Pennsylvania Blue Shield is revising its regulations for preferred providers to comply with Act 68 requirements. The revisions are effective April 1, 2002.

The changes affect Sections C and D of the regulations. Section C, which dealt with reimbursement guidelines, now addresses Act 68 managed care provisions. A new section, Section D, Reimbursement, includes expanded reimbursement language.

Blue Shield will amend these documents:

- Pennsylvania Blue Shield Regulations for Preferred Providers (form 3720)
- Pennsylvania Blue Shield PremierBlue Regulations for Preferred Providers (form PB7)

Here is the revised text, effective April 1, 2002, for the affected sections of each of these regulations:

**Amend Section C to read:**

**C. MANAGED CARE PROVISIONS**

The following provisions will apply in all instances where the preferred provider is providing services to a member enrolled in a Managed Care Plan as defined by the Quality Health Care Accountability and Protection Act of 1998, June 17, P.L. 464, No. 68, 40 Pa.C.S. § 991.2101 et seq. (“Act 68”).
1. The preferred provider acknowledges and reaffirms the hold harmless provision in Regulation B.26, and agrees that such provision shall survive the termination of the Preferred Provider Agreement and is to be construed for the benefit of the members.

2. All member records shall be kept confidential by Blue Shield and the preferred provider in accordance with section 2131 of Act 68 and other applicable state and federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Gramm-Leach-Bliley Act of 1999 (GLBA).

3. The preferred provider will maintain medical records in accordance with standards set by Blue Shield, and shall permit Blue Shield, the Department of Health, the Insurance Department, and, when necessary, the Department of Public Welfare, access to records for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Act 68, the regulations of the Department of Health adopted thereunder, and other Pennsylvania Laws, provided, however, that records shall only be accessible to Department employees or agents with direct responsibilities for the functions enumerated above.

4. The preferred provider will participate in and abide by the decisions of all quality assurance, utilization review and member complaint and grievance systems applicable to Blue Shield Managed Care Plans.

5. The preferred provider will adhere to all state and federal laws and regulations applicable to the provision of professional health care services under this Agreement.

6. Blue Shield will pay all “clean claims” (as defined in Section 2102 of Act 68) in accordance with the prompt payment standards of Section 2166 of Act 68, the Insurance Department’s regulations at 31 Pa. Code § 154.18, and any other applicable law.

7. Blue Shield will notify the preferred provider in writing at least thirty (30) days before it implements any changes to its contracts, policies or procedures that affect: (a) the preferred provider, (b) the manner in which health care services are provided to members, or (c) the manner in which Blue Shield pays for health care services. No such notice shall be required if the change is required by law or regulation.

8. Nothing in these regulations shall be construed to limit or prohibit any preferred provider’s right to discuss, and the preferred provider may freely discuss, with any member, or, where applicable, on behalf of such member with such member’s representative: (a) the process that Blue Shield uses or proposes to use to deny payment for a health care service; (b) medically necessary and appropriate care available to such member that is within the preferred provider’s scope of practice, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests, regardless of benefit coverage limitations under the terms of the member’s Blue Shield Managed Care Plan; and (c) the decision of Blue Shield to deny payment for a health care service.
9. As required by Act 68, Blue Shield will not sanction, fail to renew or terminate the preferred provider’s participation in Blue Shield Managed Care Plans for any of the following reasons:

a) The preferred provider’s advocating for medically necessary and appropriate health care for a member, where such care is consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care;

b) The preferred provider’s filing of a grievance in accordance with the terms of Act 68, or assisting members in filing their own grievances;

c) The preferred provider’s protesting a decision, policy or practice that the preferred provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the preferred provider’s ability to provide (based on the preferred provider’s clinical judgment) medically necessary and appropriate health care;

d) The preferred provider’s having a practice that includes a substantial number of patients with expensive medical conditions;

e) The preferred provider’s objecting to the provision of, or refusing to provide, perform, participate in or refer a member for health care services when the refusal of the preferred provider is based on moral or religious grounds and the preferred provider makes adequate information available to members or, if applicable, prospective members;

f) The preferred provider’s communicating with a member or a member’s representative in accordance with the terms of Regulation C.8; or

g) The preferred provider’s taking any other action specifically permitted under Sections 2113, 2121 and 2171 of Act 68 (40 P.S. §§ 991.2113, 991.2121 and 991.2171).

