PRN
Policy Review & News

Important information about Pennsylvania Blue Shield June 1999

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Pennsylvania Blue Shield's statement of financial stability

To meet its overall objective of *helping people live longer, better,* Highmark Inc. — doing business as Pennsylvania Blue Shield — strives to achieve and maintain excellent financial health. In 1998, the company accomplished this goal and established standards for continued success, while maintaining a foundation from which to ensure its future.

Blue Shield's underwriting results improved in 1998, contributing to net income of $62 million. When compared to 1997 performance, total revenues from continuing operations increased nearly $400 million, to a total of $7.5 billion. The company's general reserves — an essential measure of the financial strength of any insurer — totaled $1.8 billion at year-end.

The Blue Cross and Blue Shield Association, which requires member Plans to maintain adequate reserves as a condition of using the Blue Cross and Blue Shield trademarks, has found Blue Shield's reserves well within its performance guidelines. The reserves are also in compliance with standards set by the Pennsylvania Insurance Department.

Both the Standard & Poor's and A.M. Best rating agencies reaffirmed Blue Shield's financial rankings as "strong" and "excellent," respectively in 1998. Among the reasons cited for their assessments of Blue Shield are the company's strong balance sheet, superior capitalization, excellent market position, liquidity and improving administrative cost structure. A.M. Best and Standard & Poor's are among the most highly respected firms that evaluate the performance of the nation's health insurers.

PENNSYLVANIA BLUE SHIELD
A HIGHMARK COMPANY
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1998 was also a successful year for the company competitively, bringing the addition of more than 60,000 health care members in the western, central and northeastern areas of Pennsylvania. On the national scene, its vision-care, dental and life/disability subsidiaries added more than 1.7 million members. While Blue Shield continues its pre-eminent market share within its regional health care markets, the subsidiaries increasingly position the company for strategic success in the vital nationwide marketplace for employee benefits products and services.

Pennsylvania Blue Shield and Subsidiaries Condensed Consolidated Balance Sheet*

December 31, 1998 and 1997
(In thousands)

Assets	**1998**	**1997**
Cash and investments	$2,796,613	$2,657,511
Accounts receivable	731,388	632,976
Property and equipment	276,599	308,824
Investment in affiliates	31,582	24,492
Other assets	290,552	342,520
Total assets	**$4,126,734**	**$3,966,323**
Liabilities and reserves		
Claims outstanding	$1,048,930	$1,014,953
Unearned subscription revenue	206,135	157,212
Amounts held for others	152,537	172,485
Other payables and accrued expenses	473,496	472,896
Notes payable	216,239	233,384
Total liabilities	**$2,097,337**	**$2,050,930**
Accumulated other comprehensive income, net of income taxes	$230,720	$178,931
General reserves	1,798,677	1,736,462
Total reserves	**$2,029,397**	**$1,915,393**
Total liabilities and reserves	**$4,126,734**	**$3,966,323**

* *Pennsylvania Blue Shield is the regional trade name used by Highmark Inc. in the central, northeastern and eastern regions of Pennsylvania. These numbers are derived from audited financial statements, prepared in accordance with generally accepted accounting principles. Certain 1997 amounts have been reclassified to conform to the 1998 financial statement presentation.*

Attention FEP health care professionals: how to avoid claims processing delays

You can help reduce claims processing time of your Federal Employee Program (FEP) claims by faxing us the information that answers our follow-up questions.

Occasionally, claims are delayed because we need to request additional information from you. To avoid these delays, you can fax the additional information to us. For identification purposes, please also fax the letter we sent to you.

Fax your information to Pennsylvania Blue Shield at (717) 731-4589.

This fax number is also listed on the letters we send to request additional information.

Using red ink delays claims processing

Please do not stamp or write any information on your claims or inquiries in red ink. Use only blue or black ink.

Pennsylvania Blue Shield's image system does not recognize anything stamped or written in red on a claim or inquiry. The image we create with our system is Blue Shield's permanent record of your claim or inquiry.

If you use red ink to indicate additional information, that information will not appear on the image of your claim or inquiry. This will delay the processing of your claim or inquiry.

To prevent delays, consider filing your claims electronically. This will help you eliminate the use of red ink. If you'd like to learn more about electronic claims submission, visit **www.careconnect.com** or call Direct Access Services at (800) 992-0246.

For additional claim submission tips, refer to the article on Page 4 of the February 1999 **PRN**.

EMC News

ERA reconciles your patients' accounts efficiently

You don't have to wait to receive your Pennsylvania Blue Shield Explanation of Benefits (EOB) statement to check payment information. Direct Access Services (DAS) provides an EDI on-line report for you to view the same information that is reported on your EOBs.

You can access Electronic Remittance Advice (ERA) Monday through Friday to check payment information.

If your practice is currently billing electronically, you can experience the cost and time saving benefits immediately.

