

# PRN

## Policy Review & News

Important information about Highmark Blue Shield  
[www.highmarkblueshield.com](http://www.highmarkblueshield.com)

December 2004

### In This Issue

<b>Blue Shield announces new policy for concierge-style practices</b> .....	<b>1</b>
<b>Reminder: file claims within 365 days of last date of service</b> .....	<b>.4</b>
<b>Blue Shield seeks approval for UCR and PremierBlue Shield reimbursement changes</b> .....	<b>.5</b>



### News

#### Blue Shield announces new policy for concierge-style practices

Concierge physician practices purport to offer patients special services that are not covered under the patients' health plan benefits, in exchange for a one-time or periodic flat fee to be paid by the patient to the health care professional.

In light of Highmark Blue Shield's mission statement and commitment to providing affordable access to health care to all members of the community, Blue Shield does not believe that these types of practices are compatible with its network participation requirements.

Blue Shield believes that the delivery of health care services should be, among other things, equitable. This belief is consistent with one of the six aims of health care put forth by the Institute of Medicine (IOM) for improvement in health care delivery—that health care should be equitable. The IOM has also adopted some guiding principles regarding health insurance, which include the principle that health insurance should promote access to health care that is equitable, as well as effective, efficient, safe, timely and patient-centered. Blue Shield further maintains that services most providers typically list as "special services" in a concierge setting are often services that should be provided to members under the terms of Blue Shield's provider agreements.



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# PRN

Finally, the HHS Office of Inspector General and the Centers for Medicare and Medicaid Services have recently communicated their concerns about the concept of charging Medicare beneficiaries additional fees for services that are already covered by Medicare.

If you are planning to convert to a concierge-style practice, you should notify Blue Shield as soon as possible or at least 90 days before the planned conversion date. You may voluntarily resign from the applicable networks or Blue Shield will initiate termination (without cause) of impacted provider contracts through notification to you. When appropriate, Blue Shield will also notify members that the health care professional is no longer participating in the network(s).

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## **Avoid denials, report diagnosis codes to highest degree of specificity on all claims**

Highmark Blue Shield now requires all providers to report diagnosis codes to the highest degree of specificity. If you do not report diagnosis codes according to the most current ICD-9-CM coding manual, Blue Shield will deny your claim. This applies to electronic and paper claims. It also pertains to all Blue Shield products.

### **Excluded providers must report diagnosis codes to highest degree of specificity**

The April 2002 PRN informed you of certain providers who were not required to report diagnosis codes to the highest level of specificity. Now those providers must begin to report diagnosis codes to the highest degree of specificity for claims Blue Shield receives on or after Jan. 14, 2005.

Here are the previously excluded providers who now must report diagnosis codes to the highest degree of specificity:

- skilled nursing facilities
- home health agencies
- independent laboratories
- independent physiological laboratories
- general dentists
- orthodontists, endodontists, pedodontists
- pharmacies
- durable medical equipment suppliers
- ambulance services
- orthotic and prosthetic suppliers
- home infusion providers

# 12/2004

## **How to report ICD-9-CM diagnosis codes**

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Report ICD-9-CM diagnosis codes to the fourth or fifth digit, when applicable. For example, when you submit a claim with a diagnosis of reflux esophagitis, you must report code 530.11. Do not report code 530 (diseases of the esophagus) or 530.1 (esophagitis)—they are not acceptable.

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## **Attention Participating and PremierBlue Shield ophthalmologists and optometrists: helpful BlueCard vision claims submission tips**



Highmark Blue Shield processes claims for vision services provided to members of out-of-area Blue Plans through the BlueCard program. Please keep the following in mind regarding these claims.

- In Pennsylvania, Highmark Blue Shield's Participating and PremierBlue Shield ophthalmologists and optometrists support the BlueCard program. This means that only Participating and PremierBlue Shield health care professionals will receive direct reimbursement from Highmark Blue Shield when they provide vision services for out-of-area BlueCard members.
- These claims process as medical claims supported by your Highmark Blue Shield contract, not as vision claims supported by your Clarity Vision contract.
- Please do not use Clarity Vision's Web site to submit these claims. They will reject. Instead, follow the claim submission instructions noted below.

