

PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

February 2006

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Look for this symbol for all Medicare Advantage related information

News

New funding source helps physicians in select counties implement electronic prescription systems

On Nov. 15, 2005, Highmark Inc. announced a significant financial commitment to help eligible physicians in the 49 counties of western and central Pennsylvania pursue point-of-care technology in the outpatient practice setting.

In central Pennsylvania, eligibility is limited to physicians whose main practice is located within the 21 counties of central Pennsylvania and the Lehigh Valley. The program is not available to physicians in northeastern or southeastern Pennsylvania.

Highmark Inc. made a \$26.5 million contribution to The Pittsburgh Foundation. The Foundation created the Highmark eHealth Collaborative, a supporting organization of the Foundation. Its goal is to encourage the adoption of health information technology used in patient care. Electronic prescribing was chosen as the first project of the Collaborative because of its direct impact on patient safety.



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Highmark Inc. is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Collaborative is not a subsidiary or affiliate of Highmark Inc. It uses the name “Highmark” in accordance with a license agreement.

The Collaborative will provide funding to eligible physicians who wish to acquire and use technology, for example, a personal computer, PDA, electronic tablet or digital pen, to generate a prescription and transmit it electronically to a pharmacy. Physicians may acquire stand-alone, approved electronic prescribing systems or ambulatory electronic health records systems that include an approved electronic prescribing system.

The Collaborative encourages physicians to take advantage of this unique funding opportunity to help reduce medication errors, eliminate time-consuming administrative work associated with handwritten scripts, better manage the requirements of multiple drug formularies, and most importantly, help ensure patient safety and satisfaction.

Visit the Collaborative’s Web site at www.highmarkehealth.org for complete details, including eligibility requirements and the online application.

Attention Northeastern Pennsylvania regional providers: new joint operating agreement expands Blue Cross of Northeastern Pennsylvania’s role as Highmark Blue Shield’s agent

On Feb. 1, 2006, Blue Cross of Northeastern Pennsylvania (BCNEPA) and Highmark Blue Shield entered into a new joint operating agreement (JOA). Because of the new JOA, changes have been made to provider servicing within the two Plans.

Here are the provider contacts you should use for BCNEPA and Highmark Blue Shield business after Feb. 1, 2006.

Please note, other than for your Provider Relations contacts, there are no changes to the customer service, claims submission, or appeals process for the Federal Employee Program (FEP) and BlueCard business.

Provider Relations

As of Feb. 1, 2006, the BCNEPA Provider Relations department will answer questions for Northeastern Pennsylvania regional professional, durable medical equipment (DME), ambulance, home infusion therapy, and orthotic/prosthetic providers. The Northeastern Pennsylvania region consists of these counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming.

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Your BCNEPA Provider Relations consultant will service all lines of business supported by Highmark Blue Shield's Participating Provider, PremierBlueSM Shield, Medicare Advantage, and Ancillary provider networks. This includes FEP and BlueCard.

If you are a Participating or PremierBlue Shield provider who also participates with First Priority Health (FPH), your FPH Provider Relations consultant will handle your Highmark Blue Shield issues. If you do not know which FPH consultant is assigned to your office, or if you are not an FPH participating provider, please call the BCNEPA Provider Relations department at (800) 451-4447.

Here are the names and telephone numbers of the BCNEPA Provider Relations consultants:

Consultant	Telephone number	Consultant	Telephone number
Odette Ashby	(570) 200-4658	Dave Levenoskie	(570) 200-4673
Michele Dal Santo	(570) 200-4718	Louise LoPresto	(570) 200-4674
Paul Forlenza	(570) 200-4676	Joe Malahowski	(570) 200-4656
Lorraine Haduck	(570) 200-4669	Debbie Yager	(570) 200-4681
Cheryl Hashagen	(570) 200-4670	Rebecca Zingaretti	(570) 200-4682

Provider Customer Service

The BCNEPA Customer Service area is responsible for answering your inquiries about eligibility, benefits, and claims status.

Here are the telephone numbers you can call for answers to your questions:

- For information about members with Traditional Blue Cross Blue Shield coverage, or Participating network claims, call (888) 827-7117.
- For information about Access Care II members, call (866) 262-5635.
- For inquiries on all other members, please continue to use the same Highmark Blue Shield telephone numbers you had been using. For example, call (866) 763-3608 for inquiries about FEP members.

You may also continue to use these resources, which have not changed because of the new JOA:

- NaviNetSM (Internet-based service for enrollment and benefits information, claim status, program allowances). Call (888) 482-8057.
- OASIS (for eligibility, benefits, and status of claims). Call (800) 462-7474.
- InfoFax (for claim status and enrollment). Call (800) 891-1856.

