PRN
Policy Review & News

Important information about Pennsylvania Blue Shield December 2001

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BC
Look for this symbol for all BlueCard related information

News

Blue Shield now requires most specific ICD-9-CM coding for certain claims

To mirror the national trend toward claims standardization and current Medicare claims reporting requirements, Pennsylvania Blue Shield has implemented a claims processing change. This change will affect the way you report diagnosis codes for CustomBlue PPO, Access Care II and Comprehensive major medical claims.

Some ICD-9-CM codes must include fourth or fifth digit

If you submit Medicare claims, you are already familiar with the requirement to report ICD-9-CM codes to the highest level of specificity, that is, to the fourth or fifth digit, when applicable. Blue Shield has implemented the same requirement within the Comp I processing system. The Comp I system processes CustomBlue PPO, Access Care II and Comprehensive major medical claims. This means that, effective immediately, you must include the most specific diagnosis code appropriate for the patient's condition on CustomBlue PPO, Access Care II and Comprehensive major medical claims.

Here is an example of how to report a specific diagnosis code:

ICD-9-CM 403.0—hypertensive renal failure—is not a valid code. This code requires the fifth-digit subclassification. Please report code 403.00 or 403.01, as appropriate.

For now, this requirement applies to CustomBlue PPO, Access Care II and Comprehensive major medical claims. However, Blue Shield intends to require diagnosis coding at the highest level of specificity for all Blue Shield products by mid-year 2002.

PENNSYLVANIA BLUE SHIELD
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Therefore, if you aren't already, you should begin to report ICD-9-CM codes to the highest level of specificity for all Blue Shield products. This will give your billing staff time to adjust to any necessary changes regarding reporting of diagnosis codes.

In the near future, Blue Shield will provide you with detailed reporting instructions about this new requirement, as it pertains to all Blue Shield products.

FEP introduces Basic Option for 2002

Current and retired federal employees could select the new Federal Employee Program (FEP) health plan option, Basic Option, during the November and December open enrollment.

The October 2001 **PRN** announced the new option (see "FEP to offer Basic Option in 2002" on Page 3).

The FEP will continue to offer Standard Option, as well as Basic Option. However, it will discontinue the High Option benefit.

Members could select either option as their health care plan during open enrollment. High Option members who did not select another health care plan will be enrolled in Standard Option.

Current and retired federal employees with either Standard or Basic Option will continue to use Pennsylvania Blue Shield's preferred provider network, PremierBlue.

How to identify Basic Option members

You can identify Basic Option members by the plan's distinct identification card. Look for these enrollment codes: 111 (self only); 112 (self and family). The member's copay does not appear on the Basic Option identification card.

How a member obtains benefits under Basic Option

To receive benefits under Basic Option, the member must seek care from an in-network provider. There are no out-of-network benefits except under these circumstances:

- medical emergency and accidental injury care in a hospital emergency room,
- services provided by hospital-based, non-preferred anesthesiologists, radiologists, pathologists and emergency room providers at preferred facilities,
- laboratory services, X-rays and diagnostic tests billed by non-preferred laboratories, radiologists and outpatient facilities,
- assistant surgeon services,
- the preferred provider is unavailable in special provider access situations, or
- the services were obtained outside the United States and Puerto Rico.

In these exception situations, if services are obtained from a non-preferred provider, benefits will be provided based on Blue Shield's network allowance. Members are responsible for applicable copays or coinsurance, and any amounts in excess of Blue Shield's allowance.

Basic Option copayments

Here are the services and corresponding copayments for Basic Option.

Service	Copayment
Primary care physician office visits	$20
Specialist office visits	$30
Independently billed diagnostic services without an office visit	$20 primary care physician service $30 specialist service
Inpatient surgery (one copay per day per provider). Professional inpatient medical services are paid in full. Inpatient radiologists, anesthesiologists, emergency room physicians and pathologists copays are waived.	$100
Inpatient cosurgery (one copay per day per provider)	$100
Outpatient surgery (one copay per day per provider)	$100
Outpatient physical, occupational and speech therapy (one copay per day per provider). Copay not applied if performed in a facility setting. Fifty visit combined physical therapy, occupational therapy and speech therapy annual limit.	$20 primary care physician service $30 specialist service
Mental health and substance abuse – prior approval required	$20
Emergency room – accidental injury and medical emergency	$50
Maternity care – delivery subject to copay; prenatal and postpartum care and diagnostic tests are paid in full	$100
Transplants – prior approval required; copay applies to surgery	$100
Durable medical equipment, prosthetics, orthotics, home infusion therapy, medical supplies	30 percent coinsurance
Home nursing care – visit up to two hours Twenty-five visit maximum per year	$20
Cardiac rehabilitation – prior approval required	$20 $30 for outpatient facility provider
Chiropractic – office visit, spinal manipulations and initial set of X-rays Twenty manipulations maximum per year	$20

Mental health and substance abuse guidelines for Basic Option

PremierBlue psychiatrists and psychologists will be the network providers for mental health and substance abuse (MHSA) services. Magellan Behavioral Health, Inc. will coordinate MHSA treatments.

