

# PRN

## Policy Review & News

Important information about Highmark Blue Shield  
www.highmarkblueshield.com

December 2005

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### News

#### Blue Shield expands preventive schedule, benefits to address obesity epidemic

Highmark Blue Shield is addressing the growing epidemic of childhood obesity by expanding the Highmark Preventive Schedule to include coverage for services for the identification and management of obesity. All accounts whose benefits package includes the Highmark Preventive Schedule received the updated schedule. The expanded benefits became effective on Jan. 1, 2006.

This effort is part of a larger initiative that Blue Shield launched in 2002 to help fight this disease and its comorbidities, namely development and early onset of Type II diabetes and coronary artery disease.



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Blue Shield updated the Highmark Preventive Schedule to reflect these changes for children ages 0 to 18 years:

- Added obesity screening beginning at 2 years of age
  - Children with a body mass index (BMI) in the 95th percentile are eligible for two extra preventive follow-up office visits, specifically for obesity, per year with a blood pressure taken, two nutritional counseling visits, specifically for obesity, per year, and one set of recommended laboratory studies (lipid profile, hemoglobin HbA1c, AST, ALT, and fasting glucose).
  - Children with a BMI in the 85th percentile are eligible for one preventive follow-up office visit per year, specifically for obesity, with a blood pressure taken, and no additional laboratory studies.

Because of these preventive schedule changes, Blue Shield is helping health care professionals address the symptoms of obesity while children are still young and to help them form good nutrition and exercise habits as they grow toward adulthood.

## **Addressing obesity among adults**

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Blue Shield has also made inroads to prevent and treat obesity in the adult population. Blue Shield has increased emphasis on worksite wellness programs for its employer group customers. It has also created Lifestyle Returns, which offers incentives to members who take more responsibility for their health.

Blue Shield also made these changes to the Highmark Preventive Schedule, effective Jan. 1, 2006, for members ages 19 to 65+:

- Added obesity screening
  - Adults with a BMI over 30 are eligible for two follow-up preventive office visits and two nutritional counseling visits per year, specifically for obesity, and one set of recommended laboratory studies (lipid profile, hemoglobin HbA1c, AST, ALT, and fasting glucose).

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## **Blue Shield introduces new Web link for Trading Partners**

Highmark Blue Shield has created a new Web site for its Trading Partners. Trading Partners are those that conduct administrative transactions, such as claims and claim payment, electronically.

If you're a Trading Partner with Blue Shield, you can find everything you need to know about doing business with Blue Shield at [www.highmark.com/edi](http://www.highmark.com/edi).

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Here is what's available on the new Trading Partner Web site:

- online enrollment applications
- specifications
- Blue Shield informational resources, including:
  - what's new
  - technical updates
  - upcoming events and releases
  - HIPAA information

In future release phases, the Web site's functionality will become more dynamic by offering Real-time system outage alerts and secure access to your individual Trading Partner information. Trading Partners with a secure login identification will be able to view EDI data specific to them, including information about:

- provider affiliation
- demographics
- transactions
- current Trading Partner status

Once these changes are in place, Blue Shield will continue to expand the Web site's functionality by offering self-service tools for maintenance of your own information and business with Blue Shield through:

- updating demographic information
- adding or deleting providers, payers, and transactions
- moving transactions between test and production
- updating software information
- resetting reports (ERA, Acknowledgement, and Claim Status)

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## **National Provider Identifier: what you need to know**

If you're a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, you must obtain a unique National Provider Identifier (NPI) number no later than May 23, 2007.

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### **What is an NPI?**

An NPI is a unique identifier that will improve efficiency because it identifies and enumerates health care providers at the national level and eliminates the need for multiple identifiers from different health plans. The 10-digit enumeration won't contain any embedded demographic information, such as provider type or specialty.

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### **Who needs to apply?**

The NPI is applicable to both individual providers, for example, physician, physical therapist, etc., and organization providers, for example, a group practice, hospital, durable medical equipment supplier, home health agency, etc.

HIPAA-covered entities include providers who conduct their health care administrative transactions electronically. However, Highmark Blue Shield plans to use the NPI as the identifier for all providers eligible to receive one, regardless of electronic status.

If you aren't a HIPAA-covered entity, you can still obtain an NPI as long as you are considered an eligible provider under HIPAA. Having an NPI doesn't impose HIPAA-covered entity status on a health care provider.

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### **When and how should you apply?**

NPIs are now being assigned, and many providers already have obtained their NPIs. You have until May 23, 2007, to obtain an NPI, but you are encouraged to apply now. Blue Shield will notify you when you can begin using NPIs on standard transactions.

