PRN

Policy Review & News

Important information about Highmark Blue Shield
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August 2004

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BC

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News

Pennsylvania Insurance Department approves UCR and PremierBlue Shield reimbursement increases

On July 5, 2004, Highmark Blue Shield increased its UCR Level II and PremierBlue Shield payments for certain obstetrical, gynecological and integumentary services, musculoskeletal and nervous system surgical procedures, vestibular function tests, diagnostic sleep studies, preventive care visits, mammography, and other select evaluation and management services. Blue Shield also adjusted allowances for several procedures in the 97010–97750 code range.

For more information about Blue Shield's reimbursement increases, see "Blue Shield seeks approval for UCR and PremierBlue Shield reimbursement increases" on Pages 1-2 in the June 2004 **PRN**.

The inclusion of a procedure code and allowance in the lists on Pages 2-18 does not necessarily indicate that it is eligible for payment under Blue Shield's programs. Blue Shield will apply the appropriate network rules, member benefit limitations and medical policy guidelines to the services you report.

Blue Shield may also apply a site of service differential for facility-based services.

HIGHMARK® BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

Allowances are subject to change.

Here are the new PremierBlue Shield and UCR fees:

Procedure code	Modifier	Service	PremierBlue Shield allowance
10061		Abscess incision/drainage	$157.00
10080		Cyst incision/drainage	118.00
10081		Cyst incision/drainage	194.00
11042		Skin debridement	95.00
11043		Skin debridement	216.00
11044		Skin debridement	283.00
11200		Skin tag removal	78.50
11400		Lesion removal	104.00
12031		Wound repair	161.00
12032		Wound repair	196.00
12034		Wound repair	222.00
12035		Wound repair	241.00
12036		Wound repair	339.00
17000		Skin lesion removal	64.00
17004		Skin lesion removal	189.00
17106		Vascular lesion removal	338.00
17107		Vascular lesion removal	598.00
17110		Skin lesion removal	84.00
17304		Skin surgery/treatment	562.00
20670		Skeletal device removal	278.00
20680		Skeletal device removal	350.50
22554		Spinal surgery	1800.00
22850		Spinal surgery	785.00
22852		Spinal surgery	785.00
22855		Spinal surgery	1114.00
23120		Shoulder surgery	628.00

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Procedure code	Modifier	Service	PremierBlue Shield allowance
23125		Shoulder surgery	832.00
23130		Shoulder surgery	654.00
23410		Shoulder surgery	1034.00
23420		Shoulder surgery	1282.00
23500		Fracture treatment/collarbone	223.00
23505		Fracture treatment	361.00
23605		Fracture care/shoulder	497.00
24655		Fracture treatment/arm	439.00
25111		Forearm/wrist surgery	380.00
25112		Forearm/wrist surgery	437.00
25565		Fracture care/forearm/wrist	510.00
25605		Fracture care/forearm/wrist	578.00
25611		Fracture care/forearm/wrist	668.00
25620		Fracture care	684.00
26055		Hand/finger surgery	637.00
26145		Hand/finger surgery	494.50
26160		Hand/finger surgery	773.00
26600		Fracture treatment/hand	228.00
26605		Fracture treatment/hand	331.00
26720		Fracture treatment/finger	177.00
26725		Fracture treatment/finger	321.00
27130		Hip/pelvic surgery	1914.00
27446		Knee/leg surgery	1549.00
27447		Knee/leg surgery	2060.00
27552		Dislocation/knee	600.00
27786		Fracture treatment/leg/ankle	338.00
27788		Fracture treatment/leg/ankle	457.00
27822		Fracture treatment/leg/ankle	926.00

Procedure code	Modifier	Service	PremierBlue Shield allowance
27823		Fracture treatment	1119.50
28290		Foot surgery	570.00
28292		Foot surgery	627.00
28294		Foot surgery	763.00
28296		Foot surgery	818.50
28297		Foot surgery	803.50
28299		Foot surgery	865.00
28470		Fracture treatment/foot	267.00
28475		Fracture treatment/foot	333.50
29826		Shoulder surgery	935.00
29827		Shoulder surgery	1107.00
29848		Wrist surgery	454.00
29877		Knee surgery	795.00
29880		Knee surgery	883.00
29881		Knee surgery	831.00
29888		Knee surgery	1376.00
29889		Knee surgery	1603.00
30130		Nasal surgery	264.00
30140		Nasal surgery	317.00
31231		Diagnostic nasal procedure	122.00
31575		Larynx examination	125.00
37609		Vascular surgical procedure	356.00
37785		Vascular surgical procedure	390.00
42820		Tonsil and adenoid surgery	350.73
42825		Tonsillectomy	275.60
42831		Adenoidectomy	297.81
42836		Adenoidectomy	272.00
47562		Laparoscopic procedure	839.00

