PRN
Policy Review & News

Important information about Pennsylvania Blue Shield April 1999

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News

Blue Shield eliminates claim attachments, makes electronic claims filing even easier

As part of its efforts to encourage electronic claims submission, Pennsylvania Blue Shield is changing the way it looks at claim attachments.

As of April 1999, you can send Blue Shield almost all of your claims electronically — and not have to worry about submitting additional paper documentation.

The only exception: DME claims

For Federal Employee Program (FEP) or major medical durable medical equipment (DME) claims, please send us a paper claim accompanied by a certificate of medical necessity (CMN) the first time you submit a claim for the rental or purchase of a particular DME item. You can submit subsequent claims electronically for the same DME item, while the CMN is in effect — without submitting another copy of the CMN.

Electronic claims receive higher priority

If you don't submit DME claims, send us all your claims electronically and forget about attachments. If we need additional documentation to process the claim, we'll contact you after we've started reviewing it.

Blue Shield is changing its medical-surgical claims processing system to place a higher priority on claims filed electronically. Our goal is two-fold: to meet marketplace demands for efficiency and cost-effectiveness, and to encourage more health care professionals to convert to electronic filing.

PENNSYLVANIA BLUE SHIELD
A HIGHMARK COMPANY
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For select services, add the documentation to the electronic claim

The following chart outlines a select number of services that might be considered cosmetic where Blue Shield still requires documentation. But now, instead of sending it on a paper attachment, report this information in the narrative field of the electronic claim format.

The chart identifies the services — and tells you what information we need.

When completing the narrative field, please enter the question number, and the appropriate response to that question. Remember to report all dates in the CCYYMMDD format.

If you've obtained preauthorization for the surgical procedures you're reporting, please include the preauthorization number in the narrative field in this format: P#:123456789.

Procedure code	Required narrative
15775, 15776 (Hair transplant)	Please answer these two questions: 1) Is this due to an accident or injury? 2) If yes, what is the date of the accident or injury? Sample response: 1)Yes 2)19990118 P#:123456789 *If the procedure being performed is not due to an accident or injury, documentation may be requested post receipt of the claim.*
15780 – 15787 (Skin surgery/treatment)	Please answer these three questions: 1) Is this due to an accident or injury? 2) If yes, what is the date of the accident or injury? 3) Is this surgery being performed because of post-acne scarring? Sample response: 1)Yes 2)19990118 3)No P#:123456789 *If the patient has a functional impairment that is not the result of an accident, documentation may be requested post receipt of the claim.*

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Procedure code	Required narrative
15820, 15821, 15822, 15823 (Eyelid surgery) 67900 – 67908 (Facial and eyelid surgery)	Please answer these two questions: 1) Is visual impairment documented on the automated visual field study? 2) Do photographs indicate that part of the pupil is covered or the eyelid touches the eyelashes? Sample response: 1)Yes 2)Yes P#:123456789
15824, 15825, 15826, 15828,	Please answer this question: 1) Is there functional impairment as a result of a disease state? Sample response: 1)Yes P#:123456789 *If the answer to this question is no, documentation may be requested post receipt of the claim.*
15831 (Abdominal lipectomy)	Please answer this question: 1) Has abdominal skin fold created a symptomatic disease condition such as chronic pain, dermatitis or ulceration? Sample response: 1)Yes P#:123456789 *If the answer to this question is no, documentation may be requested post receipt of the claim.*
19140 (Breast surgery)	Please provide this information: 1) Specify the type of tissue described in the pathology report. 2) Specify the final diagnosis described in the pathology report. Sample response: 1)Fibrous 2)Fibrous breast tissue

Procedure code	Required narrative
19318 (Breast surgery/repair)	Please provide this information: 1) Report the number of grams removed from the patient. If this information does not meet our criteria, additional information may be requested. 2) Report the height of the patient. Sample response: 1)Grams 254 2)Height 5'7"
19324, 19325 (Augmentation mammoplasty)	Please answer these five questions: 1) Is unilateral breast aplasia present? 2) Has extirpative surgery, for example, mastectomy, with either immediate or delayed prosthesis, for benign disease been performed on the affected breast? 3) Has the reconstructive procedure been performed following previous radical surgery for malignant disease on the affected breast? 4) Is breast hypoplasia associated with Poland's syndrome on the affected breast? 5) Has surgery been performed for symmetry on the unaffected breast? Sample response: 1)Yes 2)No 3)Yes 4)Yes 5)No P#:123456789 *If one of the above situations does not apply, documentation may be requested post receipt of the claim.*
19328, 19330 (Removal of implants)	Please answer these three questions: 1) Has infection, allergic reaction or complication (leakage, rupture) occurred? 2) Has breast surgery, for example, mastectomy, capsulectomy, capsulotomy, been performed for benign or malignant disease? 3) Has breast surgery been performed to replace implant with a larger or smaller size?