The National Plan and Provider Enumeration System (NPPES) is the central electronic enumerating system in place for this process. You can apply in several ways:

- Complete the Web-based application process online at <https://nppes.cms.hhs.gov>.
- Download and complete a paper application from the Web site, and mail it to NPPES.
- Call NPPES at (800) 465-3203, or (800) 692-2326 (TTY) for a paper application.

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### **Report your NPI to Blue Shield**

Once you've been assigned an NPI, please notify Blue Shield of your number. You can either send your NPI to Blue Shield through fax or e-mail. Be sure to include your name, Highmark Blue Shield provider number, and NPI on any submission. Blue Shield will also accept your NPPES confirmation e-mail.

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Please send your NPI information to Blue Shield through:

Fax: (800) 236-8641, or

e-mail: [PDSNPIUPDATE@Highmark.com](mailto:PDSNPIUPDATE@Highmark.com)

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## **Blue Shield adopts NAIC model COB regulation to enhance COB claims processing**

Generally, all Highmark Blue Shield benefit contracts include a coordination of benefits (COB) provision that applies when a member is covered by two or more health insurance policies. One policy is primary (it pays first), and the other policy is secondary. Typically, the plan where the patient is enrolled as the applicant will pay first. The other plan, perhaps through a spouse, will provide secondary coverage. Whatever portion of the reimbursement is not covered by the primary policy is considered through the secondary policy.

For more details on COB rules, including those related to dependent children, please review Section 14 of the **Highmark Blue Shield Reference Guide**. The **Reference Guide** is available online in the Provider Resource Center through NaviNet<sup>SM</sup> or at [www.highmarkblueshield.com](http://www.highmarkblueshield.com).

### **Blue Shield adopts NAIC model COB regulation**

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Blue Shield has decided to further enhance its COB processing by adopting the secondary payer provision of the National Association of Insurance Commissioners (NAIC) model COB regulation. All Highmark Blue Shield commercial group products and direct pay products are included. Blue Shield will not include its senior products, Medicare Advantage product, or the Federal Employee Program. While the majority of commercial business will be moved to the NAIC model, certain national accounts and larger regional accounts will have the option to not participate in this change.

The NAIC model COB regulation applies to institutional claims, professional claims, and ancillary claims. It applies to all health care professionals and providers regardless of their participating status with Blue Shield.

The Blue Cross Blue Shield Association supports the NAIC model COB regulation. This is a common industry standard and is consistent with most insurers.

Blue Shield has begun to transition accounts to the NAIC model COB regulation, starting with December 2005 renewals. The transition may take up to 12 months to complete.

Under the NAIC model COB regulation, Blue Shield's payment as secondary will be based on the difference between what the other insurer paid and what Blue Shield would have paid as primary. In no case will Blue Shield pay more than it would have paid if it was primary.

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Here is an illustration of the NAIC model COB regulation:

<b>Example</b>	<b>Charge</b>	<b>Blue Shield's allowance</b>	<b>Primary carrier's payment</b>	<b>Blue Shield's payment</b>	<b>Amount provider receives</b>
1	\$100	\$50	\$60	-0-	\$60
2	\$100	\$50	\$20	\$30	\$50

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### **Reminders for submitting COB claims**

When submitting COB claims to Highmark Blue Shield when it is the secondary payer, please include all relative information from the primary insurer, including member liability, for example, copayment, coinsurance, and deductible.

When Highmark Blue Shield processes a COB claim as the secondary payer, your Explanation of Benefits (EOB) will clearly show the amount the primary insurer paid. The EOB will also show the member's liability. A network provider cannot balance bill the member when Highmark Blue Shield made payment as the secondary payer except for any copayment, coinsurance, or deductible under the secondary policy.

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## **New Provider Relations representative introduced, other representatives' territories change**

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### **Heather Mitten named Provider Relations representative in Central region**

Heather Mitten has been named the Highmark Blue Shield Provider Relations representative for Cumberland, Juniata, Perry, and Snyder counties. Heather replaces Elaine Rebman because Elaine has changed territories.

Heather has extensive Customer Service experience and, most recently, acted as in-house support for NaviNet<sup>SM</sup>. Heather was also responsible for assisting your Provider Relations representative with resolving complex issues.

You can contact Heather at (866) 731-2045, extension 10.

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### **Elaine Rebman changes territory**

Elaine Rebman will now be handling Berks and Schuylkill counties. You can contact Elaine at (866) 731-2045, extension 7.

