PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

June 2008

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MA

Look for this symbol for all Medicare Advantage related informaton

BC

Look for this symbol for all BlueCard® related information

News

New Medical History form introduced for services to treat direct-pay members for pre-existing conditions

Please note that, as of July 21, 2008, a new Medical History form is being used to gather information to verify whether medical conditions are pre-existing for certain members enrolled in either a medically underwritten or guaranteed issue Highmark Blue Shield direct-pay (non-group) product.

A pre-existing condition is a condition that was diagnosed or for which treatment was recommended or received within a specified time period prior to the direct-pay member's effective date of coverage. Most Blue Shield direct-pay products exclude coverage for pre-existing conditions during the first 12 months of coverage.

HIGHMARK® BLUE SHIELD

If you provide services to a Blue Shield direct-pay member within this pre-existing exclusion period to treat a condition that may be pre-existing, both you and the direct-pay member will need to complete the Medical History form.

This policy does not apply to Blue Shield's Medicare Advantage products, FreedomBlue℠ PFFS (Private-Fee-for-Service) and FreedomBlue℠ PPO.

Impact to providers

Verifying pre-existing condition status: There are two ways you can verify whether an individual is subject to a pre-existing condition exclusion period:

- *NaviNet®*: Please review Eligibility and Benefits information to verify the member's coverage.
- *Highmark Blue Shield identification card*: If the date of service is within 12 months of the individual's effective date shown on the identification card, a pre-existing condition exclusion may apply. Only direct-pay members have an effective date on their identification card.

Ensuring accurate claim processing and payment: As of July 21, 2008, if a claim is submitted for a condition that may be pre-existing, the claim may pend for 15 days from the date of receipt to allow you and the direct-pay member to complete and return the Medical History form. The information supplied on the Medical History form will allow Blue Shield to efficiently and accurately process the claim.

Submitting the Medical History form: There are two ways you can obtain and submit the Medical History form:

- *Download, print, and submit form with claim*: You can expedite claim processing by including a completed Medical History form with your claim. The Medical History form is available on the Provider Resource Center through NaviNet or at **www.highmarkblueshield.com**. To access the form, hover on Provider Forms and select Miscellaneous Forms from the fly-out menu. Then, select the Medical History form link.
- *Complete and return form you receive from Blue Shield:* When Blue Shield receives a claim for treatment of a condition that may be pre-existing, Blue Shield will mail a Medical History form to you and the direct-pay member. The Medical History form is prepopulated with information to assist you in identifying the condition at issue. Please complete the applicable sections of the Medical History form and return it **within 15 days of receipt** to Blue Shield by mail or fax as instructed within the form. If Blue Shield does not receive the Medical History form within 15 days, it will process the claim based upon the information available—in some instances, the claim may be denied.

Blue Shield seeks new members for Medical Review Committee

Highmark Blue Shield is searching for members to serve on its Medical Review Committee. The Medical Review Committee resolves disputes between participating providers and Highmark Blue Shield. These disputes may involve utilization and quality of care issues, as well as alleged violations of participating provider agreements and appeals regarding network terminations. The Committee also considers and reviews appeals for providers who have been denied privileges to provide imaging services.

Ten doctors of medicine, one doctor of osteopathy, one doctor of chiropractic medicine, one physical therapist, and two consumer representatives now serve on the Committee. The Review Committee Selection Committee appoints the members to a two-year term. Members may be re-appointed.

The Medical Review Committee generally meets four to six times a year at the Highmark Blue Shield office in Camp Hill, Pennsylvania. Blue Shield does reimburse committee members for their expenses. Members also receive an honorarium from Blue Shield.

Considerable preparation time for the meetings may be required. Members are expected to attend all meetings and be prepared to participate in each case discussion.

Committee member requirements and how to apply

All potential candidates must be a Pennsylvania licensed health care provider who participates in a Highmark Blue Shield network.

If you are interested in being considered for membership by the Selection Committee, please send a copy of your current resume or curriculum vitae, by Aug. 22, 2008, to:

Raymond J. DiBello
Secretary, Medical Review Committee
Highmark Blue Shield
1800 Center Street
Camp Hill, Pa. 17089

Blue Shield files request for UCR and PremierBlue Shield reimbursement changes

Highmark Blue Shield is filing a broad range of UCR Customary and PremierBlue℠ Shield reimbursement adjustments with the Pennsylvania Insurance Department.

If the Pennsylvania Insurance Department approves the request, Blue Shield will adjust payments for select surgical, diagnostic and evaluative services, including, but not limited to:

- cardiovascular
- dialysis
- digestive
- musculoskeletal
- urinary

Blue Shield expects to implement these reimbursement changes during the fall of 2008. Please watch your mail for a special bulletin announcing the changes.

