PRN
Policy Review & News

Important information about Highmark Blue Shield
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News

Blue Shield adds adultBasic and CHIP language to PremierBlue Shield preferred provider regulations

Highmark Blue Shield has revised its PremierBlue[SM] Shield preferred provider regulations to comply with the adultBasic/CHIP language. The revision consists of adding a new appendix, Appendix D, to the existing regulations. This revision will become effective on Nov. 11, 2007.

Blue Shield will send a copy of Appendix D to all of its PremierBlue Shield preferred providers.

The revision applies to this regulation:

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

Here is the adultBasic/CHIP language that has been included in Appendix D:

APPENDIX D

ADULTBASIC AND CHIP COMPLIANCE REQUIREMENTS

1. RELATIONSHIP TO THE AGREEMENT

This Appendix D becomes part of the PremierBlue Shield Preferred Provider Agreement with Highmark Blue Shield, the PremierBlue Shield Preferred Provider Agreement with Highmark Blue Shield for Primary Care Physicians in Managed Care Programs and the Highmark Blue Shield PremierBlue Shield Regulations for Preferred Providers to which it is attached and the terms of this Appendix D are incorporated therein as if the provisions hereof were added as provisions or a new section therein. Where there is a conflict between the provisions in the Agreement and this Appendix D, the provisions of this Appendix D will apply to preferred provider's participation in adultBasic/CHIP as available to adultBasic/CHIP members, as well as preferred provider's provision of services, and Blue Shield's payment for, covered services.

2. ADULTBASIC AND CHIP REQUIREMENTS

The following provisions will apply in all instances where the preferred provider is providing services to a member enrolled in adultBasic (as hereinafter defined) or CHIP (as hereinafter defined) (hereinafter "adultBasic/CHIP members"). For purposes hereof, "adultBasic" means the adultBasic Insurance Coverage Program in accordance with the Health Investment Insurance Act (Chapter 13 of Act 77 of 2001) (35 P.S. § 5701.1301 et seq.) as offered from time-to-time by Blue Shield pursuant to a contract with the Pennsylvania Insurance Department. Further, for purposes hereof, "CHIP" means the Children's Health Insurance Program in accordance with Title XXI of the Social Security Act, as amended to include the State Children's Health Insurance Act (42 U.S.C. §§ 1397aa et seq.) and the Children's Health Care Act, Article XXIII of the Insurance Company law of 1921, as amended via the Act of 1996-68 (40 P.S. §§ 991.2301 et seq. and the regulations promulgated thereunder) as offered from time-to-time by Blue Shield pursuant to a contract with the Pennsylvania Insurance Department.

2.1. Blue Shield and the preferred provider intend that these terms, as they relate to the provision of the preferred provider's services to adultBasic/CHIP members, will be interpreted in a manner consistent with applicable requirements under the Acts. The term "Acts" collectively means the Health Investment Insurance Act (Chapter 13 of Act 77 of 2001) (35 P.S. §§ 5701.1301 et seq.); Title XXI of the Social Security Act, as amended to include the State Children's Health Insurance Act (42 U.S.C. §§ 1397aa et seq.); and the Children's Health Care Act, Article XXIII of the Insurance Company law of 1921, as amended via the Act of 1996-68 (40 P.S. §§ 991.2301 et seq. and the regulations promulgated thereunder).

2.2. The preferred provider agrees to comply with all federal, state, municipal and local laws, rules and regulations applicable to its activities in rendering services to adultBasic/CHIP members. Such laws, rules and regulations include, but are not limited to, Act 68 (as hereinafter defined), the Acts (including but not limited to Article XXIII of the Insurance Company law of 1921, as amended via the Act of 1996-68); Titles VI and VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq. and 2000e et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701 et seq.); the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.); the provisions of the Americans with Disabilities Act (42 U.S.C. §12101 et seq.); the Pennsylvania Human Relations Act of 1955 (43 P.S. § 951 et seq., as amended); and applicable Laws relating to nondiscrimination, sexual harassment or fraud and abuse. For purposes of these provisions, the term "Act 68" means the Pennsylvania Quality Health Care Accountability and Protection Act (40 P.S. §§ 991.2101, et seq.) and its implementing regulations as promulgated by the Pennsylvania Department of Health and the Pennsylvania Insurance Department.

