

Medical Policy

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A summary of Blue Shield medical policy guidelines

This section summarizes Pennsylvania Blue Shield's policy guidelines for a number of services covered by our members' contracts. The services discussed in this section are those that generate the most questions among health care professionals and their staffs.

Please remember that an individual's coverage may vary in many ways, based on the terms of his or her contract. So, even though a particular service is listed in this section as one that we cover, it may not be covered under an individual member's contract.

Our guidelines are not intended to be practice guidelines

Pennsylvania Blue Shield's medical policy guidelines are not intended to govern the practice of medicine. Rather, they reflect our policies regarding what services Blue Shield covers and the reimbursements we provide for those services.

A leader in medical policy development

Pennsylvania Blue Shield is a leader in the development of current, sound medical policy guidelines. Our policies address hundreds of medical issues, including diagnostic and therapeutic procedures, and medical supplies and equipment.

The application of medical policy within our claims processing system assures that health care costs are reimbursed as efficiently as possible. Two of the most important provisions in all Blue Shield contracts are a medical necessity clause and the exclusion of coverage for experimental procedures. Policy guidelines are established and maintained to address these provisions for a variety of procedures.

Blue Shield's policies are based on substantial professional input and reflect the current "state-of-the-art" within the medical community. We rely on a system of approximately 250 professional consultants (practicing physicians and other health care providers) for their expertise on issues within their given specialty. The Medical Programs staff, headed by a physician, maintains an extensive library of current medical information on hundreds of topics.

The results of our research may also be referred to the Medical Affairs Committee for consideration. This committee is responsible for helping the Corporation make determinations on the efficacy and appropriateness of new procedures, as well as to help the Corporation cover medically necessary and appropriate services within the terms of its member contracts. The Committee makes recommendations to the Board of Directors on issues referred to it for evaluation.

Each step in the development of our medical policy helps Blue Shield establish up-to-date guidelines that accurately reflect accepted medical practice and support our contractual agreements with our customers.

Medical care

Evaluation and management services

The evaluation and management (E/M) section of Blue Shield's *Procedure Terminology Manual (PTM)* includes definitions for various levels of medical care. These definitions serve simply as guidelines. It is the provider who ultimately must determine the level of care performed, based on the various components of the evaluation and management service. The key components in the selection of a level of evaluation and management services are:

History

The levels of E/M services recognize four types of history that are defined as follows:

- **Problem focused**
Chief complaint; brief history of present illness or problem.
- **Expanded problem focused**
Chief complaint; brief history of present illness; problem pertinent system review.
- **Detailed**
Chief complaint; extended history of present illness; extended system review; pertinent past, family and/or social history.
- **Comprehensive**
Chief complaint; extended history of present illness, complete system review, complete past, family and social history.

Examination

The levels of E/M services recognize four types of examinations, defined as:

- **Problem focused**
An examination that is limited to the affected body area or organ system.
- **Expanded problem focused**
An examination of the affected body area or organ system and other symptomatic or related organ systems.
- **Detailed**
An extended examination of the affected body areas(s) and other symptomatic or related organ system(s).
- **Comprehensive**
A complete single system specialty examination or a complete multi-system examination.

Medical decision making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered.
- The amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed and analyzed.
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedures(s) and/or the possible management options.

Please refer to the *PTM* for a detailed explanation of each E/M code.

Emergency medical and accident services

Emergency medical care is defined by Pennsylvania Blue Shield as medical care for the initial treatment of a sudden onset of a medical condition, manifesting itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably result in:

- Permanently placing the member's health in jeopardy.
- Causing other serious medical conditions.
- Causing serious impairment to bodily functions.
- Causing serious and permanent dysfunction of any bodily organ or part.

Emergency medical care requirements

To be considered an emergency, the patient's condition must meet the following requirements:

- **Severe symptoms must occur** — sufficiently severe enough to cause a person to seek immediate medical aid, regardless of the hour of the day or night.
- **Severe symptoms must occur suddenly and unexpectedly.** A chronic condition in which subacute symptoms have existed over a period of time but would not qualify as a medical emergency, unless symptoms suddenly became severe enough to require immediate medical aid.
- **Immediate care is secured.** If medical care is not secured immediately after the onset of symptoms, it is not considered a medical emergency. A telephone call to a doctor would not satisfy this requirement, if examination and treatment by a doctor in his or her office or in the outpatient department of a hospital are deferred until the next day.
- **Immediate care is required.** The illness or condition is diagnosed (or is indicated by symptoms), and the degree of severity of the condition must indicate that immediate medical care normally would be required.

Report emergency medical care using codes W9006, W9008, W9016, W9018, W9026 or W9028. Include the appropriate terminology.

Emergency accident care is defined by Pennsylvania Blue Shield as the initial examination and non-surgical treatment performed in conjunction with a non-occupational injury.

For emergency accident care and a definitive surgical procedure performed on the same day, we combine your reported charges. Our payment will be based only on the definitive surgical procedure. Generally, Pennsylvania Blue Shield pays only for the initial emergency accident visit, since follow-up care is not considered an emergency. Some groups, however, have separate coverage for follow-up care.

Report emergency accident services using codes W9005, W9007, W9015, W9017, W9025 or W9027. Include the appropriate terminology.

Blue Shield conducts extensive post-payment audits on claims for emergency services. We request refunds for payment of services that are:

- Not properly documented in the patient's medical records; or
- Do not meet the criteria for emergency services.

Annual gynecological examinations and routine pap smears

Payment will be made for one annual gynecological examination (S0610 or S0612) regardless of the patient's condition, and one routine Pap smear (G0123, G0124, G0143-G0145, P3000, P3001) per calendar year for all females.

A gynecological exam (code S0610 or S0612) may include, but is not limited to, these services: history, blood pressure and/or weight checks, physical examination of pelvis/genitalia, rectum, thyroid, breasts, axillae, abdomen, lymph nodes, heart and lungs.