Procedure code	Required narrative
19328, 19330 (Removal of implants)	Sample response: 1)Yes 2)Yes 3)No P#:123456789 *If one of the above situations does not apply, documentation may be requested post receipt of the claim.*
19340, 19342 (Insertion of breast prosthesis)	Please answer these two questions: 1) Was the original surgery (augmentation) performed for cosmetic reasons? 2) Was the original surgery for mastectomy of benign or malignant disease? Sample response: 1)No 2)Yes P#:123456789 *If one of the above situations does not apply, documentation may be requested post receipt of the claim.*
21137, 21138, 21139, 21172, 21175, 21179, 21180 (Reduction, forehead) 21260, 21261, 21263, 21267, 21268, 21270, 21275 (Orbital/facial reconstruction)	Please answer these two questions: 1) Is this due to an accident or injury? 2) If yes, what is the date of the accident or injury? Sample response: 1)Yes 2)19990118 P#:123456789 *If the patient has functional impairment that is not the result of an accident, documentation that reflects the functional impairment may be requested post receipt of the claim.*
30400, 30410, 30420 (Nasal surgery) 30430, 30435, 30450 (Rhinoplasty)	Please answer these three questions: 1) Is this due to an accident or injury? 2) If yes, what is the date of the accident or injury? 3) Was functional breathing impaired? Sample response: 1)Yes 2)19990118 3)Yes P#:123456789 *If the patient has functional impairment that is not the result of an accident, documentation that reflects the functional impairment may be requested post receipt of the claim.*

Procedure code	Required narrative
40650, 40652, 40654 (Lip repair/surgery)	Please answer these two questions: 1) Is this due to an accident or injury? 2) If yes, what is the date of the accident or injury? Sample response: 1)Yes 2)19990118 P#:123456789 *If the answer to the first question is no, documentation may be requested post receipt of the claim.*
69300 (Ear surgery)	Please answer this question: 1) Do photographs indicate that the ears are perpendicular to the head? Sample response: 1)Yes P#:123456789
Not otherwise classified (NOC) codes	Report in the narrative field: 1) A complete description of the service(s) rendered.

Blue Shield continues to require written treatment plans for manipulation and physical therapy encounters in excess of 15 per calendar year. You can submit manipulation and physical therapy claims electronically. However, you must also complete a treatment plan on form 3861 and send it to:

Pennsylvania Blue Shield
PO Box 890140
Camp Hill, Pa. 17089-0140

For more information about filing your claims electronically, contact Direct Access Services, the electronic commerce division of Blue Shield, at (800) 992-0246.

If you have any other questions, please contact your Provider Relations representative.

Blue Shield continues to improve credentialing process

Pennsylvania Blue Shield is continually improving its credentialing process to effectively meet the credentialing demands of all its networks.

Health care professionals and their staffs can do several things to help keep this process moving along efficiently.

- After signing the Affirmation/Release of Information statement, please forward your application to us as soon as possible. The 180-day timetable to process your application as required by the National Committee for Quality Assurance (NCQA) begins the date you sign this form. The sooner it gets to us, the easier it is for us to carry out the review process — and the sooner you're added to our networks.
- Double-check your application, before you send it to us, to ensure you've included all the information and documentation we need. As a general rule, we can not process an application if information is missing. We will return it to you — and that slows down the process.

Here are the main reasons applications are stalled in the credentialing process:

- Failure to submit supporting documents such as DEA certificate, board certificate or CME credit certificates where applicable;
- Incomplete hospital privilege information;
- Lack of appropriate signatures on the application and attestation statement;
- Not providing sufficient details about malpractice case history;
- Failure to submit current malpractice cover sheet;
- Failure to indicate specialty; or,
- Incomplete work and/or education history.

For more information, contact Provider Data Services at (800) 547-3627.

New address? Notify Provider Data Services

If you are changing your practice's address or are making any changes that impact the information Pennsylvania Blue Shield maintains on you and your practice — please mail or fax the change to Provider Data Services.

The easiest way to send a change is to use the coupon on the inside, back page of **PRN**. (Page 23 of this edition.) It walks you through all the information that we need. And, it includes Provider Data Services' address and fax number.

CareConnect's Provider Information Manager feature permits you to see some of the information we have on file for your practice. It also allows you to communicate changes to that information to Provider Data Services.

Please do not attach any change notices to your claims or inquiries. This will delay claims and inquiry processing. And, it will take longer to have your records updated.

1999 PTM mailed in March

In March, Pennsylvania Blue Shield mailed the 1999 edition of the **Procedure Terminology Manual** (**PTM**) to you and your fellow health care professionals.

We designed the **PTM** to assist you in submitting claims to Blue Shield. When reporting services, always use the appropriate procedure codes. Remember, the listing of a procedure in this manual does not necessarily indicate that it is eligible for reimbursement under Blue Shield's programs.