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### **Weatta Collins changes territory**

Margie Drew, Provider Relations representative in the Philadelphia area, retired on Oct. 3, 2005. Weatta Collins who previously serviced Berks and Schuylkill counties will now service these Philadelphia County ZIP codes: 19102, 19103, 19104, 19106, 19107, 19111, 19114, 19115, 19116, 19121, 19122, 19123, 19124, 19125, 19130, 19132, 19133, 19134, 19135, 19136, 19137, 19138, 19139, 19140, 19149, 19152, 19154.

You can contact Weatta at (866) 362-6116, extension 1.

## Policy

Highmark Blue Shield's medical policies are available online in the Provider Resource Center through NaviNet<sup>SM</sup> 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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### **Blue Shield covers Fluarix**

Highmark Blue Shield now provides coverage for the new vaccine, Fluarix<sup>TM</sup>. The Food and Drug Administration approved this vaccine on Aug. 31, 2005.

Blue Shield will determine coverage for Fluarix according to the member's contract and the Childhood Immunization Act for dependent children, as well as applicants or members and their spouses who are up to and including 20 years of age. For any other individuals, Blue Shield will base its coverage decision on the member's contract.

If you administered Fluarix on or after Aug. 31, 2005, report it with code 90656.

Fluarix is an influenza vaccine for adults that contains inactivated virus. Fluarix is approved for immunizing adults 18 years of age and older against influenza virus types A and B.



Also applicable to FreedomBlue.

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### **Report Saccades testing with code 92700**

Use procedure code 92700 to report Saccades testing. When you report the not otherwise classified code 92700, please include the description "Saccades testing" in the narrative section of the electronic or paper claim.

Highmark Blue Shield covers Saccades testing as a separate component of electronystagmography.

Saccades testing evaluates involuntary abrupt movements of the eyes to test for oculomotor and central nervous system abnormalities.



Also applicable to FreedomBlue.

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## **New guidelines for ultraviolet light therapy outlined**

### **Laser ultraviolet light therapy now eligible for treating psoriasis**

Highmark Blue Shield now considers laser ultraviolet light therapy eligible for the treatment of mild to moderate psoriasis.

Report ICD-9-CM diagnosis code 696.1 when you submit a claim for laser ultraviolet light therapy for patients with psoriasis.

Use these codes, as appropriate, to report this service:

96920—laser treatment for inflammatory disease (psoriasis); total area less than 250 sq. cm.

96921—laser treatment for inflammatory disease (psoriasis); 250 sq. cm.-500 sq. cm.

96922—laser treatment for inflammatory disease (psoriasis); over 500 sq. cm.

### **Photographs required for ultraviolet light therapy**

Beginning March 13, 2006, Blue Shield will require you to take photographs of patients being treated with any form of ultraviolet light therapy. Photographs should be taken at the initial visit and every six months during ultraviolet light therapy. The photographs should be available upon request, if Blue Shield needs them.

### **Supportive documentation not required for ultraviolet light therapy**

Blue Shield no longer requires you to submit documentation when you're requesting more than 30 ultraviolet light treatments per year.

Blue Shield determines coverage for ultraviolet light therapy according to the individual or group customer benefits.



Does not apply to FreedomBlue.

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## **Blue Shield changes eligibility criteria for treatment of hyperhidrosis**

Highmark Blue Shield now considers treatment of primary hyperhidrosis, including botulinum toxin type A, BOTOX<sup>®</sup>, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands, medically necessary for patients with focal, visible, and excessive sweating of at least six months duration without apparent cause.

The patient must have **all** of these characteristics:

- sweating is bilateral and relatively symmetrical

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- sweating significantly impairs daily activities
- episodes occur at least once per week
- the age of onset is less than 25 years
- focal sweating stops during sleep

The patient must also be classified as “severe” or a “4” on the Hyperhidrosis Disease Severity Scale (HDSS) before beginning treatment for hyperhidrosis. This four-point scale includes:

1. Sweating is never noticeable and never interferes with daily activities.
2. Sweating is tolerable but sometimes interferes with daily activities.
3. Sweating is barely tolerable and frequently interferes with daily activities.
4. Sweating is intolerable and always interferes with daily activities.

The patient must have documented treatment with 10-35 percent aluminum chloride of at least six months duration that failed to reduce the severity index scale before the initiation of BOTOX, performance of endoscopic transthoracic sympathectomy, or surgical excision of axillary sweat glands.

If you perform an endoscopic transthoracic sympathectomy or surgical excision of axillary sweat glands on a patient who does not meet all of the required criteria, including the severity level of 4 on the HDSS, Blue Shield will deny the surgery as not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied surgery.