2.3. As applicable, the preferred provider and any subcontractors will respect the conscience rights of individual providers and provider organizations, and, where applicable, will comply with the Pennsylvania law prohibiting discrimination on the basis of the refusal or willingness to participate in certain abortion and sterilization-related activities, as outlined in 43 P.S. Section 955.2 and 18 Pa. C.S.A. Section 3213(d).

2.4. The preferred provider acknowledges that the payments a preferred provider receives for covered services rendered to adultBasic/CHIP members in accordance with the reimbursement rates and other payment terms and conditions contained in the Preferred Provider Agreement and these Regulations are, in whole or in part, derived from government funds and that any false or fraudulent claim or statement in any document, or any concealment of a material fact, or any other form of fraudulent activity relating to the preferred provider's involvement with adultBasic or CHIP, as the case may be, may be a cause for prosecution under applicable laws. In the event of a successful prosecution of the preferred provider related to adultBasic and/or CHIP, as the case may be, Blue Shield may, at their discretion, suspend or terminate the preferred provider's participation in adultBasic and/or CHIP, as the case may be.

2.5. The preferred provider will, at its expense, make all books, records, documents and other evidence relating to adultBasic and/or CHIP, as the case may be, and the services rendered by the preferred provider to adultBasic/CHIP members under the Preferred Provider Agreement and these Regulations, available for audit, review or evaluation by Blue Shield, applicable official bodies of the Commonwealth of Pennsylvania, or any of the preceding entities' designated representatives. The preferred provider will make such books and records available onsite, during normal business hours, or, as requested by Blue Shield or the official bodies of the Commonwealth of Pennsylvania, through the mail within fifteen (15) calendar days of any such request (in accurate, legible paper copies, unless otherwise indicated). The preferred provider will cooperate with any such review or audit by assisting in the identification and collection of any books, records, data or clinical records, and by making appropriate practitioners, other employees and involved parties available for interviews upon request.

3. TERM AND TERMINATION

This Appendix D will have the same term as the Agreement and shall immediately terminate if the Agreement terminates, in the event of a successful prosecution of a preferred provider related to adultBasic or CHIP, as the case may be, and as, described in Section 2.4. of this Appendix D Blue Shield may, at its discretion, suspend or terminate the preferred provider's participation in adultBasic or CHIP, as the case may be. The termination of this Appendix D or the preferred provider's suspension or termination from participation in adultBasic and/or CHIP, as the case may be, along shall not affect the remaining provisions of the Agreement (as it relates to members covered under network products other than adultBasic and CHIP).

4. AMENDMENTS

This Appendix D may be amended in accordance with the terms of Section A.1. of the Regulations.

5. SURVIVAL

The provisions in Section 2.5. of this Appendix D shall survive the termination of this Appendix D regardless of the cause giving rise to such termination. In addition, any of the other terms and covenants contained in this Appendix which require the performance or inaction of either party after the termination shall survive said termination.

Avoid paper claim delays and rejections: report correct number of digits for dates

If you submit paper claim forms (CMS-1500, 08/05), please follow these instructions so that you report the correct number of digits for dates:

- Report all dates of birth in the MMDDCCYY 8-digit format.

  Example: 08102007

- Report all other dates, for example, date(s) of service, in the MMDDYY 6-digit format.

  Example: 081007

  If an 8-digit format is used to report a date of service, some providers' claims software may move the last two digits of the year from the date of service section into the place of service section. The claim may then be delayed or even rejected because of an incorrect place of service code.

Additional paper claims submission tips

Here are additional tips for submitting paper claims:

- Please submit the original, red CMS-1500 (08/05) claim form.