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Changes to your practice information

As of Feb. 1, 2006, BCNEPA Provider System Support is responsible for maintaining the provider file of Highmark Blue Shield Participating and PremierBlue Shield Northeastern Pennsylvania regional providers. You can send your requests to change data about your practice, for example, address, specialty, etc., by completing the coupon on the inside back page of **PRN** and mailing it to:

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

You can also send your requests to change your practice information through your fax machine to (570) 200-6880.

If you have questions about how to change your practice information, call the Provider Relations department at (800) 451-4447.

Credentialing and recredentialing

The BCNEPA Quality Management department will provide all credentialing and recredentialing functions for Northeastern Pennsylvania PremierBlue Shield providers. You can call Diane Jones, manager of Credentialing/Risk Management, at (570) 200-4396 with questions about credentialing and recredentialing. Diane's fax number is (570) 200-6890.

Grievance or appeals

Upon written consent from the member, providers may file a grievance or appeal. These must be submitted in writing to:

Member Grievances/Appeals
PO Box 890179
Camp Hill, Pa. 17089-0179

You can call (877) 865-5847 for expedited appeals.

Provider claim appeals

Send your claim appeals to:

Provider Claims Appeal
PO Box 890179
Camp Hill, Pa. 17089-0179

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Predetermination

Requests for predeterminations for medical necessity should be sent in writing to:

Pre-Authorization
PO Box 890041
Camp Hill, Pa. 17089-0041

Claims submission

No changes have been made to the submission processes for electronic or paper claims. Please continue to submit your claims as you do now.

Blue Shield adopts CMS 2006 Oncology Demonstration Program for FreedomBlue

In 2005, the Centers for Medicare & Medicaid Services (CMS) initiated a one-year demonstration project for cancer patients undergoing chemotherapy. The project focused on measuring patient outcomes in three areas often experienced by patients receiving chemotherapy: pain, nausea and vomiting, and fatigue.

Although the 2005 project ended, CMS is continuing its efforts to promote evidence-based best practices leading to better outcomes for cancer patients. For 2006, CMS has introduced the 2006 Oncology Demonstration Program.

Key features of the 2006 Oncology Demonstration Program are:

- The program is only available to office-based hematologists and oncologists.
- It is limited to those hematologists and oncologists who provide Level 2, 3, 4, or 5 evaluation and management services to their established patients.
- It is only applicable to those patients with a primary diagnosis of cancer belonging to one of thirteen major diagnostic categories: cancer of the breast, colon, rectum, prostate, lung, stomach, esophagus, pancreas, ovary, head and neck, as well as chronic myelogenous leukemia, multiple myeloma, and non-Hodgkin's lymphoma.
- As with the 2005 project, participation in this program is voluntary.

Highmark Blue Shield has adopted this program for its Medicare Advantage product, FreedomBlueSM. Blue Shield will continue to reimburse under this program as long as it is offered by CMS.

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Blue Shield is sending details of the 2006 Oncology Demonstration Program, including coding instructions and reimbursement information, to hematologists and oncologists.

The new oncology codes (G9050-G9310) and their corresponding terminology can be found online in the Provider Resource Center through NaviNetSM or at www.highmarkblueshield.com.

How to change your practice information

Highmark Blue Shield offers you several ways to notify it of changes to your practice information. Remember to notify Blue Shield of any changes to your address, telephone number, fax number, office hours, practitioner composition, tax identification number, or other demographic information.

If you have access to NaviNetSM, you can notify Blue Shield of address, telephone, fax, office hours, and other demographic information through NaviNet. You can also use NaviNet to perform your recredentialing.

If you'd like to send your practice information changes, for example, changes to your practice, assignment account, mailing, or check address, to Blue Shield through your fax machine, please use (800) 236-8641.

The back page of each issue of **PRN** contains a coupon for you to send your requests to change data about your practice. You can complete the coupon and send it to (800) 236-8641 or to:

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

Send your credentialing information through fax

To submit your information to be credentialed for one of Blue Shield's networks, use (800) 236-5907.

Blue Shield outlines timetable for submitting NPIs on electronic claims

As you've read in recent issues of **PRN**, health care providers who are considered covered entities under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are required to obtain a unique National Provider Identifier (NPI) number no later than May 23, 2007. These providers must begin to use their NPI on all electronic transactions no later than May 23, 2007.

On that date, Highmark Blue Shield will require all NPI-eligible providers to begin using NPIs on electronic claims; therefore, even if you're not considered a HIPAA-covered entity, you'll need to obtain an NPI for use when submitting claims to Blue Shield. If you are considered an eligible provider under HIPAA, you can obtain an NPI, regardless of your electronic filing status.

