PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

October 2006

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MA

Look for this symbol for all Medicare Advantage related information

News

PRN: the information source exclusively for providers

Highmark Blue Shield holds as one of its top priorities the relationship it shares with health care professionals and providers. Communication is vital to a strong and successful relationship.

Policy, Review and News (PRN) is one of Blue Shield's key communication tools to relay official notifications of new and revised policy and procedure. Blue Shield strongly encourages all health care professionals and providers to read **PRN** and to share it with all appropriate staff members in your practice.

The **PRN** is issued bimonthly to inform you about important information that may affect the way Blue Shield reimburses you or how you should submit information to Blue Shield. Whether you have an agency or an individual who handles your billing, Blue Shield reminds all health care professionls and providers that taking time to read **PRN** will help ensure that you are aware of all new information. You can also access each issue of **PRN** on the Provider Resource Center through NaviNet® or at **www.highmarkblueshield.com**.

HIGHMARK® BLUE SHIELD

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PRN

PRN is Blue Shield's official notification to health care professionls and providers. This means that information you receive in **PRN** may be used at Medical Review Committee, administrative hearings, trials, and other administrative or legal proceedings to establish a health care professional's or provider's familiarity with the policies, recommendations, directions and other information relevant to the filing, processing, payment, and other adjudication or treatment of a provider's claims.

The **PRN** may also be submitted as evidence to prove that a health care professional or provider was advised of a particular Highmark Blue Shield policy, recommendation, direction, or other information.

Verify accuracy of all statements on claim forms

Highmark Blue Shield reminds all providers that accuracy is crucial when reporting covered services for a member. Blue Shield must hold a provider responsible for all statements made on any claim form submitted to Blue Shield with respect to such services, regardless of whether the claim was filed as a paper or electronic transaction and regardless of which method the provider used to verify benefits.

A provider who misreports services to Blue Shield shall be responsible for reimbursing Blue Shield for all payments that were caused by the misreporting.

New crossover consolidation process automatically submits Medicare claims to secondary payer

The Centers for Medicare & Medicaid Services consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement. Under this program, the COBC automatically forwards Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Streamlined process for providers—eliminates need for separate claim submission

Blue Plans implemented the Medicare crossover consolidation process systemwide. Therefore, you should experience an increased level of one-step billing for your Medicare primary claims. This new process streamlines your claim submissions and reduces your administrative costs.

The claims you submit to the Medicare carrier will cross over to the Blue Plan only after the Medicare carrier or intermediary has processed them. The Medicare carrier or intermediary automatically advises the Blue Plan of Medicare's approved amount and payment for the billed services. Then, the Blue Plan determines its liability and makes payment to the provider. This one-step process means that you do not need to submit a separate claim and copy of the Explanation of Medicare Benefits (EOMB) statement to the Blue plan after you receive the Medicare carrier's or intermediary's payment.

Duplicate claims submissions

Some providers submit paper claims and EOMB statements for secondary payment unnecessarily. Sending a paper claim and EOMB statement for secondary payment, or having your billing agency resubmit automatically, does not speed up the reimbursement of secondary payments. Instead, this costs you money and creates confusion for members. It also increases the volume of claims handled by the secondary payer and can slow down all claim processing, thereby delaying payments.

Whether you submit electronic or paper claims, it is no longer necessary to send a separate claim and EOMB statement for the purpose of obtaining payment on a secondary claim.

Please allow at least 30 days for the secondary claim to process. If you haven't received notification of the processing of the secondary payment, please do not automatically submit another claim. Rather, you should check the claim status before resubmitting. To further streamline the claim submission process to save your practice time and money, consider revising the time frame for the automated resubmission cycle of your system to accommodate the processing times of these secondary claims.

If you have questions about this process, please call your Provider Relations representative.

PO Boxes 359 and 380 closed July 28, 2006

If you send 1500 or Major Medical claims to Highmark Blue Shield through Post Office Box 359 or 380, please note that these boxes were closed out of service on July 28, 2006. This change was made because of low-volume use of these PO boxes.

Mail received at PO Box 359 is being automatically forwarded to a new box number—890393—for one year.

However, effective immediately, if you used PO Box 359, please begin sending all correspondence to the new PO Box at:

Highmark Major Medical
PO Box 890393
Camp Hill, Pa. 17089-0393

Mail received at PO Box 380 is now being automatically forwarded to a different box—898819—for one year. If you used PO Box 380, please begin to send all correspondence to this new PO Box:

Highmark
PO Box 898819
Camp Hill, Pa. 17001-9873

Please watch for more news about additional consolidation of Blue Shield PO Boxes in future issues of **PRN** and the NaviNet® Plan Central page.