Procedure code	Modifier	Service	PremierBlue Shield allowance
47563		Laparoscopic procedure	855.00
47564		Laparoscopic procedure	1035.00
47570		Laparoscopic procedure	1280.00
47600		Gallbladder surgery	839.00
47612		Gallbladder surgery	1280.00
50715		Urinary surgery	1178.00
54150		Male surgery	257.00
54160		Male surgery	265.00
56515		Lesion removal	229.00
56820		Female surgery	130.00
56821		Female surgery	173.00
57420		Female surgery	130.00
57421		Female surgery	173.00
57452		Female surgery	130.00
57454		Female surgery	173.00
57455		Female surgery	173.00
57456		Female surgery	173.00
57460		Female surgery	283.00
57461		Female surgery	315.00
58140		Female surgery	921.00
58146		Female surgery	1165.00
58290		Female surgery	1158.00
58291		Female surgery	1151.00
58545		Female surgery	921.00
58546		Female surgery	1165.00
58553		Female surgery	1158.00
58554		Female surgery	1147.00
58562		Female surgery	321.00

Procedure code	Modifier	Service	PremierBlue Shield allowance
58600		Female surgery	360.00
58605		Female surgery	328.00
58615		Female surgery	285.50
58740		Female surgery	766.00
61545		Cranial surgery	3060.00
61697		Cranial surgery	3500.00
61700		Cranial surgery	3233.00
62270		Spinal puncture	187.00
62272		Spinal puncture	219.00
62311		Injection procedure	242.00
64400		Nerve block injection	110.00
64405		Nerve block injection	109.00
64408		Nerve block injection	143.00
64410		Nerve block injection	140.00
64412		Nerve block injection	135.00
64413		Nerve block injection	122.00
64415		Nerve block injection	161.00
64416		Nerve block injection	156.00
64417		Nerve block injection	167.00
64420		Nerve block injection	167.00
64421		Nerve block injection	246.00
64425		Nerve block injection	122.00
64430		Nerve block injection	128.00
64435		Nerve block injection	134.00
64445		Nerve block injection	152.00
64446		Nerve block injection	160.00
64448		Nerve block injection	147.00
64450		Nerve block injection	93.00

Procedure code	Modifier	Service	PremierBlue Shield allowance
64470		Injection procedure	262.00
64475		Injection procedure	233.00
64630		Nerve destruction	267.00
64640		Nerve destruction	334.00
64680		Nerve destruction	349.00
69433		Ear surgery	151.00
76090	26	Mammography	35.00
76091	26	Mammography	45.00
76092	26	Mammography	36.00
76857		Pelvic ultrasound	89.50
76857	26	Pelvic ultrasound	40.50
92541		Diagnostic ear/nose/throat procedure	59.00
92541	26	Diagnostic ear/nose/throat procedure	27.00
92542		Diagnostic ear/nose/throat procedure	59.00
92542	26	Diagnostic ear/nose/throat procedure	25.00
92543		Diagnostic ear/nose/throat procedure	28.00
92543	26	Diagnostic ear/nose/throat procedure	8.00
92544		Diagnostic ear/nose/throat procedure	48.00
92544	26	Diagnostic ear/nose/throat procedure	20.00
92545		Diagnostic ear/nose/throat procedure	44.00
92545	26	Diagnostic ear/nose/throat procedure	17.50
92546		Diagnostic ear/nose/throat procedure	89.00
92546	26	Diagnostic ear/nose/throat procedure	23.00
92568		Hearing test	18.50
95810		Diagnostic sleep study	735.00
95810	26	Diagnostic sleep study	210.20
95811		Diagnostic sleep study	760.00
95811	26	Diagnostic sleep study	225.00

Procedure code	Modifier	Service	PremierBlue Shield allowance
95816		Diagnostic test/EEG	184.00
95816	26	Diagnostic test/EEG	57.00
95819		Diagnostic test/EEG	226.00
95819	26	Diagnostic test/EEG	64.89
95860		Muscle/nerve study	109.00
95860	26	Muscle/nerve study	64.76
95900		Muscle/nerve study	55.00
95900	26	Muscle/nerve study	29.18
95903		Nerve study	60.00
95903	26	Nerve study	35.00
95904		Muscle/nerve study	46.00
95904	26	Muscle/nerve study	24.74
95930		Diagnostic study	69.00
95930	26	Diagnostic study	35.48
95951		EEG monitoring	743.00
95951	26	EEG monitoring	314.00
97010		Physical medicine and rehabilitation	5.00
97012		Physical medicine and rehabilitation	14.00
97014		Physical medicine and rehabilitation	14.00
97016		Physical medicine and rehabilitation	14.00
97018		Physical medicine and rehabilitation	7.00
97020		Physical medicine and rehabilitation	5.00
97022		Physical medicine and rehabilitation	14.00
97024		Physical medicine and rehabilitation	5.00
97026		Physical medicine and rehabilitation	5.00
97028		Physical medicine and rehabilitation	7.00
97032		Physical medicine and rehabilitation	19.00
97033		Physical medicine and rehabilitation	22.00

