Blue Shield’s medical policies now available on the Web

Report tax information correctly to avoid claim delays

Computer telephone integration improves provider telephone lines

HIPAA regulations change anesthesia reporting

Blue Shield seeks anesthesia conversion factor increase

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Now you can access Pennsylvania Blue Shield’s medical policies online at www.highmark.com.

**How to request access to online medical policies**

To request access to Blue Shield’s medical policies, please complete the appropriate online form.

Follow these instructions to locate the request form:

1. Go to [www.highmark.com](http://www.highmark.com), click on “Health/Highmark Blue Cross Blue Shield.”
2. On the welcome page, click on “Provider,” select “Pennsylvania Blue Shield.”
3. At the Resource Center, click on “Medical Policy.”
4. On the first page of the Medical Policy section of the website, under “Request Login ID,” select and complete the appropriate login request form.

Once you obtain access, you can search for medical policy information by key word, code or policy number.
Pennsylvania Blue Shield is implementing a new process for 1099-Misc income reporting. The new process will not only ensure the accuracy of your 1099, it will also maximize Blue Shield’s compliance with Internal Revenue Service (IRS) regulations.

You can avoid backup withholding of your claim payments by reporting accurate tax information to Blue Shield.

To make certain that Blue Shield reports your correct tax information to the IRS:

- Ensure that the name on each check is exactly how it appears on documents you receive from the IRS. This is considered the legal name of your practice. It may be different from your “doing business as” or “D/B/A” name.

  Your legal name must be on the check. Blue Shield must report this name to the IRS on your 1099.

- If you are in a group practice, please make sure that the name on the check is consistent with how the IRS requires the income to be reported. Contact your tax advisor if you do not know the IRS requirements.

  If checks are issued in your name and you sign the check over to the group, you must begin billing under the group provider number. If you do not bill under the group number, Blue Shield will issue the 1099 in your name.

- Be aware that the mailing address of the check will be the mailing address of your 1099.

- Make sure that your tax identification number is the correct number the IRS requires you to report income. If you do not know if the correct tax identification number is being used, please contact your tax advisor.

- If you joined a new group, left a group or became incorporated, please notify Blue Shield immediately.

  Blue Shield may require you to complete a new W-9 form. The W-9 will provide accurate information about your tax status. To request a W-9 form, call the 1099 hotline at (717) 763-3328.

To change your provider information on Blue Shield’s provider file, please call Provider Data Services at (866) 763-3224. Or, complete the coupon on Page 27 of this PRN and return it to us.

Due to IRS regulations, you may receive two 1099s in the year you make a change. If you report changes to Blue Shield during the year, Blue Shield may be required to issue you more than one 1099-Misc form. This 1099 form will reflect tax information prior to and subsequent to such changes.
How to request reimbursement for CT, MRI, PET and radiation therapy

If you plan to request total charge reimbursement from Pennsylvania Blue Shield for services you provide on high-cost equipment, you must first contact Blue Shield’s Benefits Cost Management department.

Blue Shield considers equipment such as computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) and linear accelerators, as high-cost technology.

Total charge reimbursement of high-cost technology services includes the professional and technical components. The technical component involves the calculation of the:

- Machine component—the costs specific to each practice relating directly to the acquisition and installation of the medical equipment.
- Non-machine component—the indirect costs associated with performing the service, such as utilities expense.

This cost reimbursement method controls and monitors payments based on a provider’s costs. It applies to only those services provided in a free-standing setting.

If you plan to seek global reimbursement for such procedures performed in the office, contact Benefits Cost Management before submitting these claims. Call Benefits Cost Management at (717) 763-6527.

Computer telephone integration improves provider telephone lines

Pennsylvania Blue Shield is enhancing its provider telephone lines by introducing computer telephone integration (CTI) in August 2001.

Although Blue Shield encourages you to use electronic communications for your inquiries, sometimes you may need to contact us by telephone. CTI will make those telephone contacts easier. CTI will improve the routing of your telephone calls so they get to the right place the first time—minimizing transfers.

CTI will prompt you to enter the numeric portion of the member’s identification number for patients about whom you are making an inquiry. The call will then be automatically routed to the appropriate area for more efficient service.
The Health Insurance Portability and Accountability Act (HIPAA) is changing the way health care professionals will report anesthesia services to third party payers. HIPAA is standardizing anesthesia procedure codes and formats so that you no longer have to be concerned about what information is required by which insurance company.

**How to report anesthesia services**

Pennsylvania Blue Shield’s anesthesia policy guidelines are not changing. What is changing is the way you’ll report anesthesia services.

The anesthesia reporting requirements in this bulletin apply to electronic and paper claims.

For the most efficient means of claims submission, submit your anesthesia services electronically.

**Paper billers:** as of Nov. 1, 2001, do not use Blue Shield’s anesthesia claim form, No. 1500A-OL, to submit your anesthesia services. Blue Shield will no longer accept this paper claim form. You can submit anesthesia services on a 1500A or HCFA 1500 claim form.

**New anesthesia reporting requirements in effect September 2001**

Effective Sept. 15, 2001, please begin to report anesthesia services to Blue Shield with the national CPT procedure codes for anesthesia care (00100-01999), plus national anesthesia modifier codes. This is a change to the way you’ve been reporting anesthesia services.

**WJ modifier becomes invalid Nov. 1, 2001**

Now when you submit claims for anesthesia services, Blue Shield requires you to report the surgical procedure code with the local WJ anesthesia modifier. The WJ modifier indicates that you administered anesthesia.

As of Nov. 1, 2001, Blue Shield will no longer accept anesthesia services reported with the surgical code and WJ modifier.

**Blue Shield allows transition phase starting Sept. 15**

To make these reporting changes easier for you, Blue Shield is offering a transition phase beginning Sept. 15, 2001. During this transition, Blue Shield will accept two reporting methods for anesthesia services.

