PRN
Policy Review & News

Important information about Pennsylvania Blue Shield
http://www.pablueshield.com

April 2002

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BC
Look for this symbol for all BlueCard related information

News

Blue Shield to adhere to ERISA claim filing procedures

Pennsylvania Blue Shield is implementing the Department of Labor's regulation establishing new minimum standards for the filing and processing of claims for benefits that are made available through employer group health plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

For example, this regulation will affect the way Blue Shield processes post-service benefit claims submitted by its members or by you, in cases where a member has authorized you to file a benefit claim on his or her behalf. A post-service claim is any member request for a plan benefit that does not require pre-approval of the benefit in advance of obtaining the medical care. Blue Shield must process each post-service claim, and issue notice of any adverse benefit determination within a reasonable period of time, but not later than 30 days after it receives the claim.

Claim filing requirements

So that Blue Shield can comply with the regulation, all claims must contain sufficient information to identify the patient, provider and services.

Any claim you or the member submits must include this information:

- patient's full name, date of birth and address

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- member's name, group number (if applicable) and identification number (from the identification card)
- date each service was provided
- a valid procedure code or description of each service
- a valid diagnosis code or description of each service
- charge for each service
- number of units for each service (separate requirements for anesthesia claims)
- name and address of provider
- location where services were provided, if other than the provider's office
- performing provider

Certain services may require additional information such as medical notes, payment or rejection notices from other insurance carriers, origin and destination points for ambulance transfers or accident information. If Blue Shield requests additional information, the information must be returned by the date requested.

Report diagnosis codes to the highest degree of specificity on all claims

Pennsylvania Blue Shield will soon require you to report diagnosis codes to the highest degree of specificity, according to the most current ICD-9-CM coding manual. Blue Shield will begin to apply this requirement to all claims it processes on and after July 1, 2002. This applies to all Blue Shield products—including traditional and managed care.

Helpful hints for diagnosis coding

- When indicated, carry the numerical code to the fourth or fifth digit.
- Most ICD-9-CM coding manuals include a color-coded system to designate diagnosis codes that require additional digits. Please refer to your ICD-9-CM coding manual for specific instructions.
- Remember, there are approximately 100 valid three-digit codes; all other ICD-9-CM codes require additional digits.

Examples of valid and invalid levels of specificity for diagnosis codes

Here is an example of a diagnosis code that requires fifth-digit specificity:

- Valid: 403.00—hypertensive renal disease, malignant, without mention of renal failure
- Invalid: 403—hypertensive renal disease
- Invalid: 403.0—hypertensive renal disease, malignant

This example shows diagnosis codes that require either fourth or fifth digit specificity:

- Valid: 530.0—achalasia and cardiospasm
- Invalid: 530—diseases of the esophagus
- Valid: 530.11—reflux esophagitis
- Invalid: 530.1—esophagitis

Exceptions

Blue Shield will not require these providers to report diagnosis codes to the highest degree of specificity:

- skilled nursing facilities
- home health agencies
- independent laboratories
- independent physiological laboratories
- general dentists
- orthodontists, endodontists, pedodontists
- pharmacies
- durable medical equipment suppliers
- ambulance services
- orthotic and prosthetic suppliers
- home infusion providers

Please contact your Provider Relations representative if you have questions about how to report diagnosis codes.

PremierBlue payment schedules available by request

Section D, Reimbursement, of the new preferred and PremierBlue provider regulations, requires Pennsylvania Blue Shield to make payment schedules available to network providers.*

As a network provider, you can request lists of sample PremierBlue allowances for the most frequently reported procedure codes for your specialty and geographical area. You can also request a copy of your usual fee profile. To obtain this information, write to:

Pennsylvania Blue Shield
Professional Pricing and Analysis
PO Box 890089
Camp Hill, Pa. 17089-0089

Please include your full name, address and Blue Shield provider identification number when requesting payment schedules. Also, indicate if you're requesting PremierBlue allowances or usual fee allowances.

If you're linked to NaviNet, Blue Shield's internet-based inquiry system, you can obtain these allowances online.

If you have any questions about network allowances, contact your Provider Relations representative.

Blue Shield revised the preferred provider regulations, which are effective April 1, 2002, to comply with Act 68 requirements. Please see "Blue Shield changes preferred provider regulations" in the February 2002* ***PRN* *for more details about the changes.*

Report performing provider number on all claims

If your practice bills as an assignment account, or a one-person corporation, you must report the specific health care provider who personally performed the service. If you do not report the performing provider's identification number, your claims could be delayed. For some patients' claims, failure to report the performing provider number could result in an incorrect copayment being applied.