Prior approval for MHSA treatment is required, except in emergencies. The member must call Magellan at (800) 258-9808 before receiving any MHSA care. A Magellan MHSA professional will triage the call. Magellan will provide a list of appropriate preferred providers. At this time, Magellan may approve an initial number of visits. Thereafter, the provider will coordinate treatment with Magellan to ensure proper authorizations.

When necessary, Magellan will request a treatment plan from the preferred provider. A written treatment plan is necessary to determine that the care is appropriate and medically necessary.

Medicare coordination and Basic Option

For Basic Option members with Medicare Parts A and B as the primary payer, copayments and coinsurance will be waived when preferred providers are used. Basic Option members who do not use preferred providers will be responsible for their coinsurance and deductibles.

For additional information

You can find additional information about the FEP's health care plans at **www.fepblue.org**. This site provides useful information about the 2002 changes that will affect you and your patients.

You may also call FEP Customer Service at (866) 763-3608 if you have questions.

Magellan to administer FEP mental health and substance abuse services

Magellan Behavioral Health, Inc. will manage the professional provider component of mental health and substance abuse (MHSA) services for FEP members covered by Pennsylvania Blue Shield. This applies to FEP's Standard and Basic Option.

Special requirements for MHSA Basic Option benefits

Basic Option requires that only preferred providers perform MHSA services. PremierBlue psychiatrists and psychologists have been designated as preferred MHSA providers.

Under Basic Option, the member, or you, must call Magellan for prior approval before care is rendered. With this initial call, Magellan will approve the appropriate number of visits. The initial number of visits may vary by diagnosis or situation. There is a $20 copay per visit.

In certain situations, Magellan may request treatment plans. Magellan will evaluate the requested services and will approve only medically necessary and covered services. Magellan may deny treatment plans because the services are not covered or the care is not medically necessary. In these situations, Magellan will work with you to revise the treatment plan so the member receives the most effective care.

Blue Shield's anthrax exposure policy guidelines explained

As the media continues to cover bioterrorist issues—including the use of infectious diseases as a terrorist weapon—public awareness of anthrax is increasing. Anthrax is an uncommon infectious disease of the skin, and more rarely of the lungs, caused by specific bacteria. It commonly occurs in animals, but it can occur in humans who are exposed to infected animals or tissue from infected animals.

To positively diagnose infection with anthrax, certain laboratory tests are performed to confirm the presence of the anthrax bacteria. Anthrax can be treated with several antibiotic options. The anthrax bacteria is tested to determine which antibiotics should be used. Public concern about antibiotic supply and potential exposure has caused some people to purchase antibiotics "just in case." The American Medical Society (AMA) and the Centers for Disease Control and Prevention (CDC) do not recommend that people take antibiotics as a preventive measure against anthrax. Doing so could lead to antibiotic resistance.

A vaccine for anthrax is available to military and laboratory personnel, but is not generally available to the public. The federal government controls the supply of the anthrax vaccine, and decides who needs to be vaccinated. Currently, there are no plans to make the vaccine available to the general public.

Blue Shield issues coverage guidelines for anthrax

In the case of potential anthrax exposure, Pennsylvania Blue Shield will cover both testing and treatment for its members, in accordance with each member's benefit contract.

Blue Shield will pay for:

- medically necessary testing for members who have been potentially exposed to anthrax, and
- antibiotics for members with a prescription drug benefit.

Blue Shield supports the decision of the AMA and CDC to discourage prescribing antibiotics to individuals who have not been potentially exposed to anthrax.

- Individuals who have not been potentially exposed to anthrax are not encouraged to take antibiotics.
- Taking unnecessary antibiotics contributes to the problem of antibiotic resistance, which is a major public health issue.
- Overuse of antibiotics can cause bacteria to become resistant to previously effective antibiotics.
- Taking antibiotics without an infection decreases the available supply of drugs for individuals who could be infected.

Clinical information for physicians

Here are excerpts from the CDC's guidelines, which were disseminated in October 2001. You can view the CDC's guidelines online at **www.cdc.gov**.

