PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

April 2008

In This Issue

MA

Look for this symbol for all Medicare Advantage related informaton

BC

Look for this symbol for all BlueCard® related information

News

Blue Shield takes additional steps to streamline claims processing and increase provider satisfaction

Please share this information, including the coding charts, with your billing staff, as well as any applicable clearinghouses and vendors.

In 2007, Highmark Blue Shield launched a five-year program to enhance many core administrative functions within its information systems structure. Blue Shield's goal is to offer state-of-the-art efficiency in servicing all of its customers, including providers.

New edit checks for data completion and accuracy began April 11, 2008

Blue Shield announced in a Jan. 11, 2008 special bulletin that on April 11, 2008, it is moving certain edit checks for data completion and accuracy on claims from within the adjudication process to a process conducted before adjudication. With the additional up front edits, incomplete and inaccurate electronic claims will be immediately returned to the provider for correction. This allows the provider the opportunity to resubmit the claim in a timely fashion, as well as for more efficient processing. For electronic claim submitters, these new edits are reported on the X12 277 Claim Acknowledgement (277 CA) Transaction or 277 CA printable report.

In addition to the up front edits, Blue Shield no longer attempts to correct or retrieve missing information for the situations listed in the chart on Page 3 (see rejection code descriptions). Instead, in these situations Blue Shield rejects the claim in the beginning of the processing cycle so that you can resubmit the claim in a timely manner with corrected data. For paper claim submitters, these new edits result in claim denials reported on your Explanation of Benefits notice. Trading Partners using the X12 835 Electronic Remittance Advice receive the standardized Claim Adjustment Reason Codes and Remittance Advice Remark Codes.

The overall time from claim submission to finalization will be reduced because claim data discrepancies will be identified immediately and the claim will be returned to the provider for correction. And, time-consuming status inquiries may be eliminated because fewer claims will be delayed during processing.

Details for billing staff, clearinghouses, and vendors

When a claim rejects, it's important for your billing staff and/or vendor to understand exactly what was wrong and what's needed to correct it.

New edit checks, effective April 11, 2008

For claims submitted using the HIPAA 837 electronic transaction, you may encounter the following error codes and descriptions on your X12 277 CA Transaction or 277 CA printable report:

Claim status error code	Claim status category code	Claim status code description	Claim status category code description
454 and 145 with Entity code 85	A8	Procedure code for services rendered Entity's specialty or taxonomy code (Entity code 85 = Billing Provider)	Acknowledgement/rejected for relational field in error
475	A3	Procedure code not valid for patient's age	Acknowledgement/returned as unprocessable claim

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If you submit your claims on paper, you may encounter the denial codes and descriptions in the following chart on your Explanation of Benefits notices. Trading Partners using the X12 835 Electronic Remittance Advice will receive the standardized Claim Adjustment Reason Codes and Remittance Advice Remark Codes to explain the error denial.

Rejection code	Rejection code description
B5606	In order to process this claim, additional information is required. Please resubmit the claim with a prescription for this service. Electronically-enabled providers should resubmit electronically.
P5039	In order to process this claim, additional information is required. The claim should be resubmitted with a valid modifier and associated number of services rendered. Electronically-enabled providers should resubmit electronically.
P5040*	The patient's coverage does not provide for this service in the place of treatment reported. Therefore, no payment can be made.
P5010*	The procedure code reported is not appropriate for the patient's age. Please resubmit the claim with verification of the patient's age and/or a corrected procedure code. Electronically-enabled providers should resubmit electronically.
P5011*	The procedure code reported is not appropriate for the patient's age. Please resubmit the claim with verification of the patient's age and/or a corrected procedure code. Electronically-enabled providers should resubmit electronically.
P5012	The patient's sex is invalid for the reported procedure. Please resubmit the claim with verification of the patient's sex and/or a corrected procedure code or a complete description of service. Electronically-enabled providers should resubmit electronically.