## **How to submit claims for vision services for BlueCard members**

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When a BlueCard member visits your office for vision services, follow these easy claims filing tips:

- Call BlueCard Eligibility at (800) 676-BLUE (2583) to verify the member's benefits and eligibility. You'll be asked for the first three characters (alphabetical prefix) of the member's identification number. After you provide the alphabetical prefix, your call will be transferred to the member's Home Plan. The Home Plan will answer your questions about the member's benefit and coverage information.
- After you treat the member, report your services on a 1500A or CMS 1500 medical/surgical claim form and send it to:

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

- Do not use a vision claim form, No. 15, to submit vision services for BlueCard members.

# PRN

- Do not request complete payment up front. You may bill the member for services that are not covered and any applicable copayments and deductibles.
- Call (866) 731-8080 to check the status of your BlueCard vision claims.

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## **Reminder: file claims within 365 days of last date of service**

As part of its commitment to its providers, Highmark Blue Shield strives to process claims as accurately and quickly as possible.

This process includes timely claim submission. To ensure that claims are processed accurately and promptly, Blue Shield must receive all claims within 365 days of the last date of service.

Blue Shield has always enforced its “timely filing” policy and continues to do so. Blue Shield’s timely filing policy indicates the period between the claim’s last date of service or the payment or denial by the primary payer, and the date by which Blue Shield must receive the claim.

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## **Attention PremierBlue Shield providers outside of the Western and Central Regions: information about DirectBlue and SelectBlue members clarified**

In the April 2004 **PRN**, Highmark Blue Shield announced that changes were being made to better serve its DirectBlue and SelectBlue members—especially those traveling or vacationing, or those with dependents living outside of their region.

Blue Shield explained that Central Region and Western Region DirectBlue and SelectBlue members would be able to receive, in both regions, care at the higher level of benefits for covered services, effective with dates of service on or after July 1, 2004. (Central Region members are those whose coverage is underwritten in the 21 counties of central Pennsylvania and the Lehigh Valley. Western Region members are those whose coverage is underwritten in the 29 counties of western Pennsylvania.)

The article also included information specific to PremierBlue Shield providers outside of the Central and Western Regions. (This includes those providers in the Blue Cross of Northeastern Pennsylvania region or Independence Blue Cross region.) To clarify, if you provide services to a Central Region DirectBlue or SelectBlue member on or after July 1, 2004, the claim will be reimbursed at the PremierBlue Shield allowance and will process at the member’s lower level of benefits. And, because you are now considered to be “out of network” for these members, the reimbursement will be issued directly to the member, who is then responsible for payment to you.

## Policy

### **Blue Shield seeks approval for UCR and PremierBlue Shield reimbursement changes**

Highmark Blue Shield is filing a broad range of UCR Level II and PremierBlue Shield reimbursement adjustments with the Pennsylvania Insurance Department (PID). If the PID approves, Blue Shield will increase its anesthesia conversion factor and will adjust payments for select delivery services and surgical services, including but not limited to:

- integumentary
- musculoskeletal
- digestive
- urinary
- nervous system

Blue Shield is also asking for increases to payments for evaluation and management services.

If the PID approves the changes, Blue Shield expects to implement these reimbursement changes in early 2005.

### **Blue Shield adds coverage for PET imaging for Alzheimer's disease**

As of Sept. 15, 2004, Highmark Blue Shield will pay for one PET scan of the brain per lifetime for patients who meet Blue Shield's diagnostic criteria for Alzheimer's disease (AD) (331.0) and frontotemporal dementia (FTD) (331.11-331.19) when the cause of the clinical symptoms is uncertain.

Published scientific evidence has not established that PET studies of the brain are medically indicated for diagnosing patients with mild cognitive impairment, early dementia (in clinical circumstances other than those specified), or other neurodegenerative diseases or conditions.

