PRN
Policy Review & News

Important information about Pennsylvania Blue Shield June 2000

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News

Trade name change to regulations and agreements becomes effective Aug. 1, 2000

Pennsylvania Blue Shield is revising the regulations and agreements for participating and preferred providers to reflect the two geographic trade names that the company operates under in Pennsylvania. The revisions are effective Aug. 1, 2000.

Highmark does business in the 29 counties of Western Pennsylvania as Highmark Blue Cross Blue Shield and as Pennsylvania Blue Shield in the remainder of the state.

All participating and preferred providers in the 29-county Western Pennsylvania region are now participating and contracting with Highmark Blue Cross Blue Shield. Throughout the remainder of the state, participating and preferred providers participate and contract with Pennsylvania Blue Shield.

The only change to these documents is the company name. The details of the documents have not been changed.

Appendix A to all applicable regulations was previously a reprint of Article X of the Bylaws of Pennsylvania Blue Shield. This has been replaced, in all instances, by Article IX of the Bylaws of Highmark Inc.

There will be no need for existing participating and preferred providers under contract to sign a new agreement with Blue Shield.

PENNSYLVANIA BLUE SHIELD
A HIGHMARK COMPANY
An Independent Licensee of the Blue Cross and Blue Shield Association

The following documents have been revised with the appropriate name in the title and throughout the document:

- Pennsylvania Blue Shield Regulations for Participating Providers (form 346)
- Highmark Blue Cross Blue Shield Regulations for Participating Providers (form HM346)
- Pennsylvania Blue Shield Regulations for Preferred Providers (form 3720)
- Highmark Blue Cross Blue Shield Regulations for Preferred Providers (form HM3720)
- Pennsylvania Blue Shield PremierBlue Regulations for Preferred Providers (form PB7)
- Highmark Blue Cross Blue Shield PremierBlue Regulations for Preferred Providers (form HMPB7)
- PremierBlue Preferred Provider Agreement with Pennsylvania Blue Shield for Primary Care Physicians in Managed Care Programs (form PB5)
- PremierBlue Preferred Provider Agreement with Highmark Blue Cross Blue Shield for Primary Care Physicians in Managed Care Programs (form HMPB5)
- Preferred Provider Agreement with Pennsylvania Blue Shield for Primary Care Physicians in Managed Care Programs (form 3721)
- Preferred Provider Agreement with Highmark Blue Cross Blue Shield for Primary Care Physicians in Managed Care Programs (form HM3721)
- Participating Provider Agreement with Pennsylvania Blue Shield (form 815)
- Participating Provider Agreement with Highmark Blue Cross Blue Shield (form HM815)
- Preferred Provider Agreement with Pennsylvania Blue Shield (form 3723)
- Preferred Provider Agreement with Highmark Blue Cross Blue Shield (form HM3723)
- PremierBlue Preferred Provider Agreement with Pennsylvania Blue Shield (form PB4)
- PremierBlue Preferred Provider Agreement with Highmark Blue Cross Blue Shield (form HMPB4)

To obtain a copy of any of these forms, contact Blue Shield's Shipping Control Department at:

Pennsylvania Blue Shield
Shipping Control
PO Box 890089
Camp Hill, Pa. 17089-0089
(717) 763-3256

To meet Act 68 "clean claim" requirements, claims must include the proper information

Pennsylvania's Act 68 of 1998, the Quality Health Care Accountability and Protection Act, was signed into law in June 1998. It became effective Jan. 1, 1999. Recent Insurance Department regulations clarified the prompt payment provision of the act.

The prompt payment provision of Act 68 stipulates that health insurers pay "clean claims" within 45 days of receipt. A "clean claim" is defined as a claim with no defect or impropriety. It must include all the substantiating documentation required to process the claim in a timely manner. The core data required on a claim to make it *clean* was outlined in a special bulletin mailed to Pennsylvania Blue Shield health care providers in April 2000.

Unclean claims are those claims that require an investigation outside of Blue Shield to verify or find missing core data. For example, when a request is sent to the member for information about coordination of benefits. This may require obtaining a copy of an Explanation of Benefits (EOB) from the member's other carrier.

Blue Shield also considers claims *unclean* if a request is made to the health care professional for medical records. Claim investigations can delay the processing of the claim. The 45-day payment requirement only begins once all of the information needed to process the claim is obtained.