You can report anesthesia with:

- an appropriate national CPT anesthesia procedure code and a national anesthesia modifier; or

- a surgical code and WJ modifier. Remember, you can only report anesthesia in this manner until Nov. 1, 2001. Starting Nov. 1, 2001, Blue Shield will deny your claim if you report anesthesia with a surgical code and the WJ modifier.
This article provides you with the revised billing criteria for anesthesia services. Detailed reporting guidelines are included for anesthesia procedure codes, time units, modifiers, monitored anesthesia care, modifying units, medical direction, certified registered nurse anesthetist (CRNA) requirements and conscious sedation.

**Reporting guidelines for specific anesthesia services**

**Anesthesia procedure codes**

Use the national CPT anesthesia procedure codes (00100-01999) to report the administration of anesthesia.

If you report “not otherwise specified” or “not otherwise classified” anesthesia services, include a complete description of the services performed. Blue Shield will not accept the terminology of a national anesthesia procedure code as a description of the service performed. You must describe the actual service or surgery performed, otherwise, Blue Shield may reject your claim.

Blue Shield will accept an appropriate HCPCS procedure code as the description of the actual service or surgery performed. If the only suitable HCPCS procedure code is an NOC, you must include a complete description of the service performed.

Here are some examples of how to report “not otherwise specified” or “not otherwise classified” anesthesia services:

**Electronic billers:** you must report narratives (a complete description of the services performed) in the appropriate NOC Narrative Field of the format you are utilizing:

- ASC X12–3051 – loop 2400, NTE Segment
- NSF 2.0 – record HA0, Positions 40-320

Blue Shield will also accept a HCPCS procedure code as the description of the service. Report the HCPCS procedure code in the NOC Narrative Field. If the only applicable HCPCS procedure code is an NOC, you must also describe the service in the NOC Narrative Field.

**Time units**

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.
Report total anesthesia time as minutes. Blue Shield will convert total minutes to time units. Blue Shield determines time units on the basis of one time unit for each 15 minute segment or fraction thereof.

**Electronic billers:** continue to report minutes as you do today.

**Paper billers:** report total anesthesia time as minutes in block 24G, “Days or Units,” on the 1500A or HCFA 1500 claim form.

**Do not report time by means of an overlay or with verbiage. Blue Shield will ignore these reporting methods.**

**Monitored anesthesia care**

Blue Shield will pay for medically reasonable and necessary monitored anesthesia care (MAC) services on the same basis as other anesthesia services. Report the appropriate national CPT anesthesia procedure code (00100-01999). Include the QS modifier—monitored anesthesia care—with the procedure code in addition to other applicable modifiers. The QS modifier identifies the services as monitored anesthesia care.

MAC involves intraoperative monitoring of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of an adverse physiological patient reaction to the surgical procedure. MAC also includes the performance of a preanesthetic examination and evaluation; prescription of the anesthesia care required; administration of any necessary oral or parenteral medications such as atropine, demerol, valium; and provision of indicated postoperative anesthesia care.

**Medical direction**

Blue Shield defines the medical direction or supervision of anesthesia as direction, management or instruction of anesthesia by one who is physically present or immediately available in the operating suite. A physician performing medical direction should not actually administer anesthesia.

Blue Shield limits reimbursement to the medical direction of no more than four anesthesia services being performed concurrently. When the physician is medically directing more than four procedures concurrently, he or she must submit documentation of the medical necessity for directing more than four procedures. Blue Shield will then review the claim on an individual consideration basis.

A physician medically directing four or fewer anesthesia procedures can concurrently:

- address an emergency of short duration in the immediate area;
- administer an epidural or caudal anesthetic to ease labor pain;
- provide periodic, rather than continuous, monitoring of an obstetrical patient;
- receive patients entering the operating suite for the next surgery;
- check or discharge patients in the recovery room; or
- handle scheduling matters.
To identify who performed the anesthesia service, please report the appropriate anesthesia procedure code modifiers:

AA—Anesthesia services performed personally by anesthesiologist
AD—Medical supervision by a physician: more than four concurrent procedures
GC—This service has been performed in part by a resident under the direction of a teaching physician
QK—Medical direction of two, three, or four concurrent anesthesia procedures
QX—CRNA service with medical direction by a physician
QY—Medical direction of one CRNA by an anesthesiologist
QZ—CRNA service without medical direction by a physician

47—Anesthesia by surgeon: regional or general anesthesia provided by the operating surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.)

• Report modifier 47 in conjunction with the basic service, for example, the surgery code.
• Do not use modifier 47 as a modifier for anesthesia codes 00100-01999.
• Do not report modifier 47 for conscious sedation (see the conscious sedation guidelines on Pages 10-11 for more information).

Effective Nov. 1, 2001, Blue Shield will no longer accept modifiers AB, AC, AE or WP.

Electronic billers:
• Follow the medical direction guidelines on Pages 6-9 when reporting all line items.
• NSF 2.0 users: do not report medical direction with the doctor certification numeric code values 1-7, in record EA1, position 300. After Nov. 1, 2001, Blue Shield will reject your claims if you report the numeric code values. If this happens, resubmit the claim with the appropriate certification modifier.
• ASC X12–3051 users: report medical direction with a certification modifier.

Paper billers: do not report certification by means of an overlay or with verbiage. Blue Shield will ignore these reporting methods. Report medical direction with the appropriate modifiers in conjunction with codes 00100-01999.

Medical direction of an employed CRNA – 100 percent total payment

Services performed by an employed CRNA require medical direction or personal supervision by the employer. The employer must be immediately available within the operating suite or within the immediate vicinity to assume primary care of the patient, if needed.

