PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

April 2006

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MA

Look for this symbol for all Medicare Advantage related information

News

Blue Shield revises policy for collection of member deductibles, coinsurance, and copayments

In recent years, employer groups have been adding more cost-sharing components to their employees' health care benefit plans. In turn, the frequency of collection of member deductibles, coinsurance, and copayments has increased for providers.

To ensure that these member liabilities are collected appropriately, Highmark Blue Shield has revised its policy that outlines the procedures for collecting member deductibles, coinsurance, and copayments. This policy replaces the policy that was published in the June 2005 **PRN** (see "Deductible and coinsurance information available through various sources"). It permits facility, professional, and ancillary providers to collect the estimated member liability at the time of service.

Here are the procedures:

1. Provider is permitted to collect deductibles, coinsurance, and copayments at the time of service as long as these criteria are met:

    a. Provider has as a standard operating procedure the policy to collect from all patients the amount due at the time of service and that all patients are notified in advance of the policy in writing.

    b. Provider makes reasonable attempts to determine the estimated member liability by approximating the eventual adjudication of any claims. The provider cannot collect any amount above the contractual allowance for any service.

    c. Provider must submit all claims for Highmark Blue Shield members to Highmark Blue Shield.

    d. Provider must refund to member any amount in excess of that shown on the remittance/EOB as the actual member liability within 30 days of receipt of the remittance/EOB.

2. Providers may not apply their operational policy in a fashion which discriminates against Highmark Blue Shield members.

3. Providers are permitted to collect the full amount of estimated member liability without limitation.

4. Providers are required to make all attempts to collect all member liability, either at the time of service or following adjudication. When a member's benefit design includes multiple copayments, providers should collect all applicable copayments. Providers can verify a Highmark Blue Shield member's eligibility and benefits, including liability information, through NaviNet, InfoFax, or OASIS.

Blue Shield seeks approval for UCR and PremierBlue Shield reimbursement changes

Highmark Blue Shield is filing a broad range of UCR Level II and PremierBlue[SM] Shield reimbursement adjustments with the Pennsylvania Insurance Department (PID). If the PID approves the request, Blue Shield will adjust its payments for certain surgical, diagnostic, and evaluative services, including, but not limited to:

- integumentary
- psychiatric
- digestive
- neurological
- ultrasound
- cardiovascular
- otorhinolaryngologic
- mammography
- musculoskeletal
- ophthalmologic
- urinary

Blue Shield is also proposing an increase to the fees for immunization administrations. Blue Shield expects to implement these reimbursement changes in July 2006 if the PID approves the increase. Watch for more news about the proposed reimbursement changes in future issues of **PRN**.

1500A claim forms no longer available from Blue Shield

Highmark Blue Shield will no longer print its version of the 1500A universal claim form as of Oct. 1, 2006.

Blue Shield is making this change because of requirements related to the reporting of the National Provider Identifier (NPI), and the implementation of a revised claim form for federal programs.

The National Uniform Claim Committee (NUCC) is releasing a new version of the 1500 Health Insurance Claim Form that accommodates the reporting of the NPI. This form replaces the existing 1500 claim form, version 12/90, which is commonly referred to as the HCFA 1500 or CMS 1500.

If you've been using the 1500A claim form and plan to continue to submit your claims on paper after Oct. 1, 2006, you will not be able to order the forms from Blue Shield. You can find information about the release of the new NUCC claim form, including the revised form, a new reference instruction manual, a log of changes to the current form, and the recommended transition timeline at **www.nucc.org**.

Electronic claims submission more popular

Most Blue Shield network providers submit their claims electronically, so fewer providers use paper claim forms. If you are still submitting your claims on paper, and would like to switch to electronic claims submission, call your Provider Relations representative. Your representative can tell you about the efficiency and cost savings you could realize by switching.

Avoid denials: include correct member name and relationship code on all claims

Highmark Blue Shield has received many inquiries about rejected claims related to the unique member identifiers (UMI), now imprinted on all Blue Shield member identification cards.

These claims were rejected because they contained incorrect member names and relationship codes. In most cases, the name of an eligible dependent who received services in the provider's office was entered as the member on the claim form. The correct member name and relationship code must be reported on each claim for Blue Shield to process the claim correctly.