PremierBlue Shield and Participating providers: IBC processes more Personal Choice and Personal Choice 65 claims

In the April **PRN**, Highmark Blue Shield announced that it no longer processes claims for Independence Blue Cross (IBC) Personal Choice® and Personal Choice 65℠ members. IBC, which is located in southeastern Pennsylvania, now manages the processing of these claims. However, Highmark Blue Shield continues to serve as the electronic claims and remittance advice conduit to and from IBC.

All Personal Choice and Personal Choice 65 medical-surgical claims with dates of service Jan. 1, 2005 and later transitioned from Highmark Blue Shield's system to IBC's Managed Healthcare System.

Many of the changes involved in this conversion are invisible to you. At first, claims for members whose identification numbers begin with alphabetical prefixes QCA, QCB, and QCM were submitted directly to IBC. In 2006, IBC added more alphabetical prefixes to this requirement (see the April 2006 **PRN** for a listing of the alphabetical prefixes).

Please continue to send paper claims for Personal Choice and Personal Choice 65 members to:

Personal Choice Claims
PO Box 890016
Camp Hill, Pa. 17089-0016

Report appropriate NAIC code on electronic claims

To be routed correctly, electronic submissions of Personal Choice and Personal Choice 65 claims in HIPAA-compliant ANSI ASC X12 837P format must include IBC's NAIC code of 54704 in the Interchange Receiver ID (ISA08). You should continue to use IBC's NAIC code 54704 in the Application Receiver's Code (GS03).

Please check with your vendor, clearinghouse, or billing service to identify any changes that may be necessary for this transaction.

If you have questions about this billing change, please call the eBusiness Help Desk at (215) 241-2305 or write to them at **claims.edi-admin@ibx.com**.

Attention paper claim submitters: Blue Shield no longer supplying 1500A claim form

In the April 2006 **PRN**, Highmark Blue Shield notified you that as of Oct. 1, 2006, it will no longer supply its version of the 1500A universal claim form.

The National Uniform Claim Committee (NUCC) released a new version of the 1500 Health Insurance Claim form that accommodates the reporting of the National Provider Identifier (NPI). This form replaces the existing 1500 claim form, version 12/90, commonly referred to as the HCFA 1500 or CMS 1500.

If you submit paper claims after Oct. 1, 2006, you should contact your forms distributor to obtain a supply of the new 1500 Health Insurance Claim form. Your forms distributor can obtain a negative or PDF of the form from TFP Data Systems or the Government Printing Office at:

- TFP Data Systems: (800) 482-9367, extension 1770. Or write to them at **1500form@tfpdata.com**.
- Government Printing Office: (202) 512-0455

You can find information about the new NUCC claim form and a new reference instruction manual at **www.nucc.org**.

In addition, you can find step-by-step instructions for submitting the new claim form to Blue Shield by accessing the **Blue Shield Reference Guide** under the Administrative Reference Materials link on the Provider Resource Center at **www.highmarkblueshield.com**.

Submit only original claim forms to prevent delays

Please submit original claim forms to Blue Shield. Do not photocopy any claim form because it eliminates the red ink that is required by Blue Shield's Optical Character Recognition scanning system. If Blue Shield cannot scan your claims, they will be delayed.

Electronic claims submission—better than paper

The fastest way to submit claims is electronically. Some of the many benefits of electronic claims submission are elimination of claim form printing and postage costs, streamlined claims filing, and faster claim payment. If you're submitting paper claims and would like to begin submitting electronically, call your Provider Relations representative for more information.

Credentialing and continuing medical education requirements for PremierBlue Shield providers to change

Here are the new credentialing requirements for PremierBlue[SM] Shield general practitioners.

As of Jan. 1, 2007, Highmark Blue Shield will credential all new general practitioners with a member age limit of 13 years and above.

For general practitioners to be eligible to treat members under the age of 13 years they must complete 20 percent of their continuing medical education (CME) requirement in pediatrics. Their application will be presented to the Credentials Committee for consideration.

Practitioners treating members 13 years of age and older will be listed in the directory accordingly. Those practitioners who are eligible to see members under 13 years old will have no limitation listed in the directory.

For practitioners who have been credentialed, Blue Shield will apply the previously stated age eligibility requirement upon recredentialing.

CME requirements for practitioners without board certification

All doctors of medicine and osteopathic physicians without board certification who qualify for a board certification exception must provide documentation of an average of at least 50 CME hours per year in their current practice activity, including a minimum of 10 CME hours in Category 1 and six CME hours in patient safety or risk management.

Podiatrists without board certification who qualify for a board certification exception with a non-surgical practice must have an average of 15 CMEs per year (45 CMEs in three years) in podiatry. They must attest to a non-surgical practice or submit a malpractice face sheet indicating their status as non-surgical. Podiatrists without board certification who qualify for a board certification exception with a surgical focus are required to have an average of at least 50 CMEs per year in podiatry (150 CMEs in three years).