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To assist in this transition, Blue Shield has outlined the following general timetable for acceptance of NPIs on electronic claims; watch your mail and the NaviNetSM Plan Central page for updates regarding exact deadlines:

- February 2006: Blue Shield began accepting providers' NPIs along with their Highmark Blue Shield provider numbers on electronic claims; the NPI is optional, but the Blue Shield provider number is still required.
- Fall 2006: Blue Shield will accept an NPI, a Blue Shield provider number, or both an NPI and a Blue Shield provider number on electronic claim submissions.
- May 23, 2007: Blue Shield will require the use of NPIs on all electronic claims submitted and will no longer accept Blue Shield provider numbers on electronic claims.

The 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.

Obtaining an NPI

NPIs are now being assigned, and many providers already have obtained their NPIs. Although you have until May 23, 2007 to obtain an NPI, you are encouraged to apply now.

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.

Reporting your NPI to Blue Shield

Once you receive your NPI, please send your number to Blue Shield. You can 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 your submission. Blue Shield will also accept your confirmation e-mail from NPPES.

Please send your NPI information to Blue Shield through:

Fax: (800) 236-8641, or

e-mail: PDSNPIUPDATE@Highmark.com

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EDI submitters also will need to register their NPIs with Highmark Blue Shield's EDI department beginning in July 2006. This registration is necessary to activate EDI submitters' NPIs for submitting electronic claims. Blue Shield will send all EDI submitters instructions on how to register their NPI with the EDI department.

Submission process for paper claims unchanged

Highmark Blue Shield is not changing the way you submit paper claims. More information about the NPI and revised paper claim formats will follow at a later date.

Know your Blue Shield provider identification number when calling Customer Service

Before you call Highmark Blue Shield's Customer Service, please be sure to have your Highmark Blue Shield identification number handy.

Blue Shield is committed to protecting the privacy of its members and providers and to complying with privacy laws, rules, and regulations. Therefore, Blue Shield customer service representatives must ask you for your Blue Shield provider identification number before they can service your call.

Providing your identification number at the beginning of your call helps Blue Shield answer your questions quickly.

Admission and discharge dates not necessary for outpatient or office visits

Do not report admission and discharge dates on the claim if you provided services in a hospital's outpatient department or in your office.

Services related to hospitalization require admission and discharge dates

If you're reporting services you performed inpatient hospital (place of service 10) or in a skilled nursing facility (SNF) (place of service 80), include the date of admission and discharge on the claim. Remember, you can report only one set of admission and discharge dates on a claim. If the patient is still hospitalized when you submit the claims, report the last date of service as the discharge date.

Most Blue Shield forms are available online

Many of Highmark Blue Shield's provider forms are available through NaviNetSM or online in the Provider Resource Center at www.highmarkblueshield.com. You can find the forms in the Provider Forms section of the Resource Center.

Some examples of online forms that are available include: Change of Address, Assignment Account paperwork, PremierBlueSM Shield Preferred Provider Agreement, and Participating Provider Agreement.

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If a form is not available online, you may order it through Blue Shield's automated ordering system by calling (866) 731-8080, option 2, extension 4.

When ordering forms, remember to specify the form number and the quantity you need.

Attention HealthGuard providers: claims accepted until July 31, 2006

Because HealthGuard products were discontinued on Feb. 1, 2006, you should submit your claims for HealthGuard members within 180 days from the date of service. Electronic or paper claims for HealthGuard members will not be accepted for payment after July 31, 2006.

If you file your claims electronically, remember that as of Aug. 1, 2006, any claims received by Emdeon Corporation (formerly known as WebMD Corporation) for HealthGuard will be rejected and returned to the sender.

If HealthGuard receives paper claims on or after Aug. 1, 2006, it will return them to the sender.

For these reasons, network practitioners are strongly encouraged to submit electronic or paper claims for any services provided to HealthGuard patients immediately following care delivery.

Send your paper claims to:

HealthGuard
Attention: Claims
280 Granite Run Drive
Lancaster, Pa. 17601-6810

Blue Shield files request to increase anesthesia conversion factor

Highmark Blue Shield is filing a request with the Pennsylvania Insurance Department (PID) to increase the anesthesia conversion factor.

If the PID approves the request, Blue Shield will implement the increase in the spring.

Policy

Highmark Blue Shield's medical policies are available online in the Provider Resource Center through NaviNetSM or at www.highmarkblueshield.com. An alphabetical, as well as a sectional index, is available on the Medical Policy page. You can search for a medical policy by entering a key word, policy number, or procedure code.

