PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

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In This Issue

MA

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News

Direct payment to provider from a member's health care account: new option now available

Through its BlueAccount[SM] program, Highmark Blue Shield now offers a new payment option to its members with a Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), or Flexible Spending Account (FSA). As of Jan. 1, 2007, these members can opt to have their member liability paid directly to the provider from their health care account.

Health care accounts/direct-payment-to-provider option

In today's marketplace, many employers are choosing higher deductible plan options to help them manage the rising costs of health care. Through BlueAccount, Highmark Blue Shield members can open a health care spending or savings account (collectively known as "health care accounts") and use it to fund all or part of the deductible or coinsurance amounts for which they are responsible.

You may have already encountered this arrangement, because many Blue Shield members have such an account and may have used the associated debit card to pay their copayments at the time of service. The direct-payment-to-provider arrangement is another option members can select for handling cost-sharing amounts for which they are responsible. Effective January 2007, members who have funds in an HSA, FSA, or HRA can opt to have such liabilities automatically "rolled over" to access and make payment from their health care account.

Determining whether the member has chosen the direct-payment-to-provider option

To determine whether a Blue Shield member has chosen to have his or her liability paid directly to the provider from a health care account, check the NaviNet® Eligibility and Benefits function. Beginning in mid-January 2007, if the member has chosen this option, the following message will appear in the Product field, along with the name of the product under which the member has coverage: "Direct Payment to Provider – Yes." Members have the capability of selecting or deselecting this option at any time.

For members who have not chosen this option, the Product field will contain only the name of the product under which the member has coverage.

Another helpful function on NaviNet is the Benefit Accumulator. This function reflects the status of a member's deductible, based on all claims finalized and processed to date.

Full or partial payment, depending upon available funds

While employers and/or employees have the option to fund a health care account all at once at the beginning of the year, in most cases the funding is a gradual pay-period-by-pay-period process. As a result, on any given date of service, there may or may not be sufficient funds in the member's account to pay the entire amount due to the provider.

- If the member's health care account contains funds sufficient to pay the entire amount due, that amount will be paid to the provider through the remittance process.

- If the account does not contain sufficient funds for the entire amount due, the provider will receive whatever amount is available in the health care account and can then bill the member directly for the remainder. Note: as subsequent deposits are made and additional funds become available in the account, the member will receive the reimbursement.

Documenting payment from a member's health care account

Blue Shield will provide several types of documentation when payment is made directly to a provider from a member's health care account, as described below:

Explanation of Payment (EOP)

Whenever a full or a partial payment is made to the provider, both the member and the provider will receive an Explanation of Payment, or EOP, to document the transaction. NaviNet-enabled providers will receive their

EOPs through the NaviNet EOB and Remittance Inquiry function. Providers who don't have NaviNet will receive paper EOPs in the same manner as paper EOBs.

Please note that if you collected payment upfront, and subsequently receive payment through an EOP, be sure to issue the refund directly to the member.

Electronic Remittance Advice (835 transaction)
For providers receiving the Electronic Remittance Advice (ERA), Blue Shield will create a separate 835 transaction (ST to SE Segments) to document the payment from the member's health care account.

In order to make clear the relationship between Blue Shield's payment and the corresponding payment from the member's health care account, Blue Shield will use a model familiar to providers. Although this is clearly not a true coordination of benefits situation, for purposes of the ERA only, Blue Shield will treat its own payment as primary and the payment from the member's account as secondary to it. That is, the 835 transaction representing payment from the member's spending account will have the code attributes of a secondary claim payment. This 835 reporting model is designed to make use of the functionality available through providers' existing automated payment posting software.

Here is the process:

- A standard 835 transaction will be created to document Blue Shield's payment.
- Then, if the member has a health care account, has selected the direct-payment-to-provider option, and has funds available in the account, Blue Shield will create another 835 transaction to document how remaining liabilities were addressed by the payment from the member's account.

The additional 835 transaction, containing the health care account payments, will have the same structure as the 835 transactions Blue Shield currently produces. The health care account 835 transactions (ST to SE Segments) will be included in the Trading Partner's transmission file (ISA to IEA Segments) currently produced for Blue Shield.

Trading Partners will be able to distinguish the health care account 835 by these features:

- Loop 1000A, N102 – The Payer Name will be "Highmark Health Care Account."
- Loop 2100, CLP02 – The Claim Status Code for all claims contained in the 835 transaction will equal "2 – Processed as secondary."
- Loop 2100 or Loop 2110, CAS Segment – The Claim Adjustment Group and Reason Code will be OA23 for all dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.

Example: 835 Segments documenting payment from Blue Shield and payment from the member's account

In the example below, the provider's charge is $200. The Blue Shield allowance for the procedure is $180, leaving a contractual obligation of $20. Blue Shield applies $130 of that amount to the patient's deductible and pays the remaining $50 to the provider. This is spelled out in the "primary" example below, on the left.