EPOBlue Essential provides more alternatives for small employer groups

Blue Shield offered new product option Oct. 1, 2006

To assist small employer groups that may not currently be able to offer health care benefits to their full-time employees because of the cost of conventional coverage, Highmark Blue Shield developed a new, lower-cost option within its small group product portfolio.

This option, marketed as EPOBlue℠ Essential, is unique in that it features an annual (contract-year) plan maximum of $25,000 per member (based on Blue Shield's reimbursement, rather than charges), which renews each year. This feature isn't available with other EPOBlue product options or with other Blue Shield plans, such as PPOBlue℠ or ClassicBlue®.

EPOBlue Essential requires a $15 member copayment for primary care office visits and a $30 member copayment for specialist office visits.

To also help keep premiums lower, the product offers generic-only coverage for prescription drugs (along with Blue Shield's negotiated discount for brand-name medications). In addition to its $250 overall program deductible, EPOBlue Essential includes a $250 deductible per inpatient admission and a $100 emergency room copayment (waived if the patient is admitted).

In January 2006, Blue Shield introduced a product known as EPOBlue. As an exclusive provider organization, EPOBlue requires members to receive services from network providers and, with the exception of emergency services, provides no benefits for services received outside the network.

EPOBlue uses the PremierBlue℠ Shield network for professional, hospital, and other health care facility services in central Pennsylvania and the Lehigh Valley. Under all EPOBlue options, authorization is required from Healthcare Management Services for inpatient services and through National Imaging Associates, Inc. for certain advanced imaging procedures.

As with member identification cards for other EPOBlue products, the member identification card for EPOBlue Essential will only display the name EPOBlue. Be sure to verify the member's eligibility and benefits information through NaviNet® before you perform services. Check for the annual maximum amount (under Program Dollar Maximum) and for information about the group's contract year.

Make sure the forms you are completing are current version

If your practice stocks paper copies of forms, you may miss out on periodic updates. And, if you submit an obsolete version of a form or agreement, Highmark Blue Shield will ask you to complete and resubmit the latest version.

It's best to obtain all forms, applications, and agreements directly from the online Provider Resource Center on NaviNet® or at **www.highmarkblueshield.com**. Blue Shield may, on occasion, mail a form or application to you. In this instance, it's best to use the form for that one defined purpose and timeframe, and not make extra copies to keep on hand.

You can no longer obtain the 1500A claim form from Highmark Blue Shield. For information on where to obtain the 1500A claim form, please see "Attention paper claim submitters: Blue Shield no longer supplying 1500A claim form" on Page 5-6 in this **PRN**.

As a general rule, accessing forms, applications, or agreements online will guarantee that you are using the most recent version.

Exception: BCNEPA providers may use online provider forms

If you are a provider with a main practice located in the thirteen county area of Blue Cross of Northeastern Pennsylvania (Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, or Wyoming) you may continue to use the online provider forms. However, you must call (800) 451-4447 to obtain an application. Once your application is approved, the agreements will be mailed to you.

Blue Shield changes overpayment process, explains second phase of initiative

In the October 2005 **PRN**, Highmark Blue Shield explained how the procedures by which it receives and processes overpayments were changing.

The following information introduces you to the second phase of the initiative and clarifies the process.

If a provider identifies an overpayment

- As of October 2005, all NaviNet-enabled professional providers should use the Claim Investigation functionality to notify Blue Shield of an overpayment.

  If you are not NaviNet-enabled and an overpayment was made, call Blue Shield's Customer Service to advise if you want the overpayment offset from a future check.

- If Blue Shield agrees that an overpayment exists, it will adjust the payment so that the next Explanation of Benefits (EOB) statement will include details of the changes in the payment. It will also reduce the total payment for that EOB by the amount of the overpayment.

  Blue Shield has enhanced the EOB so that the detail, on a line-item basis, is clear and easy to post in your accounts receivable software. If you take advantage of the Electronic Remittance Advice 835 transaction, your office can automatically post the refund.

- While less desirable, if you prefer to refund the amount of overpayment by sending a check, please do not use NaviNet Claim Investigations or call Blue Shield's Customer Service. Rather, send a check and a copy of the EOB with the overpaid claim circled to:

  Cashier
  PO Box 898820
  Camp Hill, Pa. 17089-8820

If Blue Shield identifies an overpayment

- Beginning Jan. 19, 2007, Blue Shield will notify you of all overpayments on a separate section of your EOB. Blue Shield will no longer send notification of overpayment letters to you.

  The overpayment details in the new section of the EOB reference an overpayment that will be withheld from a future check.

- The EOB will provide detail as to the reason for the refund request. It will also serve as notice that unless appealed or paid by check, the overpayment will be deducted from an EOB approximately 60 days after the notification.

- If you agree with the refund request you should take no action. Blue Shield will automatically deduct the overpayment from a future check. The deduction will be indicated on your EOB.