As you are aware, Blue Shield member information is no longer included on eligible dependents' member identification cards. However, Blue Shield must follow HIPAA standards for electronic claims by requiring submission of the applicant member's name and the correct relationship code (member, eligible spouse, eligible dependent child, etc.) for the member being treated.

To avoid future claim rejections, please be sure to ask the patient before services are performed whether he or she is the plan member or is an eligible dependent. Providing the correct member name and relationship code on your claim will help Blue Shield to process it as quickly and efficiently as possible.

Blue Shield knows how important timely claims payments are to you, so it is working toward solutions to this problem. Blue Shield will keep you updated on its progress.

If you would like more information about UMIs and member identification cards, please refer to the June 2003 and December 2003 **PRN**.

Anesthesia conversion factor increase implemented

The February **PRN** announced Highmark Blue Shield's request to the Pennsylvania Insurance Department (PID) to increase the anesthesia conversion factor.

The PID did approve Blue Shield's request. Blue Shield increased the anesthesia conversion factor on Feb. 6, 2006.

Reimbursement level for dietitians and nutritionists changes for FreedomBlue

On July 17, 2006, Highmark Blue Shield will begin to pay for covered services provided by a dietitian or nutritionist at the lesser of the actual charge or 85 percent of the physician fee schedule for its Medicare Advantage product, FreedomBlue^{SM}.

FEP Standard Option members now have chiropractic benefits

As of Jan. 1, 2006, Federal Employee Program (FEP) Standard Option members have chiropractic care benefits.

The Standard Option of the Service Benefit Plan will cover 10 spinal manipulations, an initial exam, and a set of X-rays. Members must pay a $15 copayment when they visit a preferred provider. When services are performed by a participating or non-participating provider, reimbursement is subject to deductibles and coinsurance.

The Basic Option of the Service Benefit Plan will cover 20 spinal manipulations, an initial exam, and a set of X-rays. When seeing a preferred provider, services will be subject to the $20 visit copayment. Services are not eligible for payment when performed by a participating or non-participating provider.

Attention PremierBlue Shield and Participating providers: IBC processes more Personal Choice and Personal Choice 65 members' claims

Highmark Blue Shield no longer processes claims for Independence Blue Cross (IBC) Personal Choice® and Personal Choice 65SM members. IBC, which is located in southeastern Pennsylvania, now manages the processing of these claims. However, Highmark Blue Shield continues to serve as the electronic claims and remittance advice conduit to and from IBC.

All Personal Choice and Personal Choice 65 medical-surgical claims with dates of service Jan. 1, 2005 and later transitioned from Highmark Blue Shield's system to IBC's Managed Healthcare System.

Many of the changes involved in this conversion are invisible to you. However, in July 2005, we informed you that claims for members whose identification numbers begin with alphabetical prefixes QCA, QCB, and QCM should be submitted directly to IBC. Since that time, IBC has added these new alphabetical prefixes to this requirement:

Prefix	Account	Prefix	Account
ADQ	American Infrastructure	INW	Iron Workers
AEK	Ametek	MGL	Morgan, Lewis & Bockius
AEV	Air Products	NFY	Infrasource
AEW	Amerigas	NLR	Neighborcare
AHJ	Asplundh Tree Service	PCX	Philadelphia Coca Cola Bottling
BME	Benchmark Medical	QCA	Point of Service IBC
BYN	Bayada Nurses	QCB	Personal Choice - PPO
CDJ	CDI	QCM	Personal Choice - 65
CDQ	Comcast	SDA	Adventist Risk Management
CDZ	Communication Test Design, Inc.	SEZ	SEI Corporation
CQA	QVC	SFU	Steamfitters Local 420
CQX	Complete Healthcare Resources (1/06)	SHQ	Sheet Metal Workers
DAZ	Day & Zimmermann	SKH	SKF