Details about the proposed reimbursement changes will also be announced in a future edition of **PRN**.

Cut administrative costs by eliminating paper EOBs

Highmark Blue Shield is continually working to reduce your administrative costs. Over the past several years, Blue Shield has offered electronic functionality, such as NaviNet® to perform electronic inquiries, and, more recently, electronic funds transfer of your claims payments.

Blue Shield's newest initiative is the option for you to eliminate paper Explanation of Benefits (EOB) statements. This means that you can reduce the amount of paper coming into your office and lower administrative costs. Also, you can view your EOBs earlier than when you received them in the mail.

You may request electronic EOBs if you are:

- electronically enabled to submit claims
- enabled with electronic funds transfer (EFT)

- NaviNet-enabled or if you receive electronic remittance advice (ERA). (As of January 2008, all Highmark Blue Shield EOBs are available on NaviNet through AR Management's EOB/Remittance option, including Medicare Crossover.)

To discontinue paper EOBs, contact your Provider Relations representative at:

- Central and Lehigh Valley region providers: (866) 731-8080, option 2, then option 6
- Eastern region providers: (866) 975-7290, option 6

Northeastern region providers should call Provider Relations at (800) 451-4447 and ask to speak to their Provider consultant.

Office Manual now features printable tip sheets

The **Highmark Blue Shield Office Manual** now includes printable one-page tip sheets for your office. These tip sheets detail the steps involved in many of Highmark Blue Shield's common policies and procedures. The sheets also act as a reference point for many of Blue Shield's frequently requested materials.

Tip sheets contain information on topics such as:

- anatomy of Blue Shield's identification cards
- Baby BluePrints® maternity education and support program
- frequently used Blue Shield contact information
- new edit check procedures
- paper claims filing addresses

For a complete list of all tip sheets throughout the manual, please select "Tip Sheet Index" on the **Office Manual** homepage. The tip sheet index is listed by the corresponding unit and will link you to the same tip sheets embedded within the manual.

The **Highmark Blue Shield Office Manual** is located under Administrative Reference Materials on the Provider Resource Center. You can access the Provider Resource Center through NaviNet® or at **www.highmarkblueshield.com**.

If you have recommendations for further enhancements to the **Office Manual**, please write to us at **hbsomeditor@highmark.com**.

Blue Shield plans endoscopic services payment reduction for Medicare Advantage products

Highmark Blue Shield intends to implement a payment reduction for endoscopic services when one or more services having the same endoscopic base code are performed on the same day for the same patient.

Blue Shield is planning to implement the endoscopic payment reduction in January 2009 for only its Medicare Advantage products, FreedomBlue[SM] PFFS (Private-Fee-for-Service) and FreedomBlue[SM] PPO.

Blue Shield's payment reduction will mirror the Centers for Medicare & Medicaid Services' reduction by paying the full allowance of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. The base endoscopy codes, listed below, can also be found on the Medicare Physician Fee Schedule in the endoscopic base code field.

HCPCS	Description	Endoscopic base code
29806	Shoulder arthroscopy with surgery	29805
29807	Shoulder arthroscopy with surgery	29805
29819	Shoulder arthroscopy with surgery	29805
29820	Shoulder arthroscopy with surgery	29805
29821	Shoulder arthroscopy with surgery	29805
29822	Shoulder arthroscopy with surgery	29805
29823	Shoulder arthroscopy with surgery	29805
29824	Shoulder arthroscopy with surgery	29805
29825	Shoulder arthroscopy with surgery	29805
29826	Shoulder arthroscopy with surgery	29805
29827	Arthroscopy with rotator cuff repair	29805
29828	Arthroscopy biceps tenodesis	29805
29834	Elbow arthroscopy with surgery	29830
29835	Elbow arthroscopy with surgery	29830
29836	Elbow arthroscopy with surgery	29830
29837	Elbow arthroscopy with surgery	29830
29838	Elbow arthroscopy with surgery	29830
29843	Wrist arthroscopy with surgery	29840
29844	Wrist arthroscopy with surgery	29840
29845	Wrist arthroscopy with surgery	29840
29846	Wrist arthroscopy with surgery	29840
29847	Wrist arthroscopy with surgery	29840
29861	Hip arthroscopy with surgery	29860
29862	Hip arthroscopy with surgery	29860
29863	Hip arthroscopy with surgery	29860
29871	Knee arthroscopy with drainage	29870
29873	Knee arthroscopy with surgery	29870