  If you do not want the overpayment withheld from a future check but prefer to write a check for the overpayment, send the check and a copy of the EOB with the overpaid claim circled to:

  Cashier
  PO Box 890150
  Camp Hill, Pa. 17089-0150

Blue Shield will provide you with more details about its claims refund process, including examples of the changes to the EOB, in the December 2006 **PRN**.

Notification of the 835 changes will also be provided to clearinghouses and practice management software vendors through the Highmark EDI Trading Partner Web site.

Making more information about your practice available to members

Today's patients are using technology more than ever to help them make health care decisions. The Internet is now a widely popular tool that offers a multitude of resources to health care consumers and gives them easy access to publicly available data. To help you take advantage of this trend, Highmark Blue Shield will expand the information about you and your practice that is currently available in its online provider directory on its Web site.

In July, Blue Shield mailed a form to all providers who participate in any of its networks. Its purpose was to gather more information about your practice and make it available to your current and potentially new Blue Shield patients. Blue Shield's goal is to build upon the general data it now has online, such as practice location and specialty, by adding more detailed information, such as electronic prescribing ability, credentialing, electronic medical records, etc.

The information you provided will soon be displayed in Blue Shield's online provider directories, giving patients an enhanced view of your practice, the services you offer, and your credentials. Beginning this fall, these elements will be an integral part of the patient's expectation when viewing your information online.

Providers who did not submit these voluntary elements will still appear in Blue Shield's directories, but their listings will have "Not Available" displayed in the spaces where the enhanced information was not supplied. If you did not respond to the mailing, misplaced it, or did not receive one, please contact your Provider Relations representative.

Blue Shield is also developing physician quality data as part of this overall project. Four specific quality measures—women's health care, pediatric care, diabetic care, and cardiac care—will be viewable on the site, as applicable to each practice. In advance of the online posting, Blue Shield will mail to each physician practice a summary of its quality data, how it was generated, and how it will be represented online.

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.*

Oncologic PET imaging now eligible for gynecological malignancies

Highmark Blue Shield has expanded coverage for oncologic PET imaging to include gynecological malignancies (179, 180.0-180.9, 182.0-182.8, 183.0-183.9, 184.8, 184.9, 198.6, 198.82, 233.1, 233.2, 233.3, 236.0, 236.2, 236.3, 239.5).

Blue Shield also covers oncologic PET imaging for lymphoma, melanoma, and for malignancies of the brain, breast, head and neck (excluding the central nervous system), lung, pancreas, thyroid, esophagus, and colorectum.

Blue Shield continues to consider PET tumor imaging in other anatomic areas experimental or investigational, including the central nervous system, renal, prostate, testicular, germ cell, penile, hepatocellular neoplasms, and gastrointestinal stromal tumors of the stomach. At this time, there is insufficient scientific literature to support the clinical effectiveness of PET for these uses. Blue Shield will evaluate new information as it becomes available.

General coverage guidelines for oncologic PET imaging clarified

Blue Shield covers PET to diagnose and stage various malignancies in these clinical situations:

- in place of other conventional imaging studies when it is expected that information from other studies will be insufficient for clinical management of the patient,
- when the stage of the cancer is in doubt following a standard diagnostic workup, including conventional imaging, such as ultrasound, CT, MRI, or
- when clinical management of the patient will differ based on the stage of the cancer.

Blue Shield also covers PET imaging for restaging a malignancy. Restaging occurs after a course of treatment has been completed when:

- the health care professional suspects residual disease or a recurrence of disease,
- it's necessary to determine the extent of a known recurrence, or
- the patient develops new or additional symptoms of the disease.

Blue Shield covers PET imaging for surveillance. Blue Shield defines surveillance as periodic follow-up imaging of patients with a confirmed history of cancer who have completed a course of treatment and require periodic evaluation for potential re-occurrence. To be eligible, PET scans performed for surveillance must meet these qualifications.

Blue Shield does not cover PET imaging to monitor tumor response to treatment when no change in treatment is being considered. Blue Shield denies this use of PET as not being medically necessary. A participating, preferred, or network provider cannot bill the member for the denied service.

Blue Shield does not cover PET imaging when it's performed as a screening procedure to evaluate patients without signs or symptoms of a disease or illness. In this case, a participating, preferred, or network provider can bill the member for the denied service.

MA Does not apply to FreedomBlue. There is one exception: the coverage guidelines about PET imaging for surveillance do apply to FreedomBlue.

In vitro chemoresistance and chemosensitivity assays considered investigational

Highmark Blue Shield considers in vitro chemoresistance and chemosensitivity assays experimental or investigational tests. Therefore, they are not eligible for payment. A participating, preferred, or network provider can bill the member for the denied test.

Blue Shield will not pay for these tests because there is insufficient evidence that they affect clinical decision-making or that they improve health outcomes.

