PRN
Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

October 2005

In This Issue

Introducing BlueRx Medicare prescription drug plan 1
FEP variation on medical policies to change 4
Avoid 1099 errors: report correct provider number on claims 5
Adacel vaccine eligible for coverage 8
Mycamine to be reimbursed at 95 percent of AWP 17

MA

Look for this symbol for all Medicare Advantage related information

BC

Look for this symbol for all BlueCard® related information

News

Introducing BlueRx Medicare prescription drug plan

The Medicare Modernization Act (MMA) of 2003 makes outpatient prescription drug coverage available to all Medicare beneficiaries starting January 2006. The Centers for Medicare and Medicaid Services (CMS) has contracted with private companies, like Highmark Blue Shield, to provide the new Medicare coverage.

Beginning Nov. 15, 2005, beneficiaries can enroll in stand-alone prescription drug plans (PDPs) and get all other Medicare benefits from the traditional Medicare fee-for-service program, or they can enroll in a Medicare Advantage plan, like FreedomBlue℠ PPO, that covers all Medicare benefits, including prescription drugs.

CMS-defined standard Medicare prescription drug coverage

Under the CMS-defined standard benefit, in 2006 individuals will pay a monthly premium, estimated by the federal government to be $32.59 per month in the Pennsylvania and West Virginia region. The CMS-defined standard benefit has a $250 deductible, covers 75 percent of total drug costs up to $2,250, has zero coverage from $2,250 until $3,600 in total member out-of-pocket drug costs (known as the coverage gap), and covers 95 percent of drug costs above $3,600 total member out-of-pocket drug costs.

Introducing BlueRx

Highmark Blue Shield's BlueRx[SM] will be the only stand-alone regional Medicare prescription drug coverage option that carries the Blue branding in Pennsylvania and West Virginia. BlueRx is also available to employer groups and union groups.

Blue Shield's BlueRx will offer three Medicare PDP options to individuals: Basic, Plus, and Complete. All three plans will offer enrollees no deductibles and affordable generic and brand copayments for annual drug costs up to $2,250. They will also provide catastrophic coverage. Here are the copayments for the three plans:

Plan	Generic copayment	Brand copayment
Basic	$10	$30
Plus	$10	$25/$45
Complete	$8	$20/$40

The Plus and Complete plans will also include non-formulary coverage up to $2,250. The Complete plan will provide coverage of generic drugs through the coverage gap.

Highmark Blue Shield and other plans began marketing their Medicare PDPs on Oct. 1, 2005. Medicare beneficiaries will be able to enroll in a Medicare PDP during the initial election period that runs from Nov. 15, 2005 through May 15, 2006. Those who are eligible but do not enroll by May 15, 2005, may have to pay a penalty if they choose to enroll at a later time.

FreedomBlue also includes drug coverage

Those enrolled in FreedomBlue's individual products will also have two prescription drug benefit options available, neither of which will be subject to a quarterly prescription drug maximum.

- FreedomBlue will offer a standard benefit that covers the first $2,250 annually of total drug costs, with a gap in coverage from $2,250 until $3,600 in total member out-of-pocket drug costs. After $3,600 in member out-of-pocket drug expenses, FreedomBlue will pay 95 percent of covered drug costs. Copayments will be $10 for generic drugs and $30 for brand name drugs.

- FreedomBlue will also offer an enhanced prescription drug benefit with lower copayments of $8 for generic drugs and $20 for brand name drugs. This plan fills the coverage gap from $2,250 in total drug costs until $3,600 in total member out-of-pocket drug expenses with generic prescription drug coverage after an $8 copayment. After $3,600 in member out-of-pocket drug expenses, FreedomBlue will pay 95 percent of covered drug costs.

Medicaid recipients encouraged to enroll in a Medicare PDP

As of Jan. 1, 2006, Medicaid will no longer offer prescription drug benefits. In 2005, CMS is encouraging dually eligible individuals—beneficiaries enrolled in both Medicare and Medicaid—to enroll in a Medicare PDP before Jan. 1, 2006. Those who do not enroll in a Medicare PDP by that date will be automatically enrolled in a random plan being offered in their region by CMS. Full-benefit dually eligible individuals who enroll in BlueRx will not pay premiums or deductibles. Full-benefit dually eligible individuals who enroll in other PDPs may or may not be responsible for a premium.