HCPCS	Description	Endoscopic base code
29874	Knee arthroscopy with surgery	29870
29875	Knee arthroscopy with surgery	29870
29876	Knee arthroscopy with surgery	29870
29877	Knee arthroscopy with surgery	29870
29879	Knee arthroscopy with surgery	29870
29880	Knee arthroscopy with surgery	29870
29881	Knee arthroscopy with surgery	29870
29882	Knee arthroscopy with surgery	29870
29883	Knee arthroscopy with surgery	29870
29884	Knee arthroscopy with surgery	29870
29885	Knee arthroscopy with surgery	29870
29886	Knee arthroscopy with surgery	29870
29887	Knee arthroscopy with surgery	29870
31510	Laryngoscopy with biopsy	31505
31511	Laryngoscopy with removal of foreign body	31505
31512	Laryngoscopy with removal of lesion	31505
31513	Laryngoscopy with vocal cord injection	31505
31527	Laryngoscopy with insertion of obturator	31525
31528	Laryngoscopy and dilation	31525
31529	Laryngoscopy and dilation	31525
31530	Laryngoscopy with foreign body removal	31525
31531	Laryngoscopy with foreign body removal and operating scope	31526
31535	Laryngoscopy with biopsy	31525
31536	Laryngoscopy with biopsy and operating scope	31526
31540	Laryngoscopy with excision of tumor	31525
31541	Laryngoscopy with tumor excision and scope	31526
31545	Laryngoscopy with removal of vocal cord lesion with scope	31526
31546	Laryngoscopy with removal of vocal cord lesion; reconstruction with graft	31526
31560	Laryngoscopy with arytenoidectomy	31525
31561	Laryngoscopy with operating scope	31526
31570	Laryngoscopy with vocal cord injection	31525
31571	Laryngoscopy with vocal cord injection and operating scope	31526
31576	Laryngoscopy with biopsy	31575
31577	Laryngoscopy with removal of foreign body	31575
31578	Laryngoscopy with removal of lesion	31575
31579	Diagnostic laryngoscopy	31575
31623	Diagnostic bronchoscopy with brushing	31622
31624	Diagnostic bronchoscopy with lavage	31622
31625	Bronchoscopy with biopsy(s)	31622
31628	Bronchoscopy with lung biopsy, each	31622
31629	Bronchoscopy with needle biopsy, each	31622

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HCPCS	Description	Endoscopic base code
31630	Bronchoscopy, dilation with fracture repair	31622
31631	Bronchoscopy, dilation with stent	31622
31635	Bronchoscopy with foreign body removal	31622
31636	Bronchoscopy, bronchial stents	31622
31638	Bronchoscopy, revise stent	31622
31640	Bronchoscopy with tumor excision	31622
31641	Bronchoscopy, treat blockage	31622
31645	Bronchoscopy, clear airways	31622
38570	Laparoscopy, lymph node biopsy	49320
43201	Esophagoscopy with submucous injection	43200
43202	Esophagoscopy with biopsy	43200
43204	Esophagoscopy with sclerosis injection	43200
43205	Esophagoscopy with ligation	43200
43215	Esophagoscopy with removal of foreign body	43200
43216	Esophagoscopy with removal of lesion	43200
43217	Esophagoscopy with removal of lesion	43200
43219	Esophagoscopy with insertion of stent	43200
43220	Esophagoscopy with dilation	43200
43226	Esophagoscopy with dilation	43200
43227	Esophagoscopy with repair	43200
43228	Esophagoscopy with ablation of tumor	43200

HCPCS	Description	Endoscopic base code
43231	Esophagoscopy with ultrasound exam	43235
43232	Esophagoscopy with ultrasound fine needle biopsy	43235
43236	Upper GI endoscopy with submucosal injection	43235
43237	Upper GI with endoscopic ultrasound exam, esophagus	43235
43238	Upper GI endoscopy with ultrasound fine needle biopsy	43235
43239	Upper GI endoscopy with biopsy	43235
43240	Upper GI endoscopy with drainage of cyst	43235
43241	Upper GI endoscopy with tube	43235
43242	Upper GI endoscopy with ultrasound fine needle biopsy	43235
43243	Upper GI endoscopy and injection	43235
43244	Upper GI endoscopy with ligation	43235
43245	Upper GI endoscopy with dilation of stricture	43235
43246	Upper GI endoscopy with placement of gastrostomy tube	43235
43247	Upper GI endoscopy with removal of foreign body	43235
43248	Upper GI endoscopy with guide wire insertion	43235
43249	Upper GI endoscopy with dilation	43235
43250	Upper GI endoscopy with removal of tumor	43235
43251	Upper GI endoscopy with removal of tumor	43235