So that your claims process quickly and correctly, follow these guidelines:

Paper claims

Report the performing provider's identification number on each line of the claim, even if the same provider has performed all of the reported services. A complete provider identification number consists of a two-letter, alphabetical prefix, followed by one to seven digits—such as SM1234567.

Report the provider's identification number in block 24K (Reserved for local use) on the HCFA 1500 claim form, or in block 24H (Performing provider) on the 1500A claim form.

Electronic claims

If you submit claims electronically, please make sure your software vendor is reporting the performing provider to Pennsylvania Blue Shield correctly.

Treatment plan required for physical and manipulation therapy for FEP members

The Federal Employee Program (FEP) requires a treatment plan for all outpatient physical therapy and manipulation therapy services in excess of 15 encounters per patient, per calendar year.

Basic Option benefits

FEP Basic Option members have a 50 visit limit, per member, per calendar year, for physical, occupational or speech therapy, or a combination of all three. FEP Basic Option members also have a spinal manipulation benefit of 20 encounters per patient, per calendar year. A treatment plan is required for more than 15 physical or manipulation services per patient, per calendar year.

Standard Option benefits

FEP Standard Option members have a 50 visit physical therapy limit per member, per calendar year. A treatment plan is required when physical therapy services exceed 15 encounters per patient, per calendar year.

Benefits are limited to 25 visits, per member, per calendar year, for occupational therapy or speech therapy, or a combination of both. There are no spinal manipulation benefits under Standard Option.

Attention oral surgeons: report anesthesia with appropriate CDT-3 dental codes

Please use the appropriate dental procedure codes to report general anesthesia or IV sedation you've provided for dental services.

Here are the CDT-3 dental procedure codes for general anesthesia or IV sedation:

D9220—general anesthesia, first 30 minutes

D9221—general anesthesia, each additional 15 minutes

D9241—IV sedation/analgesia, first 30 minutes

D9242—IV sedation/analgesia, each additional 15 minutes

Report D9220 or D9241 on one line of the claim with a single charge. Report any additional time on a separate line with D9221 or D9242 with a separate charge. Please note the amount of additional time this represents.

Do not report the WJ modifier with the surgery code to designate an anesthesia service. You must report the anesthesia with the appropriate procedure code.

If the operating surgeon performs the anesthesia, report the 47 modifier in conjunction with the surgical service, not the anesthesia service.

2002 PTM mailed

In March, Pennsylvania Blue Shield mailed the 2002 edition of the **Procedure Terminology Manual (PTM)** to most health care professionals.

The **PTM** is designed to assist you in submitting claims to Blue Shield. Always use the appropriate procedure code when submitting claims to Blue Shield. The listing of a procedure in the **PTM** does not necessarily indicate that it's eligible under Blue Shield's programs.

Do not report out-of-date, deleted codes—this will delay your claims and some may be denied incorrectly.

The 2002 Health Care Common Procedure Coding System (HCPCS) and the American Medical Association's Current Procedure Terminology (CPT) changes are included in the **PTM**.

If you are an out-of-state provider, you must be participating with Blue Shield to receive a 2002 **PTM**.

If you have not received your 2002 **PTM**, please contact:

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

EMC News

Include required information when completing DataStream Subscription Application

To request a new source number or make a change to an existing source number, you must complete a DataStream Subscription Application. Be sure to provide all requested information on the application. To avoid delays, complete the application online at **www.pablueshield.com**.

Here are different scenarios that providers or groups can request:

- Assign a new electronic source number. An electronic claims signature (ECA) is required for a new electronic biller.
- Add a provider or group to an existing source number.
- Update an existing source number, that is, a change of address, name or electronic remittance advice.

Providers or groups already attached to an existing source number will be asked if they want to retain the source or be removed from it. Providers can only receive electronic remittance files to a single auto-source.

If you have questions about the DataStream Subscription Application process, call EDI Operations at (800) 992-0246.

Policy

HIPAA regulations eliminate EMG and NCV combination codes

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Pennsylvania Blue Shield standardize the codes you use to report electromyography (EMG) and nerve conduction velocity (NCV) diagnostic studies. On July 15, 2002, Blue Shield will eliminate EMG and NCV combination codes, W9591–W9595.

Although EMG and NCV diagnostic studies may be performed independently, they are usually performed together. When you performed EMG and NCV studies on the same extremity during the same session, Blue Shield instructed you to report the combination codes W9591–W9595. Because the combination codes are being deleted, Blue Shield has developed new reporting guidelines for EMG and NCV studies.

How to report EMG studies on or after July 15, 2002

Since codes W9591–W9595 are being eliminated, you must begin to report EMG studies with codes 51785, 92265, 95860-95864 or 95867-95872.