  Contact your forms distributor to obtain a supply of this form. Your forms distributor can obtain a negative or PDF of the form from:

  - TFP Data Systems: (800) 482-9367, extension 1770, or write to them at **1500form@tfpdata.com**
  - Government Printing Office: (202) 512-0455

- The print on the claim must be dark enough to be read.
- Report data within the boundaries of the boxes on the claim form.
- If you use computer billing software to complete your CMS-1500 (08/05) paper claim form, do not use software for the previous claim form, version (12/90). This will cause the data to be misaligned and unable to be read.

Other reporting tips, as well as step-by-step instructions for completing the CMS-1500 (08/05) paper claim form, are available in Chapter 5, Unit 2, Claims Submission and Billing Information, of the **Highmark Blue Shield Office Manual**. The **Office Manual** is available online on the Provider Resource Center through NaviNet® or at **www.highmarkblueshield.com**. Once you've entered the Resource Center you can access the **Office Manual** through the Administrative Reference Materials link.

Electronic claims submission encouraged

Most Highmark Blue Shield network providers have found that submitting their claims electronically saves them time and money. So, fewer providers are using paper claim forms. If you are still submitting your claims on paper, and would like to switch to electronic claims submission, call Provider Service.

Blue Shield's documentation requirements outlined

Highmark Blue Shield's documentation requirements specify that a provider must maintain medical records for patients that accurately, legibly, and completely reflect the evaluation and treatment of the patient. Blue Shield also requires providers to make entries in the patients' medical records in a timely manner and to maintain those records for at least seven years.

Regulations issued by the Pennsylvania Board of Medical Education and Licensure support Blue Shield's documentation requirements.

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Please remember to follow these additional medical records documentation tips:

- The hospital and office records must verify that a service:
  - was actually performed,
  - was performed at the level reported, and
  - was medically necessary.
- The medical records must contain enough information to clearly identify the patient, the person making the entry if the person is not the provider, the date of the medical records entry, and the patient's complaints and symptoms.
- Include clinical information about the patient that has been accumulated by the provider, either by himself or herself or through his or her agents, in the patient's medical records.
- The medical records must include diagnoses, findings and results of pathologic or clinical laboratory examinations, radiology examinations, medical and surgical treatments, and other diagnostic, corrective, or therapeutic procedures.
- Blue Shield requires that any service or procedure be adequately documented in the patient's records. This includes diagnostic tests, medical care, surgery, and any other services eligible for payment by Blue Shield.

This information is also available in the **Highmark Blue Shield Office Manual** on Page 39 in the Claims Submission and Billing Information section, Chapter 5, Unit 2. You can find the **Office Manual** on the Provider Resource Center through NaviNet® or at **www.highmarkblueshield.com**.

When you report a procedure or service, select the HCPCS code that accurately identifies the service you performed. Do not select a procedure code that merely approximates the service provided. If a code does not exist that accurately identifies the service you performed, then report services with the appropriate unlisted procedure or service code. When you report an unlisted code, remember to include a complete description of the service you performed in the narrative section of the electronic or paper claim.

Report signs and symptoms on claims

Report diagnosis codes for the signs, symptoms, or state of a patient at the time the patient presents for service. Please report all diagnosis codes to the highest degree of specificity. Also, report the most appropriate procedure code for the service you performed.

Complete and accurate reporting of services, and the reason for those services, will expedite the adjudication of your claim and avoid unnecessary claim denials.

MA Also applicable to FreedomBlue.

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

In the April 2006 and October 2006 **PRN**, Highmark Blue Shield announced that it would no longer process claims for Independence Blue Cross (IBC) Personal Choice® and Personal Choice 65℠ 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.