When you file your claims electronically:

- There is no manual intervention.
- ERA can eliminate posting errors.
- You can drastically reduce posting time.

DAS visited Beacon Medical Group Practice to talk to the billing staff about the ERA. Beacon billing specialist, Tracey Myers, is an experienced professional who uses state-of-the-art technology in an ever-changing, fast-paced medical practice.

Tracey says she considers the ERA file, when combined with their office management software, a necessity. “Electronic Remittance is one of, if not the most valuable electronic service offered by Direct Access Services. I electronically post 200 to 250 patient accounts in approximately 30 minutes. Manually posting the same number of accounts would take hours, approximately five hours or more.”

Tracey also states, “Electronic posting is more accurate than manual billing. It eliminates manual keying and posting errors.”

We’re sure that some of you can identify with spending many frustrating hours reviewing accounts looking for posting errors. The ERA is always balanced to the penny and virtually eliminates posting errors.

Another tremendous advantage of the ERA is the availability to check payment information Monday through Friday of each week. Tracy immediately touts, “We love the benefit of accessing the ERA file on Monday of each week. It allows us to know the exact dollar amount of expected receivables days before the check arrives. Early knowledge of the receivables allows us to better plan our weekly payables.”

Electronically posting to your accounts is the solution for managing your patient accounts easily and effectively.

Please check with your vendor to determine if your software has ERA capability.

Call the DAS support line at (800) 992-0246 for the information you need to take advantage of ERA.

Free PCE software training available

Here is the schedule for Direct Access Services’ (DAS) Paperless Claims Express© (PCE) training:

Date	Location	
July 15	150 Camp Hill Corporate Center, Suite 200	Camp Hill
July 27	Arena Restaurant	Bedford
Aug. 10	Days Inn	Meadville
Aug. 26	Pine Barn Inn	Danville
Sept. 9	Ramada Inn	Washington, Pa.
Sept. 23	Ramada Inn Historical Ligonier	Ligonier
Oct. 14	Location to be announced	Easton

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

Who should attend

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

What you’ll learn

In the 8 a.m. – 3:30 p.m. hands-on PCE training session, we’ll introduce our Windows-based version of PCE software. The 8 a.m - Noon session focuses on getting started,

office setup, file maintenance and enrollment. From 1 - 3:30 p.m., we'll focus on claim entry, transmission, archiving claims, reports, backup and restore.

How to register

We offer several ways to register:

Access our web site at **www.careconnect.com** and click on "Calendar of Events." Click on the "Training" button. On the PCE product-training page, click on "To Register." Complete and submit the form.

Fax your request to (717) 730-8968, attention: training coordinator. Please include your name, phone number and the name of your other attendee. DAS will contact you to confirm your registration.

Call one of our representatives at (800) 535-3576 to schedule your reservation.

Please register today. Seating is limited.

Policy

Blue Shield increases evaluation and management fees

After evaluating current allowances and claims data, Pennsylvania Blue Shield is changing the reimbursement for certain services.

Effective for claims processed on or after June 28, 1999, the UCR Level II allowances will increase for specific evaluation and management codes for certain specialties. The Pennsylvania Insurance Department approved increases to the UCR Level II allowances for these evaluation and management codes: 99202, 99203, 99204, 99214, 99215, 99233 and 99291.

The increase is intended to partially offset the increase of office expenses and other costs incurred by health care professionals.

Co-surgery now eligible for payment

Pennsylvania Blue Shield now recognizes co-surgery services for certain procedures.

Blue Shield defines co-surgery as two surgeons of different specialties performing, simultaneously or at separate times, portions of one or more surgical procedures during the same operative session. Because co-surgeons are performing portions of a procedure, the same procedure code describes the services performed by both surgeons. Therefore, both surgeons should report the same procedure code and modifier 62 — two surgeons.

Co-surgery is eligible per procedure, not per operative session. Therefore, the surgeon must have performed a portion of each procedure for those procedures to be reported as co-surgery. In other words, the performance of co-surgery services at one procedure during an operative session of multiple procedures, does not qualify all procedures performed during that session as co-surgery. When necessary, Blue Shield requests operative notes to verify the eligibility of co-surgery procedures.

When the procedure meets the criteria for co-surgery, submit the service with modifier 62. Blue Shield reimburses eligible co-surgery services at 62.5 percent of the contract allowance, per surgeon per procedure — multiple surgery guidelines will be applied.

Co-surgery differs from team surgery

Do not confuse co-surgery with team surgery. Team surgery involves more than two surgeons, usually with different skills and of different specialties, working together to perform various procedures of a complicated surgery. Please report modifier 66 — surgical team, when submitting team surgery procedures. Do not use modifier 62 when reporting team surgery.

Blue Shield will not reimburse a surgeon for assistant surgery services and co-surgery procedures performed during the same operative session.

