Blue Shield eliminates treatment plan requirements for most products

Beginning July 1, 2004, you do not need to submit treatment plans for outpatient manipulation, physical, speech or occupational therapies for most Highmark Blue Shield products.

Because treatment plans will be eliminated for services you provide on or after July 1, 2004, you do not need to request authorization for services that extend beyond June 30, 2004.

As of May 1, 2004, Blue Shield no longer includes a “last covered date” on approval letters.

As always, Blue Shield will apply a member’s benefits for outpatient therapy according to his or her group or individual contract. Please be sure to verify the member’s eligibility and benefits before you provide services. And remember, NaviNet is the fastest and most efficient tool for confirming eligibility and benefits.

Blue Shield continues to look for ways to simplify administrative processes for you and for its members. Watch for more information about the elimination of treatment plans in the June 2004 PRN.
Treatment plans for Medicare patients

For Medicare patients, treatment plans that are currently required to be sent to Medicare will continue to be required.

Important information about DirectBlue and SelectBlue

Highmark Blue Shield is making changes to better serve its DirectBlue and SelectBlue members—especially those traveling or vacationing, or those with dependents living outside of their region.

Soon, Central Region and Western Region DirectBlue and SelectBlue members will be able to receive, in both regions, care at the higher level of benefits for covered services. Central Region members are those whose health care coverage is underwritten by Highmark Blue Shield in the 21 counties of central Pennsylvania. Western Region members are those whose health care coverage is underwritten by Highmark in the 29 counties of western Pennsylvania. These changes begin for services performed on or after July 1, 2004.

Depending on your patient base and your geographic location, these changes may have minimal impact. However, for those providers on the border of the Western or Central Region, or those physicians likely to attract patients from the other region, the following details explain what you need to know.

In addition to the DirectBlue and SelectBlue network providers in the 21 counties of central Pennsylvania, Blue Shield will allow DirectBlue and SelectBlue Central Region members to receive care at the higher level of benefits for covered services when they access physicians, hospitals or other health care providers within the managed care network in the 29-county Western Region. In this instance, payment for eligible services will be made at the network level of benefits.

Western Region DirectBlue and SelectBlue members also eligible for the higher level of benefits when they access Central Region providers who participate in PremierBlue Shield

Beginning July 1, 2004, Western Region DirectBlue and SelectBlue members will be able to receive care at the higher level of benefits for covered services when they access physicians, hospitals or other health care providers within the PremierBlue Shield professional provider network and the Highmark Blue Shield facility network in the 21 counties of the Central Region. Payment for eligible services will be made at the network level of benefits.
How PremierBlue Shield network providers will be paid for services rendered to DirectBlue and SelectBlue members

PremierBlue Shield network providers in the 21 counties of central Pennsylvania and the Lehigh Valley will:

- continue to receive the network PremierBlue Shield allowance for eligible services they provide to Central Region DirectBlue and SelectBlue members.

- receive the network PremierBlue Shield allowance for Western Region DirectBlue or SelectBlue members who may require care while they’re within the 21 counties of the Central Region. This will begin on July 1, 2004.

If you are a PremierBlue Shield provider in the Blue Cross of Northeastern Pennsylvania region or Independence Blue Cross region, and you provide services to a Central Region DirectBlue or SelectBlue member on or after July 1, 2004, you will receive the PremierBlue Shield allowance. However, these claims will process at the member’s lower level of benefits.

Remember, DirectBlue and SelectBlue identification cards may reflect logos from either the Central or Western Region.

As always, please be sure to verify the member’s eligibility and benefits before you provide services.

You can determine any member’s liability by the information on the Explanation of Benefits you receive from Blue Shield.

These changes do not affect the BlueCard Program or the Federal Employee Program.

National provider identifier to be assigned to particular providers

Health care providers that are considered covered entities under HIPAA will be required to obtain a new provider identifier number beginning May 23, 2005. Covered entities include health care providers that conduct their administrative transactions in electronic form.