*These paper claim rejections correspond to the up front 277 CA edits listed in the chart on Page 2.

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Change your provider information online; PRN coupon discontinued

Now you can change your provider information online rather than completing the coupon in **PRN**. Beginning with this edition of **PRN**, the coupon for reporting changes to provider information has been eliminated. You can find online information about how to update your provider information in Chapter 1, Unit 2 of the **Highmark Blue Shield Office Manual.**

Update your provider information through NaviNet or Provider Resource Center

NaviNet®-enabled providers can update their address-related information by hovering on "Provider File Management" on Plan Central and choosing "Provider Information Changes."

You can then add a new address location, terminate an address location, update information such as phone contacts, ages accepted, office hours, and practitioners affiliated with the address.

If you are not a NaviNet-enabled provider, you can make these changes by completing an online "Address Change" form in the Provider Resource Center at **www.highmarkblueshield.com**. You can find the form by hovering on "Provider Forms," then select "Provider Information Management Forms."

BCBSA launches pilot high deductible health plan for FEP members

The Blue Cross and Blue Shield Service Benefit Plan, which administers benefits for Federal Employee Program (FEP) members, began offering a high deductible health plan option to selected members on a pilot basis on Jan. 1, 2008.

Although the high deductible health plan—named the Basic Consumer Option—is being offered only to members in Ohio, Minnesota, Tennessee, and Missouri-Kansas City, it is possible that Highmark Blue Shield network providers may see FEP members with this benefit design if the members are visiting Pennsylvania and need health care services. The member identification card that Basic Consumer Option members would present at the physician's office will look similar to this sample card:

Aimed at helping members become wiser health care consumers, the Basic Consumer Option includes a health savings account (HSA) or health reimbursement arrangement (HRA) to help members better manage health care costs. Along with their identification cards, members may also present a Blue Shield FEP debit card to pay for copays or other out-of-pocket costs using funds from their HSAs or HRAs.

Filing claims

Providers should submit claims for Basic Consumer Option members in the same manner they do for any FEP member. You may also check these members' benefits and eligibility through NaviNet®.

More information about the FEP Basic Consumer Option is available at **www.fepblue.org**.

Keep your patients informed with current practice information

Highmark Blue Shield is asking you to review your practice information that's listed on its Provider Online Directory to make sure it's correct. Keeping your practice information up to date provides your patients with accurate information.

You can find your information as it's listed in the Directory online on Blue Shield's Provider Resource Center through NaviNet® or at **www.highmarkblueshield.com**.

If you identify any incorrect information about your practice, for example, address, parking, office hours, services on site, etc., please send an e-mail with your requested changes to **pimftupdates@highmark.com**. Please include your practice name, your Highmark Blue Shield provider number, and NPI number in the subject line of your e-mail. Once Blue Shield receives your information, it will update its provider repository and Web site.

Blue Shield to use standardized national credentialing system

Attention Blue Cross of Northeastern Pennsylvania (BCNEPA) providers: BCNEPA is not using the standardized national credentialing system at this time.

To further streamline its credentialing process, Highmark Blue Shield will begin to use a standardized national online credentialing system this spring.

The Universal Credentialing DataSource — developed by the Council for Affordable Quality Healthcare (CAQH) —is a single, national process that eliminates multiple credentialing applications. Through this online service, providers complete one standardized application to meet the needs of Highmark Blue Shield and other participating health plans and health care organizations.

At this time, this change applies only to initial credentialing. Blue Shield plans to implement the recredentialing of providers through CAQH later in 2008.

The American College of Physicians (ACP) has formally supported the CAQH credentialing process since 2003, and the service is endorsed by the American Academy of Family Physicians (AAFP) for use by its more than 94,000 members.

Benefits of Universal Credentialing DataSource

Universal Credentialing DataSource offers you a number of benefits:

- You complete the standardized form once. After the form is completed, you will receive quarterly requests to make any necessary updates to the data to keep it current.
- You can allow multiple health plans unlimited access to the information.
- The service is free. Blue Shield and other health plans cover the annual fee.