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Prefix	Account	Prefix	Account
DGR	Draeger	SQT	Southco (1/06)
DPX	Dechert LLP (1/06)	SYK	Synthes
DVU	Devereux	TFE	Teleflex
EEN	Exelon	TLG	Teamsters Local Vicinity Fund
EGD	Operating Engineers	TRX	SunCom Wireless (formerly Triton)
ETF	Electronics Boutique	UBF	Urban Outfitters
GCY	GMAC Commercial Holdings	UFN	UFCW Participating Food Industry Employers
GEA	Genesis	UFP	UFCW Local 1776
GMA	GMAC Mortgage Group	UFT	UFCW Tri-State H&W Fund
HAJ	Hajoca	UTR	United Refrigeration
HXT	Community Health Systems (1/06)		

Please continue to send paper claims for Personal Choice and Personal Choice 65 members to:

Personal Choice Claims
PO Box 890016
Camp Hill, Pa. 17089-0016

To be routed correctly, electronic submissions of Personal Choice and Personal Choice 65 claims in HIPAA-compliant ANSI ASC X12 837P format must include IBC's NAIC code of 54704 in the Interchange Receiver ID (ISA08). You should continue to use IBC's NAIC code 54704 in the Application Receiver's Code (GS03).

Please check with your vendor, clearinghouse, or billing service to identify any changes that may be necessary for this transaction.

If you have questions about this billing change, please call the eBusiness Help Desk at (215) 241-2305, or write to them at **claims.edi-admin@ibx.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 for 2006, 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.

In the near future, 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 shows you how to submit your claims to ensure proper billing. 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	1500 claim form box number	837 Professional Mapping
Billing provider name	Assignment account (AA) or group name	Current: 33 Revised: 33	Loop 2010AA Billing Provider Name NM103
Billing provider address	AA or group address	Current: 33 Revised: 33	Loop 2010AA Billing Provider Address N3 Loop 2010AA Billing Provider Address N4
Billing provider tax identification number	AA or group tax identification number	Current: 25 Revised: 25	If no NPI is sent: Loop 2010AA Billing Provider Name NM109 If NPI is sent: Loop 2010AA Billing Provider Secondary Identification REF02

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Common naming convention	Blue Shield terminology	1500 claim form box number	837 Professional Mapping
Billing provider provider identifier	AA or group Highmark Blue Shield identifier	Current: 33 Revised: 33b	Loop 2010AA Billing Provider Secondary Identification REF02 (segment occurs two times when NPI is sent)
Billing provider National Provider Identifier (NPI)	AA or group NPI	Current: not applicable Revised: 33a	Loop 2010AA Billing Provider Name NM109
Performing provider name	Performing provider name (individual person who performed the service)	Current: not applicable Revised: not applicable	Loop 2310B Rendering Provider Name NM103, NM104, NM105. When required by implementation guide situational rules.
Performing provider tax identification number	Performing provider tax identification number	Current: not applicable Revised: not applicable	If no NPI is sent: Loop 2310B Rendering Provider Name NM109 If NPI is sent: Loop 2310B Rendering Provider Secondary Identification REF02
Performing provider provider identifier	Performing provider provider identifier	Current: 24K Revised: 24J, upper line	Loop 2310B Rendering Provider Secondary Identification REF02 (segment occurs two times when NPI is sent)
Performing provider NPI	Performing provider NPI	Current: not applicable Revised: 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, and give them your individual provider number.

If you would like to speak to a 1099 specialist to review your 1099 to date for 2006, please call (866) 425-8275, option 5.

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.*

When to report a preventive medicine service and office or outpatient evaluation and management service on the same day

You can report a preventive medicine evaluation and management (E/M) service and an office or outpatient E/M service on the same day if:

- an abnormality is found, or
- a pre-existing problem is addressed during the preventive medicine E/M service

The problem or abnormality must be significant to require additional work to perform the key components of a problem-oriented E/M service. In this case, please report the appropriate office or outpatient E/M service code (99201-99215) in addition to the preventive medicine E/M code (99381-99397). Add modifier 25 to the office or outpatient code to indicate that a significant, separately identifiable E/M service was provided by the same health care professional on the same day as the preventive medicine service.

Do not report an office or outpatient E/M service in addition to the preventive medicine service, if during the preventive exam an insignificant or trivial problem or abnormality is found that does not require additional work to perform the key components of a problem-oriented E/M service.

