PRN

Policy Review & News

Important information about Pennsylvania Blue Shield August 2000

In This Issue

BC
Look for this symbol for all BlueCard articles

News

Patient Report now integrated into main body of PRN

Don't bother searching for the "Patient Report" insert in this edition of **PRN**. In the interest of simplifying the publication, we've integrated the "Patient Report" into the main body of the publication.

It now has its own section — just like the "News," "EMC News" and "Policy" sections.

And, we've changed the name to "Patient News" to help differentiate it from the old style of handling stories about your patients and their benefits.

The new section starts on Page 15 of this issue.

PENNSYLVANIA BLUE SHIELD
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PRN

Save time — call the Precertification Center only in certain circumstances

Over 20,000 calls are directed to the Precertification Center each month. More than 13,000 of those calls, however, were not necessary.

Here's why. Over 3,000 of the calls were for patients who do not require precertification; 6,000 were to request precertification for procedures that did not need precertification; and 4,000 of those calls were customer service inquiries.

To save your office unnecessary calls, and to make sure you have access to the Precertification Center staff when precertification is necessary, please follow these suggestions before calling (800) 441-2330:

- Review the instructions on your patient's insurance identification card. "Precertification" is printed at the top right corner if it is a benefit requirement.
- The Precertification Center's standard program includes precertification of all admissions and the following 15 procedures (whether done inpatient or outpatient):

Bunionectomy	Hysterectomy
Carotid endarterectomy	Knee surgery
Cataract surgery	Ligation and stripping of varicose veins
Cholecystectomy	Prostate surgery
Coronary artery bypass	Spinal and vertebral surgery
Elective cesarean birth	Submucous resection (repair of deviated septum)
Hemorrhoidectomy	Tonsillectomy and adenoidectomy
Herniorrhaphy	

Other outpatient procedures, for example, sterilizations, do not need to be precertified.

Here are more precertification tips:

- Maternity admissions, other than cesarean births, only require precertification when the mother's stay exceeds two days.
- Office visits do not need to be precertified.
- For your patients covered under the CustomBlue plan, follow the Precertification Center's standard program.
- The Federal Employee Program requires precertification of inpatient admissions only. Precertification is not necessary for outpatient services.
- Direct all benefit and claim questions, and all inquiries not related specifically to precertification to the insurers' customer service department.

Following these guidelines can save your office valuable time, limit unnecessary calls and increase the availability of the Precertification Center's staff to meet your precertification needs.

Clarity Vision's refraction policies clarified

Clarity Vision's routine vision contracts specify that refraction is an integral part of the routine eye examination and refraction. Participating and preferred providers may not bill members for a refraction when it is performed as part of a routine eye examination and refraction.

Use procedure code S0620 or S0621 to report routine eye examinations and refractions under the vision program.

S0620 — routine ophthalmological examination including refraction; new patient

S0621 — routine ophthalmological examination including refraction; established patient

The guidelines issued in the "Coverage policies for refractions explained" article in the April 2000 **PRN** apply only to Pennsylvania Blue Shield medical-surgical contracts.

Special Investigations debuts website

Now you can find everything you need to know about Pennsylvania Blue Shield's Special Investigations department at **www.highmark.com**.

You'll be able to complete an online form and send it to Special Investigations if you suspect possible fraud or abuse. There's also a comment and feedback page.

Do not send EOMBs to Blue Shield

Do not submit a copy of your Explanation of Medicare Benefits (EOMB) statement to Pennsylvania Blue Shield's Medigap department — if your EOMB indicates the claim was forwarded to the patient's supplemental insurer.

Blue Shield receives claims directly from these Medicare Part B carriers: HGSAdministrators, Empire Medicare Services, United HealthCare and Nationwide Mutual Insurance Company.

You should receive an Explanation of Benefits (EOB) statement from Blue Shield within four weeks of receiving your EOMB from Medicare.

If you do not receive an EOB, please check your claim status by using one of Blue Shield's free information systems:

- InfoFax — (800) 891-1856
- OASIS — (800) 462-7474, or in the Harrisburg area (717) 975-6800
- **www.careconnect.com** — under "Sign-up," complete and submit the CareConnect network application form.

Correction

In our article "Special Investigations Unit works with doctors and members to detect and prevent fraud" (April 2000 issue), we incorrectly identified how much health care money is paid out each year under fraudulent circumstances.