Blue Shield pays for CardioWest total artificial heart

Highmark Blue Shield pays for the implantation, replacement, and/or repair of the CardioWest total artificial heart system.

Use these codes, as appropriate, to report the implantation, replacement, and/or repair of the CardioWest system:

0051T—implantation of a total replacement heart system (artificial heart) with recipient cardiectomy

0052T—replacement or repair of thoracic unit of a total replacement heart system (artificial heart)

0053T—replacement or repair of implantable component or components or total replacement heart system (artificial heart) excluding thoracic unit

The CardioWest system is used specifically as a bridge to transplantation for patients with biventricular failure.

Blue Shield considers other artificial hearts experimental or investigational because the Food and Drug Administration has not approved them. A participating, preferred, or network provider can bill the member for a denied artificial heart.



Also applicable to FreedomBlue.

Hands-free ultrasound therapy considered investigational

Hands-free ultrasound describes an alternative method of providing ultrasound therapy in which the therapist is not required to manually move the transducer.

Because the effectiveness of hands-free ultrasound compared to traditional manual ultrasound has not been firmly established, Highmark Blue Shield considers it experimental or investigational. It is not eligible for payment. A participating, preferred, or network provider can bill the member for the denied therapy.

Use procedure code 97039—unlisted modality—to report hands-free ultrasound. When you report code 97039, please provide a complete description of the therapy you performed in the narrative section of the electronic or paper claim.



Also applicable to FreedomBlue.

Catheter-based and wireless esophageal pH monitoring covered for specific indications

Highmark Blue Shield will begin to provide coverage for both catheter-based esophageal pH monitoring and wireless esophageal pH monitoring, that is, Bravo pH monitoring, on March 13, 2006 for these indications:

- evaluation of patients who have uncontrolled symptoms of gastroesophageal reflux or reflux-like pain that does not respond to acid suppression therapy
- evaluation of patients with atypical chest pain
- evaluation of patients with unusual or persistent symptoms of gastroesophageal reflux
- patients with gastroesophageal reflux that are being evaluated for anti-reflux surgery
- evaluation of infants and children who are unable to report or describe symptoms of reflux with:
 - unexplained apnea
 - bradycardia
 - refractory coughing, wheezing, or recurrent aspiration
 - persistent or recurrent laryngitis, or pneumonia

If you perform esophageal pH monitoring for any other indications, Blue Shield will deny it as not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied monitoring.

Report conventional catheter-based esophageal pH monitoring with code 91034. Use code 91035 to report wireless esophageal pH monitoring, that is, Bravo pH monitoring.

Conventional catheter-based pH monitoring involves the placement of a catheter with a pH electrode attached to its tip at 5 cm above the upper margin of the lower esophageal sphincter (LES) using manometric location. The electrode is attached to a data logger worn on a waist belt or shoulder strap. Every instance of acid reflux as well as its duration and pH is recorded, indicating gastric acid reflux over a 24-hour period. Patient recorded symptoms can then be temporally related to acid reflux events.

The Food and Drug Administration has recently approved a catheter free, temporarily implanted device, that is, Bravo pH Monitoring System, for the purposes of esophageal monitoring. Using endoscopic guidance, the capsule is temporarily implanted in the esophageal mucosa using a pin. The capsule records pH levels for up to 48 hours and transmits them through radio frequency telemetry to a receiver worn on the patient's belt. Data from the recorder is uploaded to a computer for analysis.



Does not apply to FreedomBlue.

Reporting guidelines for clinical laboratory tests explained

Highmark Blue Shield will pay for clinical lab tests only when the health care professional or independent lab that actually performed the tests reports them.

Health care professionals should report charges only for the clinical laboratory tests they perform in their offices. Independent laboratories should bill for any clinical studies referred to them by health care professionals.

If an independent laboratory, hospital laboratory, or health care professional refers a specimen from a particular patient to a reference laboratory for testing, Blue Shield will pay the referring provider for the test performed by the reference laboratory. This should only occur when the referring provider cannot perform the test. Reference laboratories are generally specialty labs that perform highly specialized tests not performed by most independent laboratories.



Also applicable to FreedomBlue.

Radiographic imaging techniques not covered

Highmark Blue Shield does not pay for radiographic imaging techniques. These imaging techniques do not represent the actual radiological procedure being performed.

Examples of these techniques include:

- Cineradiography (codes 76120, 76125)
- Digital subtraction angiography (code S9022)
- Dynamic or digital motion X-rays (code 76499)
- Subtraction radiography (code 76350)
- Videofluoroscopy (code 76499)
- Xeroradiography (code 76150)

When any of these techniques are reported, Blue Shield will deny them as not covered. A participating, preferred, or network provider cannot bill the member for this service.