Blue Shield will pay for EMG studies when performed for these indications:

- nerve compression syndromes, including carpal tunnel syndrome and other focal compressions
- radiculopathy—cervical, lumbosacral
- mono/polyneuropathy—metabolic, degenerative, hereditary
- myopathy—including poly- and dermatomyositis, myotonic and congenital myopathies

- plexopathy—idiopathic, trauma, infiltration
- neuromuscular junction disorders—myasthenia gravis
- for localization before Botulism A toxin injection
- prior to injection of phenol or other substances for nerve blocking or chemodenervation

Here are the ICD-9-CM diagnosis codes for the eligible indications for EMG studies:

138, 192.2, 192.3, 250.60-250.63, 265.1, 269.1, 272.5, 333.6, 333.7, 333.81, 333.82, 333.83, 333.84, 333.89, 333.90, 335.0, 335.8, 335.9, 335.10, 335.11, 335.19, 335.20-335.24, 335.29, 336.0-336.3, 336.8-336.9, 344.60, 344.61, 344.89, 344.9, 350.2, 350.8, 351.0, 351.8, 351.9, 352.3, 352.4, 352.5, 352.6, 353.0, 353.1, 353.2, 353.3, 353.4, 353.5, 353.8, 353.9, 354.0-354.5, 354.8-354.9, 355.0-355.9, 356.0-356.4, 356.8-356.9, 357.0-357.9, 358.0-358.2, 358.8-358.9, 359.0-359.6, 359.8-359.9, 564.6, 625.6, 710.3, 710.4, 710.5, 719.41-719.48, 721.0, 721.1, 721.2, 721.3, 721.41, 721.42, 722.0-722.11, 722.2, 722.4, 722.51, 722.52, 722.6, 722.70-722.73, 722.80-722.83, 722.91-722.93, 723.0, 723.1, 723.4, 723.5, 723.9, 724.00-724.02, 724.09, 724.1, 724.2, 724.3, 724.4, 724.5, 726.2, 728.0, 728.9, 729.1, 729.2, 729.5, 736.05, 736.06, 736.09, 738.4, 781.2, 781.3, 781.4, 781.7, 782.0, 787.6, 788.21, 788.30-788.37, 788.39, 952.00-952.09, 952.10-952.19, 952.2, 952.3, 952.4, 952.8, 952.9, 953.0-953.5, 953.8-953.9, 954.0-954.1, 954.8-954.9, 955.0-955.9, 956.0-956.5, 956.8-956.9, 957.0-957.1, 957.8-957.9, 959.0-959.2, 959.7-959.8

Blue Shield will deny EMG studies reported for any other conditions as not medically necessary. A participating, preferred or network provider cannot bill the member for the denied EMG.

A “surface” EMG (S3900) is not the same as a conventional EMG. A surface EMG includes a probe that is passed over the surface of the skin to measure electrical muscle activity. Blue Shield considers this method of EMG testing experimental or investigational. It is not eligible for payment. Scientific evidence does not demonstrate the efficacy of a surface EMG.

How to report NCV studies on or after July 15, 2002

You should begin to report NCV studies with codes 95900, 95903, 95904, 95934, 95936 or 95937. Remember, Blue Shield is eliminating the combination codes, W9591–W9595.

Blue Shield will pay for NCV studies when performed for these indications:

- focal neuropathies or compressive lesions, for localization
- traumatic nerve lesions, for diagnosis and prognosis
- diagnosis or confirmation of suspected generalized diabetic, uremic, metabolic or immune neuropathies
- repetitive nerve stimulation in the diagnosis of neuromuscular junction disorders such as myasthenia gravis, myasthenic syndrome
- differential diagnosis of symptom-based complaints, for example, pain in limb, weakness, disturbance in skin sensation or paresthesia, provided the clinical assessment supports the need for an NCV study

Here are the ICD-9-CM diagnosis codes for the eligible indications for NCV studies:

138, 250.60-250.63, 332.0, 333.6, 333.83, 333.90, 335.10-335.11, 335.19, 335.20-335.24, 335.29, 335.8, 335.9, 336.0-336.3, 336.8-336.9, 337.0, 337.1, 340, 344.00-344.01, 344.60-344.61, 350.2, 350.9, 351.0, 351.8-351.9, 352.1-352.6, 353.0, 353.1, 353.2-353.4, 353.5, 353.8, 353.9, 354.0-354.5, 354.8-354.9, 355.0-355.6, 355.71, 355.79, 355.8, 355.9, 356.0-356.4, 356.8-356.9, 357.0-357.9, 358.0-358.2, 358.8-358.9, 359.0-359.6, 359.8-359.9, 710.3, 710.4, 719.41-719.48, 721.0-721.3, 721.41-721.42, 721.5-721.8, 721.90-721.91, 722.0, 722.10-722.11, 722.2, 722.4, 722.51-722.52, 722.6, 722.70-722.73, 722.80-722.83, 722.90-722.93, 723.0, 723.1, 723.4, 723.9, 724.01, 724.02, 724.2, 724.3, 724.4, 724.5, 728.0, 728.9, 729.1, 729.2, 729.5, 738.4, 781.2, 782.0, 952.00-952.09, 952.10-952.19, 952.2, 952.3, 952.4, 952.8, 952.9, 953.0-953.5, 953.8-953.9, 954.0-954.1, 954.8-954.9, 955.0-955.9, 956.0-956.5, 956.8-956.9, 957.0-957.1, 957.8-957.9, 959.01, 959.09, 959.1-959.2, 959.7-959.8

Blue Shield will deny NCV studies reported for any other conditions as not medically necessary. A participating, preferred or network provider cannot bill the member for the denied NCV study.

Blue Shield to review allowances for EMG and NCV codes

Because of these changes, Blue Shield anticipates increased utilization of EMG and NCV procedure codes. Blue Shield will review the allowances associated with these codes and may make minor allowance adjustments.

Comprehensive reimbursement increases effective Feb. 4, 2002

On Feb. 4, 2002, Pennsylvania Blue Shield implemented a broad range of reimbursement increases for the UCR and PremierBlue products.

The reimbursement increases affect a select number of high-volume evaluation and management (E/M) services, consultation services, behavioral health services, and numerous diagnostic and therapeutic procedures.

Pulmonary rehabilitation services eligible for reimbursement

On July 15, 2002, Pennsylvania Blue Shield will begin to pay for the individual components of a pulmonary rehabilitation program. Blue Shield will pay for these services based on the individual member's contract.

Report pulmonary rehabilitation services with the procedure code that represents the service you provided.

Blue Shield to allow separate payment for certain cardiac procedures

Pennsylvania Blue Shield now pays separately for these procedures when they're performed at the same time as percutaneous atherectomy, percutaneous angioplasty or coronary stent placement:

- pre- and postcardiac injections
- selective catheter placement
- heart catheterization

As of Feb. 18, 2002, Blue Shield no longer "bundles" the allowances for these procedures with percutaneous atherectomy, percutaneous angioplasty or coronary stenting allowances. Each procedure is now processed separately, in accordance with Blue Shield's multiple surgery guidelines. These guidelines allow 100 percent for the primary procedure and 50 percent for the secondary procedure(s).

Blue Shield now pays for epidural daily management

On March 18, 2002, Pennsylvania Blue Shield began to pay separately for daily management of epidural drug administration (code 01996—daily management of epidural or subarachnoid drug administration) after the day on which the catheter was inserted. Blue Shield will not pay for the daily management of the drug when it's reported on the same day as the insertion of the catheter.

Blue Shield will pay a flat fee, per day, for code 01996. Do not report base units, time units or certification modifiers with this code.

Report the insertion of an epidural catheter and injection of an anesthetic for postoperative pain control or for treatment of a nonsurgical condition with code 62318 or 62319. Blue Shield considers this a covered service.

Blue Shield deletes local foot care codes

Pennsylvania Blue Shield is deleting local foot care codes W9080, X1101, X1102 and X1720 to comply with HIPAA requirements.

Blue Shield is also revising the guidelines you must use for reporting routine foot care, debridement of nails, debridement of foot ulcers and destruction of plantar warts.

Please follow these instructions when submitting claims for these services on or after July 15, 2002:

Routine foot care

- Procedure code S0390—routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance, per visit—represents all routine foot care services. Report code S0390 when you provide routine foot care services.
- Report routine foot care provided in the presence of an eligible systemic disease with an ICD-9-CM diagnosis code that represents the systemic disease.

Mycotic nails

- Blue Shield considers debridement of mycotic nails routine foot care. Use procedure code S0390 to report debridement of mycotic nails. Also, report the appropriate ICD-9-CM code: 110.1, 681.10, 681.11, 719.77, 729.5 or 781.2.
- As with other routine foot care services, when the debridement of mycotic nails is performed in the presence of an eligible systemic disease, report the ICD-9-CM diagnosis code that represents the systemic disease.

Hypertrophic nails

- Use procedure code 11720 or 11721 to report the debridement of hypertrophic nails. Report ICD-9-CM diagnosis code 703.8 or 757.5, as appropriate.