The new National Provider Identifier (NPI) is a number that will improve efficiency because it eliminates the need for multiple identifiers from different health plans.

The National Provider System (NPS) will assign the new NPIs. The NPS, a central electronic enumerating system operating under federal direction, will identify and enumerate health care providers at the national level.
The NPI is a 10-position numeric identifier. The NPI will not contain any imbedded intelligence about the health care provider such as facility provider type or specialty.

**When and how to apply for an NPI**

You must wait until May 23, 2005 to apply for your NPI. You have until May 23, 2007 to obtain an NPI. Providers will not be charged a fee to be assigned an NPI nor will they be charged to update their NPS data.

You must notify the NPS of any changes in your required NPS data within 30 calendar days of the changes.

For a complete listing of the NPS data elements, descriptions and usage, please visit the HIPAA pages of Highmark Blue Shield’s Web site [www.highmarkblueshield.com](http://www.highmarkblueshield.com).

The NPI application and update form will be available on the Centers for Medicare and Medicaid Services’ Web site [http://www.cms.hhs.gov](http://www.cms.hhs.gov). You can also find more information about health care provider enumeration on this site.

**Billing software must accommodate NPI**

Although the NPI compliance date is over three years away, please begin to plan for it now. Make sure your billing software can accommodate this new 10-digit identifier.

If you aren’t a HIPAA covered entity, you can still obtain an NPI. Having an NPI does not impose covered entity status on a health care provider.

The NPI was developed because of HIPAA regulations requiring the use of Standard Unique National Provider Identifiers in HIPAA standard transactions. The Department of Health and Human Services issued the final rule in the Jan. 23, 2004 *Federal Register*. You can find the final rule on the Centers for Medicare and Medicaid Services’ Web site at [www.cms.gov](http://www.cms.gov).

**Avoid claim denials: report required patient information**

Highmark Blue Shield needs complete and accurate patient information to process your claims.

Please be sure to obtain the patient’s correct information at each visit. This includes always checking your patient’s identification card to verify their alphabetical prefix and member identification number. Do not depend on alphabetical prefix listings you may have to file claims with the member’s Blue Plan, because alphabetical prefixes change as employer groups change.
Complete patient information includes:

- date of birth
- member identification number and alphabetical prefix*
- patient’s address

If you submit claims with incorrect or incomplete patient information, Blue Shield may delay or reject them.

*Do not report an alphabetical prefix for your patients who are members of the Federal Employee Program. Report the “R” from their member identification card along with the remaining digits, for example, R99999999.

New level of reimbursement available for certain Special Care members

In the past, when a Special Care member’s earnings exceeded the income level, Highmark Blue Shield offered them other coverage and terminated them from the Special Care program. Now, regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prevent Blue Shield from canceling Special Care members’ coverage if they go over the income guidelines. Because of this, Blue Shield has created a new level of membership for those Special Care members who no longer meet the income guidelines.

You can identify members enrolled in the new level of Special Care by looking for one of these group numbers on their identification card:

037910-50

037912-50

Blue Shield will not enroll new members into the second level of Special Care membership. Only members who currently participate in the Special Care Program can have their coverage under the new level.

For Special Care members with the new group numbers, Blue Shield will pay health care professionals’ services at UCR levels. The member’s premium will increase but the product benefits will remain the same.

The UCR level of reimbursement applies only to services performed on or after the effective date of the Special Care member’s coverage under the new, second-category group number. Blue Shield will pay claims for services performed before the member joined the new level of Special Care at Plan C allowance.

The Pennsylvania Blue Plans developed the Special Care program to provide affordable health care coverage to low income families and individuals who earn too much to qualify for Medical Assistance and who don’t have access to group health insurance.
To qualify for Special Care, the family’s annual income cannot exceed 185 percent of the federal poverty guidelines. Members must be Pennsylvania residents and cannot be enrolled in any other private or government health insurance plan.