Anthrax organisms can cause infection in the skin, gastrointestinal system, or the lungs. To do so, the organism must be rubbed into abraded skin, swallowed, or inhaled as a fine, aerosolized mist. Disease can be prevented after exposure to the anthrax spores by early treatment with the appropriate antibiotics. Anthrax is not spread from one person to another person.

For anthrax to be effective as a covert agent, it must be aerosolized into very small particles. This is difficult to do, and requires a great deal of technical skill and special equipment. If these small particles are inhaled, life-threatening lung infection can occur, but prompt recognition and treatment are effective.

Signs and symptoms of anthrax infection

Inhalational anthrax: A brief prodrome resembling a viral respiratory illness followed by development of hypoxia and dyspnea, with radiographic evidence of mediastinal widening. This, the most lethal form of anthrax, results from inspiration of 8,000-40,000 spores of *B. anthracis*. The incubation of inhalational anthrax among humans is unclear, but it is reported to range between one and seven days possibly ranging up to 60 days. Host factors, dose of exposure and chemoprophylaxis may play a role. Initial symptoms include sore throat, mild fever, muscle aches and malaise. These may progress to respiratory failure and shock. Meningitis frequently develops. Case-fatality estimates for inhalational anthrax are based on incomplete information regarding exposed populations and infected populations in the few case series and studies that have been published. However, case-fatality is extremely high, even with all possible supportive care including appropriate antibiotics. Estimates of the impact of the delay in post-exposure prophylaxis or treatment on survival are not known.

Gastrointestinal anthrax: Severe abdominal distress followed by fever and signs of septicemia. This form of anthrax usually follows the consumption of raw or undercooked contaminated meat. It is considered to have an incubation period of one to seven days. An oropharyngeal and an abdominal form of the disease have been described in this category. Involvement of the pharynx is usually characterized by lesions at the base of the tongue, sore throat, dysphagia, fever and regional lymphadenopathy. Lower bowel inflammation usually causes nausea, loss of appetite, vomiting and fever, followed by abdominal pain, vomiting blood and bloody diarrhea.

Cutaneous anthrax: A skin lesion evolves from a papule, through a vesicular stage, to a depressed black eschar. This is the most common naturally occurring type of infection (greater then 95 percent). It usually occurs after skin contact with contaminated meat, wool, hides or leather from infected animals. Incubation period ranges from one to 12 days. Skin infection begins as a small papule, progresses to a vesicle in one to two days followed by a necrotic ulcer. The lesion is usually painless, but patients also may have fever, malaise, headache and regional lymphadenopathy.

Blue Shield increases anesthesia conversion factor

Pennsylvania Blue Shield has increased the anesthesia conversion factor from $34 to $40 per unit for the UCR and PremierBlue products. The Pennsylvania Insurance Department approved the increase, which became effective for anesthesia services performed on or after Oct. 15, 2001.

Maternity and delivery allowance increases approved

Pennsylvania Blue Shield increased UCR and PremierBlue reimbursement rates for a select number of high utilization maternity care and delivery services, including annual gynecological exams. The Pennsylvania Insurance Department approved the increases.

The increases became effective for services performed on or after Oct. 15, 2001.

Blue Shield proposes comprehensive reimbursement increases

Pennsylvania Blue Shield is filing a broad range of reimbursement increases for UCR and PremierBlue with the Pennsylvania Insurance Department.

Blue Shield's comprehensive proposal includes increases to a select number of high-volume evaluation and management (E/M) procedure codes, mental health procedure codes, and numerous diagnostic and therapeutic procedures.

Breast pumps eligible for only certain criteria

Pennsylvania Blue Shield now pays for the rental of an electric breast pump when it is a benefit of the member's contract. Blue Shield will pay for the breast pump only when one of these criteria is met:

- Newborns detained in the hospital after the mother is discharged.

  Blue Shield will pay for the rental of a breast pump during the newborn's hospitalization. Once the newborn is discharged, Blue Shield will no longer pay for the breast pump.

- Babies who have congenital anomalies that interfere with feeding.

  Blue Shield will pay for the rental of the breast pump for the first month after the baby is discharged from the hospital. When a breast pump is used longer than this specified time, Blue Shield will determine its medical necessity on an individual consideration basis. Blue Shield will allow the purchase of a breast pump in cases where purchase of the device is more economical than the rental.

Blue Shield will pay for the purchase of a manual breast pump, instead of an electric breast pump, when one of the above criteria is met.

Breast pumps not qualifying for coverage in accordance with the criteria on Page 7 do not meet the definition of durable medical equipment (DME). Therefore, they are not covered. In these instances, the participating, preferred or network provider can bill the member for the denied breast pump.