Reporting of preventive medicine and office or outpatient E/M services on the same day should not be a common occurrence in any practice. To justify these services, the patient's records must contain sufficient documentation about the appropriateness of performing both services, and documentation that the key components of the office or outpatient E/M service have been met. If the reported office or outpatient E/M service does not meet the component requirements, Highmark Blue Shield will not pay for the second service.

Blue Shield will determine payment for the office or outpatient E/M service according to the coverage limitations of the individual member's contract. Blue Shield will consider each service separately. The member may be responsible for multiple copayments or one service may be applied to the member's deductible while the other is paid.

Also applicable to FreedomBlue.

MRI-guided high intensity ultrasound ablation of uterine fibroids considered investigational

Highmark Blue Shield considers MRI-guided high intensity ultrasound ablation of uterine fibroids an experimental or investigational procedure. It is not eligible for coverage. A participating, preferred, or network provider can bill the member for the denied procedure.

Report this procedure with the appropriate code:

0071T—focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue

0072T—focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue

MRI-guided high intensity ultrasound ablation of uterine fibroids, a non-invasive outpatient procedure, is performed under conscious sedation. The MRI allows visualization and targeting of the fibroid as well as monitoring of the temperature of the uterine tissue, as a focused ultrasound beam heats and destroys the fibroid tissue using high-frequency, high-energy sound waves.

Also applicable to FreedomBlue.

Treatment of infertility and assisted fertilization guidelines clarified

Highmark Blue Shield's medical-surgical contracts generally provide coverage for the diagnosis and treatment of infertility for both males and females. Blue Shield usually covers the diagnostic, medical, or surgical services that are used to evaluate or treat infertility unless the individual member's benefit contract excludes services to diagnose and treat infertility.

Evaluation and treatment of infertility is performed to enhance the possibility of achieving conception through normal coital activity. Such diagnosis or treatment may involve diagnostic bloodwork, ultrasound studies, ovulation induction or other medication(s), and/or surgical procedures.

Assisted fertilization services not covered

Standard Blue Shield medical-surgical contracts generally exclude assisted fertilization services. They are not eligible for payment. Blue Shield determines coverage for assisted fertilization according to individual or group benefits.

Assisted fertilization procedures are performed for infertile patients that have chosen to enter into such a program. The procedures involve manipulation of the egg and/or sperm to achieve conception. Artificial insemination (AI), in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and all other methods of assisted fertilization involve the removal of eggs and/or sperm from the patient(s) for subsequent transfer into the female reproductive system.

After evaluation and treatment for infertility has been completed and the infertility has been unresponsive to medical or surgical treatment, or is untreatable, assisted fertilization may become an option to attempt to achieve conception. Blue Shield considers all services that are performed in relation to, or in preparation for, an assisted fertilization procedure, that is, bloodwork, medication, ultrasound studies, etc., to be part of the actual assisted fertilization procedure. Blue Shield does not cover these services for members without an assisted fertilization benefit.

Some of the same services, that is, bloodwork, medication, ultrasound studies, may be performed as part of an assisted fertilization program as well as treatment for infertility outside of an assisted fertilization program. Blue Shield determines the eligibility of such services based on whether the service is being performed for the diagnosis or treatment of infertility, or whether it is being performed in conjunction with, or in preparation for, an assisted fertilization procedure. Blue Shield will then decide if the service is eligible for coverage based on the individual or group benefit.

MA Does not apply to FreedomBlue.

Safety beds covered for certain patients

Highmark Blue Shield will cover a manual or electric bed for the primary indication of a patient's safety in the home, if it determines that the patient's condition is so severe that they are prone to injury without use of the safety bed. You must include supporting medical documentation for the safety bed in the patient's medical records. The records must be available if Blue Shield requests them.

Safety beds must also meet Blue Shield's definition of durable medical equipment (DME) to be eligible for payment. Blue Shield defines DME as equipment that:

- must be able to withstand repeated use
- must be primarily and customarily used to serve a medical purpose
- should not be useful to a person in the absence of illness or injury
- should be appropriate for use in the home

All requirements of the definition must be met before Blue Shield will consider a safety bed as DME. If a safety bed does not meet this definition, Blue Shield will deny it as not covered. A participating, preferred, or network provider can bill the member for the denied bed.

