

PRN

Policy Review & News

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

June 2002

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Look for this symbol for all BlueCard related information

News

Blue Plans to administer new health care program for uninsured adults

The Pennsylvania Insurance Department has selected the Pennsylvania Blue Plans as the administrators of a new health care program for uninsured adults. The new program is called adultBasic, health insurance for adult Pennsylvanians. Applications for the program became available in April 2002. Coverage began July 2002.

adultBasic, established through proceeds of Pennsylvania's tobacco settlement according to the Health Investment Insurance Act (Act 77 of 2001), provides basic health care coverage for Pennsylvanians age 19 through 64 whose income is at or below 200 percent of the federal poverty guideline and who are not eligible for Medical Assistance. Benefits include hospitalization, physician services, routine and preventive care, and emergency accident and medical benefits. Adults must contribute \$30 each month toward the cost of their health care.

Eligibility

To be eligible for enrollment, adults must:

- be age 19 through 64,
- have been Pennsylvania residents for at least 90 days prior to enrollment and continue to reside in Pennsylvania,
- legally reside within the United States,



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- not be covered by a health insurance plan, a self-insurance plan or a self-funded plan during the three months immediately preceding the determination of eligibility, except when the adult:
 - was enrolled in the State CHIP program immediately prior to applying for adultBasic,
 - is eligible to receive benefits under the unemployment compensation law,
 - was covered under one of the above plans but at that time of application for adultBasic coverage is no longer employed and is not eligible to receive unemployment compensation benefits, or
 - is a spouse of a person who meets either of the exceptions set forth in the preceding two items, and both the eligible adult and the spouse are applying for coverage.
- not be eligible for Medical Assistance or Medicare, and
- have an annual family income that is no greater than 200 percent of the federal poverty level.

Covered services

In general, all adults are covered for the following services. Treatment of pre-existing conditions is covered.

Benefits	Remarks
Hospital	Unlimited benefits. \$25 copayment for emergency room services; waived if admitted.
Anesthesia	
Assistant surgery	
Consultations	Inpatient only, limited to one per stay.
Diagnostic medical	
Emergency medical and accident	
Mammograms	
Obstetrical care	
Outpatient medical visits	\$5 copayment for primary care physician visits; \$10 copayment for specialist visits.
Preventive	Benefits defined in accordance with predefined schedule.
Surgery	
Occupational therapy, speech therapy, chemotherapy, radiation and inpatient physical therapy	
Transplant surgery	
Second surgical opinion	Only outpatient consultation is eligible.

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Certain insurers to provide coverage

Here are the insurers, according to region, that will provide health benefits for adultBasic:

Insurer	Region
Keystone Health Plan East	southeastern Pennsylvania
First Priority Health	northeastern Pennsylvania
Keystone Health Plan Central	central Pennsylvania
Capital Blue Cross and Pennsylvania Blue Shield	Franklin and Fulton counties

How to submit adultBasic claims

Submit adultBasic claims like any other Blue Shield claim—electronically or on a paper 1500A claim form.

If you know an adult who may be eligible for adultBasic coverage, please have them call the appropriate telephone number:

(800) 464-5437—southeastern Pennsylvania residents

(800) 543-7199—northeastern Pennsylvania residents

(800) 543-7101—central Pennsylvania residents

Report valid diagnosis codes on all claims

Pennsylvania Blue Shield will soon require all providers to report ICD-9-CM diagnosis codes that are valid at the time a service is performed. Beginning July 20, 2002, you must report valid ICD-9-CM diagnosis codes on all electronic and paper claims.

Blue Shield requires you to report this information to enable it to abide by the administrative simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Use valid procedure codes and modifiers to prevent denials

Remember to report HCPCS procedure codes and HCPCS modifiers that are valid at the time a service is performed. This applies to electronic and paper claims you submit to Pennsylvania Blue Shield.

The Transaction Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) directs all health care payers to process a claim based on the medical code sets valid at the time of the service.

For more information about these reporting requirements, see “HIPAA requires new reporting method for HCPCS procedure codes” in the February 2001 **PRN** and “HCPCS modifiers must be reported according to HIPAA rules” in the June 2001 **PRN**.

Blue Cross and Blue Shield Plans to maintain original HIPAA implementation schedule

The Blue Cross and Blue Shield Plans in Pennsylvania, which have jointly agreed upon common implementation dates for the transactions and code sets portion of the Health Insurance Portability and Accountability Act (HIPAA), are evaluating those dates in light of a new law that offers provisions to apply for an extension beyond the compliance deadline.

HIPAA, enacted as part of federal health care reform policy, has many goals, including the streamlining of operations and the reduction of administrative costs. President Bush signed the Administrative Simplification Compliance Act, which amends HIPAA, into law in late December 2001. This new Act offers health care organizations an opportunity to extend the period for implementing government mandates one year beyond Oct. 16, 2002, the original government deadline. These mandates require the standardization of data exchanged electronically by health care organizations, such as the information included in an insurance claim.

The Blue Cross and Blue Shield Plans in Pennsylvania—Independence Blue Cross, Highmark Blue Cross Blue Shield, Pennsylvania Blue Shield, Blue Cross of Northeastern Pennsylvania and Capital Blue Cross—are maintaining their original implementation schedule. The Plans have been working for more than a year on revising information systems to send and receive the new, standard HIPAA-compliant transactions. By doing so, the Plans stand to experience greater efficiencies, to offer a simplified process for submitting health insurance claims and to allow health care providers and employer groups to send and receive data more efficiently.

Regarding the possibility of an extension of time in which to complete this work, the Plans are evaluating whether to apply for an extension. The Plans recognize the benefits of applying for the extension. For example, the extension may provide the opportunity for providers, trading partners and payers to develop a more systematic coordinated approach. However, it is not possible to make a final decision without seeing the final rules.