Please use code E0602 to report a breast pump. Remember to indicate whether it is manual or electric.

Avoid denials: report appropriate diagnoses when providing concurrent care

When providing concurrent care, please report only the diagnosis or diagnoses for which you are treating a patient. This will help Pennsylvania Blue Shield apply its concurrent care guidelines appropriately. If you report all diagnoses for which the patient is being treated by multiple physicians, Blue Shield may deny your claim.

Blue Shield determines the medical necessity of concurrent care on the basis of the patient's condition, as demonstrated by the reported diagnoses and documentation in the patient's medical records.

Concurrent care is care provided to an inpatient of a hospital or skilled nursing facility simultaneously by more than one doctor during a specified period of time. This type of care is usually provided when:

- two or more separate conditions require the services of two or more doctors, or
- the severity of a single condition requires the services of two or more doctors for proper management of the patient.

The attending doctor has overall responsibility for the patient's care. However, based on the patient's condition, the attending doctor may request one or more consultants or specialists to participate in the patient's care. Document the need for such care in the patient's records, daily progress notes and discharge summary. The records should document:

- the attending doctor's request for the consultant to see the patient,
- the seriousness of the patient's condition,
- each doctor's active participation in the patient's care, and
- the attending doctor's release of the consultant's care when it is no longer needed.

Concurrent care that does not meet Blue Shield's medical necessity criteria is not eligible for payment. A participating, preferred or network health care professional may not bill the patient for denied concurrent care.

How to report laser destruction of varicosities

Do not use codes 17106-17108 to report laser destruction of varicosities. Use code 37799—unlisted procedure, vascular surgery—to report this service.

Other reporting guidelines for elimination of port wine stains and spider veins

Use procedure codes 17106-17108 to report the destruction of cutaneous vascular proliferative lesions such as port wine stains.

Pennsylvania Blue Shield considers the injection of sclerosing solution into telangiectases such as spider veins cosmetic. It is not covered. Report this procedure with code 36468 or 36469, as appropriate.

Endoscopic gastroplasty with suturing of the esophagogastric junction not eligible

Pennsylvania Blue Shield considers endoscopic gastroplasty or gastroplication with suturing of the esophagogastric junction investigational. Therefore, it is not eligible for payment.

Use code 0008T—upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with suturing of the esophagogastric junction—to report this procedure.

Endoscopic gastroplasty or gastroplication with suturing of the esophagogastric junction, a minimally invasive alternative to either open or laparoscopic gastric fundoplication, is used to treat gastroesophageal reflux disease (GERD).

During upper gastrointestinal endoscopy, sutures are placed in the lower esophageal sphincter. These sutures are designed to strengthen and lengthen the sphincter in order to decrease reflux. The Bard EndoCinch Suturing System is an example of a device used in endoscopic gastroplasty with suturing.

Blue Shield considers laser ultraviolet light B investigational

Pennsylvania Blue Shield considers ultraviolet light B treatment performed with a laser investigational. Therefore, it is not a covered service.

Use procedure code 96999 to report UVB treatments provided with a laser. Please include a complete description of the service performed when reporting code 96999.

Blue Shield pays for three forms of ultraviolet light therapy: UVB, Goeckerman and PUVA. Services performed for an appropriate dermatological condition are eligible if they are a benefit of the member's contract.

Kyphoplasty not covered

Pennsylvania Blue Shield considers kyphoplasty investigational. It is not covered. Blue Shield's Board of Directors recently reaffirmed this position.

Kyphoplasty, a therapeutic interventional radiologic procedure, involves the placement of a cannula into a compressed vertebra. This allows a balloon to be passed and inflated within the bone. By expanding the bone, a cavity is created. The cavity is then injected with bone cement.

Kyphoplasty is performed to relieve pain, strengthen the bone or restore height.

Report kyphoplasty with procedure code 22899—unlisted procedure, spine. When reporting code 22899, please include a complete description of the service you performed.

More procedures eligible for cosurgery

Pennsylvania Blue Shield now considers these additional procedures eligible for payment for cosurgery:

22808—fusion of spine

22812—fusion of spine

32664—thoracoscopy, surgical

43122—partial removal of esophagus

58210—extensive hysterectomy

58950—resect ovarian malignancy

58951—resect ovarian malignancy

58952—resect ovarian malignancy

65750—corneal transplant

67036—removal of inner eye fluid

For a further explanation of cosurgery, as defined by Blue Shield, please refer to the August 2001, February 2001, February 2000 and June 1999 editions of **PRN**.