The right side of the example below displays the way the member liabilities were handled through the member's health care account, as it would appear on the 835 transaction. The entire patient deductible of $130 is being reimbursed by the member's account. The $70 difference ($20 contractual obligation plus $50 paid by Blue Shield) between the $200 charge and the $130 payment from the member's account is assigned a Claim Adjustment Group and Reason code of OA23 – "Other Adjustment/Payment adjusted due to the impact of prior payer(s) adjudication, including payments and/or adjustments."

Example:

Highmark Payment (Primary)	**Highmark Health Care Account Payment (Secondary)**
N1^PR^HIGHMARK~	N1^PR^HIGHMARK HEALTH CARE ACCOUNT~
CLP^ABC123^1^200^50^130^12^0123456789~	CLP^ABC123^2^200^130^^12^0123456789~
NM1^QC^1^DOE^JOHN^^^^MI^33344555510~	NM1^QC^1^DOE^JOHN^^^^MI^33344555510~
SVC^HC>99245^200^50~	SVC^HC>99245^200^130~
DTM^150^20060301~	DTM^150^20060301~
DTM^151^20060304~	DTM^151^20060304~
CAS^CO^45^20~	CAS^OA^23^70~
CAS^PR^1^130~	

Software coding changes may be needed to accommodate this new reporting practice for direct payments from health care accounts. Please be sure to share this important information with your billing or collections staff and/or software vendor or Trading Partner. Remind them to reference the **Provider EDI Reference Guide** on Blue Shield's Trading Partner Portal.

Other patient liability

This new direct-payment-to-provider option from a member's health care account does not eliminate your ability to collect patient liability, such as copayments or other outstanding balances, due at the time of service.

Blue Shield adds subscriber name to member ID cards in 2007

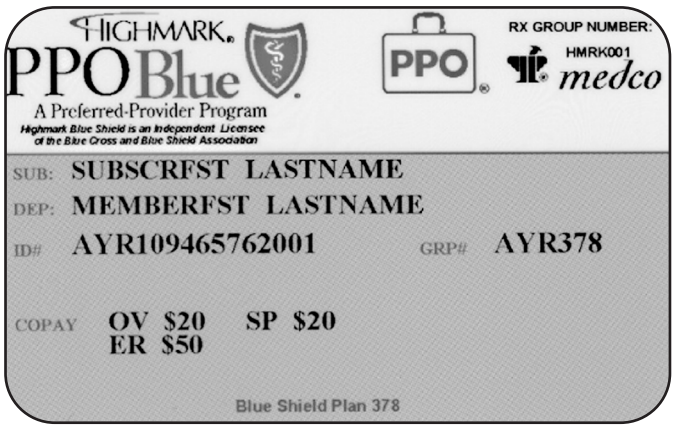
On Jan. 1, 2007, Highmark Blue Shield began adding subscribers' names to member identification cards.

This change is being made to eliminate confusion about the identity of the Blue Shield patient who is receiving care versus that of the Blue Shield subscriber.

As you know, the name you see currently on many Blue Shield member ID cards may be a dependent and not the actual plan subscriber—the person under whom the coverage has been established through a Blue Shield customer group, such as an employee who receives group coverage from his or her employer. The exception would be ID cards for any FreedomBlue℠ member; in this case, the Medicare Advantage member would also be the subscriber.

Adding the subscriber name to the member ID card—so both the card-bearing member or patient and subscriber names appear—will help you to submit more accurate claims to Blue Shield. You must include the subscriber's name on all claims, along with the identification number and name of the member or patient who received the service.

The switch to the new ID cards will occur gradually, so not all Blue Shield members will receive them at once. That means that for some time, you'll see both the "old" and "new" versions of the ID cards. Below is a sample of what a new ID card featuring a subscriber name will look like; the only change will be the addition of the subscriber name.



When you submit claims for payment to Blue Shield, remember to always include both the member's or patient's name and the subscriber's name. If the patient presents an ID card that doesn't include the subscriber's name, please ask the patient at the time of service to verify the name of the subscriber under whom the coverage has been established.

Although rare, in cases where the member's or patient's ID card indicates that the subscriber is not covered, NaviNet® will show that the subscriber does not have eligibility under the same group as the member or patient. Subscriber ineligibility may be due to many reasons, but the subscriber's status does not reflect eligibility of the member or patient and should not impact the filing of member or patient claims.

Blue Shield streamlines claims refund process

On Jan. 19, 2007, Highmark Blue Shield implemented more enhancements to streamline its claim refund process. These enhancements are the result of suggestions from the provider community.

Please share the following important information with your billing or collections staff, and/or software vendor or trading partner.