Here are the procedures for which co-surgery services are eligible:

Code	Brief description
11303	Shave skin lesion
15756	Free muscle flap, microvasc
15757	Free skin flap, microvasc
15758	Free fascial flap, microvasc
19290	Place needle wire, breast
19291	Place needle wire, breast
21344	Repair of sinus fracture
21348	Repair of nose/jaw fracture
21366	Repair cheek bone fracture
21408	Repair eye socket fracture
21423	Repair mouth roof fracture
21436	Repair craniofacial fracture
22548	Neck spine fusion
22554	Neck spine fusion
22556	Thorax spine fusion
22558	Lumbar spine fusion
22585	Additional spinal fusion
22590	Spine and skull spinal fusion
22595	Neck spinal fusion
22600	Neck spine fusion
22610	Thorax spine fusion
22612	Lumbar spine fusion
22614	Spine fusion, extra segment
22630	Lumbar spine fusion
22632	Spine fusion, extra segment
22818	Kyphectomy, one-two segments

22819	Kyphectomy, three and more segments
22842	Insert spine fixation device
22843	Insert spine fixation device
22844	Insert spine fixation device
22845	Insert spine fixation device
22846	Insert spine fixation device
22847	Insert spine fixation device
22848	Insert pelvic fixation device
22851	Apply spine prosthetic device
23616	Repair humerus fracture
24006	Release elbow joint
24516	Repair humerus fracture
24546	Repair humerus fracture
25520	Repair fracture of radius
25525	Repair fracture of radius
25526	Repair fracture of radius
25574	Treat fracture radius and ulna
27193	Treat pelvic ring fracture
27194	Treat pelvic ring fracture
27215	Pelvic fracture(s) treatment
27216	Treat pelvic ring fracture
27217	Treat pelvic ring fracture
27218	Treat pelvic ring fracture
27226	Treat hip wall fracture
27227	Treat hip fracture(s)
27228	Treat hip fracture(s)
27245	Repair of thigh fracture
27496	Decompression of thigh/knee
27497	Decompression of thigh/knee
27498	Decompression of thigh/knee
27499	Decompression of thigh/knee
27507	Treatment of thigh fracture
27511	Treatment of thigh fracture
27513	Treatment of thigh fracture
27535	Treatment of knee fracture

27558	Repair of knee dislocation
27759	Repair of tibia fracture
27826	Treat lower leg fracture
27827	Treat lower leg fracture
27828	Treat lower leg fracture
27829	Treat lower leg joint
27892	Decompression of leg
27894	Decompression of leg
28531	Treat sesamoid bone fracture
28636	Treat toe dislocation
28666	Treat toe dislocation
29850	Knee arthroscopy/surgery
29851	Knee arthroscopy/surgery
29855	Tibial arthroscopy/surgery
29856	Tibial arthroscopy/surgery
30460	Revision of nose
30462	Revision of nose
31730	Intro windpipe wire/tube
33206	Insertion of heart pacemaker
33207	Insertion of heart pacemaker
33208	Insertion of heart pacemaker
33214	Upgrade of pacemaker system
33236	Remove electrode/thoracotomy
33237	Remove electrode/thoracotomy
33238	Remove electrode/thoracotomy
33501	Repair heart vessel fistula
33800	Aortic suspension
35480	Atherectomy, open
35481	Atherectomy, open
35482	Atherectomy, open
35483	Atherectomy, open
35484	Atherectomy, open
35485	Atherectomy, open
35490	Atherectomy, percutaneous

35491	Atherectomy, percutaneous
35492	Atherectomy, percutaneous
35493	Atherectomy, percutaneous
35494	Atherectomy, percutaneous
35495	Atherectomy, percutaneous
37205	Transcatheter stent
37206	Transcatheter stent
37207	Transcatheter stent
37208	Transcatheter stent
43112	Removal of esophagus
43113	Removal of esophagus
43117	Partial removal of esophagus
43118	Partial removal of esophagus
43121	Partial removal of esophagus
43246	Place gastrostomy tube
43842	Gastroplasty for obesity
43843	Gastroplasty for obesity
49905	Omental flap
50230	Removal of kidney
50360	Transplantation of kidney
50365	Transplantation of kidney
50727	Revise ureter
50728	Revise ureter
50782	Reimplant ureter in bladder
50783	Reimplant ureter in bladder
56300	Laparoscopy; diagnostic
56301	Laparoscopy; tubal cautery
56302	Laparoscopy; tubal block
56303	Laparoscopy; excise lesions
56304	Laparoscopy; lysis
56305	Laparoscopy; biopsy
56306	Laparoscopy; aspiration
56307	Laparoscopy; removal adnexa
56308	Laparoscopy; hysterectomy
56309	Laparoscopy; removal myoma