Here is the correct information for the second paragraph of that article:

Based on the federal General Accounting Office's estimate that the nation spent $1 trillion in health care last year — that means at least $30 billion is paid out each year under fraudulent circumstances.

EMC News

EDI is new name for Direct Access Services

Direct Access Services has changed its name to Highmark EDI Services. EDI is an acronym for electronic data interchange. It's frequently used when referring to electronic transactions.

How does this change affect you?

This change does not affect you. The staff and electronic services you have come to rely on for your electronic needs are still here. And the procedures for accessing them have not changed.

Highmark EDI Services will continue to deliver and support quality electronic claim and inquiry services designed to enable you to expand the electronic capabilities of your office.

Our telephone number remains the same — (800) 992-0246. Highmark EDI Services' website address is **www.careconnect.com**.

Administrative simplification — the next Y2K

Whether or not you believe the Y2K scare was genuine or imaginary, the facts are clear — companies worldwide spent thousands of hours ensuring their computers would work properly on Jan. 1, 2000.

Today, there is an issue emerging that many people predict is going to dwarf the Y2K effort. In fact, it has sometimes been referred to as the "Health Care Electronic Data Interchange (EDI) Full Employment Act," or as *"Y2K — the sequel."*

The issue on the horizon is the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While this legislation is best known for its handling of pre-existing conditions, a part of the act deals with electronic transmission of health care information.

For anyone who transfers health care information electronically, it is important to understand that this component of the legislation is basically going to re-write the business practices of American health care. The legislation covers access to patient information, security of that information, business policies, the handling of electronic data and the way data is transmitted between relevant parties. Some of the legislated changes include:

- Instructing payers what information they can, and cannot, collect about the treatment of their members.

- Standardizing the format used by all parties for the transfer and dissemination of health care information including (but not limited to) claim and encounter submissions, claim status, enrollment and eligibility.
- Requiring provider and payer organizations to track all access to confidential, patient electronic health data by all employees.
- Deciding what types of information services a payer must offer to physicians.
- Requiring the re-training of industry employees on the proper ways to secure health data and protect patient privacy.
- Mandating health care organizations to accomplish these goals within a specific time frame.

HIPAA is going to make fundamental changes in how providers and payers conduct business, including health care electronic data interchange (EDI). When completed, these transactions will be available in uniform formats. By eliminating those unique bits of information required by specific payers or institutions, the same information can easily be passed from one organization to another. To accomplish this, all participants in the process (regardless of whether they originate, receive or just pass the information along) must ensure that the information is available in the chosen format.

The requirements of HIPAA will make health care EDI like the banking industry's ATM machines. While everyone enjoys the freedom of performing banking functions virtually anytime and anywhere, re-aligning the health care industry to accomplish this same feat will be a massive undertaking.

The U.S. Department of Health and Human Services is more than two years late in meeting some key deadlines, and in providing final, clarifying regulations.

They are reviewing tens of thousands of industry comments on the content of the proposed regulations (rules). They expect to publish the first of the final rules later this year. With limited exception, the industry will have two years to comply with the rules once they are published.

What to do at this point in time

1. Become knowledgeable.

You need to become acquainted with the administrative simplification elements of HIPAA. Learn what your responsibilities are.

Highmark EDI Services, the electronic commerce division of Pennsylvania Blue Shield, will focus on electronic transmission of claims, claim status and member eligibility. However, your responsibilities, as a health care professional, extend far beyond the claim and member eligibility issues.

The Internet is a starting point. A good place to begin is the Health Care Financing Administration's (HCFA) web page, **www.hcfa.gov/facts/f9702as.htm**. You can also review medical society websites, such as the American Medical Association at **http://www.ama-assn.org**.

You can also use your favorite search engine, for example, Yahoo or Lycos, and search for "HIPAA administrative simplification."

Non-technical sites are associated with software vendors and Highmark EDI Services does not endorse any particular organization. Consequently, with the exception of the sites previously mentioned, no specific websites are being listed in this article.