About CAQH

CAQH is a non-profit collaboration of the nation's leading health plans, networks, and industry trade associations, whose goal is to improve the health care experience for consumers and health care providers. CAQH continues to develop and implement programs that reduce administrative burdens of physicians and patients, and improve quality of care.

Payment reduction of technical component of select diagnostic imaging procedures to affect UCR and PremierBlue Shield

Highmark Blue Shield plans to reduce its payment of the technical component of certain diagnostic imaging services when more than one service is performed for the same patient, during the same session, on the same service date. Blue Shield implemented this policy for its Medicare Advantage product, FreedomBlue℠ PPO, in April 2007.

Payment reduction to affect claims processed on or after Sept. 1, 2008

Blue Shield's payment reduction for UCR and PremierBlue℠ Shield diagnostic imaging services will mirror the Centers for Medicare & Medicaid Services (CMS) Multiple Procedure Reduction of the Technical Component of Certain Diagnostic Imaging Procedures implemented in January 2006. Blue Shield's payment reduction applies to only the technical component of diagnostic studies performed within 11 families of imaging codes relating to contiguous body areas. The 11 families of imaging procedures were designated by CMS.

Blue Shield will make full payment for the highest priced procedure and will make payment at 75 percent of the technical component for each additional procedure, when performed for the same patient, during the same session on the same day.

This payment reduction will become effective for claims for the specific diagnostic imaging procedures that are processed on or after Sept. 1, 2008.

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Here are the 11 families of codes currently included in this change:

HCPCS	Description
Family 01 Ultrasound (Chest/Abdomen/ Pelvis-Non-Obstetrical)	
76604	Ultrasound exam, chest
76700	Ultrasound exam, abdomen, complete
76705	Echo exam of abdomen
76770	Ultrasound exam abdomen back wall, complete
76775	Ultrasound exam abdomen back wall, limited
76831	Echo exam, uterus
76856	Ultrasound exam, pelvic, complete
76857	Ultrasound exam, pelvic, limited
Family 02 CT and CTA (Chest/Thorax/Abdomen/Pelvis)	
71250	CT thorax without dye
71260	CT thorax with dye
71270	CT thorax without and with dye
71275	CT angiography, chest
72191	CT angiography, pelvis without and with dye
72192	CT pelvis without dye
72193	CT pelvis with dye
72194	CT pelvis without and with dye
74150	CT abdomen without dye
74160	CT abdomen with dye
74170	CT abdomen without and with dye
74175	CT angiography, abdomen without and with dye
75635	CT angiography, abdominal arteries
0067T	CT colonography; diagnostic
Family 03 CT and CTA (Head/Brain/Orbit/ Maxillofacial/Neck)	
70450	CT head/brain without dye
70460	CT head/brain with dye
70470	CT head/brain without and with dye
70480	CT orbit/ear/fossa without dye

HCPCS	Description
Family 03 CT and CTA (Head/Brain/Orbit/ Maxillofacial/Neck) (continued)	
70481	CT orbit/ear/fossa with dye
70482	CT orbit/ear/fossa without and with dye
70486	CT maxillofacial without dye
70487	CT maxillofacial with dye
70488	CT maxillofacial without and with dye
70490	CT soft tissue neck without dye
70491	CT soft tissue neck with dye
70492	CT soft tissue neck without and with dye
70496	CT angiography, head
70498	CT angiography, neck
Family 04 MRI and MRA (Chest/Abdomen/Pelvis)	
71550	MRI chest without dye
71551	MRI chest with dye
71552	MRI chest without and with dye
71555	MRI angiography, chest with or without dye
72195	MRI pelvis without dye
72196	MRI pelvis with dye
72197	MRI pelvis without and with dye
72198	MR angiography, pelvis without and with dye
74181	MRI abdomen without dye
74182	MRI abdomen with dye
74183	MRI abdomen without and with dye
74185	MRI angiography, abdomen with or without dye
Family 05 MRI and MRA (Head/Brain/Neck)	
70540	MRI orbit/face/neck without dye
70542	MRI orbit/face/neck with dye
70543	MRI orbt/face/neck without and with dye
70544	MR angiography, head without dye
70545	MR angiography, head with dye