Blue Shield consistently processes claims well within the 45-day requirement. In fact, clean claims submitted electronically receive priority processing and are finalized within seven to 14 days. With this in mind, we encourage you to submit all claims electronically to take advantage of the faster processing.

For more information on electronic claim submission or any of Blue Shield's electronic inquiry services, visit **www.careconnect.com** or call Direct Access Services at (800) 992-0246. To find detailed instructions on how to submit electronically, visit **www.careconnect.com** and refer to either the National Standard Format (NSF) 2.0 or ANSI 3051 electronic input specifications under the Specification section.

Certain specialties have specific requirements for claim submission. If you have questions about how to submit your claims please contact Blue Shield's Provider Relations department at (717) 731-2045 or (610) 362-6116.

Blue Shield realizes strong financial results for 1999

Highmark Inc. — doing business as Pennsylvania Blue Shield — is a successful and financially sound organization that serves more than six million members. The company's success is due in large measure to successful partnerships it has formed and maintained with health care professionals for more than 60 years.

Pennsylvania Blue Shield's strong financial standing is important to our community because the company's strength is an assurance of protection to all its members. It's that protection which customers have come to rely upon for support in times of need.

Two of the nation's leading financial rating agencies, Standard & Poor's and A.M. Best, reaffirmed the company's "Strong" and "Excellent" financial ratings in 1999. Among the reasons cited were a strong balance sheet, superior capitalization and excellent market position.

The Blue Cross Blue Shield Association licenses Pennsylvania Blue Shield to offer certain products and services under the Blue Shield brand name. Pennsylvania Blue Shield is an independent organization governed by its own Board of Directors, and responsible for its own obligations. A copy of Pennsylvania Blue Shield's most recent audited financial statement is available in the company's annual report. You can find it on the Internet at **www.highmark.com**.

Pennsylvania Blue Shield Condensed Consolidated Balance Sheet*

December 31, 1999 and 1998
(In thousands)

Assets	**1999**	**1998**
Cash and investments	$2,953,049	$2,796,613
Accounts receivable	880,046	742,102
Property and equipment	268,443	276,927
Investment in affiliates	36,436	31,582
Other assets	314,464	311,310
Total assets	**$4,452,438**	**$4,158,534**
Liabilities and reserves		
Claims outstanding	$1,143,452	$1,051,451
Unearned subscription revenue	226,683	206,135
Amounts held for others	168,336	184,337
Other payables and accrued expenses	572,617	470,501
Notes payable	249,513	216,713
Total liabilities	**$2,360,601**	**$2,129,137**
Net unrealized gains, net of deferred income taxes	$224,560	$230,720
General reserves	1,867,277	1,798,677
Total reserves	**$2,091,837**	**$2,029,397**
Total liabilities and reserves	**$4,452,438**	**$4,158,534**

**Pennsylvania Blue Shield is the regional trade name used by Highmark Inc. in the Central, Eastern and Northeastern regions of Pennsylvania. These numbers are derived from audited financial statements, prepared in accordance with generally accepted accounting principles. Certain 1998 amounts have been reclassified to conform to the 1999 financial statement presentation.*

Report your provider number to prevent claim delays

Always report your billing provider number when submitting claims to Pennsylvania Blue Shield. If you do not report your billing provider number or you report an incomplete number, your claims may be delayed. Blue Shield could send your payments to someone else in error if the provider number is incorrect.

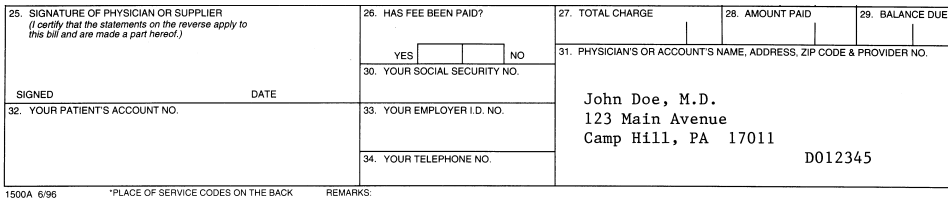
Receive priority processing: submit your claims electronically

Blue Shield gives first priority to claims filed electronically. It encourages you to submit your claims electronically to take advantage of faster service. If you are interested in electronic claim submission, visit **www.careconnect.com** or call Direct Access Services at (800) 992-0246.

How to report your provider number on paper claims

If you submit claims on paper, report your billing provider number, including the alphabetical prefix, in Block 31 of the 1500A claim form; or in Block 33 of the HCFA 1500 claim form. These blocks require you to record the physician's, account's or supplier's billing name, address, ZIP Code and provider number.

