PRN
Policy Review & News

Important information about Pennsylvania Blue Shield February 2001

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News

HIPAA requires new reporting method for HCPCS procedure codes

The Transaction Rule of the Health Insurance Portability and Accountability Act (HIPAA) directs all health care payers to process a claim based on the medical code sets valid at the time of the service.

Beginning May 12, 2001, Pennsylvania Blue Shield will require all providers to report HCPCS procedure codes that are valid at the time a service is performed. Please refer to Blue Shield's **Procedure Terminology Manual** or the **Procedure Terminology Manual for Ancillary Providers** for appropriate HCPCS procedure codes.

This reporting requirement applies to providers that submit electronic or paper claims.

What to do if your service is rejected

If Blue Shield determines that the HCPCS procedure code you reported was not valid at the time the service was performed, it will deny the service. Blue Shield will send you a rejection notice if this happens. The notice will tell you that the service was not valid for the date the service was reported. You should select the appropriate HCPCS procedure code and re-submit the claim.

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PRN

EMC News

Blue Shield's seven-digit provider identification numbers may cause electronic claims to reject

In March, Pennsylvania Blue Shield will begin to assign its new providers a seven-digit provider identification number. This change, if not compatible with your software, could cause your electronic claims to be rejected because of an invalid provider number.

Change will not affect most providers

You will not experience any changes to the processing of your electronic claims if you are:

- An existing Blue Shield provider with a six-digit provider identification number.
- A provider that submits vision claims though Clarity Vision's website, **www.clarityvision.com**.

To avoid rejected electronic claims, please contact your software vendor to verify that your software is set up properly to accommodate the seven-digit number.

NSF 2.0 specifications allocate ten positions for provider identification numbers. Blue Shield's specifications allot for this quantity. The unused three positions are filled with leading zeroes. Some software programs handle this situation by automatically inserting a fixed quantity of leading zeroes. If the number of leading zeroes is too large, the last number of a seven-digit provider number may be deleted and your claims will be rejected. ASC X12 3051 uses variable length records. While the probability of deleting the last digit is greatly reduced, the possibility still exists.

Download Blue Shield's specifications from **www.highmark.com** (click on "Health," then "Provider") for additional details.

For more information, please contact Lew Luftig at **lluftig@highmark.com** or at (717) 760-9562.

Policy

Blue Shield expands coverage for Synagis

During the past year, a number of pediatricians sought clarification of Pennsylvania Blue Shield's coverage policy for Synagis. As a result, Blue Shield has reviewed its product coverage for Synagis therapy. Blue Shield found that some of its traditional products did not cover this therapy, resulting in some claim denials.

Blue Shield's goal is to ensure that Synagis is covered under all of its products. Effective Jan. 1, 2001, Blue Shield now covers Synagis under the medical-surgical portion of its traditional Blue Shield and major medical products.

Blue Shield will continue to provide coverage for Synagis in accordance with the American Academy of Pediatrics' guidelines.

Please use code 90378—RSV immune globulin (RSV-IgIM)—to report the immunizing agent.

Since Synagis is available in both a 50 mg and 100 mg vial, report procedure code 90378 per 50 mg. Indicate the appropriate multiple service code in the number of services field

for each 50 mg administered. For example, if a total of 100 mg is administered, report that dose by entering "2" in the number of services field.

Blue Shield follows American Academy of Pediatrics' guidelines for RSV treatment

Immune prophylaxis is available with the use of Palivizumab (Synagis), a humanized RSV monoclonal antibody that can be administered intramuscularly.

Prophylaxis should be initiated at the onset of the RSV season and terminated at the end of the RSV season. The usual time for the beginning of outbreaks is October to December. Termination is March to May; however, regional differences may occur. During the RSV season, your patients should receive monthly injections.

Immune prophylaxis with Synagis is recommended for these infants and children:

- Infants and children younger than 2 years of age with chronic lung disease (CLD) (also known as bronchopulmonary dysplasia [BPD]), who have required medical therapy for their CLD within six months before the anticipated RSV season.
- Infants born at 28 weeks of gestation or earlier may benefit from prophylaxis for up to 12 months of age.
- Infants born at 29 to 32 weeks of gestation may benefit from prophylaxis for up to 6 months of age.