Blue Shield will pay for BOTOX only in the treatment of primary axillary hyperhidrosis that has been inadequately managed with topical agents. If BOTOX is used to treat a patient who has palmar, plantar, or facial hyperhidrosis or primary axillary hyperhidrosis, but does not meet the required criteria nor is classified as the severity level of 4 on the HDSS, Blue Shield will deny the BOTOX. In such instances, Blue Shield considers BOTOX not medically necessary—it is not eligible for coverage. A participating, preferred, or network provider cannot bill the member for the denied BOTOX.

Hyperhidrosis is a condition involving excessive perspiration, beyond a level required to maintain normal body temperature in response to heat or exercise.



Also applicable to FreedomBlue.

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## New vaccine, ProQuad, eligible for coverage

Highmark Blue Shield now covers the new vaccine, ProQuad®. The Food and Drug Administration approved ProQuad on Sept. 6, 2005.

Blue Shield will determine coverage for ProQuad according to the member's contract and the Childhood Immunization Act for dependent children as well as applicants or members and their spouses who are up to and including 20 years of age. For all other individuals, Blue Shield will base its coverage decision on the member's contract.

If you administered ProQuad on or after Sept. 6, 2005, report it with code 90710.

ProQuad is a combination vaccine of M-M-R® II (Measles, Mumps and Rubella virus vaccine live) and Varivax® (Varicella virus vaccine live). It is indicated for simultaneous vaccination against all four of these diseases in children 12 months to 12 years of age.



Does not apply to FreedomBlue.

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## Pathology: report the service, not the method

When reporting pathology services, report the specific pathology test performed. Do not report the method by which the test was performed.

The following codes represent method codes. Highmark Blue Shield does not cover them. A participating, preferred, or network provider cannot bill the member for these services when Blue Shield denies them because of inappropriate reporting, that is, by the method.

<b>Procedure code</b>	<b>Terminology</b>
82190	Atomic absorption spectroscopy, each analyte
82397	Chemiluminescent assay
82487	Chromatography, qualitative; paper, 1-dimensional, analyte not elsewhere specified
82488	Chromatography, qualitative; paper, 2-dimensional, analyte not elsewhere specified
82489	Chromatography, qualitative; thin layer, analyte not elsewhere specified
82491	Chromatography, quantitative, column (eg, gas liquid or HPLC); single analyte not elsewhere specified, single stationary and mobile phase

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<b>Procedure code</b>	<b>Terminology</b>
82492	Chromatography, quantitative, column (eg, gas liquid or HPLC); multiple analytes, single stationary and mobile phase
82541	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; qualitative, single stationary and mobile phase
82542	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase
82543	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, single analyte, quantitative, single stationary and mobile phase
82544	Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), analyte not elsewhere specified; stable isotope dilution, multiple analytes, quantitative, single stationary and mobile phase
82664	Electrophoretic technique, not elsewhere specified
83519	Immunoassay; analyte, quantitative; by radiopharmaceutical technique (eg, RIA)
83520	Immunoassay; analyte, quantitative; not otherwise specified
83788	Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; qualitative, each specimen
83789	Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen
83883	Nephelometry, each analyte not elsewhere specified
84311	Spectrophotometry, analyte not elsewhere specified
85130	Chromogenic substrate assay

If you perform a pathology test by a method for which an appropriate code for the specific test does not exist, use the not otherwise classified code 84999. When you report code 84999, please provide a complete description of the test in the narrative field of the electronic or paper claim.



Also applicable to FreedomBlue.

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## **Total body hyperbaric oxygen therapy covered for certain conditions**

Highmark Blue Shield covers hyperbaric oxygen therapy (HBO) when it's administered in a chamber to the entire body.

Blue Shield will cover total body HBO therapy for these conditions:

- actinomycosis refractory to antibiotics and surgical treatment (039.0-039.9)
- anemia with exceptional blood loss (280.0, 285.1, 785.59)
- carbon monoxide intoxication (acute) (986)
- chronic refractory osteomyelitis (730.10-730.19)
- crush injuries and suturing of severed limbs, when loss of function, limb or life is threatened (927.00-927.09, 927.10-927.11, 927.20-927.21, 927.3, 927.8, 927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0, 929.9)
- cyanide poisoning (987.7, 989.0)
- decompression illness (993.3)
- gas embolism (958.0, 999.1)
- gas gangrene (040.0)
- necrotizing fasciitis (728.86)
- osteoradionecrosis as an adjunct to conventional treatment (526.89)
- peripheral arterial insufficiency (acute) (444.21-444.22)
- preparation and preservation of compromised skin grafts (V42.3)

This is not intended to cover preparation for an initial skin graft. Blue Shield only covers attempts to preserve an existing skin graft that is compromised, that is, showing signs of failure or rejection, dying tissue, etc.

