Important information about Highmark Blue Shield
www.highmarkblueshield.com

December 2007

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News

Blue Shield offers coverage for your uninsured patients

Informational brochures for patients available free to provider offices

Highmark Blue Shield’s community mission is to provide access to affordable, quality health care, enabling individuals to live longer, healthier lives.

That is why Blue Shield offers a comprehensive selection of health insurance products, including those geared to meet the needs of uninsured and low-income residents in our communities. Blue Shield offers a host of direct-pay products that are designed for people who are in various stages of life and may have no access to care—from children and recent college graduates, to families and seniors, to those who have recently become unemployed. These direct-pay products include:

• Income-based programs

• Children’s Health Insurance Program (CHIP) PPO: for all uninsured children and teens under 19 years of age, regardless of income
• adultBasic PPO: for adults ages 19 through 64 whose household income falls within certain limits

• SpecialCareSM: provides basic health care benefits to individuals whose household income falls within certain limits when SpecialCare providers and hospitals are used*

• Guaranteed-issue programs (health coverage available regardless of current health)*

• ClassicBlue® comprehensive major medical program

• PPOBlueSM individual high-deductible program

• Programs for Medicare-eligible consumers+

• FreedomBlueSM PPO

• BlueRxSM Medicare Part D prescription drug plan

• MedigapBlueSM Medicare supplemental program

• Programs requiring a medical evaluation*

• DirectBlue® individual PPO

• PPOBlue individual high-deductible program

Blue Shield offers informational brochures with additional details about its direct-pay products, and you can obtain them for free to distribute to your patients who lack medical coverage. If you wish to order copies of the brochures for display or distribution at your office, please contact Provider Service and reference the brochure’s inventory number, which is 23801.

*These direct-pay products are available to individuals from birth to age 64 who are not eligible for Medicare.

+Effective Jan. 1, 2008, Blue Shield will begin to offer Medicare-eligible beneficiaries a new Medicare Advantage plan option called FreedomBlueSM PFFS (Private Fee-for-Service) that isn’t featured in the direct-pay product brochures noted here that are available free to provider offices.
**NPI Registry link now available through Highmark Blue Shield Office Manual**

On Sept. 4, 2007, the Centers for Medicare & Medicaid Services, through its National Plan and Provider Enumeration System, released the National Provider Identifier (NPI) Registry.

For your convenience, Highmark Blue Shield has added a link to the NPI Registry to its Highmark Blue Shield Office Manual, which is available through the Provider Resource Center under Administrative Reference Materials.

To access the NPI Registry link, simply open the Office Manual and scroll down to “Chapter 8: Appendix, Unit 1.” The NPI Registry replaces the Facility ID list formerly included in the Highmark Blue Shield Office Manual.

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**Proof of Medicare eligibility required for newly credentialed practitioners**

Historically, the Unique Physician Identification Number (UPIN) had been the identifying element to determine Medicare eligibility for physicians and allied practitioners who bill on CMS-1500 claim forms. However, the Centers for Medicare & Medicaid Services (CMS) discontinued assigning UPINs on June 29, 2007. CMS will continue to maintain its UPIN public lookup functionality and Registry Web site, www.upinregistry.com, through May 23, 2008.

**New form of proof of eligibility accepted for newly credentialed providers**

While all Medicare-eligible practitioners must have a National Provider Identifier (NPI) number, the NPI cannot be used as proof of Medicare eligibility as not every practitioner with an NPI participates in Medicare.

Therefore, at the time of credentialing, all newly credentialed practitioners who joined or are joining the PremierBlueSM Shield and Medicare Advantage network on or after June 29, 2007 will be asked to supply a Medicare welcome (participation) letter as proof of Medicare eligibility.

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**New BlueCard coordination of benefits questionnaire now available online**

In recent years, Highmark Blue Shield has been streamlining its information systems and making electronic tools available to you to simplify and improve the claims submission and reimbursement processes. Such advancements have helped to reduce delays and speed up your payments.