There is still some uncertainty about how the application for an extension will work. The Plans are awaiting guidance from the federal Department of Health and Human Services on this and other key issues. The Plans are studying the potential impacts the extension may have on them, their trading partners and their business associates. They also are assessing both their current compliance progress and that of key trading partners to confirm a reasonable readiness date.

The Administrative Simplification Compliance Act does not affect the HIPAA Privacy standards aimed at ensuring the confidentiality of patient information. The Privacy compliance date is April 14, 2003.

Note: This information does not apply to Medicare.

Use 81 to designate independent laboratory place of service

When services are performed at an independent laboratory, please report 81 as the place of service code.

This reporting guideline applies to electronic and paper claims.

Avoid payment delays: report date of accident or onset of condition

Always include the date of accident or onset of condition when reporting ICD-9-CM diagnosis codes within the 800–900 range.

If you do not report the date of accident or onset of condition, Pennsylvania Blue Shield will contact your office for the missing information. This will delay your payment.

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Morphometric analysis eligible for certain conditions

Pennsylvania Blue Shield considers morphometric analysis medically necessary for certain conditions. Here are the current ICD-9-CM diagnosis codes for the eligible conditions:

153.0–153.9	194.0	230.9	236.91
155.0–155.2	197.0	231.2	238.3
159.1	197.5	233.0	239.0
162.2	197.7	233.2	239.1
162.3	197.8	233.4	239.3
162.4	198.0	233.7	239.4
162.5	198.1	235.2	239.5
162.8	198.81	235.3	530.2
174.0–175.9	198.82	235.5	555.9
185	202.8	235.7	556.9
188.0–188.9	230.3	236.5	
189.0–189.9	230.8	236.7	

Blue Shield will pay for morphometric analysis for an eligible condition once per year, per patient. If this test is reported for a diagnosis other than those listed, Blue Shield will deny it as not being medically necessary. A participating, preferred or network provider cannot bill the member for the denied test.

Use code 88358 to report morphometric analysis.

When semi-thin plastic-embedded sections are performed in conjunction with morphometric analysis, Blue Shield will pay only for the morphometric analysis. In this case, a participating, preferred or network provider cannot bill the member for the semi-thin plastic-embedded sections.

When semi-thin plastic-embedded sections are performed independently, Blue Shield will pay for them. Report semi-thin plastic-embedded sections with the appropriate surgical pathology code—88300–88309.

Morphometric analysis uses a quantitative image analysis system (light or fluorescent microscopy with quantitative morphometry and computerized data reduction) to assess a tumor sample. Morphometric analysis is not used to diagnose malignancy. The sample is assessed after the diagnosis of malignancy has already been established by

histopathology. However, once the diagnosis has been made, this study can assist in the prediction of tumor prognosis for certain types of cancer. It may also be helpful in planning treatment.

Patient selection criteria expanded for in vitro allergy testing

RAST (radioallergosorbent test), FAST (fluoroallergosorbent test), and multiple antigen simultaneous tests are in vitro tests that detect antigen-specific IgE antibodies in the patient's serum. Pennsylvania Blue Shield will pay for in vitro allergy testing under these circumstances:

- direct skin testing is impossible due to an extensive dermatitis or marked dermographism,
- direct skin testing is contraindicated because of concomitant drug treatment, for example, psychotropic drugs frequently have H₁ blocking characteristics,
- when there is difficulty in testing uncooperative patients, for example, small children or patients with mental or physical impairments,
- if direct skin testing has been inconclusive, or
- as adjunctive tests for allergic bronchopulmonary aspergillosis or parasitic disease.

Use code 86003 to report in vitro allergy testing. Please indicate the number of allergens tested.

Coverage changes for echocardiography color flow velocity mapping

On June 24, 2002, Pennsylvania Blue Shield began to pay separately for Doppler echocardiography color flow velocity mapping (code 93325) when it's reported with a related echocardiography procedure code.

Report code 93325—Doppler echocardiography color flow velocity mapping—in conjunction with an appropriate echocardiography procedure code: 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321 or 93350.

Since the current reimbursement levels for echocardiography procedures factor in Doppler color flow velocity mapping as an integral component, Blue Shield will review the allowances associated with these procedures and may make adjustments to maintain reasonability.

Because Blue Shield considers color flow velocity mapping to be of little value when it's performed alone, it will deny it as not medically necessary when it's reported without a related echocardiography code. A participating, preferred or network provider cannot bill the member for the denied service.

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Manipulation and physical therapy reporting changes explained

To comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pennsylvania Blue Shield is revising the codes you use to report manipulation therapy and physical therapy.

Please follow these guidelines when reporting manipulation therapy and physical medicine and rehabilitation services provided on or after Oct. 7, 2002.

Manipulation therapy

Procedure codes S8901–S8910 will no longer be valid for reporting services to Blue Shield, effective Oct. 7, 2002. Do not report codes S8901–S8910 for manipulation therapy services provided on or after Oct. 7, 2002. Instead, report the procedure code that is most appropriate for the individual services performed, for example, 98925–98929 or 98940–98943.

The manipulation codes include a premanipulation patient assessment. This means an evaluation and management (E/M) service should be reported separately only in these instances:

- the initial examination for a new patient or new condition,
- an acute exacerbation of symptoms or a significant change in the patient's condition, or
- distinctly different indications unrelated to the manipulation.

You may report additional E/M services if the patient's condition requires a significant, separately identifiable E/M service, above and beyond the usual pre- and postservice work associated with the procedure. Report these E/M services with a 25 modifier. Include documentation in the patient's medical record to support the necessity of the additional E/M service.