Blue Shield will deny PET imaging of the brain for other non-malignant neurodegenerative diseases or dementias as not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied scan.

# PRN

Blue Shield will pay for one PET study of the brain per lifetime when these criteria are met:

- The onset, clinical presentation, or course of cognitive impairment is atypical for AD, and FTD is suspected as an alternative neurodegenerative cause of the cognitive decline.
- The patient has had a comprehensive clinical evaluation as defined by the American Academy of Neurology. It must include a medical history from the patient and a well-acquainted associate, an assessment of activities of daily living, physical and mental status examinations (including formal documentation of cognitive decline occurring over at least six months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging or computed tomography.
- A health care professional experienced in the diagnosis and assessment of dementia should have conducted the comprehensive clinical evaluation.
- The evaluation did not identify a specific neurodegenerative disease or cause for the clinical symptoms, and information acquired through the PET study is reasonably expected to clarify the diagnosis and/or guide future treatment.
- The PET scan is performed in a facility accredited to operate such equipment. An expert in nuclear medicine, radiology, neurology, or psychiatry who has experience interpreting such scans in the presence of dementia interprets the PET scan.
- A brain single photon emission computed tomography (SPECT) or PET scan has not been performed for the same indication.

You must document the following information in the patient's clinical records. These records must be available for Blue Shield's review upon request. Do not send or attach this documentation with your original claim submission.

- the date the symptoms began,
- a diagnosis of clinical syndrome (normal aging, mild cognitive impairment, moderate or severe dementia),
- a mini mental status exam (MMSE) or similar test score,
- a presumptive cause (possible, probable, uncertain AD),
- any neuropsychological testing performed,

# 12/2004

- the results of structural MRI or CT imaging,
- the relevant laboratory tests (B12, thyroid hormone),
- the number and name of prescribed medications.

Please report code G0336—PET imaging, brain imaging for differential diagnosis of Alzheimer’s disease with aberrant features vs. frontotemporal dementia—for this service.

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## **Blue Shield seeks approval to revise allowances for injectable drugs and biologicals**

Highmark Blue Shield is planning to decrease allowances for certain injectable drugs and biologicals in early 2005, if the Pennsylvania Insurance Department approves.

Blue Shield also expects to increase the allowances for related chemotherapy and therapeutic administration codes.

Blue Shield will also revise its process of updating all injectable drug and biological allowances to once a month instead of quarterly. This will increase timeliness and responsiveness to marketplace changes. Blue Shield revises these fees according to changes in the average wholesale price (AWP) and the median rate of generic and brand equivalents.

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## **Closures after surgery considered part of global surgery allowance**

Highmark Blue Shield does not pay separately for closures after surgery. Blue Shield considers closures after surgery to be part of the global surgery allowance.

### **Guidelines for repairs after the excision of skin lesions**

Blue Shield will include payment for simple closures of the wound after the excision of skin lesions in the global surgery allowance. If more complex repairs are needed after the removal of skin lesions, Blue Shield will pay separately for those repairs.

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## **Boston Scleral Lens eligible for specific conditions**

Highmark Blue Shield pays for the Boston Scleral Lens (BSL) when the patient has severe ocular surface disease resulting in ocular pain and photophobia, and attempted treatments failed.

Blue Shield considers severe ocular surface disease to include these conditions:

- corneal stem cell deficiencies resulting from Stevens-Johnson syndrome (695.1) and toxic epidermal necrolysis (TEN) (695.1), chemical injuries (940.2, 940.3, 940.4) and thermal injuries, ocular pemphigoid (694.61), or aniridia (743.45)
- keratitis sicca (710.2) due to disorders of the lacrimal gland (for example, Sjogren's syndrome, graft vs. host disease, irradiation, surgery) and meibomian gland deficiency
- neurotrophic corneas resulting from herpes simplex or zoster keratitis, congenital corneal anesthesia (dysautonomia), diabetes, acoustic neuroma surgery, trigeminal ganglionectomy, or trigeminal rhizotomy
- persistent non-infectious corneal ulcers and epithelial defects associated with stem cell deficient and neurotrophic corneas

When the BSL is used only for the correction of refractive errors, Blue Shield will not cover it under the member's medical-surgical benefits. A participating, preferred, or network provider can bill the member for the denied BSL.