For infants born between 32 to 35 weeks, the American Academy of Pediatrics recommends that treatment be reserved for those infants with additional risk factors until more data are available. Factors that influence the decision for use of prophylaxis include:

- underlying conditions that predispose to respiratory complications (for example, neurologic disease in very low birth weight infants);
- young siblings in the home;
- childcare center attendance;
- exposure to tobacco smoke in the home;
- anticipated cardiac surgery; or
- distance to and availability of hospital care for severe respiratory illness.

The FDA has not approved Synagis for patients with congenital heart disease (CHD). Additionally, prophylaxis has not been evaluated in randomized trials in immunocompromised children. Although specific recommendations for immunocompromised patients cannot be made, children with severe immunodeficiencies (for example, severe combined immunodeficiency or severe acquired immunodeficiency syndrome) may benefit from prophylaxis.

Botulinum toxin type A now eligible for chronic anal fissures

Pennsylvania Blue Shield will pay for botulinum toxin type A (code J0585) for the treatment of chronic anal fissure (565.0). Payment for botulinum toxin type A for this indication becomes effective for claims processed on or after May 14, 2001.

See "Botulinum toxin type A (chemodenervation) coverage expanded" in the April 1999 **PRN** for additional coverage guidelines.

Blue Shield allows foot orthotics when prescribed for surgically-treated fractures

Pennsylvania Blue Shield will pay for foot orthotics when they are prescribed for surgically-treated fractures. To be covered, the devices must meet the definition of orthotics as defined by Blue Shield.* They must also be a benefit of the member's contract. This change is effective for claims processed on or after May 14, 2001.

Foot orthotics prescribed for non-surgically treated fractures are not routinely eligible for reimbursement. Blue Shield will pay for foot orthotics in these instances only when the claim or inquiry includes documentation that satisfactorily establishes the orthotic's medical necessity in each individual medical case.

See the December 1999 **PRN**, "Foot orthotics allowed for certain conditions," for more information about Blue Shield's guidelines for foot orthotics and eligible diagnoses.

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

Additional co-surgery procedures now eligible

Pennsylvania Blue Shield considers these additional procedure codes eligible for payment for co-surgery:

58353—Endometrial ablation, thermal

61581—Craniofacial approach, skull

These procedures are eligible for reimbursement beginning Jan. 1, 2001.

For a further explanation of co-surgery, as defined by Blue Shield, please refer to the June 1999 and February 2000 issues of **PRN**.

Oscillatory devices eligible for certain conditions

Effective May 14, 2001, Pennsylvania Blue Shield will consider oscillatory devices eligible for reimbursement when prescribed for patients with pulmonary conditions that limit the ability to expectorate secretions. These devices must also be a benefit of the member's contract.

Please use these codes to report oscillatory devices:

S8200—Chest compression vest

Examples of chest compression vests are the ABI vest and Thairapy vest.

S8205—Chest compression system generator and hoses (for use with chest compression vest—S8200)

Use code E1399 to report other oscillatory devices, for example, Flutter, In-exsufflator, Percussionaire.

When reporting code E1399, please include a complete description of the item.

Please continue to use code E0480 to report percussors.

Guidelines clarified for specific durable medical equipment

Here are Pennsylvania Blue Shield's coverage guidelines for strollers, negative pressure wound therapy devices, noninvasive positive pressure respiratory assistance devices and continuous positive airway pressure devices. Blue Shield classifies these items as durable medical equipment (DME).

To qualify as DME, Blue Shield requires that the equipment or device must:

- be able to withstand repeated use;
- primarily and customarily be used to serve a medical purpose;
- generally not be useful to a person in the absence of illness or injury; and
- be appropriate for use in the home.

If Blue Shield denies a DME item because it does not meet these requirements, the denial is contractual in nature. A participating, preferred or network provider can bill the member for the denied item.