The 1999 Health Care Financing Administration Common Procedure Coding System (HCPCS) changes are included in the **PTM**. These additions, revisions and deletions were effective Jan. 1, 1999. If you report out-of-date, deleted codes, it will delay your claims — and some claims may be denied incorrectly.

If you have not received your copy of the **PTM**, please contact:

Pennsylvania Blue Shield
Shipping Control Department
PO Box 890089
Camp Hill, Pa. 17089-0089

Claims processing system changes: now gives first priority to claims filed electronically

Pennsylvania Blue Shield has changed its medical and surgical claims processing system to place a higher priority on claims filed electronically. Our goal is two-fold: to meet marketplace demands for efficiency and cost-effectiveness, and to encourage more health care professionals to convert to electronic filing.

Our system upgrades took effect in April 1999. Electronic claims will typically process in seven to 14 calendar days, whereas paper claims will process in 21 to 27 calendar days. These payment targets are in compliance with timely claims payment regulations defined by Act 68 of 1998 (Article II: The Provision For Quality Health Care Accountability and Protection) and reflect processing of claims that do not require manual intervention or investigation.

Approximately 60 percent of the more than two million professional health care claims processed by Blue Shield each month are filed electronically. Providers who currently file claims electronically are already enjoying the inherent benefits of electronic submission.

Field support, vendor advice, claims clearinghouse link — all available for offices converting to electronic filing

For most health care professionals, electronic claims filing means using a personal computer, software, a modem and a dedicated telephone line to file claims. When you are ready to begin the conversion to electronic claims filing, we are prepared to make the process easy for you.

Your Provider Relations representative will review the details of this initiative with you and assist your office through the transition. He or she can also provide information on equipment requirements for compatibility with our electronic claims submission software. This information is also available through Direct Access Services (DAS). Furthermore, DAS is ready to:

- Provide a list of software vendors approved by DAS who offer electronic commerce

modules for your existing programs — if you already have an electronic office management system and are using it for other business applications. Or, you can contact your vendor to work out the changes.

- Provide those offices that still bill on paper the VIP Vendor list. These approved vendors can help you get started in electronic claims filing with software and equipment. They can also help you use your new PC to automate other office processes.
- Link you to a claims clearinghouse where you can electronically submit Blue Shield claims and claims for other insurers.
- Provide free web-browser technology, enabling you to verify enrollment, eligibility and claims status, create electronic referrals and identify allowances. The ROAR system (Referral or Authorization Request) is also accessible through the Internet for those physicians who participate in the managed care programs of Keystone Health Plan West.
- Offer you a toll-free, fax-back inquiry service that allows you to request claim status information on Blue Shield members through your touch-tone telephone. Your inquiries are answered within minutes through your fax machine.
- Provide convenient and accessible technical support through a toll-free phone line.

Efficient and cost effective for everyone

Your practice, as well as our members, will benefit from this initiative to promote electronic claims filing. Our experience shows that, once your office is set up to file electronically, you will realize benefits beyond the time you save to submit claims and receive payment. Other provider practices have told us how they also realized savings in staff time and other administrative costs by introducing computer technology to their practice.

Because of the inherent speed and cost-effectiveness, electronic transactions and on-line communications are integral to today's business world. Electronic transactions between health care professionals and insurers are essential to maintain efficiency and are, in fact, encouraged by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As part of our system enhancements strategy, Blue Shield is working to improve its state-of-the-art electronic claims submission capabilities. We have established an internal task force to pursue upgrades that will make electronic submission even simpler and more effective. If you have suggestions on how to improve electronic submission, please notify us through your Provider Relations representative.

For general questions about this initiative, contact your Provider Relations representative.

To take the first step in preparing your office for electronic claims submission, call DAS directly at (800) 992-0246. You may also visit the DAS website at: **www.careconnect.com**.

Consumer Bill of Rights grants FEP members access to certain information

In February 1998 President Clinton issued an executive memorandum that resulted in the Consumer Bill of Rights and Responsibilities giving members of the Federal Employee Program (FEP) the right to access certain information about their health plan and their health care professionals.

This directive was implemented Dec. 31, 1998. You may receive requests for information under the Consumer Bill of Rights and Responsibilities from FEP members as a result of this directive for federal programs.

Pennsylvania Blue Shield has taken a number of steps to inform FEP members about health plan information they have a right to know. Members may contact our customer service department and obtain a fact sheet about their health plan that describes such things as: who we are, what we do and how many years we have been in existence.

The Consumer Bill of Rights also requires that additional information be provided, upon request, about the health care professionals who make up its networks. Examples of the information requested may include the physician's board certification, languages spoken, translation services available, accessibility to disabled patients and office hours.