**Blue Shield uses InterQual criteria to assess medical necessity and appropriateness**

Highmark Blue Shield now uses McKesson Health Solution’s InterQual® criteria in its processes for assessing the medical necessity and appropriateness of health care services. Blue Shield began to use InterQual’s criteria for medical necessity assessments made on or after March 1, 2004.

Blue Shield did use Milliman Care Guidelines™ for assessing the medical necessity and appropriateness of health care services. Blue Shield’s Utilization Management Committee approved the adoption of InterQual criteria to simplify the care management review process and to align Blue Shield’s criteria with the criteria set most familiar to providers.

Blue Shield will apply InterQual criteria to its assessment of acute adult, acute pediatric, acute rehabilitative, long-term acute, skilled nursing and home health services. These criteria will be applied in conjunction with applicable Highmark medical policy.

*InterQual is a registered trademark of McKesson Health Solutions LLC.*

*Milliman Care Guidelines is a trademark of Milliman USA.*

**BlueCard reminders**

Here are some general BlueCard reminders about how to submit claims and respond to requests for medical records.

**Remember to file claims locally**

Always submit claims for BlueCard members to Highmark Blue Shield.

Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three-character alphabetical prefix. Do not make up alphabetical prefixes. If the alphabetical prefix or member identification number is missing or is incorrect, your claim will be delayed.

Highmark Blue Shield will send you your payment and/or notification about the resolution of the claim.
Medical record requests from other Blue Plans

On occasion, Highmark Blue Shield may request medical records from its providers for other Blue Plan area members who received services while traveling or living in its region. Highmark Blue Shield will always send these requests to you. Please follow these guidelines when you receive a request for medical records:

• Please respond to requests for medical records as quickly as possible. The Blue Cross Blue Shield Association encourages a response time frame of 10 days or less. Your prompt attention to medical record requests helps to expedite the review process.

• When you send medical records, include the original letter of request from Blue Shield. Always return the medical records and the request letter to the exact name and address provided on the letter. Otherwise, the records may not reach the correct department.
**Blue Shield adjusts reimbursement for removal of multiple skin lesions**

Highmark Blue Shield has changed the way it reimburses you for the removal of more than five skin lesions during one session. Blue Shield will pay you 100 percent of the allowance for the removal of the first lesion, and 50 percent of the allowance for the removal of all subsequent lesions, providing this amount does not exceed the billed charge.

Before, Blue Shield reimbursed the removal of more than five subsequent lesions during one session at 10 percent of the allowance.

Blue Shield identifies the removal of lesions by the codes that are appropriate for the method of removal as well as the type and number of lesions, for example, 11400-11446 for excision of benign lesions, 11600-11646 for excision of malignant lesions, and 17000-17004 for chemosurgical, cryosurgical, or electrosurgical destruction of lesions, destruction by laser, or surgical curettelement.

**Elastomeric infusion pump coverage determined by patient’s benefits**

Highmark Blue Shield does not pay separately for the insertion or removal of a catheter used for local delivery of analgesia to operative sites for postoperative pain (17999—unlisted procedure, skin, mucous membrane, and subcutaneous tissue). Blue Shield includes the allowance for the catheter insertion or removal in the fee for the surgical procedure. A participating, preferred, or network provider cannot bill the member separately for the catheter insertion or removal.

The health care professional who inserts the catheter for the delivery of the analgesia may also provide an elastomeric infusion pump—and Blue Shield may pay them for the pump. An elastomeric infusion pump, for example, Pain Buster, is a supply most commonly reported as a facility expense. However, when a health care professional submits a claim for an elastomeric infusion pump, Blue Shield may provide coverage for the pump if the patient’s benefits allow it.

Use one of these codes, as appropriate, to report an elastomeric infusion pump:

- A4305—disposable drug delivery system, flow rate of 50 ml or greater per hour
- A4306—disposable drug delivery system, flow rate of 5 ml or less per hour
**Blue Shield pays for wheelchair power standing system for select conditions**

Highmark Blue Shield pays for power standing systems for wheelchairs for patients with:

- cerebral palsy (333.7, 343.0-343.9)
- spasticity (781.0)
- multiple sclerosis (340)
- parapareses (344.1, 344.9)

If any other conditions are reported for these systems, Blue Shield will give individual consideration to those claims.