HCPCS	Description
Family 05 MRI and MRA (Head/Brain/Neck) (continued)	
70546	MR angiography, head without and with dye
70547	MR angiography, neck without dye
70548	MR angiography, neck with dye
70549	MR angiography, neck without and with dye
70551	MRI brain without dye
70552	MRI brain with dye
70553	MRI brain without and with dye
Family 06 MRI and MRA (Spine)	
72141	MRI neck spine without dye
72142	MRI neck spine with dye
72146	MRI chest spine without dye
72147	MRI chest spine with dye
72148	MRI lumbar spine without dye
72149	MRI lumbar spine with dye
72156	MRI neck spine without and with dye
72157	MRI chest spine without and with dye
72158	MRI lumbar spine without and with dye
Family 07 CT (Spine)	
72125	CT neck spine without dye
72126	CT neck spine with dye
72127	CT neck spine without and with dye
72128	CT chest spine without dye
72129	CT chest spine with dye
72130	CT chest spine without and with dye
72131	CT lumbar spine without dye
72132	CT lumbar spine with dye
72133	CT lumbar spine without and with dye

HCPCS	Description
Family 08 MRI and MRA (Lower Extremities)	
73718	MRI lower extremity without dye
73719	MRI lower extremity with dye
73720	MRI lower extremity without and with dye
73721	MRI joint of lower extremity without dye
73722	MRI joint of lower extremity with dye
73723	MRI joint of lower extremity without and with dye
73725	MR angiography, lower extremity with or without dye
Family 09 CT and CTA (Lower Extremities)	
73700	CT lower extremity without dye
73701	CT lower extremity with dye
73702	CT lower extremity without and with dye
73706	CT angiography, lower extremity without and with dye
Family 10 MR and MRI (Upper Extremities and Joints)	
73218	MRI upper extremity without dye
73219	MRI upper extremity with dye
73220	MRI upper extremity without and with dye
73221	MRI joint upper extremity without dye
73222	MRI joint upper extremity with dye
73223	MRI joint upper extremity without and with dye
Family 11 CT and CTA (Upper Extremities)	
73200	CT upper extremity without dye
73201	CT upper extremity with dye
73202	CT upper extremity without and with dye
73206	CT angiography, upper extremity without and with dye

Watch for more information about this change in future issues of **PRN**.

Attention ancillary providers: Ancillary Provider Reference Guide combined with Office Manual

Ancillary providers have relied on the **Ancillary Provider Reference Guide** as a point of reference to information about Highmark Blue Shield's freestanding ancillary provider network. The information in the **Ancillary Provider Reference Guide** applies to ambulance service providers, home infusion therapists, durable medical equipment suppliers, respiratory therapy equipment suppliers, and orthotic-prosthetic suppliers.

Ancillary Provider Reference Guide now under construction

Blue Shield is consolidating the information found in the **Ancillary Provider Reference Guide** into the **Highmark Blue Shield Office Manual** so that you have one reference source for answers to all of your questions about doing business with Blue Shield.

The **Office Manual**, launched in 2007, is a revised and reorganized compilation of the western Pennsylvania **Network Practitioner Office Manual** and the statewide **Highmark Blue Shield Reference Guide**.

The **Office Manual** is designed to give you access to "how to" information such as filing claims, researching patient benefits, and joining one of Blue Shield's networks. It also explains how to communicate with Blue Shield through automated and electronic systems, and lists additional informational resources should your questions require a more in-depth explanation. And, now it contains information specific to ancillary providers.