Blue Shield provides Service Benefit Plan directories to members, which include the PremierBlue health care professionals' names, addresses, telephone numbers and specialties. Because the directories do not include the additional information listed above, we advise FEP members to contact you directly to obtain this additional information.

Finally, some information you need to know: The Consumer Bill of Rights also requires health care professionals to reveal to members any ownership or affiliation with a provider group or with an institution or facility that, through a referral, may provide a service to the health care professionals' patients. The bill also requires that the health care professional explain how he or she is compensated for the referral. You should explain this at the time of service or referral, and upon request by an FEP member.

EMC News

Ready to go on-line?: DAS can help

Fact: over 60 percent of all Pennsylvania Blue Shield professional claims and nearly all facility claims are submitted electronically.

If you're unsure about going electronic, Direct Access Services (DAS) is here to help.

Our experienced staff is ready to help simplify your business operations through the use of electronic data interchange (EDI) or, the computer delivery of information. EDI technology is not new. In fact, it has been a part of our everyday lives for years.

Each time you make an ATM deposit or withdrawal or make a purchase with a credit card, an EDI transaction is initiated. As consumers, EDI transactions provide value-added benefits like convenience, efficiency and transaction record management.

DAS provides:

- Expert knowledge and experience
- Authorization forms

- Application processing
- Electronic source number assignment
- Toll-free technical support. Call (800) 992-0246 between 8 a.m. and 5 p.m. and you can talk to a support analyst. Leave a message after those hours and an analyst will return your call.

DataStream℠ accepts claims and encounters electronically

DAS' claims clearinghouse receives electronic claims and encounters from more than 20,000 health care professionals. Our DataStream claims clearinghouse can accept Blue Shield claims and encounters electronically, as well as primary claims from other commercial payers.

Electronic submission provides the added benefit of both claim preparation and delivery at your convenience. Electronic claims can be submitted 24 hours a day, seven days a week, 365 days a year. It is safe, immediate and direct to Blue Shield without human intervention. EDI security standards ensure your claim data remains confidential and secure.

Electronic claim submission increases staff productivity by speeding claim preparation and delivery. Many of the paper claim processes are eliminated, such as form printing, bundling, postage and mailing. Many errors experienced in the keying and processing of paper claim forms are reduced or eliminated. Electronic claim submission means greater claim acceptance rates and reduced staff time in rejected claim research and re-submissions.

DataStream provides EDI on-line reports to enhance your ability to track and monitor your claim transactions. These include:

- Confirmation/Acknowledgement Report — available immediately after transmission. This report verifies that DataStream received your claim file and indicates if the file was "accepted" or "rejected."
- Submission Summary Report — available approximately 24 hours after your submission. This report provides a summary and detailed analysis of your claim file. After the DataStream editing process, you will be able to verify that your claims were "accepted" and forwarded to the payer for claim processing. This report identifies errors in claims you need to correct and resubmit for them to be processed.
- Electronic Remittance Advice (ERA) — available by Wednesday of each week. This electronic file contains the same information that is reported on your Blue Shield Explanation of Benefits. Because we offer this information on-line, you don't have to wait to receive this information in the mail.

Note: Some Practice Management Software Systems have the capability of automatically posting this information directly to your patient accounts receivables.

CareConnect® — information available at your convenience

CareConnect, our interactive on-line service, links over 5,500 health care professionals to large information databases and reference materials. Think of it as your on-line customer service representative who's available seven days a week, 24 hours a day.

CareConnect will assist you in improving your office efficiency and effectiveness, lower your administrative costs and improve your cash flow projections.

CareConnect database resources allow you to review enrollment information, monitor the progress and status of claims, and research medical policy. It can also be used as an online **PTM** and **ICD-9-CM** reference.

For more information about submitting electronic claims call DAS at (800) 992-0246. Or, visit our website at **www.careconnect.com**.

Note: We do recommend that new electronic claim billers perform electronic claim submission testing, although it is not required.

Technology: purchasing the best PC for your office

This is an updated version of an article published in the December 1997 **PRN**. If you read the first one, you'll want to read this one because it contains information about zip drives and other more current helpful hints.

One of the most common questions health care professionals and their office managers ask members of the Direct Access Services (DAS) staff is: "What kind of PC should I buy?"

Scott Mangol, director of Electronic Commerce Technologies for Pennsylvania Blue Shield, put together the following analysis of that question. (Mangol can be reached for further technology questions at the Internet e-mail address of **drtechnology@careconnect.com**.)