Beginning Jan. 1, 2008, these efforts continue when Blue Shield adds a new coordination of benefits (COB) questionnaire for commercial BlueCard® (out-of-area) members to its online Provider Resource Center. The availability of this questionnaire to you marks the first step that Highmark Blue Shield and the Blue Cross and Blue Shield Association are taking to automate receipt of COB information across all Blue Plans nationwide for out-of-area members.
The questionnaire is available under the Provider Resource Center’s Blue Card Information Center link.

**Ask BlueCard members to submit COB questionnaire to their “home” Blue Plan**

If you care for out-of-area Blue members, and you are aware that they have other health insurance coverage, we ask for your assistance in obtaining this information by giving a copy of the questionnaire to them during their visit. Ask them to complete the form and then send it to their “home” Blue Plan—the Blue Plan through which they are covered—as soon as possible after leaving your office. Members should mail the form to the plan address listed on the back of their member identification card, where they will also find their home Blue Plan’s telephone number if they have questions.

Your assistance with this process will eliminate the need to gather this information later, thereby reducing delays in processing of your claims.

If you have questions or need more information about the new BlueCard COB questionnaire, please contact your Provider Relations representative through Provider Service.

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**Reminder: follow paper claims reporting tips to avoid payment delays**

Highmark Blue Shield receives numerous paper claims that do not meet its Optical Character Recognition (OCR) scanner standards. Because these claims need special handling, processing is delayed.

If you continue to submit claims using the CMS-1500 (08/05) paper claim form, please refer to the Highmark Blue Shield Office Manual for paper claim submission tips. Please follow these tips to guarantee that your paper claims process more efficiently. You can find these tips in Chapter 5, Unit 2, Claims Submission and Billing Information, in the Office Manual. The Highmark Blue Shield Office Manual is available online on the Provider Resource Center through NaviNet® or at www.highmarkblueshield.com. Once you’ve entered the Provider Resource Center you can access the Office Manual through the Administrative Reference Materials link.

**Avoid processing delays, submit your claims electronically**

Blue Shield encourages its providers to submit their claims electronically. Electronic claims typically process in seven to 14 days, whereas paper claims process in 21 to 27 days.

If you are interested in submitting claims electronically, please contact Electronic Data Interchange Services at (800) 992-0246, or access the EDI Services link on the Provider Resource Center at www.highmarkblueshield.com.
Attention Philadelphia region PremierBlue Shield and Participating providers:
do not send Independence Administrators claims to Blue Shield

Highmark Blue Shield would like to make you aware of some misdirected claims coming to Blue Shield that may be causing a delay in processing and payment for you.

In July 2007, Independence Administrators was launched in the Greater Philadelphia area, offering third-party administration services to self-funded health plans. Please note that all claims for patients who present Independence Administrators identification cards should not be sent to Highmark Blue Shield. Rather, these claims should be submitted as follows:

Electronic claims:

use payer ID number TA720

Paper claims:

Independence Administrators
PO Box 1010
Horsham, Pa. 19044

Please share this information with your staff or billing service.
Blue Shield covers Thoratec HeartMate for certain patients

Highmark Blue Shield pays for the implantation (33975, 33976) and removal (33977, 33980) of these devices as destination therapy in accordance with FDA-approved use:

- Thoratec HeartMate® XVE LVAS
- Thoratec HeartMate Left Ventricular Assist System (SNAP VE LVAS)

Blue Shield defines destination therapy as implanting the XVE LVAS or the SNAP VE LVAS device as permanent support for end-stage heart failure patients not eligible for heart transplants.