Please remember, claims for members whose identification numbers begin with these alphabetical prefixes should be submitted directly to IBC:

Alphabetical prefix	Account
ADQ	American Infrastructure
AEK	Ametek
AEV	Air Products
AEW	Amerigas
AHJ	Asplundh Tree Service
BME	Benchmark Medical
BYN	Bayada Nurses
CDJ	CDI

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Alphabetical prefix	Account
CDQ	Comcast
CDZ	Communication Test Design, Inc.
CQA	QVC
CQX	Complete Healthcare Resources
DAZ	Day & Zimmermann
DGR	Draeger
DPX	Dechert LLP
DVU	Devereux
EEN	Exelon
EGD	Operating Engineers
ETF	Electronics Boutique
GCY	GMAC Commercial Holdings
GEA	Genesis
GMA	GMAC Mortgage Group
HAJ	Hajoca
HXT	Community Health Systems
INW	Iron Workers
MGL	Morgan, Lewis & Bockius
NFY	Infrasource
NLR	Neighborcare
PCX	Phila. Coca Cola Bottling
QCA	Point of Service IBC

Alphabetical prefix	Account
QCB	Personal Choice - PPO
QCM	Personal Choice - 65
SDA	Adventist Risk Management
SEZ	SEI Corporation
SFU	Steamfitters Local 420
SHQ	Sheet Metal Workers
SKH	SKF
SQT	Southco
SYJ	Sytex
SYK	Synthes
TFE	Teleflex
TLG	Teamsters Local Vicinity Fund
TRX	SunCom Wireless (formerly Triton)
UBF	Urban Outfitters
UFN	UFCW Participating Food Industry Employers
UFP	UFCW Local 1776
UFT	UFCW Tri-State H&W Fund
UTR	United Refrigeration

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

Report appropriate NAIC code on electronic claims

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).

Alert your vendor, clearinghouse, or billing service

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**.

Blue Shield reimbursement changes approved

On Aug. 1, 2007, Highmark Blue Shield adjusted its UCR Level II and PremierBlue℠ Shield payments for select surgical, diagnostic and evaluative services, including but not limited to: integumentary, digestive, urinary, obstetrical and gynecological, neurological, MRI, CT, PET, echocardiography, ophthalmologic, and evaluation and management services.

In addition, Blue Shield implemented changes to its payment differential for services performed in the facility compared to services performed in a non-facility setting. The changes will simplify pricing and will consolidate the site of service and surgical tray concepts into one methodology, similar to that used by the Medicare program. More liberal than Medicare's program, Blue Shield's payment differential:

- does not apply to diagnostic services
- applies a 15 percent differential for evaluation and management services
- calculates payment for surgical services performed in a facility setting at a maximum of Medicare's site of service differential

For more information about Blue Shield's reimbursement changes, see "Blue Shield seeks approval for UCR and PremierBlue Shield reimbursement changes" on Page 9 in the April 2007 **PRN**.

You may review a list of the 2007 global fee initiative procedure codes and corresponding adjusted fees on NaviNet® under "Administrative Reference Materials." Please be aware that provider payment allowances are for informational purposes only, are not a guarantee of payment, and are subject to change. Blue Shield may apply a site of service differential for facility-based services.

Coordination of benefits policy to be modified

Members are routinely asked to alert their insurer and health care providers if they have coverage with more than one carrier, that is, "dual coverage" or "coordination of benefits" situations. Upon enrollment and reenrollment, Highmark Blue Shield requests that all members indicate "yes" or "no," so that it can maintain their dual coverage information in its membership database and process claims correctly.

Effective in early 2008 for some lines of business, if a member's information is missing, Blue Shield will change its processing policy to allow payment of the first eligible claim only. A message on the Explanation of Benefits will alert the member that subsequent claims will be denied as billable by the provider until the member responds with a confirmation on whether or not dual coverage exists. Once the member responds with the missing information, Blue Shield will resume payment for all eligible services.

Please note that this change will not apply to some membership, including direct pay customers, and some group customers, such as self-insured.

Watch for more information about this change in a future **PRN**. Blue Shield is also planning to implement some member-targeted communications to support the collection of dual coverage information, including identification card stickers and member newsletter articles.