However, if Blue Shield denies a DME item as not medically necessary, a participating, preferred or network provider cannot bill the member for the denied item.

Strollers

Strollers are durable and can be used in the home. Therefore, they meet some of the criteria of Blue Shield's definition of DME. However, as they do not primarily and customarily serve a medical purpose and are useful in the absence of illness or injury, they do not meet all the criteria for DME. Thus, Blue Shield does not consider strollers to be eligible as durable medical equipment.

Negative pressure wound therapy device

Effective May 14, 2001, Blue Shield will pay for a negative pressure wound therapy (NPWT) device as durable medical equipment according to specific guidelines.

NPWT is the controlled application of subatmospheric pressure to a wound. This therapy uses an electrical pump (K0538). The pump intermittently or continuously conveys subatmospheric pressure through connecting tubing to a specialized wound dressing (K0539). The dressing includes a resilient, open-cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site, thereby promoting wound healing. Drainage from the wound is collected in a canister (K0540).

The purpose of the NPWT device is to promote wound healing. Blue Shield defines wound healing as improvement occurring in either surface area or depth of the wound. Lack of improvement of a wound is defined as a lack of progress in quantitative measurements of wound characteristics including wound length and width (surface area), or depth measured serially and documented over a specified time interval.

The NPWT device must be prescribed by a physician. A health care professional licensed to assess wounds and/or administer wound care must, on a regular basis:

- directly assess the wound(s) being treated with the NPWT pump;
- supervise or directly perform the NPWT dressing changes; and
- at least monthly, document changes in the ulcer's dimensions and characteristics.

The health care professional must also record wound measurements consistently and regularly in the patient's records. Documentation of wound measurements and characteristics is necessary to establish the medical necessity of the device for the individual patient. This information must be entered in the patient's records so that coverage continues for an eligible NPWT device.

An NPWT pump and supplies are covered for these conditions:

A. Ulcers and wounds in the home setting

1. The patient has a chronic Stage III or IV pressure ulcer, neuropathic ulcer (for example, diabetic, venous or arterial insufficiency ulcer), or a chronic ulcer of mixed etiology, that is, being present for at least 30 days.
2. A wound therapy program, as applicable to the type of wound (see the following description), should have been tried or considered and ruled out prior to application of NPWT.
    a. For all ulcers or wounds, the wound therapy program must include a minimum of all of these general measures, which should either be addressed, applied or considered and ruled out prior to application of NPWT:
        - documentation in the patient's medical record of evaluation, care and wound measurements by a licensed health care professional;
        - application of dressings to maintain a moist wound environment;
        - debridement of necrotic tissue, if present; and
        - evaluation of and provision for adequate nutritional status.
    b. For Stage III or IV pressure ulcers:
        - the patient has been appropriately turned and positioned;
        - the patient has used a support surface for trunk or pelvis pressure ulcers; and
        - the patient's moisture and incontinence have been appropriately managed.
    c. For neuropathic ulcers, for example, diabetic ulcers:
        - the patient has been on a comprehensive diabetic management program; and
        - reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
    d. For venous insufficiency ulcers:
        - compression bandages and/or garments have been consistently applied; and
        - leg elevation and ambulation have been encouraged.

B. Continuation of treatment of ulcers and wounds in the home following treatment in an inpatient setting

- An ulcer or wound is encountered in the inpatient setting and, after wound treatments have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.
- The patient has complications of a surgically-created wound (for example, dehiscence), or a traumatic wound (for example, pre-operative flap or graft). For these wounds, there must be documentation of the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments. For example, the patient has other conditions that will not allow for healing times achievable with other topical wound treatments.

If these criteria are not met for use of the NPWT device in either setting, Blue Shield will deny the pump and supplies as not medically necessary.

The NPWT pump must be capable of accommodating more than one wound dressing set for multiple wounds on a patient. Therefore, if you bill for more than one pump (K0538) per patient for the same time period, Blue Shield will deny these devices as not medically necessary.