When a physician performs a systemic physical examination that includes an annual gynecological examination, the appropriate evaluation and management code (99201-99215, 99381-99397) may be reported in addition to the annual gynecological examination (code S0610 or S0612).

Concurrent care

Concurrent care is defined by Pennsylvania Blue Shield as care provided to an inpatient of a hospital or skilled nursing facility simultaneously by more than one doctor during a specified period of time.

Such care is usually provided when:

- Two or more separate conditions require the services of two or more doctors.
- The severity of a single condition requires the services of two or more doctors for proper management of the patient.

Establishing medical necessity for concurrent care

The medical necessity for concurrent care is established on the basis of the patient's condition, as demonstrated by the reported diagnosis and other documentation. The necessity of each doctor's particular skill is determined by considering the respective specialties and the diagnosis for which the services were provided.

In the event Blue Shield requires additional information to establish medical necessity, we may review hospital records. These records should:

- Document the primary doctor's request for the consultation to see the patient.
- Include sufficient documentation to indicate the seriousness of the patient's condition.

Concurrent care payment guidelines

Pennsylvania Blue Shield applies the following payment guidelines to certain types of concurrent care:

Medical-medical concurrent care

- Under some circumstances concurrent care services are not required on a daily basis for the entire hospitalization.
- The admitting doctor is responsible for primary care and may be paid for medical care, unless the patient is transferred to the consultant.
- Blue Shield may pay for the concurrent treatment of two or more separate conditions by doctors not of the same specialty (recognized by Pennsylvania Blue Shield).
- Blue Shield may not pay for the concurrent treatment of two or more separate conditions by doctors of the same specialty (recognized by Pennsylvania Blue Shield).
- Blue Shield may not pay for the concurrent treatment of the same condition by doctors of the same specialty (recognized by Pennsylvania Blue Shield).
- Blue Shield may not pay for the concurrent treatment of the same condition by doctors of different specialties (recognized by Pennsylvania Blue Shield).

Medical-surgical concurrent care

- Blue Shield may pay for medical-surgical concurrent care for concurrent medical care provided by a doctor who is not in charge of the case, and whose particular skills are required for the treatment of a serious condition that is not related to the surgical procedure performed.
- Based on documented evidence of meaningful service, Blue Shield may pay for concurrent medical care in cases where the patient has a history of a medical condition that may be aggravated by surgery, provided that:
 - a) The surgeon has requested a medical evaluation of the medical condition.
 - b) The complicating condition would be life threatening should an acute exacerbation occur.
- Payment for concurrent medical care to regulate postoperative fluid or electrolyte balance is limited to patients with a serious fluid or electrolyte problem.

Inpatient preoperative and postoperative care

Pennsylvania Blue Shield's allowance for a definitive surgical procedure includes payment for the routine in-hospital preoperative care and the routine postoperative care in or out of the hospital, when provided by a surgeon, his or her surgical associate or a surgical assistant.

One day of inpatient preoperative care is considered to be routine and is included in the payment to the operating surgeon for performing the operation.

Payment guidelines for inpatient preoperative care

The following guidelines apply to Pennsylvania Blue Shield's payment of claims for inpatient preoperative care:

- Blue Shield may pay for all necessary preoperative medical care provided by a physician other than the operating surgeon, his or her surgical associate or a surgical assistant.
- If the surgeon, his or her surgical associate or a surgical assistant, renders two or more days care prior to the surgery, Blue Shield may pay for the days of care reported from the date of admission to the date of surgery. We also may pay even if there is a lapse of time between the last medical visit and the surgery.
- If the surgeon, his or her surgical associate, or a surgical assistant renders one day of care prior to definitive surgery, Blue Shield usually will pay for one day of care reported from the date of admission to the date of surgery. On an inquiry basis, we will pay only if unusual and extenuating circumstances are documented.

Generally, Pennsylvania Blue Shield pays for medical care provided on days prior to and after those definitive surgical procedures with zero postoperative days. Medical care is not eligible for payment when it is provided on the same day as a definitive surgical procedure by the same doctor, his or her associate, or a surgical assistant, for the same condition. However, when medical care is provided on the same day as a diagnostic surgical procedure, it is eligible for payment.

Newborn care

Blue Shield pays for routine inpatient care of a newborn for the following codes: 99221, 99222, 99231, 99232, 99238, 99239, 99431, 99433 and 99435. If other medical care codes are reported for routine care of a healthy newborn, the need for such care must be documented including codes 99223 and 99233.

If the doctor who performs the delivery also provides routine care for the newborn after delivery, Blue Shield can pay for both services. Furthermore, when a doctor other than the delivering doctor reports both attendance at delivery and daily medical care of the newborn, both services are eligible for payment. The code for attendance at delivery is:

- Attendance at cesarean section, at risk neonate – 99436
- Attendance at vaginal delivery, at risk neonate – 99436

Medical visits and associated services

Pennsylvania Blue Shield will not pay separately for services it considers an integral part of a doctor's medical or surgical care.