Use code S0515—scleral lens, liquid bandage device, per lens—to report the BSL.

The BSL is a specially designed fluid-ventilated gas-permeable contact lens that is intended to benefit patients by: 1) masking abnormal corneal astigmatism when traditional rigid gas-permeable corneal contact lenses fail or are contraindicated, and 2) managing severe ocular surface disease.

At this time, the BSL is available only at the Boston Foundation for Sight. New patients are not accepted without a written referral. Sufficient clinical information must also be available to allow the Foundation to evaluate the potential of the lens to offer the patient a significant benefit.

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



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## **CT angiography for the evaluation of coronary arteries is investigational**

Highmark Blue Shield considers computed tomographic angiography (CTA) for the evaluation of coronary arteries experimental or investigational. Blue Shield will deny this service because it is not eligible for reimbursement. A participating, preferred, or network provider can bill the member for services denied as experimental or investigational.

Information and data obtained through clinical trials and research studies are needed to:

- assess the effectiveness of CTA as a noninvasive alternative method for evaluating conditions of the coronary arteries including, but not limited to, obstructive coronary artery disease, coronary artery bypass graft patency, coronary artery aneurysm, and congenital coronary artery anomalies,
- document the clinical effectiveness of this technology and correlate the results obtained using CTA vs. conventional angiography and other noninvasive alternatives, and
- evaluate the impact on long-term patient outcomes when used in an acute clinical setting, for example, in the emergency room, or to diagnose and treat high-risk patients and patients on cholesterol lowering therapies.

Report code S8093—computed tomographic angiography (CTA), coronary arteries, with contrast material(s)—when you submit claims for this procedure.

CTA, a noninvasive imaging study, uses intravenously administered contrast material and high-resolution, rapid imaging CT equipment to obtain detailed volumetric images of blood vessels.

Advanced rapid imaging technologies, such as electron beam CT (EBCT) and helical CT scanning, also referred to as spiral CT scanning, are used to perform CTA of the coronary arteries. This new generation of CT scanners is capable of producing images at greater speed than conventional CT technology by acquiring the very thin sections necessary to provide the spatial resolution for high quality 3-D reconstruction.

Other examples of advances in CT technology include multi-detector row helical CT scanners (MDCT) and multi-slice CT (MSCT). These scanners are equipped with an array of multiple X-ray detectors that simultaneously image multiple sections of a patient's anatomy during rapid volumetric image acquisition. These scanners can also be used to perform CTA of the coronary arteries.

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## **Blue Shield pays for interferential stimulators used in the home**

Highmark Blue Shield pays for interferential stimulators used in the home when prescribed by a health care professional for:

- symptomatic relief and management of chronic pain,
- edema reduction, or
- improvement in range of motion.

Blue Shield will deny the stimulator as not medically necessary if it's prescribed for any other conditions. A participating, preferred, or network provider cannot bill the member for the denied stimulator.

Use code E1399 to report an interferential stimulator for home use. When you report code E1399, please include the term “interferential stimulator” in the narrative section of the electronic or paper claim.

Coverage for interferential stimulation or for an interferential stimulator is subject to any applicable physical therapy and/or durable medical equipment limitation in the member's benefit contract.

If you perform interferential therapy in a clinical setting, please use code 97014—application of a modality to one or more areas; electrical stimulation (unattended)—to report it.

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## **Coverage for magnetic resonance cholangiopancreatography explained**

Highmark Blue Shield considers magnetic resonance cholangiopancreatography (MRCP) medically necessary for the diagnostic evaluation of the pancreatobiliary system. One of these conditions must be met:

- There is a low likelihood that the patient will need a therapeutic intervention or tissue sampling with endoscopic retrograde cholangiopancreatography (ERCP) or percutaneous transhepatic cholangiography (PTC).
- ERCP has been technically unsuccessful.
- ERCP is considered unsafe or very unlikely to be successful. Examples include but are not limited to, pediatric patients, or when there are major medical comorbidities, or complex pancreatobiliary anatomy such as post biliary-enteric bypass.