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

Report safety beds with code E1399. When you report code E1399, please include the term "safety bed" along with the brand name of the specific bed in the narrative section of the electronic or paper claim.

MA Also applicable to FreedomBlue.

How to report stab phlebectomies

Highmark Blue Shield pays for stab phlebectomies when they're performed to treat symptomatic varicose veins.

Use these procedure codes, as appropriate, to report a stab phlebectomy:

37765—stab phlebectomy of varicose veins, one extremity; 10–20 stab incisions

37766—stab phlebectomy of varicose veins, one extremity; more than 20 incisions

Report code 37765 or 37766 only when you perform stab incisions.

For fewer than 10 incisions, report unlisted procedure code 37799. When you report code 37799, please provide a complete description of the service in the narrative field of the electronic or paper claim.

When you perform stab phlebectomies on both extremities, report modifier 50 or RT/LT along with code 37765 or 37766.

Do not report code 37785 when you perform a stab phlebectomy. Code 37785 represents the ligation, division, and/or excision of varicose vein clusters. Because code 37785 represents a unilateral procedure, report it once per extremity.

Blue Shield will pay for surgical treatment of varicose veins for the contralateral extremity only if that leg is also symptomatic.

Treatment of reticular veins or superficial telangiectases not covered

Blue Shield will not cover any method of treatment for reticular veins and/or superficial telangiectases because treatment of these superficial veins is primarily cosmetic. A participating, preferred, or network provider can bill the member for services that are denied as cosmetic.

MA Also applicable to FreedomBlue.

Coverage guidelines for intra-articular hyaluronan injections for osteoarthritis of the knee apply to Synvisc, Hyalgan, Supartz, and Orthovisc

Highmark Blue Shield determines coverage for intra-articular injections of hyaluronan, such as Synvisc®, Hyalgan®, Supartz®, or Orthovisc® according to each patient's individual or group benefits. If the patient's benefits allow for intra-articular hyaluronan injection of the knee, Blue Shield will cover it if all of these criteria have been met:

1. The patient has symptomatic osteoarthritis of the knee (715.16, 715.26, 715.36, 715.96).
2. The patient has failed to respond to conservative therapy, such as analgesics, NSAIDs, or intra-articular corticosteroid injections, or is unable to tolerate conservative therapy methods because of adverse side effects.
3. There are no contraindications to the injection of Synvisc, Hyalgan, Supartz, or Orthovisc.
4. The hyaluronan product is approved by the Food and Drug Administration (FDA) for intra-articular injection of the knee. The FDA has approved Synvisc, Hyalgan, Supartz, and Orthovisc for this indication.

Remember to include information in the patient's medical record about his or her failure to tolerate or respond to more conservative therapies.

If the arthrocentesis and the injection are performed for reasons other than those stated in the above criteria, Blue Shield will deny both the arthrocentesis and the preparation as not medically necessary. The services will not be covered. A participating, preferred, or network provider cannot bill the member for the denied services.

Here are the frequency requirements for Synvisc, Hyalgan, Supartz, and Orthovisc:

Synvisc—one injection per week for three weeks

Hyalgan—one injection per week for three or five weeks

Supartz—one injection per week for five weeks

Orthovisc—one injection per week for three to four weeks

Blue Shield will give individual consideration to repeat treatment cycles, that is, any further injections over and above the specified frequency requirements, for patients who have responded to the previous courses of treatment. Blue Shield will consider repeat treatments for coverage under these circumstances:

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

When you report intra-articular injections of hyaluronan, please use procedure code J7320 for Synvisc, J7317 for Hyalgan or Supartz, and J3490 for Orthovisc.

Intra-articular injections of hyaluronan, such as Synvisc, Hyalgan, Supartz, and Orthovisc, act as lubricants to restore elasticity and viscosity to the arthritic knee. These products are injected after the existing synovial fluid is aspirated from the knee.

Also applicable to FreedomBlue.

Artificial spinal disc replacement not covered

Highmark Blue Shield considers intervertebral disc replacement or spinal arthroplasty using an artificial spinal disc, for example, Charité, experimental or investigational in the treatment of degenerative disc disease. It is not eligible for coverage. A participating, preferred, or network provider can bill the member for the denied procedure.