Blue Shield will deny an NPWT pump and supplies as not medically necessary if one or more of the following are present:

- necrotic tissue with eschar in the wound, if debridement is not attempted;
- untreated osteomyelitis within the vicinity of the wound;
- cancer in the wound; or
- fistula to an organ or body cavity within the vicinity of the wound.

If any of the following occurs, Blue Shield will deny the pump and supplies as not medically necessary:

- adequate wound healing has occurred to the degree that NPWT may be discontinued, in the judgment of the treating physician;
- any measurable degree of wound healing has failed to occur over the prior month as documented in the patient's records; or
- four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT device in the treatment of any wound.

Supplies for NPWT are limited to:

- K0539—15 dressings per month. Additional dressings per month must be supported by documentation that the wound size requires more than one dressing kit for each dressing change.
- K0540—10 canisters per month. Additional canister sets per month must be supported by documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day).

Blue Shield will deny requests for amounts greater than the stated limits as not medically necessary.

Blue Shield will consider paying for coverage of NPWT beyond four months based on additional documentation. This additional documentation must address the initial condition of the wound including measurements, efforts to address all aspects of wound care, subsequent monthly wound measurements, and what changes in wound therapy are being applied to effect wound healing. This information must be updated with each subsequent request for additional months of use of NPWT.

Noninvasive positive pressure respiratory assistance device

Noninvasive positive pressure respiratory assistance (NPPRA) is the administration of positive air pressure, using a nasal and/or oral mask interface that creates a seal, avoiding the use of more invasive airway access, for example, tracheostomy. It may sometimes be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is to be distinguished from the invasive ventilation administered through a securely intubated airway, in a patient for whom interruption or failure of ventilatory support would lead to death.

Beginning May 14, 2001, Blue Shield will pay for NPPRA therapy for patients with clinical disorder groups characterized as:

- Group I, restrictive thoracic disorders (that is, progressive neuromuscular diseases or severe thoracic cage abnormalities);
- Group II, severe chronic obstructive pulmonary disease (COPD);
- Group III, central sleep apnea (CSA); or
- Group IV, obstructive sleep apnea (OSA) (K0532 only).

Criteria for respiratory assist devices for certain disorders

Disorder group	**Duration**	**Procedure codes**
(Group I) Restrictive thoracic disorders	3 months	K0532, K0533

Criteria:

If all these criteria are not met, Blue Shield will deny the device and related accessories as not medically necessary:

- presence of a progressive neuromuscular disease, for example, amyotrophic lateral sclerosis, or a severe thoracic cage abnormality; and
- an arterial blood gas of $Paco_2$, done while the patient is awake and breathing their usual FIO_2, is greater than or equal to 45 mm Hg; or
- sleep oximetry demonstrates oxygen saturation level is less than 88 percent for at least five continuous minutes, done while the patient is breathing their usual FIO_2; or
- for a progressive neuromuscular disease (only), maximal inspiratory pressure is less than 60 cm H_2O or forced vital capacity is less than 50 percent predicted; and
- COPD does not contribute significantly to the patient's pulmonary limitation.

Disorder group	Duration	Procedure code
(Group II) Severe COPD	3 months	K0532

Criteria:

If all the following criteria are not met, Blue Shield will deny the device and related accessories as not medically necessary. If K0533 is billed, but the criteria for a K0532 device are met, Blue Shield will base payment on the allowance for the least costly medically appropriate alternative, K0532.

- an arterial blood gas $Paco_2$, done while awake and breathing the patient's usual FIO_2, is greater than 52 mm Hg;
- sleep oximetry demonstrates oxygen saturation level of less than 88 percent for at least five continuous minutes, done while breathing oxygen at two LPM or the patient's usual FIO_2 (whichever is higher); and
- prior to initiating therapy, OSA (and treatment with continuous positive airway pressure [CPAP]) has been considered and ruled out.

Disorder group	Duration	Procedure code
(Group II) Severe COPD	2 months	K0533

Criteria:

Blue Shield will not pay for a K0533 device for a patient with COPD during the first two months. Therapy with a K0532 device with proper adjustments of the settings and patient accommodation to its use will usually result in sufficient improvement without need of a back-up rate.