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HCPCS	Description	Endoscopic base code
43255	Upper GI endoscopy with control of bleeding	43235
43256	Upper GI endoscopy with stent	43235
43257	Upper GI endoscopy with thermal treatment	43235
43258	Upper GI endoscopy with tumor ablation	43235
43259	Upper GI endoscopy with endoscopic ultrasound exam	43235
43261	Endoscopic cholangiopancreatography	43260
43262	Endoscopic cholangiopancreatography	43260
43263	Endoscopic cholangiopancreatography	43260
43264	Endoscopic cholangiopancreatography	43260
43265	Endoscopic cholangiopancreatography	43260
43267	Endoscopic cholangiopancreatography	43260
43268	Endoscopic cholangiopancreatography	43260
43269	Endoscopic cholangiopancreatography	43260
43271	Endoscopic cholangiopancreatography	43260
43272	Endoscopic cholangiopancreatography	43260
44361	Small bowel endoscopy with biopsy	44360
44363	Small bowel endoscopy with removal of foreign body	44360
44364	Small bowel endoscopy with removal of tumor	44360
44365	Small bowel endoscopy with removal of tumor	44360
44366	Small bowel endoscopy with control of bleeding	44360
44369	Small bowel endoscopy with ablation of tumor	44360
44370	Small bowel endoscopy with stent	44360
44372	Small bowel endoscopy with placement of tube	44360
44373	Small bowel endoscopy with conversion of tube	44360
44377	Small bowel endoscopy with biopsy	44376
44378	Small bowel endoscopy with control of bleeding	44376
44379	Small bowel endoscopy with stent	44376
44389	Colonoscopy with biopsy	44388
44390	Colonoscopy for foreign body	44388
44391	Colonoscopy for bleeding	44388
44392	Colonoscopy and polypectomy	44388
44393	Colonoscopy, lesion removal	44388
44394	Colonoscopy with snare	44388
44397	Colonoscopy with stent	44388
45303	Proctosigmoidoscopy with dilation	45300
45305	Proctosigmoidoscopy with biopsy	45300
45307	Proctosigmoidoscopy with removal of foreign body	45300
45308	Proctosigmoidoscopy with removal of lesion	45300
45309	Proctosigmoidoscopy with removal of lesion	45300
45315	Proctosigmoidoscopy with removal of lesion	45300
45317	Proctosigmoidoscopy with control of bleeding	45300
45320	Proctosigmoidoscopy with ablation of tumor	45300

HCPCS	Description	Endoscopic base code
45321	Proctosigmoidoscopy with decompression of volvulus	45300
45327	Proctosigmoidoscopy with stent	45300
45331	Sigmoidoscopy and biopsy	45330
45332	Sigmoidoscopy with foreign body removal	45330
45333	Sigmoidoscopy with removal of tumor	45330
45334	Sigmoidoscopy with control of bleeding	45330
45335	Sigmoidoscopy with submucosal injection	45330
45337	Sigmoidoscopy with decompression	45330
45338	Sigmoidoscopy with tumor removal	45330
45339	Sigmoidoscopy with ablation of tumor	45330
45340	Sigmoidoscopy with balloon dilation	45330
45345	Sigmoidoscopy with stent	45330
45379	Colonoscopy with foreign body removal	45378
45380	Colonoscopy with biopsy	45378
45381	Colonoscopy with submucous injection	45378
45382	Colonoscopy with control of bleeding	45378
45383	Colonoscopy with tumor ablation	45378
45384	Colonoscopy with tumor removal	45378
45385	Colonoscopy with tumor removal	45378
45386	Colonoscopy with dilation of stricture	45378
45387	Colonoscopy with stent	45378
45391	Colonoscopy with endoscopic ultrasound	45378
45392	Colonoscopy with endoscopic fine needle biopsy	45378
46604	Anoscopy with dilation	46600
46606	Anoscopy with biopsy	46600
46608	Anoscopy with removal of foreign body	46600
46610	Anoscopy with removal of lesion	46600
46611	Anoscopy with removal of tumor, polyp, lesion	46600
46612	Anoscopy with removal of lesions	46600
46614	Anoscopy with control of bleeding	46600
46615	Anoscopy with ablation of tumor, polyp, lesion	46600
47553	Biliary endoscopy with biopsy	47552
47554	Biliary endoscopy with removal of calculus	47552
47555	Biliary endoscopy with dilation of stricture	47552
47556	Biliary endoscopy with dilation of stricture	47552
49321	Laparoscopy with biopsy	49320
49322	Laparoscopy with aspiration	49320
49323	Laparoscopy with drainage of lymphocele	49320
49324	Laparoscopy with insertion of permanent intraperitoneal catheter	49320
49325	Laparoscopy with revision of permanent intraperitoneal catheter	49320
50555	Renal endoscopy with biopsy	50551
50557	Renal endoscopy with or without treatment	50551