The services listed below are considered integral services:

- Administration of IV Innovar
- Amsler Grid Test

- Analysis of date from Swan-Ganz catheterization
- Anoscopy without biopsy (46600)
- Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (35400)
- Application of external fixation system (20690)
- Application of halo type appliance for maxillofacial fixation, includes removal (21100)
- Application of splint (29130-29131)
- Application of traction, suspension or corrective appliance (non-fracture care)
- Blood pressure check
- Blue field entoptoscopic exam
- Breast exam
- Brightness Acuity Test
- Canalith repositioning procedure (also known as, Epley maneuvers, Otolith repositioning)
- Care plan oversight services (99374-99380)
- Catheter site inspection by physician
- Changing of tubes:
 - connecting tube
 - gastrostomy tube or button (43760)
 - tracheostomy tube
 - tracheotomy tube (31502)
 - ureterostomy tube (50688)
- Chemical cauterization of granulation tissue (17250)
- Chemical pleurodesis, for example, for recurrent or persistent pneumothorax (32005)
- Corneal scrapings (65430)
- Corneal topography/computer-assisted photokeratoscopy
- Dressing change (for other than burns) under anesthesia (other than local) (15852)
- Ear/pulse oximetry (94760-94762)
- Enterostomal therapy (S9474)
- Eye tonometry (92100)
- Foreskin manipulation including lysis of preputial adhesions and stretching (54450)
- Gastric saline load test (91060)
- Grenz ray therapy
- Hydrotubation of oviduct (tubal lavage), including materials (58350)
- Injection of corpora cavernosa with pharmacologic agent(s), for example, papaverine, phentolamine, etc. (54235)
- Injection of sinus tract (therapeutic) (20500)
- Insertion of pessary (57160)
- Irrigation and/or application of medicament for treatment of bacterial, parasitic or fungoid disease (57150)
- IV infusion therapy, administered by physician or under direct supervision of physician
- IV therapy for severe or intractable allergic disease in physician's office or institution with theophyllines, corticosteroids, antihistamines (excludes cost of the drug)
- Laryngoscopy, indirect/mirror, without biopsy (31505)
- Laser interferometry or retinometry
- Magnified penile surface scanning (penoscopy)
- Manual, gross visual fields

- Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality (96902)
- Miller-Nadler Glare test
- Muscle testing (95831-95834, 95851-95852, 95875)
- Nasopharyngolaryngoscopy (indirect)
- Nasopharyngoscopy (92511)
- Nonpressurized inhalation treatment for acute airway obstruction (94640)
- Ophthalmodynamometry (92260)
- Ophthalmoscopy (92225, 92226)
- Otoscopy (no removal of foreign body)
- Phototherapy (for neonatal jaundice)
- Placement of nasogastric feeding tube
- Potential acuity testing (visual):
 - PAM (potential acuity meter)
 - Guyton – Minkowski test
 - Visometer or retinometer
 - Macular integrity or electro-laser test
- Prolonged services (99354-99359)
- Prostatic massage
- Removal of cerumen (69210)
- Removal non-contraceptive pellets or capsules (**FEP and special contracts only; Not covered under standard contracts**)
- Rhinoscopy (no removal of foreign body)
- Scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with interpretation and report, unilateral (92135)
- Schirmer test
- Slit lamp test (biomicroscopy, binocular microscopy and fluorescein staining) (92504)
- Screening test, visual acuity (99173)
- Special services (99050-99056)
- Starting of an IV (36000)
- Stat charges for laboratory services
- Strapping of joint, including flexible, gel, and soft casts (29200-29280, 29520-29590)
- Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (99070)
- Telemetry
- Tuning for test
- Venipuncture (36400-36410)

These services are considered an integral part of a medical visit and are not covered as separate and distinct services.

Participating or preferred providers cannot bill the patient for an integral service in addition to any payment received for the primary service, that is, the medical or surgical care.

Consultation

Consultation is defined by Pennsylvania Blue Shield as a professional service performed by a second physician at the written or verbal request of the attending physician. A consultation includes:

- a history;
- examination of the patient;
- evaluation of tests, when applicable; and
- a written report filed with the patient's permanent record.

Consultation payment guidelines

Generally, payment for consultation is limited to one consultation per consultant during any one period of hospitalization. Blue Shield will, however, pay for medically necessary consultations, performed by physicians of different specialties, even though the consultations may be billed under a group provider number.

Blue Shield will not pay separately for inpatient preoperative consultations normally provided by a surgeon as part of a surgical procedure. This global payment concept applies when a consultation and surgery or a delivery are performed by the same physician.

Voluntary second surgical opinion program

Pennsylvania Blue Shield offers the Voluntary Second Surgical Opinion Program to assist members in deciding whether or not to undergo surgery. The program also provides alternative treatments to surgery, when appropriate, and helps avoid unnecessary elective surgery.

- A member is eligible to obtain a second surgical opinion as soon as a surgeon recommends elective surgery. The recommendation is called the "first opinion" and is usually given by the surgeon who intends to perform the surgery. Neither this visit, nor any prior visits to a family physician or other doctor are covered under the Voluntary Second Surgical Opinion Program. However, the member may have other benefits that provide coverage.
- To obtain a second opinion, a member must make an appointment with a surgeon or other specialist who is not associated with the surgeon who provided the first opinion.
- The second opinion consultant may perform additional diagnostic services (such as X-rays, electrocardiograms and laboratory tests) as needed, and will provide an opinion regarding the need for surgery. If the two opinions differ, the member may have a third opinion consultation.
- Pennsylvania Blue Shield will pay for these consultations and all necessary diagnostic services in accordance with the member's Pennsylvania Blue Shield agreement.
- The Voluntary Second Surgical Opinion Program places an important responsibility on the member. Participation in the program is strictly voluntary, and a second surgical opinion consultation may be provided only at the member's request.
- Some Blue Shield coverage programs include the Mandatory Second Surgical Opinion Program (MSSOP). It is different from the Voluntary Second Surgical Opinion Program, in that it requires members to obtain second surgical opinions for certain surgical procedures.
- If members with MSSOP do not receive a second opinion before having certain elective surgeries, Blue Shield may not fully cover the procedure. (See Section 11, Utilization Review, for more information on MSSOP).
- Under Pennsylvania Blue Shield's standard consultation benefit, an inpatient consultation performed by the surgeon, his or her associate, or an assistant surgeon is considered part of the global surgery fee, and is not payable in addition to the surgery. (See Section 11, Utilization Review, for additional information.) However, under the Voluntary and Mandatory Second Surgical Opinion Programs,

second (or third) opinion consultations performed by the surgeon, his or her associate, or an assistant surgeon are not considered part of the global surgery fee. Therefore, Blue Shield may pay for both the surgery and the second opinion (or third opinion) consultation, in accordance with the member's second surgical opinion benefit.