Chemoresistance and chemosensitivity assays are intended to aid in choosing chemotherapy drugs. They can either rule out or aid in selecting a treatment drug. The various assays differ in their processing and in the technique used to measure sensitivity or resistance. However, there are four basic steps common to all:

1. isolation of cells

2. incubation of cells with drugs

3. assessment of cell survival

4. interpretation of results

A tumor's response to the drug is classified as sensitive or resistant, although sometimes tumors are described as intermediate. The assay results may be used in making a treatment decision. A drug with a "sensitive" result on assay is thought to be potentially effective in vivo chemotherapy. Drugs identified as "resistant" are thought to be potentially ineffective chemotherapies.

Use code 89240 to report chemoresistance assays, including but not limited to, extreme drug resistance assays, for example, ChemoFx assay or cell culture drug resistance testing.

Use code 89240 to report chemosensitivity assays, including but not limited to, the histoculture drug response assay or a fluorescent cytoprint assay.

When you report code 89240, please include a complete description of the service you performed in the narrative field of the electronic or paper claim.

MA Also applicable to FreedomBlue.

Use code 97799 to report dry hydro massage

Do not use code 97039 to report dry hydro massage. Instead, use code 97799 to report this service. When you report code 97799, please include "dry hydro massage" in the narrative section of the electronic or paper claim.

Highmark Blue Shield considers dry hydro massage not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied service.

Hydrotherapy refers to the use of water in the treatment of disease or trauma. The patient lies on the surface of a hydrotherapy table. A mattress filled with heated water is under the surface of the table. A pump propels the water toward the patient through hydro-jets. The pressure of the water against the patient's body provides the massage. This is unattended hands-free massage.

Examples of devices used to perform hydrotherapy include, but are not limited to, the Profiler and Aqua PT.

MA Also applicable to FreedomBlue.

Computer-assisted musculoskeletal surgical navigational orthopedic procedures not covered

Highmark Blue Shield does not cover computer-assisted musculoskeletal surgical navigational orthopedic procedures (0054T, 0055T, 0056T). Blue Shield will deny these procedures as not being covered because the procedure code is not representative of the surgical procedure being performed. A participating, preferred, or network provider cannot bill the member for the denied service.

Use procedure code 0054T, 0055T, or 0056T to report computer-assisted musculoskeletal surgical navigational orthopedic procedures. List these codes separately in addition to the code for the primary procedure.

Computer-assisted musculoskeletal surgical navigational orthopedic procedures involve the use of navigation systems that provide additional information and attempt to further integrate preoperative planning with improved intraoperative arthroplasty orientation or fracture alignment and fixation.

MA Does not apply to FreedomBlue.

How to report endoscopic procedures performed with a biopsy

An endoscopy with excision or removal of cyst, tumor, mass, lesion, or polyp includes the biopsy performed at the same surgical site.

Do not report the endoscopic biopsy separately, for example, 43202 is included as part of 43216. If you report the biopsy on the same day as the endoscopic procedure with excision or removal of cyst, tumor, mass, lesion, or polyp, Highmark Blue Shield will combine the services and process them under the appropriate procedure code for the endoscopic study with excision or removal of cyst, tumor, mass, lesion, or polyp, for example, 43216.

Beginning Jan. 15, 2007, if you perform an endoscopic biopsy, for example, code 43202, on a separate surgical site, unrelated to the endoscopic excision or removal of cyst, tumor, mass, lesion, or polyp, for example, 43216, Blue Shield will consider the endoscopic biopsy for separate payment. In these cases, please report modifier 59 with the biopsy, for example, code 43202. Please include information in the patient's medical record about the surgical sites to which the services were provided.

MA Also applicable to FreedomBlue.

Infrared coagulation of hemorrhoids coverage guidelines outlined

Highmark Blue Shield considers infrared coagulation (IRC) of hemorrhoids medically necessary for persistently bleeding or painful first and second degree internal hemorrhoids (455.0, 455.1, 455.2). If IRC of hemorrhoids is reported for any other indications, Blue Shield will deny it as not covered. A participating, preferred, or network provider cannot bill the member for the denied service.

Use procedure code 46934—destruction of hemorrhoids, any method; internal—to report IRC of hemorrhoids. Code 46934 should be reported only once per operative session regardless of the number of hemorrhoids treated.

Blue Shield will pay for a maximum of four IRC treatments within a six-month period.

IRC, also called photocoagulation, is used to treat symptomatic first- and second-degree internal hemorrhoids. Pulses of infrared radiation are applied to the hemorrhoidal base through a hand-held applicator. These pulses produce a discreet area of necrosis, which heals to form a scar. This reduces or eliminates blood flow through the hemorrhoid, thereby shrinking it. The mucosa then becomes fixed to the underlying tissue. The procedure is easily performed in a health care professional's office.

MA Does not apply to FreedomBlue.