When reporting medical direction of a CRNA employee, two lines are required.

When reporting medical direction of a CRNA employee, report the name and Blue Shield provider identification number of the physician who is medically directing the service.
Electronic billers:

- NSF 2.0 users: when reporting medical direction of a CRNA employee, report the Blue Shield provider identification number of the physician who is medically directing the service in the Rendering Provider Identification field, record FA0, positions 93-107.

- ASC X12-3051 users: when reporting medical direction of a CRNA employee, report the Blue Shield provider identification number of the physician who is medically directing the service in the Rendering Provider Information Loop 2310A, segment NM1 or 2420A, segment NM1.

Paper billers: When reporting medical direction of a CRNA employee, report the Blue Shield provider identification number of the physician who is medically directing the service in block 24K of the HCFA 1500 claim form or block 24H of the 1500A claim form. Report the name of the physician who is medically directing the service in block 31 of the HCFA 1500 claim form or block 32 of the 1500A claim form. **Do not include the CRNA’s name on the claim.**

Here is an example of correct reporting on a paper claim:

<table>
<thead>
<tr>
<th>Medical direction of a non-employed CRNA – 50 percent total payment</th>
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<tbody>
<tr>
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<td>DATE</td>
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<td>09/15/2001</td>
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<table>
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<tr>
<th>Medical direction of an intern or resident – 100 percent total payment</th>
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| Personally performed by physician – 100 percent total payment |

Report “by me personally” only under these circumstances:

- The physician personally provides the entire service.

- The physician is present in the operating room for the entire case and is actively participating in the administration of anesthesia, even if an anesthetist assists in the care of the patient.
Modifying units

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required.

Report modifying units (representative of age, emergency, total body hypothermia and controlled hypotension) with the following HCPCS procedure codes. Do not report units.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99100</td>
<td>Age</td>
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<tr>
<td>99116</td>
<td>Total body hypothermia</td>
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<tr>
<td>99135</td>
<td>Controlled hypotension</td>
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<tr>
<td>99140</td>
<td>Emergency</td>
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</tbody>
</table>

Blue Shield will pay these HCPCS codes at a flat fee.

You must report procedure codes 99100, 99116, 99135 or 99140 on the same claim as the anesthesia service (00100-01999).

**Exception:** you can report physical status with the applicable modifier. Report this modifier only in conjunction with the appropriate anesthesia procedure code (00100-01999). Here are the modifiers:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Modifying Units</th>
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<tbody>
<tr>
<td>P1</td>
<td>Physical status 1</td>
<td>0</td>
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<td>P2</td>
<td>Physical status 2</td>
<td>0</td>
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<td>P3</td>
<td>Physical status 3</td>
<td>1</td>
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<td>P4</td>
<td>Physical status 4</td>
<td>2</td>
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<td>P5</td>
<td>Physical status 5</td>
<td>3</td>
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<tr>
<td>P6</td>
<td>Physical status 6</td>
<td>0</td>
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</tbody>
</table>

Effective Nov. 1, 2001, Blue Shield will no longer accept modifiers AF, AG, WK, WM or WN.

Electronic billers:

- NSF 2.0 users: do not report additional modifying units as numeric code values in record EA1, positions 291-297. After Nov. 1, 2001, Blue Shield will not accept numeric code values.

Report additional modifying units with the appropriate procedure code or modifier (see procedure codes and modifiers on Page 9).
• ASC X12-3051 users: do not report additional modifying units as numeric code values in the 2-240QTY (Loop 2300) segment. After Nov. 1, 2001, Blue Shield will not accept numeric code values.

Report additional modifying units with the appropriate procedure code or modifier (see procedure codes and modifiers on Page 9).

**Paper billers:** do not report modifying units by means of an overlay or with verbiage. Blue Shield will ignore these reporting methods. Use the procedure codes and modifiers on Page 9 to report these services.

**Independently practicing (non-employed) CRNA reporting requirements**

- Report anesthesia services with the national CPT anesthesia codes (00100-01999).
- Report total time in minutes.
- Report one of these modifiers to identify whether or not the service was medically directed:

  **QX**—CRNA service with medical direction by a physician – 50 percent payment

  | DATES OF SERVICE | MED. DE. YR | TYPE OF SERVICE | PROCEDURE CODES | MODIFIER | DATA OR UNITS | WORK UNIT | EXPENSES | PAY CODE | PAYMENT
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  QZ—CRNA service without medical direction by a physician – 100 percent payment

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**Electronic billers:**

- Report all line items according to the guidelines for independently practicing (non-employed) CRNAs.

**Conscious sedation**

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 performances and documentation of pre- and postsedation evaluations of the patient; administration of the sedation and/or analgesic agent(s); and monitoring of cardiorespiratory function, that is, pulse oximetry, cardiorespiratory monitor and blood pressure.

Report conscious sedation with:

- 99141—Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation; or
- 99142—Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal
Report conscious sedation with the applicable certification modifier in conjunction with 99141 or 99142 to indicate if the service was performed personally or medically directed. When conscious sedation is performed by the operating surgeon, or his or her employee, report the surgery and anesthesia on the same claim. Report time in minutes for code 99141 or 99142.

Other Modifiers
If you must administer anesthesia to a patient at two separate and distinct times during the same day, you must identify each anesthesia service you performed within the separate session. Report modifier 78 or 79, as appropriate, on each service line.

78—Return to the operating room for a related procedure during the postoperative period
79—Unrelated procedure or service by the same physician during the postoperative period

Reminders
Beginning Nov. 1, 2001, Blue Shield will:
• require you to use the national CPT anesthesia procedure codes (00100-01999) to report the administration of anesthesia;
• no longer accept the local modifiers (AB, AC, AE, AF, AG, WJ, WK, WM, WN, WP or WQ) on either electronic or paper claims;
• ignore modifying units and medical direction if reported by overlays or with verbiage;
• not accept anesthesia claim form 1500A–OL;
• require two lines when reporting medical direction of a CRNA employee.