Background

In the October 2005 and October 2006 **PRN**, Blue Shield explained the new procedures through which it receives and processes claim overpayments. You can find these issues of **PRN** by using the Publications & Mailings link on the Provider Resource Center, accessible through NaviNet® or at **www.highmarkblueshield.com**. Blue Shield also posted information in the **Provider EDI Reference Guide**, which explains how these procedures impact the Electronic Remittance Advice (ERA) 835 transaction. You'll find this communication on the Provider Resource Center under Electronic Data Interchange (EDI) Services and Specifications.

New offset option to streamline claims refund process

As of Jan. 19, 2007, you will have a convenient, new choice in how to deal with an overpayment that was identified by Blue Shield. Blue Shield will notify you on your paper Explanation of Benefits (EOB) notice or through your ERA—if you receive an 835 transaction.

You will have 60 days to appeal, or you may submit a refund check according to the current process. If you do plan to appeal, please do so within the 60-day window. This will allow enough time to complete the appeal review before the scheduled check or electronic fund transfer (EFT) reduction.

A new option, added for your convenience, is the automatic offset—meaning that if you do not take action within 60 days, Blue Shield will automatically proceed to offset the overpayment from your check or EFT. This new option eliminates your having to write and send checks to Blue Shield.

Streamlining the claim-level detail and automated offset option into the EOB and ERA will help you incorporate all overpayment information into your EOB or ERA account receivable process, rather than rely on separate mailings that can be misplaced. With the exception of difficult refund cases, this new process will eliminate Blue Shield's form letters that contain the details of an overpayment.

Paper process: new page added to EOB

You'll see a new page—"Future Offset Detail"—in your EOB. This page will show claim overpayments that have been identified by Blue Shield. The overpayments displayed will be offset from the provider check or EFT payment in approximately 60 days. (Note: claim overpayments identified by you will continue to be displayed on the existing "Claim Detail" page of your EOB. These claim overpayments will continue to be immediately eligible for offset from the provider check or EFT payment.)

To assist you with reconciling your accounts, you will receive up to four pages with your EOB:

- Provider and Payment Summary, summarizing the payments and offsets for this EOB
- Provider Offset Summary, detailing offsets applied to this EOB
- Claim Detail, detailing the adjudication of the claims that finalized for the week; will continue to include overpayments identified by the provider
- Future Offset Detail, detailing the new overpayments identified by Blue Shield during this week and providing you 60 days to appeal

Electronic (835) process

In the 835 transaction, a Blue Shield-identified overpayment will be reflected in the same manner as a provider-identified overpayment. The refund detail will be shown through a reversal claim (Claim Status Code CLP02=22) and a corrected claim (Claim Status Code CLP02=1, 2, 3, or 4). The difference is that a Blue Shield-identified overpayment check or EFT deductions will be delayed 60 days from the date of notification to allow for an appeal. If you plan to appeal, please do so within the 60-day window. This will allow enough time to complete the appeal review before the scheduled check or EFT reduction.

The delay in deducting the overpayment is accomplished in the 835 by reporting a negative offsetting PLB Segment dollar amount with the PLB Adjustment Reason Code = WO.

You may delay auto-posting these refund adjustments to your Account Receivable (AR) systems due to the potential for appeal. To assist trading partners and providers with AR system management of these refund claims, these two identification features are being implemented:

- Claim Sorting with the LX Segment—Before, only one LX segment was reported in the 835. With the Jan. 19, 2007 change, 835 transactions that include Blue Shield-identified overpayments will have a second LX Loop. This is a similar sorting process as reflected on the provider's paper EOB notice.
  - The claim sort where LX01=1 will contain all claims presently reflected in the 835 today (paid, denied, adjusted, provider-identified overpayments).
  - The claim sort where LX01=2 (NEW Sort) will contain the Blue Shield-identified overpayment Reversal and Correction claims.
- Unique PLB Reference Identification (PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, or PLB13-2)—For Blue Shield-identified overpayments, the PLB Reference Identification associated to the offsetting dollar amounts will contain the claim number from the reversal and correction detail followed by the word "DEFER" with no space.

Example "06123456789DEFER"

If you do not file an appeal before the 60-day review period expires, Blue Shield will assume you agree with the refund request. You should update your AR system accordingly. Blue Shield will automatically deduct the overpayment from a future check or EFT. The deduction will be reflected in the PLB Segment of the 835.

- The PLB Adjustment Reason Code will be WO.
- The PLB Reference Identification will contain the claim number from the reversal and correction claim.

Please alert your software vendor or trading partner

Software coding changes may be needed to accommodate this new reporting practice for overpayments. In early October 2006, Blue Shield communicated the technical details of this change to all clearinghouses, billing services, and practice management software vendors through the **Provider EDI Reference Guide** on Blue Shield's Trading Partner Portal.

