

# PRN

## Policy Review & News

Important information about Highmark Blue Shield  
www.highmarkblueshield.com

April 2007

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### News

#### **Blue Shield takes next steps to streamline claims processing and increase provider satisfaction**

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

Highmark Blue Shield is taking more steps to launch its five-year program to continue enhancing many of the core administrative functions within its information systems structure.

On April 13, 2007, Blue Shield began the next phase of this endeavor by updating its procedure for processing electronic claims.



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## **Strengthening data validation and communication on claim errors**

On April 13, 2007, Blue Shield began to make additional system checks on all claims for data completion and accuracy before adjudication. For example, one of the edit checks makes sure that the beginning date of service is not greater than the ending date of service. With these additional upfront edits, incomplete and inaccurate electronic claims are identified and resolved quickly, thus allowing for more efficient processing and increased member and provider satisfaction. Specifically, the system checks will enhance overall processing by reducing claim suspensions, increasing the timeliness of claim processing, and avoiding time-consuming status inquiries.

When a claim rejects, it's important for your billing staff to understand exactly what was wrong and what's needed to correct it. So, in addition to strengthening data validation, on April 13, 2007, Blue Shield also implemented new Claim Status Category Codes to further define errors on rejected claims.

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## **What you need to know**

As of April 13, 2007, Blue Shield no longer attempts to correct or retrieve the missing information in the situations listed in the charts on Pages 3-5. Instead, these situations will result in a rejected claim.

You will need to resubmit the claim with corrected data. To assist your billing staff in submitting a corrected claim, Blue Shield began to issue enhanced details on why the claim rejected. (See "New Claim Status Category Codes" on Page 6.)

If you are electronically enabled, it would be to your benefit to resubmit the claim electronically. Blue Shield will perform the same data validation on both electronic and paper claims. Therefore, do not drop rejected electronic claims to paper for resubmission—this will slow down the adjudication process and result in the same edit rejection.

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## **Real-time validation now available**

Blue Shield implemented a real-time claim submission NaviNet<sup>®</sup> service on April 13, 2007. You can submit a single claim through NaviNet, and the appropriate response is generated within 30 seconds of submission.

Blue Shield will apply the additional edit checks to the real-time submission, as well as the existing HIPAA Level 1-5 editing, and other pre-adjudication edits.

So far, Blue Shield has enabled one trading partner with real-time validation. Throughout 2007, it will enable additional providers and trading partners.

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## **We're here to help!**

Blue Shield is dedicated to supporting its provider community with gaining more efficient electronic connectivity. It is actively working to help initiate or maximize electronic claims submission. Electronic claims submission will eliminate your need to pay for printed claim forms and postage, and should also streamline claim filing and claim payment. Remember, electronic claims process within seven to 14 days, while paper claims may take 21 to 27 days to process.

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If you are currently submitting paper claims and are interested in becoming electronically enabled, contact EDI Operations at (800) 992-0246, Monday through Friday, 8 a.m. to 5 p.m., visit EDI's Web site at [www.highmark.com/edi](http://www.highmark.com/edi), or contact Provider Service.

## *Details for billing staff, clearinghouses, and vendors*

### **New edit checks, effective April 13, 2007**

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If you submit your claims using the HIPAA 837 electronic transaction, you may encounter these error codes on your X12 277 Claim Acknowledgment (277CA) transaction or 277CA printable report.

<b>Claim status error code</b>	<b>Claim Status Category Code</b>	<b>Claim status description</b>
679	A3	Submit newborn services on mother's claim
676, with entity ID 82 or 85	A6	Entity possibly compensated by facility 82 = Rendering provider 85 = Billing provider
675	A8	Facility admission through discharge dates
672	A3	Other payer's payment information is out of balance
454	A8	Procedure code for services rendered
453	A8 or A6	Procedure code modifier(s) for service(s) rendered
286	A6	Other payer's Explanation of Benefits or payment information
249	A8	Place of service
190	A6	Facility discharge date
189	A6	Facility admission date
187	A8 or A7 or A6	Date(s) of service
164, with entity ID IL	A6	Entity's contract or member number IL = Insured or subscriber
158, with entity ID QC and 187	A8	Entity's date of birth QC = Patient 187 = Date(s) of service

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<b>Claim status error code</b>	<b>Claim Status Category Code</b>	<b>Claim status description</b>
156	A6 or A3	Patient relationship required
145, with entity ID 85 and 454	A8	Entity's specialty code 85 = Billing provider 454 = Procedure code for services rendered
138, with entity ID 77	A6	Entity's site ID 77 = Service location
129	A8	Entity's provider ID
126, with entity ID IL	A6	Entity's address IL = Insured or subscriber
116	A3	Claim submitted to incorrect payer
33	A3	Subscriber and subscriber ID not found

If you submit paper claims with incorrect or missing information corresponding to the following new edits, you will encounter these denial codes and descriptions on your paper 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.