Following 61 days of use of K0532, Blue Shield will apply these criteria when establishing the need for K0533:

- an arterial blood gas $Paco_2$ is repeated while the patient is awake and breathing their usual FIO_2 and the level remains 52 mm HG; and
- a sleep oximetry, while the patient is breathing with the K0532 device demonstrates O_2 saturation of less than 88 percent for at least five continuous minutes, done while breathing oxygen at two LPM or the patient's usual FIO_2, whichever is higher.

Disorder group	Duration	Procedure codes
(Group III) Central sleep apnea	3 months	K0532, K0533

Criteria:

Prior to initiating therapy, an attended polysomnogram performed on stationary equipment, must be performed documenting:

- the diagnosis of CSA;
- the exclusion of OSA as the predominant cause of sleep-associated hypoventilation;
- the ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation;

- oxygen saturation level of less than 88 percent for at least five continuous minutes, done while breathing the patient's usual FIO_2; and
- significant improvement of the sleep-associated hypoventilation with the use of a K0532 or K0533 device on the settings that will be prescribed for initial use at home, while breathing the patient's usual FIO_2.

If these criteria are not met, Blue Shield will deny the device and related accessories as not medically necessary.

Disorder group	Duration	Procedure codes
(Group IV) Obstructive sleep apnea	3 months	K0532, K0533

Criteria for K0532:

- an attended polysomnogram, performed on stationary equipment, has established the diagnosis of OSA; and
- a single level device, CPAP (E0601), has been tried and was not effective.

Note: If K0532 is billed and these criteria are not met but the coverage criteria for CPAP are met, Blue Shield will pay for the device based on the allowance for the least costly medically appropriate alternative, E0601.

Criteria for K0533:

A K0533 device is not medically necessary if the primary diagnosis is OSA. However, Blue Shield will pay for K0532 or E0601 as a least costly medically appropriate alternative.

Continued coverage beyond the initial three months of therapy
To establish the medical necessity of continued coverage of these devices, re-evaluation must occur within 61 to 90 days from the date the therapy was initiated. Documentation from this evaluation should become part of the patient's medical record. It should include information on the progress of relevant symptoms and patient usage of the device up to that time.

These accessories are reimbursable when used with K0532 or K0533:

Accessory	Replacement amounts
K0183	One per three months
K0184	Two per one month
K0185	One per six months
K0186	One per six months
K0187	One per one month
K0188	Two per one month
K0189	One per six months

Blue Shield considers requests for more than the usual replacement amount not medically necessary. However, Blue Shield will, on an individual consideration basis, consider requests for larger quantities. You must submit documentation to justify the larger quantity.

Heated and non-heated humidification is eligible for use with a covered respiratory assist device when prescribed by the treating physician to meet the needs of the individual patient.

All equipment and accessories are covered as DME. They must be prescribed by a physician.

A DME supplier cannot perform arterial blood gas, sleep oximetry or polysomnographic studies. Blue Shield does not consider a DME supplier a qualified provider or supplier of these tests. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests.

Polysomnographic studies must be performed on stationary equipment.

Continuous positive airway pressure device

Continuous positive airway pressure (CPAP) is a non-invasive technique for providing low levels of air pressure from a flow generator through a nasal mask. The purpose of CPAP is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in OSA.

Used in the treatment of OSA, Blue Shield will pay for a CPAP device as durable medical equipment when all of these criteria are met:

1. Sleep study results
    a. Apnea-hypopnea Index equal to or greater than 15 (also called the Respiratory Disturbance Index or RDI); or
    b. Two of the following four are met:
        1. Apnea-hypopnea Index greater than 10-14;
        2. greater than 20 episodes of oxygen desaturation less than 85 percent or any one episode of oxygen desaturation less than 70 percent;
        3. Type II second degree heart block or pause greater than 3 seconds or ventricular tachycardia at a rate greater than 140/minute lasting greater than 15 complexes; or
        4. excessive daytime sleepiness documented by either Epworth greater than 10 or Multiple Sleep Latency Test (MSLT) less than six.
2. Results of CPAP trial (at optimum CPAP pressure)
    a. Apnea-hypopnea Index less than 5;
    b. no oxygen desaturation less than 85 percent;
    c. abolition of arrhythmia(s) described in 1.b.3; or
    d. in patients with Apnea-hypopnea Index equal to or greater than 15, reduction greater than 75 percent.