Dually eligible individuals already enrolled in a Highmark Blue Shield Medicare Advantage plan in 2005 will not be automatically enrolled in a random PDP plan. Blue Shield will enroll these individuals in a Blue Shield Medicare Advantage PDP.

Blue Shield has senior-specific formulary

Highmark Blue Shield's Pharmacy and Therapeutics Committee, comprised of network physicians and pharmacists, developed a formulary specifically for the senior population. The **Formulary Book**, which was distributed to all network pharmacists and physicians earlier this year, has three formularies:

1. The Highmark Select/Choice Formulary

2. The Highmark Open Formulary

3. The Highmark Medicare-approved Select/Choice Formulary. FreedomBlue members have the Medicare-approved Select/Choice formulary benefit.

Members with a Select Formulary benefit have coverage only for those medications listed in the applicable Select/Choice Formulary section of the **Formulary Book**.

Members with the Choice Formulary benefit may pay a lower copayment or coinsurance for medications listed in the applicable Select/Choice Formulary section of the **Formulary Book**, and a higher copayment or coinsurance for non-formulary medications.

When medically appropriate, please prescribe formulary drugs.

The complete formulary is also available on Blue Shield's Provider Resource Center through NaviNet℠ or at **www.highmarkblueshield.com** under the Pharmacy/Formulary Information link.

Blue Shield has developed and continues to expand a nationwide pharmacy network that will offer significant access to its Medicare PDP members.

Blue Shield streamlines claims refund process

Highmark Blue Shield now offers a streamlined process that will simplify how you notify Blue Shield electronically of a claim overpayment. This improved process allows Blue Shield to adjust your account in a timelier manner.

Here's how the process works.

If a provider finds an overpayment and notifies Blue Shield

- As of October 2005, all NaviNet[SM]-enabled professional providers should continue to use NaviNet to notify Blue Shield when an overpayment has been made.
- If Blue Shield agrees that an overpayment exists, it will make the adjustment and will show the overpayment in your next Explanation of Benefits (EOB) statement. This will include a line-item level detail of the adjustment so you can go to the specific account to easily find the information.
- Refund adjustments will display on your electronic 835 transactions as reversals and corrections.

If Blue Shield finds an overpayment

- If Blue Shield finds a claim overpayment, it will send you a letter to notify you of the overpayment.
- In 2006, Blue Shield will enhance the way it handles claim overpayments it discovers. Watch for more information about this in future editions of **PRN**.

Please do not send Blue Shield a refund check for a claim overpayment. Blue Shield no longer accepts overpayment refund checks from providers since these overpayments can be adjusted directly on the EOB and/or 835. These adjustments save you time and money because you do not have to prepare and mail a refund check.

FEP variation on medical policies to change

The Federal Employee Program (FEP) variation on Highmark Blue Shield's medical policies will begin to change in January 2006. These changes will occur gradually. You'll see changes to the variations on surgical procedure policies first.

The variation on most policies will state:

"This medical policy may not apply to FEP. Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits are determined by the Federal Employee Program."

Blue Shield's medical policies are available online in the Provider Resource Center through NaviNet[SM] or at **www.highmarkblueshield.com**.

You can find answers to your questions about benefit information through NaviNet. If you do not have access to NaviNet, please call Blue Shield's Customer Service department at (866) 763-3608 with your benefit questions.

Avoid 1099 errors: report correct provider number on claims

Each year Highmark Blue Shield receives many requests from providers to make corrections to their miscellaneous income statement (form 1099-Misc). About 70 percent of the requests are for income to be moved from an individual provider's 1099 to the group's 1099.

Blue Shield has found that more than 80 percent of these 1099s are incorrect because the claims submitted by the provider identify the billing provider incorrectly. The claims list the performing provider in the billing provider field, so payments and 1099s are issued to the individual.