Debridement of foot ulcers

- To report the debridement of foot ulcers, use procedure codes 11040–11044, 97601 or 97602. Select the code that most closely describes the level of care rendered during the debridement.

Destruction of plantar warts

- Use procedure codes 17000–17004 to report the destruction of plantar warts for both initial and subsequent treatments.

Electronic spirometer considered part of overhead expense

Pennsylvania Blue Shield considers an electronic spirometer, code S8190, part of the provider's overhead expense. Blue Shield will not pay separately for an electronic spirometer. A participating, preferred or network provider cannot bill the member for overhead expenses.

For more information on overhead expenses, please see the June 2001, June 1996 and March 1994 editions of **PRN**.

Please refer to the October 2001 **PRN** for details about home spirometry.

Haberman feeder allowed for cleft lip and cleft palate

Pennsylvania Blue Shield now pays for the Haberman feeder for babies with cleft lip and/or cleft palate (525.8, 749.00-749.04, 749.10-749.14, 749.20-749.25).

Please use code S8265—Haberman feeder for cleft lip/palate—to report the Haberman feeder.

Blue Shield determines coverage for durable medical equipment according to the individual or group customer benefits.

Blue Shield discontinues trial period for non-elastic binders

Pennsylvania Blue Shield no longer requires a two-month trial period before it will pay for non-elastic binders for patients with lymphedema. Blue Shield required the trial period as proof that compression was an effective treatment for a patient's lymphedema.

Blue Shield will pay for non-elastic binders for the extremities for patients diagnosed with lymphedema (457-457.9, 757.0).

Use codes A4465, S8420-S8431, as appropriate, to report non-elastic binders.

Bilateral deep brain stimulation now covered

Pennsylvania Blue Shield will now pay for bilateral deep brain stimulation (DBS) as a treatment for essential tremor or Parkinson's disease. Bilateral DBS should be a last resort when all other treatments, including medication, have failed to control the tremors. Further, the patient should receive medical and neurophysiological monitoring before and after the implantation.

Blue Shield has been paying for unilateral DBS for the treatment of essential tremor or Parkinson's disease.

Use code 61862—twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)—to report bilateral DBS.

Coverage guidelines for tumor markers clarified

Pennsylvania Blue Shield will pay for these tumor markers when they're reported for the cancer diagnoses indicated:

- CA 125—for ovarian cancer (183.0, 198.6, 233.3, V10.43), primary peritoneal carcinoma, and metastatic adeno cancer of unknown origin in the peritoneum (158-158.9, 197.6). Use procedure code 86304 to report CA 125.
- CA 27.29—for stage II or stage III breast cancer (174-174.9, 175-175.9, 198.81, V10.3). Use procedure code 86300 to report CA 27.29.
- CA 19-9—for monitoring response to treatment in patients with an established diagnosis of pancreatic cancer (157.0-157.9, 197.8, 230.9, 235.5). Blue Shield will pay for this test once every three months during treatment. Use procedure code 86301 to report CA 19-9.
- BTA or NMP-22—bladder tumor antigen (BTA) or nuclear matrix protein 22 (NMP-22)—when reported as an adjunct to surveillance cystoscopy in patients with a history of bladder cancer and to monitor for eradication of the cancer, or recurrences after eradication (188.0-188.9, 198.1, 233.7, 239.4, V10.51). Use procedure code 86294 to report BTA. Report NMP-22 with code S3701.

Blue Shield considers CA 125, CA 27.29, CA 19-9, BTA and NMP-22 experimental or investigational, if they're reported for other malignancies. These tests are not covered. A participating, preferred or network provider can bill the member for the denied test. There is insufficient scientific evidence to determine the use of CA 125, CA 27.29, CA 19-9, BTA and NMP-22 in the clinical management of other malignancies.

If CA 125, CA 27.29, CA 19-9, BTA or NMP-22 is reported with a non-malignant diagnosis, Blue Shield considers it not medically necessary. In this case, Blue Shield will deny the test as not covered. A participating, preferred or network provider cannot bill the member for the denied test.

Guidelines for other tumor markers

Blue Shield will pay for these tumor markers when they are medically necessary:

- Prostate specific antigen (PSA); total – 84153
- Prostate specific antigen (PSA); free – 84154
- Prostate specific antigen (PSA); complexed (direct method) – 84152
- Alpha-fetoprotein (AFP); serum – 82105
- Carcinoembryonic antigen (CEA) – 82378

When tumor marker testing is performed for asymptomatic patients, Blue Shield considers it screening. In this instance, tumor marker testing is covered only if it's a benefit of the member's contract.

Blue Shield considers immunoassays of the following tumor markers experimental or investigational. They are not eligible for payment. A participating, preferred or network provider can bill the member for the denied tumor marker.