Procedure code	Modifier	Service	PremierBlue Shield allowance
97034		Physical medicine and rehabilitation	14.00
97035		Physical medicine and rehabilitation	14.00
97036		Physical medicine and rehabilitation	22.00
97039		Physical medicine and rehabilitation	14.00
97110		Physical medicine and rehabilitation	23.50
97112		Physical medicine and rehabilitation	23.50
97113		Physical medicine and rehabilitation	23.50
97116		Physical medicine and rehabilitation	22.00
97124		Physical medicine and rehabilitation	22.00
97139		Physical medicine and rehabilitation	19.00
97140		Physical medicine and rehabilitation	23.50
97150		Physical medicine and rehabilitation	19.00
97504		Physical medicine and rehabilitation	23.50
97520		Physical medicine and rehabilitation	23.50
97530		Physical medicine and rehabilitation	23.50
97532		Physical medicine and rehabilitation	22.00
97533		Physical medicine and rehabilitation	23.50
97535		Physical medicine and rehabilitation	23.50
97537		Physical medicine and rehabilitation	23.50
97542		Physical medicine and rehabilitation	23.50
97703		Physical medicine and rehabilitation	22.00
97750		Physical medicine and rehabilitation	23.50
99203		Office/outpatient visit	95.00
99245		Consultation	225.00
99291		Medical care	220.00
99381		Preventive medical care	110.00
99382		Preventive medical care	110.00
99383		Preventive medical care	110.00

Procedure code	Modifier	Service	PremierBlue Shield allowance
99384		Preventive medical care	120.00
99385		Preventive medical care	120.00
99386		Preventive medical care	131.00
99387		Preventive medical care	142.00
99391		Preventive medical care	90.00
99392		Preventive medical care	90.00
99393		Preventive medical care	90.00
99394		Preventive medical care	105.00
99396		Preventive medical care	115.00
99397		Preventive medical care	115.00
G0202		Mammography	130.50
G0204		Mammography	135.00
G0204	26	Mammography	45.50
G0206		Mammography	109.00
G0206	26	Mammography	37.00
S0610		Female exam	92.00
S0612		Female exam	85.00

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Procedure code	Modifier	Service	UCR allowance
10061		Abscess incision/drainage	$175.00
10080		Cyst incision/drainage	118.00
10081		Cyst incision/drainage	194.00
11040		Skin debridement	42.00
11043		Skin debridement	245.00
11044		Skin debridement	323.00
11200		Skin tag removal	80.50
11400		Lesion removal	104.00
12031		Wound repair	161.00
12032		Wound repair	196.00
12034		Wound repair	222.00
12035		Wound repair	241.00
12036		Wound repair	339.00
17000		Skin lesion removal	66.00
17004		Skin lesion removal	210.00
17106		Vascular lesion removal	338.00
17107		Vascular lesion removal	598.00
17110		Skin lesion removal	95.00
17304		Skin surgery/treatment	562.00
20670		Skeletal device removal	278.00
22612		Spinal surgery	1730.00
22850		Spinal surgery	850.00
22852		Spinal surgery	850.00
22855		Spinal surgery	1266.00
23120		Shoulder surgery	628.00
23130		Shoulder surgery	654.00
23410		Shoulder surgery	1175.00
23500		Fracture treatment/collarbone	223.00

Procedure code	Modifier	Service	UCR allowance
23505		Fracture treatment	361.00
23605		Fracture care/shoulder	497.00
24655		Fracture treatment/arm	439.00
25112		Forearm/wrist surgery	437.00
25565		Fracture care/forearm/wrist	510.00
25605		Fracture care/forearm/wrist	656.00
25611		Fracture care/forearm/wrist	668.00
25620		Fracture care	684.00
26055		Hand/finger surgery	637.00
26160		Hand/finger surgery	773.00
26600		Fracture treatment/hand	228.00
26605		Fracture treatment/hand	331.00
26720		Fracture treatment/finger	177.00
26725		Fracture treatment/finger	321.00
27786		Fracture treatment/leg/ankle	384.00
27788		Fracture treatment/leg/ankle	520.00
27823		Fracture treatment	1160.00
28294		Foot surgery	803.00
28297		Foot surgery	835.00
28470		Fracture treatment/foot	303.00
28475		Fracture treatment/foot	379.00
29827		Shoulder surgery	1139.00
30130		Nasal surgery	297.00
30140		Nasal surgery	330.00
31231		Diagnostic nasal procedure	138.00
31575		Larynx examination	149.00
36245		Vascular injection	293.00
37200		Vascular injection	225.00