Heated and non-heated humidification is eligible for use with CPAP when prescribed by the treating physician to meet the needs of the individual patient.

These guidelines for the CPAP device become effective May 14, 2001.

Automated visual field testing

Pennsylvania Blue Shield will allow automated visual field testing (92081-92083) for any of these conditions or indications, beginning May 14, 2001:

ICD-9-CM	Description
094.81-094.89	Syphilis
095.8	Other specified forms of late symptomatic syphilis
190.0-190.9	Malignant neoplasm of eye
191.0-191.9	Malignant neoplasm of brain
192.0	Malignant neoplasm of cranial nerves
192.1	Malignant neoplasm of meninges
198.4	Secondary malignant neoplasm of other parts of nervous system
224.0-224.9	Benign neoplasm of eye
225.0	Benign neoplasm of brain
225.1	Benign neoplasm of cranial nerves
227.3	Benign neoplasm pituitary glands and related structures
234.0	Carcinoma in situ of eye
237.0	Neoplasm, pituitary gland
237.1	Neoplasm, pineal gland
237.70	Fibromatosis
239.7	Neoplasm of unspecified nature, endocrine glands and other parts of nervous system
239.8	Neoplasm of unspecified nature, other specified sites (eye)
242.00-242.01	Toxic diffuse goiter
242.10-242.11	Toxic uniocular goiter
250.50-250.53	Diabetes with ophthalmic manifestations
259.8	Other specified endocrine disorders (Progeria)
264.0-264.9	Vitamin A deficiency
300.11	Conversion disorder (hysterical blindness)
346.00-346.01	Classical migraine-during symptoms
346.10-346.11	Common migraine
346.20-346.21	Variants of migraine (for example, lower half retinal) during symptoms
346.80-346.81	Other forms of migraine
346.90-346.91	Migraine unspecified
348.2	Benign intracranial hypertension
360.23	Siderosis
360.29	Degenerative globe disorders, other
361.00-361.07	Retinal detachment with retinal defect

ICD-9-CM	Description
361.10-361.19	Retinoschisis and retinal cysts
361.2	Serious retinal detachment
361.81-361.89	Other forms of retinal detachment
361.9	Unspecified retinal detachment
362.30-362.37	Retinal vascular occlusion
362.40-362.43	Retinal layers separation
362.50-362.57	Macular degeneration and posterior pole
362.60-362.64	Peripheral retinal degenerations
362.70-362.77	Hereditary retinal dystrophies
362.81-362.89	Retinal disorders, other
362.9	Unspecified retinal disorder
363.00-363.08	Focal chorioretinitis and focal retinochoroiditis
363.10-363.15	Disseminated chorioretinitis and disseminated retinochoroiditis
363.20-363.22	Chorioretinitis and retinochoroiditis, other and unspecified
363.40-363.43	Choroidal degenerations
363.50-363.57	Heredity choroidal dystrophies
363.61-363.63	Choroidal hemorrhage and rupture
363.70-363.72	Choroidal detachment
363.8-363.9	Other disorders of choroid
365.00-365.04	Borderline glaucoma (suspect)
365.10-365.15	Open-angle glaucoma
365.20-365.24	Primary angle-closure glaucoma
365.31-365.32	Corticosteriod-induced glaucoma
365.41-365.44	Glaucoma associated with congenital anomalies, dystrophies, etc.
365.51-365.59	Glaucoma associated with disorders of the lens
365.60-365.65	Glaucoma associated with other ocular disorders
365.81-365.89	Other specified forms of glaucoma
365.9	Glaucoma, unspecified
368.00-368.03	Amblyopia ex anopsia
368.10-368.16	Subjective visual disturbances
368.2	Diplopia
368.40-368.47	Visual field defects
368.60-368.69	Night blindness
368.8-368.9	Other and unspecified visual disturbances
369.00-369.08	Profound impairment both eyes