Blue Shield also requires that these general criteria for wheelchair options and accessories must be met:

- the patient has a wheelchair that meets coverage criteria, and
- the patient’s condition is such that without the use of a wheelchair, he or she would otherwise be bed confined (an individual may qualify for a wheelchair and still be considered bed confined) or chair confined, and
- the options or accessories are necessary for the patient to:
  - function in the home, or
  - perform instrumental activities of daily living.

You must document the medical necessity for all options and accessories in the patient’s medical records. Those records must be available upon Blue Shield’s request.

Blue Shield does not cover an option or accessory that primarily allows the patient to perform leisure or recreational activities. A participating, preferred, or network provider can bill the member for the denied option or accessory.

Use code E2301 to report the power standing system.

Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.
More procedures eligible for co-surgery

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>20956</td>
<td>Bone graft with microvascular anastomosis; iliac crest</td>
</tr>
<tr>
<td>22532</td>
<td>Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic</td>
</tr>
<tr>
<td>22533</td>
<td>Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar</td>
</tr>
<tr>
<td>22534</td>
<td>Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment</td>
</tr>
<tr>
<td>22804</td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments</td>
</tr>
<tr>
<td>23180</td>
<td>Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle</td>
</tr>
<tr>
<td>34805</td>
<td>Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis</td>
</tr>
<tr>
<td>35697</td>
<td>Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery</td>
</tr>
<tr>
<td>44153</td>
<td>Colectomy, total, abdominal, without protectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy</td>
</tr>
<tr>
<td>Code</td>
<td>Terminology</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>58400</td>
<td>Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments</td>
</tr>
<tr>
<td>63300</td>
<td>Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical</td>
</tr>
<tr>
<td>63301</td>
<td>Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach</td>
</tr>
</tbody>
</table>

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

**Blue Shield covers abdominoplasty for certain patients**

Highmark Blue Shield considers abdominoplasty reconstructive surgery rather than cosmetic when:

- the panniculus hangs at or below the level of the pubis, and,
- the patient’s medical records document that the panniculus causes chronic intertrigo that consistently recurs or remains refractory to appropriate medical therapy, that is, treatment of the rash includes prescription medication over a period of three months.

Blue Shield will cover an abdominoplasty for patients meeting these criteria.

When you request preauthorization for an abdominoplasty, procedure code 15831, please include the preoperative photographs including one full-body photograph of the patient standing straight and one photograph of the abdominal fold lifted up to document any reported skin changes, for example, dermatitis.

**Coverage guidelines for reconstructive and cosmetic surgery**

Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness or congenital birth defect. Blue Shield usually pays for reconstructive surgery.

Typically, Blue Shield does not pay for cosmetic surgery because it’s performed solely to improve an individual’s appearance.
**Breast duct endoscopy considered investigational**

Highmark Blue Shield considers breast duct endoscopy investigational since its effectiveness has not been proven. It is not eligible for reimbursement. When Blue Shield denies breast duct endoscopy, a participating, preferred, or network health care provider can bill the member for the denied service.

Use unlisted procedure code 19499 to report breast duct endoscopy. When you report code 19499, please provide a complete description of the service in the narrative field of the electronic or paper claim.

**Home apnea monitor guidelines change**

Highmark Blue Shield now pays for the rental of a home cardiorespiratory monitor, for example, apnea, SIDS, for infants:

- who have experienced an apparent life-threatening event,
- with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise,
- with neurologic or metabolic disorders affecting respiratory control, or
- with chronic lung disease, that is, bronchopulmonary dysplasia, particularly those requiring supplemental oxygen, continuous positive airway pressure, or mechanical ventilation.

Use code E0618 or E0619 to report the home apnea monitor.

For more information about infant apnea monitors and related services, please see the October 1999 and June 2002 editions of PRN.

Blue Shield determines coverage for durable medical equipment according to the individual or group customer benefits.