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.*

Blue Shield changes coverage guidelines for erythropoiesis-stimulating agents

Highmark Blue Shield changed its coverage guidelines for the erythropoiesis-stimulating agents (ESA) epoetin alfa [Epogen®, Procrit®] and darbepoetin alfa [Aranesp®] on July 9, 2007. Blue Shield made these changes because of the U.S. Food and Drug Administration's (FDA) warnings about certain dangerous side effects of ESAs.

In March 2007, the FDA issued a public health advisory outlining new safety information, including revised product labeling about ESAs.

In response to the FDA ESA alerts and labeling changes, Blue Shield updated its Highmark Medical Policy Bulletin I-7, Erythropoiesis Stimulating Agents (epoetin alfa [Epogen®, Procrit®], darbepoetin alfa [Aranesp®], to comply with the changes.

New ESA coverage guidelines

Blue Shield will determine coverage for ESAs according to the individual or group customer benefits.

Blue Shield may consider ESAs reasonable and necessary for the treatment of anemia when reversible causes of anemia are identified and managed. ESAs may be initiated when the patient's hematocrit (HCT) is less than 36 percent or when their hemoglobin (Hgb) is less than 12g/dL, and when their anemia is associated with any of these conditions:

- End stage renal disease (ESRD) (ICD-9-CM code 585.6) on dialysis, or chronic kidney disease (CKD) Stage V on dialysis

  If an ESA is administered on the same day as dialysis, Blue Shield considers it an integral part of the dialysis. The ESA is not eligible as a separate service.

  If the ESA is reported on the same day as dialysis and the charges are itemized, Blue Shield will combine the charges and will pay for only the dialysis. In this instance, Blue Shield's payment for dialysis performed on the same date of service includes the allowance for the ESA. A participating, preferred, or network provider may not bill the member separately for the ESA.

  If the ESA is given independently, report it with code J0882, J0886, or Q4081 (see "How to report an ESA" on Page 14 for each code's terminology).

- Chronic renal failure not on dialysis, or CKD Stage II-V not on dialysis (ICD-9-CM codes 585.1, 585.2, 585.3, 585.4, 585.5, 585.9)

- Renal tubular damage secondary to cisplatin chemotherapy

- Treatment of anemia associated with documented multiple myeloma

- The patient may or may not be receiving chemotherapy.

- Antineoplastic therapy

  The patient should be receiving a course of antineoplastic therapy or should have received antineoplastic therapy within the last three months.

- Acquired Immunodeficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) receiving zidovudine (AZT) therapy

All of these patient indications should apply:

- AZT doses of 4200 mg or less per week
- Endogenous levels of erythropoietin of 500 MU/ml or less
- Treatment lasting no longer than three months following the discontinuation of AZT

- Myelodysplastic syndrome

  Endogenous erythropoietin level should be less than 500 MU/ml.

- Anemia of prematurity
- Anemia associated with chronic illness

  Anemia of chronic illness is a secondary manifestation of an underlying disorder. Because anemia of chronic disease is typically not severe, epoetin alfa administration may not be the appropriate treatment of choice.

- Preoperative use

  All of these patient indications must apply:

  - Patient is undergoing noncardiac or nonvascular surgery.
  - Patient is not a candidate for autologous blood transfusion.
  - Patient is expected to lose more than two units of blood during surgery.
  - Preoperative workup has revealed that anemia is related to chronic disease.
  - Antithrombotic prophylaxis should be strongly considered for concurrent use.

If an ESA is used for any other indication, Blue Shield considers it not medically necessary; therefore, it is not covered. A participating, preferred, or network provider may not bill the member for the denied ESA.

How to report an ESA

Here are the ESA procedure codes and their corresponding terminology for your reporting purposes:

J0881—darbepoetin alfa, 1 microgram (non-ESRD use)

J0882— darbepoetin alfa, 1 microgram (for ESRD on dialysis)

J0885— epoetin alfa, (for non-ESRD use), 1000 units

J0886— epoetin alfa, 1000 units (for ESRD on dialysis)

Q4081—epoetin alfa, 100 units (for ESRD on dialysis)

MA Does not apply to FreedomBlue.