Please report the appropriate procedure code for the radiological study performed.



Also applicable to FreedomBlue.

Supplies and materials considered overhead expenses

Highmark Blue Shield considers code 99070—supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)—overhead expenses. Since Blue Shield considers overhead expenses part of a provider's professional service, do not bill separately for them. A participating, preferred, or network provider cannot bill the member for the denied expenses.

Before, Blue Shield considered the supplies and materials represented by code 99070 an integral part of a provider's medical care. Blue Shield's payment for the medical care performed on the same date of service included the allowance for code 99070. As such, a participating, preferred, or network provider could not bill the member separately for code 99070. However, if code 99070 was reported independently of medical care, Blue Shield made payment according to the terms of the member's contractual benefits for durable medical equipment.

When you use a supply or material that is durable medical equipment, orthotics, or prosthetics, do not report code 99070. Report the appropriate code for the supply or equipment you are providing.



Also applicable to FreedomBlue.

Blue Shield revises coverage guidelines for first trimester fetal nuchal translucency testing

Highmark Blue Shield now pays for measuring fetal nuchal translucency thickness in the first trimester for women who may be at risk of having a child with Down syndrome.

To be eligible, fetal nuchal translucency testing in the first trimester must be performed in conjunction with maternal serum markers quantitative human chorionic gonadotropin (code 84702) and pregnancy-associated plasma protein-A (PAPP-A) (code 84163). The patient should be adequately counseled before the procedure.

Blue Shield considers fetal nuchal translucency testing when it's performed alone in the first trimester experimental or investigational for all uses, including, but not limited to screening for chromosomal abnormalities such as Down syndrome. In these instances, Blue Shield will deny fetal nuchal translucency testing. A participating, preferred, or network provider can bill the member for the denied test.

The technique for measuring nuchal translucency and the criteria for defining increased nuchal translucency as the sole method of testing in the first trimester has not yet been standardized in the clinical setting. Additional short and long term studies involving larger numbers of patients are necessary to confirm the effectiveness of first trimester nuchal translucency without serum markers before this modality can be accepted for routine clinical use.

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Use code 76999—unlisted ultrasound procedure—to report fetal nuchal translucency. When you report code 76999, please include a complete description of the procedure in the narrative field of the electronic or paper claim.

All fetuses have a layer of fluid on the back of their bodies between the skin and the underlying soft tissue. Babies with chromosomal and heart defects tend to have more fluid in this layer. This layer is translucent on ultrasound, and its thickness is measured at the level of the neck.

Fetal nuchal translucency, a prenatal genetic testing procedure, can be used to detect subcutaneous edema in the fetal neck. The fluid is measured between the inner aspect of the fetal skin and the outer aspect of soft tissue overlying the cervical spine or the occipital bone. Increased fetal nuchal translucency has been associated with chromosomal defects, most commonly Down syndrome, and other genetic syndromes, as well as abnormalities of the heart and great arteries, and a wide range of skeletal dysplasias.



Also applicable to FreedomBlue.

Intravitreal injection of triamcinolone acetonide considered investigational

Highmark Blue Shield considers intravitreal injection of triamcinolone acetonide (Kenalog) an experimental or investigational service. Blue Shield will not pay for this injection because there is insufficient evidence in medical literature regarding its safety, effectiveness, and long-term effects. A participating, preferred, or network provider can bill the member for the denied service.

Triamcinolone acetonide is a corticosteroid similar to prednisone. Currently, the Food and Drug Administration has approved triamcinolone acetonide specifically for intrabursal and intramuscular use, but not for intravitreal use, necessitating “off-label” use for treatment of ophthalmic disorders.

Use procedure code 67028—intravitreal injection of a pharmacologic agent (separate procedure)—to report the intravitreal injection. Code J3301—injection triamcinolone acetonide, per 10 mg—should be used to report the pharmacologic agent.

Intravitreal Kenalog is used in the treatment of macular edema associated with various retinal disorders, such as diabetic cystoid macular edema, central and branch retinal vein occlusion, uveitis, pseudophakic macular edema following cataract surgery, and choroidal neovascularization secondary to age-related macular degeneration.



Also applicable to FreedomBlue.

Meniscal allograft transplantation now eligible for reimbursement

Highmark Blue Shield now covers meniscal allograft transplantation.