Add Section D

D. REIMBURSEMENT

Payment will be made by Blue Shield directly to the preferred provider in accordance with the payment schedule(s) currently in effect. Blue Shield will make the payment schedules available by posting them on its internet site or by other readily accessible means, and will provide printed schedules of payment allowances, by specialty, upon request. Payments will be subject to the coinsurance, copayment and deductible provisions of the member’s benefit contract and to Blue Shield’s policies and reimbursement guidelines.

Note: The April 2002 PRN will provide you with more information about what methods will be available for accessing PremierBlue allowances.
How to order the new preferred provider regulations

To obtain a copy of the revised regulations, contact Blue Shield’s Shipping Control Department at:

Pennsylvania Blue Shield
Shipping Control Department
PO Box 890089
Camp Hill, Pa. 17089-0089

You may also call Blue Shield’s automated ordering system at (717) 763-3256.

New PO box for provider correspondence

Do not send your provider correspondence to PO Box 2720. On Jan. 1, 2002, provider correspondence PO Box 2720 was eliminated.

Now you can send your professional provider correspondence to:

Pennsylvania Blue Shield
PO Box 890035
Camp Hill, Pa. 17089-0035

Policy

Blue Shield's consultations prior to anesthesia policy clarified

In the August 2001 PRN, Pennsylvania Blue Shield announced that it no longer considers consultations performed by an anesthesiologist as part of the global anesthesia allowance. This change was the result of a similar change Blue Shield made to consultations performed prior to surgery and obstetrical delivery. See “Blue Shield allows payment for consultations prior to surgery and obstetrical delivery” in the April 2001 PRN.

Blue Shield’s policy of including consultations by the surgeon or anesthesiologist in the global surgery or anesthesia allowance was long-standing. However, based on input from members of the medical community, Blue Shield determined that the policy did not reflect the current standard of care.

Blue Shield partners with the medical community to keep informed of new technology and changing medical trends. This partnership resulted in the change to Blue Shield’s policy for consultations prior to surgery and anesthesia.

Blue Shield's requirements for consultations

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 in the patient’s permanent record. If the service performed does not meet this definition, please do not report the service as a consultation.

In order for an anesthesiologist to bill a preoperative consultation, the attending physician, for example, the surgeon, must request the consultation. The request may be either verbal or written. A written report must then be provided to the attending physician by the anesthesiologist for inclusion in the member’s medical chart.
As with all services reported to Blue Shield, the patient’s records should include appropriate documentation for the reported services.

Coverage for consultations may vary, based on the individual member’s contract.

When a benefit, Blue Shield will pay for preoperative consultations regardless of whether the service was performed on the same day of surgery or prior to the day of surgery.

If you have additional questions about this policy, please contact your Blue Shield Provider Relations representative.

**Blue Shield pays for special stains used for histological exam of tissue**

Beginning May 20, 2002, Pennsylvania Blue Shield will pay separately for special stains such as periodic acid-Schiff reaction and Masson-trichromic stain used for histological examination of tissue. Previously, Blue Shield had combined the charges for special stains (88312–88314) with the allowance for gross and microscopic tissue examinations (88304–88309).

Blue Shield anticipates increased utilization of special stain codes. Blue Shield will review the allowances associated with these procedures and may make minor adjustments to ensure reasonability.

**Scintimammography eligible in certain situations**

Pennsylvania Blue Shield considers scintimammography, radionuclide imaging of the breast, eligible in these situations:

- to evaluate and characterize breast masses or lesions of one centimeter and larger found through conventional imaging procedures, for example, mammography, MRI and/or ultrasound, when the results of the conventional imaging procedure are indeterminate, equivocal or inconclusive.

- to evaluate the post-surgical breast for residual or recurrent cancer when the results of conventional imaging procedures, for example, mammography, MRI and/or ultrasound, are indeterminate, equivocal or inconclusive.

Radionuclide imaging of the breast is not eligible when it’s used as:

- a screening procedure,
- an alternative to conventional mammography, or
- a replacement or substitute for surgical biopsy.

Use code S8080—scintimammography (radioimmunoscintrigraphy of the breast) unilateral, including supply of radiopharmaceutical—to report this nuclear imaging procedure.