Reporting code change for surface EMGs

The Blue Cross and Blue Shield Association has recently approved code S3900—surface electromyography (EMG)—for reporting surface EMGs. S3900 replaces Pennsylvania Blue Shield's local code W9587, effective immediately.

Surface EMGs are not the same as conventional EMGs. They involve the use of a probe that is passed over the surface of the skin to measure electrical muscle activity.

Blue Shield considers surface EMGs investigational or experimental. Scientific evidence does not demonstrate the efficacy of these studies.

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

AMA creates new CPT Category III tracking codes

Recently, the American Medical Association (AMA) created a new set of national procedure codes called CPT Category III tracking codes.

The Category III codes represent new and emerging technologies, services or procedures that may be within the FDA approval process, but have not yet been approved.

The Category III codes are temporary codes. Use these codes until the FDA approves the technology, service or procedure. Once FDA approved, the AMA will assign a permanent CPT code for the technology, service or procedure.

Pennsylvania Blue Shield will independently make an eligibility determination for each technology, service or procedure.

The AMA will publish the CPT Category III tracking codes twice a year—in January and July. To date, the AMA has created 22 CPT III procedure codes. The codes range in sequential order from 0001T through 0026T.

Please see "2001 **PTM** changes" on Pages 11-12 of this **PRN** for the new CPT III procedure codes along with their description.

2001 PTM changes

Please make these changes to your 2001 **PTM**:

Page	Code	Terminology	Action
71	0014T	Meniscal transplantation, medial or lateral, knee (any method)	Add
85	0012T	Arthroscopy, knee, surgical, implantation of osteochondral graft(s) for treatment of articular surface defect; autografts	Add
85	0013T	Arthroscopy, knee, surgical, implantation of osteochondral graft(s) for treatment of articular surface defect; allografts	Add
108	0001T	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; modular bifurcated prosthesis (two docking limbs)	Add
108	0002T	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; aorto-uni-iliac or aorto-unifemoral prosthesis	Add
120	0024T	Non-surgical septal reduction therapy (eg, alcohol ablation), for hypertrophic obstructive cardiomyopathy; with coronary arteriograms, with or without temporary pacemaker	Add
134	0008T	Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with suturing of the esophagogastric junction	Add

Page	Code	Terminology	Action
179	0003T	Cervicography	Add
181	0009T	Endometrial cryoablation with ultrasonic guidance	Add
185	0021T	Insertion of transcervical or transvaginal fetal oximetry sensor	Add
195	0019T	Extracorporeal shock wave therapy; involving musculoskeletal system	Add
195	0020T	Extracorporeal shock wave therapy; involving plantar fascia	Add
215	0016T	Destruction of localized lesion of choroid (eg, choroidal neovascularization), transpupillary thermotherapy	Add
215	0017T	Destruction of macular drusen, photocoagulation	Add
246	0007T	Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous, radiological supervision and interpretation, each vessel	Add
275	0026T	Lipoprotein, direct measurement, intermediate density lipoproteins (IDL) (remnant lipoproteins)	Add
286	0010T	Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response	Add
296	0023T	Infectious agent drug susceptibility phenotype prediction using a genotypic comparison to known genotypic/phenotypic database, HIV 1	Add
310	0018T	Delivery of high power, focal magnetic pulses for direct stimulation to cortical neurons	Add
314	0025T	Determination of corneal thickness (eg, pachymetry) with interpretation and report, bilateral	Add
324	0005T	Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous; initial vessel	Add
324	0006T	Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	Add

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

Central Region

Hershey HealthStyle mental health administrator changes

On Oct. 1, 2001, APB Healthcare became the behavioral health administrator for mental health and substance abuse services for Hershey HealthStyle members.

Please call APS Healthcare at (888) 454-6225 to access mental health or substance abuse services for HealthStyle members.

BlueCard identification icon added to HealthStyle cards

The addition of the "empty suitcase" symbol on the HealthStyle Point of Service member identification card distinguishes member eligibility in the BlueCard program. You can also determine BlueCard eligibility by the three-digit alphabetical prefix preceding the member's identification number on the card.

The BlueCard program enables HealthStyle members to receive plan benefits when traveling outside the Capital Blue Cross and Pennsylvania Blue Shield service area.

Call Provider Services at (800) 892-3033 to verify member eligibility and to obtain preauthorization for BlueCard.

Notes

Notes

Need to change your provider information?

Fax the information to us!

You can fax us changes about your practice information, such as the information listed on the coupon below. The fax number is (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 _____

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Acknowledgement

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

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