<b>Rejection code</b>	<b>Rejection code description</b>
E0782	Submit claim to Independence Blue Cross.
E0793	In order to process the claim, additional information is required. The claim should be resubmitted with the alpha prefix and identification number clearly indicated.
E5058	A discrepancy exists between the date(s) of service reported, the admission and discharge dates reported, and the place of service reported. Please resubmit the claim with the correct date(s) of service, admission and discharge dates, and/or place of service for further consideration.
E5059	A discrepancy exists between the date(s) of service reported, the admission and discharge dates reported, and the place of service reported. Please resubmit the claim with the correct date(s) of service, admission and discharge dates, and/or place of service for further consideration.

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<b>Rejection code</b>	<b>Rejection code description</b>
E5128	In order to process the claim, additional information is required. The claim should be resubmitted with the exact date(s) of service for each service reported.
E5173	This claim was submitted to us in error. Please submit this claim to the local BCBS Plan in the state where the services were provided for processing.
E5404	A discrepancy exists between the Medicare coverage reported and the service(s) reported.
E5478	Anesthesia time required for anesthesia services. Please resubmit the claim with a clear indication of the amount of anesthesia time involved.
P5004	In order to process the claim, additional information is required. Please resubmit the claim with the specific procedure description.
P5036	We do not cover this service when performed by this type of provider. Therefore, no payment can be made for this service.
P5085	In order to process the claim, additional information is required. The claim should be resubmitted with the skilled nursing facility admission and discharge dates.
P5089	This service was submitted without a provider charge amount. Please resubmit the service with the appropriate provider charge amount.
P5130	A HCPCS procedure code in combination with an anesthesia modifier is no longer valid. Please resubmit the claim using the appropriate CPT procedure code and national modifier.
P5151	This service was submitted without a provider charge amount. Please resubmit the service with the appropriate itemized provider charge amount.
S0001	We are unable to identify this patient from the identification number reported above. Please verify the name, number, and alpha prefix indicated on the identification card. If the patient is covered by us, please resubmit the claim.
S0011	In order to process the claim, additional information is required. The claim should be resubmitted making sure the name and address of the subscriber is clearly indicated.
S0018	The member's address on the claim is the same as your address. The claim should be resubmitted with the subscriber's correct address.
S0098	We are unable to identify this patient from the identification number reported above. Please verify the name, number, and alpha prefix indicated on the identification card. If the patient is covered by us, please resubmit the claim.

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## **New Claim Status Category Codes, effective April 13, 2007**

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To further define errors on rejected claims, the X12 277CA transaction has been enhanced to include new Claim Status Category Codes. The format of the transaction will remain the same. On the 277CA printable report, a new column titled “CAT” will list the category code to help you understand why the claim was not accepted. Descriptions of the category codes will be located at the bottom of the 277CA printable report.

This chart shows the possible Claim Status Category Codes and their corresponding description.

<b>Claim Status Category Code</b>	<b>Description</b>
A2	Acknowledgment/acceptance into adjudication system. The claim has been accepted into the adjudication system.
A3	Acknowledgment/returned as unprocessable claim. The claim has been rejected and has not been entered into the adjudication system.
A6	Acknowledgment/rejected for missing information. The claim is missing the information specified in the status details and has been rejected.
A7	Acknowledgment/rejected for invalid information. The claim has invalid information as specified in the status details and has been rejected.
A8	Acknowledgment/rejected for relational field in error.

## **Tip: maximize your electronic submissions**

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Blue Shield can help you to better understand many of the different resources and options available for electronically submitting all of your claims, including:

- using the Paperwork Segment (PWK) to electronically submit claims when you have paper attachments
- receiving and reviewing your 277CA that details your claim submissions, including any rejection codes
- ensuring all secondary claims, including Medicare claims, are submitting electronically through your practice
- management software or through the Medicare Crossover arrangement

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## **Blue Shield accepts and processes electronic secondary claims**

Highmark Blue Shield can accept and process electronically-submitted secondary claims.

Secondary claims are those where the member's primary insurance is through another payer, and their secondary coverage is through Highmark Blue Shield. The claim processes through the other payer first, then it's sent to Blue Shield. Blue Shield determines if there is additional coverage, then payment is made accordingly.

The HIPAA standards for electronic claims contain segments that allow for the reporting of the adjudication information from the primary payer necessary to process the secondary coverage. You can find the specifications for how to report this information at [www.highmark.com/edi](http://www.highmark.com/edi).

Your Practice Management Claim Submission software may require additional program logic to allow for electronic submission of secondary claims. If you are not already submitting secondary claims electronically, please contact your vendor and ask them if they can provide this capability.

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## **Calls to Provider Relations reps now forwarded to Provider Service**

On April 2, 2007, Highmark Blue Shield changed one option on its toll-free provider telephone line to help providers who don't yet have NaviNet® or the applicable HIPAA transactions get answers to their questions more quickly.