ICD-9-CM	Description
369.10-369.18	Moderate or severe impairment, better eye; profound impairment, lesser eye
369.20-369.25	Moderate or severe impairment, both eyes
369.3	Unqualified visual loss, both eyes
369.4	Legal blindness defined in United States
369.60-369.69	Profound impairment, one eye
369.70-369.76	Moderate or severe impairment, one eye
369.8-369.9	Unqualified and unspecified visual loss
373.8-373.9	Other and unspecified inflammation of eyelid
374.30-374.34	Ptosis of eyelid
374.87	Dermatochalasis
376.21-376.22	Endocrine exophthalmos
376.30-376.36	Exophthalmic conditions, other
376.40-376.47	Deformity of orbit
376.50-376.52	Enophthalmos
376.6	Foreign body, retained (old)
376.81-376.89	Orbital disorders, other
376.9	Unspecified disorder of orbit
377.00-377.04	Papilledema
377.10-377.16	Optic atrophy
377.21-377.24	Optic disc disorders, other
377.30-377.39	Optic neuritis
377.41-377.49	Optic nerve disorders, other
377.51-377.54	Optic chiasm disorders
377.61-377.63	Visual pathway disorders, other
377.71-377.75	Visual cortex disorders
377.9	Unspecified disorder of optic nerve and visual pathways
378.50-378.56	Paralytic strabismus
378.81-378.87	Binocular eye movement disorders, other
379.50-379.59	Nystagmus codes with neuro-ophthalmic disorders
379.92	Swelling and/or mass of the eye
431	Intracerebral hemorrhage
432.0-432.9	Other and unspecified intracranial hemorrhage
433.00-433.01	Occlusion and stenosis of precerebral arteries, basilary
433.10-433.11	Occlusion and stenosis of precerebral arteries, carotid

ICD-9-CM	Description
433.20-433.21	Occlusion and stenosis of precerebral arteries, vertebral
433.30-433.31	Occlusion and stenosis of precerebral arteries, multiple
433.80-433.81	Occlusion and stenosis of precerebral arteries, other specified
433.90-433.91	Occlusion and stenosis of precerebral arteries, unspecified
434.00-434.01	Cerebral thrombosis
434.10-434.11	Cerebral embolis
434.90-434.91	Cerebral artery occlusion
435.0-435.9	Transient cerebral ischemia
436	Acute, but ill defined cerebrovascular disease
437.0-437.9	Other and ill-defined cerebrovascular disease
446.5	Giant cell arteritis
743.20-743.22	Buphthalmos
743.51-743.59	Congenital anomalies of posterior segment
743.61	Congenital ptosis
950.0-950.9	Injury to optic nerve and pathways
951.0	Injury to oculomotor nerve
V58.69	Long term (current) use of other medication
V67.51	Following completed treatment with high-risk medications, not otherwise classified

Blue Shield will deny automated visual field examinations, if reported for any other conditions or indications, as not medically necessary.

A participating, preferred or network provider cannot bill the patient for these denied services.

In general, services provided for screening purposes are not covered except for those groups or programs that specifically include this coverage in their benefits.

Procedure code for gait analysis still available

The **2001 HCPCS Update Publication** announced that procedure code S9033—gait analysis—was being deleted.

The Blue Cross Blue Shield Association has reinstated this code. Please continue to report code S9033 for gait analysis.

How to report codes E1377-E1385

The **2001 HCPCS Update Publication** incorrectly instructed you to report Q0036 in place of deleted codes E1377-E1385.

Please use code E1399 when you are reporting services for these deleted codes.

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

Please make these changes to your 2000 **PTM**:

Page	Code	Terminology	Action
308	Y0099	Unlisted procedure, lens, general	Delete, effective 4/16/01.
308	Y0106	Refractive recheck	Delete, effective 4/16/01.
308	Y9783	Frames, dispensing fee	Delete, effective 4/16/01.
308	Y9785	Lens for prescription sunglasses	Delete, effective 4/16/01.
308	Y9786	Sunglass tint	Delete, effective 4/16/01.