Procedure code	Modifier	Service	UCR allowance
37204		Vascular injection	1200.00
37609		Vascular surgical procedure	356.00
37785		Vascular surgical procedure	390.00
42820		Tonsil and adenoid surgery	400.00
42825		Tonsillectomy	400.00
42831		Adenoidectomy	300.00
42836		Adenoidectomy	300.00
47562		Laparoscopic procedure	900.00
47563		Laparoscopic procedure	967.50
47564		Laparoscopic procedure	1125.00
47570		Laparoscopic procedure	1350.00
47600		Gallbladder surgery	900.00
47612		Gallbladder surgery	1350.00
50715		Urinary surgery	1178.00
54150		Male surgery	257.00
54160		Male surgery	265.00
57461		Female surgery	315.00
58146		Female surgery	1323.00
58290		Female surgery	1200.00
58546		Female surgery	1323.00
58553		Female surgery	1200.00
61545		Cranial surgery	3500.00
61697		Cranial surgery	3500.00
61700		Cranial surgery	3500.00
62270		Spinal puncture	197.00
62272		Spinal puncture	230.00
62311		Injection procedure	251.00
64400		Nerve block injection	115.00

Procedure code	Modifier	Service	UCR allowance
64405		Nerve block injection	114.00
64408		Nerve block injection	143.00
64410		Nerve block injection	140.00
64412		Nerve block injection	135.00
64413		Nerve block injection	128.00
64415		Nerve block injection	161.00
64416		Nerve block injection	156.00
64417		Nerve block injection	167.00
64420		Nerve block injection	167.00
64421		Nerve block injection	246.00
64425		Nerve block injection	128.00
64430		Nerve block injection	134.00
64435		Nerve block injection	134.00
64445		Nerve block injection	152.00
64446		Nerve block injection	160.00
64448		Nerve block injection	147.00
64450		Nerve block injection	98.00
64470		Injection procedure	276.00
64475		Injection procedure	245.00
64630		Nerve destruction	267.00
64640		Nerve destruction	334.00
64680		Nerve destruction	349.00
69433		Ear surgery	171.50
76092		Mammography	97.50
76092	26	Mammography	43.50
76857		Pelvic ultrasound	109.00
76857	26	Pelvic ultrasound	49.00
92541		Diagnostic ear/nose/throat procedure	67.00

Procedure code	Modifier	Service	UCR allowance
92541	26	Diagnostic ear/nose/throat procedure	33.00
92542		Diagnostic ear/nose/throat procedure	67.00
92542	26	Diagnostic ear/nose/throat procedure	26.50
92543		Diagnostic ear/nose/throat procedure	38.50
92543	26	Diagnostic ear/nose/throat procedure	8.50
92544		Diagnostic ear/nose/throat procedure	54.00
92544	26	Diagnostic ear/nose/throat procedure	21.00
92545		Diagnostic ear/nose/throat procedure	50.00
92545	26	Diagnostic ear/nose/throat procedure	18.50
92546		Diagnostic ear/nose/throat procedure	89.00
92546	26	Diagnostic ear/nose/throat procedure	24.00
92568		Hearing test	20.00
95165		Allergy therapy	10.00
95810		Diagnostic sleep study	769.00
95810	26	Diagnostic sleep study	217.00
95811		Diagnostic sleep study	794.00
95811	26	Diagnostic sleep study	225.00
95816		Diagnostic test/EEG	194.00
95816	26	Diagnostic test/EEG	63.00
95819		Diagnostic test/EEG	238.00
95819	26	Diagnostic test/EEG	74.00
95860		Muscle/nerve study	115.00
95860	26	Muscle/nerve study	72.00
95900		Muscle/nerve study	55.00
95900	26	Muscle/nerve study	30.00
95903		Nerve study	60.00
95903	26	Nerve study	39.50
95904		Muscle/nerve study	46.00

Procedure code	Modifier	Service	UCR allowance
95904	26	Muscle/nerve study	25.00
95930		Diagnostic study	80.00
95930	26	Diagnostic study	36.00
95951		EEG monitoring	782.00
95951	26	EEG monitoring	314.00
97010		Physical medicine and rehabilitation	5.00
97012		Physical medicine and rehabilitation	15.00
97014		Physical medicine and rehabilitation	15.00
97016		Physical medicine and rehabilitation	15.00
97018		Physical medicine and rehabilitation	7.00
97020		Physical medicine and rehabilitation	5.00
97022		Physical medicine and rehabilitation	15.00
97024		Physical medicine and rehabilitation	5.00
97026		Physical medicine and rehabilitation	5.00
97028		Physical medicine and rehabilitation	7.00
97032		Physical medicine and rehabilitation	20.00
97033		Physical medicine and rehabilitation	23.50
97036		Physical medicine and rehabilitation	23.50
97110		Physical medicine and rehabilitation	25.00
97112		Physical medicine and rehabilitation	25.00
97113		Physical medicine and rehabilitation	25.00
97116		Physical medicine and rehabilitation	23.50
97124		Physical medicine and rehabilitation	23.50
97139		Physical medicine and rehabilitation	20.00
97140		Physical medicine and rehabilitation	25.00
97150		Physical medicine and rehabilitation	20.00
97504		Physical medicine and rehabilitation	25.00
97520		Physical medicine and rehabilitation	25.00