Additional indications covered for intracoronary stents

Highmark Blue Shield now pays for placement of an FDA-approved coronary stent for these additional indications:

- primary revascularization after myocardial infarction involving ST-segment elevation
- focal lesions in saphenous-vein grafts
- treatment of total coronary occlusions

Use procedure code 92980, 92981, G0290, or G0291, as appropriate, to report coronary stent placement.

MA Does not apply to FreedomBlue.

New HPV vaccine GARDASIL covered

Highmark Blue Shield began to cover the new FDA-approved vaccine GARDASIL® (Quadrivalent Human Papillomavirus [Types 6, 11, 16, 18] Recombinant Vaccine) on June 8, 2006.

GARDASIL is the first vaccine developed to prevent cervical cancer, precancerous genital lesions, and genital warts. GARDASIL was approved for girls and women ages 9 to 26. GARDASIL is administered in a series of three intramuscular injections over a six-month period.

Blue Shield will determine coverage for GARDASIL 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 individuals outside this population, Blue Shield will base coverage for the vaccine on the member's contract.

Report the GARDASIL vaccine with code 90649.

MA Does not apply to FreedomBlue.

Coverage for percutaneous lumbar discectomy discontinued

Highmark Blue Shield has determined that there are inadequate published data to permit scientific conclusions about the long-term safety and effectiveness of percutaneous lumbar discectomy (PLD). For this reason, Blue Shield considers PLD experimental or investigational, and will no longer pay for it. A participating, preferred, or network provider can bill the member for the denied PLD.

Use procedure code 62287 to report PLD.

PLD is a minimally invasive surgical technique developed as an alternative to open discectomy for treatment of back pain related to disc herniation.

MA Does not apply to FreedomBlue.

Unattended portable comprehensive polysomnograms and home sleep studies coverage guidelines outlined

Highmark Blue Shield considers portable comprehensive polysomnograms and unattended home sleep studies for the diagnosis of obstructive sleep apnea experimental or investigational. A participating, preferred, or network provider can bill the member for the denied studies.

Blue Shield may consider paying for these tests when the patient:

- has severe symptoms requiring immediate treatment and attended polysomnography or sleep studies are not available
- is non-ambulatory and cannot be studied in a sleep lab
- requires follow-up testing to evaluate response to therapy

The use of unattended portable home sleep studies and portable polysomnograms to diagnose obstructive sleep apnea as an alternative to in-laboratory polysomnography is not accepted standard practice. The accuracy and quality of data from portable polysomnogram equipment does not equal the data from polysomnograms performed on standard equipment. In addition, the quality of the data collected can be markedly affected by dislodged probes and monitoring devices as the patient moves around in bed during sleep. The quality of data improves substantially with a technician in constant attendance. Also with some parameters of sleep, visualization is necessary.

Use procedure code 95806—sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist—to report unattended sleep studies. Use procedure code 94799—unlisted pulmonary service or procedure—to report portable comprehensive polysomnograms. When you report code 94799, please include a complete description of the service you performed in the narrative section of the electronic or paper claim.

MA Does not apply to FreedomBlue.

Low density lipid apheresis coverage guidelines explained

Highmark Blue Shield covers low density lipid (LDL) apheresis for patients with:

- homozygous familial hypercholesterolemia (272.0) as an alternative to plasmapheresis
- heterozygous familial hypercholesterolemia who have failed a 6 month trial of diet therapy, and maximum tolerated combination drug therapy (Blue Shield defines maximum tolerated drug therapy as a trial of drugs from at least two separate classes of hypolipidemic agents such as bile acid sequestrants, HMG-CoA reductase inhibitors, fibric acid derivatives, or Niacin/Nicotinic acids), and who meet these FDA-approved indications:
  - functional hypercholesterolemic heterozygotes with LDL greater than 300 mg/dl
  - functional hypercholesterolemic heterozygotes with LDL greater than 200 mg/dl and documented coronary artery disease

If LDL apheresis is provided for any other indication, Blue Shield considers it not medically necessary. It is not covered. A participating, preferred, or network provider cannot bill the member for the denied service.

Most patients with high cholesterol levels can be treated using a combination of diet, exercise, and drugs. Some patients who have dangerously high cholesterol, however, do not respond to strong drug treatments.

Here are the procedure codes you should use to report LDL apheresis treatment:

- code 37799 for LDL apheresis treatment using the dextran sulfate system, for example, the Liposorber 15 System
- code S2120 for LDL apheresis treatment using the heparin-induced extracorporeal LDL precipitation system

LDL apheresis describes a variety of technologies used to acutely remove LDL from the plasma. The patient initially undergoes an apheresis procedure to isolate the plasma. The LDLs are then selectively removed from the plasma by immunoadsorption, heparin-induced extracorporeal LDL precipitation, or dextran sulfate adsorption.