Electronic billers: you may need to contact your software vendor for assistance with your specific electronic claims submission needs.

Blue Shield seeks anesthesia conversion factor increase
Pennsylvania Blue Shield is filing an increase for the UCR and PremierBlue anesthesia conversion factor with the Pennsylvania Insurance Department. If the Insurance Department approves the increase, it will become effective during the fall of 2001. The adjustment is intended to partially offset rising medical practice and medical malpractice expenses.
Blue Shield proposes maternity and delivery reimbursement increases

Pennsylvania Blue Shield is filing increases for certain UCR and PremierBlue maternity and delivery services with the Pennsylvania Insurance Department. Blue Shield is also proposing increases for annual gynecological exams. If approved, the increases will become effective during the fall of 2001.

Blue Shield is pursuing these allowance adjustments after it evaluated its current compensation rates. It also considered the increasing medical malpractice rates health care professionals incur.

Blue Shield expands coverage of PET

Pennsylvania Blue Shield will provide coverage for PET imaging in clinical situations when the information obtained by PET determines the necessity for an invasive diagnostic procedure, and/or identifies the precise anatomic site to perform an invasive diagnostic procedure.

Blue Shield pays for PET studies of the brain and myocardium for specific nonmalignant conditions. It also pays for PET studies for malignancies of the brain, lung and pancreas, colorectal and esophageal cancers, melanoma and lymphoma (including Hodgkin’s and non-Hodgkin’s disease).

Beginning July 1, 2001, Blue Shield expanded coverage for PET to include malignancies of the head and neck.

In all situations, you must maintain clinical documentation in the patient’s medical file to support the medical necessity for the PET procedure.

If Blue Shield denies a PET procedure as not medically necessary, a participating, preferred or network health care professional cannot bill the member for the denied service.

Blue Shield considers PET not medically indicated when used to monitor tumor response during a planned course of treatment when no change in treatment is being contemplated. This use of PET is not eligible for reimbursement.

Additionally, PET imaging used to evaluate asymptomatic patients is considered screening, that is, performing a procedure on a patient without specific signs and symptoms of disease. Blue Shield generally excludes screening studies from coverage. They are not eligible for reimbursement.

The following information summarizes Blue Shield’s current policy on all PET imaging procedures. It explains what Blue Shield considers medically necessary and eligible for payment, and what is not covered.

**Brain**

For nonmalignant conditions - code G0229:

Blue Shield considers PET imaging of the brain medically necessary when used in the presurgical evaluation of refractory seizures (345-345.9).

For malignancies - codes 78608, 78609:

Blue Shield considers PET imaging for malignancies of the brain (191-191.9, 198.3) medically necessary and eligible for payment.
Blue Shield considers PET imaging of the brain for any other conditions not medically indicated. It would not be eligible for payment in these instances.

**Colorectal** (codes G0213, G0214, G0215)

Blue Shield considers colorectal PET imaging medically necessary and eligible for reimbursement when used in diagnosing, staging and restaging colorectal carcinomas (153-153.9, 154-154.8, 197.5, 230.3, 230.4, 230.5, 235.2, 239.0). This includes the use of PET in evaluating patients who show clinical signs or symptoms of recurrent colorectal cancer, and related hepatic and/or extrahepatic metastases.

Blue Shield considers colorectal PET imaging for any other conditions as not medically indicated. Colorectal PET imaging in these instances would not be eligible for payment.

**Esophageal** (codes G0226, G0227, G0228)

Blue Shield considers esophageal PET imaging medically necessary when used in diagnosing, staging and restaging esophageal cancer (150-150.9, 230.1, 235.5, 239.0). In most cases, CT and/or endoscopic ultrasound studies are the standard imaging methods to assess patients with esophageal cancer. When CT and/or endoscopic ultrasound are indeterminate or inconclusive, PET imaging may be used to obtain the necessary information to determine treatment management.

Blue Shield considers esophageal PET imaging for any other conditions not medically necessary. Blue Shield will not pay for esophageal PET imaging in these cases.

**Head and neck, excluding central nervous system and thyroid** (codes G0223, G0224, G0225)

Blue Shield considers PET imaging of the head and neck medically necessary when used in the diagnosis, staging and restaging of cancers of the head and neck (140-140.9, 141-141.9, 142-142.9, 143-143.9, 144-144.9, 145-145.9, 146-146.9, 147-147.9, 148-148.9, 149-149.9, 160-160.9, 161-161.9, 162.0, 162.2, 170.0-170.1, 171.0, 173.0-173.4, 176.2, 190-190.9, 194.1, 194.3, 195.0, 196.0, 210-210.9, 212.0-212.1, 213.0-213.1, 215.0, 216.0-216.4, 224-224.9, 228.03, 230.0, 231.0, 231.1, 231.8, 232.0-232.4, 234.0, 235.0-235.1, 235.6, 237.0, 238.0, 238.2, 238.8, 239.0, 239.1, 239.2, 239.8).

Blue Shield considers PET imaging of the head and neck for any other conditions not medically indicated. Thus, it is not eligible for payment.

PET imaging of the head and neck helps determine the site of the primary tumor to prevent the adverse effects of invasive surgical procedures such as biopsy, neck dissection or unnecessary radiation therapy treatment.

Coverage of PET imaging of the head and neck excludes the central nervous system (CNS) and thyroid. Blue Shield considers these uses investigational. They are not eligible for payment.