Procedure code	Modifier	Service	UCR allowance
97530		Physical medicine and rehabilitation	25.00
97532		Physical medicine and rehabilitation	23.50
97533		Physical medicine and rehabilitation	25.00
97535		Physical medicine and rehabilitation	25.00
97537		Physical medicine and rehabilitation	25.00
97542		Physical medicine and rehabilitation	25.00
97703		Physical medicine and rehabilitation	23.50
97750		Physical medicine and rehabilitation	25.00
99203		Office/outpatient visit	95.00
99245		Consultation	225.00
99291		Medical care	220.00
99381		Preventive medical care	110.00
99382		Preventive medical care	110.00
99383		Preventive medical care	110.00
99384		Preventive medical care	120.00
99385		Preventive medical care	120.00
99386		Preventive medical care	131.00
99387		Preventive medical care	142.00
99391		Preventive medical care	90.00
99392		Preventive medical care	90.00
99393		Preventive medical care	90.00
99394		Preventive medical care	105.00
99396		Preventive medical care	115.00
99397		Preventive medical care	115.00
G0202		Mammography	154.50
G0204		Mammography	164.50
G0204	26	Mammography	55.50
G0206		Mammography	132.50

Procedure code	Modifier	Service	UCR allowance
G0206	26	Mammography	45.00
S0610		Female exam	92.00
S0612		Female exam	85.00

Report valid medical code sets on all claims

Remember to report medical code sets, that is, diagnosis codes and procedure codes, that are valid at the time a service is performed on all electronic and paper claims. Highmark Blue Shield requires that you report appropriate medical code sets because of the administrative simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Blue Shield follows the Centers for Medicare and Medicaid Services' (CMS) effective date guidelines for diagnosis and procedure codes. Blue Shield does not allow 90-day grace periods.

Always check information on member's identification card before submitting claims

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

If Blue Shield rejects a claim because it could not identify the patient from the identification number you reported, you should verify the name and number on the member's identification card. If the patient is covered by Blue Shield, please resubmit the claim with the correct information to Blue Shield.

Blue Shield needs complete, accurate patient information to process 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.

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.

Medical Review Committee seeks members

Highmark Blue Shield is searching for members to serve on its Medical Review Committee. The Medical Review Committee is charged with resolving disputes between participating providers and Highmark Blue Shield. These disputes may involve utilization and quality of care issues, as well as other alleged violations of the participating provider agreement and appeals regarding network terminations.

The Committee is currently comprised of ten doctors of medicine, two osteopathic physicians and two laymembers. Members are appointed by the Selection Committee of the Highmark Blue Shield Board of Directors to a two-year term. The members may be re-appointed.

The Medical Review Committee generally meets four times a year at the Highmark Blue Shield office in Camp Hill, Pennsylvania. Blue Shield reimburses Committee members for their expenses. Members also receive an honorarium from Blue Shield.

A Pennsylvania licensed health care provider who participates in a Highmark Blue Shield network is eligible to serve as a member.

If you are interested in being considered for membership by the Selection Committee, please send a copy of your curriculum vitae or resume by Sept. 20, 2004 to:

Highmark Blue Shield
Attention: Raymond J. DiBello
Secretary, Medical Review Committee
1800 Center Street
Camp Hill, Pa. 17089

Blue Shield revises consultant review process

In the August 2003 **PRN** Highmark Blue Shield explained its postpayment practice pattern review process. Since then Blue Shield has made changes to the consultant review portion of the process.

Before, if you disagreed with the initial reviewer's opinion Blue Shield permitted another review by a second consultant. Blue Shield is changing this to only allow for one review by one professional consultant. This will allow for a more timely conclusion to the review process.

If you and Blue Shield are not able to reach an agreement based on the findings of this reviewer, the matter may be referred to the Medical Review Committee (MRC). This will be your last chance for an appeal. You will be able to provide Blue Shield with additional documentation, that is, clinical information, to support your position.

PRN

Blue Shield will provide your additional information to the MRC.

The MRC decision is binding on you, the provider, and Blue Shield, the insurer.

Policy

Blue Shield now pays for lung volume reduction surgery for severe emphysema

Highmark Blue Shield's Board of Directors recently approved coverage of lung volume reduction surgery for non-high risk patients with severe upper lobe emphysema.