Every Sunday you see ads in your local newspaper selling PCs at low, low prices. The headlines for these ads mean something to everyone, but the "technotalk" that accompanies each ad is likely to drive even the most skilled PC users crazy. Let's analyze an ad from a recent newspaper and explain each item in detail. It reads:

High performance machines at great low prices

Quick specs:

CD-ROM	40x
Zip drive	Iomega 100 MB
Fax/modem	56 Kbps technology
Warranty	One year on-site warranty, toll free technical support – six days a week
Pentium processor	366 MHz
RAM	64 MB
Hard drive	6.4 GB
Windows 98™ included	

- The CD-ROM drive is very similar to the one you may have on your stereo system at home. In fact, PCs today have the added benefit of playing your music CDs. The speed indicator (40x) is the comparative ratio of data transfer on this CD versus the original CD introduced five to six years ago. A 40x CD is standard on most new machines and can handle nearly all your data requirements for the foreseeable future.
- A zip drive is the latest in "floppy" drives (Iomega is the leading manufacturer of these drives). The zip diskette is almost the same size as the 3.5-inch floppy, but

™Windows 98 is a trademark of Microsoft Inc.

holds about 70 times more data. It is used for data backup and storage. Since most programs are larger than 1.44 Mbps (3.5-inch capacity), zip drives appear in most new machines.

- A fax modem is your electronic connection (through a telephone line) to Pennsylvania Blue Shield, other PCs and the Internet. Modem is short for modulator/demodulator. A modem converts the PC speech into telephone speech and back again on the other end. A fax modem also allows you to send and receive faxes through your PC.
- Modem speeds of 33.6 Kbps or 56 Kbps are available. Usually a disclaimer reminds you that 56 Kbps is the maximum speed. The actual connection speed depends on your phone company, the condition of the phone line and the capabilities of the machine your are connecting to.
- Processor speed is one of the most important PC features. This is the "metabolism" of your PC. The higher the metabolism, the faster the PC will work and produce results. For the majority of software written today, a 200 MHz machine will work fine. Most ads offer a 300, 366 or 400 MHz option. For most of what your offices do today, any one of these machines will work. The only issue is cost.
- For the novice user, customer support may be the most important item on the ad. Nearly all ads list a basic warranty and toll-free technical support. The warranty service is either one or three years. What differentiates one from another is where the service is performed. A one-year, on-site warranty is better than one where you return the machine to the factory for servicing.
- Memory is one of the real confusing points for any PC purchase. It comes in two forms, RAM and hard drive. RAM is short for Random Access Memory. It is the amount of area the PC has to shuffle programs and tasks that are active or in use. Picture your desktop as a work area. The bigger the desktop, the more papers and piles of papers you can have on top. This analogy also holds for the hard drive, which is analogous to your filing cabinets. It is a program storage area for programs that aren't being worked on now. When you need a file, retrieve it from the filing cabinets (hard drive) and place it on your desktop (RAM).
- Memory cost: As far as cost per benefit, this is a personal decision. The basic machines offered today have 32 MB (32 million bytes) or 64 MB of "work space" and are sufficient for your current needs. Best of all, most machines allow you to add more memory. If you buy a machine with 32 MB, you can upgrade the memory later by adding another 32 MB to achieve 64 MB. A hard drive replacement is a total replacement, but buying an office machine for basic functionality requires less than 6.4 GB.
- Be sure to have the operating system preloaded. The operating system is the instruction the PC uses to process data and run programs. If the operating system is not included, expect to pay an additional price for the software.
- Extra tip. Since some manufacturers do not adhere to an open architecture or design, ask the salesperson if the machine is easily upgraded. If the architecture is open, the machine will expand as your needs expand. If the system is proprietary, a total replacement is in your future.

- One additional note, when comparing prices, make sure the cost of the monitor is included in the price you are quoted. In many cases, this is listed separately.
- Your basic outlay for today's machine, with all the features noted above, is around $899. Add an extra $200 for a printer and you're ready to go. This machine can handle all of the basic office functions, including claim submission (DataStream) and inquiry access (CareConnect) and still have plenty of horsepower for other applications like word processing and spreadsheets. And, with the time you save by submitting electronically, you may even get in a few games of solitaire!

If you have a question you'd like us to respond to, send it to:

Scott Mangol
C/O Direct Access Services
PO Box 890089
Camp Hill, Pa. 17089-0089

Or send us an e-mail to our Internet mail address at **drtechnology@careconnect.com**. You can also contact us in the Comments section of the DAS home page at **www.careconnect.com**.

Connections '99 set for June

This is your last chance in 1999 to meet face-to-face with EDI vendors and have your questions answered by the experts.

Direct Access Services (DAS) is accepting registrations for the Connections event to be held on June 8-9, 1999 at the Sheraton Inn Pittsburgh North, Mars.

Call (800) 535-3576 to register.

Attention PCE users: free software training available

Direct Access Services (DAS) is offering free training sessions for Paperless Claims Express© (PCE) in 1999.