To guarantee that your 1099 is correct for 2005, make sure that your billing agent is using the correct provider number on all claims—paper or electronic. This is important for individual providers that received 1099s in their personal name and Social Security number, then request the 1099 be changed to the group practice name and tax identification number.

In the near future, Blue Shield will not make changes to 1099s if the claims were submitted with the performing provider incorrectly listed as the billing provider.

In order for the 1099 to be correctly processed to the group, all claims must be paid to the group. So that your claims and 1099 are processed correctly, you must report the group's provider number as the billing provider.

To confirm what your group's provider number is, contact Provider Data Services at (866) 763-3224, option 4.

If you would like to speak to a 1099 specialist to review your 1099 to date for 2005, please call (866) 425-8275, option 5.

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

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

You can make coverage available either directly or through an on-call arrangement with another PremierBlue Shield provider. This arrangement allows the member or another provider direct access to a provider (or his or her designee) in urgent or emergent situations.

The 24/7 coverage can be accomplished through an answering service, pager, or through direct telephone access whereby the provider (or his or her designee) can be accessed if needed.

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

These specialties are exempt from this requirement:

- audiology
- dermatopathology
- pathology (only if working outside of the acute care setting)
- physical medicine
- preventive medicine
- speech language pathology
- speech therapy

Blue Shield recognizes two Podiatric Boards

There are a number of Podiatric Boards currently in existence in the United States. Some are more geared toward a social organization, while others offer training programs, education services, and foster quality improvement within the Podiatric community.

Highmark Blue Shield strives to admit only high-quality health care professionals who are boarded in their specialty to its "boarded" networks.

Therefore, after much discussion with the Podiatric Society, internal staff, and consultants, as of July 1, 2005, Blue Shield recognizes only these Podiatric Board organizations as part of its credentialing criteria:

- American Board of Podiatric Surgery
- American Board of Podiatric Orthopedics and Primary Podiatric Medicine

New Ancillary Field representative available to answer your questions

Lynette Enders recently assumed the Ancillary Field representative position for Highmark Blue Shield. Lynette's territory includes the 21 counties of Central Pennsylvania and the Lehigh Valley, as well as northeastern and southeastern Pennsylvania.

Lynette assists free-standing ancillary providers in the Mid-Atlantic region whose services include orthotics and prosthetics, home infusion, ambulance services, and durable medical equipment.

Lynette can help ancillary providers enroll in Blue Shield's networks, obtain access to NaviNet^{SM}, and answer questions that cannot be resolved through electronic inquiries or through Customer Service representatives. These include questions about the application of medical policy and complex questions or claims issues that cannot be resolved through NaviNet or over the telephone.

You can reach Lynette at (866) 731-2045, option 4, extension 6.

Attention HealthGuard providers: last day to submit claims is July 31, 2006

July 31, 2006 will be the last day that HealthGuard will accept electronic or paper claims for payment.

If you file your claims electronically, please note 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.

For this reason, network practitioners are strongly encouraged to submit claims for any services provided to HealthGuard patients immediately following care delivery.

Paper claims should be sent to:

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

The HealthGuard products will be discontinued on Jan. 31, 2006.

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.*

Adacel vaccine eligible for coverage

Highmark Blue Shield began to provide coverage for the new FDA-approved vaccine, Adacel™, on June 10, 2005.

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

Report Adacel with procedure code 90715.

Adacel is a combination tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine adsorbed (Tdap). Adacel is given as a single dose to individuals aged 11 to 64 years. Adacel is the first booster to address pertussis (whooping cough) protection across a wide range of ages. Adacel is the first and only such booster licensed for adults in the United States.

MA

Does not apply to FreedomBlue.

Deep brain stimulator programming and analysis coverage revised

Intensive electronic analysis and programming of a deep brain stimulator may be necessary immediately after implantation to achieve optimal stimulus parameters. Because Highmark Blue Shield recognizes these needs, on Nov. 21, 2005 it will begin to pay for six analysis or programming visits within 60 days of the initial surgical implantation of the deep brain stimulator, and once every 30 days thereafter.