Special exception

Blue Shield will not use this process when refunds are requested as a result of postpayment review of a provider's practice pattern.

Claim acknowledgment reports to improve in 2007

Please share this information with your billing staff, clearinghouse, and practice management software vendors, as software coding changes may be needed to accommodate this new information.

Highmark Blue Shield will update the 277 Claim Acknowledgment (X12 transaction) and the Claim Acknowledgment printable report in April 2007 to include more detailed information about electronic claim (837) submission edit rejections.

The enhanced status will include using additional claim status category codes and combining multiple status codes for errors resulting from related claim data elements.

New claim status category codes to be used in 2007

The Claim Acknowledgment currently uses these claim status category codes to indicate the general status:

A0—Acknowledgment/forwarded to another entity

A2—Acknowledgment/acceptance into the adjudication system

A3—Acknowledgment/returned as unprocessable

Although Blue Shield will continue to use the general "A3" category code for some rejection claim statuses, in April 2007, it will use additional claim status category codes to define the reason the claim data was rejected during the submission and editing process. These new category codes more clearly identify the status of the claim data that caused the submission error:

A6—Acknowledgment/rejected for missing information

A7—Acknowledgment/rejected for invalid information

A8—Acknowledgment /rejected for relational field in error

Status code examples

Here are coding examples that show the use of claim status category and claim status reason codes to explain claim submission rejections. For purposes of illustration, these claim status reason codes will be used:

- 187—date(s) of service
- 189—admission date

Claim submission error: The admission date is missing

A6: 189

Claim submission error: The admission date is invalid for the claim

A7: 189

Claim submission error: The admission date and date of service are in conflict. For example, the admission date is after the date(s) of service.

A8: 187 and A8: 189

277 Claim Acknowledgment (X12 transaction) changes

- the 277 transaction structure is not changing
- new category codes will be used
- increased use of multiple STC Segments and also elements STC10 and STC11

Claim Acknowledgment printable report changes

- Accepted claims (A2) will continue to be sorted together under the status heading of "Accepted"
- Rejected claims (A3, A6, A7, and A8) will be sorted together under the status heading of "Rejected"
- The claim and service line claim status category codes (CAT) will be shown along with the claim status reason (RSN) and entity (ENT) codes. Here is an example of the status headings for the printable report:

CAT	RSN	ENT	CAT	RSN	ENT	CAT	RSN	ENT
A6	189							
A8	187		A8	189				
A6	138	77						

Record time spent performing time-based procedures

Highmark Blue Shield requires that you document time in the patient's medical record when you perform certain time-based services. These time-based services include, but are not limited to:

- discharge day management (99238, 99239)
- critical care (99291, 99292)
- physical medicine (97032–97546)

Please record the amount of time you spent performing the procedure by using start and stop times, for example, 1300 to 1430, or the actual amount of time, for example, 60 minutes.

Multiple procedure payment reduction planned for certain diagnostic imaging procedures

Highmark Blue Shield plans to reduce payment for certain diagnostic imaging services when more than one service is performed for the same patient, during the same session, on the same service date.

Blue Shield's payment reduction will be similar to the policy implemented by the Centers for Medicare & Medicaid Services in January 2006.

Blue Shield's payment reduction will affect only the technical component of the diagnostic imaging services. Implementation of the payment reduction is planned for spring 2007.

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

Attention PremierBlue Shield providers: 24/7 coverage required for members

Highmark Blue Shield requires all PremierBlue[SM] Shield providers to offer coverage for its members 24 hours a day, seven days a week.

You can make coverage available either directly or through an on-call arrangement with another PremierBlue Shield provider. This arrangement allows the member or another provider direct access to a provider (or his or her designee) in urgent or emergent situations. The 24/7 coverage can be accomplished through an answering service, pager, or through direct telephone access whereby the provider (or his or her designee) can be accessed if needed.

A referral to a crisis line or the nearest emergency room isn't acceptable coverage unless an arrangement has been made between the provider and the crisis line or emergency room whereby the provider (or his or her designee) can be contacted directly. A non-primary care physician should not refer a patient to his or her primary care physician after normal business hours.

These specialists are exempt from this requirement:

- audiologists
- dermatopathologists
- dieticians/nutritionists (Federal Employee Program and FreedomBlue only)
- occupational therapists (FreedomBlue only)
- pathologists (only if working outside of the acute care setting)
- physical therapists
- preventive medicine specialists
- speech therapists

DME requests for FEP members require specific documentation

If you are prescribing a durable medical equipment item for a member who has coverage through the Federal Employee Program (FEP), you must submit specific documentation so that your claims pay accurately and promptly. The documentation may be submitted on a Certificate of Medical Necessity (CMN), letter of medical necessity, or a prescription.