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

Central Region

Preauthorization procedure for Hershey HealthStyle members made easier

The preauthorization process for HealthStyle members has been simplified by:

- Shortening and refining the list of services requiring preauthorization.
- No longer requiring preauthorization for most services after the first two visits (with the exception of those specified on the preauthorization list).
- Not requiring preauthorization of diagnostic services over $300.
- Allowing the treating physician to obtain preauthorization, instead of the primary care physician (PCP).

  By allowing the treating provider (the provider who identifies the necessity for a service that requires preauthorization) to contact Medical Management for the preauthorization approval, network provider offices should notice significant administrative efficiencies.

Treating provider now responsible for preauthorization

The PCP referral process is not changing. The PCP can write referrals for services that will be provided over the ninety-day period following the date of referral.

Beginning Jan. 1, 2001, the treating provider will be responsible for obtaining preauthorization for services that require preauthorization.

The treating provider must obtain preauthorization for certain services when the member self-refers.

Within 48 hours of authorization activity, Medical Management will notify the member's PCP of receipt of and determination of preauthorization.

HealthStyle network providers should have received this information to assist them in the transition to the new preauthorization process:

- focused preauthorization list, "Preauthorization Guide;"
- revised PCP referral form;
- quick reference address and telephone guide;
- revised sections of the referral and preauthorization process for insertion into the **HealthStyle Provider Guide**.

PCP referral forms Nos. 2451-1 and 241A-1 have been eliminated. Please discard these forms.

The new PCP referral form is form No. MC1-771 (10/2000). This form will accommodate either an addressograph or a handwritten entry. Please order a supply of the new forms through the usual reorder process or contact your Pennsylvania Blue Shield Provider Relations representative.

Specialist offices should order a supply of the self-referral forms for members to use upon request for services that are not coordinated by the PCP. Please specify form No. MC1-786 for a supply of self-referral forms. This form replaces form No. 2452-A, which should be discarded.

Eastern Region

New central site group

The AstraZeneca group has elected a central site processing arrangement with Pennsylvania Blue Shield. This arrangement is effective for services rendered on or after Jan. 1, 2001.

Group name	Group number	Alphabetical prefix	Coverage type	Effective date
AstraZeneca	AZP190000	AZP	PPO*	Jan. 1, 2001

For the most efficient means of claims submission, submit these services electronically. Call EDI Support at (800) 992-0246 for more information about electronic claims submission.

You can also submit claims on a 1500A claim form. Send paper 1500A forms to:

Pennsylvania Blue Shield
PO Box 898852
Camp Hill, Pa. 17089-8852

**PPO coverage using the PremierBlue network is being offered to AstraZeneca employees.*

Direct inquiries to:
Pennsylvania Blue Shield
PO Box 890071
Camp Hill, Pa. 17089-0071
(717) 975-8288

Eastern and Central Region

Paraxel claims process through NASCO

Paraxel's claims began to process through a central site (NASCO) arrangement on Jan. 1, 2001.

Group name	Group number	Alphabetical prefix	Coverage type	Effective date
Paraxel	PXL401000	PXL	PPO*	Jan. 1, 2001

For the most efficient means of claims submission, submit services for this account electronically. Call EDI Support at (800) 992-0246 for more information about electronic claims submission.

You can also submit your claims on a 1500A claim form.

Send paper claims to:

Pennsylvania Blue Shield
PO Box 898852
Camp Hill, Pa. 17089-8852

Direct inquiries to:
Pennsylvania Blue Shield
PO Box 890071
Camp Hill, Pa. 17089-0071
(717) 975-8288

**PPO coverage using the PremierBlue network is being offered to Paraxel employees.*

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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Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the Physician's Current Procedural Terminology, as contained in CPT-2001, Copyright 2000, by the American Medical Association. **PRN** includes CPT descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures and other materials that are copyrighted by the American Medical Association.

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