Blue Shield will deny MRCP for other conditions as not medically necessary. In this instance, a participating, preferred, or network provider cannot bill the member for the denied service.

# 12/2004

Use procedure code S8037—magnetic resonance cholangiopancreatography (MRCP)—to report this service.

MRCP, a noninvasive method, images the biliary and pancreatic ducts using magnetic resonance imaging. It can be performed as an alternative to more invasive imaging procedures, such as ERCP, PTC, or intravenous cholangiography. For example, MRCP is able to visualize the ducts beyond an obstructing lesion whereas this may be difficult with ERCP or PTC. MRCP can be performed on commercially available magnetic resonance imaging machines using FDA-approved software products as appropriate.

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## **Blue Shield adds new information about off-labeled use for anti-cancer drugs to policy**

Highmark Blue Shield is updating its chemotherapy guidelines to explain coverage for the use of off-labeled drugs in an anti-cancer chemotherapeutic regimen.

A cancer treatment regimen includes drugs used to treat toxicities or side effects of the cancer treatment regimen when the drug is administered incident to a chemotherapy treatment.

For Blue Shield to consider off-labeled use for anti-cancer drugs, the patient must have failed all approved first line therapies, or their condition prohibits their use and no other therapeutic options are available.

An off-labeled use of a drug is one that is not included as an indication on the drug's label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered if Blue Shield determines the use to be medically acceptable. Blue Shield considers the major drug compendia, authoritative medical literature and/or accepted standards of the medical practice.

Blue Shield will evaluate off-labeled uses of FDA approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen for a medically accepted indication according to the following conditions.

An off-label usage of an FDA approved drug will be considered for coverage when there are no specific contraindications and one of these criteria is met:

- Its usage is supported by one or more citations in at least one of these drug compendia, and the usage is not listed as “not indicated” in any of the compendia:
  - **American Hospital Formulary Service Drug Information**
  - **American Medical Association Drug Evaluations**
  - **United States Pharmacopoeia Drug Information (USPDI)**

# PRN

- The use is supported by clinical research that appears in peer-reviewed medical literature. This applies only when an off-labeled use does not appear in any of the compendia or is listed as insufficient data or investigational. Peer-reviewed medical literature includes scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This does not include in-house publications of pharmaceutical manufacturing companies or abstracts, including meeting abstracts.

Blue Shield will base its coverage determination on the results of peer-reviewed medical literature published in:

- **American Journal of Medicine**
- **Annals of Internal Medicine**
- **The Journal of the American Medical Association**
- **Journal of Clinical Oncology**
- **Blood**
- **Journal of the National Cancer Institute**
- **The New England Journal of Medicine**
- **British Journal of Cancer**
- **British Journal of Hematology**
- **British Medical Journal**
- **Cancer**
- **Drugs**
- **European Journal of Cancer**
- **Lancet**
- **Leukemia**
- **Journal of Pediatric Hematology/Oncology**

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

# 12/2004

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## **Instant vertebral assessment considered experimental**

Highmark Blue Shield considers instant vertebral assessment (IVA) an experimental or investigational procedure for all indications. Blue Shield will deny claims for IVA. A participating, preferred, or network provider can bill the member for a service denied as investigational.

Recent studies have focused on IVA as part of an osteoporosis risk assessment program. However, published information has not established the clinical impact of IVA on diagnosing vertebral fracture or risk of fracture, therapeutic treatment management, and long-term patient outcomes. Further research is needed to establish standardized indications for performing this study, interpreting the results, and proving its clinical use among various patient populations.

Beginning Jan. 1, 2005, you can report IVA with code 76077—dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment.