- CA 15-3—scientific evidence does not demonstrate the efficacy of CA 15-3 in screening or diagnosing. There is controversy in the medical community regarding CA 15-3 in establishing prognosis and monitoring response to treatment.

  Use code 86300 to report CA 15-3. Please indicate the tumor marker being performed when reporting code 86300.

- LASA-P—lipid-associated sialic acid. Scientific evidence does not demonstrate the effectiveness of LASA-P in screening, diagnosing, as a prognostic test or in monitoring response to treatment. Use procedure code 86316 to report LASA-P.

Guidelines for immunoassay for tumor antigen, code 86316

- Report procedure code 86316—immunoassay for tumor antigen; other antigen, quantitative—for tumor markers not designated by a specific procedure code. Please indicate which tumor marker was performed when you report code 86316.
- When 86316 is reported for cancer diagnoses, Blue Shield will deny it as experimental or investigational.
- When 86316 is reported for a non-malignant diagnosis, Blue Shield will deny it as not medically necessary.
- If immunoassay for tumor antigen, 86316, is performed for asymptomatic patients, Blue Shield considers it screening. This service is covered only if it's a benefit of the member's contract.

Reminder: report obstetrical ultrasounds with appropriate codes

Report ultrasound studies performed for a pregnant patient using the procedure codes specifically designated for obstetrical ultrasound. Always report obstetrical ultrasound codes whether the approach used is abdominal or transvaginal.

The codes and terminology for obstetrical ultrasound studies are:

76805—ultrasound, pregnant uterus, B-scan and/or real time with image documentation; complete, (complete fetal and maternal evaluation)

76810—ultrasound, pregnant uterus, B-scan and/or real time with image documentation; complete, (complete fetal and maternal evaluation), multiple gestation, after first trimester

76815—ultrasound, pregnant uterus, B-scan and/or real time with image documentation; limited (fetal size, heart beat, placental location, fetal position, or emergency in the delivery room)

76816—ultrasound, pregnant uterus, B-scan and/or real time with image documentation; follow-up or repeat

Obstetrical ultrasound is a highly developed technique capable of detecting many fetal structural and functional abnormalities. It is used to:

- detect ectopic pregnancy and multiple pregnancy,
- assess fetal life and function,
- diagnose physical anomalies, and
- guide physicians in their efforts to treat the fetus.

How to report ECMO

To report extracorporeal membrane oxygenation (ECMO), please submit the procedure codes that are specific to this service:

- 33960—prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours
- 33961—prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours
- 36822—insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)

Reporting anesthesia and conscious sedation time units

For anesthesia services, including conscious sedation, you must report anesthesia time in minutes. Incorrect reporting may result in delayed or incorrect processing of your claims.

Anesthesia time begins when the physician or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the physician or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under customary postoperative supervision. You must document this time in the anesthesia record.

Conscious sedation is used to achieve a medically-controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and ability to

respond to stimulation or verbal commands. Conscious sedation includes performance and documentation of pre- and postsedation evaluation of the patient; administration of the sedation and/or analgesic agent(s); and monitoring of cardiorespiratory function. Report conscious sedation with code 99141 or 99142.

See the August 2001 **PRN** for additional details on how to report anesthesia.

Avoid denials: do not report therapeutic administration codes 90780-90784

Do not report therapeutic administration codes 90780-90784 when administering chemotherapy agents or rescue agents. If you report these codes, Pennsylvania Blue Shield may deny the chemotherapy services.

Please report the appropriate chemotherapy administration codes 96400-96549. Please see Page 360 in the 2002 **PTM** for a complete description of these codes.

Report correct codes for radiopharmaceuticals

Do not use code 78990 or A4641 to report the radiopharmaceuticals with the brand name OncoScint, Cardiolite, MiraLuma or Myoview.

Please use the appropriate code to report these radiopharmaceutical agents:

A4642—satumomab pendetide (for example, OncoScint)

A9500—Technetium TC 99m Sestamibi (for example, Cardiolite, MiraLuma)

A9502—Technetium TC 99m Tetrofosmin (for example, Myoview)

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

2002 PTM changes

Please make these changes to your 2002 **PTM**:

Page	Code	Terminology	Action
38	S8262	Mandibular orthopedic repositioning device, each	Add. Effective 4/1/02.
122	S2017	Adoptive immunotherapy, i.e., development of specific anti-tumor reactivity (e.g., tumor-infiltrating lymphocyte therapy) per course of treatment	Add. Effective 4/1/02.
165	S9034	Extracorporeal shockwave lithotripsy for gallstones	Add. Effective 4/1/02.
182	S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Add. Effective 4/1/02.
195	S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	Add. Effective 4/1/02