- soft tissue radionecrosis as an adjunct to conventional treatment (990)
- traumatic peripheral ischemia (acute), when loss of function, limb, or life is threatened. (927.00-927.09, 927.10-927.11, 927.20-927.21, 927.3, 927.8, 927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0, 929.9)

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- prophylactic pre- and post-treatment for member undergoing dental surgery of a radiated jaw (V07.8, V07.9)

Blue Shield will deny HBO therapy as not medically necessary when it's used for any other conditions. A participating, preferred, or network provider cannot bill the member for the denied therapy.

Topical application of oxygen does not meet Blue Shield's definition of HBO therapy. Blue Shield considers it investigational. A participating, preferred, or network provider can bill the member for the denied therapy.

### **HBO therapy coverage expanded for treating lower extremity diabetic wounds**

Blue Shield has expanded total body HBO therapy to include coverage for the treatment of diabetic wounds of the lower extremities in patients who have:

- Type I or Type II diabetes and a lower extremity wound that is due to diabetes (250.70-250.73, 250.80-250.83, 707.10-707.19),
- a wound classified as Wagner grade III or higher, and,
- failed an adequate course of standard wound therapy.

Blue Shield will cover the use of HBO therapy as an adjunctive therapy only after there are not measurable signs of healing for at least 30 days of treatment with standard wound therapy. The HBO therapy must be used in addition to standard wound care. Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days.

Wounds must be evaluated at least every 30 days during the administration of HBO therapy. Blue Shield will not cover continued treatment with HBO therapy if measurable signs of healing have not occurred within any 30-day period of treatment.

Standard wound care in patients with diabetic wounds includes:

- assessment of a patient's vascular status and correction of any vascular problems in the affected limb, if possible,
- optimization of nutritional status and glucose control,
- debridement by any means to remove devitalized tissue,
- maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings,
- appropriate off-loading, and,
- the necessary treatment to resolve any infection that might be present.



Also applicable to FreedomBlue.

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## How to report allergy immunotherapy-whole body extract

Procedure code 95170—professional services for the supervision and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)—is intended for reporting only the whole body arthropod or arachnoid extract preparation technique.

For example, whole body fire ant extract should be reported with code 95170. Although dust mites are environmental arthropods, they are not considered biting or stinging insects; therefore, do not report code 95170.



Also applicable to FreedomBlue.

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## Blue Shield allows botulinum toxin type A for more conditions

Highmark Blue Shield now covers botulinum toxin type A, BOTOX<sup>®</sup>, for the treatment of these additional conditions:

- Multiple sclerosis (340)
- other demyelinating diseases of central nervous system (341.8)
- demyelinating disease of central nervous system, unspecified (341.9)
- quadriplegia and quadriparesis (344.00-344.09)
- paraplegia (344.1)
- diplegia of upper limbs (344.2)
- monoplegia of lower limb (344.30-344.32)
- monoplegia of upper limb (344.40-344.42)
- unspecified monoplegia (344.5)
- late effects of cerebrovascular disease (438.20-438.22, 438.30-438.32, 438.40-438.42, 438.50-438.53)

Use code J0585 to report botulinum toxin type A injections.

Blue Shield will pay for electromyography guidance when it's needed for botulinum toxin type A injections.



Does not apply to FreedomBlue.

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## **Coverage guidelines clarified for home-based, real-time cardiac surveillance monitoring**

Highmark Blue Shield will pay for home-based, real-time cardiac surveillance monitoring for patients who have demonstrated a need for cardiac monitoring and who:

- require monitoring for known, non life-threatening arrhythmias, such as atrial fibrillation, other supra-ventricular arrhythmias, evaluation of various bradyarrhythmias, and intermittent bundle branch block,
- are recovering from coronary artery bypass graft surgery or valve replacement surgery who have had documented atrial arrhythmias,
- have symptomatic underlying structural disease,
- do not have structural heart disease but who have recurrent severe symptoms, that is, recurrent syncope, in whom all testing is negative and an implantable event recorder is contemplated, or
- have uncontrolled atrial fibrillation post-pneumectomy.

The patient must also have one of these conditions or diagnoses for Blue Shield to allow home-based, real-time cardiac surveillance monitoring:

- atrioventricular block, complete (426.0)
- atrioventricular block, other and unspecified (426.10-426.13)
- left bundle branch hemiblock (426.2)
- other left bundle branch block (426.3)
- right bundle branch block (426.4)
- bundle branch block, other and unspecified (426.50-426.54)
- other heart block (426.6)
- anomalous atrioventricular excitation (426.7)
- other specified conduction disorders (426.81, 426.82, 426.89)

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- conduction disorder, unspecified (426.9)
- paroxysmal supraventricular tachycardia (427.0)
- atrial fibrillation (427.31)
- atrial flutter (427.32)
- supraventricular premature beats (427.61)
- sinoatrial node dysfunction (427.81)
- syncope and collapse (780.2)

To report home-based, real-time cardiac surveillance monitoring, use code 93799—unlisted cardiovascular service or procedure. When you report code 93799, please include the description “ECG arrhythmia detection and alarm system” in the narrative section of the electronic or paper claim.