56311	Laparoscopy; lymph node biopsy
56312	Laparoscopy; lymphadenectomy
56313	Laparoscopy; lymphadenectomy
56314	Laparoscopy; drain lymphocele
56315	Laparoscopy; appendectomy
56350	Hysteroscopy; diagnostic
56351	Hysteroscopy; biopsy
56352	Hysteroscopy; lysis
56353	Hysteroscopy; resect septum
56354	Hysteroscopy; remove myoma
56355	Hysteroscopy; remove impact
56356	Hysteroscopy; ablation
56405	I and D of vulva/perineum
56605	Biopsy of vulva/perineum
56606	Biopsy of vulva/perineum
56631	Extensive vulva surgery
56632	Extensive vulva surgery
56633	Extensive vulva surgery
56634	Extensive vulva surgery
56637	Extensive vulva surgery
56810	Repair of perineum
57284	Repair paravaginal defect
57460	Cervix excision
58262	Vaginal hysterectomy
58263	Vaginal hysterectomy
58345	Reopen fallopian tube
61460	Incise skull for surgery
61520	Removal of brain lesion
61526	Removal of brain lesion
61530	Removal of brain lesion
61531	Implant brain electrodes
61548	Removal of pituitary gland
61760	Implant brain electrodes
62351	Implant spinal catheter

63001	Removal of spinal lamina
63003	Removal of spinal lamina
63005	Removal of spinal lamina
63011	Removal of spinal lamina
63012	Removal of spinal lamina
63015	Removal of spinal lamina
63016	Removal of spinal lamina
63017	Removal of spinal lamina
63020	Neck spine disk surgery
63030	Low back disk surgery
63035	Added spinal disk surgery
63040	Neck spine disk surgery
63042	Low back disk surgery
63045	Removal of spinal lamina
63046	Removal of spinal lamina
63047	Removal of spinal lamina
63048	Removal of spinal lamina
63075	Neck spine disk surgery
63076	Neck spine disk surgery
63077	Spine disk surgery, thorax
63078	Spine disk surgery, thorax
63085	Removal of vertebral body
63086	Removal of vertebral body
63087	Removal of vertebral body
63088	Removal of vertebral body
63090	Removal of vertebral body
63091	Removal of vertebral body

Diagnostic and definitive surgeries defined

Pennsylvania Blue Shield adopted Medicare's designated pre and postoperative days for surgical procedures on Jan. 11, 1999. To provide further consistency between Medicare and Blue Shield, as well as to match national processing standards, Blue Shield has also adopted Medicare's diagnostic and definitive surgery designations for all Private Business products.

Diagnostic and definitive surgery designations are defined as:

Diagnostic surgery: Procedure codes with 10 or fewer postoperative days are considered diagnostic or minor surgical procedures.

Definitive surgery: Procedure codes with more than 10 postoperative days are considered definitive or major surgical procedures. Definitive surgical procedures typically also include one day of preoperative care.

These revised designations could impact your reimbursements. Under Blue Shield products, related medical care performed by the same doctor on the same day with a definitive surgical procedure is not eligible for separate reimbursement. Related medical care, including any applicable pre and postoperative care, is included in the global allowance for the surgery.

Please refer to your 1999 **Procedure Terminology Manual** for postoperative day information for each surgical procedure.

SNS for urinary urge incontinence now recognized

Pennsylvania Blue Shield now recognizes sacral nerve stimulation (SNS) for urinary urge incontinence (for example, InterStim Continence Control Therapy System) as eligible for reimbursement.

Blue Shield will make payment for SNS only when the patient meets the following criteria:

- Has a diagnosis of urinary urge incontinence (788.31) that is not due to a neurologic condition.
- Symptoms of urge incontinence have been present for at least one year's duration and have resulted in significant disability. For example, the frequency and/or severity of leakages are limiting the patient's ability to work or participate in activities outside the home.
- Has tried and failed conservative treatment, including pharmacological and behavioral treatments.
- Has had a successful screening peripheral nerve evaluation test.
- A test stimulation of the device has provided at least a 50 percent reduction in incontinence symptoms.

SNS therapy involves electrical stimulation of the sacral nerves that control voiding function. It is performed in two stages: test stimulation and permanent implantation. SNS modulates the neural pathways controlling bladder function/contractions.

Report SNS with the appropriate following codes:

64555 — Percutaneous implantation of neurostimulator electrodes; peripheral nerve.

64575 — Incision for implantation of neurostimulator electrodes; peripheral nerve.

64585 — Revision or removal of peripheral neurostimulator electrodes.

64590 — Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling.

64595 — Revision or removal of peripheral neurostimulator pulse generator or receiver.

Other applications of SNS are considered investigational. Therefore, they are not eligible for reimbursement. These applications include, but are not limited to:

- Treatment of urge incontinence due to a neurologic condition, for example, detrusor hyperreflexia.

- Stress incontinence.
- Other types of chronic voiding dysfunction.

Site of service differential affects reimbursement

Pennsylvania Blue Shield has reduced the reimbursement rates for select procedures — depending upon where they're performed. These procedures are commonly performed in the office or patient's home. However, when they are performed in a facility setting, such as the inpatient or outpatient departments of a hospital, the rates will be lower.