Example:



If you do not know your complete provider number, call Blue Shield's Provider Data Services department at (717) 763-3224.

EMC News

HealthOne electronic claims require special reporting criteria

Remember to check your patients' identification cards to verify any changes in their health care coverage.

In January, a number of groups implemented coverage changes. Some Point-of-Service members converted to HealthOne. This change was announced in the February 2000 **PRN**.

HealthOne claims and encounters are not processed the same as Pennsylvania Blue Shield Point-of-Service claims. Because of this, please submit HealthOne claims and encounters with a National Association Insurance Commissioners (NAIC) code of 54720PS2 — not the 54771 NAIC code you submit for other Blue Shield claims.

Electronic reporting requirements for HealthOne claims and encounters

Please follow these reporting requirements when submitting HealthOne claims or encounters:

- Include an "A" alphabetical prefix along with your HealthOne provider number. Enter this number in the HMO/network provider number field.
- Do not include the member's three-position alphabetical prefix (located on their identification card) in the member number field.

Report these data elements as:

NAIC code

NSF 2.0 — BA0 record, positions 138-142 and 143-149

ASC X12, 837 version 3051 — loop 2110-A, position 055, segment NM1, element NM108

HMO/network provider number

NSF 2.0 — BA0 record, positions 150-164, for example, 000A123456

ASC X12, 837 version 3051 — loop 2010-A, position 035, segment REF, element REF02, for example, A123456

Member identification

NSF 2.0 — DA0 record, positions 160-181

ASC X12, 837 version 3051 — loop 2110-B, position 055, segment NM1, element NM109

Contact your software vendor with any questions about the reporting of this data within your practice management system.

How to register for electronic claims submission

If you are not submitting HealthOne claims and encounters electronically, and would like to, you will need to complete two forms. You can complete the forms, DataStream subscription application and Tier 1 addendum, through Direct Access Services' (DAS) website **www.careconnect.com**. Access the "Sign-up" section and complete the forms online.

You can obtain paper copies of the forms through your fax machine. Call DAS at (800) 992-0246, select Option 1 for the fax-back service. Follow the voice prompts and request document No. 102 to receive the subscription application.

Policy

UCR and PremierBlue reimbursement changes pending Insurance Department approval

Pennsylvania Blue Shield plans to change its reimbursement for certain services under its UCR and PremierBlue products. The Pennsylvania Insurance Department is currently reviewing these proposed changes.

If the Insurance Department grants approval, reimbursement changes will be effective for claims processed on or after July 3, 2000.

The changes include:

- Revising Blue Shield's UCR Level II allowances for clinical laboratory services to match the current Medicare national limit. Blue Shield will decrease allowances that are greater than the national limit. Blue Shield will increase allowances that are less than the national limit.
- Increasing Blue Shield's UCR Level II allowances for conventional diagnostic or screening Pap smear laboratory tests.
- Decreasing Blue Shield's PremierBlue reimbursement levels for procedures with allowances that are significantly higher than Medicare's.

Reimbursement for durable medical equipment, prosthetics and orthotics changes

Pennsylvania Blue Shield is changing its reimbursement for durable medical equipment, prosthetics and orthotics. The allowance changes will standardize the pricing methodology for reimbursing these services. Allowances will now be consistent with the industry norm.

Effective immediately, Blue Shield will revise DME, prosthetics and orthotic allowances under its UCR and PremierBlue programs. The revisions will include a number of both decreases and increases.

Blue Shield withdraws coverage of autologous bone marrow or peripheral stem cell transplantation for metastatic breast cancer

Pennsylvania Blue Shield no longer provides coverage for autologous bone marrow and/or peripheral stem cell transplantation for the treatment of metastatic breast cancer. This change in policy began May 1, 2000.

Blue Shield considers autologous bone marrow transplantation and peripheral stem cell transplantation in these cases investigational. They are not covered.

Recent studies indicate that compared with maintenance chemotherapy in conventional doses, high-dose chemotherapy plus autologous bone marrow and/or peripheral stem cell transplantation soon after the induction of a complete or partial remission with conventional-dose chemotherapy, does not improve survival in women with metastatic breast cancer.

Blue Shield will continue to cover this treatment for other cancers, such as leukemia and lymphoma.