Before, Blue Shield covered such adjustments for deep brain stimulators only after the normal postoperative period, unless required due to complications.

Use procedure codes 95970-95975, 95978, or 95979, as appropriate, to report the analysis or programming of a

deep brain stimulator.

Deep brain stimulation involves the stereotactic implantation of electrodes in the deep brain, for example, thalamus and periaqueductal gray matter. The electrodes are connected by lead wires under the skin to a pulse generator(s) implanted in the chest. This electronic system helps control primary dystonia as well as tremors due to conditions such as essential tremor and Parkinson's disease.

MA

Also applicable to FreedomBlue.

Certain low vision rehabilitation services not covered

Highmark Blue Shield does not cover these low vision rehabilitation services:

- G9041—low vision rehabilitation services, certified licensed occupational therapist, each 15 minutes
- G9042—low vision rehabilitation services, certified orientation and mobility specialist, each 15 minutes
- G9043—low vision rehabilitation services, certified low vision therapist, each 15 minutes
- G9044—low vision rehabilitation services, qualified rehabilitation teacher, each 15 minutes

A participating, preferred, or network provider can bill the member for these denied services.

The non-specific terminology of each of these codes does not allow for proper application of member benefits and contractual limitations. Please report the most specific procedure codes that represent the actual modalities performed.

MA

Also applicable to FreedomBlue.

Aquatic therapy reporting guidelines outlined

Highmark Blue Shield will cover aquatic therapy when it's performed with the expectation of restoring a patient's level of function that has been lost or reduced by injury or illness.

Blue Shield determines coverage for aquatic therapy according to the individual or group customer physical medicine benefits.

When aquatic therapy is performed to maintain a level of function, Blue Shield considers it a maintenance program. It is not eligible for payment. A participating, preferred, or network provider can bill the member for the denied therapy.

Use procedure code 97113 to report aquatic therapy with therapeutic exercises.

Provide aquatic services according to these guidelines:

- The provider must have direct (one to one) patient contact when he or she reports aquatic therapy. Supervising multiple patients in a pool at one time and billing for each of these patients per 15 minutes of therapy time is not acceptable.
- Blue Shield's payment for procedure code 97113 includes whirlpool (97022) and/or Hubbard tank (97036) treatments. Blue Shield will not pay separately for code 97022 or 97036 in addition to code 97113 for a single patient encounter.

How to document aquatic therapy services

Blue Shield no longer requires you to submit treatment plans. However, you should include a treatment plan in the patient's medical record. And, that treatment plan should be available for retrospective reviews by Blue Shield if necessary.

The treatment plan should include:

- short-term and long-term goals that the patient can be reasonably expected to accomplish through the aquatic therapy program
- the specific modalities or procedures to be used in the treatment
- the patient's diagnosis
- the degree of severity of the problem (mild, moderate, severe)
- impairment characteristics
- physical examination findings—X-ray or other pertinent findings
- a reasonable estimate of when the goals will be reached (estimated duration of treatment, for example, number of weeks)
- the frequency of treatment, for example, number of times per week
- equipment and/or techniques utilized
- indication of pool temperature

Proper documentation should also include:

- Documentation indicating whether the patient was in shallow or deep water. An aquatic therapy program undertaken for upper extremity exercises should take place in water deep enough so that the patient's upper extremities are submerged. Water depth should be at a level that provides the best postural position for exercise therapy.

- For resistance and strengthening exercises, please record the number of repetitions, the number of sets, the type(s) of equipment, which body area(s) and the specific type(s) of exercise performed by the patient for each therapy session.

  If a provider cannot confirm increased resistance experienced as the patient exercises in water, Blue Shield will consider the session as endurance or conditioning rather than progressive resistance exercises to strengthen.

- Specific goals regarding decreasing inflammation, decreasing pain, increasing circulation, increasing strength, etc., and the means by which the specific goals will be achieved.