Here is the tentative schedule:

Date	Location	
May 18	Clarion Hospital	Clarion
May 20	Holiday Inn	Warren
June 8	Sheraton Inn Pittsburgh North	Mars/Cranberry (Connections)
June 10	Sheraton Inn Pittsburgh North	Mars/Cranberry
June 11	Sheraton Inn Pittsburgh North	Mars/Cranberry
July 15	150 Camp Hill Corporate Center	Camp Hill
July 27	To be announced	Bedford
Aug. 10	To be announced	Meadville
Aug. 27	To be announced	Bloomsburg
Sept. 9	To be announced	Washington, Pa.
Sept. 23	To be announced	Latrobe

Training dates and locations are subject to change. Call (800) 535-3576 to confirm. Seating is limited to two attendees per office.

Who should attend

Health care professionals, office personnel or billing agents using PCE and who would like PCE for Windows™ training.

What you will learn

In the 8 a.m. – 3:30 p.m. hands-on PCE training session, we introduce our Windows-based version of PCE software. The 8 a.m. - Noon session focuses on getting started, office setup, file maintenance and enrollment. From 1 - 3:30 p.m. we focus on claim entry, transmission, archiving claims, reports, backup and restore.

The 4 – 5:15 p.m. CareConnect® training session covers the types of information available on our CareConnect network. Hands-on training enables attendees to access information for enrollment, benefits, claim status, allowances and much more.

How to register

There are three ways you can register:

- Call (800) 535-3576 and speak with a Marketing Support representative.
- Fax your request to (717) 730-8968, to "Training Coordinator." Please include your name, phone number and the name of your other attendee. DAS will contact you to verify your registration.
- Access our website at **www.careconnect.com** and click on "Calendar of Events." Then, click on the "Training" button. On the "PCE Product Training" page, click on "To Register." Complete and submit the form.

Make your reservations today — space is limited.

CareConnect expands functions on the Internet

Direct Access Services (DAS) is working toward a new milestone in CareConnect technology. Expanded Internet functions targeted for implementation the second quarter of 1999, will help advance your office into the new millennium.

In addition to the services you have come to expect with CareConnect, the expanded Internet functions will prove invaluable in building and redefining your professional practice. Included will be an unlimited reference library, automated forms, and much more.

During the second quarter of 1999, new CareConnect Discovery requests will receive CareConnect.com. Current CareConnect Discovery users should begin to look ahead to this new technology and the resources it offers.

Free on-line service simplifies vision claims submission

Clarity Vision is making it easier for you to submit claims by using the Internet. Our new service, requiring only a browser (Netscape™ 4.04 or higher or Microsoft Internet Explorer® 4.0 or higher), allows you to submit claims through our website at **www.clarityvision.com**.

Providers in our networks who are making the transition to paperless claims and do not have any other method to bill us directly, will find this to be an invaluable tool.

To take advantage of this free service, you must be a Clarity Vision network member and have a provider number.

We've included claims completion instructions on our site along with a "Help" feature. A security feature keeps unauthorized users from accessing the site and protects confidential patient and provider information.

On-line claims submission offers many benefits:

- postage savings
- time savings on claims corrections
- faster claims payments

Information about on-line claim submission and how to join one of the networks is available on our website on our Provider Services page.

Policy

Act 98 provides for diabetic supplies

On Feb. 12, 1999, the state Diabetes Supplies and Education Mandate, Act 98 of 1998, became effective. Act 98 requires insurers to provide reimbursement for diabetic services and supplies for patients with insulin or noninsulin dependent diabetes, insulin or noninsulin using diabetes, or gestational diabetes (**ICD-9-CM** codes 250 – 250.93, 648.8 – 648.84, 775.1).

Only legally authorized health care professionals can prescribe these diabetic services and supplies.

This mandate permits the application of benefits through a combination of policies, contracts, certificates or riders, such as Blue Cross Blue Shield and major medical. For the majority of Pennsylvania Blue Shield's members, the mandated services will be covered through this combination of programs.

However, your patients who have coverage only under Basic Blue Shield will be affected. For these members, coverage for the mandated services, which would have been covered under Blue Cross or major medical, will be added to their Basic Blue Shield agreement.

Report concurrent care correctly to avoid payment delays or denials

When reporting concurrent care, report only those diagnoses for the conditions you are actually treating. Proper diagnosis reporting will help you avoid payment delays or incorrect denials.

Concurrent care is care provided to an inpatient of a hospital or skilled nursing facility simultaneously by more than one doctor during a specified period of time. This type of care is usually provided when:

- Two or more separate conditions require the services of two or more doctors; or,
- The severity of a single condition requires the services of two or more doctors for proper management of the patient.

The admitting doctor has overall responsibility for the patient's care. However, on the basis of the patient's condition, the attending doctor may request one or more consultants or specialists to participate in the patient's care. You must document the need for such care in the patient's records, your daily notes and in the discharge summary. These records should:

- Document the attending doctor's request for the consultant to see the patient;
- Include sufficient documentation to indicate the seriousness of the patient's condition;
- Document each doctor's active participation in the patient's care; and,
- Document the attending doctor's release of the consultant's care when it is no longer needed.