Many of the sections from the **Ancillary Provider Reference Guide** have already been transitioned to the **Office Manual**. To keep the rest of the transition efficient, new and updated information in the **Office Manual** will be presented in blue italics to denote the areas of revision.

You can find the **Office Manual** online in the Provider Resource Center through NaviNet® or **www.highmarkblueshield.com**.

New address for Personal Choice paper claims

The address for filing paper claims for Personal Choice® has changed. The new mailing address is:

Personal Choice
PO Box 69352
Harrisburg, Pa. 17106-9352

Please use this address for all future Personal Choice paper claim submissions. Be sure to share this information with the person that handles billing in your office. Please do not send these claims to Highmark Blue Shield.

Blue Shield is your one-stop shop for BlueCard!

Provider satisfaction is Highmark Blue Shield's top priority. If you need help with claims or benefits information for out-of-area patients with Blue coverage, look to us first!

As Highmark Blue Shield continues to improve BlueCard® claims processing, customer service, and electronic transactions, your feedback helps us set priorities and streamline operations. Throughout 2008, the Blue Cross and Blue Shield Association will conduct ongoing provider satisfaction surveys to receive timely feedback on your satisfaction with servicing out-of-area members. If your office is contacted, we encourage you to participate—your opinions are important.

The research vendor will ask to speak to office staff with the most knowledge about BlueCard claims filing and/or billing. Please inform the appropriate staff to anticipate being contacted by our vendor. As always, we look forward to and appreciate your feedback.

In the meantime, if you have suggestions for improvement, contact your Provider Relations representative.

If you need information about the BlueCard Program, visit the online BlueCard Information Center in the Provider Resource Center, accessible through NaviNet® o**r www.highmarkblueshield.com**.

Avoid 1099 errors: report correct provider number on claims

Each year Highmark Blue Shield receives numerous requests from providers to make corrections to their miscellaneous income statement (form 1099-Misc). About 70 percent of the requests are for income to be moved from an individual provider's 1099 to the group's 1099.

Blue Shield has found that more than 80 percent of these 1099s are incorrect because the claims submitted by the provider identify the billing provider incorrectly. The claims list the performing provider in the billing provider field, so payments and 1099s are issued to the individual.

To guarantee that your 1099 is correct, make sure that your billing agent is using the correct provider number on all claims—paper or electronic. This is important for individual providers that received 1099s in their personal name and Social Security number, then request the 1099 be changed to the group practice name and tax identification number.

Blue Shield will not make changes to 1099s if the claims were submitted with the performing provider incorrectly listed as the billing provider.

In order for the 1099 to be correctly processed to the group, all claims must be paid to the group. So that your claims and 1099 are processed correctly, you must report the group's provider number as the billing provider.

Here is a detailed matrix that will show you how to submit your claims. The information in this matrix does not apply to individual health care professionals who report their services under their personal tax identification number, including sole proprietorships.

Common naming convention	Blue Shield terminology	CMS 1500 claim form box number	837 Professional Mapping
Billing provider name	Assignment account (AA) or group name	33	Loop 2010AA Billing Provider Name NM103
Billing provider address	AA or group address	33	Loop 2010AA Billing Provider Address N3 Loop 2010AA Billing Provider Address N4
Billing provider tax identification number	AA or group tax identification number	25	Loop 2010AA Billing Provider Secondary Identification REF02
Billing provider provider identifier	AA or group Highmark Blue Shield identifier	33b	
Billing provider National Provider Identifier (NPI)	AA or group NPI	33a	Loop 2010AA Billing Provider Name NM109
Rendering provider name	Performing provider name (individual person who performed the service)	Not applicable	Loop 2310B Rendering Provider Name NM103, NM104, NM105. When required by implementation guide situational rules.
Rendering provider tax identification number	Performing provider tax identification number	Not applicable	Loop 2310B Rendering Provider Secondary Identification REF02
Rendering provider provider identifier	Performing provider provider identifier	24J, upper line	
Rendering provider NPI	Performing provider NPI	24J, lower line	Loop 2310B Rendering Provider NM109

To confirm your group's provider number, contact Provider Data Services at (866) 763-3224, option 4.