Zoledronic acid covered for Paget's disease

Highmark Blue Shield covers zoledronic acid (Reclast®), a bisphosphonic acid and inhibitor of osteoclastic bone resorption, for the treatment of Paget's disease.

If Reclast is used for any other diagnosis, Blue Shield will consider it experimental or investigational. In this instance, Blue Shield will deny the drug as not covered. A participating, preferred, or network provider may bill the member for the denied injection.

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

Use code Q4095 to report zoledronic acid (Reclast).

Reclast is FDA-approved for the treatment of Paget's disease of bone (ICD-9-CM code 731.0) in men and women. Treatment is indicated in patients with Paget's disease of bone with elevations in serum alkaline phosphatase of two times or higher than the upper limit of the age-specific normal reference range, or those who are symptomatic, or those at risk for complications from their disease, to induce remission (normalization of serum alkaline phosphatase).

A single dose of Reclast injection should not exceed 5 mg. The duration of infusion should be no less than 15 minutes.

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

The safety and effectiveness of the use of Reclast in pediatric patients have not been established.

MA Does not apply to FreedomBlue.

Treatment of ruptured aortic aneurysms with endoprostheses not covered

Highmark Blue Shield does not cover endoprostheses as a treatment of ruptured abdominal aortic aneurysms (AAA) (ICD-9-CM code 441.3) because it's considered experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Blue Shield does cover an endovascular stent-graft for non-ruptured AAAs as a treatment for these indications:

- aneurysms measuring 5.0 centimeters or greater, or,
- aneurysms measuring 4.5–5.0 that are rapidly expanding or are symptomatic.

If the endovascular stent grafting performed for a non-ruptured AAA does not meet the previous indication guidelines, Blue Shield will deny it as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service.

Select the appropriate code within this range to report endoprostheses: 34800–34834.

Also applicable to FreedomBlue.

Ear or pulse oximetry considered integral to evaluation and management services

Highmark Blue Shield considers non-invasive ear or pulse oximetry for oxygen saturation, single determination or multiple determination, an integral part of a provider's evaluation and management (E&M) service.

If ear or pulse oximetry is reported on the same day as an E&M service, and the charges are itemized, Blue Shield will combine the charges and will pay for only the E&M service. Blue Shield's payment for the E&M service performed on the same date of service includes the allowance for the ear or pulse oximetry. A participating, preferred, or network provider may not bill the member separately for these services in this case.

If an ear or pulse oximetry is performed independent of an E&M service, Blue Shield will pay for the ear or pulse oximetry.

You may add modifier 25 to the E&M service to identify it as a significant, separately identifiable service from the integral service. When you report the 25 modifier, you must explain in the patient's records that you performed a separately identifiable E&M service.

Use code 94760—non-invasive ear or pulse oximetry for oxygen saturation—to report a single determination. Report code 94761—non-invasive ear or pulse oximetry for oxygen saturation—for multiple determinations, for example, during exercise.

MA Also applicable to FreedomBlue.

Blue Shield does not cover Agile Patency Capsule

Highmark Blue Shield considers the Agile Patency Capsule experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Use code 91299 to report the Agile Patency Capsule. When you report code 91299, please provide this description in the narrative section of the electronic or paper claim: "Agile Patency Capsule."

The Agile Patency Capsule is an accessory to the PillCam video capsule. It is intended to verify adequate patency of the gastrointestinal tract in patients with known or suspected strictures before administration of the PillCam.

MA Also applicable to FreedomBlue.