Before, when providers called (866) 731-2045 (central and Lehigh Valley region) or (866) 362-6116 (eastern region) and selected option 4, they accessed a voice mailbox for their Provider Relations representative and left a message. Now, callers are automatically connected to Blue Shield's Provider Service department when they select option 4.

This change was made to improve customer service to you, since you are connected directly to a Provider Service representative instead of leaving a message and waiting for your Provider Relations representative to return your call. This change improves Blue Shield's response time to your inquiries.

You still have access to your Provider Relations representative. Provider Service will continue to be available to forward a message to your representative, if necessary.

A recorded message announcing this change is being broadcast on the toll-free lines from April 2 through July 2007 to make sure callers are aware of this service improvement.

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## **Attention NaviNet-enabled providers: continue to use NaviNet for routine inquiries**

Blue Shield encourages providers to use the electronic resources available to them—NaviNet and the applicable HIPAA transactions—for routine eligibility, claim status and general benefit inquiries, to request authorizations, and to verify if an authorization has been issued. NaviNet-enabled providers who call Provider Service for routine inquiries will be directed to NaviNet for the requested information.

On occasion, NaviNet-enabled providers may have an eligibility or benefit inquiry that requires more information than is available on NaviNet. For example, does family history of a particular condition impact eligibility? In these instances, if you are a NaviNet-enabled provider and need to call Provider Service, you should be very specific about what information you need. Make sure you explain that you need a level of detail that you can't get through a normal NaviNet inquiry.

Using NaviNet is more convenient than calling Provider Service, and the Web-based system offers many time-saving tools and advantages, such as:

- eligibility and benefits verification
- claim investigation and claim status inquiry functions
- medical policy inquiry
- electronic submission of authorization requests and authorization status inquiries for most Blue Shield members (not available for Federal Employee Program members)
- recredentialing online
- access to provider directories
- allowance inquiries
- availability from 5 a.m. to midnight, Monday through Saturday. Sunday, 5 a.m. to 5 p.m.

To learn more about the benefits of NaviNet for your practice, or to sign up for access to the system, contact Provider Service.

As of December 2006, approximately 77 percent of providers in Blue Shield's 21-county central Pennsylvania and Lehigh Valley region were NaviNet-enabled.



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## **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<sup>SM</sup> Shield reimbursement adjustments with the Pennsylvania Insurance Department (PID).

If the PID approves the request, Blue Shield will adjust its payments for select surgical, diagnostic, and evaluative services, including, but not limited to:

- digestive
- echocardiography
- integumentary
- MRI, CT, PET
- neurological
- obstetrical and gynecological
- ophthalmologic
- urinary

Blue Shield expects to implement these reimbursement changes in July 2007, if the PID approves the request. Details about the proposed reimbursement changes will be announced in future issues of **PRN**.

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## **Reminder: direct your Blue Shield patients to network providers**

If you need to refer your Highmark Blue Shield patient to another health care provider, please direct him or her to a Highmark Blue Shield network provider for additional health care services. For example, if you are a PremierBlue<sup>SM</sup> Shield physician, you should refer any PPOBlue<sup>SM</sup> member who needs laboratory work to a PremierBlue Shield participating laboratory. If you send lab specimens to a nonparticipating lab, your patients will incur higher out-of-pocket costs.

The regulations governing Blue Shield's credentialed networks require a network provider to refer a Blue Shield member to another network provider and/or network hospital or facility. There are two exceptions: emergency situations or when Blue Shield grants prior approval.

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While referrals are not required for Blue Shield members to receive services, when referrals are made, they must be to network providers.

Also, please direct Blue Shield patients to network providers when ordering services such as medical items and/or supplies, and diagnostic services.

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## **Blue Shield plans changes to site of service payment differential**

Highmark Blue Shield plans to change its payment differential for services performed in a facility compared to services performed in a non-facility setting.

The changes will simplify pricing. And, it will consolidate the site of service and surgical tray concepts into one methodology, similar to that used by the Medicare program.

Blue Shield is planning on implementing this change during the summer of 2007, contingent upon Pennsylvania Insurance Department approval.

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## **Report ET modifier to identify emergency services**

When you report initial emergency services, remember to use the appropriate evaluation and management procedure code along with the ET—emergency services—modifier.

When you report the ET modifier, include the diagnosis code (coded to the highest degree of specificity) that identifies the service as emergency medical or emergency accident. Highmark Blue Shield needs this information to apply the member's benefits during claims processing. Blue Shield determines its payment for emergency services according to the member's coverage.

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## **Blue Shield reissues some FreedomBlue member identification cards**

Highmark Blue Shield has reissued some FreedomBlue<sup>SM</sup> member identification cards that contained an incorrect alphabetical prefix—**ZAR**—preceding the unique member identifier (UMI) number.

This primarily affected members of the FreedomBlue BasicRx product. In January 2007, Blue Shield reissued replacement identification cards containing the correct alphabetical prefix.

Blue Shield asked the affected members to destroy the incorrect cards. However, if a FreedomBlue patient presents you with an identification card containing an alphabetical prefix other than **FER** or **FEM**, which are the correct alphabetical prefixes, please contact Provider Service so that it can resolve the situation promptly.