LDL apheresis must be distinguished from plasma exchange (plasmapheresis). In plasma exchange, the plasma is collected during a pheresis procedure, then discarded and replaced with crystalloids. In contrast, LDL apheresis is a selective procedure in which only pathogenic LDLs are removed. The plasma is then returned to the patient.

MA Also applicable to FreedomBlue.

PRN

ZOSTAVAX vaccine now covered

Highmark Blue Shield began to provide coverage for the FDA-approved vaccine ZOSTAVAX® on May 25, 2006. Blue Shield will determine coverage for ZOSTAVAX according to the member's contract.

ZOSTAVAX is for use in people 60 years of age and older to reduce the risk of shingles (herpes zoster). ZOSTAVAX is given as a single injection under the skin.

Report the ZOSTAVAX vaccine with code 90736.

MA Does not apply to FreedomBlue.

Blue Shield covers safety enclosure frame or canopy for use with a hospital bed

Highmark Blue Shield covers a safety enclosure frame or canopy used with a hospital bed if it determines the frame or canopy is medically necessary. Blue Shield will subject all claims for a safety enclosure frame or canopy to a medical review.

If Blue Shield determines that the safety enclosure frame or canopy is not medically necessary, it will deny the item. A network provider cannot bill the member for the denied safety enclosure frame or canopy.

Use code E0316 to report a safety enclosure frame or canopy for use with any type of hospital bed.

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

MA Also applicable to FreedomBlue.

Vertebral axial decompression not eligible for payment

Highmark Blue Shield considers the use of vertebral axial decompression (decompression therapy) experimental or investigational. A participating, preferred, or network provider can bill the member for the denied therapy.

Use procedure code S9090—vertebral axial decompression, per session to report this service.

Vertebral axial decompression is a non-surgical treatment for chronic back pain. The treatment is performed through the application of pelvic traction. Traction is provided through the use of a split table specifically designed to slowly separate, thereby applying a distraction force to the lumbar spine. While the patient lies prone on the table, the distraction force is applied in cycles of traction (decompression) and relaxation. The intensity of the decompression cycle can be adjusted to the patient's level of tolerance or comfort. Several devices, including VAX-D, DRX9000, and Triton DTS, are used to provide this service.

MA Does not apply to FreedomBlue.

CT colonography covered in certain instances

Highmark Blue Shield now covers CT colonography when it is medically indicated for patients who cannot tolerate an endoscopic colonoscopy. Examples of covered indications include:

- an incomplete standard endoscopic colonoscopy of the entire colon because the colonoscope could not be passed proximally,
- an obstructing neoplasm, spasm, redundant colon, extrinsic compression, abnormal anatomy, or scarring from prior surgery (153.0-153.9, 154.0-154.8, 197.5, 235.2, 560.81-560.89, 560.9, 751.2),
- complications from a previous standard colonoscopy,
- increased sedation risk, for example, COPD, previous anesthesia adverse reaction,
- diverticulitis with increased risk of perforation (562.11).

Blue Shield will deny CT colonography for any other conditions as not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied procedure.

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

Report CT colonography with procedure code 0066T or 0067T, as appropriate. Do not use the procedure codes for CT of the pelvis (72192-72194), CT of the abdomen (74150-74170), or the codes for 3-dimensional and/or holographic reconstruction (76376, 76377) to report CT colonography.

CT colonography is also referred to as "virtual colonoscopy." This diagnostic imaging technique can be used as an alternative to conventional endoscopic colonoscopy to visualize the colon. CT colonography acquires high-resolution imaging data that a computer uses to reconstruct 2- and 3-dimensional images of the inside of the colon. These images are similar to the endoluminal images obtained by conventional endoscopic colonoscopy. This helps the health care provider detect any abnormalities that may require a closer look.

MA Does not apply to FreedomBlue.

Blue Shield reimburses Lucentis at 95 percent of AWP

Highmark Blue Shield sets its initial 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 first approved by the FDA. After the one-year introductory period expires, Blue Shield will price the drug or biological at 85 percent of the AWP.

Lucentis was approved by the FDA on June 30, 2006. Blue Shield will price it at 95 percent of the AWP for one year.

Drug	FDA approval date	Effective date	Revision date
Lucentis (ranibizumab)	June 30, 2006	June 30, 2006	June 30, 2007

MA Does not apply to FreedomBlue.

More procedure codes identified as not applicable to Blue Shield commercial products

Highmark Blue Shield has determined that these codes do not apply to its commercial products:

G9013—ESRD demo basic bundle level 1

G9014—ESRD demo expanded bundle including venous access and related services

These codes are typically, but not always, developed by the Centers for Medicare & Medicaid Services for the Medicare Part B program. Often, the terminology for the codes is specific to a Medicare demonstration project or is limited to the Medicare Program in some fashion.

Blue Shield does not cover these codes under its commercial products unless otherwise specified. If you are a participating, preferred, or network provider, you cannot bill the member for these non-covered services.