Blue Shield does not pay for procedures or modalities that are performed solely to prepare the patient for a manipulation procedure. This includes application of hot or cold packs (97010) and massage therapy (97124). Do not report these services separately when they're performed in conjunction with a manipulation procedure.

Blue Shield considers manual therapy techniques (97140) components of manipulation. It will not pay for these services separately when they're performed in conjunction with a manipulation procedure.

When codes 97010, 97124 or 97140 are reported for a separate body region, unrelated to the manipulation procedure, Blue Shield will consider these procedures for separate payment.

Physical therapy and rehabilitation services

Procedure codes W9715 and W9720 will no longer be valid for reporting services to Blue Shield, effective Oct. 7, 2002. Do not report codes W9715 or W9720 for physical therapy and rehabilitation services performed on or after Oct. 7, 2002. You should report the procedure code most appropriate for the individual service you performed, for example, 97010–97799.

Blue Shield will pay for physical therapy when it's performed with the expectation of restoring the patient's level of function that has been impacted by illness or injury. Maintain written treatment plans in the patient's medical records.

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To maintain appropriate and reasonable payments for these therapy services, Blue Shield will review the allowances associated with these procedure codes and may make minor adjustments.

Note: These coding changes will not impact the current treatment plan review requirements.

Blue Shield changes coverage for digitization of mammographic film

On June 24, 2002, Pennsylvania Blue Shield began to pay separately for the digitization of mammographic film when it's reported with a related code for conventional mammography.

Do not submit the codes for digitization of mammographic film images (76085, G0236) alone. Report these codes only when mammographic images are acquired through conventional film mammography and those film images are converted to a digital image.

Blue Shield will deny digitization of mammography film when it is not reported in conjunction with a related conventional mammography code. A participating, preferred or network provider cannot bill the member for the denied service.

These codes represent 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)

Note: report code 76085 with code 76092.

- 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)

Note: report code G0236 with either code 76090 or 76091.

Digital mammography coverage clarified

Pennsylvania Blue Shield pays for conventional and digital mammography. Blue Shield applies the same coverage criteria to all mammographic studies, regardless of the technique used to acquire the images.

Use one of these codes to report mammography performed on equipment that produces a direct digital image:

G0202—screening mammography, producing direct digital image, bilateral, all views

G0204—diagnostic mammography, producing direct digital image, bilateral, all views

G0206—diagnostic mammography, producing direct digital image, unilateral, all views

Do not report code 76085 or G0236 (digitization of mammographic film) when a mammography study is performed using equipment that produces a direct digital image. Use code 76085 or G0236 only when mammographic images are acquired through conventional film mammography (codes 76090, 76091, 76092) and the film images are then converted to a digital image.

For more information about Blue Shield's guidelines for digitization of mammographic film, please refer to "Blue Shield changes coverage for digitization of mammographic film" on this page.

Blue Shield allows extended ophthalmoscopy as separate service

Pennsylvania Blue Shield now pays for extended ophthalmoscopy as a separate service.

Maintain the documentation, including retinal drawings, in the patient's medical records—they must be available upon request. These documents and drawings support the medical necessity for the extended ophthalmoscopy. You should also keep documentation specific to the method of examination, for example, lens, instrument used, in the patient's medical records.

Use code 92225 or 92226 to report extended ophthalmoscopy.

Blue Shield to pay for specialist's interpretation of infant apnea monitor

Pennsylvania Blue Shield now pays for the interpretation of the download from an infant apnea monitor when performed by a specialist other than the attending physician. In some cases, the attending physician may want a specialist to interpret the results of the apnea monitor download.

If a specialist interprets an apnea monitor download, use code 94799 to report the service. Remember to include a complete description of the service you performed when reporting this code.

When the attending physician interprets the download, Blue Shield considers it an integral part of the physician's medical care. It is not eligible as a distinct and separate service. A participating, preferred or network provider cannot bill the member for the denied service.

For more information about infant apnea monitors, please see "How to report polysomnograms, pneumograms and infant apnea monitors" in the October 1999 **PRN**.

Blue Shield allows speech generating devices, patient must meet certain criteria

Pennsylvania Blue Shield now pays for a speech generating device (SGD) when the treating physician prescribes the device and the patient meets certain criteria.

The SGD must also be a benefit of the member's contract. Blue Shield determines coverage for durable medical equipment according to the individual or group member benefits.

The patient must meet all of these criteria:

1. A speech language pathologist must perform a formal evaluation of the patient's cognitive and communication abilities. A formal written evaluation should document the findings of the assessment. These findings must be forwarded to the patient's treating physician before the device is prescribed.

The written evaluation must include:

- a) a description of the current communication impairment, including the type, severity, language skills, cognitive ability and anticipated course of the impairment,
- b) an assessment of whether the individual's daily communication needs could be met using other natural modes of communication,
- c) a description of the functional communication goals expected to be achieved and treatment options,

- d) rationale for selection of a specific device and any accessories,
 - e) demonstration that the patient possesses the cognitive and physical abilities to effectively use the selected device and any accessories to communicate,
 - f) a treatment plan that includes a training schedule for the selected device, and
 - g) for a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the patient of the upgrade compared to the initial SGD.
2. The patient's medical condition is one resulting in a severe expressive speech impairment.
 3. The patient's speaking needs cannot be met using natural communication methods.
 4. Other forms of treatment have been considered and ruled out.
 5. The patient's speech impairment will benefit from the device ordered.

If the patient does not meet the criteria, Blue Shield will deny the SGD as not medically necessary. A participating, preferred or network provider cannot bill the member for the denied SGD.