**Blue Shield allows ESWL for treatment of gallbladder stones for certain patients**

Highmark Blue Shield now pays for extracorporeal shock wave lithotripsy (ESWL) to treat gallbladder stones when it’s provided in conjunction with ursodiol therapy.
Blue Shield will cover ESWL when it’s used to treat gallbladder stones only for patients:

- with symptomatic non-calcified single gallstones measuring 20 mm or less who are not candidates for either open or laparoscopic cholecystectomy because of comorbidities, or

- who refuse surgery.

Use code S9034 to report ESWL for the treatment of gallbladder stones.

**Blue Shield considers fluency-enhancing devices investigational**

Highmark Blue Shield considers fluency-enhancing devices used in the treatment of stuttering, for example, SpeechEasy, Fluency Master, investigational. There is a lack of long-term studies demonstrating the effectiveness of these devices. A participating, preferred, or network provider can bill the member for the denied device.

Use code E1399 to report a fluency-enhancing device used in the treatment of stuttering. When you report code E1399, please include a complete description of the item in the narrative section of the electronic or paper claim.

Blue Shield determines coverage for durable medical equipment according to the individual or group customer benefits.

**How to report endovenous radiofrequency obliteration of the greater saphenous vein**

Report endovenous radiofrequency obliteration of the greater saphenous vein with code S2130—endoluminal radiofrequency ablation of refluxing saphenous vein.

Do not report catheter placement, for example, 36010, 36011, as a separate service. If you report catheter placement separately, Highmark Blue Shield will deny it as being not covered. A participating, preferred, or network provider cannot bill the member for the denied service.

Blue Shield will pay for intraoperative ultrasonic guidance in addition to endovenous radiofrequency obliteration of the greater saphenous vein. Report intraoperative ultrasonic guidance with code 76986.
Coverage criteria for obstetrical ultrasound in the first trimester explained

Highmark Blue Shield provides coverage for obstetrical ultrasound studies when they're performed in the first trimester for these diagnoses or conditions:

- ectopic pregnancy (633.00-633.11, 633.20-633.21, 633.80-633.81, 633.90-633.91)
- molar pregnancy/hydatidiform mole (630-631)
- hemorrhage in early pregnancy (640.01-640.03, 640.81-640.83, 640.91-640.93)
- missed abortion (632)
- hyperemesis gravidarum with metabolic disturbance, antepartum (643.11-643.13)
- habitual aborter (646.31-646.33)
- other antepartum hemorrhage (antepartum or intrapartum, associated with trauma, uterine leiomyoma) (641.81-641.83)
- abnormal findings on previous ultrasound (796.5)
- absence of fetal heart tones (659.73)
- adnexal mass (654.43)
- advanced maternal age (659.53, 659.63)
- carcinoma of cervix uteri (233.1)
- early pregnancy with pain (646.80, 646.83)
- fever (780.6)
- hemoperitoneum (568.81)
- history of greater than 1 loss in first trimester (V23.49)
- history of previous cesarean section (654.20, 654.23)
• history of uterine abnormality (654.03, 752.3)
• incompetent cervix (654.50, 654.53)
• leukocytosis (288.8)
• pain, unilateral or generalized (789.00, 789.03, 789.09)
• pregnancy with hypertension (642.93)
• size less than due date (656.53)
• size greater than due date (656.63)
• spotting early in pregnancy (641.93)
• syncope (hypovolemic) (780.2)
• tenderness without rebound (789.67)
• twin pregnancy (651.03)
• triplet pregnancy (651.13)
• twin pregnancy with one fetal loss (651.33)
• triplet pregnancy with one or two fetal loss (651.43)
• tumors of body of uterus (654.13)
• other known or suspected fetal abnormality, not elsewhere classified (655.83)

Blue Shield considers the first trimester to be less than 14 weeks gestation.

Blue Shield applies these same criteria for first trimester obstetrical ultrasound procedures whether they are performed using the transabdominal or the transvaginal approach.