Blue Shield will pay for lung volume reduction surgery for severe emphysema according to these criteria:

Assessments	Coverage criteria
Radiographic	High resolution computer tomography (HRCT) scan shows evidence of bilateral emphysema
Pulmonary function (pre-rehabilitation)	Forced expiratory volume in one second ≤ 45 percent predicted (≥ 15 percent predicted if age ≥ 70 years) Total lung capacity ≥ 100 percent predicted post-bronchodilator Residual volume ≥ 150 percent predicted post-bronchodilator
Arterial blood gas level (pre-rehabilitation)	PCO2 ≤ 60 mm Hg (PCO2 ≤ 55 mm Hg if one mile above sea level) PO2 ≥ 45 mm Hg on room air (PO2 ≥ 30 mm Hg if one mile above sea level)
Exercise	Post-rehabilitation 6 minute walk of ≥ 140 m; able to complete three minutes unloaded pedaling in exercise tolerance test (pre- and post-rehabilitation)
Smoking	Plasma cotinine level ≤ 13.7 ng/mL (or arterial carboxyhemoglobin ≤ 2.5 percent if using nicotine products) Non-smoking for four months prior to initial interview and throughout evaluations for surgery

Use procedure code 32491—removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure—to report this service.

How to report home-based, real-time cardiac surveillance

Report home-based, real-time cardiac surveillance with procedure code 93799—unlisted cardiovascular service or procedure. When you report this service with code 93799, include the description "ECG arrhythmia detection and alarm system" in the narrative field of the electronic or paper claim.

You should also report either modifier TC (technical) or 26 (professional) to identify what component of the monitoring was performed.

The technical component of this service includes patient hook-up and disconnection, patient education and instruction, transmission, receipt of transmission and analysis by non-physician personnel, medical chart recording, equipment maintenance, and all supplies necessary for completion of the surveillance. The professional component includes review and interpretation of each 24-hour cardiac surveillance, as well as 24-hour availability and response to surveillance events.

An independent physiological laboratory (IPL) or an independent diagnostic testing facility (IDTF) can perform the technical component of this service. A health care professional who performs the interpretation of the service can purchase the technical component from the IPL or IDTF and can bill Highmark Blue Shield for the total component. The IPL or IDTF cannot bill Blue Shield for the technical component.

For more information on purchased services and how to bill for them, please refer to the October 2003 **PRN**.

Blue Shield pays for home-based, real-time cardiac surveillance for specific indications for patients who demonstrate a need for cardiac monitoring.

Blue Shield allows radioimmunotherapy using Bexxar to treat certain non-Hodgkin's lymphomas

Highmark Blue Shield pays for radiation therapy using the tositumomab/iodine I-131 tositumomab (Bexxar®) radioimmunotherapy treatment regimen for patients with relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma, including patients with rituximab refractory follicular non-Hodgkin's lymphoma (200.00-200.88, 202.00-202.08, 202.80-202.88).

Patients receiving the tositumomab/iodine I-131 tositumomab therapeutic regimen must meet all of these criteria:

- have had at least four doses of rituximab without an objective response,
- have a platelet count greater than or equal to 100,000 cells/mm^3,
- have a neutrophil count greater than 1,500 cells/mm^3,
- have an average of less than or equal to 25 percent of the intrabecular marrow space involved by lymphoma, and
- have no evidence of progressive disease arising in a field irradiated with greater than 3500 cGy (centigrays) within one year of completion of irradiation.

The tositumomab/iodine I-131 tositumomab therapeutic regimen is a single course of treatment. The safety and toxicity profile from multiple courses of this regimen has not been established.

This radioimmunotherapeutic regimen is not medically indicated for these applications (this is not an all-inclusive list):

- in combination with other forms of irradiation or chemotherapy,
- as the initial treatment for patients with CD20 positive non-Hodgkin's lymphoma,
- for the treatment of conditions other than relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma.

Blue Shield will deny this treatment regimen for these and any other ineligible conditions or uses. A participating, preferred or network health care professional cannot bill the member for the denied service in this situation.

Radioimmunotherapy is a radiation therapy method that uses the targeting features of a monoclonal antibody attached to a radionuclide agent to deliver radiation to a tumor. The tositumomab/iodine I-131 tositumomab regimen is provided in these two steps:

1. The dosimetric step uses nuclear images acquired over a seven-day period to evaluate the patient's candidacy for this treatment regimen and to calculate the therapeutic dose of the radioactive monoclonal antibody appropriate for each patient.
2. The therapeutic step consists of the administration of the radiolabeled monoclonal antibody (iodine I-131 tositumomab) as determined through the dosimetric step. The therapeutic dose is typically given seven to 14 days after the dosimetric step.