Blue Shield will implement a 15 percent reduction to the PremierBlue and Level II Customary UCR allowances for these procedures beginning June 28, 1999. This applies to those procedures identified for the site of service differential under the 1998 Medicare program.

When a service is provided in the health care professional's office or the patient's home, the professional incurs the overhead expenses associated with providing the service. Conversely, a health care professional does not incur the overhead expenses for services provided in a facility setting.

Blue Shield has identified these procedures as those subject to the site of service differential when performed in an inpatient or outpatient facility setting:

G0104	G0105	G0127	10040	10060	10061	10080	10081	10120
10121	10140	10160	11040	11041	11042	11055	11056	11057
11100	11101	11200	11201	11300	11301	11302	11303	11305
11306	11307	11308	11310	11311	11312	11313	11400	11401
11402	11403	11404	11420	11421	11422	11423	11424	11440
11441	11442	11443	11444	11446	11600	11601	11602	11603
11604	11620	11621	11622	11623	11624	11640	11641	11642
11643	11644	11719	11720	11721	11730	11732	11740	11750
11752	11760	11762	11765	11900	11901	12021	12031	12032
12041	12042	12051	12052	13100	13101	13120	13121	13131
13132	13151	13152	14000	14040	14041	15200	15201	15220
15221	15240	15241	15260	15261	15600	15610	15620	15780
15781	15782	15783	15852	16000	16020	17000	17003	17004
17106	17107	17110	17111	17250	17260	17261	17262	17263
17264	17266	17270	17271	17272	17273	17274	17276	17280
17281	17282	17283	17284	17304	17305	17306	17307	17340
17360	19000	19001	19100	20000	20225	20500	20520	20550
20600	20605	20610	20615	20670	21025	21026	21029	21030
21031	21032	21040	21210	21215	21300	21310	21315	21320
21400	21421	21440	21445	21451	21453	21480	21485	21493

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21550	21920	23031	23330	23620	23931	24065	24200	24362
24650	25065	25500	25530	25600	25622	25624	25630	25635
25650	26010	26070	26432	26600	26605	26720	26725	26740
27086	27323	27520	27604	27613	27760	27780	27786	27788
27816	27824	28001	28003	28010	28022	28024	28035	28052
28108	28124	28126	28153	28160	28190	28220	28222	28230
28232	28234	28270	28272	28313	28400	28430	28450	28455
28470	28475	28490	28495	28510	28515	28540	28570	28600
28630	28635	28665	29010	29015	29020	29025	29035	29049
29065	29075	29085	29105	29125	29126	29130	29131	29200
29220	29260	29280	29345	29355	29358	29365	29405	29425
29435	29440	29450	29515	29520	29540	29550	29580	29590
29700	29705	29740	29750	29850	30000	30020	30100	30110
30124	30200	30210	30220	30300	30560	30580	30801	30901
31000	31002	31233	31235	31237	31238	31505	31525	31570
31575	31579	31612	33011	36000	36400	36405	36406	36410
36430	36450	36470	36471	36510	36522	36860	38300	38505
38790	38792	40490	40800	40801	40804	40808	40810	40812
40814	40816	40819	40820	41000	41008	41100	41105	41108
41110	41112	41113	41800	41806	41825	41826	42000	42100
42106	42107	42160	42300	42310	42330	42335	42340	42400
42405	42650	42660	42700	42800	43200	43202	43234	43235
43239	44385	44388	44389	44391	44392	44393	44394	45300
45303	45305	45308	45309	45330	45331	45333	45378	45379
45380	45385	45520	46050	46083	46221	46230	46320	46500
46600	46604	46606	46611	46614	46615	46900	46910	46916
46917	46934	46935	46936	46940	46942	46945	46946	47505
51700	51705	51710	51720	52000	52010	52265	52281	52285
52332	53270	53600	53601	53620	53621	53660	53661	53670
54050	54055	54056	54057	54065	54235	55000	55250	55700
56405	56420	56501	56515	56605	56606	57061	57100	57150
57160	57180	57452	57454	57460	57500	57505	57510	57511
57800	58100	58301	59300	59425	59426	59430	59812	60000
60100	61001	61070	62284	64400	64405	64408	64412	64413
64418	64435	64440	64441	64445	64450	64505	64508	64555
65205	65210	65220	65222	65286	65430	65435	65436	65600