**Lungs** (codes G0125, G0210, G0211, G0212)

Blue Shield considers PET imaging of the lungs medically necessary for the diagnosis, staging and restaging of lung cancers (162-162.9, 163-163.9, 164.8, 164.9, 196.1, 197.0, 197.1, 231.2, 235.7, 235.8, 239.1).
Typically, a CT scan provides evidence of the initial detection of a primary tumor. When the CT scan shows an indeterminate or possibly malignant lesion, a PET study may be necessary to determine malignancy in order to plan treatment and future management of the patient.

Blue Shield considers PET imaging of the lungs for any other conditions not medically indicated. Blue Shield will not pay for PET imaging in these cases.

**Lymphoma** (codes G0220, G0221, G0222)

PET imaging is medically necessary in diagnosing, staging and restaging lymphoma (196.1, 200-200.88, 201-201.98, 202-202.98).

Blue Shield considers PET imaging for any other conditions not medically indicated. They are not eligible for payment.

**Melanoma** (codes G0216, G0217, G0218, G0219)

PET imaging for melanoma (172-172.9) is medically necessary for the diagnosis, staging and restaging of melanoma (codes G0216, G0217, G0218). Blue Shield will pay for PET imaging in these instances.

PET studies performed to evaluate regional nodes in melanoma patients (G0219) is not medically indicated. It is not eligible for reimbursement.

Blue Shield considers PET imaging for any other conditions not medically indicated. They are not eligible for reimbursement.

**Myocardium or heart** (codes 78459, 78491, 78492, G0030-G0047, G0230)

PET imaging of the myocardium following an inconclusive SPECT study is useful in assessing myocardial perfusion to diagnose and treat coronary artery disease, and myocardial viability to determine a patient’s candidacy for a revascularization procedure (410-410.9, 411-411.89, 413-413.9, 414.0-414.03, 414.1-414.9).

A myocardial SPECT study is typically performed to distinguish between dysfunctional, but viable, myocardial tissue and scar tissue. This information helps to identify patients with compromised ventricular function, partial loss of heart muscle movement, or hibernating myocardium who may be candidates for a revascularization procedure. When the results of the SPECT study are in doubt or inconclusive, Blue Shield considers a PET study of the myocardium, whether at rest alone or rest with stress, an eligible procedure.

Blue Shield considers PET imaging of the heart or myocardium for any other conditions not medically indicated. Therefore, it is not eligible for payment.

**Pancreas** (code 78810)

Blue Shield considers pancreatic PET imaging medically necessary for patients with suspected pancreatic adenocarcinoma (157-157.9).

PET is useful when results of other standard imaging modalities, for example, CT, endoscopic retrograde cholangiopancreatography (ERCP), ultrasonography, are in doubt, inconclusive or equivocal.

Blue Shield considers pancreatic PET imaging for any other diagnoses or conditions not medically indicated. They would not be eligible for payment.
**Malignancies in other anatomic areas**  (code 78810)

Blue Shield considers PET tumor imaging for malignancies in other anatomic areas and sites investigational for all other uses. Examples include, but are not limited to the diagnosis, staging, restaging and monitoring of treatment for other diseases and malignancies including but not limited to the CNS, thyroid, breast, musculoskeletal, cervix or ovaries, prostate, or germ-cell cancers and thymoma.

**Reminder:** Report procedure code S8085 when you perform a PET study on a Coincidence Detection Imaging System (a non-dedicated PET scanner).

<table>
<thead>
<tr>
<th>Carotid angioplasty considered investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania Blue Shield considers carotid angioplasty, with or without associated stenting, investigational. It is not covered. Blue Shield’s Board of Directors recently reaffirmed this decision.</td>
</tr>
<tr>
<td>To report carotid angioplasty with or without associated stenting, use code 37799—unlisted procedure, vascular surgery.</td>
</tr>
<tr>
<td>Blue Shield considers carotid angioplasty, with or without associated stenting, a minimally invasive alternative to open carotid endarterectomy. Carotid endarterectomy is a covered procedure.</td>
</tr>
<tr>
<td>Use code 35301—thromboendarterectomy, with or without patch graft, carotid, vertebral, subclavian by neck incision—to report carotid endarterectomy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Electrical bone growth stimulation eligible for nonunion fractures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania Blue Shield will pay for electrical bone growth stimulation (EBGS) when it’s used to treat nonunion fractures.</td>
</tr>
<tr>
<td>Include diagnosis code 733.82 when reporting EBGS for a nonunion fracture. This code identifies the condition as a nonunion of fracture.</td>
</tr>
<tr>
<td>Also report these codes, as appropriate:</td>
</tr>
<tr>
<td>20974—Electrical stimulation to aid bone healing; noninvasive (nonoperative)</td>
</tr>
<tr>
<td>20975—Electrical stimulation to aid bone healing; invasive (operative)</td>
</tr>
<tr>
<td>Blue Shield defines a nonunion fracture as a fracture that has not united within a minimum of 3 months.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extracorporeal magnetic innervation considered experimental</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinical efficacy of extracorporeal magnetic innervation (ExMI) technology has not been proven. Therefore, Pennsylvania Blue Shield considers ExMI experimental.</td>
</tr>
<tr>
<td>Use procedure code 97799 to report this service. When reporting code 97799, include “extracorporeal magnetic innervation” as the description of the service.</td>
</tr>
<tr>
<td>ExMI technology used in the pelvic floor therapy system provides non-invasive electromagnetic stimulation of pelvic floor musculature. The stimulation is performed to strengthen weak pelvic muscles to improve neuromuscular control for the treatment of stress, urge and mixed urinary incontinence in women.</td>
</tr>
</tbody>
</table>
Blue Shield to pay for Twinrix

Effective immediately, Pennsylvania Blue Shield will provide coverage for the new FDA-approved vaccine, Twinrix. Coverage will be in accordance with the member’s contract and the Childhood Immunization Act for dependent children as well as applicants or members and their spouses who are up to and including 20 years of age. For individuals outside this population, coverage will be based on the member’s contract.