- In order for Pennsylvania Blue Shield to properly reimburse consultation services, you must use modifiers "YY" (second surgical opinion) or "ZZ" (third surgical opinion) when reporting consultations under the Voluntary and Mandatory programs. You may use these modifiers with any set of consultation codes: 99241-99245, 99251-99255, 99271-99275. When you don't report these modifiers, Pennsylvania Blue Shield will assume that the consultations are not second (or third) surgical opinion consultations, and will base payment on the member's coverage for medical consultations.

Surgery

Multiple surgery guidelines

Independent procedures are defined in Blue Shield's *PTM* as those services commonly performed with other more major (or primary) surgical procedures, and therefore, do not warrant additional payments beyond payment for the major service.

An independent procedure is eligible for separate reimbursement only when performed alone or when it is the highest-paying procedure of multiple surgical procedures.

Multiple surgical procedures other than independent procedures performed by the same doctor at the same time will be reimbursed as follows:

- 100 percent of the allowance for the primary (highest-paying) procedure;
- 50 percent of the allowance for each secondary procedure.

When multiple surgical procedures are performed as a result of trauma (such as emergency, life- or member-threatening situations) Blue Shield makes the reimbursement as follows:

- 100 percent of the allowance for the primary (highest-paying) procedure;
- 75 percent of the allowance for the second highest-paying procedure;
- 50 percent of the allowance for each additional surgical procedure thereafter.

To indicate trauma situations, add modifier WH to the procedure code.

Use combination codes, when possible

We encourage you to use combination codes when appropriate, including those specifying bilateral procedures. When we receive itemized charges for services that should be reported with a combination code, we will combine the charges and process the claim under the combination code.

If no single procedure code combines or lists the multiple surgical procedures for which you are requesting payment, please report each one separately, and itemize your charge for each. This will help us process your payment more quickly.

The following examples illustrate our payment methodology for multiple surgical procedures:

- Abdominal hysterectomy and appendectomy — The appendectomy is considered an independent procedure and we will pay for the abdominal hysterectomy. Additional examples of common

independent procedures are: casting and strapping, thoracentesis, insertion of temporary transvenous electrode, colonoscopy, proctosigmoidoscopy, exploratory laparotomy and D and C.

- Lysis of adhesions and ovarian cystectomy — Both of these procedures are classified as independent procedures. Payment will be made only for the highest paying procedure, which, in this case, is most likely to be the lysis of adhesions.
- Hallux valgus correction, bilateral — Since the same procedure was performed bilaterally, we pay 100 percent and then 50 percent of the allowance established for the procedure.
- Multiple skin lesions (special guidelines apply) — first (highest allowance) — 100 percent; second through fifth — 50 percent each; lesion removals in excess of five at one session will be priced at 10 percent of the allowance.

Removal of multiple skin lesions

Report claims for the removal of lesions using the codes appropriate to:

- the type of removal, as well as,
- the type and number of lesions.

For example, report 11300-11313 for shaving of dermal lesions; 11400-11446 for excision of benign lesions; 11600-11646 for excision of malignant lesions; 17000-17004 for cryosurgical or electrosurgical destruction of benign or premalignant lesions; and 17260-17286 for destruction of malignant lesion, any method.

Blue Shield processes claims for multiple procedures up to and including five at one session, according to multiple surgery guidelines.

Reporting guidelines for procedure codes 17000-17004 are specific to the terminology within the definitions of the codes. Report these codes in the following manner:

- Procedure code 17000 should only be reported once per session regardless of the number of lesions removed or the number of anatomical sites treated. Always report “1” as the service multiplier.
- Procedure code 17003 should be reported if more than one lesion is treated at one time. Report this code with a multiplier for each lesion in excess of one up to a maximum of 13. The appropriate multipliers to report with procedure code 17003 are 1 through 13.
- If more than 14 lesions are treated, only report code 17004. Reimbursement for procedure code 17004 includes an allowance for procedure codes 17000 and 17003 x 13. Always report code 17004 with a multiplier of 1.

Procedure code 17004 is an all inclusive code. It should not be billed with procedure codes 17000 and 17003.

Here are examples of how you should report codes 17000-17004:

- Removal of one lesion — report procedure code 17000 x 1
- Removal of 2-14 lesions — report procedure code 17000 x 1 and code 17003 x 1 to 13
- Removal 15 or more lesions — report procedure code 17004 x 1

Removal procedures in excess of five at one session are paid at 10 percent of the reasonable charge, providing this amount does not exceed the billed charge.

If payment is questioned, our medical director or professional consultant will review claims reporting unusual circumstances or for more than five procedures.

Assistant surgery

The eligibility of an assistant surgeon's services is based on:

- The complexity and difficulty of the surgical procedure; and
- Whether or not the procedure routinely requires the services of an assistant surgeon.

An assistant surgeon must actively assist the operating surgeon in performing the covered surgery and must be able to complete the surgery in the event the surgeon is unable to continue.

Surgical assistance is not covered when performed by a professional provider who also performs and bills for another surgical procedure during the same operative session.

In addition, under certain contracts, Blue Shield will not pay for assistant surgery performed in a hospital where qualified residents or house staff are utilized for such assistance.

Cosmetic surgery vs. reconstructive surgery

Cosmetic surgery is performed to improve a person's appearance and is generally ineligible for payment.

Reconstructive surgery is performed to improve or restore bodily function and is generally eligible for payment.