## Claim submission guidelines for First Priority Health and First Priority Life Insurance Company explained

You may see patients with coverage through First Priority Health (FPH) or First Priority Life Insurance Company (FPLIC) in your practice. If so, please note that Blue Cross of Northeastern Pennsylvania (BCNEPA) and Highmark Blue Shield have entered into joint ownership of the two companies, FPH and FPLIC. FPH was formerly a subsidiary of BCNEPA, and FPLIC was introduced in early 2007.

If you provide care to these members, it's important that you submit the claims as you would for any Highmark Blue Shield member. As always, it's based on your contract status and location.

To ensure that all FPH and FPLIC claims are processed efficiently, please follow the claim submission instructions in the following two charts:

### *Provider contracted with Highmark Blue Shield*

<b>Provider is contracted with...</b>	<b>Provider practice is located...</b>	<b>FPH products</b>	<b>FPLIC products</b>	<b>Submit electronic claims to...</b>	<b>Submit paper claims to...</b>
Highmark Blue Shield's PremierBlue <sup>SM</sup> Shield or Participating Provider Network	Outside of these 13 BCNEPA counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming	Member alphabetical prefix:  <b>YZH</b> – BlueCare HMO, BlueCare POS	Member alphabetical prefixes:  <b>QFG</b> – BlueCare PPO (includes Qualified High Deductible Health Plan) <b>QFC</b> – BlueCare PPO Individual Conversion <b>QFD</b> – BlueCare Direct <b>QFT</b> – BlueCare Traditional <b>QFM</b> – BlueCare Comprehensive <b>NTJ, NTQ, NNU, SNQ, AUV, SVQ, EBU</b> – custom prefixes BlueCare PPO	Highmark Blue Shield, using NAIC code 54771 in the receiver and payer loops	Highmark Blue Shield PO Box 890062 Camp Hill, Pa. 17089-0062

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*Provider contracted with FPH or FPLIC*

<b>Provider is contracted with...</b>	<b>Provider practice is located...</b>	<b>FPH products</b>	<b>FPLIC products</b>	<b>Submit electronic claims to...</b>	<b>Submit paper claims to...</b>
FPH	Outside of these 13 BCNEPA counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming	Member alphabetical prefix:  <b>YZH</b> – BlueCare HMO and BlueCare POS	N/A	Follow the FPH and BCNEPA billing standards for the receiver and payer loops	First Priority Health PO Box 69699 Harrisburg, Pa. 17106-9699
FPLIC	Outside of these 13 BCNEPA counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming	N/A	Member alphabetical prefixes:  <b>QFG</b> – BlueCare PPO (includes Qualified High Deductible Health Plan) <b>QFC</b> – BlueCare PPO Individual Conversion <b>QFD</b> – BlueCare Direct <b>QFT</b> – BlueCare Traditional <b>QFM</b> – BlueCare Comprehensive <b>NTJ, NTQ, NNU, SNQ, AUV, SVQ, EBU</b> – custom prefixes BlueCare PPO	Follow the FPLIC and BCNEPA billing standards for the receiver and payer loops.	BCNEPA/FPLIC PO Box 890179 Camp Hill, Pa. 17089-0179

If you have questions about these guidelines, please call Provider Service using the appropriate regional telephone number:

- Central Pennsylvania and Lehigh Valley 21-county region: (866) 731-8080
- Eastern Pennsylvania 5-county region: (866) 975-7290
- Northeastern Pennsylvania (BCNEPA) region: (800) 451-4447

## Policy

*Highmark Blue Shield's medical policies are available online in the Provider Resource Center through NaviNet® or at [www.highmarkblueshield.com](http://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.*

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### **Laparoscopic adjustable gastric banding eligible for reimbursement**

Highmark Blue Shield now covers laparoscopic adjustable gastric banding (Lap-Band® System).

Blue Shield considers laparoscopic adjustable gastric banding medically necessary for patients who meet all of these selection criteria:

- The patient must be morbidly obese.

Blue Shield defines morbid obesity as a condition of consistent and uncontrollable weight gain that is characterized by a weight that is at least 100 pounds or 100 percent over ideal weight, or a BMI of at least 40 (V85.4) or a BMI of 35 (V85.35-V85.39) with comorbidities, for example, hypertension, cardiovascular heart disease, dyslipidemia, diabetes mellitus type II, sleep apnea.

- The patient must be at least 18 years old.
- The patient must have received non-surgical treatment, for example, dietitian or nutritionist consultation, low calorie diet, exercise program, and behavior modification. The patient's attempts at weight loss have failed.
- The patient must participate in and meet the criteria of a structured nutrition and exercise program. This includes dietitian or nutritionist consultation, low calorie diet, increased physical activity, behavioral modification, and/or pharmacologic therapy. This information must be documented in the patient's medical record.