- Periodic re-evaluation indicating the number of times the patient has had rehabilitative aquatic therapy, the patient's pain level before beginning the program, the current pain level, and future goals for the patient's care.

Aquatic therapy is the performance of physical medicine services in a water-filled pool. Water provides buoyancy and support to the patient in an environment that provides resistance-enhanced exercise. Proper water temperature allows for muscle relaxation and allows the patient to stretch while reducing the sensation of pain.

Does not apply to FreedomBlue.

Additional procedures eligible for co-surgery

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

43123—partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

49201—excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive

58240—pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination

thereof

58943—oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para-aortic and pelvic lymph node biopsies, peritoneal washing, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s), with or without omentectomy

58953—bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking

61333—exploration of orbit (transcranial approach); with removal of lesion

61512—craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial

61550—craniectomy for craniosynostosis; single cranial suture

62165—neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach

67400—orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy

MA Remember, other Blue Shield medical policies may impact the eligibility of these codes.

Also applicable to FreedomBlue.

How to report conscious sedation

Report conscious sedation with one of these codes:

- 99141—sedation with or without analgesia (conscious sedation); intravenous, intramuscular, or inhalation, or
- 99142—sedation with or without analgesia (conscious sedation); oral, rectal, and/or intranasal

When you report code 99141 or 99142, please include the appropriate certification modifier to indicate if the service was performed personally or was medically directed.

When conscious sedation is performed by the operating surgeon, or his or her employee, report the surgery and anesthesia on the same claim. Report time in minutes for code 99141 or 99142.

Blue Shield does not pay seperately for conscious sedation when it's performed by the surgeon. Blue Shield will pay for conscious sedation when it's performed by the surgeon's CRNA employee. In this instance, report modifier QZ—CRNA service; without medical direction by a physician—along with the appropriate anesthesia

procedure code. See the August 2003 **PRN** for more information about employed CRNA services.

Conscious sedation is used to achieve a medically-controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes, and ability to respond to stimulation or verbal commands. Conscious sedation includes performances and documentation of pre- and post-sedation evaluations of the patient; administration of the sedation and/or analgesic agent(s); and monitoring of cardiorespiratory function, that is, pulse oximetry, cardiorespiratory monitor, and blood pressure.

MA

When you administer conscious sedation for FreedomBlue members, report code 99141 or 99142 only when the conscious sedation is being administered by the health care professional who is also performing the procedure for which conscious sedation is being provided. If a health care professional other than the health care professional performing the procedure provides the conscious sedation, report the appropriate CPT anesthesia code (00100-01999).

Additional guidelines for the administration of Xolair

Because there is a risk of anaphylaxis following the administration of Xolair® (omalizumab), observation of the patient is generally required. Highmark Blue Shield considers patient observation a part of the drug's administration. Blue Shield will not pay separately for observation.

Blue Shield also considers reconstitution and preparation of Xolair as part of the drug's administration. Blue Shield will not pay separately for this service.

MA

A participating, preferred, or network provider cannot bill the member for observation of the patient following the administration of Xolair, or for the reconstitution and preparation of this drug.

Also applicable to FreedomBlue.

Neutron beam radiotherapy covered for specific applications

Highmark Blue Shield pays for neutron beam radiotherapy for these applications:

- Salivary gland tumors (142.0-142.9, 198.89, 210.2-210.4, 230.0, 235.0-235.1, 239.0) that are classified as T3b or greater, that is, tumors larger than 4 centimeters, and,
  - in which disease-free surgical margins are not obtainable, or,

  - where local recurrence has developed

- Advanced or recurrent soft tissue sarcomas (158.0, 171.0-171.9, 176.1) without nodal involvement or distant metastases as:

  - primary treatment of T2 tumors, that is, tumors larger than 5 cm, or

  - treatment of tumor recurrence, that is, T1 or T2 tumors

- Advanced unresectable adenocarcinoma of the prostate (185) when neutron beam therapy is used in combination with photon radiotherapy, that is, mixed beam therapy, and the tumor extends

  - into or beyond the prostatic capsule, that is, tumors classified C or T3, or

  - into neighboring tissues, that is, tumors classified D or T4

Blue Shield does not consider neutron beam radiotherapy reasonable and necessary for any other application. A participating, preferred, or network provider cannot bill the member for the denied radiotherapy.