Use code 76801 or 76802 to report an obstetrical ultrasound study in the first trimester using the transabdominal approach. Report code 76817 when using the transvaginal approach.
CT colonography considered experimental

Highmark Blue Shield considers CT colonography, also referred to as virtual colonoscopy, an experimental or investigational procedure. When it is reported, Blue Shield will deny it. A participating, preferred or network health care professional can bill the member for the denied service.

CT colonography has not been evaluated in average- and high-risk patient colon cancer screening to determine if it can effectively reduce morbidity or mortality from colorectal cancer. Further studies are also needed to compare CT colonography with results obtained using current modalities such as conventional colonoscopy or sigmoidoscopy.

Reminder: when to report an annual gynecological exam and medical exam on the same day

You can report an annual gynecological exam and an evaluation and management (E/M) visit on the same day if you find a medical condition or abnormality during the gynecological exam. Your treatment of the medical condition or abnormality may result in additional work requiring the key components associated with an E/M service. In this case, please report the appropriate E/M code (99201-99215, 99381-99397) in addition to the annual gynecological exam code (G0101, S0610 or S0612). You must include documentation in the patient’s records that the key components of the E/M service have been met.

Do not report an E/M visit in addition to the annual gynecological exam if you find an insignificant problem during the gynecological exam that does not require additional work, and the components of an E/M service are not met.

An annual gynecological exam may include, but is not limited to, patient history, blood pressure and weight check, physical exam of the pelvis, rectum, thyroid, breasts, axillae, abdomen, lymph nodes, heart and lungs.

Computer assisted surgery not covered

Highmark Blue Shield considers computer assisted surgery for orthopedic applications investigational. Therefore, it is not covered.

Use these codes, as appropriate, to report computer assisted surgery:
0054T—computer assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)

0055T—computer assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT and MRI images (List separately in addition to code for primary procedure)

0056T—computer assisted musculoskeletal surgical navigational orthopedic procedure, image-less (List separately in addition to code for primary procedure)

Questions or comments on these new medical policies?

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

Write to us at medicalpolicy@highmark.com.