Blue Shield will pay for the services of the speech language pathologist—for the evaluation of the patient and the training in the use of the SGD. Please report code G0197–G0199, as appropriate, for the service you provided.

SGDs are speech aids that provide severe speech-impaired individuals the ability to meet their functional speaking needs. SGDs provide digitized speech (K0541–K0542) as well as synthesized speech (K0543, K0544). Please use code K0543 or K0544 to report devices that can generate both digitized and synthesized speech.

SGDs do not include external speech processors that are part of a cochlear device or system used to capture and amplify sound.

Coverage guidelines for SGD accessories

Blue Shield will pay for SGD accessories (K0547) if the patient meets the coverage criteria for the SGD. The medical necessity for each accessory must be clearly documented in the speech language pathologist's written evaluation.

If Blue Shield denies the SGD, it will not pay for the accessories. A participating, preferred or network provider cannot bill the member for the denied accessories.

Examples of SGD accessories include, but are not limited to:

- access devices that enable selection of letters, words or symbols through direct or indirect selection techniques, for example, optical head pointers, joysticks, switches, wheelchair integration devices and SGD scanning devices,
- replacement accessories such as batteries, battery chargers and AC adapters.

Do not bill separately for any software, interfaces, cables, adapters, interconnects or switches necessary for the accessory to interface with the SGD (K0541–K0545).

Speech generating software programs may be covered

Speech generating software programs (K0545) enable a laptop computer, desktop computer or personal digital assistant (PDA) to function as an SGD. Blue Shield will pay for speech generating programs if the patient meets the SGD criteria. Blue Shield will not pay separately for the installation of the software or for technical support.

SGDs (K0541–K0544) and speech generating software programs (K0545) perform the same essential function—speech generation. Therefore, Blue Shield will deny requests for more than one SGD as not medically necessary. A participating, preferred or network provider cannot bill the member for the denied service.

SGDs (K0541–K0544) include the device, any applicable software, batteries, battery charger and AC adapters. Do not bill for these items in addition to the device.

Use code K0547 to report upgrades to K0541–K0544. These upgrades are subsequent versions of the device’s software program or memory modules that may include enhanced features or other improvements.

Do not use K0545 to report software included with the initial provision of the SGD (K0541–K0544), or for software included with the initial provision of the access device (K0547). The software cost is included in these codes. However, use code K0545 to report upgrades to subsequent versions of a speech generating software program that may include enhanced features or other improvements. Mounting systems (K0546) are devices necessary to place the SGD device, switches, and other access devices within the patient’s reach.

Devices not meeting DME definition will be denied

Laptop computers, desktop computers, PDAs or other devices that are not dedicated SGDs are not covered. They do not meet Blue Shield’s definition of durable medical equipment. Communication aids that are not speech generating devices, for example, communication boards (E1902), also do not meet the definition of durable medical equipment. Blue Shield will deny these items as not covered. A participating, preferred or network provider can bill the member for the denied device.

Blue Shield revises coverage guidelines for bilaminate skin substitutes

Pennsylvania Blue Shield has revised two of its guidelines for the application of bilaminate skin substitutes:

- Blue Shield now pays separately for the preparation of the wound bed on the same day as the application of the bilaminate skin substitute.
- Blue Shield has eliminated the requirement that diabetics must maintain a blood sugar level of 200 mg/dl or lower.

See “Blue Shield allows bio-engineered tissue for chronic venous ulcers” in the June 2000 **PRN**, for more information about the required criteria.

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HIPAA regulations change emergency services reporting

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is changing the way health care professionals will report emergency services. HIPAA is standardizing emergency service procedure codes by eliminating the local procedure codes.

Do not report these local procedure codes for emergency accident and emergency medical services performed on or after Sept. 16, 2002: W9005, W9006, W9007, W9008, W9015, W9016, W9017, W9018, W9023, W9024, W9025, W9026, W9027 or W9028. If you report these local procedure codes after Sept. 16, 2002, Pennsylvania Blue Shield may delay or deny your claim.

ET modifier identifies emergency services

To report initial emergency services provided on or after Sept. 16, 2002, use the appropriate evaluation and management procedure code along with the ET—emergency services—modifier.

When reporting the ET modifier, include a diagnosis code that identifies the service as emergency medical or emergency accident. Blue Shield needs this information to apply the member's benefits.

Blue Shield deletes chemotherapy local codes

Due to requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pennsylvania Blue Shield will delete all local procedure codes for chemotherapy visits, drugs and rescue agents. These codes will be deleted on Sept. 30, 2002.

Please report the appropriate national procedure code for the chemotherapy drug or rescue agent administered on or after Sept. 30, 2002. If a national procedure code does not exist for the drug or biological, report the not otherwise classified code J9999.

Always include a complete description of the service you performed when you report code J9999. Blue Shield may deny your claim if you do not provide a description of the chemotherapy drug or rescue agent.

Blue Shield will also delete local chemotherapy visit codes, W9601–W9606, on Sept. 30, 2002. To report chemotherapy visits performed on or after Sept. 30, 2002, use the appropriate national procedure code for the level of evaluation and management service provided.

When you report chemotherapy visits, drugs or rescue agents, remember to report an ICD-9-CM diagnosis code that appropriately reflects the condition for which the patient is being treated.

Please see “2002 **PTM** changes” in this **PRN** for a listing of the local chemotherapy codes being deleted.

Local asymptomatic codes to be deleted in September

As required by the Health Insurance Portability and Accountability Act (HIPAA), Pennsylvania Blue Shield is deleting the local codes that identify services performed for asymptomatic patients. Blue Shield will delete the codes on Sept. 16, 2002.