Report this service with the appropriate code:

0090T—total disc arthroplasty (artificial disc), anterior approach, including diskectomy to prepare interspace (other than for decompression); single interspace, cervical

0091T—total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar

0092T— total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, each additional interspace (list separately in addition to code for primary procedure)

0093T—removal of total disc arthroplasty, anterior approach; single interspace, cervical

0094T—removal of total disc arthroplasty, anterior approach; single interspace, lumbar

0095T—removal of total disc arthroplasty, anterior approach; each additional interspace (list separately in addition to code for primary procedure)

0096T—revision of total disc arthroplasty, anterior approach; single interspace, cervical

0097T—revision of total disc arthroplasty, anterior approach; single interspace, lumbar

0098T—revision of total disc arthroplasty, anterior approach; single interspace, each additional interspace (list separately in addition to code for primary procedure)

Artificial intervertebral disc implants are designed for use as a last resort for treatment of severe degenerative disc disease as an alternative to spinal fusion.

MA Also applicable to FreedomBlue.

Report hands-free ultrasound therapy with code 97799

The February 2006 **PRN** instructed you to report hands-free ultrasound with procedure code 97039—unlisted modality. See "Hands-free ultrasound therapy considered investigational" on Page 10.

Please do not report this service with code 97039. Instead, use code 97799—unlisted physical medicine/rehabilitation service or procedure—to report hands-free ultrasound therapy. When you report code 97799, please include a complete description of the therapy you performed in the narrative section of the electronic or paper claim.

MA Also applicable to FreedomBlue.

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

New codes available for electrocardiographic monitoring

Here are three new codes you can use to report electrocardiographic monitoring. These codes became available April 1, 2006.

Code	Terminology
S0345	Electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real-time notification of monitoring station, 24-hour attended monitoring, including recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation; per 24-hour period
S0346	Electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real-time notification of monitoring station, 24-hour attended monitoring, including recording, monitoring, receipt of transmissions, and analysis; per 24-hour period
S0347	Electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real-time notification of monitoring station, 24-hour attended monitoring, including physician review and interpretation; per 24-hour period

Deleted codes

Highmark Blue Shield deleted these codes on April 1, 2006. Below are the codes and their corresponding terminology.

Replacement codes, if available, are also included for your reporting purposes. If more than one replacement code is listed, please select the most appropriate code according to the service you provided.

Deleted code	Terminology	Replacement code
Q3019	ALS vehicle used, emergency transport, no ALS level services furnished	none
Q3020	ALS vehicle used, non-emergency transport, no ALS level services furnished	none
S0133	Histrelin implant (vantas), 50 mg	J9225

Deleted code	Terminology	Replacement code
S2362	Kyphoplasty, one vertebral body, unilateral or bilateral injection	22523–22524
S2363	Kyphoplasty, one vertebral body, unilateral or bilateral injection; each additional vertebral body (List separately in addition to code for primary procedure)	22525
S3701	Immunoassay for nuclear matrix protein 22 (nmp-22), quantitative	86294
S8093	Computed tomographic angiography, coronary arteries, with contrast material(s)	0144T–0151T
S8260	Oral orthotic for treatment of sleep apnea, includes fitting, fabrication, and material	E0485–E0486

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 (800) 236-8641. Blue Cross of Northeastern Pennsylvania (BCNEPA) providers should use fax number (570) 200-6880. 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:

Highmark Blue Shield
Provider Data Services
PO Box 898842
Camp Hill, Pa. 17089-8842

For BCNEPA providers:

Blue Cross of Northeastern Pennsylvania
Provider System Support
19 North Main Street
Wilkes-Barre, Pa. 18711

Name _____ Provider ID number _____

Electronic media claims source number _____

Please make the following changes to my provider records:

Practice name _____

Practice address _____

Mailing address _____

Telephone number ( ) _____ Fax number ( ) _____

E-mail address _____

Tax ID number _____

Specialty _____

Provider's signature _____ Date signed _____

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Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the Current Procedural Terminology, as contained in CPT-2006, Copyright 2005, 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.

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Policy Review & News

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