Neutron beam radiotherapy must be performed at a facility or site that meets the technical standards established by the National Cancer Institute for the performance of neutron beam radiotherapy.

Radiation therapy uses penetrating beams of radiation to treat disease. Conventional radiation therapy includes photon (X-ray) and electron radiation, which is available at many facilities and locations. These beams are produced by electron accelerators or from radioactive sources such as cobalt. Particle therapy includes protons and neutrons that are generated using proton accelerators.

Neutron beam radiotherapy is primarily used for the treatment of unresectable or recurrent tumors. Certain tumor types or histologies, sometimes referred to as being radioresistant, are very difficult to destroy using conventional radiation therapy. Neutron beam radiotherapy specializes in treating selected inoperable and/or radioresistant tumors.

BNCT is investigational

Blue Shield considers boron neutron capture therapy (BNCT) experimental or investigational. Published scientific literature indicates that BNCT is an evolving radiation therapy technology that is currently being studied in early clinical trials. A participating, preferred, or network provider can bill the member for the denied BNCT.

MA

Also applicable to FreedomBlue.

10/2005

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15

Cranial orthoses to treat synostotic plagiocephaly now covered

Highmark Blue Shield will now pay for cranial orthotic devices that are used in the postoperative treatment of synostotic plagiocephaly (craniosynostosis). Blue Shield will pay for these devices when they're prescribed for infants with moderate to severe residual plagiocephaly after surgical correction of the synostotic plagiocephaly.

A two-month trial of conservative therapy, that is, repositioning, after surgery must have failed to improve the deformity.

MA Cranial orthotic devices used in the postsurgical treatment of plagiocephaly include, but are not limited to, the DOC Band PostOp.

When cranial orthotic devices are reported as the sole treatment for synostotic plagiocephaly, Blue Shield considers both the helmet and the band experimental or investigational. They are not covered. A participating, preferred, or network provider can bill the member for the denied device.

The Food and Drug Administration has not approved the cranial orthotic device for the treatment of synostotic plagiocephaly without surgery.

Use code S1040 to report a cranial remolding orthotic device used in the treatment of plagiocephaly.

Report ICD-9-CM diagnosis code 756.0 to indicate a diagnosis of synostotic plagiocephaly.

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

Please see the October 2001 and February 2002 editions of **PRN** for additional guidelines for cranial orthotic devices used in the treatment of non-synostotic plagiocephaly.

Also applicable to FreedomBlue.

Hair removal guidelines explained

Highmark Blue Shield classifies hair removal by any method, for example, electrolysis, laser, waxing, for hirsutism cosmetic. Because cosmetic procedures are performed to improve an individual's appearance, Blue Shield does not cover them.

Blue Shield will pay for targeted permanent hair removal when it's performed to prevent the recurrence of pilonidal cysts and for when ingrown hairs are responsible for repeated painful cysts. In these cases, Blue Shield considers the hair removal a reconstructive procedure.

MA Reconstructive procedures are performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Blue Shield generally provides coverage for reconstructive procedures.

Use code 17380 to report each one half hour of electrolysis for permanent hair removal.

Use code 17999—unlisted procedure, skin, mucous membrane and subcutaneous tissue—to report hair removal performed with a laser. When you report code 17999, please provide a complete description of the service you performed in the narrative field of the electronic or paper claim.

Also applicable to FreedomBlue.

Vitrectomy eligible for additional conditions

Highmark Blue Shield will now pay for a vitrectomy (65810, 67005, 67010, 67036, 67038, 67039, 67040) when it is used to treat patients with retained cataract fragments in the eye following cataract surgery, and for infantile cataract.

When you submit a claim for a vitrectomy, report the appropriate ICD-9-CM diagnosis code:

- 998.82 for cataract fragments in the eye following cataract surgery
- 366.00-366.09 for infantile cataract

Also applicable to FreedomBlue.