2. Talk to your software vendor and assess the state of their HIPAA awareness.

At this time, the final rules have not been issued. Therefore, don't expect your vendor to be HIPAA compliant. However, your vendor should be familiar with the subject. They should be able to tell you how they are preparing for HIPAA and describe the issues and liabilities that you will face. Your vendor should be able to explain how they (or the company that provides the software they distribute) are organizing their resources to accomplish the HIPAA mandates in the required time frames. This includes EDI transmission, data security, password management and tracking who has access to patient records.

Policy

Allowances developed for electrical stimulation procedures — reimbursements now consistent

Pennsylvania Blue Shield has developed allowances for these electrical stimulation procedures:

20974 — Electrical stimulation to aid bone healing; noninvasive (nonoperative)

20975 — Electrical stimulation to aid bone healing; invasive (operative)

The allowance will be applied to claims for these services processed on or after Sept. 11, 2000.

Claims for electrical stimulation services are reviewed on an individual consideration basis.

By standardizing the allowances for these procedures, Blue Shield will now provide consistent reimbursement.

Blue Shield allows use of tumor markers CA 19.9 and BTA

Pennsylvania Blue Shield now pays for tumor markers CA 19.9 (cancer antigen 19.9) and BTA (bladder tumor antigen).

Blue Shield will pay for CA 19.9 when used for monitoring response to treatment in patients with an established diagnosis of pancreatic cancer. CA 19.9 is not indicated for diagnosing pancreatic cancer. Payment will be made once every three months during treatment.

Blue Shield will pay for BTA when it's used as an adjunct to surveillance cystoscopy in patients with a history of bladder cancer. And when it's used to monitor for eradication of the cancer, or recurrences after eradication.

Reporting guidelines for CA 19.9 and BTA

Report CA 19.9 or BTA with procedure code 86316 and a descriptor, CA 19.9 or BTA. Be sure to include one of these appropriate **ICD-9-CM** diagnosis codes:

ICD-9-CM	Description
157.0-157.9	Malignant neoplasm of pancreas
188.0-188.9	Malignant neoplasm of bladder
197.8	Secondary neoplasm of other digestive organs and spleen
198.1	Secondary malignant neoplasm of other urinary organs
230.9	Carcinoma in situ of other and unspecified digestive organs
233.7	Carcinoma in situ of the bladder
235.5	Neoplasm of uncertain behavior of other and unspecified digestive organs
239.4	Neoplasm of unspecified nature, bladder
V10.51	Personal history of malignant neoplasm of bladder

When reporting code 86316, always include a descriptor to indicate which tumor marker you are performing.

You can also use code 86316 to report CA-125 and CA 27.29. CA-125 is a tumor marker used to diagnose ovarian cancer and primary carcinoma and metastatic adenocarcinoma of unknown origin in the peritoneum. CA 27.29 is a tumor marker for the diagnosis of stage II or stage III breast cancer.

Blue Shield considers tumor markers reported under code 86316 for other cancer diagnoses investigational. They are not eligible for reimbursement.

Blue Shield approves multivisceral transplantation procedure

Pennsylvania Blue Shield's Board of Directors recently approved multivisceral transplantation as a covered procedure.

Blue Shield will pay for multivisceral transplantation when:

- The patient has irreversible intestinal failure of more than two of the abdominal visceral organs, including the small bowel; and
- When the patient has been managed with long-term total parenteral nutrition (TPN) and has developed other gastrointestinal problems such as:
  - Thromboses of the celiac axis and the superior mesenteric artery
  - Massive gastrointestinal polyposis and/or adenomas
  - Mesenteric desmoid tumors infiltrating the differential visceral organs or their axial blood supply
  - Generalized hollow visceral myopathy or neuropathy (pseudo-obstruction syndrome)

Report these codes and terminology for multivisceral transplantation:

S2055 — Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor

S2054 — Transplantation of multivisceral organs

Radiofrequency ablation of the soft palate and/or tongue base not covered

Pennsylvania Blue Shield considers radiofrequency ablation of the soft palate and/or tongue base for the treatment of obstructive sleep apnea as an investigational procedure. Therefore, it is not eligible for payment.

Radiofrequency ablation of the soft palate and uvula for the treatment of snoring is also not covered.*

Radiofrequency ablation of the soft palate and/or tongue base, also known as somnoplasty, is designed to use radiofrequency (RF) energy to reduce and tighten excess tissue in the upper airway responsible for obstructive sleep apnea, including the base of the tongue. Delivery of radiofrequency energy into the soft palate and uvula is performed to treat patients with snoring without documented obstructive sleep apnea.