The medical necessity of concurrent care must be established on the basis of the patient's condition, as demonstrated by the reported diagnoses and the documentation in the patient's record.

Pennsylvania Blue Shield will deny concurrent care that does not meet medical necessity criteria. A participating or preferred provider may not bill the patient for concurrent care services denied because of a lack of medical necessity.

Rotavirus vaccine now covered

The Advisory Committee on Immunization Practices (ACIP) has endorsed the rotavirus vaccine. Therefore, Pennsylvania Blue Shield will reimburse health care professionals for the vaccine, in accordance with the Childhood Immunization Insurance Act (Act 35 of 1992).

Blue Shield reimburses childhood immunizations in accordance with Act 35. If a childhood immunization conforms to the standards of the ACIP of the Centers for Disease Control, as determined by the Pennsylvania Department of Health, coverage can be granted.

The rotavirus vaccine is administered as an oral formulation to infants at 2, 4 and 6 months of age. The three-dose series should be completed by age 1.

Please report this vaccine with procedure code 90680. An additional allowance will not be made for the oral administration of this vaccine.

Coverage for breast MRI expanded

Pennsylvania Blue Shield pays for magnetic resonance imaging (MRI) of the breast for the following indications:

- Evaluation of the breast when mammography and ultrasound are equivocal, and there is still the suspicion of breast cancer.
- Evaluation of the breast for additional lesions following a diagnosis of breast cancer.
- Evaluation of the breast following treatment for a diagnosis of breast cancer.
- Evaluation of breast cancer in women with breast implants.
- Detection of a rupture of breast implant(s).

MRI studies of the breast for all other indications (including the evaluation of a palpable breast mass) are considered investigational. They are not eligible for payment.

Blue Shield does not cover MRI studies of the breast when performed as a screening study.

Services performed on the dedicated MRI breast scanners in a freestanding setting are reimbursed under the cost based payment methodology. If you are interested in total component reimbursement for these services, please contact the Benefits Cost Management department at (717) 763-6527.

Radiographic imaging techniques not covered

Pennsylvania Blue Shield makes no additional allowance for radiographic imaging techniques such as:

- Cineradiography (codes 76120, 76125)
- Digital subtraction angiography (code S9022)
- Subtraction radiography (code 76350)
- Xeroradiography (code 76150)

These image-enhancing techniques are not the actual radiological procedure performed.

When reported, Blue Shield will deny the imaging technique as non-covered. A participating or preferred health care professional cannot bill the member for this service.

Please report the appropriate procedure code for the radiological study performed.

Botulinum toxin type A (chemodenervation) coverage expanded

Effective immediately, Pennsylvania Blue Shield recognizes botulinum toxin type A (code J0585) for the treatment of the following additional conditions:

- Idiopathic torsion dystonia (333.6)
- Symptomatic torsion dystonia (333.7)
- Orofacial dyskinesia (333.82)
- Organic writer's cramp (333.84)
- Hereditary spastic paraplegia (334.1)

- Neuromyelitis optica (341.0)
- Schilder's disease (341.1)
- Spastic hemiplegia (342.11-342.12)

Botulinum toxin type A (chemodenervation) is also considered medically necessary for patients with laryngeal spasm (478.75) and torticollis (723.5) (whether congenital, due to childbirth injury or trauma), and for patients with achalasia (530.0) who have not responded to dilation therapy or are considered poor surgical candidates.

Blue Shield has been allowing the use of botulinum for these conditions:

- Blepharospasm (333.81)
- Strabismus (378.00, 378.10, 378.20, 378.30, 378.31, 378.40-378.43, 378.5-378.56, 378.6-378.63, 378.73, 378.9)
- Facial spasms (351-351.9)
- Hemifacial spasms (351.8)
- Spasmodic torticollis (333.83)
- Spasmodic dysphonia (478.79)
- Infantile cerebral palsy (343-343.9)

Leuprolide acetate eligible for certain procedures

For those Pennsylvania Blue Shield contracts that provide benefits for therapeutic or chemotherapy injections, leuprolide acetate (LUPRON) is eligible for payment when used in the treatment of certain conditions.

LUPRON (J1950, J9217, J9218 or S0066) is a synthetic analog of gonadotropin releasing hormone (GnRh). Although leuprolide has potent GnRh agonist properties during short-term or intermittent therapy, the principal effect of the drug during long-term administration is inhibition of gonadotropin (LH, FSH) secretion and suppression of ovarian and testicular steroidogenesis.

Blue Shield considers LUPRON to be eligible for payment when used to treat the following conditions:

- Endometriosis (617-617.9)
- Prostate cancer (185, 189.3, 198.1, 198.82, 233.4, 233.9)
- Central precocious puberty (259.1)
- Uterine leiomyomata (fibroids) (218.0-218.9)

Blue Shield will deny the use of this drug for any other conditions as not medically necessary. A participating or preferred health care professional may not bill the member for this service.