Blue Shield allows bio-engineered tissue for chronic venous ulcers

Pennsylvania Blue Shield now covers the use of bilaminate, bio-engineered tissue (for example, Apligraf) in the treatment of chronic venous ulcers (454.0). Blue Shield will deny services reported for reasons other than to treat chronic venous ulcers (for example, diabetic ulcers, decubitus ulcers, burns, etc.) as investigational.

Patients chosen for this therapy must meet these criteria:

- Prior to the use of this product, the patient should have been treated with conventional therapy, for example, wet/dry dressings, compression dressings, Unna boots, control of edema, etc., for at least three months without significant improvement.
- If the patient is a diabetic, the blood sugar should be relatively stable at less than 200 mg/dl.
- If the patient is a smoker, there should be evidence that efforts were made to decrease cigarette consumption.
- The patient should have demonstrated compliance with wound care.
- The ulcer bed should not be infected.
- There should be adequate blood supply and absence of significant arterial disease.

Blue Shield considers preparation of the ulcer bed performed on the same day as the placement of the tissue as part of the procedure. Use procedure code G0170 or G0171 to report the preparation of the ulcer bed, application of the tissue and any additional postoperative care rendered within the 10-day postoperative period.

New reporting guidelines for coronary artery scanning by EBCT

Effective immediately, please use code S8092 — Electron beam computed tomography — to report coronary artery scanning by electron beam CT (EBCT).

Pennsylvania Blue Shield considers coronary artery scanning by EBCT investigational. It is not a covered service.

Coronary artery scanning or cardiovascular CT is generally performed using an EBCT scanning system rather than a standard CT scanner. The electron beam CT scanner uses high-speed tomographic technology rather than a standard X-ray tube to produce the image of an anatomic structure.

Document critical care services in patient's medical record

In the February 2000 **PRN**, Pennsylvania Blue Shield provided coding instructions for reporting critical care services provided on, or after, Jan. 1, 2000.

This change in coding and reporting, resulting from the 2000 HCPCS update, does not change the medical necessity or the documentation requirements of Blue Shield's medical policy related to critical care services.

Blue Shield will reimburse medically necessary critical care services as they are reported. Blue Shield will also reimburse critical care services in accordance with the member's contractual benefits. Continue to document all covered critical care services in the patient's medical record.

Comprehensive critical care coding and reporting guidelines are listed on Pages 373-375 of the 2000 **Procedure Terminology Manual (PTM)**. Please review this information to ensure that you are properly reporting services provided to critically ill patients.

Papnet and autopap rescreening are part of pap smear

Pennsylvania Blue Shield considers the papnet and autopap computerized re-screenings as part of the pap smear code. Do not report these services independently.

Refer to Pages 288-289 in the 2000 **Procedure Terminology Manual (PTM)** for a complete listing of pap smear codes.

Supplies and materials integral to medical or surgical services

Pennsylvania Blue Shield considers code 99070 — supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided) — an integral part of a health care professional's medical or surgical care. It is not eligible for payment as a distinct and separate service.

Any payment for medical or surgical care performed on the same date of service includes the allowance for code 99070. A participating or preferred health care professional cannot bill the patient separately for code 99070 in those cases.

If the medical or surgical care provided on the same day is not eligible for payment, or if code 99070 is reported alone, Blue Shield considers the service not covered. A participating or preferred health care professional may bill the patient for the service.

When a supply or material used is durable medical equipment, orthotics or prosthetics, do not report code 99070. Report the appropriate code for the supply or equipment you are providing.

Blue Shield defines team surgery

Pennsylvania Blue Shield defines team surgery as two or more surgeons with different skills, and generally of different specialties, working together to carry out various procedures of a complicated surgery. To be eligible for reimbursement, the component surgery billed by a member of the surgical team must be a covered service if performed alone.

Surgical operations that could fall under the team surgery concept include, but are not limited to, such surgeries as re-attachment of a limb and organ transplants.

Please report modifier 66 — surgical team — when submitting team surgery procedures.

Blue Shield allows thyrogen as chemotherapy service

Pennsylvania Blue Shield does not reimburse thyrotropin alfa (thryrogen) under the pharmacy benefit. It is paid as a chemotherapy service.

Use code J3240 per 0.9 mg. to report thryogen.

Thyrogen is used as a diagnostic aid to monitor for recurrence of thyroid cancer.