Scintimammography is also known as mammoscintigraphy or breast scintigraphy. It is a nuclear imaging procedure that uses a radiopharmaceutical diagnostic imaging agent (for example, MiraLuma™ [generically known as technetium sestamibi]) to provide tumor-specific imaging of the breast. After the administration of the radiopharmaceutical, the breast is evaluated with planar or single photon emission computed tomography (SPECT) radionuclide imaging.
Effective Jan. 1, 2002, Pennsylvania Blue Shield considers phototherapeutic keratectomy (PTK) eligible for these conditions:

- corneal scar and opacities (371.0)
- stromal corneal dystrophy (371.56)

If PTK is reported for other conditions, Blue Shield will review the service on an individual basis for medical necessity. If Blue Shield determines that PTK was not medically necessary, it will deny it. In these instances, a participating, preferred or network provider cannot bill the member for the denied service.

PTK involves the use of the excimer laser to treat visual impairment or irritative symptoms relating to diseases of the anterior cornea. Use procedure code S0812 to report PTK.

Photorefractive keratectomy (PRK) corrects refractive errors of the eye, for example, myopia, hyperopia, astigmatism. Correction of such refractive problems is a standard exclusion under Blue Shield medical-surgical contracts. Report PRK with code S0810.

Pennsylvania Blue Shield’s Board of Directors recently approved coverage for transmyocardial revascularization (TMR) when it’s performed as an adjunct to coronary artery bypass grafting (CABG). TMR is performed on patients undergoing CABG who have documented vascular areas refractory to bypass grafting.

Use code 33141 to report TMR as an adjunct to CABG.

**TMR performed independently is not covered**

Blue Shield considers TMR investigational when it’s performed as a stand-alone procedure. It is not covered. Blue Shield’s Board of Directors recently reaffirmed this position.

To report TMR as a separate procedure, use code 33140.

Pennsylvania Blue Shield considers these services an integral part of a health care professional’s medical or surgical care:

- asthma education, non-physician provider, per session (S9441);
- collection and interpretation of physiologic data, (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified provider, requiring a minimum of 30 minutes of time (99091);
- impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic (S0395); and
- pulsed irrigation of fecal impaction (91123).

These services are not eligible as separate and distinct services when performed with medical or surgical care.
Blue Shield considers Q0091 integral part of an exam

Pennsylvania Blue Shield considers code Q0091—screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory—an integral part of a gynecological examination or evaluation and management service. Therefore, Blue Shield’s payment for a gynecological examination or evaluation and management service on the same date of service includes the allowance for code Q0091. In this instance, a participating, preferred or network health care professional cannot bill the member separately for code Q0091.

Coverage guidelines for HIV genotyping and phenotyping

Pennsylvania Blue Shield will pay for testing for HIV resistance to antiretroviral drugs, that is, HIV genotyping or phenotyping, for patients who have failed a prior course of antiviral therapy.

Because of a lack of documented studies, Blue Shield considers other applications of HIV resistance testing and combined HIV genotyping and phenotypic testing, including but not limited to its use in patients with previously untreated HIV, investigational. These tests are not eligible for payment.

Use code 87901 to report HIV genotyping. Codes 87903 and 87904 should be used to report HIV phenotyping.

Non-implantable pelvic floor electrical stimulator coverage outlined

Pennsylvania Blue Shield now pays for a non-implantable pelvic floor electrical stimulator when it’s used to treat stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. The device must be a benefit of the member’s contract.

Blue Shield defines a failed trial of PME training as: no clinically significant improvement in urinary continence after completing four weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Please use code E0740 to report non-implantable pelvic floor electrical stimulators.

Blue Shield allows additional coverage for ocular photodynamic therapy

Pennsylvania Blue Shield now recognizes ocular photodynamic therapy (OPT) with verteporfin (Visudyne), as an eligible treatment for:

- occult neovascularization (362.50),
- pathologic myopia (360.21) and
- ocular histoplasmosis (115.92).

Blue Shield provides coverage for OPT for classic or predominately classic subfoveal choroidal neovascularization (362.16, 362.52).

Blue Shield considers all other applications of OPT investigational.

Use procedure code 67221 or 67225, as appropriate, to report ocular photodynamic therapy. Use procedure code J3395 to report the verteporfin.

For additional coverage guidelines, see “Ocular photodynamic therapy eligible for specific conditions” in the October 2000 PRN.
Blue Shield pays for amnioreduction and fetoscopic laser therapy for twin-twin transfusion syndrome

Twin-twin transfusion syndrome (762.3), a severe and often fatal complication, occurs as a result of a circulatory placental defect in monozygotic twins. Two treatments—serial amnioreduction and fetoscopic laser therapy—can correct this abnormality.

As of Jan. 1, 2002, Pennsylvania Blue Shield pays for amnioreduction, or removal of amniotic fluid to restore normal volume, when it’s used to treat twin-twin transfusion syndrome. Use code 59001—amniocentesis; therapeutic amniotic fluid reduction; includes ultrasound guidance—to report amnioreduction.