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This structured nutrition and exercise program must meet all of these criteria:

- a. The nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dietitians and/or nutritionists.
- b. The nutrition and exercise program(s) must be for a cumulative total of six months or longer.
- c. The nutritional and exercise program must occur within two years before the surgery.
- d. The patient's participation in a structured nutrition and exercise program must be documented in their medical record by the attending physician that supervised the patient's progress.

A physician's summary letter is not sufficient documentation. Documentation should include medical records of the physician's on-going assessments of the patient's progress throughout the course of the nutrition and exercise program. For patients who participate in a structured nutrition and exercise program, medical records documenting the patient's participation and progress must be available for Blue Shield's review.

- The patient must complete a psychological evaluation performed by a licensed mental health care professional. The mental health care professional should provide the recommendation for the bariatric surgery. The patient's medical record documentation should indicate that all psychosocial issues have been identified and addressed.

Patient selection is a critical process requiring psychiatric evaluation and a multidisciplinary team approach. The patient's understanding of the procedure, and ability to participate and comply with life-long follow-up and the life-style changes, for example, changes in dietary habits, and beginning an exercise program, are necessary for the procedure to succeed.

If the patient does not meet all of the criteria for laparoscopic adjustable gastric banding, Blue Shield will deny it as not medically necessary. A participating, preferred, or network provider may not bill the patient for the denied procedure.

Use procedure codes 43770-43774, S2083, as appropriate, to report laparoscopic adjustable gastric banding, replacement, revision, or removal of the adjustable gastric band component and/or subcutaneous port component.



Does not apply to FreedomBlue.

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## **Cardiac (atrial) pacing for treating obstructive sleep apnea not covered**

Highmark Blue Shield considers atrial overdrive pacing for the treatment of obstructive sleep apnea (OSA) experimental or investigational. Blue Shield does not cover this procedure because there is insufficient evidence to demonstrate its safety and effectiveness in the treatment of OSA. A participating, preferred, or network provider may bill the member for the denied procedure.

Use procedure code 93799—unlisted cardiovascular service or procedure—to report atrial pacing for the treatment of obstructive sleep apnea. When you report code 93799, please provide this description in the narrative section of the electronic or paper claim: “atrial overdrive pacing for the treatment of obstructive sleep apnea.”

The use of atrial overdrive pacing by means of an implantable cardiac pacemaker has been evaluated as a treatment for OSA patients and in certain patients with some degree of heart failure. Atrial overdrive pacing consists of pacing at a rate higher than the mean nocturnal sinus rate. Proponents of this treatment theorize that atrial overdrive pacing will improve vagal tone and increase upper airway muscle activity in OSA patients.



Also applicable to FreedomBlue.

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## **How to report microcavitation**

Report microcavitation with procedure code 93799—unlisted cardiovascular service or procedure. When you report code 93799, please include the words “microcavitation studies” in the narrative section of the electronic or paper claim.

Microcavitation, an ultrasound procedure, is typically performed in conjunction with echocardiography. Microcavitation is performed to assess cardiac blood flow patterns because it improves cavity delineation and detects intracardiac shunts. This study evaluates a patient for any physiologic or anatomic shunting, such as an atrial septal defect, patent foramen ovale, or severe obstructive pulmonary disease with shunting. It can also assess conditions that suggest shunting may be present, such as an unexplained right heart dilatation or known corrected or uncorrected congenital heart disease.



Also applicable to FreedomBlue.

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## **Measurement of serum holotranscobalamin as a marker of vitamin B12 status not covered**

Highmark Blue Shield considers tests to measure serum holotranscobalamin as a marker for vitamin B12 (cobalamin) deficiency experimental or investigational. A participating, preferred, or network provider may bill the member for the denied test.

Blue Shield does not cover this testing because there are inadequate data to establish holotranscobalamin testing as an alternative to either total serum cobalamin or levels of metabolites, MMA, or homocysteine. Studies of a large population of patients whose cobalamin status is unknown are needed. In addition, for all patients at risk of vitamin B12 deficiency, this testing would not change patient management. The recommended treatment of subclinical disease is further dietary supplementation of cobalamin. This recommendation is appropriate, regardless of the level of measured cobalamin.

Use procedure code 0103T—Holotranscobalamin, quantitative—to report this test.

The diagnosis of vitamin B12 deficiency has traditionally been based on low levels of total serum cobalamin. However, this laboratory test has been found to be poorly sensitive and specific. Therefore, attention has turned to measuring metabolites (methylmalonic acid [MMA] and homocysteine) of cobalamin as a surrogate marker and also to the quantitative measurement of the fraction of cobalamin bound to the carrier protein transcobalamin in serum to diagnose vitamin B12 deficiency.



Also applicable to FreedomBlue.

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## **Pediatric critical care with ventilatory assistance, only critical care covered**

When pediatric critical care transport (codes 99289 and 99290) and ventilatory assistance are reported on the same day by the same physician, Highmark Blue Shield will deny the charges for the ventilatory assistance. Blue Shield will pay for only the critical care. A participating, preferred, or network provider may not bill the patient separately for the ventilatory assistance.