Report procedure code 42299 for radiofrequency ablation of the soft palate and/or tongue base (somnoplasty) for the treatment of obstructive sleep apnea or snoring.

Blue Shield will pay for radiofrequency ablation of the nasal turbinates (30802) when performed to reduce hypertrophic inferior turbinates.

**Pennsylvania Blue Shield's contracts allow for medically necessary services when performed for the diagnosis or direct treatment of the patient's disease, illness or injury. Snoring is not considered a disease, illness or injury. Therefore, Blue Shield does not cover radiofrequency ablation of the soft palate and uvula when used solely for the correction of snoring.*

Carotid angioplasty/ stenting considered investigational

Pennsylvania Blue Shield considers carotid angioplasty — with or without associated stenting — investigational. It is not covered.

To report carotid angioplasty with or without associated stenting, use code 37799 — unlisted procedure, vascular surgery. Do not report any other procedure code (for example, 35475, 37205) for carotid angioplasty.

Carotid angioplasty, with or without associated stenting, is considered a minimally invasive alternative to open carotid endarterectomy.

Carotid endarterectomy is considered an appropriate treatment option for patients with extensive occlusions of the carotid artery. It decreases the incidence of subsequent cerebral embolism and stroke. Carotid endarterectomy is a covered service. Use code 35301 — thromboendarterectomy, with or without patch graft, carotid, vertebral, subclavian, by neck incision — to report the procedure.

Additional indications for coverage of Erythropoietin

Erythropoietin (EPO) is eligible as a covered service for anemic patients scheduled for surgery. The patients must meet all these indications:

- hemoglobin level between 10.0 and 13.0 mg/dL;
- scheduled to undergo either total knee replacement or total hip replacement; and
- at risk for perioperative transfusions due to significant, anticipated blood loss. This includes patients who are expected to require greater than two units of blood, and are not able or willing to participate in an autologous blood donation program.

Report codes Q9920-Q9940 for the administration of EPO for an end stage renal disease (ESRD) patient. Use these codes to also report a non-malignant diagnosis. Select the appropriate "Q" code as it correlates to the hematocrit and hemoglobin level indicated in the code description.

Use code Q0136 to report the administration of EPO for patients with a malignant disease.

How to report HBO therapy

Report hyperbaric oxygen therapy (HBO) when it is performed in either an inpatient or outpatient hospital setting with code 99183 — physician attendance and supervision of hyperbaric oxygen therapy, per session. You do not need to include the level of medical care.

HBO therapy exposes the entire body to oxygen under increased atmospheric pressure.

Pennsylvania Blue Shield limits payment to HBO therapy administered in a chamber to the entire body. It must be performed in either an inpatient or outpatient hospital setting. Blue Shield will deny HBO therapy as not medically necessary if it is performed in any other place of service. Participating, preferred or network providers cannot bill the member for the denied service.

Topical application of oxygen does not meet the definition of HBO therapy. Blue Shield considers it investigational.

Reporting tips for home infusion therapy

Here are some useful tips for reporting home infusion therapy:

- Use the following codes, as appropriate, to report a per diem charge for the durable medical equipment (DME) and medical supplies to administer home infusion therapy when a nurse is not present. The codes represent a pro-rated, global, per diem allowance for the DME and medical supplies. Continue to report drugs, formulas and blood products separately.

S5018 — pain therapy administration supplies (PCA or continuous), per day

S5019 — chemotherapy administration supplies (with pump), per day

S5020 — chemotherapy administration supplies (without pump), per day

S5021 — hydration therapy administration supplies, per day

S9035 — medical equipment or supplies distributed by home care provider without professional nursing intervention, per day

S9062 — non-infusion central line maintenance catheter care; implantable device, per day (NASC)

- Follow this guide to determine the appropriate S code to report:

Previously reported code with nursing services	Code to report without nursing services
S9200	S5018
S9300	S9035, B4034 or B4036*
S9310	S9035
S9395	S5021
S9400	S9035
S9410	S9035
S9420	S9062
S9425	S5019 or S5020

- Continue to report S9543 — administration of medication intramuscularly or subcutaneously, in the home setting, including all nursing care, equipment and supplies, per diem — when a nurse has visited the home to administer an intramuscular or subcutaneous injection. Report the various "A" codes (for example, A4245, A4206 and A4209) for the individual supplies provided to the member when a nurse has *not* visited the home on that date and the member is self-administering the injection.