IVA is an imaging technique used to identify vertebral deformities in patients at risk for osteoporosis or osteoporotic fractures. It is also called morphometric X-ray absorptiometry (MXA) or lateral vertebral assessment (LVA). It is typically performed in conjunction with a DXA scan using the same equipment with specialized software. IVA provides a rapid assessment, usually in about 10 seconds, of the presence or absence of vertebral deformities including vertebral fractures. Specific areas of interest can be magnified or the entire spine can be viewed at once.

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## **Carotid artery stenting coverage guidelines explained**

As of Jan. 1, 2005, Highmark Blue Shield began to pay for carotid artery stenting when it's performed on high-risk, symptomatic patients. These patients include those with carotid stenosis greater than 50 percent with any of these indications:

- contralateral carotid occlusion
- contralateral laryngeal nerve palsy
- radiation therapy to neck
- radical neck surgery
- previous CEA with recurrent stenosis
- severe tandem lesions
- class III or IV heart failure
- left ventricular ejection fraction less than 30 percent
- open heart surgery within six weeks
- myocardial infarction one to four weeks prior to stenting
- class III or IV angina
- severe pulmonary disease
- lesions that extend too high to be accessible for endarterectomy, but can be stented
- not a surgical candidate (you must document this in the patient's medical records)

Blue Shield considers carotid angioplasty with stenting for any other indications, including asymptomatic patients, experimental or investigational. It is not covered. A participating, preferred, or network provider can bill the member for the denied service.

Report this service with the appropriate procedure code:

37215—transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

37216—transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection

0075T—transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiological supervision and interpretation, percutaneous; initial vessel

0076T—transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiological supervision and interpretation, percutaneous; each additional vessel (list separately in addition to code for primary procedure)

Codes 37215, 37216, 0075T, and 0076T include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral carotid arteriography, and all related radiological supervision and interpretation.

Carotid angioplasty with stenting uses a catheter-based technique to treat carotid artery stenosis. Carotid artery stenosis is treated to prevent stroke.

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## **Ovarian and internal iliac vein embolization to treat pelvic congestion syndrome not eligible for coverage**

Highmark Blue Shield considers ovarian and internal iliac vein embolization to treat pelvic congestion an experimental or investigational procedure. It is not eligible for coverage. A participating, preferred, or network provider can bill the member for the denied procedure.

Use code 58999 to report ovarian and internal iliac vein embolization. When you report code 58999, please enter a complete description of the procedure you performed including the specific vein catheterization(s) and embolization(s) in the narrative section of the electronic or paper claim.

Ovarian and internal iliac varicosities are a source of chronic pelvic pain or pelvic congestion syndrome in women. The technique of transcatheter embolotherapy for ovarian and pelvic varices involves selective catheterization of the ovarian and internal iliac veins, followed by contrast venography and embolization. Embolization interrupts the blood flow to select veins, in an attempt to alleviate symptoms of pressure and pain.

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## **Foot orthotics eligible for clubfoot**

Highmark Blue Shield now pays for foot orthotics when they are prescribed for the diagnosis of clubfoot.

Orthotic shoes (L3204, L3206, L3207) attached to a brace, including an abduction bar (L3140, L3150), are included in this coverage for those with clubfoot. For foot orthotics to be covered, the devices must meet Blue Shield's definition of orthotics.\* They must also be a benefit of the member's contract.

When you submit claims for foot orthotics for clubfoot, report ICD-9-CM diagnosis code 736.71, 754.51, or 754.70.

See the December 1999, February 2001, and December 2003 editions of **PRN** for more information about Blue Shield's guidelines for foot orthotics and eligible diagnoses.

*\*Orthotics protect, restore or improve function of moveable parts of the body with orthopedic appliances or apparatus that support, align or prevent or correct deformities. Foot orthotics may or may not include a shoe and/or any modifications or transfers necessary to make the orthotic functional and effective. Orthotics are prescribed by a health care professional and are fabricated to meet the specific needs of the patient.*

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## **Rapid platelet function assay—ASA to determine aspirin resistance not covered**

Highmark Blue Shield considers rapid platelet function assay—ASA (RPFA-ASA) to determine aspirin resistance experimental or investigational. Therefore, it is not eligible for payment. A participating, preferred, or network provider can bill the member for the denied test.