Catheter ablation eligible for specific indications

Highmark Blue Shield recognizes catheter ablation as an eligible surgical procedure when it's performed for any of these indications:

Indication	ICD-9-CM diagnosis code
Accessory bypass tract arrhythmia (Wolff-Parkinson-White Syndrome)	426.7
Atrial ablation for elimination of atrial fibrillation	427.31
Atrial tachycardia or atrial flutter	427.32
Ischemic or idiopathic cardiomyopathy with ventricular tachycardia	414.8, 425.4
"Normal" supraventricular tachycardia	426.81, 426.82
Paroxysmal supraventricular tachycardia	427.0

Indication	ICD-9-CM diagnosis code
Patients without structural heart disease, that is, ischemic or idiopathic cardiomyopathy, with symptomatic sustained monomorphic ventricular tachycardia; or bundle branch reentrant ventricular tachycardia	427.1
Pulmonary vein isolation for management of atrial fibrillation	427.31
Radiofrequency catheter ablation or modification of the atrioventricular junction for ventricular rate control of symptomatic atrial tachyarrhythmias	427.89
Symptomatic sustained atrioventricular nodal reentrant tachycardia	426.89

Blue Shield considers any other uses of catheter ablation not medically necessary; therefore, they are not covered. A participating, preferred, or network provider may not bill the member for the denied surgery.

Use procedure code 93650, 93651, or 93652 to report catheter ablation.

MA Does not apply to FreedomBlue.

Corneal hysteresis determination considered experimental

Highmark Blue Shield considers corneal hysteresis determination experimental or investigational. Blue Shield will deny claims reporting this service. A participating, preferred, or network provider may bill the member for the denied service.

Use code 0181T—corneal hysteresis determination, by air impulse, bilateral, with interpretation and report—to report this procedure.

MA Also applicable to FreedomBlue.

ImmunoCyt test covered for monitoring bladder cancer recurrence

Highmark Blue Shield covers the ImmuoCyt test when it's reported as an adjunct to cytology and cystoscopy to monitor bladder cancer recurrence.

Use procedure code 88346—immunoflourescent study, each antibody, direct method—to report the ImmunoCyt test.

The ImmunoCyt test uses fluorescence immunohistochemistry using antibodies to mucin glycoprotein and a carcinoembryonic antigen. These antigens are found on bladder tumor cells. This test is intended to increase the sensitivity of cytology for the detection of tumor cells in the urine of individuals previously diagnosed with bladder cancer. It is indicated for use in conjunction with cytoscopy as an aid in the management of bladder cancer.

MA Also applicable to FreedomBlue.

Coverage guidelines for arthrocentesis modified

Except for local anesthetics, Highmark Blue Shield now pays for the cost of the drugs or biologicals used in an arthrocentesis, in addition to the procedure.

Report the appropriate code for the drug administered during the arthrocentesis.

If a separate charge for a local anesthetic is reported with an arthrocentesis, Blue Shield will deny it as not covered. A participating, preferred, or network provider may bill the member for the denied service.

MA Also applicable to FreedomBlue.

Non-invasive electrodiagnostic testing considered investigational

Highmark Blue Shield considers non-invasive electrodiagnostic testing with an automated computerized hand-held device, for example, NC-Stat, experimental or investigational. It is not eligible for coverage. A participating, preferred, or network provider may bill the member for the service.

To report this type of testing, use procedure code S3905.

Automated non-invasive nerve conduction testing has been developed to stimulate and measure neuromuscular signals that are useful in diagnosing and evaluating conditions involving nerve entrapment.

MA Does not apply to FreedomBlue.

Magnetoencephalography and magnetic source imaging now eligible

Highmark Blue Shield will pay for magnetoencephalography (MEG) or magnetic source imaging (MSI) when they're used in the presurgical evaluation of certain patients with medically refractory epilepsy in these instances:

- non-lesional superficial cortical epilepsy
- lesional epilepsy within or adjacent to the eloquent cortex
- epilepsy associated with large structural lesions
- ongoing or recurrent seizure activity following previous resections for epilepsy
- cases where the seizure focus has not been detected or well localized by traditional methods

If MEG or MSI are used for any other indications, Blue Shield considers them experimental or investigational. They are not covered. A participating, preferred, or network provider may bill the member for the denied service.

You may report MEG with code 95965, 95966, or 95967. Use code S8035 to report MSI.