Blue Shield considers meniscal allograft transplantation medically necessary for patients who meet these criteria:

- the patient has had a total or near-total meniscectomy,
- the patient is experiencing persistent pain in the tibio-femoral compartment during activities of daily living,
- radiographs do not show evidence of advanced arthrosis, including joint space narrowing, and,
- the knee is stable prior to surgery or can be stabilized by performing a concomitant ligament repair.

If the patient does not meet all of the criteria for meniscal allograft transplantation, Blue Shield will deny it as not medically necessary. A participating, preferred, or network provider cannot bill the patient for the denied surgery.

Use procedure code 29868 to report meniscal allograft transplantation.



Also applicable to FreedomBlue.

Infliximab coverage expanded

As of Sept. 15, 2005, Highmark Blue Shield covers Remicade[®] when it's used to treat ulcerative colitis (556.0-556.9).

The Food and Drug Administration has approved Remicade for the reduction of signs and symptoms, achieving clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy (oral corticosteroids, azathioprine [AZA], 6-mercaptopurine [6-MP] and/or aminosalicylates).

The recommended dose of infliximab for ulcerative colitis is 5mg/kg given as an induction regimen at 0, 2, and, 6 weeks followed by a maintenance regimen of 5mg/kg every 8 weeks thereafter.

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



Also applicable to FreedomBlue.

Additional procedures eligible for co-surgery

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

33768—anastomosis, cavopulmonary, second superior vena cava (list separately in addition to primary procedure)

33880—endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

33881—endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

33883—placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension

33884—placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (list separately in addition to code for primary procedure)

33886—placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta

33889—open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral

33891—bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

37184—primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel

37185—primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (list separately in addition to code for primary mechanical thrombectomy procedure)

37186—secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (list separately in addition to code for primary procedure)

37187—percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

37188—percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy

Other Blue Shield medical policies may also determine the eligibility of these codes.



Also applicable to FreedomBlue.

Presbyopia correcting function of intraocular lens not covered

Highmark Blue Shield does not consider presbyopia-correcting function of intraocular lens (code V2788) eligible for coverage. Blue Shield will deny claims reporting this prosthetic. A participating, preferred, or network provider can bill the member for the denied prosthetic.

Code V2788—presbyopia-correcting function of intraocular lens—is an add-on code to be used with code L8699. Code L8699 represents the presbyopia-correcting intraocular lens, for example, CrystaLens, RESTOR, ReZoom. When you report code L8699, please include the term "presbyopia-correcting intraocular lens" in the narrative section of the electronic or paper claim.

For more information about presbyopia-correcting intraocular lenses, please see the December 2005 **PRN**.

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



Does not apply to FreedomBlue.

Blue Shield covers transplantation for chondral defects for specific indications

Highmark Blue Shield considers autologous chondrocyte transplantation (ACT) medically necessary when it's performed to repair symptomatic, cartilaginous defects of the femoral condyle (medial, lateral, or trochlear) caused by acute or repetitive trauma in patients who have inadequately responded to prior arthroscopic or other surgical repair when the patient has:

- reached skeletal maturity,
- an isolated full-thickness defect between 2.5 and 10 cm squared in total area size on the femoral condyle,
- a stable and aligned knee without meniscal deficiency that is surrounded by healthy articular cartilage capable of supporting the graft, and
- the ability and willingness to comply with the postoperative rehabilitation protocol.

Use procedure code 27412 to report ACT.

Blue Shield considers the culturing component of the procedure a part of the facility expense. Procedure code J7330 represents the culturing component.

Blue Shield will pay for osteochondral allograft transplantation for cartilaginous defects when the patient has:

- reached skeletal maturity,
- a full-thickness unipolar defect greater than or equal to 2 cm squared in total area size on the femoral condyle or patellar articular surface,
- a stable and aligned knee without meniscal deficiency that is surrounded by healthy articular cartilage capable of supporting the graft, and
- the ability and willingness to comply with the postoperative rehabilitation protocol.

Use procedure code 27415 (open) or 29867 (arthroscopic) to report osteochondral allograft transplantation.

Blue Shield will pay for osteochondral autograft transplantation for cartilaginous defects when the patient has:

- reached skeletal maturity,
- a full-thickness unipolar defect between 1 and 3 cm squared in total area size on the femoral condyle or patellar articular surface,

- a stable and aligned knee without meniscal deficiency that is surrounded by healthy articular cartilage capable of supporting the graft, and
- the ability and willingness to comply with the postoperative rehabilitation protocol.

Use procedure code 29866 to report osteochondral autograft transplantation.