Some of the most frequently reported cosmetic/reconstructive surgical services are:

- Abdominal lipectomy (15831)
- Eyelid surgery:
 - Blepharoplasty (15820-15823)
 - Blepharoptosis (67900-67906)
- Breast surgery:
 - Reduction mammoplasty (19318)
 - Augmentation mammoplasty (19324-19325)
 - Mastectomy for gynecomastia (19140)
- Dermabrasion (15780-15787)
- Hair transplant (15775-15776)
- Otoplasty (69300)
- Rhinoplasty (30400-30450)
- Rhytidectomy (15824-15829)
- Scar revision

Mastectomy and reconstructive surgery

Mastectomy

Pennsylvania Blue Shield contracts cover medically necessary services that are appropriate for the symptoms and diagnosis, or treatment of the member's condition, illness or injury. The services must also be in accordance with current standards of good medical care.

Mastectomy (19160-19240) is the removal of all or part of a breast. Mastectomies are typically performed as a treatment for cancer. However, mastectomies are also performed for the treatment of benign disease.

Mastectomy for fibrocystic breasts

Although fibrocystic breasts may not be considered a disease state, it is considered a condition or a "disorder."

There may be no symptoms, but for those women who do have symptoms, they range from mild to severe. Mastectomy is not the appropriate treatment for fibrocystic breasts in all cases. However, mastectomy for fibrocystic breasts may be indicated when the patient is symptomatic and has been unresponsive to conservative treatment and/or biopsy has been performed.

Symptoms of fibrocystic breasts include, but are not limited to: breast engorgement attended by pain and tenderness, generalized lumpiness or isolated mass or cyst. However, the presence of nipple discharge is rarely present in a fibrocystic breast.

Conservative treatment for fibrocystic breasts consists of, but is not limited to: support bras, avoiding trauma, avoiding caffeine, medication for pain, anti-inflammatory drugs, hormonal manipulation, use of vitamin E, use of diuretics and salt restrictions.

The type of mastectomy (subcutaneous, partial, modified or radical) and the timing of the surgery varies for each patient and is determined by the surgeon.

Reconstructive surgery

Reconstructive breast surgery is defined as those surgical procedures designed to restore the normal appearance of a breast following a mastectomy. Effective Feb. 1, 1998, Act 51 of 1997 (Women's Health Security Act) requires coverage for reconstructive surgery and prosthetic devices incident to a mastectomy.

Act 51 of 1997 defines reconstructive surgery to include all surgery on the affected breast and surgery on the contralateral normal breast to re-establish symmetry between the two breasts or to alleviate functional impairment caused by the mastectomy.

Symmetry is defined as approximate equality in size and shape of the nondiseased breast with the diseased breast after definitive reconstruction surgery on the diseased or nondiseased breast has been performed.

Reconstructive surgery includes many procedures

The most common type of reconstructive surgery following mastectomy is the insertion of a silicone gel-filled or saline-filled breast implant. The implant can be inserted immediately at the time of the mastectomy (19340), or sometime afterward in conjunction with the previous use of a tissue expander (19342, 19357).

Other types of reconstruction on the diseased breast include, but are not limited to:

- Nipple/areola reconstruction (19350)
- Nipple tattooing (19499)
- Transverse rectus abdominis myocutaneous flap (TRAM) (19367-19369), latissimus dorsi flap (19361) or free flap (19364)

The following procedures performed on the contralateral normal breast to provide symmetry with the reconstructed breast are also considered reconstructive procedures:

- Augmentation mammoplasty (19324, 19325)
- Reduction mammoplasty (19318)
- Mastopexy (19316)

Breast prosthetics

Act 51 of 1997 requires coverage for prosthetic devices incident to a mastectomy. The act defines prosthetics as the use of initial and subsequent artificial devices to replace the removed breast or portion of the breast.

Act 51 also requires coverage for a home health visit when a woman is discharged within 48 hours following her admission for a mastectomy. This visit is covered by Blue Cross.

When the implantable breast prosthesis (L8600) is provided by the hospital, the charge should be billed to Blue Cross. When the physician incurs the cost of the implant, the charge should be billed to Blue Shield.

Charges for an implantable breast prosthesis will be denied as cosmetic when the implant is provided in conjunction with a cosmetic augmentation mammoplasty (19324-19325).

The following prosthetics are covered:

- Breast prosthesis, mastectomy bra (L8000)
- Breast prosthesis, mastectomy sleeve (L8010)
- Breast prosthesis, mastectomy form (L8020)
- Breast prosthesis, silicone or equal (L8030)
- Breast prosthesis, not otherwise specified (L8039)
- Adhesive skin support attachment for use with external breast prosthesis, each (A4280)
- External breast prosthesis garment, with mastectomy form, post mastectomy (L8015)
- Custom breast prosthesis, post mastectomy, molded to patient model (L8035)
- Implantable breast prosthesis, silicone or equal (L8600)

Coverage for the services defined in Act 51 of 1997 are subject to any copayment, coinsurance or deductibles, and all other terms and conditions set forth in the patient's contract.

Removal of cosmetic implants

Implant removal covered for medical reasons

The removal of a cosmetic implant (such as, breast, synthetic hair, etc.) that has caused an infection or an allergic reaction in a patient is a covered service regardless of whether the original implant was eligible for payment. Claims for this service will be processed under the appropriate procedure code for the implant removal (such as, 19328 or 19330 — breast, 10121 — synthetic hair).

Cosmetic removals not covered

The removal of an intact mammary implant (19328) solely for cosmetic purposes (such as, to replace with a larger or smaller implant) is not covered.

Capsulectomy coverage outlined

When a periprosthetic capsulectomy (19371) or periprosthetic capsulotomy (19370) is reported, the allowance for the capsulectomy or capsulotomy includes the allowance for code 19328 (removal of the intact mammary implant). However, separate payment can be made for code 19330 (removal of mammary implant material) in addition to the capsulectomy or capsulotomy. Separate payment can also be made for the insertion of implant (19340, 19342) following capsulectomy or capsulotomy when the original breast implant procedure was reconstructive rather than cosmetic surgery.