Annual gynecological examination codes changed

Effective Jan. 1, 1999, use the following codes to report annual gynecological examinations:

S0610 – Annual gynecological examination, new patient

S0612 – Annual gynecological examination, established patient

Codes X5740 and X5741 have been deleted — do not report them after Jan. 1, 1999.

Reporting changes outlined for routine foot care and nail procedures

Effective for claims processed on or after April 26, 1999, Pennsylvania Blue Shield is revising the codes you use to report routine foot care and nail-related procedures.

We are deleting as many local codes as possible, in an ongoing effort to comply with future HIPAA requirements. These requirements include a national procedure coding system, with minimal "local" codes.

The coding instructions below apply to all product lines offered by Blue Shield.

- *Routine foot care*. Please use code W9080 to report all routine foot care, regardless of where the services are performed. The terminology for code W9080 will be revised to simply "routine foot care." Codes W9081 through W9084 have been deleted.
- *Mycotic nails*. The debridement of mycotic nails is considered routine foot care. Report code W9080 for the debridement of mycotic nails. Codes X1170 and X1171 have been deleted.
- *Hypertrophic nails*. The debridement of hypertrophic nails is a covered procedure. Blue Shield has deleted codes X1164 through X1167. Use codes 11720-11721 to report the debridement of hypertrophic nails.
- *Avulsion of nails and nail matrix*. Codes X1172, X1174, X1175 and X1177 have been deleted. Use codes 11730-11732 and 11750 to report avulsion or excision of nails and nail matrices.

Use the list below to update your 1999 **PTM**:

Page	Code	Terminology	Action
18	X1164	Debridement of hypertrophic nail; initial, single	Delete, use 11720
18	X1165	Debridement of hypertrophic nail, subsequent, single	Delete, use 11720
18	X1166	Debridement of hypertrophic nails; initial, multiple	Delete, use 11720, 11721
18	X1167	Debridement of hypertrophic nails; subsequent, multiple	Delete, use 11720, 11721
18	X1170	Debridement of mycotic nail	Delete, use W9080
18	X1171	Debridement of mycotic nails, multiple or complicated	Delete, use W9080
18	X1172	Avulsion of nail; partial, one nail	Delete, use 11730

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Page	Code	Terminology	Action
19	X1174	Avulsion of nail; complete, one nail	Delete, use 11730
19	X1175	Excision of nail and nail matrix; partial, one nail	Delete, use 11750
19	X1177	Excision of nail and nail matrix; complete, one nail	Delete, use 11750
369	W9080	Routine foot care	Change terminology
369	W9081	Routine foot care; home	Delete, use W9080
369	W9082	Routine foot care; in-hospital	Delete, use W9080
369	W9083	Routine foot care; nursing home	Delete, use W9080
369	W9084	Routine foot care; skilled nursing facility	Delete, use W9080

Page	Changes to notes in PTM	Action
Page 15	Change Note under Paring or Cutting to: (Do not use codes 11055, 11056 and 11057 for the paring, curettement, chemical cauterization or debridement of clavi, use W9080)	Change note
Page 18	Note following code 11721 – (Note: Do not use 11720, 11721. To report, see X1164-X1167, X1170-X1171)	Delete note
Page 19	Note following code X1174 – (Note: Do not use 11730-11732 for avulsion of nail. To report, see X1172, X1174)	Delete note
Page 19	Note following code X1177 – (Note: Do not use code 11750 for excision of nail. To report, see codes X1175, X1177)	Delete note

Screening PAP smears

Effective immediately, please report codes G0123, G0124, G0143 - G0145 or P3000 - P3001 for screening PAP smears. Code Z8810 has been deleted.

Local codes deleted

Effective immediately, do not report codes W0356, X0003, W9293 or W9294.

Use the following codes, as appropriate, to report these services:

S0056	Injection, Carboplatin, 150 mg
S0057	Injection, Carboplatin, 450 mg
S0070	Injection, Palivizumab, intramuscular, 100 mg
S0090	Sidenafil Citrate, 25 mg

Notes

Need to change your provider information?

Fax the information to us!

You can fax us changes about your practice information, such as the information listed on the coupon below. The fax number is (717) 731-2896. You may also continue to send information by completing the coupon below.

Coupon for changes to provider information

Please clip and mail this coupon, leaving the **PRN** mailing label attached to the reverse side to:

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

Name: _____ Provider ID Number: _____

Electronic Media Claims Source Number: _____

Please make the following changes to my provider records:

Practice Name: _____

Practice Address: _____

Mailing Address: _____

Specialty: _____

Telephone Number: _____

Tax ID Number: _____

Provider's Signature: _____ Date Signed: _____

PRN

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