If you submit electronic 837 claims, you may use the DME PWK CMN indicator to identify how the CMN will be applied.

The request for DME must include this information:

- patient's name
- patient's identification number
- patient's diagnosis or reason the patient needs the equipment
- length of time the equipment is required

You can order the Highmark Blue Shield CMN form (No. CL328 G 7.03) by calling (717) 302-5105.

The CMN form does not list all DME equipment. However, there is a space provided on the form to enter all the necessary documentation for the DME requested.

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.*

CT angiography of coronary arteries coverage revised

Highmark Blue Shield now covers computed tomographic angiography (CTA) to assess coronary arteries for suspected congenital anomalies of coronary circulation.

The intraservice work involved in the performance of coronary CT and CTA studies includes:

- review of scout views of the area to be imaged
- review of noncontrast CT images to localize the vascular phase sequence
- supervision of administration of low or iso-osmolar contrast material
- review of the enhanced phase CT images to ensure adequate anatomic coverage
- prescribe and review delayed images as necessary

- supervise and/or create 2-D and 3-D reconstructions of the heart and adjacent structures. Interpret and annotate.
- adjust the projection of 3-D reconstruction to optimize visualization of anatomy or pathology
- interpret the axial source images of the precontrast arterial and venous phase sequences, as well as the 2-D and 3-D images, including cine review
- compare to all pertinent available prior studies

The cardiac CT and CTA procedure codes 0145T–0151T specify "....and further sections" in their terminology. The interpreting health care professional is responsible for interpreting the complete study, including the heart and coronary vessels, as well as any other abnormalities seen in the field of view.

Blue Shield continues to consider CTA of the coronary arteries for all other clinical indications and applications, including calcium scoring, experimental or investigational. There is insufficient scientific evidence to prove the clinical effectiveness of this procedure as an alternative to other methods for evaluating coronary arteries or its effect on patient outcomes. Blue Shield will deny these procedures as experimental or investigational. A participating, preferred, or network provider may bill the member for the denied procedures.

Blue Shield does not cover CT angiography for evaluation of coronary arteries when it's performed as a screening procedure to evaluate patients without signs and/or symptoms of disease or illness. In this case, a participating, preferred, or network provider may bill the member for the denied procedure.

Report codes 0144T–0151T, as appropriate, for CTA of the heart and/or coronary arteries.

MA Does not apply to FreedomBlue.

Removal of cervical cerclage under anesthesia now eligible

Highmark Blue Shield now pays for the removal of cervical cerclage under anesthesia (except local) separately from the delivery. Removal of cerclage sutures before delivery under local anesthesia or without anesthesia remains an integral part of a vaginal delivery, cesarean section, or delivery after previous cesarean delivery.

Use procedure code 59871 to report the removal of cervical cerclage under anesthesia (except local).

Cervical cerclage involves the placement of sutures within an incompetent cervix during pregnancy to keep the cervix closed and prevent miscarriage or premature birth.

MA Also applicable to FreedomBlue.

ANCA and ASCA serum antibody markers for diagnosing inflammatory bowel disease are investigational

Highmark Blue Shield considers the determination of anti-neutrophil cytoplasmic antibody (ANCA) and anti-Saccharomyces cerevisiae antibody (ASCA) experimental or investigational in the workup and monitoring of patients with inflammatory bowel disease (IBD). A participating, preferred, or network provider may bill the member for the denied tests.

Blue Shield does not cover ANCA or ASCA because there is a lack of scientific evidence that the use of these tests is likely to alter the diagnostic workup, the final diagnosis made, or the treatment provided for patients with suspected IBD.

Use procedure code 89240—unlisted miscellaneous pathology test to report ANCA or ASCA. When you report code 89240, please provide this description in the narrative section of the electronic or paper claim: "Analysis of anti-neutrophil cytoplasmic antibody (ANCA) and anti-Saccharomyces cerevisiae antibody (ASCA)."

Also applicable to FreedomBlue.

Blue Shield expands coverage for wireless capsule endoscopy

Highmark Blue Shield now pays for wireless capsule endoscopy, procedure code 91110, when it is used for surveillance of the small bowel in patients with hereditary gastrointestinal polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome.

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

- Hereditary gastrointestinal polyposis syndromes (211.2)
- Familial adenomatous polyposis (211.3)
- Peutz-Jeghers syndrome (759.6)

Does not apply to FreedomBlue.

Lucentis covered for neovascular age-related macular degeneration

Highmark Blue Shield covers ranibizumab (Lucentis™) injection for the treatment of patients with neovascular (wet) age-related macular degeneration (362.52).

Blue Shield considers the use of Lucentis for any other indication experimental or investigational. In these instances, it would not be covered. A participating, preferred, or network provider may bill the member for the denied medication.