65772	65805	65855	65860	66030	66761	66762	66770	67028
67031	67101	67105	67141	67145	67208	67210	67220	67228
67505	67515	67700	67710	67800	67801	67805	67810	67820
67825	67830	67840	67850	67875	67915	67922	67930	67938
68020	68100	68110	68135	68200	68400	68420	68440	68530
68705	68760	68761	68770	68801	68810	68815	68840	69000
69005	69020	69100	69105	69200	69210	69222	69420	69424
69433	69540	69610	92002	92004	92012	92014	92019	92020
92100	92120	92130	92135	92140	92225	92226	92230	92260
92504	92506	92507	92508	92510	92511	92512	92516	92520
92525	92526	92565	92571	92575	92576	92577	93539	93540
93543	93544	93720	93722	93797	93798	95010	95015	95056
95065	95075	95144	95145	95146	95147	95148	95149	95165
95180	95831	95832	95833	95834	95851	95852	95857	96405
96406	96445	96450	96542	99201	99202	99203	99204	99205
99211	99212	99213	99214	99215	99241	99242	99243	99244
99245	99271	99272	99273	99274	99275	99354	99355	

Ultraviolet light therapy guidelines change

Pennsylvania Blue Shield no longer considers ultraviolet light therapy to be an integral part of an office visit.

Blue Shield will allow ultraviolet light therapy two to three times per week for eight weeks or a maximum of 24 treatments. Medical necessity must be established for claims reporting more than 24 treatments. In these instances, Blue Shield will contact you for additional information.

Ultraviolet light therapy is eligible according to these guidelines:

Ultraviolet light B (UVB), procedure code 96900

Blue Shield considers ultraviolet light B medically necessary for patients who have not responded to conservative treatment and when used in the treatment of any of the following diagnoses:

- Vitiligo* - 709.01, 103.2
- Psoriasis – 696.1
- Atopic dermatitis/severe eczema – 691.8
- Pruritus of renal disease
- Parapsoriasis – 696.2
- Polymorphic light eruptions – 692.72

* *Ultraviolet light therapy provided to patients with vitiligo is limited to those patients whose condition affects either the skin of the face and/or neck area or other body areas in excess of 30 percent of body area.*

- Lichens planus – 697.0

Psoralen and ultraviolet light A (PUVA), procedure codes 96912, 96913

PUVA is eligible for reimbursement for individuals who have a disabling psoriasis that does not respond adequately to other treatments such as UVB or topical steroids. In addition to the diagnoses that have been approved for UVB, PUVA is also an approved treatment for mycosis fungoides (cutaneous T-cell lymphoma, 202.1). Oxsoralen is the only psoralen derivative eligible for treatment of psoriasis. Ultraviolet light therapy provided with psoralens other than oxsoralen is considered investigational, and is not covered.

Goeckerman regimen, procedure codes 96910, 96913

Goeckerman therapy is approved for reimbursement in the treatment of:

- Psoriasis – 696.1
- Atopic dermatitis/severe eczema – 691.8

Evaluation and management services reported on the same date as ultraviolet light therapy are appropriate in the following circumstances:

- with the initial evaluation and assessment;
- during periodic assessment of the patient's response to therapy;
- if the patient's condition worsens;
- if a complication occurs, for example, burns; or,
- if the patient has a new complaint.

Home ultraviolet light therapy is an eligible service when provided to patients who have a documented response to UVL and have chronic or recalcitrant disease requiring long term maintenance exceeding four months. Home therapy should be limited to UVB. Home phototherapy is appropriate for the following diagnoses:

- Severe psoriasis – 696.1
- Atopic dermatitis/severe eczema – 691.8
- Pruritus of renal disease

Eligibility for a home therapy device is contingent upon compliance with the following criteria:

- The patient's condition must comply with one of the eligible diagnoses listed above.
- The patient must have a documented positive response to UVL.
- The condition must be chronic in nature.
- The device must be ordered by the physician.
- The device must be approved by the Food and Drug Administration.
- The device must be appropriate for the body surface/area being treated.

Blue Shield will limit payment to the most appropriate device that adequately meets the needs of the patient.

How to report ECMO

To report extracorporeal membrane oxygenation (ECMO), please report the specific procedure performed such as 36488 — placement of central venous catheter or 36620 — arterial catheterization, and /or a procedure code for a medical visit or prolonged detention care.

Do not report procedure code 33960 — prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours or 33961 — prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours.

Please use procedure code 36822 to report cannula insertion for prolonged extracorporeal circulation.

New codes established for annual gynecological examinations

Effective for claims processed on or after Jan. 1, 1999, please use codes S0610 or S0612 to report annual gynecological examinations. These codes apply to all Pennsylvania Blue Shield product lines including SecurityBlue.

S0610 — Annual gynecological examination, new patient

S0612 — Annual gynecological examination, established patient

Procedure codes S0610 and S0612 replace the deleted local codes X5740 and X5741.

These codes were established to comply with the state mandate. The mandate requires that a patient history, physical, weight check and physical examination of pelvis/genitalia, rectum, thyroid, breasts, axillae, abdomen, lymph nodes, heart and lungs be included in a routine gynecological examination.

Blue Shield does not recognize duplicative procedure code G0101. G0101 was created by the Health Care Financing Administration (HCFA) to reimburse for a cancer screening, including a pelvic and breast examination.