HCPCS	Description	Endoscopic base code
50561	Renal endoscopy with removal of foreign body	50551
50572	Renal endoscopy with catheterization	50570
50574	Renal endoscopy with biopsy	50570
50575	Renal endoscopy with endopyelotomy	50570
50576	Renal endoscopy with or without biopsy	50570
50580	Renal endoscopy with removal of foreign body	50570
50953	Ureteral endoscopy	50951
50955	Ureteral endoscopy with biopsy	50951
50957	Ureteral endoscopy with or without biopsy	50951
50961	Ureteral endoscopy with removal of foreign body	50951
50974	Ureteral endoscopy with biopsy	50970
50976	Ureteral endoscopy with or without biospy	50970
52001	Cystourethroscopy with removal of clots	52000
52005	Cystourethroscopy with ureteral catheterization	52000
52007	Cystourethroscopy with biopsy	52000
52010	Cystourethroscopy with duct catheterization	52000
52204	Cystourethroscopy with biopsy	52000
52214	Cystourethroscopy with fulguration	52000
52224	Cystourethroscopy with fulguration	52000
52234	Cystourethroscopy with fulguration of small tumors	52000
52235	Cystourethroscopy with fulguration of medium tumors	52000
52240	Cystourethroscopy with fulguration of large tumors	52000
52250	Cystourethroscopy with insertion of radioactive substance	52000
52260	Cystourethroscopy with dilation for interstitial cystitis, general anesthesia	52000
52265	Cystourethroscopy with dilation for interstitial cystitis, local anesthesia	52000
52270	Cystourethroscopy with internal urethrotomy, female	52000
52275	Cystourethroscopy with internal urethrotomy, male	52000
52276	Cystourethroscopy with direct vision internal urethrotomy	52000
52277	Cystourethroscopy with resection	52000
52281	Cystourethroscopy with calibration	52000
52282	Cystourethroscopy with implantation of stent	52000
52283	Cystourethroscopy with steroid injection	52000
52285	Cystourethroscopy with treatment	52000
52290	Cystourethroscopy with treatment	52000
52300	Cystourethroscopy with resection	52000
52301	Cystourethroscopy with resection	52000
52305	Cystourethroscopy with incision or resection	52000
52310	Cystourethroscopy with removal of foreign body	52000
52315	Cystourethroscopy with removal of foreign body, complicated	52000

HCPCS	Description	Endoscopic base code
52317	Litholapaxy with removal of bladder stone	52000
52318	Litholapaxy with removal of bladder stone	52000
52320	Cystourethroscopy with removal of calculus	52000
52325	Cystourethroscopy with fragmentation of calculus	52000
52327	Cystourethroscopy with injection	52000
52330	Cystourethroscopy with manipulation	52000
52332	Cystourethroscopy with catheter insertion	52000
52334	Cystourethroscopy with guide wire insertion	52000
52341	Cystourethroscopy with ureteral stricture treatment	52000
52342	Cystourethroscopy with ureteropelvic junction stricture treatment	52000
52343	Cystourethroscopy with renal stricture treatment	52000
52344	Cystourethroscopy with ureteral stricture treatment	52000
52345	Cystourethroscopy with ureteropelvic junction stricture	52351
52346	Cystourethroscopy with renal stricture treatment	52351
52352	Cystourethroscopy with stone removal	52351
52353	Cystourethroscopy with lithotripsy	52351
52354	Cystourethroscopy with biopsy	52351
52355	Cystourethroscopy with resection of tumor	52351
52400	Cystourethroscopy with congenital repair	52000
52402	Cystourethroscopy with resection or incision of ejaculatory duct	52000
57454	Colposcopy with biopsy and curettage	57452
57455	Colposcopy with biopsy	57452
57456	Colposcopy with endocervical curettage	57452
57460	Colposcopy with loop electrode biopsy of cervix	57452
57461	Colposcopy with loop electrode conization of cervix	57452
58541	Laparoscopy, hysterectomy for uterus 250 g or less	49320
58550	Laparoscopy with vaginal hysterectomy	49320
58558	Hysteroscopy with biopsy	58555
58559	Hysteroscopy with lysis of adhesions	58555
58560	Hysteroscopy with resection of septum	58555
58561	Hysteroscopy with removal of leiomyomata	58555
58562	Hysteroscopy with removal of foreign body	58555
58563	Hysteroscopy with endometrial ablation	58555
58565	Hysteroscopy with sterilization	58555