Also applicable to FreedomBlue.

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## **Laboratory tests for heart transplant rejection not eligible**

Highmark Blue Shield considers these laboratory tests for heart transplant rejection experimental or investigational:



- measurement of volatile organic compounds with the Heartsbreath test to assist in the detection of grade 3 heart transplant rejection
- evaluation of genetic expression in the peripheral blood, including, but not limited to the detection of acute heart transplant rejection or graft dysfunction, for example, AlloMap™

A participating, preferred, or network provider may bill the member for the denied tests.

Blue Shield does not cover these tests because current data do not permit scientific conclusions about the use of either Heartsbreath or the AlloMap test in the management of heart transplant recipients. There is a lack of published studies that examine how either test could be integrated into the management of the patient, either to select or deselect patients for endomyocardial biopsy (the gold standard for assessing heart transplant rejection), or replace endomyocardial biopsy altogether.

Use procedure code 0085T—breath test for heart transplant rejection—to report the measurement of volatile organic compounds to detect heart transplant rejection, for example, the Heartsbreath test.

Use procedure code 89240—unlisted miscellaneous pathology test—to report the evaluation of genetic expression in the peripheral blood, including, but not limited to the detection of acute heart transplant rejection or graft dysfunction, for example, AlloMap. When you report code 89240, please provide this description in the narrative section of the electronic or paper claim: “evaluation of genetic expression in peripheral blood to detect acute heart transplant rejection or graft dysfunction, for example, AlloMap.”



Also applicable to FreedomBlue.

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## **Breast reduction surgery coverage criteria explained**

Highmark Blue Shield defines cosmetic surgery as surgery performed solely to improve an individual's appearance. Cosmetic surgery is generally not eligible for payment. However, some group or customer benefits provide coverage for cosmetic surgery when it's performed to correct a condition resulting from an accident.

Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Reconstructive surgery is generally eligible for payment.

Blue Shield will cover breast reduction as reconstructive surgery when all these criteria are met:

1. When severe symptomatic hyperplasia (hypermastia) exists.
2. There must be documentation that the size and weight of the breasts are causing symptoms.

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3. There must be a minimum of 700 grams (total) removal bilaterally for patients of average stature (5'5").

For women of small stature, you can use this sliding scale to determine the required grams to be removed.

<b>Height</b>	<b>Grams</b>
5'5"	700
5'4"	650
5'3"	600
5'2"	550
5'1"	500
5'0"	465
4'11"	435
4'10"	400

Blue Shield will give individual consideration to all questionable cases or cases involving women of very small stature.

Please report breast reduction surgery with procedure code 19318—reduction mammoplasty.

Note: Act 51 of 1997, Women's Health Security Act, defines reconstructive surgery to include all surgery on the affected breast and surgery on the contralateral normal breast to re-establish symmetry between the two breasts or to alleviate functional impairment caused by the mastectomy.

Therefore, Blue Shield will cover breast reduction when it's performed on the contralateral breast to provide symmetry with the affected breast following mastectomy.



Does not apply to FreedomBlue.

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## **Electrodes and related supplies considered overhead expenses**

Beginning July 16, 2007, Highmark Blue Shield will consider these supplies part of a provider's overhead expense:

- electrodes (A4556)
- lead wires (A4557)
- conductive paste or gel (A4558)

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Blue Shield includes the cost of supplies used in providing a covered professional service with the professional service's allowance. Please do not bill for the supplies independently because Blue Shield does not pay separately for any overhead expense. A participating, preferred, or network provider may not bill the member for overhead expenses.

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



Also applicable to FreedomBlue.

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## **Measurement of long-chain omega-3 fatty acids in red blood cell membranes as a cardiac risk factor denied**

Highmark Blue Shield considers the measurement of long-chain omega-3 fatty acids in red blood cell membranes, including but not limited to its use as a cardiac risk factor, experimental or investigational. A participating, preferred, or network provider may bill the member for the denied test.

Blue Shield does not cover this testing because there is a lack of published studies that explore how the measurement of red blood cell membrane omega-3 fatty acids may be used to improve patient management.

Use procedure code 0111T—long-chain (C20-22) omega-3 fatty acids in red blood cell membranes—to report this testing.

It has been hypothesized that a diet rich in omega-3 fatty acids may contribute to a reduced risk of sudden cardiac death. Long-chain omega-3 fatty acids may be detected in the red cell membrane using gas chromatography. It has been suggested this measurement may be clinically useful as a cardiac risk factor for sudden cardiac death.



Also applicable to FreedomBlue.

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## **Blue Shield subjects Mohs chemosurgery to multiple surgery reductions**

In 2007, the American Medical Association removed the Mohs chemosurgery codes from Appendix E of its **Current Procedural Terminology (CPT)** manual. Appendix E lists CPT codes that are exempt from the use of modifier 51—multiple procedures.