Suction assisted lipectomy (SAL)

Suction assisted lipectomy claim guidelines:

- Suction assisted lipectomy done solely for cosmetic purposes is not eligible for payment.
- Suction assisted lipectomy performed as the sole method of treatment for an otherwise covered service

(such as, removal of lipoma) is eligible for payment — based on individual consideration.

- No separate or additional allowance should be made for suction assisted lipectomy when performed in conjunction with a covered surgical procedure.
- Suction assisted lipectomy performed on a prior date of service in preparation for a covered reconstructive procedure (such as, knee surgery) is eligible for payment based on individual consideration.

Team surgery

Team surgery — When more than two surgeons with different skills, and of generally different specialties, work together to carry out various procedures of a complicated surgery.

The individual procedure performed by each doctor on the surgical team will be considered on its own merit. Modifier 66 — surgical team, should be used to identify team surgery procedures. To be eligible for reimbursement, the component surgery billed by a member of the surgical team must be a covered service if performed alone.

Examples of surgical operations that could fall under the team surgery concept:

- Reattachment of limb, digit, etc.
- Organ transplants, such as a kidney transplant that could involve the services of a general surgeon, a urologist and/or a vascular surgeon to remove the diseased kidney (50340), to implant the donated kidney (50360-50365) and to transplant the ureters (50780).

Co-surgery

Co-surgery is recognized for certain procedures. It is defined as two surgeons of different specialties performing, either simultaneously or at separate times, portions of one or more surgical procedures during the same operative session. Because co-surgeons are performing portions of a procedure, the same procedure code describes the services performed by both surgeons.

Co-surgery is, therefore, eligible per procedure, not per operative session. This means that the performance of co-surgery at one procedure during an operative session for multiple procedures, does not qualify all procedures performed during that session as co-surgery. Only those procedures, in which the surgeon actually performs a portion of the procedure, will be considered co-surgery.

Co-surgery procedures must be reported with the primary modifier 62 — two surgeons. The co-surgery allowance for these procedures is 62.5 percent of the contract allowance, per surgeon per procedure. Multiple surgery guidelines are also applicable.

See the February 2000 *PRN* for a listing of procedures eligible for co-surgery.

Payment may not be made to the same surgeon for assistant surgery and co-surgery procedures performed during the same operative session.

Co-surgery vs. team surgery

Co-surgery is not the same as team surgery, which is defined as more than two doctors, usually with different skills and of different specialties, working together to carry out various procedures of a complicated surgery.

Fracture care

Occasionally, the services of more than one doctor are utilized in the treatment of a fracture — one doctor for

the initial treatment, and another for the follow-up care. In the event the initial patient contact is made by a doctor who provides minimal treatment and diagnosis and then refers the patient to an orthopedist or surgeon for reduction or immobilization of the fracture, the services of the first doctor are eligible for consideration as emergency accident care.

When one doctor performs the initial reduction and/or immobilization and another doctor performs the follow-up care, the “Sun Valley Rule” method of payment is applied — each doctor receives the respective portion of the allowance he or she would have received if he or she had performed total care.

These payments include:

- Displaced fracture, initial care two-thirds the allowance for total care
- Displaced fracture, follow-up care one-third the allowance for total care
- Undisplaced fracture, initial care one-third the allowance for total care
- Undisplaced fracture, follow-up care two-thirds the allowance for total care

The Sun Valley Rule gets its name from the likelihood of fractures from skiing accidents, which occur away from the patient’s home — such as in Sun Valley, Idaho.

Payment for application and removal of a cast for a fracture, when performed by the same doctor, is included in the global allowance for the doctor’s overall fracture care. Therefore, it does not warrant separate payment. In addition, related follow-up medical care is also included in the allowance for the fracture care.

However, the removal of a cast is eligible for payment when performed by a provider other than the doctor (or his or her associate/partner) who applied it.

Obstetrical delivery and associated services

The following services are considered to be an integral part of a vaginal delivery (59400-59410), cesarean section (59510-59515) or delivery after previous cesarean delivery (59610-59622) and are not eligible as distinct and separate services:

- a) Induction of labor (for example, PEGGELL insertion)
- b) Removal of shirodkar sutures prior to delivery
 - under anesthesia (except local) (59871)
 - under local anesthesia or without anesthesia
- c) Any method used to alter presentation (rotation, internal or external version [59412], forceps, etc.)
Separate payment may be made for external version (59412) when reported by a physician other than the attending obstetrician or associate.
- d) Suturing of episiotomy (W9280)
- e) Fetal scalp blood sampling (59030)
- f) Fetal monitoring

Fetal testing

Payment will be made for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (for example, oxytocin) and is generally administered intravenously. These tests are utilized to determine fetal status and viability.

Payment should be made for fetal non-stress testing (59025) once per day, regardless of the number of gestations.

Attendance of labor is a payable service to a doctor other than the doctor who performs the delivery, his or her assistant or his or her associate. Attendance at labor is only eligible for emergency or at-risk cases. Routine attendance at labor is not a covered service.

Payment for obstetrical care (59400 and 59410) includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (for example, the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta (59414), as well as for antepartum care (59425, 59426) and/or postpartum care (59430), as appropriate.

Multiple birth guidelines

The following guidelines apply to payment for multiple births:

- If infants are delivered by the same method (vaginal or cesarean section), payment will be made for one delivery.
- If one or more infants are delivered vaginally and one or more by cesarean section, payment will be made for one vaginal and one cesarean section delivery in full. Only one delivery code will be paid with antepartum and postpartum care.

Payment for delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate payment may be made for fetal monitoring to a physician other than the attending physician (code 59050 or 59051) when any one of the following criteria is met:

- For any high-risk pregnancy.
- For multiple gestation with complications.
- For any unusual or abnormal fetal heart rate findings.
- When there is a need for scalp pH.
- For fetal decelerations that are recurrent and of unknown etiology.
- When there are atypical fetal responses with maternal medical diseases.
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

Fetal monitoring not covered same day as consultation

When fetal monitoring (59050 or 59051) is provided on the same day as a consultation by the same health care professional, the fetal monitoring is not eligible for separate payment. When consultations are a benefit, the fetal monitoring is included in the allowance for the consultation.