HCPCS	Description	Endoscopic base code
58660	Laparoscopy with lysis of adhesions	49320
58661	Laparoscopy with removal of adnexa	49320
58662	Laparoscopy with excision of lesions	49320
58670	Laparoscopy with tubal cautery	49320
58671	Laparoscopy with tubal block	49320
58672	Laparoscopy with fimbrioplasty	49320
58673	Laparoscopy with salpingostomy	49320
66711	Ciliary endoscopic ablation	66710

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

Recent updates to the Highmark Blue Shield Office Manual

Highmark Blue Shield made the following updates and additions to the **Highmark Blue Shield Office Manual**:

- "Updating Physician Information On the Web" unit revised (Chapter 1, Unit 2)
- "Requesting a Copy of Your Contract" unit added (Chapter 2, Unit 4)
- All-new "Ancillary Providers" unit added (Chapter 2, Unit 7)
- All-new "Policies and Procedures for MDs/DOs" unit added (Chapter 2, Unit 8)
- "Healthcare Gift Card" unit added (Chapter 3, Unit 1)
- "Denials, Grievances and Appeals" unit revised (Chapter 4, Unit 4)
- "New Edit Checks Reported on 277 Claim Acknowledgment Report" unit added (Chapter 5, Unit 1)
- "Additional Edit Checks For Paper Billers" unit added (Chapter 5, Unit 2)
- "Electronic Process For Finding Designated Outpatient Laboratories" unit added (Chapter 6, Unit 5)
- "QualityBLUE 2008 Provider Information Submission Schedule" unit revised (Chapter 7, Unit 2)

The **Office Manual** is available on the Provider Resource Center. You can access the Resource Center through NaviNet® or at **www.highmarkblueshield.com**. Click on **Highmark Blue Shield Office Manual**, under Administrative Reference Materials, to access the manual.

Watch **PRN**, **Behind the Shield**, and the NaviNet Plan Central page for news about future updates to the **Highmark Blue Shield Office Manual**.

Blue Shield seeks approval for UCR and PremierBlue Shield reimbursement changes

Highmark Blue Shield is requesting approval from the Pennsylvania Insurance Department to increase UCR Customary and PremierBlue[SM] Shield reimbursements for select urinary, endoscopic, respiratory, and auditory procedures.

Blue Shield expects to implement the reimbursement changes in summer 2008, if the Insurance Department approves the increases.

Watch for more news about these proposed reimbursement changes in future issues of **PRN**.

BlueCard news: watch for these improvements

BC

Medical record requests

Later this year, all Blue Plans will have an electronic means to better manage the flow of medical records between providers and Plans. Requests for medical records typically come to you through Highmark Blue Shield. Blue Shield uses this process today, so when received, it will electronically route the records to the Home Plan.

However, if you receive requests for medical records from other Blue Plans before you perform services as part of the pre-authorization process, please submit them directly to the member's Plan.

BlueCard Eligibility Line always available

The BlueCard Eligibility Line's automated voice response system, (800) 676-BLUE, is now accessible to providers 24 hours a day, seven days a week. This access supports the growing trend of self-service and guarantees that providers have the means to reach Home Plans' self-service eligibility information at all times.

The BlueCard Eligibility Call Center is a centralized service that routes providers to the member's Home Plan for benefit and eligibility information, using the member's alphabetical prefix. During normal business hours, weekdays, 7 a.m. to 10 p.m., Eastern time, the voice recognition router handles over 88 percent of the calls without agent intervention. But, if you need an agent, they are also available during these hours.

Many Plans have increased availability of self-service voice response applications beyond the normal work day, so calls initiated through (800) 676-BLUE can often be accommodated after normal business hours as well. Otherwise, callers will receive a message that the service is closed, including information about the actual hours of operation.

Claim submission instructions for Independence Administrators claims

Please share this information with your office staff or billing service.

To avoid processing and payment delays for Independence Administrators claims (alphabetical prefixes YXA and YXB), please follow these claim submission instructions:

If you contract with	Submit claims to	Use this Payor ID on electronic claims	Mail paper claims to
PremierBlue℠ Shield, ***not*** Personal Choice	Highmark Blue Shield	***ISA08*** = 54771 ***GS03*** = 54771	Highmark Blue Shield PO Box 890062 Camp Hill, Pa. 17089-0062
Personal Choice, ***no***t PremierBlue Shield	Independence Administrators	***ISA08*** = 54704 ***GS03*** = 54763 or TA720	Independence Administrators PO Box 1010 Horsham, Pa. 19044
Personal Choice ***and*** PremierBlue Shield	Independence Administrators	***ISA08*** = 54704 ***GS03*** = 54763 or TA720	Independence Administrators PO Box 1010 Horsham, Pa. 19044

In July 2007, Independence Administrators was launched in the Greater Philadelphia area, offering third party administration services to self-funded health plans.