Both of these criteria must be met:

- The patient has end-stage heart failure (ICD-9-CM codes 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9), and,

- The patient is not eligible for heart transplantation

The following enrollment criteria, which are required for the REMATCH trial, must also be met:

- The patient must be at least 18 years of age.
- The patient must have chronic heart failure (NYHA Class III or IV on inotropes/IABAP).
- The patient is not eligible for heart transplant due to age, diabetes, kidney failure, or other co-morbidity.
- The patient is receiving reasonable doses of digoxin, diuretics, and ACE inhibitors (unless intolerant).
- The patient has a left Ventricular Ejection Fracture less than or equal to 25 percent.
- The patient has a VO2 max less than or equal to 14 ml/kg/min, unless failed inotrope wean.
The exclusion criteria include:

- any medical condition that if corrected would improve heart function
- any condition that could result in a poor surgical risk
- prior heart transplant, left ventricular reduction, or cardiomyoplasty
- stroke, impaired cognitive function, history of severe cerebral vascular disease
- severe end-organ damage

For FreedomBlue coverage guidelines, see Medicare Advantage medical policy bulletin S-60.

**Supervision of services guidelines explained**

Highmark Blue Shield pays for covered services only when they are personally performed by an eligible professional provider or under that provider’s personal supervision, in accordance with certain licensure and employment criteria.

Eligible professional providers are those providers defined by Blue Shield’s enabling legislation, duly licensed, and acting within their scope of license. They include:

- Audiologists
- Certified clinical nurse specialists
- Certified community health nurses
- Certified enterostomal therapy nurses
- Certified psychiatric mental health nurses
- Certified registered nurses
- Certified registered nurse anesthetists
- Certified registered nurse practitioners
- Clinical laboratories
- Dentists
PRN

- Doctors of chiropractic
- Doctors of medicine
- Doctors of osteopathy
- Nurse midwives
- Optometrists
- Physical therapists
- Podiatrists
- Psychologists
- Speech pathologists
- Teachers of the hearing impaired

Blue Shield will also reimburse covered services when they are performed by licensed health care practitioners, who are employed and personally supervised by eligible professional providers.

For purposes of this guideline, Blue Shield defines “health care practitioner” as a person who is licensed to perform health-related services, but is not eligible for direct reimbursement from Blue Shield. Examples of health care practitioners include a registered nurse, licensed practical nurse, physician assistant, and licensed clinical social worker.

“Personal supervision” means that the professional provider must be present in the immediate vicinity or must be immediately available by electronic means, for example, telephone, radio, and telecommunications, in the event his or her personal assistance is required for care of the patient. All supervision must be in accordance with the state licensure requirements of the performing licensed health care practitioner.

When providing care to his or her patient, the professional provider has medical and legal responsibility for the services provided, whether performed personally or by a licensed employee. This includes the ability to take over the procedure or to care for the patient in the event it becomes necessary. For example, patients may experience an acute medical problem such as syncopal episode, cardiac arrest, even during non-invasive diagnostic procedures. It is also possible for equipment failure to result in circumstances that require patient management by a physician.
For reimbursement purposes, Blue Shield requires that services reported for its members are either personally performed by the eligible professional provider or under that provider’s personal supervision. Blue Shield cannot pay some health care practitioners directly. Rather, Blue Shield will pay either the supervising participating, preferred, or network physician, or the patient. When reporting supervised services, the supervising provider should report the service on the claim as if he or she performed it personally and document the details in the patient’s medical record.

Certain diagnostic tests have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include Holter monitoring (93224, 93230, and 93235), cardiac event monitoring (93268), and sleep studies (95807-95811). These procedures are performed under the physician’s overall management and control, but the physician is not present for the duration of the test.

There may be exceptions to these guidelines depending on the individual member’s contract, and provider network rules.

Does not apply to FreedomBlue.

Otoplasty to improve hearing impairment considered reconstructive surgery

Beginning March 17, 2008, Highmark Blue Shield will consider otoplasty as reconstructive surgery when it’s performed to improve hearing impairment, whether the ears are absent or deformed from trauma, surgery, disease, or congenital defect.

Blue Shield defines hearing impairment as a loss of at least 15 decibels outside the normal hearing range in the affected ear(s) documented by audiogram. The degree of hearing loss refers to the severity of the loss. Normal range or no hearing loss = 0dB to 20dB. If an otoplasty is performed for any other indications, Blue Shield will consider it as cosmetic surgery rather than reconstructive.