Use code 85576—platelet, aggregation [in vitro], each agent—to report this test.



## Codes

### **New code for PET brain imaging for Alzheimer's available Sept. 15, 2004**

Code G0336 became available on Sept. 15, 2004 for reporting PET imaging of the brain to diagnose Alzheimer's disease. Here is the terminology:

<b>Code</b>	<b>Terminology</b>
G0336	PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. frontotemporal dementia

## Patient News – Information about your patients who are Highmark Blue Shield customers

### Central and Eastern Region

#### **Liberty Mutual moves to BlueCard PPO in January**



The Liberty Mutual group moved from a BlueCard Point of Service (POS) processing arrangement to a BlueCard Preferred Provider Organization (PPO) processing arrangement on Jan. 1, 2005.

The new alphabetical prefix for these Liberty Mutual members is **LMH**. When you provide services for one of these Liberty Mutual members on or after Jan. 1, 2005, report the new alphabetical prefix **LMH** with the member's identification number on their claims. Report alphabetical prefix **XXK** on claims for services you performed before Jan. 1, 2005 for Liberty Mutual's BlueCard POS members.

# PRN

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## Notes

# 12/2004

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## 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

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Name \_\_\_\_\_ Provider ID number \_\_\_\_\_

Electronic media claims source number \_\_\_\_\_

Please make the following changes to my provider records:

Practice name \_\_\_\_\_

Practice address \_\_\_\_\_

Mailing address \_\_\_\_\_

Telephone number ( ) \_\_\_\_\_ Fax number ( ) \_\_\_\_\_

E-mail address \_\_\_\_\_

Tax ID number \_\_\_\_\_

Specialty \_\_\_\_\_

Provider's signature \_\_\_\_\_ Date signed \_\_\_\_\_

# PRN

## Contents

Vol. 2004, No. 6

### News

Blue Shield announces new policy for concierge-style practices .....	1
Avoid denials, report diagnosis codes to highest degree of specificity on all claims .....	2
Attention Participating and PremierBlue Shield ophthalmologists and optometrists: helpful BlueCard vision claims submission tips .....	3
Reminder: file claims within 365 days of last date of service .....	4
Attention PremierBlue Shield providers outside of the Western and Central Regions: information about DirectBlue and SelectBlue members clarified .....	4

### Policy

Blue Shield seeks approval for UCR and PremierBlue Shield reimbursement changes .....	5
Blue Shield adds coverage for PET imaging for Alzheimer's disease .....	5
Blue Shield seeks approval to revise allowances for injectable drugs and biologicals .....	7
Closures after surgery considered part of global surgery allowance .....	7
Boston Scleral Lens eligible for specific conditions .....	8
CT angiography for the evaluation of coronary arteries is investigational .....	9
Blue Shield pays for interferential stimulators used in the home .....	10
Coverage for magnetic resonance cholangiopancreatography explained .....	10

Blue Shield adds new information about off-labeled use for anti-cancer drugs to policy .....	11
Instant vertebral assessment considered experimental .....	13
Carotid artery stenting coverage guidelines explained .....	14
Ovarian and internal iliac vein embolization to treat pelvic congestion syndrome not eligible for coverage .....	15
Foot orthotics eligible for clubfoot .....	16
Rapid platelet function assay-ASA to determine aspirin resistance not covered .....	16

### Codes

New code for PET brain imaging for Alzheimer's available Sept. 15, 2004 .....	17
---	----

### Patient News

Liberty Mutual moves to BlueCard PPO in January .....	17
Need to change your provider information? .....	19

### Acknowledgement

The five-digit numeric codes that appear in PRN were obtained from the Current Procedural Terminology, as contained in CPT-2004, Copyright 2003, by the American Medical Association. PRN includes CPT descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.

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