Use these procedure codes, as appropriate, to report the services included in the tositumomab/iodine I-131 tositumomab radioimmunotherapy treatment regimen:

78800—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area

78801—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas

78802—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging

78804—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging

79403—radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion

A9533—supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per millicurie

A9534—supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per millicurie

G3001—administration and supply of tositumomab, 450 mg

Extracorporeal shock wave therapy for plantar fasciitis not covered

Highmark Blue Shield no longer pays for extracorporeal shock wave therapy for plantar fasciitis.

Extracorporeal shock wave therapy is used as an alternative to surgery to treat patient's who have had plantar fasciitis longer than six months and for whom conservative treatment has failed.

Blue Shield will continue to not cover this procedure when it's performed for other musculoskeletal conditions.

Medical literature does not clearly establish the clinical effectiveness of extracorporeal shock wave therapy for any of these conditions.

Wireless capsule endoscopy eligible for suspected Crohn's disease

Highmark Blue Shield now pays for wireless capsule endoscopy, procedure code 91110, for patients with suspected Crohn's disease of the small intestine.

When you submit a claim for wireless capsule endoscopy, please report ICD-9-CM diagnosis code 555.0 to indicate Crohn's disease of the small intestine.

See the February 2003 **PRN** for more information about Blue Shield's guidelines for wireless capsule endoscopy and for eligible diagnoses.

Radioimmunotherapy using Zevalin eligible for some non-Hodgkin's lymphomas

Highmark Blue Shield pays for radiation therapy using the ibritumomab tiuxetan (Zevalin™) radioimmunotherapy treatment regimen for patients with relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma, including patients with rituximab refractory follicular non-Hodgkin's lymphoma (200.00-200.88, 202.00-202.08, 202.80-202.88).

Patients receiving the ibritumomab tiuxetan therapeutic regimen must meet all of these criteria:

- have less than or equal to 25 percent lymphoma marrow involvement and/or impaired bone marrow reserve,
- have a platelet count greater than 100,000 cells/mm^3,
- have a neutrophil count greater than 1,500 cells/mm^3,
- have no evidence of hypocellular bone marrow (less than or equal to 15 percent cellularity or marked reduction in bone marrow precursors), and
- have no history of failed stem cell collection.

The ibritumomab tiuxetan therapeutic regimen is a single course of treatment. The safety and toxicity profile from multiple courses of this regimen has not been established.

This radioimmunotherapeutic regimen is not medically indicated for these applications (this is not an all-inclusive list):

- in combination with, preceding, or following other forms of therapeutic irradiation,
- as the initial treatment for patients with CD20 positive non-Hodgkin's lymphoma,
- in patients with a platelet count less than 100,000/mm^3,
- for the treatment of conditions other than relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma.

Blue Shield will deny this treatment regimen for these and any other ineligible conditions or uses. A participating, preferred or network health care professional cannot bill the member for the denied service in this situation.

Radioimmunotherapy is a method of radiation therapy that uses the targeting features of a monoclonal antibody attached to a radionuclide agent to deliver radiation to a tumor. The ibritumomab tiuxetan radioimmunotherapy regimen involves the administration of:

- the monoclonal antibody rituximab to optimize targeting the tumor cells,
- an imaging dose of Indium-111 (In^{111}) ibritumomab tiuxetan (In-111 Zevalin) to confirm the expected biodistribution, and
- the therapeutic radiation treatment using radiolabeled Yttrium-90 (Y^{90}) ibritumomab tiuxetan (Y-90 Zevalin).

Use these procedure codes, as appropriate, to report the services included in the ibritumomab tiuxetan radioimmunotherapy treatment regimen:

78800—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area

78801—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas

78802—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging

78804—radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging

79403—radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion

A9522—supply of radiopharmaceutical diagnostic imaging agent, Indium-111 ibritumomab tiuxetan, per mCi

A9523—supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per mCi

J9310—rituximab, 100 mg

Patient selection criteria for bariatric surgery clarified

For Highmark Blue Shield to consider payment for the surgical treatment of morbid obesity all of these patient selection criteria must be met:

- The patient must be morbidly obese.

  Blue Shield defines morbid obesity as a condition of consistent and uncontrollable weight gain that is characterized by:

  - a weight that is at least 100 pounds or 100 percent over ideal weight, or
  - a BMI of at least 40 or a BMI of 35 with comorbidities, for example, hypertension, cardiovascular heart disease, dyslipidemia, diabetes mellitus type II, sleep apnea.

- The patient must be at least 18 years old.
- The patient must receive non-surgical treatment, for example, dietitian or nutritionist consultation, low calorie diet, exercise program, and behavior modification. The patient's attempts at weight loss have failed.
- The patient must participate in and meet the criteria of a structured nutrition and exercise program. This includes dietician or nutritionist consultation, low calorie diet, increased physical activity, behavioral modification, and/or pharmacologic therapy. This information must be documented in the patient's medical record.