For services performed on or after Sept. 16, 2002, report the appropriate national procedure code. Also, please report an appropriate ICD-9-CM diagnosis code—one that reflects the reason for the service, for example, routine general medical exam.

Please see “2002 **PTM** changes” in this **PRN** for a listing of the asymptomatic codes being deleted.

Blue Shield eliminates all local modifiers

Because of HIPAA requirements, Pennsylvania Blue Shield will delete all local modifiers. Please see “2002 **PTM** changes” on Page 14 in this **PRN** for the deleted modifiers, and for when they’ll be deleted.

Reporting instructions for deleted YY, ZZ, WR and WS modifiers

Do not report local modifiers YY or ZZ for second and third surgical opinions. Blue Shield will delete these modifiers on July 1, 2002. To report second or third surgical opinion services, use the national modifier SM—second surgical opinion, or SN—third surgical opinion.

As of Sept. 16, 2002, do not use the WR—newborn care—local modifier to report healthy newborn care. Blue Shield is deleting the WR modifier. Instead, report the appropriate evaluation and management procedure code for newborn care. Remember to report an ICD-9-CM diagnosis code that reflects the condition for which the patient is being treated.

Beginning Sept. 16, 2002, do not use the WS local modifier to indicate the rental of durable medical equipment. Instead, report the national modifier RR—DME rental.

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

2002 PTM changes

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

Page	Code	Terminology	Action
A-10	SK	Member of high risk population (use only with codes for immunization)	Add. Effective 7/1/02.
A-10	SL	State supplied vaccine	Add. Effective 7/1/02.
A-10	SM	Second surgical opinion	Add. Effective 7/1/02.
A-10	SN	Third surgical opinion	Add. Effective 7/1/02.
A-11	WG	Reconstructive surgery	Delete. Effective 9/30/02.
A-11	WO	Course of treatment ended	Delete. Effective 9/30/02.
A-11	WR	Newborn care	Delete. Effective 9/16/02.
A-11	XX	No generic equivalent for brand name drug	Delete. Effective 9/30/02.
A-11	YY	Second surgical opinion	Delete. Effective 7/01/02.
A-11	ZA	Drug and/or alcohol detoxification	Delete. Effective 9/30/02.
A-11	ZR	Services were provided at a teaching hospital that has a residency program for the surgical service reported, but a resident was not available	Delete. Effective 9/30/02.
A-11	ZS	Services were provided at a teaching hospital that does not have a residency program for the surgical services reported on the claim.	Delete. Effective 9/30/02.
A-11	ZT	Services were provided at a non-teaching hospital	Delete. Effective 9/30/02.
A-11	ZZ	Third surgical opinion	Delete. Effective 7/01/02.
3	W9310	Electrocardiogram, routine ECG with at least 12 leads; routine service, asymptomatic	Delete. Effective 9/16/02.
3	W9315	Cardiovascular stress test, asymptomatic patient	Delete. Effective 9/16/02.
3	Y7608	Mammography, asymptomatic patient; unilateral	Delete. Effective 9/16/02.
4	Z8030	General health screen panel, asymptomatic patient	Delete. Effective 9/16/02.
4	Z8100	Urinalysis (pH, specific gravity, protein, tests for reducing substances such as glucose); with microscopy, asymptomatic patient	Delete. Effective 9/16/02.
4	Z8246	Cholesterol, serum; asymptomatic patient	Delete. Effective 9/16/02.
4	Z8502	Blood count; hemogram, automated, and differential WBC (CBC), asymptomatic patient	Delete. Effective 9/16/02.

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Page	Code	Terminology	Action
4	Z8503	Blood count; hemogram, manual complete CBC (RBC, WBC, Hgb, Hct, differential and indices), asymptomatic patient	Delete. Effective 9/16/02.
4	Z8555	Blood count; hematocrit, asymptomatic patient	Delete. Effective 9/16/02.
4	Z8557	Blood count; hematocrit and hemoglobin (HCT and Hgb), asymptomatic patient	Delete. Effective 9/16/02.
4	Z8558	Blood count; hemoglobin, colorimetric, asymptomatic patient	Delete. Effective 9/16/02.
4	Z8628	Hemagglutination inhibition tests (HIA), each (e.g., rubella, viral), asymptomatic patient	Delete. Effective 9/16/02.
4	Z8658	Skin test; tuberculosis, tine test, asymptomatic patient	Delete. Effective 9/16/02.
16		Do not use codes 11055, 11056, and 11057 for the paring, curettement, chemical cauterization or debridement of clavi, see W9080	Change W9080 to S0390.
16	X1720	Plantar verruca or verrucae, removal by any method except excision, such as superficial cutting or paring, chemotherapy, etc., subsequent treatment	Delete. Effective 7/15/02.
16		X1720 has been deleted. To report, see 17000–17004	Add note.
16	X1101	Debridement of ulcer, foot; initial	Delete. Effective 7/15/02.
16	X1102	Debridement of ulcer, foot; subsequent	Delete. Effective 7/15/02.
16		X1101 and X1102 have been deleted. To report, see 11010–11044, 97601–97602	Add note.
49	S8433	Skin support for breast prosthesis, each	Delete. Effective 7/1/02.
88	S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	Delete IP indicator from the guidelines.
89	29875	Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection)	Add IP indicator to the guidelines.
90	29895	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial	Delete IP indicator from the guidelines.
90	29897	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited	Delete IP indicator from the guidelines.
90	29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	Delete IP indicator from the guidelines.
90	29999	Unlisted procedure, arthroscopy	Delete IP indicator from the guidelines.
127	X3823	Bone marrow harvesting for transplantation; autologous (Homologous harvesting, use 38230)	Delete code and note. Effective 9/16/02.