If you would like to speak to a 1099 specialist to review your 1099, please call (866) 425-8275, option 5.

Policy

*Highmark Blue Shield's medical policies are available online in the Provider Resource Center through NaviNet® or at **www.highmarkblueshield.com**. An alphabetical, as well as a sectional index, is available on the Medical Policy page. You can search for a medical policy by entering a key word, policy number, or procedure code.*

Boniva coverage guidelines clarified

Highmark Blue Shield covers ibandronate sodium (Boniva®) injection for the treatment of osteoporosis in postmenopausal women (ICD-9-CM diagnosis code 733.01) who have failed oral bisphosphonate therapy.

Osteoporosis may be confirmed by the presence or history of osteoporotic fracture or by a finding of low bone mass (bone mineral density more than 2.5 standard deviations below the normal adult reference population, that is, T-score).

Blue Shield considers a 6-12 month trial of oral bisphosphonates adequate to determine treatment failure. Blue Shield defines failure as:

- new fracture despite bisphosphonate therapy of six months or more, or
- a T-score of less than or equal to -3.0 despite bisphosphonate therapy of 12 months or more.

Blue Shield may give individual consideration to claims for Boniva injections when the patient has difficulty with oral bisphosphonate dosing requirements, which include an inability to sit upright 30 to 60 minutes and/or swallow a pill. Individual consideration may also be given for claims for Boniva injections when the patient has esophagitis, gastritis, or esophageal or gastric ulcers prohibiting the use of oral bisphosphonates.

The recommended dose of Boniva injection for the treatment of postmenopausal osteoporosis is 3 mg every 3 months administered over a period of 15 to 30 seconds. Boniva injection must be administered intravenously only by a health care professional.

If the patient can tolerate oral bisphosphonates then Blue Shield considers the injectable form not medically necessary; therefore, it is not covered. A participating, preferred, or network provider may not bill the member for the denied medication.

If Boniva is used for any other indication, Blue Shield considers it experimental or investigational. It is not covered. A participating, preferred, or network provider may bill the member for the denied medication.

Report code J1740 for Boniva injection.

Blue Shield determines coverage for Boniva injection according to the individual or group customer benefits. Boniva injection is not covered under the prescription drug benefit.

MA Does not apply to FreedomBlue PFFS or FreedomBlue PPO.

Consultations defined

Highmark Blue Shield defines consultation as a professional service furnished to a patient by a second physician at the written or verbal request of the attending physician. The written or verbal request for a consultation must be documented in the patient's medical record.

A consultation includes a history, examination of the patient, and evaluation of tests, when applicable. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician.

Blue Shield determines coverage for consultations according to individual or group customer benefits.

Use the appropriate procedure code within the 99241-99255 range to report consultations.

MA Also applicable to FreedomBlue PFFS and FreedomBlue PPO.

Reclast guidelines for postmenopausal osteoporosis explained

Highmark Blue Shield covers zoledronic acid (Reclast®) injection, a bisphosphonic acid and inhibitor of osteoclastic bone resorption, for the treatment of:

- Paget's disease of bone (ICD-9-CM diagnosis code 731.0) in men and women
- osteoporosis in postmenopausal women (ICD-9-CM diagnosis code 733.01) who have documented failure of oral bisphosphonate therapy

Osteoporosis may be confirmed by the presence or history of osteoporotic fracture or by a finding of low bone mass (bone mineral density more than 2.5 standard deviations below the normal adult reference population, that is, T-score).

Blue Shield considers a 6-12 month trial of oral bisphosphonates adequate to determine treatment failure. Failure will be defined as:

- new fracture despite bisphosphonate therapy of six months or more, or
- a T-score less than or equal to -3.0 despite bisphosphonate therapy of 12 months or more.