You can report this service once per day. Monitoring should not exceed 14 days. If you report this monitoring for longer intervals, Blue Shield will give the services individual consideration based on documentation that supports the medical necessity of the continued surveillance.

Home-based, real-time cardiac surveillance monitoring is performed by means of an automatically activated device. The device does not require patient intervention to either capture or transmit an arrhythmia when it occurs. This device provides an analysis and report of 24 hours of monitoring, similar to Holter studies. Therefore, the simultaneous use of cardiac surveillance, Holter monitoring, and/or event monitoring would not be medically necessary.



Also applicable to FreedomBlue. There is one exception for FreedomBlue providers, you must bill one unit for procedure code 93799 per a course of treatment that includes up to 21 consecutive days of cardiac monitoring.

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## **Endovascular aneurysm repair coverage guidelines explained**

Here are Highmark Blue Shield's coverage guidelines for endovascular aneurysm repairs.

### **Abdominal aortic aneurysm**

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Blue Shield will cover endovascular stent-grafting for abdominal aortic aneurysms (34800-34834) and associated radiological services (75952, 75953) when they're performed as treatment for:

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

If endovascular stent grafting is reported for any other indications, Blue Shield considers it not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied service.

### **Iliac artery aneurysm**

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Blue Shield pays for endovascular stent grafting for iliac artery aneurysms (34808, 34825, 34826, 34900) and associated radiology services (75954).

### **Thoracic aortic aneurysm**

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Blue Shield covers endovascular stent grafting for descending thoracic aortic aneurysms (0033T-0037T) and associated radiology services (0038T-0040T) when they're performed to treat aneurysms of 23-37 mm of inner aortic diameter. An endoprosthesis that's been approved by the Food and Drug Administration, for example, GORE TAG, must be used.

Blue Shield does not cover endovascular stent grafts when they're used to treat thoracic aortic arch aneurysms or aortic dissections (37799). Blue Shield considers these grafts investigational. A participating, preferred, or network provider can bill the member for the denied service.



Also applicable to FreedomBlue.

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## **Blue Shield covers surgery for inserting post-cataract presbyopia-correcting IOL**

Highmark Blue Shield does not cover a presbyopia-correcting intraocular lens (IOL), for example, CrystaLens, RESTOR, ReZoom.

If the patient chooses to have a presbyopia-correcting IOL inserted after cataract surgery, Blue Shield will deny the IOL. However, Blue Shield will pay for the surgical procedure.

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Blue Shield will deny any additional pre- and postoperative services beyond those typically provided in conjunction with a cataract extraction with insertion of a standard IOL.

The participating, preferred, or network provider must obtain a signed agreement from the patient before surgery. By signing the agreement, the patient assumes responsibility for the entire cost of the presbyopia-correcting IOL and any additional pre- and postoperative services beyond those typically provided in conjunction with a cataract extraction with insertion of a standard IOL. You must retain the signed agreement in the patient's medical records. The agreement must be available if Blue Shield requests a copy.

If a participating, preferred, or network provider does not obtain a signed agreement before surgery, he or she will be liable for the cost of the presbyopia-correcting IOL and any additional pre- and postoperative services beyond those typically provided in conjunction with a cataract extraction with insertion of a standard IOL.

If a presbyopia-correcting IOL is inserted only for the correction of refractive errors, not for cataract surgery, Blue Shield will deny the lens, the surgical procedure, and all pre- and postoperative care as not covered. A participating, preferred, or network provider can bill the member for the denied services.

Use code L8699 to report a presbyopia-correcting IOL. When you report code L8699, please include the term "presbyopia-correcting intraocular lens" along with the brand name of the specific lens, in the narrative section of the electronic or paper claim.

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

A presbyopia-correcting intraocular lens is an artificial lens used to correct the visual impairment of aphakia after cataract surgery. It is intended to restore a patient's ability to see objects far away and near, in most cases without the use of contacts or eyeglasses. A presbyopia-correcting intraocular lens can also be used solely to correct refractive errors.



Does not apply to FreedomBlue.

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## **New diagnostic criteria determines eligibility of pulmonary hypertension treatment**

Beginning March 13, 2006, Highmark Blue Shield will require that you perform a Doppler echocardiography, and/or direct measurement of pulmonary arterial pressure to confirm a diagnosis of pulmonary hypertension.