Correction: New reporting guidelines for intra-articular hyaluronan injections

The February 1999 **PRN** article entitled, "New reporting guidelines for intra-articular hyaluronan injections" incorrectly reported the terminology for code J7320.

The correct terminology for code J7320 is, "Hylan G-F 20, 16 mg for intra-articular injection." The corrected term is underlined.

CRNA employment requirements explained

Because Pennsylvania Blue Shield is receiving numerous inquiries about denials and payment reductions on anesthesia claims for services provided by certified registered nurse anesthetists (CRNAs), we're providing you with the following guidelines.

Health care professionals who employ CRNAs must provide Blue Shield with sufficient documentation to establish an employer-employee relationship. This documentation can be in the form of:

- The CRNA's W-2 form;
- A copy of the contract between the health care professional and the CRNA; and/or

- A letter from the facility administrator attesting to the billing arrangement.

If you intend to submit claims for the services of CRNAs you employ, the following criteria must be met.

An employment relationship is established between the health care professional and the nurse anesthetist if the following criteria are sufficiently documented:

1. The health care professional has the power to hire and fire the nurse anesthetist.
2. The health care professional has the power to direct the work performed by the nurse anesthetist and has ultimate responsibility for the manner of its performance.
3. The health care professional has the duty to pay wages, fringe benefits and establish the level of compensation of the nurse anesthetist.
4. The health care professional is personally responsible for withholding federal income tax and social security contributions for the nurse anesthetist's compensation and is personally responsible for making contributions for the nurse anesthetist under the Pennsylvania Unemployment Compensation Act (43 ¶§ 751 et. Seq.) and is personally responsible for ensuring the nurse anesthetist's liability under the Pennsylvania Workers' Compensation Act (77 ¶§ 1 et. Seq.).
5. No hospital receives any compensation whatsoever for the services of the nurse anesthetist during the period the anesthetist is employed by the anesthesiologist.

Only health care professionals who have supplied the CRNA employment documentation and verified the employment relationship receive 100 percent of the approved allowance for covered services from Blue Shield when they medically direct (supervise) their employee.

If this information is not on file with our Benefits Cost Management department, we will reimburse you 50 percent of the approved allowance. Blue Shield continues to require you to complete the anesthesia claim form, including information relevant to the CRNA employment on every claim form.

Please be aware of Blue Shield's employee supervision policy that requires the CRNA to be supervised when performing services as your employee. Non-medically directed or supervised services performed by the CRNA, as your employee, are considered non-covered and are not eligible for reimbursement.

Please hold all claims for services of CRNAs that you employ until Benefits Cost Management advises you to start submitting those claims.

Please direct inquiries and responses concerning this information to:

Pennsylvania Blue Shield
Benefits Cost Management Department
PO Box 890089
Camp Hill, Pa. 17089-0089

Or, call (717) 763-6524.

Defining medical direction of anesthesia services

Pennsylvania Blue Shield defines medical direction (or supervision) of anesthesia as anesthesia direction, management or instruction by one who is physically present or immediately available in the operating suite. In this instance, a health care professional, such as an anesthesiologist, should not be administering anesthesia in another operating room. In addition, a health care professional should not be personally performing other services while providing medical direction, with exception to the following:

- Addressing an emergency of short duration in the immediate area;
- Administering an epidural or caudal anesthetic to ease labor pain;
- Providing periodic, rather than continuous monitoring of an obstetrical patient;
- Receiving patients entering the operating suite for the next surgery;
- Checking or discharging patients in the recovery room;
- Handling scheduling matters.

We limit reimbursement of medical direction to no more than four anesthesia services performed concurrently. In accordance with Blue Shield's policy guidelines, payment is made to the anesthesiologist at 100 percent of the anesthesia allowance for covered anesthesia services in the following instances:

- The anesthesiologist personally provided the full anesthesia service.

  Report this as "I certify the full anesthesia service was performed by me personally."
- The anesthesiologist is present in the operating room for the entire case, and is actively participating in the administration of the anesthesia, even if the certified registered nurse anesthetist (CRNA) assists him or her in the care of a single patient.

  Report this as "I certify the full anesthesia service was performed by me personally."
- The anesthesiologist medically directs a CRNA, hired and paid by the anesthesiologist.

  Report this as "Anesthesia services were provided by my employee under my medical direction."
- The anesthesiologist medically directs a physician-in-training (such as a resident).

  Report this as "Anesthesia services were provided by a non-employee physician-in-training under my medical direction."
- In addition, payment is made to the anesthesiologist at 50 percent of the anesthesia allowance for covered anesthesia services when the anesthesiologist medically directs a CRNA not employed by the anesthesiologist (a hospital compensated CRNA or an independently practicing CRNA).

  Report this as "Anesthesia services were provided by a non-employee under my medical direction."