**Use S9035 to report the per diem charge for the enteral feeding supplies for pump-fed patients when a nurse has not visited the home on that date.*

**Use B4034 to report the per diem charge for the enteral feeding supplies for syringe-fed patients when a nurse has not visited the home on that date.*

**Use B4036 to report the per diem charge for the enteral feeding supplies for gravity-fed patients when a nurse has not visited the home on that date.*

- Home infusion codes may be range dated when service dates are consecutive. For example, when two weeks of antibiotic therapy are prescribed that require two training visits and one follow-up visit with a nurse, the services should be reported as:

From date	To date	Procedure code	Number of days/units
06012000	06012000	S9400	1
06022000	06042000	S9035	3
06052000	06052000	S9400	1
06062000	06092000	S9035	4
06102000	06102000	S9400	1
06112000	06142000	S9035	4

Radiofrequency thermal ablation of liver tumors considered investigational

Pennsylvania Blue Shield considers radiofrequency thermal ablation of liver tumors (RITA) an investigational service. It is not eligible for payment.

RITA is a form of thermal therapy that uses radiofrequency energy to treat malignant liver tumors. This procedure can be performed percutaneously under ultrasound guidance as well as during an open surgical procedure or laparoscopic surgery. The laparoscopic and open surgical techniques differ from the percutaneous approach only by degree of hepatic exposure.

Questions or comments on these new medical policies?

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

Write to us at **medicalpolicy@highmark.com**.

Codes

2000 PTM changes

Page	Code	Terminology	Action
407	Q2001	Oral, Cabergoline, 0.5 mg	Add
332	Q2002	Injection; Elliotts B solution, per ml	Add
405	Q2003	Injection; Aprotinin, 10,000 KIU	Add
407	Q2004	Irrigation solution for treatment of bladder calculi, per 500 ml	Add
405	Q2005	Injection; Corticorelin Ovine Triflutate, per dose	Add
405	Q2006	Injection; Digoxin Immune Fab, per vial	Add
405	Q2007	Injection; Ethanolamine Oleate, 100 mg	Add
405	Q2008	Injection; Fomepizole, 1.5 ml	Add
405	Q2009	Injection; Fosphenytoin, 50 mg	Add
405	Q2010	Injection; Glatiramer Acetate, per dose	Add
405	Q2011	Injection; Hemin, per 1 mg	Add
405	Q2012	Injection; Pegademase Bovine, 25 IU	Add
405	Q2013	Injection; Pentastarch, 10% solution, per 100 ml	Add
405	Q2014	Injection; Sermorelin Acetate, 0.5 mg	Add
405	Q2015	Injection; Somatrem, 5 mg	Add
405	Q2016	Injection; Somatropin, 1 mg	Add
333	Q2017	Injection; Teniposide, per 50 mg	Add
405	Q2018	Injection; Urofollitropin, 75 IU	Add
407	Q2019	Injection; Basiliximab, 20 mg	Add
405	Q2020	Injection; Histrelin Acetate, 10 mg	Add
405	Q2021	Injection; Lepirudin, 50 mg	Add
407	Q2022	Von Willebrand Factor Complex, human, per IU	Add
246	Q3001	Radioelements for brachytherapy, any type, each	Add
252	Q3002	Supply of radiopharmaceutical diagnostic imaging agent, Gallium GA 67, per mCi	Add
252	Q3003	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m Bicisate, per unit dose	Add
252	Q3004	Supply of radiopharmaceutical diagnostic imaging agent, XENON XE 133, per 10 mCi	Add
252	Q3005	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99m Mertiatide, per mCi	Add