Because Highmark Blue Shield uses this appendix as the “national source” for bypasses to its multiple surgery logic, Blue Shield has adopted the new guidelines for its commercial products.

# PRN

This means that, as of April 2, 2007, Blue Shield subjects the Mohs procedure previously included on Appendix E as code 17304 to multiple surgery reductions. Code 17304 has been replaced with codes 17311 and 17313. To ensure appropriate reimbursement, Blue Shield has reviewed the fees and increased them as needed.



Blue Shield's Medicare Advantage product, FreedomBlue<sup>SM</sup>, follows guidelines established by the Centers for Medicare & Medicaid Services and Highmark Medicare Services. These 2007 changes have already been implemented for FreedomBlue.

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## **Blue Shield no longer covers Oncology Demonstration Program services**

For the 2006 HCPCs update, the Centers for Medicare & Medicaid Services (CMS) introduced the **2006 Oncology Demonstration Program**. This program was associated with physician evaluation and management visits for established patients with cancer.

Highmark Blue Shield elected to offer its own voluntary program, based in part upon CMS' **2006 Oncology Demonstration Program**, for its Medicare Advantage product, FreedomBlue<sup>SM</sup>.

For the 2007 HCPCs update, CMS announced that it would stop covering codes G9050-G9139. Blue Shield also no longer covers these services for FreedomBlue when they're provided after Dec. 31, 2006.

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## **Genotyping for cytochrome p450 polymorphism considered experimental**

Highmark Blue Shield considers genotyping to determine cytochrome p450 (CYP450) genetic polymorphisms, for example, the AmpliChip microarray test, for aiding in the choice of drug or dose to increase effectiveness and/or avoid toxicity experimental or investigational. A participating, preferred, or network provider may bill the member for the denied test.

The clinical value of this type of genetic testing has not been established. Prospective studies are needed to assess the benefits and potential risks of this technology in guiding drug selection and dose adjustment.

Use procedure codes 88384-88386—array-based evaluation of multiple molecular probes, 11 through 500 probes—or codes 83890-83914 when less than 11 probes are evaluated to report this testing.

Recent advances in molecular biology have improved the understanding of genetic factors underlying many adverse drug reactions that are responsible for many debilitating side effects and are a major cause of death following drug therapy. A significant proportion of adverse drug reactions are caused by genetic polymorphism and genetically based inter-individual differences in drug absorption, disposition, excretion, or metabolism.



Also applicable to FreedomBlue.

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## Anticoagulant management guidelines outlined

Highmark Blue Shield covers anticoagulant management of patients receiving long-term anticoagulant therapy in an office or outpatient setting. Use these codes to report this service:

- 99363—anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)
- 99364—each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)

These guidelines apply to anticoagulant management services:

- To report either of these 90-day increment codes, the physician must manage the patient on anticoagulation therapy for at least 60 continuous days.
- Do not report code 99363 or 99364 if short-term anticoagulant management is completed in less than 60 days. When this occurs, report code 99211. If anticoagulant management occurs during a more complex level of an outpatient or office visit, anticoagulant management is included in the service.
- A separate Evaluation and Management (E/M) service or Care Plan oversight should not be reported with anticoagulation management services. However, if a significant, separately identifiable E/M service is performed for other clinical conditions or problems, report the appropriate E/M code with modifier 25.
- If anticoagulation therapy is initiated in the inpatient or observation setting, services provided after discharge should be reported with code 99364, and not with the initial therapy code, 99363. In this example, the initial therapy has already occurred during the inpatient service.
- If outpatient treatment is resumed after hospitalization, report subsequent outpatient therapy with code 99364.
- Anticoagulant management services are eligible in the outpatient setting only. Therefore, these codes should not be used to report services provided during observation care, hospital inpatient care, or critical care.
- Code 99363 or 99364 should not be used to report anticoagulant management services provided to patients with mechanical heart valve(s) who are receiving prothrombin time monitoring using a home device. Use code G0250—physician review, interpretation and patient management of home INR testing for a patient with a mechanical heart valve(s) who meets other coverage criteria, per 4 tests (does not require face-to-face service)—to report this service.

# PRN

- Do not report these services with codes 99371-99373 or 0074T when telephone or on-line services address anticoagulation with warfarin management.



Also applicable to FreedomBlue.

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## Select code G0380-G0384 based on level of care provided

Procedure codes G0380-G0384 represent emergency care provided in a hospital or facility that is not accessible on a 24 hours a day, 7 days a week basis.

To report these services, select the most appropriate procedure codes within the G0380-G0384 range based on the level of care provided.

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## Additional procedures eligible for co-surgery

Highmark Blue Shield now considers these procedure codes eligible for payment for co-surgery:

19271—excision of chest wall tumor involving ribs, with plastic reconstruction; without mediastinal lymphadenectomy

22857—total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace

22862—revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace

22865—removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace

39531—repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty)

49324—laparoscopy, surgical; with insertion of intraperitoneal cannula or catheter, permanent

49325—laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed

50546—laparoscopy, surgical; nephrectomy, including partial ureterectomy

58541—laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less

58542—laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)

58543—laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g

58544—laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

58548—laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed

Please be aware that other Blue Shield medical policies may impact the eligibility of these procedures.