Report otoplasty with procedure code 69300—otoplasty, protruding ear, with or without size reduction.

Blue Shield defines cosmetic and reconstructive surgery

Blue Shield defines cosmetic surgery as surgery performed exclusively to improve an individual’s appearance. Cosmetic surgery is generally not eligible for payment. A participating, preferred, or network provider may bill the member for the denied cosmetic surgery. However, Blue Shield will cover cosmetic surgery when it’s performed to correct a condition resulting from an accident, in accordance with the member’s benefit contract.
Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Blue Shield generally covers reconstructive surgery.

Also applicable to FreedomBlue.

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### How to report time-based physical medicine services with an E/M service

Time-based physical medicine services include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Therefore, a separate evaluation and management (E/M) service must be medically necessary. The separate E/M service should not routinely be reported with physical medicine services.

Report separate E/M services only in these circumstances:

- initial examination of a new patient or condition,
- acute exacerbation of symptoms or a significant change in the patient’s conditions, or
- distinctly different indications, which are separately identifiable and unrelated to the physical medicine service.

If medical care is reported for any of the above circumstances, report modifier 25 with the E/M service to identify it as a separately identifiable service.

Please include documentation in the patient’s medical record that a separate E/M service was performed in addition to the therapeutic procedure or modality.

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Does not apply to FreedomBlue.

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### Chelation therapy with edetate calcium disodium to be denied as not medically necessary

Highmark Blue Shield currently allows coverage for chelation therapy (J0600) for these conditions:

- control of ventricular arrhythmias or heart block associated with digitalis toxicity
- emergency treatment of hypercalcemia
- heavy metal poisoning
• thalassemia intermedia with hemochromatosis

• Wilson’s disease

As of March 17, 2008, Blue Shield is changing its coverage position for edetate calcium disodium when it’s reported for any other conditions. In these cases, Blue Shield will deny the edetate calcium disodium as not medically necessary instead of not covered. A participating, preferred, or network provider may not bill the member for the denied service.

If edetate disodium (EDTA) is reported with procedure code J3520 in the treatment of atherosclerosis, arteriosclerosis, or any other condition, Blue Shield considers it experimental or investigational. It is not covered. A participating, preferred, or network provider may bill the member for the denied service.

Does not apply to FreedomBlue.

Constant and supervised attendance modalities reporting guidelines clarified

Physical medicine modalities vary according to whether direct (one-on-one) or supervised contact is required for the treatment.

Direct one-on-one contact requires that the provider is physically present and maintains visual, verbal, and/or manual contact with the patient throughout the procedure.

Constant attendance modalities (codes 97032-97039) are those modalities that require direct one-on-one patient contact by the provider. These are time-based codes that include the time required to perform all aspects of the service, including pre-, intra- and post-service work. Documentation must include the amount of time spent in providing all aspects of this service.

Supervised modalities (codes 97010-97028) do not require direct one-on-one patient contact. These are not time-based codes. Report these codes only once during a patient encounter (visit), regardless of the amount of time spent supervising the modality or the number of body areas treated.

Documentation for all physical medicine modalities and therapeutic procedures must include:

• the patient’s subjective complaint,

• an objective assessment,

• the region being treated, and

• the specific modality or therapeutic procedure performed.
When you report electrical stimulation, remember to include documentation in the patient’s medical records that indicates whether the modality was attended (electrical stimulation with constant attendance, code 97032) or unattended (supervised electrical stimulation, code 97014).

Also applicable to FreedomBlue.

Blue Shield changes obstetrical ultrasound and fetal biophysical profiling reimbursement policy

Highmark Blue Shield now pays separately for obstetrical ultrasound studies in addition to fetal biophysical profiling (codes 76818, 76819) when performed during the same session on the same day.

Each study must have a separate interpretation and report signed by the interpreting physician. Both studies are performed using ultrasound imaging; however, the data acquired in each test differs.

Also applicable to FreedomBlue.

New coverage guidelines for treating port wine stains and rosacea begin March 2008

Highmark Blue Shield has established new coverage criteria for the treatment of port wine stains and the non-pharmacological treatments of rosacea. Blue Shield will apply these criteria beginning March 17, 2008.