The structured nutrition and exercise program must meet all of these criteria:

a. The nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists.

b. The nutrition and exercise program(s) must be for a cumulative total of six months or longer.

c. The nutritional and exercise program must occur within two years before the surgery.

d. The patient's participation in a structured nutrition and exercise program must be documented in the medical record by the attending physician that supervised the patient's progress. A physician's summary letter is not sufficient documentation.

   Documentation should include medical records of the physician's on-going assessments of the patient's progress throughout the course of the nutrition and exercise program. For patients who participate in a structured nutrition and exercise program, medical records documenting the patient's participation and progress must be available for review.

Patient selection is a critical process requiring psychiatric evaluation and a multidisciplinary team approach. The patient's understanding of the procedure, and ability to participate and comply with life-long follow-up and life-style changes, for example, changes in dietary habits, and beginning an exercise program, are necessary for the procedure to succeed.

Growth hormone for the treatment of short bowel syndrome now covered

Highmark Blue Shield now pays for Zorbtive, a recombinant human growth hormone, for the treatment of short bowel syndrome.

The Food and Drug Administration approved Zorbtive (somatropin [rDNA origin] for injection), for the treatment of short bowel syndrome in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of short bowel syndrome.

Specialized nutritional support may consist of a high carbohydrate, low-fat diet, adjusted for individual patient requirements and preferences. Nutritional supplements may be added according to the discretion of the treating health care professional. Optimal management of short bowel syndrome may include dietary adjustments, enteral feedings, parenteral nutrition, fluid and micronutrient supplements, as needed.

Administration of Zorbtive for more than four weeks has not been adequately studied.

Use code J2941—somatropin, 1 mg—to report Zorbtive.

Short bowel syndrome (ICD-9-CM diagnosis code 579.3) is a rare, serious, and potentially life-threatening condition. It occurs after extensive surgical removal of portions of the small intestine as a treatment for acute or chronic disorders of the intestine.

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**.

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

Central Region

Blue Shield becomes host plan for Voith Hydro Siemens and Voith Turbo

On Jan. 1, 2004, Highmark Blue Shield became a host plan for Voith Hydro Siemens and Voith Turbo employees. These employees have a self-insured health care plan through Blue Cross Blue Shield of North Carolina.

These employees are in either the BlueCard PPO program or they have comprehensive major medical coverage.

Claims, eligibility and customer service are handled through a partnership with Blue Cross Blue Shield of South Carolina's operations center. You can call the customer service center at (800) 830-1501, 8 a.m. through 8 p.m. EST, Monday through Friday.

When you file claims for Voith employees, please use these alphabetical prefixes:

- alphabetical prefix **IVO** for PPO members
- alphabetical prefix **IVH** for comprehensive major medical members

Central and Eastern Region

Welch's moves to BlueCard PPO in August

The Welch's group moved from a BlueCard Point of Service (POS) processing arrangement to a BlueCard Preferred Provider Organization (PPO) processing arrangement on Aug. 1, 2004.

The new alphabetical prefix for these Welch's members is **WCH**. When you provide services for one of these Welch's members on or after Aug. 1, 2004, report the new alphabetical prefix **WCH** with the member's identification number on their claims. Report alphabetical prefix **XXK** on claims for services you performed before Aug. 1, 2004 for Welch's BlueCard POS members.

National City members receive new identification cards in July

On July 1, 2004, Blue Cross Blue Shield of Illinois issued new identification cards to National City members whose identification numbers carry an **NNN** alphabetical prefix. The new identification cards have a 12 character identification number—the three character **NNN** alphabetical prefix followed by a 9 byte randomly generated number in the 820xxxxxx to 850xxxxxx range.

The new identification cards replace National City members' former cards that contained their Social Security numbers.

Report correct identification number for services requiring authorization

All services for National City members that require managed care authorization after July 1, 2004 must have those authorizations submitted and approved under the member's new identification number. Updating records that overlap the effective dates of the two identification numbers will ensure proper processing of these services for the higher level of payment.

Examples of services impacted include those that require precertification of a series of therapies or visits.

Here are examples of how to report these services for updating the managed care records:

Current record in system		Updated record with new identification information	
NNN123456789		NNN820123456	
Patient	Sam Jones	Patient	Sam Jones
Provider	MA12536	Provider	MA12536
Procs/mods	98940 00	Procs/mods	98940 00
Start date	06/15/2004	Start date	07/01/2004
End date	08/30/2004	End date	08/30/2004
Total approved treatments	10	Total approved treatments	8

The current record will be used for services performed June 15, 2004 through June 30, 2004. Because these services were performed before July 1, 2004, they are reported on claims with the member's Social Security based identification number. The managed care record reflects the Social Security based identification number for this period of time.

The updated record is for the remaining services that would be performed July 1, 2004 through Aug. 30, 2004. Those services should be reported with the new member identification number. The updated managed care record will reflect the new member identification for services performed during this period of time.

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Notes

8/2004

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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