Blue Shield considers ACT, osteochondral allograft transplantation, or osteochondral autograft transplantation not medically necessary when the patient has any of these conditions:

- degenerative arthritis
- uncorrected malalignment and/or ligament reconstruction for instability
- meniscal insufficiency
- steroid dependency
- any associated pathology or condition that may affect graft incorporation

A participating, preferred, or network provider cannot bill the member for the denied service.

ACT, osteochondral allograft transplantation, and osteochondral autograft transplantation are performed for the treatment of cartilaginous defects of the knee.



Also applicable to FreedomBlue.

Audiometric testing includes both ears

Audiometric tests, codes 92551–92588, include testing of both ears. Do not report multiple services when you test both ears.

If you test only one ear, report modifier 52 along with the appropriate code, 92551–92588.

When you perform audiometric testing more than once on the same date of service, please include documentation of the medical necessity of the multiple tests in the patient's medical records.



Also applicable to FreedomBlue.

Blue Shield defines purchased services

Highmark Blue Shield defines “purchased” services as those that are not actually performed by the provider that orders and reports them. The concept typically applies to procedures with separate professional and technical components, such as radiological and diagnostic medical tests. The patient’s physician may perform the professional component (interpretation), however, that physician may have purchased the technical component from another entity.

The provider that performs the professional services, including the professional component (interpretation) of diagnostic tests, must always report them. A provider may not report a professional service that is performed by another entity. In other words, a provider may not “purchase” a professional service.

Technical services may be purchased

Technical services, such as the technical component of a diagnostic test, may be purchased. A provider may report the technical component of a service ordered from and rendered by another entity.

Independent Diagnostic Testing Facilities (IDTF) often provide technical services. IDTFs are business entities that generally do not provide a direct service to Blue Shield’s members. IDTFs do not meet the definition of an eligible professional provider according to Blue Shield’s enabling legislation. Because of this, IDTFs are not able to receive reimbursement directly from Blue Shield. However, providers may purchase technical services from IDTFs and report them to Blue Shield. (See Example A)

In some instances, IDTFs contract with physicians to interpret test results. The IDTF then “sells” the total service to the ordering physician. Providers may not report purchased total services to Blue Shield, because they may not report a professional service performed by another entity. (See Example B)

Here are examples of various billing arrangements:

Example A—acceptable billing arrangement

A cardiologist purchases the technical component of cardiac monitoring services from an IDTF. The cardiologist interprets the results of the service and reports the total procedure to Blue Shield. The single fee from the physician includes his or her cost for the technical portion of the test, as well as his or her professional interpretation fee.

Example B—unacceptable billing arrangement

A family practitioner purchases a total radiology service from an IDTF or a radiologist. The family practitioner cannot report this service to Blue Shield, since he or she did not interpret the results and therefore has not provided a covered professional service. In this example, the radiologist who interprets the study should report the total service to Blue Shield.

Example C—acceptable billing arrangement

An internist requests a diagnostic cardiac test from a cardiologist. The internist interprets the results of the service and reports the professional component to Blue Shield. The cardiologist who owns the equipment reports the technical component of the test to Blue Shield. There is no “purchased” service in this example. Each physician reports the applicable component he or she provided.

Reporting guidelines

For reporting purposes, total component procedures should be reported with the appropriate procedure code. No modifier is necessary to identify a code as a “total” service. When reporting only the professional or technical components, use the appropriate procedure code for the individual component, if applicable, or use an appropriate modifier with the procedure code (modifier 26—professional component; modifier TC—technical component).



Also applicable to FreedomBlue.

Blue Shield allows automatic implantable cardioverter-defibrillator for new indications

Highmark Blue Shield pays for the implantation of an automatic cardioverter-defibrillator (codes 33246, G0297, G0298, or 33249, G0299, G0300) for these new indications:

- symptomatic ischemic dilated cardiomyopathy with a history of myocardial infarction at least 40 days before AICD treatment and left ventricular ejection fraction of 35 percent or less (427.1, 427.41, 427.9)
- symptomatic nonischemic dilated cardiomyopathy for more than 9 months’ duration and left ventricular ejection fraction of 35 percent or less (427.1, 427.41, 427.9).

Please see the April 2003 **PRN** for additional covered indications and guidelines for automatic implantable cardioverter-defibrillators.

The implantable automatic cardioverter-defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias.



Does not apply to FreedomBlue.

Manipulation services guidelines clarified

When a patient's benefits allow for manipulation services, Highmark Blue Shield will cover manipulation (adjustment) of both spinal and extraspinal regions when it's performed with the expectation of restoring the patient's level of function that has been lost or reduced by injury or illness. You should provide adjustments in accordance with an ongoing, written treatment plan. The treatment plan must be maintained in the patient's medical record. Although Blue Shield does not require you to submit treatment plans for payment purposes, they should be available upon request.