Assisted fertilization

Infertility is the medically documented absence of, or diminished ability to conceive or induce conception. A couple is considered infertile if pregnancy does not occur over a one-year period of normal coital activity between a male and female partner without contraceptives. The cause of infertility can be a female or male factor, or a combination of both.

Assisted fertilization techniques enhance sperm-egg interaction. Management of the infertile couple with assisted fertilization is generally limited to those couples who do not respond to standard infertility treatments (such as, tuboplasty for the female, microsurgical reconstruction for the male).

Assisted fertilization techniques include, but are not limited to:

- Artificial insemination (AI)
- In vitro fertilization (IVF)
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)

Assisted fertilization is not covered, except for certain group programs. When assisted fertilization is a benefit, the following procedures are covered services as part of the program.

<u>Code</u>	<u>Terminology</u>
58321	Artificial insemination; intracervical (AI)
58322	Artificial insemination; intrauterine (AI)
58323	Sperm washing for artificial insemination
58970	Follicle puncture for oocyte retrieval, any method such as, laparoscopy, colposcopy
58974	Embryo transfer, intrauterine (IVF)
58976	Gamete, zygote, or embryo intrafallopian transfer, any method (GIFT, ZIFT)
58999	Ovulation induction (drug therapy and management, e.g., Pergonal injections)
76948	Ultrasonic guidance for aspiration of ova
84702	Gonadotropin, chorionic; quantitative (i.e., implantation monitoring - HCG assay)
89250	Culture and fertilization of oocyte(s)
89251	Culture and fertilization of oocyte(s); with co-culture of embryos
89252	Assisted oocyte fertilization microtechniques (any method) (e.g., Intracytoplasmic Sperm Injections, ICSI, sperm microinjection)
89253	Assisted embryo hatching, microtechniques (any method) (e.g., zona drilling)
89254	Oocyte identification from follicular fluid
89255	Preparation of embryos for transfer (any method)
89256	Preparation of cryopreserved embryos for transfer (includes thaw)
89257	Sperm identification from aspiration (other than seminal fluid)
89260	Sperm isolation: simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis
89261	Sperm isolation: complex prep (e.g., per col gradient, albumin gradient) for insemination or diagnosis with semen analysis
89264	Sperm identification from testis tissue, fresh or cryopreserved

Assisted fertilization case management

When reported, assisted fertilization case management will be processed under the appropriate procedure codes for the services rendered. Assisted fertilization case management generally includes, but is not limited to, such services as a history and physical, daily visits, consultations for medication adjustment and counseling.

Although assisted fertilization is contractually excluded from standard coverage, payment can be made for evaluation of infertility and for managing the pregnancy and delivery, should the fertilization process be successful.

Anesthesia

Anesthesia services

The following types of anesthesia qualify for payment as anesthesia services:

- Inhalation
- Regional
- Spinal (low spinal, saddle block)
- Epidural (caudal)
- Nerve block (retrobulbar, brachial plexus block, etc.)
- Field block
- Intravenous
- Rectal

Local anesthesia, which is direct infiltration of the incision, wound or lesion, is not a covered service under most Blue Shield contracts.

Payment based on procedure, difficulty and unit values

Payment for anesthesia services is evaluated through the use of relative values. Basic unit values have been assigned to most surgical procedures and reflect the degree of difficulty for the anesthesia services, including the usual preoperative and postoperative care and evaluation. Therefore, it is not necessary to report basic unit values.

Blue Shield determines payment for anesthesia services on the basic unit value, plus time units reported, plus eligible modifying units reported, multiplied by the anesthesia conversion factor.

Blue Shield reimburses anesthesia services only when performed in conjunction with other covered services and performed by a physician other than the operating surgeon, the assistant surgeon or the attending physician.

Standby anesthesia implies “availability” of a physician (such as an anesthesiologist) with no actual physician involvement and no direct patient care. Consequently, standby anesthesia is not covered.

Medical direction/supervision of anesthesia

Medical direction/supervision of anesthesia is defined by Blue Shield as anesthesia direction, management or instruction by a provider who is physically present or immediately available in the operating suite. A provider rendering this service should not actually be concurrently administering anesthesia in another operating room.

For concurrent supervision, reimbursement is limited to no more than four anesthesia services performed concurrently. Blue Shield pays for medical direction of anesthesia as follows:

- When a provider such as an anesthesiologist medically directs a physician-in-training, Blue Shield pays in the same manner as for the anesthesiologist’s personal performance of the anesthesia service.
- When a provider such as an anesthesiologist medically directs a certified registered nurse anesthetist (CRNA), hired and paid by the anesthesiologist, Blue Shield pays in the same manner as for the anesthesiologist’s personal performance of the anesthesia service.
- When a provider such as an anesthesiologist medically directs a CRNA not employed by the anesthesiologist, Blue Shield pays up to 50 percent of the fee allowed for the anesthesiologist’s personal performance of the anesthesia service.

- When a provider such as an anesthesiologist medically directs a CRNA who is directly billing his or her services on a fee-for-service basis, Blue Shield pays up to 50 percent of the allowance for the anesthesiologist's personal performance of the anesthesia services. In this instance, a CRNA who is directly billing his or her service on a fee-for-service basis may also be paid up to 50 percent of the anesthesia allowance.

An anesthesiologist medically directing four or fewer anesthesia procedures can concurrently provide the following:

- Address an emergency of short duration in the immediate area;
- Administer an epidural or caudal anesthetic to ease labor pain;
- Provide periodic, rather than continuous, monitoring of an obstetrical patient;
- Receive patients entering the operating suite for the next surgery;
- Check or discharge patients in the recovery room; or
- Handle scheduling matters.