Page	Code	Terminology	Action
127	X3825	Peripheral stem cells transplantation Note: Use code X3825 to report blood-derived peripheral stem cell transplantation allogenic or autologous. Continue to use codes 38240 and 38241 to report bone marrow transplantation.	Delete code and note. Effective 9/16/02.
135	X4297	Pre-surgical orthopedic device utilized prior to surgical repair of the unilateral or bilateral cleft lip with bony displacement of the alveolar segment	Delete. Effective 8/18/02. To report, use 42299.
135	X4298	Orthodontic treatment of congenital cleft palates involving the maxillary arch to correct bony deficits associated with a complete cleft of the maxillary alveolus, requiring bone grafting	Delete. Effective 8/18/02. To report, use 42229.
145	44139	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure.)	Delete IP indicator from the guidelines. Effective 4/29/02.
149	X4530	Proctosigmoidoscopy; routine service, asymptomatic patient	Delete. Effective 9/16/02.
186	57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	Delete IP indicator from the guidelines.
186	57260	Combined anteroposterior colporrhaphy	Delete IP indicator from the guidelines.
187	57410	Pelvic examination under anesthesia	Remove the note below the code.
187	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Add. Effective 8/19/02.
190	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral (tubal ligation, Pomeroy)	Delete IP indicator from the guidelines.
190	58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral during same hospitalization	Delete IP indicator from the guidelines.
190	58611	Ligation or transection of fallopian tube(s) when done at time of cesarean delivery or intra-abdominal surgery	Delete IP indicator from the guidelines.
191	58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection or debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	Delete IP indicator from the guidelines.
204	G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment	Add. Effective 7/1/02.
226	67221	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion)	Delete 90 postoperative days.

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Page	Code	Terminology	Action
239	Y7100	Radiologic examination, chest, two views, (PA and lateral), routine service, asymptomatic patient	Delete. Effective 9/16/02.
253	Y7608	Mammography, asymptomatic patient; unilateral	Delete. Effective 9/16/02.
272	Z8030	General health screen panel, asymptomatic patient	Delete. Effective 9/16/02.
278	Z8100	Urinalysis (pH, specific gravity, protein, tests for reducing substances such as glucose); with microscopy, asymptomatic patient	Delete. Effective 9/16/02.
281	Z8246	Cholesterol, serum; asymptomatic patient	Delete. Effective 9/16/02.
292	Z8555	Blood count; hematocrit, asymptomatic patient	Delete. Effective 9/16/02.
292	Z8557	Blood count; hematocrit and hemoglobin (HCT and Hgb), asymptomatic patient	Delete. Effective 9/16/02.
292	Z8558	Blood count; hemoglobin, colorimetric, asymptomatic patient	Delete. Effective 9/16/02.
293	Z8502	Blood count; hemogram, automated, and differential WBC (CBC), asymptomatic patient	Delete. Effective 9/16/02.
293	Z8503	Blood count; hemogram, manual complete CBC (RBC, WBC, Hgb, Hct, differential and indices), asymptomatic patient	Delete. Effective 9/16/02.
297	Z8628	Hemagglutination inhibition tests (HIA), each (e.g., rubella, viral), asymptomatic patient	Delete. Effective 9/16/02.
298	Z8658	Skin test; tuberculosis, tine test, asymptomatic patient	Delete. Effective 9/16/02.
322	S9484	Crisis intervention mental health services, per hour	Add. Effective 7/1/02.
333	W9254	Electromyography, complete	Delete. Effective 9/30/02.
336	92973	Percutaneous transluminal coronary thrombectomy	Change postoperative days from 90 to 0.
337	W9310	Electrocardiogram, routine ECG with at least 12 leads; routine service, asymptomatic	Delete. Effective 9/16/02.
337	W9315	Cardiovascular stress test, asymptomatic patient	Delete. Effective 9/16/02.
348	W9415	Continuous positive pressure (CPAP) via mask without ventilation (Use W9415 for non-critically ill patients [unassisted respirations])	Delete code and note. Effective 9/30/02. Use code 94799 to report.
351	W9516	Immunotherapy injection(s) by other than prescribing physician	Delete. See codes 95115 and 95117.
360	W9640	Chemotherapy for malignant disease, perfusion	Delete. Effective 9/30/02.
361	W9166	Depo-Provera; 400 mg	Delete. Effective 9/30/02.

Page	Code	Terminology	Action
362	W9302	Hydrocortisone Sodium Succinate; 500 mg	Delete. Effective 9/30/02.
362	W2925	Methylprednisolone Sodium Succinate; 40 mg	Delete. Effective 9/30/02.
362	W2935	Methylprednisolone Sodium Succinate; 125 mg	Delete. Effective 9/30/02.
363	W9400	Administration of chemotherapy for malignant disease, oral	Delete. Effective 9/30/02.
363	W9800	Lorazepam; 4 mg/ml	Delete. Effective 9/30/02.
364	W9802	Diphenhydramine HCL; 10 mg	Delete. Effective 9/30/02.
364	W9804	Diphenhydramine HCL; 50 mg	Delete. Effective 9/30/02.
364	W9806	Prochlorperazine; 5 mg	Delete. Effective 9/30/02.
364	W9812	Dexamethasone Sodium Phosphate; 4 mg	Delete. Effective 9/30/02.
364	W9814	Dexamethasone; 4 mg	Delete. Effective 9/30/02.
364	W9822	Furosemide; 20 mg	Delete. Effective 9/30/02.
364	W9826	Mannitol; 25%/50 ml	Delete. Effective 9/30/02.
364	W9828	Prednisolone; 25 mg	Delete. Effective 9/30/02.
364	W9830	Prednisolone Phosphate; 20 mg	Delete. Effective 9/30/02.
364	W9832	Prednisolone Tebutate; 20 mg	Delete. Effective 9/30/02.
364	W9834	Metoclopramide HCL; 10 mg/2 ml amp	Delete. Effective 9/30/02.
364	W9835	Metoclopramide HCL; 50 mg	Delete. Effective 9/30/02.
364	W9836	Trimethobenzamide HCL; 100 mg	Delete. Effective 9/30/02.
364	W9844	Hydroxyzine; 50 mg	Delete. Effective 9/30/02.
366	W9601	Office, home or outpatient visit; brief, in connection with cancer chemotherapy	Delete. Effective 9/30/02.
366	W9602	Office, home or outpatient visit; intermediate, in connection with cancer chemotherapy	Delete. Effective 9/30/02.
366	W9603	Office, home or outpatient visit; extended, in connection with cancer chemotherapy	Delete. Effective 9/30/02.
366	W9604	Follow-up office, home or outpatient visit; brief for cancer chemotherapy	Delete. Effective 9/30/02.
366	W9605	Follow-up office, home or outpatient visit; intermediate, for cancer chemotherapy	Delete. Effective 9/30/02.