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Page	Code	Terminology	Action
197	0027T	Endoscopic lysis of epidural adhesions with direct visualization using mechanical means (e.g., spinal endoscopic catheter system) or solution injection (e.g., normal saline) including radiologic localization and epidurography	Add. Effective 4/1/02.
223	S9092	Canolith repositioning, per visit	Add. Effective 4/1/02.
253	0028T	Dual energy X-ray absorptiometry (DEXA) body composition study, one or more sites	Add. Effective 4/1/02.
255	S8042	Magnetic resonance imaging (MRI), low-field	Add. Effective 4/1/02.
327	S9105	Evaluation by ocularist	Add. Effective 4/1/02.
337	S2211	Transcatheter placement of intravascular stent(s), carotid artery, percutaneous, unilateral (if performed bilaterally, use 50 modifier)	Add. Effective 4/1/02.
363	S0108	Mercaptopurine, oral, 50 mg	Add. Effective 4/1/02.
367	S8945	Physical medicine treatment (constant attendance by provider) to one area, initial 30 minutes, each visit; phonophoresis	Add. Effective 4/1/02.
426	S9145	Insulin pump initiation, instruction in initial use of pump (pump not included)	Add. Effective 4/1/02.
426	S9401	Anticoagulation clinic, inclusive of all services except laboratory tests, per session	Add. Effective 4/1/02.
426	S9444	Parenting classes, non-physician provider, per session	Add. Effective 4/1/02.
426	S9447	Infant safety (including CPR) classes, non-physician provider, per session	Add. Effective 4/1/02.
426	S9449	Weight management classes, non-physician provider, per session	Add. Effective 4/1/02.
426	S9451	Exercise classes, non-physician provider, per session	Add. Effective 4/1/02.
426	S9452	Nutrition classes, non-physician provider, per session	Add. Effective 4/1/02.
426	S9453	Smoking cessation classes, non-physician provider, per session	Add. Effective 4/1/02.
426	S9454	Stress management classes, non-physician provider, per session	Add. Effective 4/1/02.
426	S9970	Health club membership, annual	Add. Effective 4/1/02.
426	S9975	Transplant related lodging, meals, and transportation, per diem	Add. Effective 4/1/02.
449	S0122	Injection, menotropins, 75 IU	Add. Effective 4/1/02.
449	S0126	Injection, follitropin alfa, 75 IU	Add. Effective 4/1/02.

Page	Code	Terminology	Action
449	S0128	Injection, follitropin beta, 75 IU	Add. Effective 4/1/02.
449	S0130	Injection, chorionic gonadotropin, 5000 units	Add. Effective 4/1/02.
449	S0132	Injection, ganirelix acetate, 250 mcg	Add. Effective 4/1/02.
450	S0106	Bupropion HCL sustained release tablet, 150 mg, per bottle of 60 tablets	Add. Effective 4/1/02.
450	S4993	Contraceptive pills for birth control	Add. Effective 4/1/02.
450	S4995	Smoking cessation gum	Add. Effective 4/1/02.

2002 PTM for Ancillary Providers changes

Page	Code	Terminology	Action
3	Q3017	Ambulance service, advanced life support (ALS) assessment, no other ALS services provided	Delete. Effective 4/1/02.
3	Q3019	ALS vehicle used, emergency transport, no ALS level services furnished	Add. Effective 4/1/02.
3	Q3020	ALS vehicle used, non-emergency transport, no ALS level services furnished	Add. Effective 4/1/02.
3	T2001	Non-emergency transportation; patient attendant/escort	Add. Effective 4/1/02.
3	T2002	Non-emergency transportation; per diem	Add. Effective 4/1/02.
3	T2003	Non-emergency transportation; encounter/trip	Add. Effective 4/1/02.
3	T2004	Non-emergency transportation; commercial carrier, multi-pass	Add. Effective 4/1/02.
3	T2005	Non-emergency transportation; non-ambulatory stretcher van	Add. Effective 4/1/02.
3	T2006	Ambulance response and treatment, no transport	Add. Effective 4/1/02.
6	K0561	Ostomy skin barrier, non-pectin based, paste, per ounce	Add. Effective 4/1/02.
6	K0562	Ostomy skin barrier, pectin-based, paste, per ounce	Add. Effective 4/1/02.
6	K0563	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each	Add. Effective 4/1/02.
6	K0564	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each	Add. Effective 4/1/02.
6	K0565	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each	Add. Effective 4/1/02.