Laser therapy may be preceded by either angiography or doppler sonography to identify target vessels for laser therapy. There are no specific procedure codes for doppler sonography or angiography of the placenta. If you perform these procedures, report them with the appropriate not otherwise classified (NOC) code:

- 76499—unlisted diagnostic radiologic procedure (Use this code to report the angiography)
- 76999—unlisted ultrasound procedure (Use this code to report the doppler sonography)

When reporting these NOC codes, please remember to include a complete description of the service you performed.

Fetal surgery performed in utero is eligible for certain conditions

Effective Jan. 1, 2002, Pennsylvania Blue Shield pays for fetal surgery for the correction of these conditions:

- urinary tract obstruction (use code S2401)
- congenital diaphragmatic hernia (use code S2400)
- congenital cystic adenomatoid malformation (use code S2402)
- extralobar sequestration (use code S2403)
- removal of sacrococcygeal teratoma (use code S2409)

Blue Shield considers fetal surgery for all other conditions, including myelomeningocele (code S2404), investigational or experimental. Scientific evidence does not demonstrate the efficacy of fetal surgery performed for other indications.

Blue Shield will review each claim for fetal surgery on an individual consideration basis.

Fetal surgery is performed in-utero to correct prenatally diagnosed malformations. This typically involves opening the gravid uterus, surgically correcting an existing fetal abnormality, returning the fetus to the uterus, and restoring uterine closure.
Digitization of mammographic film images not covered

Pennsylvania Blue Shield does not pay an additional allowance for radiographic image enhancing techniques. This includes the digitization with computer analysis of mammographic film images.

The digitization of a mammographic film image does not represent the actual radiological study. It is not eligible for payment in addition to the allowance for the conventional mammogram.

Blue Shield will deny separate charges reported for the digitization of mammographic film images as not covered. A participating, preferred or network provider cannot bill the member for the denied service.

Here are the codes for digitization of mammographic film:

- 76085—Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to the code for primary procedure).
  Report code 76085 only with code 76092 or Y7608.

- G0236—Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure).
  Report code G0236 only with code 76090 or 76091.

Intensity modulated radiation therapy considered investigational

Pennsylvania Blue Shield considers intensity modulated radiation therapy (IMRT) investigational. Recent medical literature focuses on the short-term outcomes associated with the use of IMRT. However, the safety and efficacy of IMRT in long-term outcomes has not yet been proven in clinical studies.

How to report IMRT

Here is how to report IMRT treatment planning and delivery:

- IMRT treatment planning: use code 77301—intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications.

- IMRT treatment delivery: use code 77418—intensity modulated treatment delivery, single or multiple fields/arcs, via narrow and temporally modulated beams (e.g., binary, dynamic MLC), per treatment session.

IMRT is a form of conformal radiation treatment. A computer geometrically modulates the dose of radiation delivered to a specific treatment area and conforms it to the tumor. Using previously acquired CT images and sophisticated physics and dosimetry, a higher dose of radiation is delivered to the target tumor volume. Sensitive or critical structures and tissues are spared through the use of decreasing radiation dosages, special shields and multiple variations in blocking within the treatment field.
Pennsylvania Blue Shield considers autologous chondrocyte transplantation (ACT) investigational. It is not covered. Blue Shield’s Board of Directors recently reaffirmed this decision.

To report ACT, use code 27599—unlisted procedure, femur or knee. Please include a complete description of the service you performed when reporting this code.

ACT is a treatment for cartilage damage within the knee joint. It is used to treat patients who have not responded to arthroscopic or other surgical repair procedures.

Pennsylvania Blue Shield now pays for a continuous positive airway pressure (CPAP) device used in the treatment of obstructive sleep apnea (OSA) when all of these criteria are met:

- Sleep study results:
  - Apnea-Hypopnea Index (AHI) equal to or greater than 5 (also called the Respiratory Disturbance Index or RDI).
- Results of CPAP trial (at optimum CPAP pressure):
  - AHI less than 5, or for patients with AHI greater than 20, reduction in AHI is greater than 75 percent.
  - No oxygen desaturation less than 85 percent.
  - Abolition of arrhythmia (s), for example, Type II second degree heart block or pause greater than 3 seconds or ventricular tachycardia at a rate greater than 140/minute lasting greater than 15 complexes.