MA Does not apply to FreedomBlue.

Blue Shield reviews Avastin coverage position

In the August 2006 **PRN**, Highmark Blue Shield announced that it would deny Bevacizumab (Avastin®) as experimental or investigational when it's used to treat age-related macular degeneration.

Blue Shield is now reviewing its coverage decision for Avastin because of a request from the Ophthalmology community. If Blue Shield changes its coverage guidelines for Avastin, it will announce them in **PRN**.

In the meantime, off-label coverage of Avastin for age-related macular degeneration will continue during Blue Shield's review. No individual case review is required at this time.

MA 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:

22326—open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; cervical

45112—proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)

50545—laparoscopy, surgical; radical nephrectomy (includes removal of gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)

55866—laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing

58954—bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy

61304—craniectomy or craniotomy, exploratory; supratentorial

63303—vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach

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

MA Also applicable to FreedomBlue.

Naltrexone extended release injection not covered

Highmark Blue Shield considers naltrexone extended release injection (Vivitrol™) not medically necessary because scientific evidence does not confirm that this new intramuscular formulation improves outcomes over the oral formulation.

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

MA Also applicable to FreedomBlue.

Definition of myocutaneous muscle flap corrected

The definition of a myocutaneous muscle flap that was published in the August 2006 **PRN** (see "Include description of myocutaneous muscle flap procedure in operative report" on Page 20) should have read:

"A myocutaneous muscle flap is an axial pattern flap that requires dissection from surrounding structures and preserves the vascular pedicles that nourish the flap. These flaps extend through skin and subcutaneous fat and into the aponeurosis of the fascia, with preservation of the fascia's vasculature and nerve supply and including partial or complete release and/or dissection of the muscle."

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**.

New codes available October 1

These new procedure codes became available Oct. 1, 2006:

Code	Terminology
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders, includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing
K0800	Power operated vehicle, Group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, Group 1 heavy duty, patient weight capacity, 301 to 450 pounds
K0802	Power operated vehicle, Group 1 very heavy duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, Group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, Group 2 heavy duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, Group 2 very heavy duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle, not otherwise classified
K0813	Power wheelchair, Group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0814	Power wheelchair, Group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, Group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, Group 1 standard, captains chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, Group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821	Power wheelchair, Group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, Group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0823	Power wheelchair, Group 2 standard, captains chair, patient weight capacity up to and including 300 pounds
K0824	Power wheelchair, Group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, Group 2 heavy duty, captains chair, patient weight capacity 451 to 600 pounds

Code	Terminology
K0826	Power wheelchair, Group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827	Power wheelchair, Group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, Group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829	Power wheelchair, Group 2 extra heavy duty, captains chair, patient weight capacity 601 pounds or more
K0830	Power wheelchair, Group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0831	Power wheelchair, Group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds
K0835	Power wheelchair, Group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, Group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, Group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838	Power Wheelchair, Group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, Group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840	Power wheelchair, Group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841	Power wheelchair, Group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, Group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds
K0843	Power wheelchair, Group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0848	Power wheelchair, Group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, Group 3 standard, captains chair, patient weight capacity up to and including 300 pounds

Code	Terminology
K0850	Power wheelchair, Group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851	Power wheelchair, Group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds
K0852	Power wheelchair, Group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853	Power wheelchair, Group 3 very heavy duty, captains chair, patient weight capacity, 451 to 600 pounds
K0854	Power wheelchair, Group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, Group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more
K0856	Power wheelchair, Group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857	Power wheelchair, Group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0858	Power wheelchair, Group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0859	Power wheelchair, Group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, Group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0861	Power wheelchair, Group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862	Power wheelchair, Group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863	Power wheelchair, Group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864	Power wheelchair, Group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0868	Power wheelchair, Group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869	Power wheelchair, Group 4 standard, captains chair, patient weight capacity up to and including 300 pounds

Code	Terminology
K0870	Power wheelchair, Group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871	Power wheelchair, Group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877	Power wheelchair, Group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878	Power wheelchair, Group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0879	Power wheelchair, Group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880	Power wheelchair, Group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
K0884	Power wheelchair, Group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0885	Power wheelchair, Group 4 standard, multiple power option, captains chair, weight capacity up to and including 300 pounds
K0886	Power wheelchair, Group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0890	Power wheelchair, Group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891	Power wheelchair, Group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0898	Power wheelchair, not otherwise classified
K0899	Power mobility device, not coded by SADMERC or does not meet criteria
S0147	Injection, alglucosidase alfa, 20 mg
S2325	Hip core decompression

Modifier GS terminology revised

As of Oct. 1, 2006, the terminology for modifier GS has been changed. Here is the revised terminology:

Modifier	Terminology
GS	Dosage of EPO or Darbepoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level

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:

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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

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Acknowledgement

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