Blue Shield will cover the treatment of port wine stain lesions on the face and neck as reconstructive surgery. Blue Shield considers the treatment of port wine stain lesions on the trunk or extremities as cosmetic.

Blue Shield will consider the non-pharmacological treatments of rosacea, including but not limited to, laser and light therapy, dermabrasion, chemical peels, surgical debulking, and electrosurgery, as cosmetic.

These guidelines are appropriate for the majority of individuals. Each person’s unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Report procedure codes 17106-17108 for the treatment of port wine stains.

You may report the following procedure codes for the non-pharmacological treatment of rosacea. This is not an all-inclusive list.

15780-15783 for dermabrasion

15788-15793 for chemical peels
17000-17004 for electrosurgery
17106-17108 for laser treatment
96900 for light therapy

Blue Shield defines cosmetic surgery as surgery performed solely to improve an individual’s appearance. Cosmetic surgery is generally not eligible for payment. A participating, preferred, or network provider may bill the member for the denied surgery. However, cosmetic surgery is eligible when performed to correct a condition resulting from an accident, in accordance with the member’s benefit contract.

Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Blue Shield generally covers reconstructive surgery.

Does not apply to FreedomBlue.

**Manipulation services require specific medical record documentation**

Highmark Blue Shield requires that manipulation services (98925-98929, 98940-98943) be appropriate for the diagnosis you report. Also, you must include certain documentation in the patient’s medical record for each service performed for each date of service.

Documentation must include the following to validate the appropriateness of the manipulation:

- A record of the patient’s subjective complaint,
- An objective assessment or physical findings to support the manipulation,
- A clear description of the type of adjustment provided, including the body region to which the adjustment was performed, and,

The five spinal regions referred to in the descriptions for codes 98940-98942 are: cervical (includes atlanto-occipital joint), thoracic (includes costovertebral and costotransverse joints), lumbar, sacral, and pelvic (sacroiliac joint).

Report services based on the number of regions manipulated, for example, if two regions are manipulated, report code 98940. If more than one segment is manipulated in a single region, it is still considered one region for reporting purposes.
The five extraspinal regions identified for code 98943 are: the head (including temporomandibular joint, excluding the atlanto-occipital), lower extremities, upper extremities, rib cage (excluding costotransverse and costovertebral joints), and abdomen.

Procedure code 98943 describes treatment to one or more extraspinal regions; therefore, report the service once regardless of how many individual extraspinal manipulations are performed.

Eleven regions are identified for codes 98925-98929. These include: head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdomen, and visceral.

A region includes all muscles or ligaments attached to the region being treated. For example, the trapezius muscle is in the same region as the cervical and thoracic spine.

In your documentation you may include these phrases: spinal manipulation, spinal adjustment, manual adjustment, manual manipulation, chiropractic adjustment, chiropractic manipulation, osteopathic manipulation, or abbreviations such as CMT or OMT. It is also appropriate to record the actual chiropractic or osteopathic technique being employed.

Additional instructions for related modalities
Blue Shield considers physical medicine procedures and modalities that are performed solely to relax and prepare the patient for a manipulation procedure (application of hot or cold packs [97010] and massage [97124]) an inherent part of the manipulation. These services are not eligible for separate payment when reported on the same day as manipulation. A participating, preferred, or network provider may not bill the member for the denied services.

Joint mobilization (97140) can be used to treat spinal or extraspinal conditions. Blue Shield considers code 97140 an inherent part of a manipulation procedure. It is not eligible for separate payment when reported on the same day as the manipulation. A participating, preferred, or network provider may not bill the member for the denied service.