Adjustments can be provided manually or with the assistance of various mechanical or computer operated devices. Blue Shield does not allow additional payment for the use of the device or for the device itself. This includes, but is not limited to, computer-controlled systems such as the Forced Recording and Analysis (FRAS) System.

Components of manipulation service

The pre, intra and postservice components of a manipulation service, as documented in the medical record, include these components:

- an update of the patient's history regarding any changes, positive or negative, since the prior visit,
- a review of the chart, prior treatment plan, or diagnostic imaging,
- performance of a physical assessment to determine the location and intensity of the patient's symptoms and medical necessity of the manipulation (with or without an instrument as the assessment tool, for example, FRAS System),
- manual palpation that documents pain or tenderness including location, intensity, quality, tissue response of muscles (spasms, hypertonicity, etc.),
- motion palpation, joint evaluation, or whatever technique is used to locate and evaluate joint dysfunction or fixation,
- manipulation of the joint(s) identified in the evaluation to restore normal joint motion/mechanics,
- proper documentation of each area manipulated, including technique or instrumentation used if not done by hand,
- a documented postmanipulation evaluation of the patient's response to the treatment,
- a determination to continue, cease or minimally alter the treatment plan, and,
- patient education or instructions.

Evaluation and management services

Manipulation includes a premanipulation assessment. This means that Blue Shield will pay for a separate evaluation and management (E/M) service only in these circumstances:

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

When you report E/M services, the level reported should be consistent with the complexity of the history, physical and medical decision making involved in the patient encounter. Documentation in the patient's medical record should demonstrate the components of the separate and distinct E/M service as well as the reasons for performing the separate E/M service.

Physical medicine modalities

Blue Shield considers physical medicine modalities performed solely to relax and prepare the patient for the adjustment (application of hot or cold packs [97010] and massage [97124]) an inherent part of the manipulation service. Blue Shield will not pay separately for these services when they're reported on the same day as a manipulation.

Blue Shield considers joint mobilization (97140) an inherent part of an adjustment procedure. It is not eligible for separate payment when it's reported on the same day as the adjustment.

If you perform procedures 97010, 97124, and 97140 on a separate body region, unrelated to the adjustment procedure, Blue Shield may consider them for separate payment. In these cases, report modifier 59 with code 97010, 97124, or 97140. Please report in the patient's medical records the different body regions to which the services were provided.

Do not use procedure code 97750—physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes—to report the physical assessment routinely performed as part of either the manipulation or the E/M service. Assessments performed during a manipulation or as part of an E/M encounter include the assessment of muscle strength, ROM, flexibility, and endurance to establish the diagnosis and severity of the condition. Do not use code 97750 to report computer generated information obtained through devices such as the FRAS system.

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Maintenance services not eligible

Blue Shield does not cover manipulations that are performed repetitively to maintain the patient's level of function. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Use code S8990 to report maintenance.

Blue Shield determines coverage for manipulation of the spine according to individual or group customer benefits.



Does not apply 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

Changes to 2006 HCPCS revision

Please update the **2006 HCPCS Update** publication with these changes:

Code	2006 HCPCS Update	Action
57450	Noted as being deleted	This code was never a valid code; therefore, it was not deleted.
57451	Noted as being deleted	This code was never a valid code; therefore, it was not deleted.
78810	Noted as being deleted	This code had been deleted in 2005.

2/2006

New codes available for reporting home-based, real-time cardiac surveillance system

The Blue Cross Blue Shield Association has created three new codes for reporting the home-based, real-time cardiac surveillance system. As of April 1, 2006, you can use the new codes to report this service instead of code 93799—unlisted cardiovascular service or procedure.

Because of the terminology of the new codes, Highmark Blue Shield will pay for this service on a “per day” basis. This applies to all of Blue Shield’s products, including FreedomBlueSM.

Here are the codes and their corresponding terminology:

S0345—electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real-time notification of monitoring station, 24-hour attended monitoring, including recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation; per 24-hour period

S0346—electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real-time notification of monitoring station, 24-hour attended monitoring, including recording, monitoring, receipt of transmissions, and analysis; per 24-hour period

S0347—electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real-time notification of monitoring station, 24-hour attended monitoring, including physician review and interpretation; per 24-hour period

For more information about Blue Shield’s coverage guidelines for home-based, real-time cardiac surveillance monitoring, please see the December 2005 **PRN**.



Also applicable to FreedomBlue.

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Notes

2/2006

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-2006, Copyright 2005, by the American Medical Association. **PRN** includes CPT descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.

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Policy Review & News

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