosensory evoked potential (SEP) study. An SEP study stimulates a peripheral nerve and measures response from a distance point. A DSEP study stimulates an area of skin that is supplied by a particular nerve root.

## Blue Shield deletes routine maintenance therapy code, W9700

Pennsylvania Blue Shield is deleting procedure code W9700—routine physical or manipulation therapy maintenance treatment—on Oct. 7, 2002. Do not use code W9700 to report services provided on or after Oct. 7, 2002.

Blue Shield does not pay for manipulation or physical therapy performed routinely or repetitively to maintain a level of function and to prevent regression. Blue Shield will deny claims for routine physical or manipulation therapy maintenance treatment as not covered.

Maintenance therapy begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

## HIPAA regulations eliminate local emergency YC and Y4 modifiers

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is standardizing how health care professionals report modifiers by eliminating local modifiers.

Effective Sept. 16, 2002, do not report these local modifiers for emergency services:

YC—emergency service, initial

Y4—emergency service, follow-up

### Use the ET modifier to identify emergency services

To report emergency services performed on or after Sept. 16, 2002, please use the national ET modifier—emergency services—along with an appropriate procedure code for the service performed.

When reporting the emergency ET modifier, include a diagnosis code that identifies the service as an emergency medical or emergency accident service. Pennsylvania Blue Shield needs this information to apply the member's benefits.

# 8/2002

## New code available for sodium hyaluronate

Code J7316—sodium hyaluronate, 5 mg for intra-articular injection—will be deleted on Oct. 1, 2002.

To report intra-articular injections of sodium hyaluronate administered on or after Oct. 1, 2002, use code Q3030—sodium hyaluronate, per 20 to 25 mg dose. When you report code Q3030, you do not need to report units in the number of services field.

# Codes

## 2002 PTM changes

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

| Page | Code | Terminology | Action |
|---|---|---|---|
| A-11 | WA | Cosmetic surgery | Delete. Effective 9/30/02. |
| A-11 | XI | FDA approved drug | Delete. Effective 9/30/02. |
| A-11 | XJ | Non-approved FDA drug | Delete. Effective 9/30/02. |
| A-11 | YC | Emergency service, initial | Delete. Effective 9/16/02. |
| A-11 | Y4 | Emergency service, follow-up | Delete. Effective 9/16/02. |
| A-11 | ZL | Genetic metabolic enteral formulae (ACT 191) | Delete. Effective 9/30/02. |
| 367 | W9700 | Routine physical or manipulation therapy maintenance treatment | Delete. Effective 10/7/02. |
| 368 | | Note: Do not use 97140 for joint mobilization/ manipulation. See codes S8901–S8910. For myofascial release/soft tissue mobilization, manual lymphatic drainage and manual traction, report 97140. | Delete note. Effective 10/7/02. |
| 368 | G0129 | Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day | Change terminology. |
| 369 | W9715 | Physical therapy, two or more modalities and/or more procedures; initial 30 minutes | Delete. Effective 10/7/02. |
| 369 | W9720 | Physical therapy, two or more modalities and/or more procedures; each additional 15 minutes of W9715 | Delete. Effective 10/7/02. |

| Page | Code | Terminology | Action |
|---|---|---|---|
| 370 | | Note: Do not use 98925–98929. See codes S8901–S8910. | Delete note. Effective 10/7/02. |
| 370 | | Note: Do not use 98940–98943. See codes S8901–S8910. | Delete note. Effective 10/7/02. |
| 371 | S8901 | Manipulation/mobilization of spinal region(s) with or without preparatory or post-service physical modalities and involving minimal assessment of patient status | Delete. Effective 10/7/02. |
| 371 | S8902 | Manipulation/mobilization of spinal region(s) with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status, and treatment which includes: manipulation/ mobilization of one or more region(s) of the spine; and straightforward decision making | Delete. Effective 10/7/02. |
| 371 | S8903 | Manipulation/mobilization of spinal region(s) with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status, and treatment which includes: manipulation/ mobilization of one or more region(s) of the spine; and decision making of low complexity | Delete. Effective 10/7/02. |
| 371 | S8904 | Manipulation/mobilization of spinal region(s) with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status, and treatment which includes: manipulation/ mobilization of one or more region(s) of the spine; and decision making of moderate complexity | Delete. Effective 10/7/02. |
| 371 | S8905 | Manipulation/mobilization of spinal region(s) with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status, and treatment which includes: manipulation/ mobilization of one or more region(s) of the spine; and decision making of high complexity | Delete. Effective 10/7/02. |
| 372 | S8906 | Manipulation/mobilization of body region(s), other than spine, with or without preparatory or post-service physical modalities and involving minimal assessment of patient status | Delete. Effective 10/7/02. |

| Page | Code | Terminology | Action |
|---|---|---|---|
| 372 | S8907 | Manipulation/mobilization of body region(s), other than spine, with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status and treatment which includes: manipulation/mobilization of one or more body region(s); and straightforward decision making | Delete. Effective 10/7/02. |
| 372 | S8908 | Manipulation/mobilization of body region(s), other than spine, with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status and treatment which includes: manipulation/mobilization of one or more body region(s); and decision making of low complexity | Delete. Effective 10/7/02. |
| 372 | S8909 | Manipulation/mobilization of body region(s), other than spine, with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status and treatment which includes: manipulation/mobilization of one or more body region(s); and decision making of moderate complexity | Delete. Effective 10/7/02. |
| 372 | S8910 | Manipulation/mobilization of body region(s), other than spine, with or without preparatory or post-service physical modalities and involving subjective and objective assessment of patient status and treatment which includes: manipulation/mobilization of one or more body region(s); and decision making of high complexity | Delete. Effective 10/7/02. |

## Rely on member's identification card for valid alphabetical prefix

Always check your patient's identification card to verify their alphabetical prefix. Alphabetical prefixes can change—what was correct for your patient during their last visit may now be different. If you report an incorrect alphabetical prefix, your claims and payments may be delayed.

Do not depend on alphabetical prefix listings you may have to file claims to the member's Blue Plan—alphabetical prefixes change as employer groups change.

Alphabetical prefixes are the three characters that precede the member's identification number on the Blue Plan identification card. The alphabetical prefix identifies the member's Blue Cross and Blue Shield Plan or national account. It is also critical for confirming membership and coverage.

Submit your claims to Pennsylvania Blue Shield and it will process the claim. If Pennsylvania Blue Shield cannot process your claim, it will forward it to the member's home plan.

## 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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### Policy



### Codes



### Patient News



### Acknowledgement



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