When codes 97010, 97124, or 97140 are performed on a separate body region, unrelated to the manipulation procedure, Blue Shield will consider them for separate payment. For example, patients may experience referred symptoms, such as sciatica, to an extremity caused by spinal misalignment. In such cases, treatment of the causative diagnosis, for example, spinal misalignment, is medically necessary. However, Blue Shield will consider separate treatment of the extremity medically necessary only if objective findings demonstrate a distinct, unrelated physical problem with the extremity. Otherwise, Blue Shield will consider treatment to the extremity in this example to be related to the primary service (treatment of spinal misalignment).
When codes 97010, 97124, and/or 97140 are performed on separate body regions and are unrelated to the manipulation procedure, report modifier 59 along with them. In these instances, include documentation in the patient’s medical record that identifies the distinct body regions and diagnoses for which these services were provided.

Does not apply to FreedomBlue.

**Report code 97799 for electromagnetic therapy performed for treating musculoskeletal conditions**

Do not use code G0295 to report electromagnetic therapy performed to treat musculoskeletal conditions, since G0295 is defined for the treatment of wounds. Instead, use code 97799 to report this therapy for treatment of musculoskeletal conditions. When you report code 97799, please include the term “electromagnetic therapy” in the narrative section of the electronic or paper claim.

Highmark Blue Shield considers electromagnetic therapy experimental or investigational when it’s used to treat musculoskeletal conditions. A participating, preferred, or network provider may bill the member for the denied therapy.

Blue Shield pays for electromagnetic therapy only when it’s used to treat chronic ulcers. For specific guidelines about treating chronic ulcers, see the June 2004 PRN.

Does not apply to FreedomBlue.

**Coverage changes for retrobulbar injection**

Highmark Blue Shield no longer considers retrobulbar injection a Procedure of Questionable Current Usefulness (POQCU). Blue Shield pays for POQCU procedures only if documentation satisfactorily establishes the procedure’s medical necessity in the case at hand.

As of Oct. 29, 2007, claims for retrobulbar injection process in accordance with Blue Shield’s standard guidelines for surgical services.

Use code 67500—retrobulbar injection; medication (separate procedure, does not include supply of medication)—to report retrobulbar injection.

Also applicable to FreedomBlue.
Blue Shield reimburses Ceprotin and Supprelin LA at 95 percent of AWP

Highmark Blue Shield sets its initial UCR and PremierBlueSM 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.

Ceprotin was approved by the FDA on March 30, 2007. Supprelin LA was approved on May 3, 2007. Blue Shield will price both of these drugs at 95 percent of the AWP for one year.

<table>
<thead>
<tr>
<th>Drug</th>
<th>FDA approval date</th>
<th>Effective date</th>
<th>Revision date</th>
</tr>
</thead>
</table>

Also applicable to FreedomBlue.
Questions or comments on these new medical policies?

We want to know what you think about our new medical policy changes. Send us an e-mail with any questions or comments that you may have on the new medical policies in this edition of PRN.

Write to us at medicalpolicy@highmark.com.

Codes

New brachytherapy code

Code 0182T—high dose rate electronic brachytherapy, per fraction—is a new code that became available on July 1, 2007 for your reporting purposes.
Need to change your provider information?

Fax the information to us!
You can fax us changes about your practice information, such as the information listed on the coupon below. The fax number is (800) 236-8641. Blue Cross of Northeastern Pennsylvania (BCNEPA) providers should use fax number (570) 200-6880. You may also continue to send information by completing the coupon below.

Coupon for changes to provider information
Please clip and mail this coupon, leaving the PRN mailing label attached to the reverse side, to:

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

For BCNEPA providers:

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

Name ___________________________ Provider ID number ___________________________

Electronic media claims source number ____________________________________________

Please make the following changes to my provider records:

Practice name ___________________________ 

Practice address _____________________________________________________________

Mailing address ______________________________________________________________

Telephone number ( ) __________________ Fax number ( ) __________________________

E-mail address _______________________________________________________________

Tax ID number _______________________________________________________________

Specialty ________________________________________________________________

Provider’s signature ___________________________ Date signed _____________________
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Acknowledgement
The five-digit numeric codes that appear in PRN were obtained from the Current Procedural Terminology, as contained in CPT-2007, Copyright 2006, by the American Medical Association. PRN includes CPT descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.

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