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Page	Code	Terminology	Action
366	W9606	Follow-up office, extended; for cancer chemotherapy	Delete. Effective 9/30/02.
397		(NOTE: Report modifier '-SM' or '-SN' with codes 99241–99245 when applicable)	Change note as indicated.
399		(NOTE: Report modifier '-SM' or '-SN' with codes 99251–99255 when applicable)	Change note as indicated.
402		(NOTE: Report modifier '-SM' or '-SN' with codes 99271–99275 when applicable)	Change note as indicated.
404	W9080	Routine foot care	Delete.
404	S0390	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance, per visit	Add.
425	G0245	Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: 1. the diagnosis of LOPS; 2. a patient history; 3. a physical examination that consists of at least the following elements: a) visual inspection of the forefoot, hindfoot and toe web spaces, b) evaluation of a protective sensation, c) evaluation of foot structure and biomechanics, d) evaluation of vascular status and skin integrity, e) evaluation and recommendation of footwear, and 4. patient education.	Add.
425	G0246	Follow-up evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: 1. a patient history; 2. a physical examination that includes: a) visual inspection of the forefoot, hindfoot and toe web spaces, b) evaluation of protective sensation, c) evaluation of foot structure and biomechanics, d) evaluation of vascular status and skin integrity, e) evaluation and recommendation of footwear, and 3. patient education.	Add.
425	G0247	Routine foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include, if present, at least the following:	Add.

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Page	Code	Terminology	Action
		a. local care of superficial wounds, b. debridement of corns and calluses, and c. trimming and debridement of nails.	
425	G0248	Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing	Add. Effective 7/1/02.
425	G0249	Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in home and reporting of test results to physician; per 8 tests	Add. Effective 7/1/02.
425	G0250	Physician review, interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 8 tests (does not require face-to-face service)	Add. Effective 7/1/02.
433	S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem (do not use with home infusion codes S9365–S9368 using daily volume scales)	Revise terminology.
433	S9365	Home infusion therapy, total parenteral nutrition (TPN); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem	Revise terminology.
433	S9366	Home infusion therapy, total parenteral nutrition (TPN); more than one liter but not more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem	Revise terminology.
433	S9367	Home infusion therapy, total parenteral nutrition (TPN); more than two liters but not more than three liters per day, administrative services, professional pharmacy service, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty	Revise terminology.

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Page	Code	Terminology	Action
		amino acid formulas, drugs and nursing visits coded separately), per diem	
433	S9368	Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem	Revise terminology.
434	S9490	Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Add. Effective 7/1/02.
436	S9806	RN services in the infusion suite of the IV therapy provider, per visit	Add. Effective 7/1/02.
443	Q0144	Azithromycin Dihydrate, oral, capsules/powder, 1 gram	Add. Effective 7/1/02.
443	W1105	Dexamethasone Acetate, 8 mg/cc	Delete. Effective 9/30/02.
446	W2615	Poison Ivy Extract, 1 ml	Delete. Effective 9/30/02.
446	W2635	Prednisolone, 25 mg/ml	Delete. Effective 9/30/02.
446	W2678	Fluphenazine HCL, 2.5 mg/ml	Delete. Effective 9/30/02.
447	W3415	Vistaril, 50 mg/ml	Delete. Effective 9/30/02.
447	W3425	Vitamin B Complex, 1 ml	Delete. Effective 9/30/02.
449	S0112	Injection, darbepoetin alfa, 1 mcg	Add. Effective 7/1/02.
450	X0013	Prescription drugs(s)	Delete. Effective 9/30/02.

Changes to 2002 PTM for Ancillary Providers

Page	Code	Terminology	Action
2	KX	Specific required documentation on file	Add.
2	RR	Rental (use the RR modifier when DME is to be rented)	Add.
2	TK	Extra patient or passenger, non-ambulance	Add.
2	TP	Medical transport, unloaded vehicle	Add.
2	TQ	Basic life support transport by a volunteer ambulance provider	Add.
2	WS	DME rental	Delete. Effective 9/16/02. To report, use the national RR modifier.