CPAP is a non-invasive technique for providing low levels of air pressure from a flow generator through a nasal mask. The purpose of CPAP is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in OSA.

For more information about the CPAP device, please see “Guidelines clarified for specific durable medical equipment” in the February 2001 PRN.

Coverage for durable medical equipment is determined according to individual or group customer benefits.

Pennsylvania Blue Shield now pays for the change of a gastrostomy tube as a separate service.

Please use code 43760—change of gastrostomy tube—to report this procedure.
New codes available for induced abortions using Mifepristone

Please begin to report induced abortions using Mifepristone with code S0190, S0191 or S0199. These codes became available on Jan. 1, 2002.

Report code S0190—Mifepristone, oral, 200 mg—for the oral administration of Mifepristone during the first office visit.

Report the administration of Misoprostol with code S0191—Misoprostol, oral, 200 mcg. Misoprostol is generally given two days after Mifepristone.

Pennsylvania Blue Shield’s allowance for S0199 includes the medically induced abortion by oral ingestion of medication including all associated services and supplies (for example, patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm complete abortion) except drugs.

In March 2001, Blue Shield introduced coverage for induced abortions using Mifepristone (RU486) for those members whose medical-surgical contract covers elective and non-elective abortions. Not otherwise classified code 59899 had previously been used to report this service.

Cranial orthoses procedure codes changed

Pennsylvania Blue Shield is revising its reporting guidelines for cranial orthoses because of changes to certain procedure codes’ terminology. The terminology changes were effective Jan. 1, 2002.

Please report code L0100 when using a cranial orthotic device. Cranial orthotic devices include, but are not limited to, Dynamic Orthotic Cranioplasty (DOC) Band, OPI Band, Hanger Cranial Band, Star Band and CranioCap.

Report procedure code L0110 to report a non-molded cranial helmet when it’s used as a protective device following surgery.

You can review Blue Shield’s coverage guidelines for cranial orthoses in the October 2001 PRN (see “Coverage guidelines for cranial orthoses used to treat plagiocephaly”).

How to report anesthesia modifiers AA and 47

The AA modifier—anesthesia services performed personally by anesthesiologist—is one of several modifiers Pennsylvania Blue Shield requires to identify who is performing an anesthesia service. Although this modifier’s terminology states “performed personally by an anesthesiologist,” any duly licensed and trained health care professional who is personally performing anesthesia services can report it. The AA modifier is not limited to physicians who specialize in anesthesiology.

If an operating surgeon administers regional or general anesthesia, he or she should report the 47 modifier—anesthesia by surgeon—in conjunction with the basic service, that is, the surgical procedure code.

However, if an operating surgeon administers conscious sedation (99141, 99142), he or she should report the AA modifier in addition to the conscious sedation procedure code, for example, 99141 AA.
How to report rapid fetal fibronectin

Please use code 82731—fetal fibronectin, cervicovaginal secretions, semi-quantitative—to report semi-quantitative rapid fetal fibronectin testing.

To report rapid qualitative testing use the not otherwise classified code 84999. Remember to include a complete description of the service you performed.

Reporting code changes for port flush catheter maintenance

Please begin to report services for port flush catheter maintenance with code 96530—refilling and maintenance of implantable pump or reservoir.

Do not use code X3649, which has been deleted, or code 37799 to report this service.

Questions or comments on these new medical policies?

We want to know what you think about our new 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

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>13</td>
<td>S9526</td>
<td>Skilled nursing visits for blood product administration, including pump and all related supplies; per service</td>
<td>Delete. Effective 1/1/02.</td>
</tr>
<tr>
<td>13</td>
<td>S9546</td>
<td>Home infusion of blood products, nursing services, per visit</td>
<td>Add. Effective 1/1/02.</td>
</tr>
</tbody>
</table>

Correction to 2002 HCPCS Update

On Page 21 of the 2002 HCPCS Update, we included an incorrect procedure code.

Code S9093—global fee urgent care centers—is the wrong code. The correct code is S9083. Please change code S9093 to S9083 to avoid reporting errors.
Patient News - Information about your patients who are Pennsylvania Blue Shield customers

Central Region

Correction: Hershey HealthStyle mental health administrator changes

In the first paragraph of our article “Hershey HealthStyle mental health administrator changes” (December 2001 issue), the name of the new administrator is incorrect.

Here is the correct information for the first paragraph of the article:

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

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Please clip and mail this coupon, leaving the PRN mailing label attached to the reverse side to:

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Camp Hill, Pa. 17089-8842

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Contents

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