Twinrix protects individuals 18 years of age and older against diseases caused by the hepatitis A virus (HAV) and the hepatitis B virus (HBV). Twinrix, (code 90636) combines two already approved vaccines, Havrix (Hepatitis A vaccine, [Inactivated]) and Engerix-B (Hepatitis B vaccine [Recombinant]).

Percutaneous balloon valvuloplasty of the aortic valve eligible for specific conditions

Beginning Nov. 19, 2001, Pennsylvania Blue Shield will recognize percutaneous balloon valvuloplasty of the aortic valve as an eligible surgical procedure in the treatment of calcified valves (424.1). Use code 92986—Percutaneous balloon valvuloplasty; aortic valve—to report this service.

Blue Shield will pay for percutaneous balloon valvuloplasty of the aortic valve when it’s used in the treatment of congenital aortic stenosis. This procedure is most commonly performed on neonates, infants, children and young adults.

Blue Shield considers this treatment for any other conditions investigational. Therefore, in those cases, it is not eligible for payment.

Reporting guidelines for percutaneous vertebroplasty

Pennsylvania Blue Shield considers percutaneous vertebroplasty investigational. It is not covered. Blue Shield’s Board of Directors recently reaffirmed this decision.

To report percutaneous vertebroplasty and radiological guidance, use these codes, as appropriate:

22520—Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic

22521—Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar

22522—Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

76012—Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under flouroscopic guidance

76013—Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under CT guidance

Percutaneous vertebroplasty is a therapeutic, interventional radiologic procedure that consists of the injection of a biomaterial (usually a barium polymethylmethacrylate mixture) into a cervical, thoracic or lumbar vertebral body lesion for the relief of pain and the strengthening of bone.
Blue Shield defines consultation

Pennsylvania Blue Shield defines a consultation as a professional service performed for a patient by a second physician at the written or verbal request of the attending physician. It includes a history, examination of the patient, evaluation of tests, when applicable, and written report filed with the patient’s permanent record. If the service performed does not meet this definition, please do not report the service as a consultation.

For more information about consultations, please refer to Pages 378-384 in the 2001 edition of the Procedure Terminology Manual (PTM).

Blue Shield allows payment for consultation services by anesthesiologists

Effective immediately, Pennsylvania Blue Shield no longer considers payment for a consultation (preoperative work up) performed by an anesthesiologist prior to definitive surgery as part of the care included in the anesthesia allowance.

Blue Shield will pay for a consultation performed by an anesthesiologist prior to surgery, according to the patient’s benefits.

Guidelines for reporting preventive and medical visits on the same day

If you are performing a routine preventive medicine evaluation and management service (procedure codes 99381-99397) and/or a gynecological examination (procedure code S0610 or S0612), you may encounter a medically-focused condition.

In some instances, treatment for a medically-focused condition may require more extensive medical evaluation, treatment and management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, report the appropriate medical E/M code (99201-99215) in addition to the preventive medicine service or gynecological examination.

Reporting more than one visit per day should not be a common occurrence in any practice. Pennsylvania Blue Shield conducts random audits on preventive medicine and E/M services reported on the same day. To justify these services, the patient’s records must contain sufficient documentation regarding the appropriateness of performing both services. You should also document that the key components of the E/M service have been met. If the reported E/M service does not meet the component requirements, Blue Shield will not pay for the second service. In cases where payment has occurred, Blue Shield will require a refund.

For CustomBlue or Access Care II members: charge the member for only one office visit copayment.
Pennsylvania Blue Shield considers ductal lavage an investigational procedure. Therefore, it is not eligible for payment.

Use code 19499 to report ductal lavage. When reporting code 19499, also include a complete description of the procedure performed.

Ductal lavage, dubbed “Pap smear for the breast,” is a new approach for monitoring changes in the cells lining the milk ducts where the majority of all breast cancers begin. These cells may show the first signs of cancer months or even years before a tumor can be seen on a mammogram or felt in a physical exam. Ductal lavage may be considered for women who are at high risk for developing breast cancer and for women with a history of breast cancer.

Ductal lavage is a minimally invasive procedure that involves three steps. In the first step, those ducts among the six to eight which open in the nipple that are most likely to contain abnormal cells are identified. In the second, saline is infused through a microcatheter into the duct to collect epithelial cells. The ductal fluid is then withdrawn through the catheter and deposited into a collection vial. The third step is the analysis by the cytology laboratory to determine the presence of normal, atypical, suspicious or malignant cells.

Pennsylvania Blue Shield will pay for the placement of an FDA-approved coronary stent (procedure code 92980 or 92981) for:

- Emergency management of abrupt vessel closure after angioplasty (PTCA).
- Treatment of large target vessels (>3.0 mm) and new focal lesions (<15 mm), especially if dissection of the coronary vessel is likely.
- Lesions previously angioplastied that have restenosed.
- Primary management of geometrically complex lesions.

If these criteria are not met, Blue Shield considers placement of the intracoronary stent investigational. Thus, it is not eligible for payment.
Repeat treatment cycles of intra-articular hyaluronan injections may be covered

Effective Sept. 10, 2001, Pennsylvania Blue Shield may pay for repeat treatment cycles of intra-articular hyaluronan injections for patients who have responded to the previous course of treatment. Blue Shield will give individual consideration to these injections when these criteria are met:

- At least 6 months have elapsed since the prior series of injections.
- The medical record must objectively document significant improvement in pain and functional capacity of the knee joint.

Coverage for intra-articular injections of hyaluronan, for example, synvisc or hyalgan, for osteoarthritis of the knee depends on the member’s contract.

Please use code 20610—Arthrocentesis, major joint or bursa—for the aspiration and/or injection procedure, and code J7320 for synvisc or J7315 for hyalgan.