Codes

New modifiers and codes available April 1

These new modifiers and procedure codes became available April 1, 2004. Use them, as appropriate, to report these services on your claims.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Terminology</th>
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</thead>
<tbody>
<tr>
<td>KD</td>
<td>Drug or biological infused through DME</td>
</tr>
<tr>
<td>KF</td>
<td>Item designated by FDA as Class III device</td>
</tr>
<tr>
<td>SW</td>
<td>Service provided by a certified diabetic educator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4644</td>
<td>Supply of low osmolar contrast material (100-199 mgs of iodine)</td>
</tr>
<tr>
<td>A4645</td>
<td>Supply of low osmolar contrast material (200-299 mgs of iodine)</td>
</tr>
<tr>
<td>A4646</td>
<td>Supply of low osmolar contrast material (300-399 mgs of iodine)</td>
</tr>
<tr>
<td>Code</td>
<td>Terminology</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>K0627</td>
<td>Traction equipment, cervical, free-standing, pneumatic, applying traction force to other than mandible</td>
</tr>
<tr>
<td>K0628</td>
<td>For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient’s foot, including arch, base layer minimum of 1/4 inch material of Shore A 35 durometer or 3/16 inch material of Shore A 40 (or higher), prefabricated, each</td>
</tr>
<tr>
<td>K0629</td>
<td>For diabetics only, multiple density insert, custom molded from model of patient’s foot, total contact with patient’s foot, including arch, base layer minimum of 3/16 inch material of Shore A 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each</td>
</tr>
<tr>
<td>K0630</td>
<td>Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0631</td>
<td>Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>K0632</td>
<td>Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting adjustment</td>
</tr>
<tr>
<td>K0633</td>
<td>Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>K0634</td>
<td>Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0635</td>
<td>Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>Code</td>
<td>Terminology</td>
</tr>
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</tr>
<tr>
<td>K0636</td>
<td>Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0637</td>
<td>Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0638</td>
<td>Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>K0639</td>
<td>Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0640</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0641</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>K0642</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>Code</td>
<td>Terminology</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>K0643</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>K0644</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0645</td>
<td>Lumbar sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>K0646</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0647</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>Code</td>
<td>Terminology</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>K0648</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacroccocygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>K0649</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacroccocygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated</td>
</tr>
<tr>
<td>S0158</td>
<td>Injection, laronidase, 0.58 mg</td>
</tr>
<tr>
<td>S0159</td>
<td>Injection, agalsidase beta, 35 mg</td>
</tr>
<tr>
<td>S0160</td>
<td>Dextroamphetamine sulfate, 5 mg</td>
</tr>
<tr>
<td>S0161</td>
<td>Calcitrol, 0.25 mcg</td>
</tr>
<tr>
<td>S0162</td>
<td>Injection, efalizumab, 125 mg</td>
</tr>
<tr>
<td>S0163</td>
<td>Injection, risperidone, long acting, 12.5 mg</td>
</tr>
<tr>
<td>S0164</td>
<td>Injection, pantoprazole sodium, 40 mg</td>
</tr>
<tr>
<td>S0165</td>
<td>Injection, abarelix, 100 mg</td>
</tr>
<tr>
<td>S0194</td>
<td>Dialysis/stress vitamin supplement, oral, 100 capsules</td>
</tr>
<tr>
<td>S0618</td>
<td>Audiometry for hearing aid evaluation to determine the level and degree of hearing loss</td>
</tr>
<tr>
<td>S2082</td>
<td>Laparoscopy, surgical; gastric restrictive procedure, adjustable gastric band (includes placement of subcutaneous port)</td>
</tr>
<tr>
<td>S2083</td>
<td>Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline</td>
</tr>
<tr>
<td>Code</td>
<td>Terminology</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>S2131</td>
<td>Endovascular laser ablation of long or short saphenous vein, with or without proximal ligation or division</td>
</tr>
<tr>
<td>S2255</td>
<td>Hysteroscopy, surgical; with occlusion of oviducts bilaterally by micro-inserts for permanent sterilization</td>
</tr>
<tr>
<td>S3890</td>
<td>DNA analysis, fecal, for colorectal cancer screening</td>
</tr>
<tr>
<td>S9976</td>
<td>Lodging, per diem, not otherwise specified</td>
</tr>
<tr>
<td>S9977</td>
<td>Meals, per diem, not otherwise specified</td>
</tr>
<tr>
<td>S9988</td>
<td>Services provided as part of a phase I clinical trial</td>
</tr>
</tbody>
</table>

**Central and Eastern Region**

**SUPERVALU moves from BlueCard POS to BlueCard PPO**

The SUPERVALU group moved to a BlueCard Preferred Provider Organization (PPO) processing arrangement on March 1, 2004. Before March 1, the SUPERVALU group had a BlueCard Point of Service (POS) processing arrangement.

The new alphabetical prefix for SUPERVALU members is SVH. You should report the SVH alphabetical prefix on claims for services you performed on or after March 1, 2004 for SUPERVALU members. Report the SVI alphabetical prefix on claims for services you performed before March 1, 2004 for SUPERVALU BlueCard POS members.
Need to change your provider information?

Fax the information to us!
You can fax us changes about your practice information, such as the information listed on the coupon below. The fax number is (866) 731-2896. You may also continue to send information by completing the coupon below.

Coupon for changes to provider information
Please clip and mail this coupon, leaving the PRN mailing label attached to the reverse side, to:

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

Name ___________________________ Provider ID number ___________________________

Electronic media claims source number ___________________________

Please make the following changes to my provider records:

Practice name ________________________________________________________________

Practice address _____________________________________________________________

Mailing address _____________________________________________________________

Telephone number (  ) _______________________ Fax number (  ) _________________________

E-mail address ________________________________________________________________

Tax ID number ______________________________________________________________

Specialty ________________________________________________________________

Provider’s signature ________________________ Date signed ____________________________
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Acknowledgement

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