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Page	Code	Terminology	Action
252	Q3006	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99m Glucepatate, per 5 mCi	Add
333	Q3007	Supply of radiopharmaceutical diagnostic imaging agent, Sodium Phosphate P32, per mCi	Add
252	Q3008	Supply of radiopharmaceutical diagnostic imaging agent, Indium 111-in Pentreotide, per 3 mCi	Add
252	Q3009	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99m Oxidronate, per mCi	Add
252	Q3010	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m labeled Red Blood Cells, per mCi	Add
252	Q3011	Supply of radiopharmaceutical diagnostic imaging agent, Chromic Phosphate P32 suspension, per mCi	Add
252	Q3012	Supply of oral radiopharmaceutical diagnostic imaging agent, Cyanocobalamin Cobalt Co57, per 0.5 mCi	Add
343	W9918	Physician attendance and supervision of hyperbaric oxygen therapy, per session (other than inpatient)	Delete, effective Sept. 18, 2000. To report, see code 99183
396	90378	Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg each	Change terminology
398	90669	Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use	Change terminology
398	90702	Diphtheria and tetanus toxoids (DT) absorbed for use in individuals younger than seven years, for intramuscular use	Change terminology
398	90718	Tetanus and diphtheria toxoids (Td) absorbed for use in individuals seven years or older, for intramuscular or jet injection	Change terminology
399	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and polio virus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use	Add
399	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use	Change terminology

Page	Code	Terminology	Action
399	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (three-dose schedule), for intramuscular use	Add
399	90743	Hepatitis B vaccine, adolescent (two-dose schedule), for intramuscular use	Add
399	90744	Hepatitis B vaccine, pediatric/adolescent dosage (three-dose schedule), for intramuscular use	Change terminology
399	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (four-dose schedule), for intramuscular use	Change terminology
A-1	-27	**Multiple Outpatient Hospital E/M Encounters on the Same Date:** For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding the modifier "-27" to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by a physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see Evaluation and Management, Emergency Department or Preventive Medicine services codes.	Add modifier

2000 PTM for Ancillary Providers changes

Page	Code	Terminology	Action
11	K0535	Gauze, impregnated, hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing	Add
11	K0536	Gauze, impregnated, hydrogel, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Add
11	K0537	Gauze, impregnated, hydrogel, pad size more than 48 sq. in., without border, each dressing	Add

BlueCard reminders

Alphabetical prefixes must be verified and reported

These tips will help you verify and report your patients' alphabetical prefixes on out-of-area claims:

- Ask to see your patient's most current identification card at each visit to ensure you have a copy of the most recent card in their file. Remember, alphabetical prefixes change with coverage changes.
- Include the most current identification number and the alphabetical prefix on all your claim submissions.
- If you are an electronic biller, verify with your software vendor that the member's alphabetical prefix is programmed to appear on the claim format. And that the alphabetical prefix has been "mapped" to transmit properly.
- If you refer your patient for auxiliary services, (that is, laboratory tests and/or X-rays), always supply the performing provider with the patient's full identification number — including the alphabetical prefix. When laboratories or hospitals perform these services, they are responsible for billing these services and are required to report the alphabetical prefix to receive correct reimbursement.

The three-character alphabetical prefix at the beginning of a member's identification number is the key element used to *identify* and *correctly route* out-of-area claims. The alphabetical prefix identifies the Plan or national account to which the member belongs.

There are two types of alpha prefixes: plan-specific and account-specific.

- Plan-specific alpha prefixes are assigned to every Plan and start with X, Y, Z or Q. The first two positions identify the Plan that holds the member's coverage. The third position identifies the product in which the member is enrolled.
- Account-specific alpha prefixes are assigned to centrally processed national accounts. National accounts are employer groups that have offices and branches in more than one area, but offer uniform coverage benefits to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically a national account prefix will relate to the name of the group. All three positions are used to identify the national account.

BlueCard provider/host telephone unit now available

We are pleased to announce that a BlueCard provider/host telephone unit was established on June 26, 2000. You can reach the unit by calling the appropriate customer service number and following the instructions for BlueCard host claims.

Here are the regional telephone numbers for the BlueCard provider/host unit:

Customer Service Central — (717) 731-8080

Customer Service East — (215) 564-2131

Customer Service West — (717) 975-5054

The unit's staff is available to help you with your BlueCard host claims questions. When you call, please have the member's identification number available, including the alphabetical prefix on the member's most current identification card.

Notes

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 _____

Telephone number (___) _____ Fax number (___) _____

E-mail address _____

Tax ID number _____

Specialty _____

Provider's signature _____ Date signed _____

PRN

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PRN
Policy Review & News

Pennsylvania Blue Shield
Camp Hill, Pennsylvania 17089