Intra-articular injections of hyaluronan for osteoarthritis of the knee are eligible for payment when all of these criteria are met:

- The patient has symptomatic osteoarthritis of the knee (715.16, 715.26, 715.36, 715.96);
- The patient has failed to respond to conservative therapy such as analgesics, intra-articular corticosteroid injections, NSAIDs or is unable to tolerate therapy, for example, NSAIDs, because of adverse side effects;
- There are no contraindications to the hyaluronan injections; and
- The hyaluronan product is FDA-approved for intra-articular injections of the knee.

You must document failure to tolerate or respond to more conservative therapies in the patient’s record.

Intra-articular injections of hyaluronan act as lubricants to restore elasticity and viscosity to the osteoarthritic knee. Treatment using synvisc requires one injection per week for three weeks. In contrast, treatment with hyalgan requires one injection per week for five weeks.
Effective immediately, Pennsylvania Blue Shield considers the following additional procedure codes eligible for payment for co-surgery:

<table>
<thead>
<tr>
<th>Code</th>
<th>Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>61580</td>
<td>Craniofacial approach, skull</td>
</tr>
<tr>
<td>61582</td>
<td>Craniofacial approach, skull</td>
</tr>
<tr>
<td>61583</td>
<td>Craniofacial approach, skull</td>
</tr>
<tr>
<td>61584</td>
<td>Orbitocranial approach/skull</td>
</tr>
<tr>
<td>61585</td>
<td>Orbitocranial approach/skull</td>
</tr>
<tr>
<td>61586</td>
<td>Resect nasopharynx, skull</td>
</tr>
<tr>
<td>61590</td>
<td>Infratemporal approach/skull</td>
</tr>
<tr>
<td>61591</td>
<td>Infratemporal approach/skull</td>
</tr>
<tr>
<td>61592</td>
<td>Orbitocranial approach/skull</td>
</tr>
<tr>
<td>61595</td>
<td>Transtemporal approach/skull</td>
</tr>
<tr>
<td>61596</td>
<td>Transcochlear approach/skull</td>
</tr>
<tr>
<td>61597</td>
<td>Transcondylar approach/skull</td>
</tr>
<tr>
<td>61598</td>
<td>Transpetrosal approach/skull</td>
</tr>
<tr>
<td>61600</td>
<td>Resect/excise cranial lesion</td>
</tr>
<tr>
<td>61601</td>
<td>Resect/excise cranial lesion</td>
</tr>
<tr>
<td>61605</td>
<td>Resect/excise cranial lesion</td>
</tr>
<tr>
<td>61606</td>
<td>Resect/excise cranial lesion</td>
</tr>
<tr>
<td>61607</td>
<td>Resect/excise cranial lesion</td>
</tr>
<tr>
<td>61608</td>
<td>Resect/excise cranial lesion</td>
</tr>
<tr>
<td>61609</td>
<td>Transect artery, sinus</td>
</tr>
<tr>
<td>61610</td>
<td>Transect artery, sinus</td>
</tr>
<tr>
<td>61611</td>
<td>Transect artery, sinus</td>
</tr>
<tr>
<td>61612</td>
<td>Transect artery, sinus</td>
</tr>
<tr>
<td>61613</td>
<td>Remove aneurysm, sinus</td>
</tr>
<tr>
<td>61615</td>
<td>Resect/excise lesion, skull</td>
</tr>
<tr>
<td>61616</td>
<td>Resect/excise lesion, skull</td>
</tr>
<tr>
<td>61618</td>
<td>Repair dura</td>
</tr>
<tr>
<td>61619</td>
<td>Repair dura</td>
</tr>
<tr>
<td>62100</td>
<td>Repair brain fluid leakage</td>
</tr>
<tr>
<td>62140</td>
<td>Repair of skull defect</td>
</tr>
<tr>
<td>62141</td>
<td>Repair of skull defect</td>
</tr>
</tbody>
</table>
How to report injections of Adenosine

Procedure codes J0150 and J0151 represent different dosages of Adenosine.

Here’s how to report Adenosine injections to Pennsylvania Blue Shield:

- Report J0150 per 6 mg when Adenosine is administered as an antiarrhythmic agent.
- Report code J0151 per 90 mg when administering Adenosine as a diagnostic adjunct for those patients who cannot exercise adequately during cardiac stress testing.

Correction

In our article “Blue Shield expands coverage for epoprostenol sodium” (June 2001, Pages 3-4) we included an incorrect ICD-9-CM diagnosis code.

On Page 3, the second bullet should have read, “secondary pulmonary hypertension (416.8) related to congenital heart disease and associated New York Heart Association Class III or IV who do not respond adequately to conventional therapy, for example, oral vasodilator therapy.”

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.
### 2001 PTM changes

Please make these changes to your 2001 Pennsylvania Blue Shield *Procedure Terminology Manual* (PTM):

<table>
<thead>
<tr>
<th>Page</th>
<th>Code</th>
<th>Terminology</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>W0030</td>
<td>Anesthesia for nonsurgical or diagnostic services (specify exact service)</td>
<td>Delete; effective 11/1/01</td>
</tr>
<tr>
<td>258</td>
<td>A9508</td>
<td>Supply of radiopharmaceutical diagnostic imaging agent, lobenguane Sulfate I-131, per 0.5 mCi</td>
<td>Add</td>
</tr>
<tr>
<td>258</td>
<td>A9510</td>
<td>Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC99M Disofenin, per vial</td>
<td>Add</td>
</tr>
<tr>
<td>376</td>
<td>W9004</td>
<td>Unlisted inpatient evaluation and management service</td>
<td>Delete; effective 11/1/01</td>
</tr>
<tr>
<td>421</td>
<td>S5010</td>
<td>5% dextrose and 0.45% normal saline, 1000 ml</td>
<td>Change terminology</td>
</tr>
<tr>
<td>421</td>
<td>S5013</td>
<td>5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1000 ml</td>
<td>Change terminology</td>
</tr>
<tr>
<td>421</td>
<td>S5014</td>
<td>5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1500 ml</td>
<td>Change terminology</td>
</tr>
</tbody>
</table>

### Review

**Blue Shield to require annual clinical lab permit**

Pennsylvania Blue Shield now requires all participating providers billing for laboratory services performed in the office to annually furnish a copy of their Pennsylvania Department of Health clinical laboratory permit.