Blue Shield defines pulmonary arterial hypertension as a mean pulmonary arterial pressure of greater than or equal to 25 mmHg, with a pulmonary capillary wedge pressure of less than 15 mmHg. The results from the Doppler echocardiography or direct measurement of pulmonary arterial pressure must meet Blue Shield's pulmonary hypertension diagnosis requirements.

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Blue Shield determines coverage for the treatment of pulmonary hypertension according to individual or group customer benefits. If the member has this benefit, Blue Shield will cover treatment for pulmonary hypertension if the results from the diagnostic procedures prove that the patient does have pulmonary hypertension, and if the patient meets Blue Shield's diagnosis criteria for the drugs used to treat this condition.

## **Pulmonary hypertension medications allowed for certain conditions**

Blue Shield covers epoprostenol sodium (Flolan<sup>®</sup>), treprostinil (Remodulin<sup>®</sup>), and iloprost (Ventavis<sup>®</sup>) when they're used to treat pulmonary hypertension. The patient must have a certain diagnosis that has not responded to conventional therapy.

Here are the diagnosis requirements for each drug:

### **Flolan**

Blue Shield will cover treatment with continuous intravenous infusion of Flolan (J1325) for patients who have:

- Primary pulmonary hypertension (416.0) and associated New York Heart Association (NYHA) Class III or IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy,
- Secondary pulmonary hypertension (416.8) related to congenital heart disease and associated NYHA Class III or IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy, or,
- Secondary pulmonary hypertension (416.8) related to connective tissue diseases, that is, scleroderma, CREST syndrome, systemic lupus erythematosus, and associated NYHA Class III or IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy.

### **Remodulin**

Blue Shield will cover treatment with continuous subcutaneous infusion of Remodulin (J3285) for patients who have:

- Primary pulmonary hypertension (416.0) and associated NYHA Class II, III, or IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy,
- Secondary pulmonary hypertension (416.8) related to congenital heart disease and associated NYHA Class II, III, or IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy, or,
- Secondary pulmonary hypertension (416.8) related to connective tissue diseases, that is, scleroderma, CREST syndrome, systemic lupus erythematosus, and associated NYHA Class II, III, or IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy.

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## **Ventavis**

Blue Shield will cover treatment with inhalation administration of Ventavis (Q4080) for patients who have:

- Primary pulmonary hypertension (416.0) and NYHA Class III or Class IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy, or,
- Secondary pulmonary hypertension (416.8) related to collagen vascular disease, congenital systemic-to-pulmonary shunt, portal hypertension, Human Immunodeficiency Virus (HIV) infection, drugs and toxins, and appetite suppressants; and persistent pulmonary hypertension of the newborn and NYHA Class III or Class IV symptoms that do not respond adequately to conventional therapy, for example, oral vasodilator therapy.

Ventavis is formulated for inhalation only through an aerosol delivery system. Before Aug. 24, 2005, the only delivery system available was the Prodose<sup>®</sup> Adaptive Aerosol Delivery (AAD) System. On Aug. 24, 2005, the Food and Drug Administration (FDA) approved the I-Neb Adaptive Aerosol Delivery (AAD) System for use with Ventavis inhalation solution.

Blue Shield will deny treatments with Flolan, Remodulin, or Ventavis as not medically necessary when they are used for conditions other than those approved by the FDA. A participating, preferred, or network provider cannot bill the member for the denied treatment.

If Flolan, Remodulin, or Ventavis are used in combination with each other, Blue Shield will deny them as not medically necessary. The FDA has not approved these drugs to be used as combination therapy with each other. A participating, preferred, or network provider cannot bill the member for the denied drug.

### **Tracleer and Revatio available through member's retail prescription drug benefit**

Bosentan (Tracleer<sup>™</sup>) and sildenafil (Revatio<sup>™</sup>) are indicated for the treatment of pulmonary hypertension. They are available only through the member's retail prescription drug benefit.

Because the FDA has not approved the use of Tracleer or Revatio along with Flolan, Remodulin, or Ventavis, Blue Shield will deny them as not medically necessary when any are used as combination therapy with each other. A participating, preferred, or network provider cannot bill the member for the denied drug.



Does not apply to FreedomBlue.

# 12/2005

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## **Blue Shield expands coverage for vitrectomy**

Highmark Blue Shield now pays for a vitrectomy (65810, 67005, 67010, 67036, 67038, 67039, 67040) when it is used to treat patients with vitreous opacities, vitreous membranes and strands, and vitreous prolapse.