The recommended dosage regimen of Lucentis is 0.5 mg (0.05 mL) to be administered by intravitreal injection once a month.

Although less effective, treatment may be reduced to one injection every three months after the first four injections if monthly injections are not feasible. Compared to continued monthly dosing, dosing every 3 months will lead to an approximate 5-letter (1-line) loss of visual acuity benefit, on average, over the following 9 months. Patients should be evaluated regularly.

Report code J3490 or J3590 for Lucentis. When you report J3490 or J3590, provide the name of the drug and the dosage administered in the narrative section of the electronic or paper claim.

Report code 67028—intravitreal injection of a pharmacologic agent—for the administration.

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

MA Also applicable to FreedomBlue.

Blue Shield determines ductal lavage and suction collection systems to be experimental

Highmark Blue Shield considers techniques of collecting nipple aspiration fluid for cytologic analysis of epithelial cells experimental or investigational. These techniques include, but are not limited to, ductal lavage and suction. A participating, preferred, or network provider may bill the member for the denied services.

These collection systems have been investigated as diagnostic and risk assessment tools in patients at high risk of breast cancer but without clinical or mammographic findings. There is insufficient evidence in medical literature to support the effectiveness of these procedures. More investigational trials are needed to determine whether ductal lavage and suction techniques to collect nipple aspirates to assess breast cancer risk and management of high risk patients will affect outcomes.

How to report ductal lavage and suction techniques

Ductal lavage is a minimally invasive procedure that involves these three steps:

1. Those ducts among the six to eight which open in the nipple that are most likely to contain abnormal cells are identified.

2. Saline is infused through a microcatheter into the duct to collect epithelial cells. The ductal fluid is then withdrawn through the catheter and deposited into a collection vial.

3. Analysis by the cytology laboratory to determine the presence of normal, atypical, suspicious, or malignant cells.

The FirstCyte Breast Test (Cytyc) is a device used for ductal lavage that has been cleared for marketing by the Food and Drug Administration (FDA).

To report ductal lavage, please use procedure code 0046T—catheter lavage of a mammary duct for collection of cytology specimen, in high-risk individuals (Gail risk scoring or prior personal history of breast cancer), each breast; single duct. For each additional duct, report code 0047T.

A suction collection system, the HALO NAF Collection system (Neomatrix) has also received clearance from the FDA as a technique to collect ductal epithelial cells. In this system, small breast cups are placed on the woman's breast and adjusted to fit. The system is then engaged and automatically warms the breast and applies light suction to bring nipple aspirate fluid to the surface. Similar to ductal lavage, the fluid is then analyzed microscopically for cytologic abnormalities.

To report suction techniques to collect nipple aspirations, please use code 19499—unlisted breast procedure. When you report code 19499, please provide a description of the suction technique, for example, HALO NAF, in the narrative section of the electronic or paper claim.

MA Also applicable to FreedomBlue.

Phototherapy lights covered for seasonal affective disorder

As of Jan. 1, 2007, Highmark Blue Shield considers a high-intensity light unit for light box therapy medically necessary for members who have seasonal affective disorder (SAD) and who meet both of these criteria:

- The member is diagnosed with bipolar disorder or recurrent major depression (296.00-296.99, 300.4, 301.10-301.13, 311), and

- The member meets DSM-IV criteria for a seasonal mood disorder (at least 2 years of seasonal depressive episodes, which completely remit when daylight increases in the spring and which substantially outnumber any non-seasonal depressive episodes).

A physician must perform an evaluation and recommend light box therapy.

When the above criteria are met, Blue Shield will cover the rental of the high-intensity light unit for the first month to determine if home phototherapy is effective in relieving the member's depression. If the treating physician determines that the high-intensity light unit is effective, Blue Shield will pay for the purchase of one high-intensity light unit during the member's lifetime.

Blue Shield considers these uses of light box therapy experimental or investigational:

- Light box therapy for indications other than SAD,
- Any other light delivery source, for example, light visor, for the treatment of SAD,
- Extraocular light therapy (application of phototherapy to areas of the body other than the retina) for the treatment of members with SAD.

There is a lack of long term studies proving the effectiveness of these indications. A participating, preferred, or network provider may bill the member for the denied phototherapy.

Use code E0203 to report a table top therapeutic light box with a minimum intensity of 10,000 lux.

Use code E1399 to report any other type of phototherapy light devices used in the treatment of SAD. When you report code E1399, please include the term "phototherapy light device used in the treatment of seasonal affective disorder" along with the brand name of the specific light device, in the narrative section of the electronic or paper claim.

Blue Shield determines coverage for durable medical equipment according to the individual or group customer benefits.

Phototherapy is the use of light in the treatment of a condition or disease. This therapy has been used in the treatment of SAD. SAD is defined as a history of major depressive episodes that recur regularly at a particular time of year, typically winter. It is associated with decreases in ambient light exposure during the winter season.