Coverage for laparoscopic surgery explained

Highmark Blue Shield considers most laparoscopic surgeries, for example, laparoscopic appendectomy, splenectomy, intestinal resection, etc., eligible for reimbursement. In most instances, Blue Shield's reimbursement for the laparoscopic surgical procedure will equal the reimbursement level of the corresponding open procedure.

MA When an open procedure is resorted to after the initiation of a laparoscopic procedure, Blue Shield will make payment only for the open procedure.

If a laparoscopic procedure does not have an assigned procedure code, report it with an appropriate unlisted code. When you report an unlisted code, please provide a complete description of the service you performed in the narrative field of the electronic or paper claim.

Also applicable to FreedomBlue.

PRN

Paravertebral facet joint nerve block coverage clarified

Highmark Blue Shield considers diagnostic and therapeutic paravertebral facet joint nerve blocks eligible when they're performed for the assessment and treatment of chronic pain patients with:

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- cervical spondylosis without myelopathy (721.0)
- cervical spondylosis with myelopathy (721.1)
- thoracic spondylosis without myelopathy (721.2)
- lumbosacral spondylosis without myelopathy (721.3)
- spondylosis with myelopathy, thoracic region (721.41)
- spondylosis with myelopathy, lumbar region (721.42)
- cervicalgia (723.1)
- lumbago (724.2)
- sprains and strains of the cervical, thoracic, and lumbar areas of the neck and back (847.0, 847.1, 847.2)

If paravertebral facet joint nerve block procedures are performed for other diagnoses, Blue Shield considers them not medically necessary. They are not eligible for coverage. A participating, preferred, or network provider cannot bill the member for the denied procedure.

MA

Use procedure code 64470, 64472, 64475, or 64476 to report paravertebral facet joint nerve block procedures.

Codes

corticosteroid agents to temporarily relieve joint pain, thereby confirming the source of the pain.

Also applicable to FreedomBlue.

Mycamine to be reimbursed at 95 percent of AWP

Highmark Blue Shield will set its UCR and PremierBlue^{SM} Shield reimbursement at 95 percent of the average wholesale price (AWP) for all new therapeutic injections and chemotherapy drugs approved by the Food and Drug Administration (FDA) on or after Jan. 1, 2005.

These reimbursement rates will remain in effect for one year from the date the drug is approved by the FDA.

After the one-year introductory period expires, Blue Shield will price the drug or biological at 85 percent of the AWP.

Mycamine, which was approved by the FDA on April 28, 2005, will be priced at 95 percent of the AWP for one year.

Drug	FDA approval date	Effective date	Revision date
Mycamine (micafungin sodium)	April 28, 2005	April 28, 2005	April 28, 2006

Does not apply to FreedomBlue.

Blue Shield to apply occupational therapy benefits to code 97530

Beginning Jan. 1, 2006, Highmark Blue Shield will process claims for procedure code 97530 in accordance with the patient's contractual occupational therapy benefits. Blue Shield already applies this guideline to claims reporting codes 97504–97546.

Code 97530—therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes—involves activities that help a patient regain essential functions and resume activities of daily living.

Occupational therapy services can be provided by any health care professional licensed to perform them.

Please continue to use physical medicine procedure code 97110—therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility—to report therapeutic exercises as part of a rehabilitative program.

Also applicable to FreedomBlue.

New codes available October 1

These new procedure codes became available Oct. 1, 2005:

Code	Terminology
G9041	Low vision rehabilitation services, certified licensed occupational therapist, each 15 minutes.
G9042	Low vision rehabilitation services, certified orientation and mobility specialist, each 15 minutes.

G9043	Low vision rehabilitation services, certified low vision therapist, each 15 minutes.
G9044	Low vision rehabilitation services, qualified rehabilitation teacher, each 15 minutes.