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Page	Code	Terminology	Action
16	S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem (do not use with home infusion codes S9365–S9368 using daily volume scales)	Revise terminology.
16	S9365	Home infusion therapy, total parenteral nutrition (TPN); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem	Revise terminology.
16	S9366	Home infusion therapy, total parenteral nutrition (TPN); more than one liter but not more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem	Revise terminology.
16	S9367	Home infusion therapy, total parenteral nutrition (TPN); more than two liters but not more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem	Revise terminology.
16	S9368	Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs and nursing visits coded separately), per diem	Revise terminology.
17	S9490	Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Add. Effective 7/1/02.
17	S9806	RN services in the infusion suite of the IV therapy provider, per visit	Add. Effective 7/1/02.
25	K0082	22 NF non-sealed lead acid battery, each	Revise terminology. Effective 7/1/02.
25	K0083	22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	Revise terminology. Effective 7/1/02.
25	K0084	Group 24 non-sealed lead acid battery, each	Revise terminology. Effective 7/1/02.

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Page	Code	Terminology	Action
25	K0085	Group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	Revise terminology. Effective 7/1/02.
25	K0086	U-1 non-sealed lead acid battery, each	Revise terminology. Effective 7/1/02.
25	K0087	U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	Revise terminology. Effective 7/1/02.
25	K0088	Battery charger, single mode, for use with only one battery type, sealed or non-sealed	Revise terminology. Effective 7/1/02.
25	K0089	Battery charger, dual mode, for use with either battery type, sealed or non-sealed	Revise terminology. Effective 7/1/02.

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

Central and Eastern Region

Participating, PremierBlue psychiatrists and psychologists provide behavioral health services for Blue Shield members

On April 1, 2002, Pennsylvania Blue Shield's participating and PremierBlue psychiatrists and psychologists began to provide covered behavioral health services for customers of Blue Shield's new products. Members with ClassicBlue Traditional, ClassicBlue Comprehensive, DirectBlue, PPOBlue or SelectBlue coverage will receive behavioral health services from a Blue Shield participating or PremierBlue psychiatrist or psychologist.

Blue Shield has contracted with Magellan Behavioral Health, Inc., and its affiliated companies, to act as its behavioral health manager. Keystone Health Plan Central (KHPC) continues to administer the HMO products. KHPC behavioral services are not affected by Blue Shield's relationship with Magellan.

If a member's plan requires preauthorization and management of behavioral health services, Magellan will preauthorize and manage the services. At least through Dec. 31, 2002, Blue Shield will require preauthorization for inpatient treatment, regardless of the member's health insurance product. For inpatient treatment, you or the admitting facility must call Magellan at (800) 628-0816 to obtain preauthorization. Members calling on their own behalf must call the member services' number listed on their identification card.

Blue Shield does not require preauthorization of outpatient treatment for its new products. Blue Shield is encouraging its members to have their primary care physician coordinate their care. However, even under SelectBlue, members can self refer to a behavioral health professional for outpatient care and will receive the highest level of reimbursement.

Members are subject to specific benefit limits for inpatient or outpatient treatment. Benefit limits vary according to group and product.

How to submit behavioral health claims

Blue Shield will process and pay all eligible behavioral health claims. Send your paper claims to:

Pennsylvania Blue Shield
PO Box 890173
Camp Hill, Pa. 17089-0173



The way you file claims for BlueCard members is not changing. To identify out-of-area members, look for the suitcase at the top of their identification card. An empty suitcase signifies that the member's plan uses Blue Shield's participating provider network. The "PPO in a suitcase" logo means Blue Shield's PremierBlue providers will provide services. To verify BlueCard benefits and eligibility information, call (800) 676-BLUE (2583).

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Blue Shield continues to process central site account claims

Please submit claims for services you provide to members of these central site accounts directly to Pennsylvania Blue Shield:

Account name	Alphabetical prefix
American Home Products	AHP
Ashland Oil	ASH
AstraZeneca	AZP
British Tire and Rubber	BTR, BRI
Baltimore Life	BMR
Bayer Corporation	BYR
Bissell	BIM, NBI
Budd	BDC, NBU
Daimler Chrysler	NCH, NCE
Dean Foods	DNF, DFN
Delphi Automotive	DEH, DMM, DTP
Federal Reserve Bank	FRH, FBD, FRA
Ford	FMR, FMA, CMP, FMP, MCS
General Motors	NGM, GMM
H & S Bakery	NHS
Homewood	HRP
RE Michael	NRM
ILGWU	ESN, ESP, SNJ, UAE
Letica Corporation	NKK
Liberty Mutual	LMI
Oaktree Packaging	OAT
Osram	SYV, SYL
Parexel International	PXL
Republic Engineered	RES, RSI
Pathmark	NSG
TJX Companies	TJJ, TXX
Welch's	WLC
Whiting Turner	NWT

Submit these claims electronically or on a 1500A claim form. For paper claims, remember to report the three-character alphabetical prefix before the member's identification number, for example, NHS123456789. For electronic claims, report the identification number exactly as it appears on the member's identification card.

Send 1500A paper claim forms for central site accounts to:

Pennsylvania Blue Shield
PO Box 898852
Camp Hill, Pa. 17089-8852

BlueCard EOB changes



Pennsylvania Blue Shield recently changed your explanation of benefits (EOB) statement for out-of-area members' services. In April 2002, Blue Shield modified the patient liability field of the EOB for BlueCard host claims—it no longer includes member benefit information. BlueCard host claims are claims for services performed by a Blue Shield provider for out-of-area members.

This verbiage replaces the member benefit information:

“The allowed amount has been reduced due to limitations specified by the patient’s coverage. This claim was coordinated with another insurance carrier and the limitations may include non-covered services, deductible, copayments, coinsurance or payment maximums.”

Participating or PremierBlue providers can bill the patient for the amount that appears in the patient liability field.

The member benefit information will still appear on EOBs for local claims. Local claims are claims for services performed by a Blue Shield provider for Blue Shield members.

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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 _____

PRN

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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-2002, Copyright 2001, 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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Policy Review & News

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