Beginning February 2002, Blue Shield will modify its claims system to prevent any future reimbursement to providers billing for lab services without a permit on file.

Pennsylvania labs are subject to licensure under the Clinical Laboratory Act of the Commonwealth of Pennsylvania. This includes all testing, for example, dipstick urines, whole blood glucose, strep screens, hemocults, etc., performed anywhere, including the physician’s office, nursing homes, clinics, hospitals and independent labs.

Please send a copy of your current Pennsylvania lab permit by Dec. 31, 2001 to:

Attention: Laboratory Certification
Pennsylvania Blue Shield
Benefits Utilization Management
PO Box 890089
Camp Hill, Pa. 17089
If you have questions about the certification process, please write to:
Pennsylvania Department of Health
Bureau of Laboratories
110 Pickering Way
Lionville, Pa. 19353

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

Central and Eastern Region

Avoid rejections: report correct alpha prefix for Auto Zone members

Please report the correct alphabetical prefix, AZO (alpha letter “O”), when submitting claims for Auto Zone employees. Some providers have been submitting claims for these members with an AZ0 (numeric zero) prefix instead of AZO.

If you report the incorrect prefix, AZ0, Pennsylvania Blue Shield may delay or reject your claims.


Central Region

Attention HealthStyle providers: HealthStyle members to obtain injectable medications through NPA plan

Beginning June 1, 2001, HealthStyle members now obtain all injectable prescription medications, including chemotherapy, whether self-administered or physician administered, through HealthStyle’s prescription drug program. National Prescription Administrators (NPA) administers HealthStyle’s prescription drug program. The member’s prescription benefit plan reimburses prescription drug expenses above the member’s applicable coinsurance costs.

Any member currently undergoing a course of treatment that involves an injectable medication may continue to receive their medications through the HealthStyle medical benefits. These members may receive their medications in this manner until their course of treatment is completed.

Certain drugs will not require member coinsurance costs

While these prescription drugs are covered and obtained through the NPA plan, the member will not be responsible for coinsurance costs:

• Remicaid
• Lupron Depot for intramuscular (IM) injection
• Sandostatin depot
• Synvisc
• Thyrogen (2 vial)
• Synagis
• Rabies series
Members may obtain these drugs at the retail pharmacy or through Central Fill Inc. (CFI), the mail order service for NPA. The CFI mail order service is being made available for all injectables to facilitate timely provision and for direct delivery to the physician’s office.

This is not intended to alter the current practice of reimbursing physicians through the medical plan for the administration and cost of commonly stocked, STAT injectable pharmaceuticals such as the initial antibiotic dosage, immunizations, allergy serums, Benadryl, lidocaine SQ, hydrocortisone, epinephrine, tetanus, Demerol and Glucagon. However, for physician-administered injectables, you should give the member a prescription to take to the retail pharmacy. You may also contact CFI for delivery to your office. Call CFI at (800) 233-7139, or fax your request to them at (877) 755-4676.

Some injectable drugs require prior authorization from NPA or CFI.

Central and Eastern Region

Out-of-area HMO patients to seek care from Blue Shield participating providers

Blue Cross Blue Shield HMO members affiliated with other Blue Cross Blue Shield Plans are being instructed to seek follow-up or urgent care, when outside their local service area, from a Pennsylvania Blue Shield participating provider.

If you treat one of these members, you must verify their eligibility. Then submit their claims through the BlueCard program.

How to identify out-of-area HMO members

You can identify Blue Cross Blue Shield HMO members from other Blue Plans by the three-character alphabetical prefix preceding the member’s identification number on their identification card.

Verify the member’s eligibility by calling BlueCard Eligibility at (800) 676-BLUE. Give the operator the member’s three-character alphabetical prefix that appears on their identification card.

How to submit BlueCard claims

Handle claims for these members as you do for Pennsylvania Blue Shield members and Blue Cross Blue Shield traditional patients from other Blue Plans.

If you see the empty-suitcase identifier on the member’s identification card, file the claim through the BlueCard program.

Here’s what to do with claims for Blue Cross Blue Shield HMO members affiliated with other Blue Plans:

- Once the member receives care, please do not ask for full payment up front. You may request payment for out-of-pocket expenses such as co-payment, coinsurance and non-covered services.

- Submit the member’s claim with the member’s complete identification number, including the alphabetical prefix, to Pennsylvania Blue Shield. You can submit these claims electronically or on a paper 1500A claim form.
Send paper 1500A claim forms to:
Pennsylvania Blue Shield
PO Box 890062
Camp Hill, Pa. 17089-0062

• You will receive direct reimbursement from Pennsylvania Blue Shield. If you have questions about Blue Cross Blue Shield HMO members affiliated with other Blue Plans, or the BlueCard program, contact your Provider Relations representative.
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 (866) 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 ____________

Acknowledgement

The five-digit numeric codes that appear in PRN were obtained from the Physician's Current Procedural Terminology, as contained in CPT-2001, Copyright 2000, by the American Medical Association. PRN includes CPT descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures and other materials that are copyrighted by the American Medical Association.
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Camp Hill, Pennsylvania 17089