MEG measures neurological activity of the brain using magnetic fields. This information can be superimposed on an anatomic image of the brain, typically an MRI, to produce a functional or anatomic image of the brain, referred to as magnetic source imaging. MEG and MSI have been found to be useful in anatomical localization of areas of seizure focus and epileptogenic lesions in the brain.

Refractory epilepsy refers to the failure of adequate trials of different classes of FDA-approved antiepilepsy medications to control seizure activity, when taken in appropriate doses and carefully monitored for effectiveness and patient compliance.

MA Does not apply to FreedomBlue.

Polysomnograms performed on portable equipment not covered

Highmark Blue Shield considers polysomnograms performed on portable equipment in any place of service experimental or investigational. This includes polysomnograms attended by a technologist, as well as unattended studies. A participating, preferred, or network provider may bill the member for the denied study.

Blue Shield does not cover portable polysomnograms because there is no evidence that the portable equipment has advanced to the point where the accuracy and quality of data equal a polysomnogram performed on standard equipment.

Use procedure code 94799—unlisted pulmonary service or procedure—to report portable polysomnograms. When you report code 94799, please include this description in the narrative section of the electronic or paper claim: "portable polysomnography."

MA Does not apply to FreedomBlue.

Blue Shield reimburses Soliris at 95 percent of AWP

Highmark Blue Shield sets its initial UCR and PremierBlue℠ Shield reimbursement at 95 percent of the average wholesale price (AWP) for all new therapeutic injections and chemotherapy drugs approved by the Food and Drug Administration (FDA) on or after Jan. 1, 2005.

These reimbursement rates will remain in effect for one year from the date the drug is first approved by the FDA. After the one-year introductory period expires, Blue Shield will price the drug or biological at 85 percent of the AWP.

Soliris was approved by the FDA on March 16, 2007. Blue Shield will price it at 95 percent of the AWP for one year.

Drug	FDA approval date	Effective date	Revision date
Soliris	March 16, 2007	March 16, 2007	March 16, 2008

MA Also applicable to FreedomBlue.

When to report code 96523

Use code 96523 to report irrigation of implanted venous access devices for drug delivery systems when the irrigation is provided on a different day from the injection or infusion service.

Highmark Blue Shield pays for subcutaneous catheter maintenance as a distinct and separate service on a day in which drug delivery through the implanted access device is not provided. Do not report procedure code 96523 if an injection or infusion through the port is provided on the same day.

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 and modifiers

These new procedure codes and modifiers became available for your reporting purposes on July 1, 2007.

Code	Terminology
K0553	Combination oral/nasal mask, used with continuous positive airway pressure device, each
K0554	Oral cushion for combination oral/nasal mask, replacement only, each
K0555	Nasal pillows for combination oral/nasal mask, replacement only, pair
Q4087	Injection, immune globulin, (Octogam), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4088	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4089	Injection, RHO (d) immune globulin (human), (RHOphylac), intravenous, 100 iu
Q4090	Injection, Hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 ml
Q4091	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4092	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4093	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)
Q4094	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)

Code	Terminology
Q4095	Injection, Zoledronic acid (Reclast), 1 mg
S3905	Non-invasive electrodiagnostic testing with automatic computerized hand-held device to stimulate and measure neuromuscular signals in diagnosing and evaluating systemic and entrapment neuropathies
S9152	Speech therapy, re-evaluation

Modifier	Terminology
KG	DMEPOS item subject to DMEPOS Competitive Bidding Program Number 1
KK	DMEPOS item subject to DMEPOS Competitive Bidding Program Number 2
KL	DMEPOS item delivered via mail
KT	Beneficiary resides in a competitive bidding area and travels to a non-competitive area and receives item from a non-contract supplier
KU	DMEPOS item subject to DMEPOS Competitive Bidding Program Number 3

Code G8300 deleted on July 1

Highmark Blue Shield deleted code G8300—clinician documented that patient was not an eligible candidate for optic nerve head evaluation during the reporting year—on July 1, 2007. There is no replacement code for G8300.

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-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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