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Page	Code	Terminology	Action
6	K0566	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each	Add. Effective 4/1/02.
6	K0567	Ostomy pouch, drainable, with karaya based barrier attached, without built-on convexity, (1 piece), each	Add. Effective 4/1/02.
6	K0568	Ostomy pouch, drainable, with standard wear barrier attached, without built-in convexity, (1 piece), each	Add. Effective 4/1/02.
6	K0569	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), each	Add. Effective 4/1/02.
6	K0570	Ostomy skin barrier, with flange (solid, flexible or accordion),without built-in convexity, 4 x 4 inches or smaller, each	Add. Effective 4/1/02.
6	K0571	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each	Add. Effective 4/1/02.
6	K0572	Tape, non-waterproof, per 18 square inches	Add. Effective 4/1/02.
6	K0573	Tape, waterproof, per 18 square inches	Add. Effective 4/1/02.
6	K0574	Addition to ostomy pouch, filter, integral or added separately to pouch, each	Add. Effective 4/1/02.
6	K0575	Addition to ostomy pouch, rustle-free material, per pouch	Add. Effective 4/1/02.
6	K0576	Addition to ostomy pouch, friction and irritant-reducing, absorbent, interface layer (comfort panel), per pouch	Add. Effective 4/1/02.
6	K0577	Addition to ostomy pouch, odor barrier, incorporated into pouch laminate, per pouch	Add. Effective 4/1/02.
6	K0578	Addition to ostomy pouch, faucet-type tap with valve for draining urinary pouch, each	Add. Effective 4/1/02.
6	K0579	Addition to ostomy pouch, absorbent material (sheet/pad/crystal packet) to thicken liquid stomal output, for use in pouch, each	Add. Effective 4/1/02.
6	K0580	Addition to ostomy pouch, flange locking mechanism, each	Add. Effective 4/1/02.
7	S8265	Haberman feeder for cleft lip/palate	Add. Effective 4/1/02.
49	S8433	Skin support for breast prosthesis, each	Add. Effective 4/1/02.

American Home Products changes name, carrier and alphabetical prefix

On April 1, 2002, Horizon Blue Cross Blue Shield of New Jersey began to administer the health care plan for employees of Wyeth, formerly known as American Home Products. Empire Blue Cross Blue Shield of New York was the insurance carrier for American Home Products.

Wyeth employees will present a new identification card with the Horizon Blue Cross Blue Shield of New Jersey logo along with the "PPO in a suitcase" logo. The identification card will contain specific deductible and coinsurance information.

The alphabetical prefix for Wyeth employee has changed from AHP to WYE. For claims with a date of service prior to April 1, 2002, please report the AHP alphabetical prefix. Report the WYE alphabetical prefix for claims with an April 1, 2002, or later, date of service.

For patients with Medicare or any other primary insurance, please submit balances and applicable explanation of benefits to:

Horizon Blue Cross Blue Shield of New Jersey
PO Box 1219
Newark, NJ 07101-1219

Ed Wargo is new director of Physician Recruitment

Ed Wargo, the new director of Physician Recruitment and Relations, comes to Pennsylvania Blue Shield with more than 30 years experience in health care. After a short stint as a hospital pharmacist, Wargo assumed an administrative position at Suburban General Hospital in Norristown. "I knew almost from the start the challenges associated with the efficient delivery of quality health services were where I wanted to focus my professional career." After obtaining a master's degree in health care administration, his interest and work with providers in developing PPOs led him to accept a position as president of the Berkshire Health Plan in Reading.

Ed Wargo

"I had a lot of fun working with the providers and business community in Reading. During the 10 years I spent there, I gained a tremendous amount of respect for the physicians and hospital executives who labored tirelessly to ensure access to care." Under Wargo's leadership, Berkshire's membership grew from a few thousand to nearly 50,000.

Wargo hopes to maintain the strong partnership between Pennsylvania Blue Shield and its network physicians. "Our provider network is one of our greatest strengths and I see my primary objective as making Pennsylvania Blue Shield the most physician-friendly company providers deal with."

Meet Martha Economedes, Provider Relations representative for the Mid-Atlantic region

Martha Economedes

Martha is a graduate of The Pennsylvania State University with a degree in health planning and administration. For the past six years she has worked at Keystone Health Plan Central. Her career at Keystone started as a sales and marketing representative for the SeniorBlue managed care product. The last four years has found Martha servicing the specialists' network of Lehigh County as their Provider Relations representative. Now her focus has turned to the physician community-at-large, servicing the networks in Lehigh and Northampton counties, portions of Bucks County and select counties in New Jersey. Martha says she is looking forward to this new and exciting challenge.

For assistance, you can contact Martha at (866) 731-2045, ext. 4.

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