Codes

1999 PTM changes

Page	Code	Terminology	Action
17	11424	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm	Change postop days to 10
19	11730	Avulsion of nail plate, partial or complete, simple; single	Change postop days to 0
19	11732	Avulsion of nail plate, partial or complete, simple; each additional nail plate	Change postop days to 0
19	11750	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal	Change postop days to 10
22	13160	Secondary closure of surgical wound or dehiscence, extensive or complicated	Change postop days to 90
22	14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	Change postop days to 90
41	21343	Open treatment of depressed frontal sinus fracture	Change postop days to 90
41	21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	Change postop days to 90
55	25101	Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body	Change postop days to 90
63	26560	Repair of syndactyly (web finger) each web space; with skin flaps	Change postop days to 90
72	27566	Open treatment of patellar dislocation, with or without partial or total patellectomy	Change postop days to 90
78	X2825	Tenotomy and/or partial capsulotomy, closed, puncture or snap type, metatarsophalangeal joint	Delete procedure code. Add note: (X2825 has been deleted. To report, use code 28899.)
79	X2830	Arthroplasty of foot; lesser metatarsophalangeal joint	Delete procedure code. Add note: (X2830 has been deleted. To report, use code 28899.)

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Page	Code	Terminology	Action
79	X2835	Arthroplasty of foot; phalangeal-phalangeal joint	Delete procedure code. Add note: (X2835 has been deleted. To report, use code 28899.)
79	X2836	Arthroplasty of foot; first metatarsophalangeal joint, total joint replacement	Delete procedure code. Add note: (X2836 has been deleted. To report, use code 28899.)
79	X2837	Arthroplasty of foot; inter-phalangeal joint, with implant	Delete procedure code. Add note: (X2837 has been deleted. To report, use code 28899.)
79	X2838	Arthroplasty of foot; metatarsal-phalangeal joint, with implant	Delete procedure code. Add note: (X2838 has been deleted. To report, use code 28899.)
82	X2912	Application of short arm splint (forearm to hand); under age 10 years static	Delete procedure code. Add note: (X2912 has been deleted. To report, see code 29125.)
83	X2934	Application of long leg cast (thigh to toes); under age 10 years	Delete procedure code. Add note: (X2934 has been deleted. To report, see code 29345.)
90	31580	Laryngoplasty; for laryngeal web, two-stage, with keel insertion and removal	Change postop days to 90
97	33218	Repair of pacemaker electrode(s) only; single chamber, atrial or ventricular	Change postop days to 90
114	36822	Note: For maintenance of prolonged extracorporal circulation, use 33960.	Delete note following code 36822.

Page	Code	Terminology	Action
142	46945	Ligation of internal hemorrhoids; single procedure	Change postop days to 90
163	54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	Change postop days to 90
163	54600	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis	Change postop days to 90
164	55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	Change postop days to 0
165	55605	Vesiculotomy; complicated	Change postop days to 90
208	67208	Destruction of localized lesion of retina (e.g., Maculopathy, choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy	Change code to 67028
219	Y7030	Radiology diagnostic, both mandible and temporomandibular joints, panoramic views	Delete procedure code. Add note: (Y7030 has been deleted. To report, see code 70355.)
220	Y7033	Magnetic resonance (e.g., proton imaging, temporomandibular joint, with contrast material	Delete procedure code. Add note: (Y7033 has been deleted. To report, see code 70336.)
220	Y7034	Magnetic resonance (e.g., proton imaging, temporomandibular joint, without contrast material followed by contrast material	Delete procedure code. Add note: (Y7034 has been deleted. To report, see code 70336.)
338	99078	Note: (Do not use code 99078 for diabetic instructions. To report see G0108 or G0109.)	Add note under code 99078.
339	X0015	Insulin training	Delete procedure code effective 5/3/99. Use G0108 or G0109.
397	J2790	RHO(D) immune globulin, human, one dose package	Change terminology

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Page	Code	Terminology	Action
397	J2792	RHO(D) immune globulin, intravenous, human, solvent detergent, 100 IU	Change terminology
398	S0018	Amphotericin B, per 50 mg	Delete procedure code. Add note: (S0018 has been deleted. To report, see code J0285.)
A-2	32	Mandated services	Add note following terminology: (Do not report this modifier.)
A-6	FP	Service provided as part of Medicaid family planning program	Add note following terminology: (Do not report this modifier.)
A-7	QD	Recording and storage in solid state memory by a digital recorder	Add note following terminology: (Do not report this modifier.)
A-7	QT	Recording and storage on tape by an analog tape recorder	Add note following terminology: (Do not report this modifier.)

Notes

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: _____

Specialty: _____

Telephone Number: _____

Tax ID Number: _____

Provider's Signature: _____ Date Signed: _____

PRN

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Acknowledgement

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Pennsylvania Blue Shield
Camp Hill, Pennsylvania 17089