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Blue Shield may give individual consideration to claims for Reclast in documented cases for patients who have difficulty with oral bisphosphonate dosing requirements, which include an inability to sit upright for 30 to 60 minutes and/or swallow a pill. Individual consideration may also be given for patients who have esophagitis, gastritis, or esophageal or gastric ulcers prohibiting the use of oral bisphosphonates.

Reclast injection contains the same active ingredient found in Zometa®, which is used for oncology indications. A patient already being treated with Zometa should not be treated with Reclast.

If the patient can tolerate oral bisphosphonates then Blue Shield considers the injectable form not medically necessary; therefore, it is not covered. A participating, preferred, or network provider may not bill the member for the denied injection.

Blue Shield considers the use of Reclast for any other indication as experimental or investigational. It is not covered. A participating, preferred, or network provider may bill the member for the denied injection.

Use code J3488 to report zoledronic acid (Reclast).

Blue Shield determines coverage for Reclast according to individual or group customer benefits. Reclast is not reimbursable under the prescription drug benefit.

Does not apply to FreedomBlue PFFS or FreedomBlue PPO.

Certain services to be included in critical care payment

Highmark Blue Shield will begin to include certain services in its payment for critical care codes 99291 and 99292 as of Aug. 18, 2008.

Blue Shield considers the following services to be part of critical care codes 99291 and 99292 when they're performed during the critical period by the physician providing critical care:

- interpretation of cardiac output measurements (93561, 93562)
- chest X-rays (71010, 71015, 71020)
- pulse oximetry (94760, 94761, 94762)
- blood gases, and information data stored in computers, for example, ECGs, blood pressures, hematologic data (99090)
- gastric intubation (43752, 91105)
- temporary transcutaneous pacing (92953)

- ventilatory management (94002-94004, 94660, 94662)
- vascular access procedures (36000, 36410, 36415, 36591, 36600)

If you report these services in addition to code 99291 or 99292, Blue Shield will include payment for those services in its payment for the critical care.

If you perform any services that are not listed on Pages 14-15 during the critical period, please report those services separately.

MA For FreedomBlue PFFS and FreedomBlue PPO guidelines, see Medicare Advantage medical policy bulletin V-20.

How to bill for assistant surgery for vaginal and cesarean deliveries

When you bill Highmark Blue Shield for assistant surgery for vaginal or cesarean deliveries, please bill the code that includes the vaginal delivery only (59409) or the cesarean delivery only (59514).

Correction to number of regions identified for codes 98925-98929

In the December 2007 **PRN**, we incorrectly told you that eleven regions are identified for codes 98925-98929 (see "Manipulation services require specific medical records documentation" on Pages 13-15).

The third paragraph on Page 14 should have read, "Ten regions are identified for codes 98925-98929. These include: head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, and abdomen/visceral.

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 in this edition of **PRN**.

Write to us at **medicalpolicy@highmark.com**.

Codes and modifier updates for April 2008

Here are four reinstated codes, four new codes, and one new modifier for your reporting purposes.

Code	Terminology	Effective date
J7611	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg	Reinstated April 1, 2008
J7612	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg	Reinstated April 1, 2008
J7613	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg	Reinstated April 1, 2008
J7614	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg	Reinstated April 1, 2008
Q4096	Injection, von Willebrand factor complex, human, Ristocetin cofactor (not otherwise specified), per I.U. VWF:RCO	April 1, 2008
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	April 1, 2008
Q4098	Injection, iron dextran, 50 mg	April 1, 2008
S3628	Placental alpha microglobulin-1 rapid immunoassay for detection of rupture of fetal membranes	April 1, 2008

Modifier	Terminology	Effective date
KT	Beneficiary resides in a competitive bidding area and travels outside that competitive bidding area and receives a competitive bid item	April 1, 2008

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Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the Current Procedural Terminology, as contained in CPT-2008, Copyright 2007, by the American Medical Association. **PRN** includes CPT descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.

Visit us at www.highmarkblueshield.com

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Policy Review & News

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