Report these ICD-9-CM diagnoses codes, as appropriate, when you submit a claim for a vitrectomy:

- vitreous opacities (379.24, 743.51)
- vitreous membranes and strands (379.25)
- vitreous prolapse (379.26)



Also applicable to FreedomBlue.

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## **Attention NaviNet providers: unlisted procedure code fee bulletin now available**

Now you can find fees for frequently reported not otherwise classified (NOC) procedures in a fee bulletin on Highmark Blue Shield's Provider Resource Center through NaviNet<sup>SM</sup>.

These procedures do not have national procedure codes established. They are reported under NOC procedure codes.

The online fee bulletin contains a listing that is categorized by body section.

When assistant surgery and co-surgery procedures are reported with an NOC code and those procedures are not listed on the fee bulletin, Blue Shield reviews their eligibility on an individual consideration basis. If assistant surgery or co-surgery procedures are listed on the fee bulletin, they are eligible subject to the terms of the member's benefits.



Also applicable 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).

# PRN

Patient News – Information about your patients who are Highmark Blue Shield customers

## Central and Eastern Region

### New Jersey Plus business transitioned Jan. 1, 2006

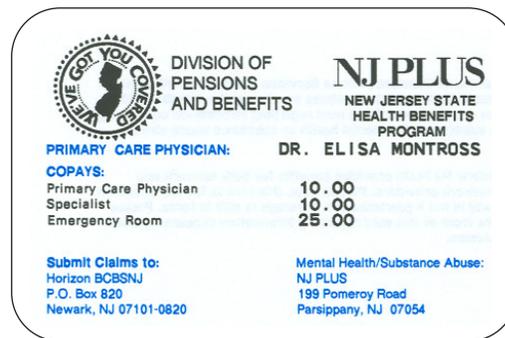
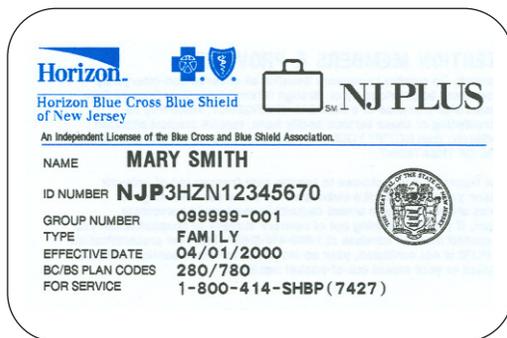


On Jan. 1, 2006, Horizon Blue Cross Blue Shield of New Jersey, administrator of NJ PLUS, stopped using the Independence Blue Cross Personal Choice network within Pennsylvania. Instead, they transitioned this par point-of-service product to an indemnity-based program for the purpose of BlueCard processing.

This change will not affect the way Horizon Blue Cross Blue Shield administers the NJ PLUS point-of-service plan. However, it will affect the way you, as a Highmark Blue Shield participating provider, report services for the NJ PLUS members you treat today.

Horizon Blue Cross Blue Shield is aggressively expanding its network of primary care physicians (PCP) in Pennsylvania with a focus on those PCPs who now provide services to NJ PLUS members. If you are a Highmark Blue Shield participating PCP, and you have not joined Horizon's network, you may still treat NJ PLUS members. Your participating provider agreement with Highmark Blue Shield will allow you to be considered an in-network provider for these members. If you are a Highmark Blue Shield participating specialist you will also be considered an in-network provider for these members.

You can recognize these members by the alphabetical prefix **NJP** on their identification card:



If you provide services for an NJ PLUS member before or on Dec. 31, 2005, submit those claims with the member's Social Security number based identification number. If you provide services for an NJ PLUS member on or after Jan. 1, 2006, report the member's new personal identification number on those claims.

If you do not contract directly with Horizon Blue Cross Blue Shield and you are an electronic biller, please refer to Highmark Blue Shield's **Provider EDI Reference Guide** for payer identification instructions on claims for specific dates of service for NJ PLUS members. You can find the **EDI Reference Guide** in the Specifications section of the EDI Trading Partner Web site at [www.highmark.com/edi](http://www.highmark.com/edi). The instructions are explained in detail on the "837P Payer ID Chart" in the **EDI Reference Guide**.

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If you do not contract directly with Horizon Blue Cross Blue Shield and you submit paper claim forms, send your claims for NJ PLUS members to Highmark Blue Shield to be processed through BlueCard.

Send paper claims for NJ PLUS members to:

Highmark Blue Shield  
PO Box 890062  
Camp Hill, Pa. 17089-0062

or

Highmark Blue Shield  
PO Box 890072  
Camp Hill, Pa 17089-0072

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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. 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

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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-2005, Copyright 2004, 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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# PRN

## Policy Review & News

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