Code	Terminology
Q0480	Driver for use with pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
Q0483	Monitor/display module for use with electric ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
Q0488	Power pack base for use with electric ventricular assist device, replacement only
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only
Q0490	Emergency power source for use with electric ventricular assist device, replacement only
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only
Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device,

replacement only

	Q0496	Battery for use with electric or electric/pneumatic ventricular assist device, replacement only
BC	Q0497	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only

Code	Terminology
Q0498	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0499	Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0500	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0501	Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only
Q0503	Battery for pneumatic ventricular assist device, replacement only, each
Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type
Q0505	Miscellaneous supply or accessory for use with ventricular assist device
S2075	Laparoscopy, surgical; repair incisional or ventral hernia
S2076	Laparoscopy, surgical; repair umbilical hernia
S2077	Laparoscopy, surgical; implantation of mesh or other prosthesis for incisional or ventral hernia repair (list separately in addition to code for the incisional or ventral hernia repair)
S2114	Arthroscopy, shoulder, surgical; tenodesis of biceps
S2117	Arthroereisis, subtalar
S3626	Maternal serum quadruple marker screen including alpha-fetoprotein (AFP), estriol, human chorionic gonadotropin (hCG) and inhibin

Notes

GM expands worksite wellness program; PremierBlue Shield providers may treat LifeSteps participants

The General Motors Corporation has announced the expansion of its worksite wellness program, LifeSteps, to include employees at all eligible GM facilities nationwide.

Because of this expansion, PremierBlue[SM] Shield providers may care for GM employees who are participating in the LifeSteps program. This program uses health screenings, physician office visits and other activities to help participants prevent disease and improve their health with the direction of their personal physicians.

LifeSteps billing procedures

Report the most appropriate CPT office visit procedure code from this range of codes: 99201–99215. These codes are payable under LifeSteps.

Report the most appropriate ICD-9-CM diagnosis code based on the patient's specific risk factors, that is, high blood glucose, high blood pressure, high cholesterol, obesity, or tobacco use.

LifeSteps covers 50 percent of the cost of up to two office visits. Members are responsible for the remaining 50 percent.

Submit your claims according to the established Blue Cross Blue Shield Association procedures.

For general benefit information please call the BlueCard provider inquiry number—(800) 676-BLUE (2583).

Need to change your provider information?

Fax the information to us!

You can fax us changes about your practice information, such as the information listed on the coupon below. The fax number is (800) 236-8641. You may also continue to send information by completing the coupon below.

Coupon for changes to provider information

Please clip and mail this coupon, leaving the **PRN** mailing label attached to the reverse side, to:

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

Name _____ Provider ID number _____

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Specialty _____

Provider's signature _____ Date signed _____

PRN

Contents

Vol. 2005, No. 5

News

Inroducing BlueRx Medicare prescription drug plan 1
Blue Shield streamlines claims refund process 4
FEP variation on medical policies to change 4
Avoid 1099 errors: report correct provider number on claims....5
Attention PremierBlue Shield providers: 24/7 coverage required for members 5
Blue Shield recognizes two Podiatric Boards 6
New Ancillary Field representative available to answer your questions 7
Attention HealthGuard providers: last day to submit claims is July 31, 2006....7

Policy

Adacel vaccine eligible for coverage 8
Deep brain stimulator programming and analysis coverage revised 8
Certain low vision rehabilitation services not covered 9
Aquatic therapy reporting guidelines outlined 9
Additional procedures eligible for co-surgery 11
How to report conscious sedation....12
Additional guidelines for the administration of Xolair 13
Neutron beam radiotherapy covered for specific applications....13
Cranial orthoses to treat synostotic plagiocephaly now covered 15
Hair removal guidelines explained....15
Vitrectomy eligible for additional conditions....16
Coverage for laparoscopic surgery explained 16
Paravertebral facet joint nerve block coverage clarified 17
Mycamine to be reimbursed at 95 percent of AWP 17
Blue Shield to apply occupational therapy benefits to code 97530 18

Codes

New codes available October 1 18

Patient News

GM expands worksite wellness program; PremierBlue Shield providers may treat LifeSteps participants 21

Need to change your provider information?....23

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