Light box therapy requires a high-intensity light unit, for example, Bio-Light, Brite Lite, Dawn Simulator, etc. This high-intensity light unit is not the same as a tanning light that gives off an entirely different band or spectrum of light.

Also applicable to FreedomBlue.

Elaprase eligible for patients with Hunter syndrome

Highmark Blue Shield now pays for Elaprase™ (idursulfase) for patients with Hunter syndrome (Mucopolysaccharidosis II, MPS II) (277.5).

Elaprase has been shown to improve walking capacity in these patients.

The recommended dosage regimen of Elaprase is 0.5 mg/kg of body weight administered every week as an intravenous infusion.

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

Report code J3490 for Elaprase. When you report code J3490, provide the name of the drug and dosage in the narrative section of the electronic or paper claim.

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

Also applicable to FreedomBlue.

Blue Shield reimburses Elaprase 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.

Elaprase was approved by the FDA on July 24, 2006. Blue Shield will price it at 95 percent of the AWP for one year.

Drug	FDA approval date	Effective date	Revision date
Elaprase (Idursulfase)	July 24, 2006	July 24, 2006	July 24, 2007

Does not apply to FreedomBlue.

Coverage defined for implantable infusion pump

Highmark Blue Shield will pay for the surgical implantation of an infusion pump for these FDA-approved usages:

- Delivery of morphine into the superior vena cava.
- Delivery of morphine into the epidural area for the treatment of severe or unremitting pain in cancer patients who are unresponsive to conventional forms of analgesia.
- Intra-arterial administration of antineoplastic agents.
- Intrathecal injection of baclofen for severe spasticity of spinal cord origin in patients who are unresponsive to or who cannot tolerate oral baclofen therapy.
- Intrathecal administration of morphine or Ziconotide (Prialt®) for the treatment of chronic intractable pain of nonmalignant or malignant origin.

Use code 36260 to report the implantation of an infusion pump.

The implantable infusion pump is a drug delivery system that provides continuous infusion of an agent, for example, morphine, heparin, at a constant and precise flow rate. It is frequently used to deliver chemotherapy directly to the hepatic artery or superior vena cava.

MA Also applicable to FreedomBlue.

Vitamin B-12 injection coverage expanded

Highmark Blue Shield will pay for Vitamin B-12 injections when they're administered as part of a pre-medication regimen before and during treatment with certain drugs or biologicals with potential significant adverse effects (995.20), such as with Pemetrexed for injection (Alimta®).

Report Vitamin B-12 injections with procedure code J3420.

Blue Shield determines coverage for Vitamin B-12 injections according to the individual or group customer benefits.

MA Also applicable to FreedomBlue.

Pheresis therapy eligible for more indications

Highmark Blue Shield covers pheresis therapy treatment for these additional indications:

- Before solid-organ transplant, treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients, and those receiving an ABO incompatible organ.
- Following solid-organ transplant, treatment of antibody-mediated rejection.

Report pheresis therapy with one of these codes:

36511—therapeutic apheresis; for white blood cells

36512—therapeutic apheresis; for red blood cells

36513—therapeutic apheresis; for platelets

36514—therapeutic apheresis; for plasma pheresis

Pheresis therapy uses specialized equipment to remove selected blood constituents (plasma or cells) from whole blood. The remaining constituents are then returned to the person from whom the blood was taken.

MA Does not apply to FreedomBlue. Exception: FreedomBlue does cover pheresis therapy in the treatment of acute humoral rejection after kidney transplantation.

Modifier 59 reporting guideline explained

Report modifier 59—distinct procedural service—when a nerve block and surgery are performed by the same provider as treatment for two separate conditions. In this instance, report modifier 59 with the nerve block procedure code.

When you report modifier 59, Highmark Blue Shield will allow payment for both the nerve block and the surgical procedure on initial processing in accordance with multiple surgery payment methodology, that is, 100 percent for the primary procedure and 50 percent for the secondary procedure.

MA FreedomBlue does not require modifier 59 when a nerve block and surgery are reported by the same provider.

Tests of sperm DNA integrity and fragmentation not covered

Tests of DNA integrity and fragmentation have emerged as a tool to explore the etiologies of idiopathic male infertility. Highmark Blue Shield considers tests of sperm DNA integrity, including but not limited to, sperm chromatin assays and sperm DNA fragmentation assays experimental or investigational. A participating, preferred, or network provider may bill the member for the denied tests.

Blue Shield does not cover these tests because there is insufficient published data to allow scientific conclusions about tests of DNA integrity of sperm as a diagnostic test used in the management of infertile couples.