Blue Shield announces Provider Relations staff appointments

Matthew L. Vogel, vice president of Physician Recruitment and Relations at Highmark Blue Shield, recently announced two senior leadership appointments that will serve to strengthen Blue Shield's longstanding commitment to personally serve the needs of its network providers.

Edward Wargo has been named director of Strategic Physician Relations and is responsible for recruiting and the direction, administration, and maintenance of positive relationships between Blue Shield and large health-system-affiliated professional providers in central and southeastern Pennsylvania. Mr. Wargo is also responsible for physician practice quality improvement efforts associated with Blue Shield's transparency efforts and its physician pay-for-performance program, QualityBLUE^{SM}. He manages a specialized team of Provider Relations representatives and Medical Management consultants.

From left, Edward Wargo, Michelle Sherman, Matthew Vogel, and Nancy Knox

Mr. Wargo is a graduate of Temple University with a master's degree in pharmacy, and he also earned a master's of business administration degree from LaSalle University. He has 35 years of experience in health care, focused in hospital administration and health insurance. Mr. Wargo previously served as director of Provider Relations for Blue Shield, a position he held for seven years.

Michelle Sherman has been appointed manager of Provider Relations. She is responsible for recruiting and the direction, administration, and maintenance of positive relationships between Blue Shield and independent professional provider practices in central and southeastern Pennsylvania. Ms. Sherman manages a staff of Provider Relations representatives.

She is a graduate of Millersville University, with a bachelor's degree in business administration. Ms. Sherman has worked for Blue Shield since 1990 and has held a number of positions in the Hospital Relations, Operations, and Customer Service departments. She most recently served as the senior Institutional Provider Relations representative.

Rounding out Mr. Vogel's executive staff is Nancy Knox. Ms. Knox continues to serve as manager of Provider Relations Staff Services, including a team of business analysts, and oversees support functions to assist in the recruitment, education, and servicing of the professional provider network in central and southeastern Pennsylvania.

Ms. Knox is a graduate of Mount St. Mary's University, with a bachelor's degree in business administration. She has worked for Blue Shield since 1971 and has held a variety of positions in the Provider Relations area.

In total, Blue Shield's Physician Recruitment and Relations Department is committed to offering excellent service to you—the physicians and clinicians or providers who serve its members.

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.*

Natalizumab covered for treating Crohn's disease

Highmark Blue Shield will provide coverage for natalizumab (Tysabri®) for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn's disease with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional Crohn's disease therapies and inhibitors of TNF-α.

Natalizumab should not be used in combination with immunosuppressants, for example, 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate, or inhibitors of TNF-α. Aminosalicylates may be continued during treatment with natalizumab.

The recommended dose of natalizumab for Crohn's disease is 300 mg intravenous infusion over one hour every four weeks. If the patient with Crohn's disease has not experienced a therapeutic benefit by 12 weeks of induction therapy, discontinue natalizumab. For patients with Crohn's disease that start natalizumab while on chronic oral corticosteroids, taper steroid use as soon as a therapeutic benefit of natalizumab has occurred. If the patient with Crohn's disease cannot be tapered off of oral corticosteroids within six months of starting natalizumab, discontinue natalizumab. Other than the initial six-month taper, providers should consider discontinuing natalizumab for patients who require additional steroid use that exceeds three months in a calendar year to control their Crohn's disease.

Tysabri is not approved for use in patients under age 18.

Only providers registered in the Crohn's disease TOUCH™ Prescribing Program may prescribe natalizumab for Crohn's disease.

Blue Shield considers the use of natalizumab for any indication other than Crohn's disease or multiple sclerosis (please refer to "Natalizumab covered for relapsing forms of multiple sclerosis" on Pages 7-8 in the August 2006 **PRN** for coverage guidelines) experimental or investigational. Therefore, it is not eligible for payment. A participating, preferred, or network provider may bill the member for the denied medication.

Use code J2323 to report natalizumab.

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

MA Also applicable to FreedomBlue PFFS and FreedomBlue PPO.