Also applicable to FreedomBlue.

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## **Transforaminal epidural injection covered for certain indications**

Highmark Blue Shield covers transforaminal epidural injections in certain diagnostic situations and for specific therapeutic purposes.

### **Diagnostic coverage guidelines**

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Blue Shield covers transforaminal epidural injections in these diagnostic situations:

- When it's used to differentiate between diagnoses, in these instances:
  - providing assistance in distinguishing between differential diagnoses
  - pain appears to be due to a classic disease of a nerve root, but the neurodiagnostic studies have failed to provide a structural explanation
  - radiological studies demonstrate an abnormality related to an adjacent nerve root only
  - differentiate between an anatomic variation or a true positive finding of the cause of pain
  - the clinical picture is suggestive, but not typical, for both nerve root and distal nerve or joint disease
- A discrepancy exists between the demonstrated pathology and the symptoms, complaints, or findings
- Multiple sources of pain are present
- To determine whether the origin of pain is central or peripheral

# PRN

## **Covered therapeutic purposes**

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Blue Shield covers transforaminal epidural injections for these therapeutic purposes:

- Radicular pain resistant to, or patient with a contraindication to, other therapeutic means, or when surgery is contraindicated
- Post-decompressive radiculitis or post-surgical scarring
- Monoradicular pain, confirmed by diagnostic blockade, in which a surgically correctable lesion cannot be identified
- Treatment of acute herpes zoster or post-herpetic neuralgia
- Reflex sympathetic dystrophy or causalgia or complex regional pain syndrome I and II, instead of sympathetic block

## **Non-covered situations**

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Blue Shield does not cover transforaminal epidural injections when it's:

- performed without fluoroscopic or CT guidance
- used for the treatment of low back pain associated with “myofascial pain syndrome,” or for the treatment of a soft-tissue source of pain in which no nerve root pathology exists
- performed on the same day as an interlaminar or caudal epidural or intrathecal injection, facet joint or nerve block, sacroiliac joint injection, lumbar sympathetic block, or other nerve block, unless:
  1. the anesthetic response to the first injection was assessed and documented to have resulted in incomplete pain relief prior to proceeding with an additional injection, or
  2. the patient has multiple sources of pain, and also requires anticoagulants, but has discontinued the anticoagulant treatment for the pain treatment injections in order to receive multiple block injections on the same day.

To report transforaminal epidural injections, please select the appropriate procedure code within this range: 64479-64484.

Transforaminal epidural injection is a neural blockade technique used in the management of acute and chronic pain.



Also applicable to FreedomBlue.



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## Administration of vaccine for Part D drug not reimbursable

The Centers for Medicare & Medicaid Services developed code G0377—administration of vaccine for Part D drug—for its Medicare Part D drug program.

Because the code does not apply to Highmark Blue Shield's commercial products, Blue Shield does not cover it. A participating, preferred, or network provider may not bill the member for this denied service.



Does not apply to FreedomBlue.

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## 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](mailto:medicalpolicy@highmark.com).

## Codes

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### New codes available April 1, 2007

Here are six new codes that became available April 1, 2007.

<b>Code</b>	<b>Terminology</b>
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S0270	Physician management of patient home care, standard monthly case rate (per 30 days)
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S0271	Physician management of patient home care, hospice monthly case rate (per 30 days)
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S0272	Physician management of patient home care, episodic care monthly case rate (per 30 days)
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S0273	Physician visit at member's home, outside of a capitation arrangement
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S0274	Nurse practitioner visit at member's home, outside of a capitation arrangement
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S3618	Blood chemistry for free beta human chorionic gonadotropin (HCG)
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# PRN

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## Deleted codes

Here are six codes that Highmark Blue Shield has deleted. Replacement codes, if available, are listed for your reporting purposes.

<b>Code</b>	<b>Terminology</b>	<b>Date deleted</b>	<b>Replacement codes</b>
J7319	Hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection	3/31/2007	Q4083, Q4084, Q4085, Q4086
S0167	Injection, apomorphine hydrochloride, 1 mg	3/31/2007	J0364
S0820	Computerized corneal topography, unilateral	3/31/2007	92025
S1025	Inhaled nitric oxide for the treatment of hypoxic respiratory failure in the neonate; per diem	1/1/2007	No replacement code
S2213	Implantation of gastric electrified stimulation device	4/1/2007	43644, 43645, 43647, 43648
S2250	Uterine artery embolization for uterine fibroids	3/31/2007	37210

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## Terminology changes for code S9351

The terminology for procedure code S9351 changed on April 1, 2007. Here is the new terminology, with the change underlined:

Home infusion therapy, continuous or intermittent anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and visits coded separately), per diem

# 4/2007

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## 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

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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-2007, Copyright 2006, 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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