Use procedure code 89240—unlisted miscellaneous pathology test—to report this testing. When you report code 89240, please provide a description of the test in the narrative section of the electronic or paper claim. The description must begin with "Sperm DNA integrity" followed by the name of the type of testing performed. For example, "Sperm DNA integrity, chromatin assays and DNA fragmentation assays."

Also applicable to FreedomBlue.

Boniva coverage indications explained

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

If Boniva is used for any other indication, Blue Shield will consider it not medically necessary. It would not be covered. A participating, preferred, or network provider cannot bill the member for the denied medication.

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

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

- new fracture despite bisphosphonate therapy, or
- a T-score of ≤ -3.0 despite bisphosphonate therapy

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

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

Report code J3490 for Boniva injection. When you report J3490, include the name of the drug and the dosage administered in the narrative section of the electronic or paper claim.

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

Does not apply to FreedomBlue.

Stereotactic radiosurgery and stereotactic radiotherapy covered for certain conditions

Highmark Blue Shield covers stereotactic radiosurgery (SRS) and stereotactic radiotherapy for these conditions:

- arteriovenous malformations (747.81)
- acoustic neuromas (225.1)
- pituitary adenomas (227.3)
- non-resectable, residual, or recurrent meningiomas (225.2)
- solitary or multiple brain metastases in patients having good performance status and no active systemic disease (defined as extracranial disease that is stable or in remission) (191.0-191.9)
- primary malignancies of the central nervous system, including but not limited to high-grade gliomas (initial treatment or treatment of recurrence)
- trigeminal neuralgia refractory to medical management (350.1)

Blue Shield considers SRS and stereotactic radiotherapy experimental or investigational when they're used to treat all other functional disorders, including but not limited to epilepsy, chronic pain, and for treatment of extracranial sites. A participating, preferred, or network provider may bill the member for the denied services.

SRS delivers high doses of ionizing radiation to small intracranial targets with the use of a head frame. This technique differs from other methods of treatment with radiation. SRS uses highly-focused convergent beams of radiation in a single session. Only the desired target is radiated, sparing adjacent structures or tissue. SRS is typically performed in one session, usually requiring no more than an overnight stay.

SRS can be performed using various devices that deliver the radiation using different energy sources, for example: the Gamma Knife (gamma-ray), a linear accelerator (LINAC), or charged particle sources such as proton or neutron beam.

Stereotactic radiotherapy is the stereotactically guided delivery of radiation treatment in multiple fractions over the course of several days rather than in one session. This fractionated form of radiation therapy can also be delivered using recently developed noninvasive repositioning devices instead of a head frame.

MA Does not apply to FreedomBlue.

Noncovered services

Highmark Blue Shield continues to consider the following procedures as not covered. Please note that this is not an all inclusive list.

Please check the members' benefits to verify their eligibility for these procedures.

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

A4632	G0344	G9014	S2107
A4890	G0378	Q3014	S3005
A6000	G0379	S0201	S5035
E0231	G9001	S0220	S5036
E0232	G9002	S0221	S5100
E0616	G9003	S0250	S5101
E0783	G9004	S0255	S5102
E0785	G9005	S0257	S5105
E0786	G9006	S0302	S5108
G0154	G9007	S0315	S5109
G0155	G9008	S0316	S5110
G0156	G9009	S0317	S5111

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G0175	G9010	S0320	S5115
G0176	G9011	S1001	S5116
G0177	G9012	S1002	S5120
G0248	G9013	S1025	S5121
S5125	S8040	S9465	0118T
S5126	S9083	S9470	0027T
S5130	S9088	S9473	0030T
S5131	S9097	S9475	0018T
S5135	S9098	S9482	0027T
S5136	S9122	S9484	0030T
S5140	S9125	S9485	0041T
S5141	S9126	S9562	0043T
S5145	S9127	S9900	0060T
S5146	S9335	S9970	0061T
S5150	S9381	S9975	0074T
S5151	S9401	S9981	0130T
S5160	S9444	S9982	0140T
S5161	S9445	S9986	64580
S5162	S9446	S9988	80103
S5165	S9447	S9989	86891
S5170	S9449	S9990	90882
S5175	S9451	S9991	90885

S5185	S9452	0115T	99027
S5190	S9453	0116T	99075
S5199	S9454	0117T	99078
99080	99148	99500	99506
99082	99149	99501	99507
99100	99150	99502	99509
99116	99185	99503	99510
99135	99186	99504	99511
99140	99420	99505	

MA Also applicable to FreedomBlue.

Services not covered by Blue Shield; are covered by FreedomBlue

Here are more services that are not covered by Blue Shield. However, the Medicare Advantage program, FreedomBlue, does cover them:

G0333	Q0513	Q0514	81050
82820	83026	86891	86910
86911	86945	86965	86970
86971	86972	86975	86976
86977	86978	86985	88240
88241	88349		

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**.

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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