Diagnostic services: professional and technical components reporting guidelines explained

When both components of a diagnostic procedure are performed by the same eligible professional provider in a setting other than inpatient hospital, outpatient hospital, skilled nursing facility, or ambulatory surgical center, a single charge should be reported for the total procedure.

If a "total charge" procedure is reported in an inpatient hospital setting, outpatient hospital setting, skilled nursing facility, or an ambulatory surgical center, Highmark Blue Shield will limit its payment to the eligible professional provider for only the interpretation or professional component. Any technical costs of a diagnostic procedure performed in a facility setting are reimbursed to the facility.

Blue Shield can pay separately for the two components of a diagnostic procedure when each is performed by different eligible professional providers, for example, the provider who owns the equipment reports only the technical component; the interpreting provider reports only the professional component. Each provider should report the procedure code with the appropriate modifier to reflect the actual services performed, for example, modifier 26 for professional component; modifier TC for technical component.

Most diagnostic services, such as radiology studies and diagnostic medical procedures, include a distinct technical component, consisting of equipment and technical personnel costs. There is also a professional component, which represents the interpretation of diagnostic test results by the eligible professional provider.

MA Also applicable to FreedomBlue PFFS and FreedomBlue PPO.

Triesence covered for FDA approved indications

On Nov. 30, 2007, the U.S. Food and Drug Administration (FDA) approved Triesence™ (triamcinolone acetonide injectable suspension) 40 mg/ml to promote visualization during vitrectomy and for treatment of sympathetic ophthalmia, temporal arteritis, uveitis, and ocular inflammatory conditions unresponsive to topical corticosteroids. Highmark Blue Shield will cover Triesence for the new FDA approved indications.

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

Triesence is a preservative-free synthetic corticosteroid prepared as an injectable suspension specifically developed for use in the eye.

MA Also applicable to FreedomBlue PFFS and FreedomBlue PPO.

Cognitive rehabilitation now eligible for payment

Highmark Blue Shield now pays for cognitive rehabilitation for a brain injury related to these conditions:

- anoxia (ICD-9-CM 348.1, 994.1)
- brain hemorrhage and cerebral thrombosis (ICD-9-CM 430, 431, 432.0-432.9, 433.00-433.91, 434.00-434.91, 438.0, 438.10-438.19, 997.01-997.02)
- concussion (ICD-9-CM 850.0, 850.11-850.12, 850.2-850.9, 852.00-852.59, 853.00-853.19, 854.00-854.19, 907.0, 959.01)
- encephalopathy (ICD-9-CM 348.30-348.31, 349.82)
- fractured skull (ICD-9-CM 800.00-800.99, 801.00-801.99, 803.00-803.99, 804.00-804.99, 905.0)
- post-concussion syndrome (ICD-9-CM 310.1, 310.2, 310.8, 310.9)

Conditions designated by a range of ICD-9-CM diagnosis codes include all valid codes within that range. When choosing a diagnosis code, select one that best represents the member's condition. And, please remember to report diagnosis codes to the highest level of specificity.

When cognitive rehabilitation is reported for a condition that is not included in the above list, Blue Shield will consider it experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Use code 97532—development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes—to report cognitive rehabilitation.

Procedure code 97532 is listed as part of the occupational therapy benefits. Blue Shield determines coverage for occupational therapy according to individual or group customer benefits.

MA Does not apply to FreedomBlue PFFS or FreedomBlue PPO.

Questions or comments on these new medical policies?

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

Write to us at **medicalpolicy@highmark.com**.

Codes

New codes and modifier available

Here are 12 new procedure codes and one new modifier for your reporting purposes:

Code	Terminology	Effective date
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation	3/13/2008
G0399	Home sleep study test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG heart rate and 1 oxygen saturation	3/13/2008
G0400	Home sleep test (HST) with type IV portable monitor, unattended, minimum of 3 channels	3/13/2008
K0672	Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each	4/1/2008
Q4099	Formoterol fumarate, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms (Perforomist)	4/1/2008
S3628	Placental alpha microglobulin-1 rapid immunoassay for detection of rupture of fetal membranes	4/1/2008
0188T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	7/1/2008
0189T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	7/1/2008

Code	Terminology	Effective date
0190T	Placement of intraocular radiation source applicator (List separately in addition to primary procedure)	7/1/2008
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach	7/1/2008
0192T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach	7/1/2008
90738	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	7/1/2008

Modifier	Terminology	Effective date
CG	Policy criteria applied	7/1/2008

Code G0377 deleted December 2007

Code G0377—administration of vaccine for Part D drug—was deleted on Dec. 30, 2007. There is no replacement code for G0377.

Notes

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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-2008, Copyright 2007, 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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