Guidelines for tumor localization of the prostate

Pennsylvania Blue Shield covers tumor localization of the prostate only in these situations:

- For imaging pelvic lymph nodes in patients with newly diagnosed, biopsy proven prostate cancer.
- In postprostatectomy patients with rising PSA in whom there is a high clinical suspicion of occult metastatic disease.

Blue Shield considers tumor localization of the prostate for other diagnoses or conditions as not medically necessary. A participating or preferred health care professional cannot bill the member for this service when it is denied as not medically necessary.

Please use codes 78800-78803, as appropriate, to report tumor localization of the prostate. Report code A9507 for the monoclonal antibody diagnostic imaging agent Indium-111 Capromab pendetide (for example, ProstaScint).

Tumor localization of the prostate is a nuclear imaging study used to diagnose and treat patients who have clinically localized prostate cancer.

Xenon cerebral blood flow CT studies not covered

Pennsylvania Blue Shield does not consider xenon cerebral blood flow CT imaging to be generally accepted within the medical community as clinically useful in diagnosing or treatment. Therefore, Blue Shield will not pay for this procedure. A participating or preferred health care professional cannot bill the member for this service.

Please use code S9023 to report xenon cerebral blood flow CT studies.

Xenon cerebral blood flow computed tomography (CT) studies quantitatively measure cerebral blood flow to various areas of the brain in acute neurologic conditions.

Codes

2000 PTM changes

Please make these changes to your 2000 Pennsylvania Blue Shield **Procedure Terminology Manual (PTM)**:

Page	Code	Terminology	Action
121	38505	Biopsy or excision of lymph node(s); by needle, superficial (e.g., cervical, inguinal, axillary)	Add IP to the guidelines column.
121	38510	Biopsy or excision of lymph node(s); deep cervical node(s)	Remove IP from the guidelines column.
121	38520	Biopsy or excision of lymph node(s); deep cervical node(s) with excision scalene fat pad	Remove IP from the guidelines column.
121	38525	Biopsy or excision of lymph node(s); deep axillary node(s)	Remove IP from the guidelines column.
211	67208	Intravitreal injection of pharmacological agent (separate procedure)	Change code 67208 to 67028. Change terminology.
212	67028	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; cryotherapy, diathermy	Change code 67028 to 67208. Change terminology.

Review

Pennsylvania regulations for clinical laboratories

All laboratories operating in the state of Pennsylvania are subject to licensure under the Clinical Laboratory Act of the Commonwealth of Pennsylvania as well as certification under the Federal Clinical Laboratory Improvement Amendments of 1988 (CLIA '88).

This includes all testing (dipstick urinalysis, whole blood glucose, strep screens, etc.) performed anywhere, including a physician's office, nursing home, clinic, hospital and independent laboratory.

A laboratory is any place where material derived from the human body is tested and/or examined for the purpose of ascertaining a state of health. A physician's office laboratory may perform clinical laboratory testing on its own patients or those of the practice. Any office performing laboratory studies must have a clinical laboratory permit from the Department of Health to operate a laboratory. If the office is not certified by the State to perform these tests, a certified laboratory must be utilized to process the services.

Pennsylvania Blue Shield will conduct audits of providers billing laboratory services performed in the office setting to ensure that claims have paid appropriately according to the office's level of certification. Any health care provider duly authorized to practice under the applicable laws of the Commonwealth of Pennsylvania as a participating provider of Blue Shield must maintain a current license and comply with all regulations of the Pennsylvania Department of Health.

Manipulation and physical therapy treatment form being revised

Pennsylvania Blue Shield is redesigning the therapy treatment plan form. The form, No. 3861, is for submitting a written treatment plan for manipulation and physical therapy treatments in excess of 15 per calendar year.

Once the form is revised and available, Blue Shield will mail a sample form, along with guidelines and tips for completion, to all providers who report these services.

Until you receive the new form, continue to fax your treatment plans (initial, revisions and appeals) to (717) 972-0668. This fax number is only for patients who have coverage under our traditional indemnity products, that is, basic Blue Shield, comprehensive major medical or comprehensive wraparound major medical. The only exception to this is for those members who self refer out of network under SelectBlue and CommunityBlue Point-of-Service products. They may use the same fax number.

Any treatment plans with more than 10 pages of documentation should be mailed rather than faxed.

Mail them to:
Pennsylvania Blue Shield
PO Box 890140
Camp Hill, Pa. 17089-0140

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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Vol. 2000, No. 3

Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the Physician's Current Procedural Terminology, as contained in CPT-2000, Copyright 1999, 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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