Coverage for CRNA services

Pennsylvania Blue Shield recognizes covered services performed by a certified registered nurse anesthetist (CRNA), providing such services are within the scope of a CRNA's license, and are otherwise eligible for payment.

A CRNA employed by a health care facility or an anesthesiology group is not an eligible provider according to Act 209 of 1986. However, if a CRNA also wishes to simultaneously maintain a separate and independent practice, the CRNA can become an eligible provider with Pennsylvania Blue Shield and can bill for services performed, but only within the independent practice.

Pain management services

Pain management techniques may be used to control pain both after surgery and in other situations. Here are Pennsylvania Blue Shield's guidelines for the most commonly used pain management techniques:

Patient controlled analgesia (PCA) therapy involves self-administration of intravenous drugs through an infusion device. PCA for post-surgical pain control is considered routine postoperative pain management warranting no separate payment, regardless of who provides it.

When PCA is used for non-surgical pain management, such as for cancer, it is considered an integral part of a doctor's medical care, and is not eligible for payment as a separate distinct service. A participating doctor cannot bill the patient separately for PCA in such cases.

There is no distinct procedure code for patient controlled analgesia.

Epidural analgesia (code 62318 or 62319, as appropriate) involves administering a narcotic drug through an epidural catheter. This type of analgesia is eligible as a separate and distinct service when used for postoperative management following major surgical procedures, such as total hip and knee replacement and major vascular surgery. Epidural analgesia includes the preoperative, intra-operative or postoperative insertion of an epidural catheter as well as subsequent pain management services such as adjustments, re-injections and visits.

Payment also can be made for the insertion of an epidural catheter (code 62318 or 62319, as appropriate) for the treatment of a non-surgical condition.

Payment for the administration of epidural anesthesia for the relief of pain during labor and delivery is based on time and basic anesthesia units. The basic units are equated to those for either vaginal delivery or cesarean section (for example, 59400 or 59510). Report modifier **WJ** (anesthesia service) together with the appropriate obstetrical code.

The time spent providing continuous epidural anesthesia during labor and delivery includes:

- The *actual time* in attendance by the physician during placement of the epidural catheter.
- The *actual time* in attendance by the physician with the patient during the period of re-injection of the drugs into the epidural catheter.
- The *actual time* in attendance by the physician during delivery and perineal repair.

Don't report a separate code for epidural nerve blocks (for example, 62311) or for the insertion of an epidural catheter (code 62318 or 62319, as appropriate). In this instance, a participating doctor cannot bill the patient separately for the labor epidural.

A **nerve block** involves injecting an anesthetic agent into or around a given nerve.

For nerve blocks performed as anesthesia for a surgical or obstetrical service, report the appropriate surgical or obstetrical procedure code with a **WJ** modifier. You may also report time units.

Nerve blocks administered as pain management *for a surgical condition or obstetrical care* are considered routine pain management, regardless of who performs them, and are not eligible for separate payment.

Therapeutic nerve blocks for the treatment of a non-surgical/non-obstetrical condition (independent of any surgical or obstetrical procedure) are covered surgical services. Report procedure codes 62273-62282, 62310-62319, 64400-64450, 64470-64484, 64505-64530, as appropriate. Do not include the **WJ** modifier or time units, since therapeutic nerve blocks are considered to be surgical services.

Pathology

Clinical laboratory testing

- Blue Shield pays for clinical laboratory testing only when reported by the doctor or independent clinical laboratory that actually performed the test. Clinical laboratory tests performed by a hospital laboratory that is not an independent laboratory, must be billed to the local Blue Cross Plan.
- Independent laboratories may bill for tests performed by a reference laboratory when the independent laboratory has performed a majority of the tests.
- Doctors should only report charges for clinical laboratory tests performed in their offices, unless the tests are part of a battery of tests that are commonly performed on automated equipment referred to an independent laboratory. The independent laboratory should bill for any clinical studies referred to it by doctors.
- The **collection and handling of specimens** is a covered service under standard Blue Shield programs.

Surgical pathology guidelines

Procedure codes 88300-88309 designate surgical pathology studies. A **specimen** is defined as tissue or tissues submitted for individual and separate attention, requiring individual examination and pathologic diagnosis.

- Code 88300 represents any specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination.

- Code 88302 is used when gross and microscopic examination is performed on a specimen to confirm identification or absence of disease.
- Codes 88304-88309 represent all other specimens requiring gross and microscopic examination, and represent additional ascending levels of physician work.

Levels 88302 through 88309 are specifically defined by the assigned specimens.

Allergy testing

Here are Pennsylvania Blue Shield's guidelines for its coverage of allergy testing:

- **Skin testing** – Blue Shield will pay for up to 60 medically necessary skin tests per patient per year, regardless of the test method (for example, percutaneous, intracutaneous). These tests are limited to inhalants and foods.
- **In vitro testing** – Blue Shield will pay for up to 15 medically necessary in vitro tests, per patient per year, regardless of the type (i.e., RAST, FAST, multiple antigen simultaneous test, ELISA). These tests are limited to inhalants and foods.
- **Combination testing** – Blue Shield will not pay for both skin testing and in vitro testing for the same allergens.
- **Medical necessity** – Blue Shield bases medical necessity for all allergy testing on the pertinent clinical findings. A “check-off” history sheet completed by the patient can supplement, but not replace, a history and physical examination. You should always perform a complete history and physical exam.
- **Documentation** – The patient's medical record should indicate sufficient information, based on the clinical findings, to justify the medical necessity for allergy testing.

Coverage threshold set per patient, per year

It is Blue Shield's position that, based on these sources, it is rarely medically necessary to exceed 15 in vitro or 60 skin tests per patient per year. In most instances, you'll need fewer than these established maximums to thoroughly evaluate the patient.

Therefore, Blue Shield will not pay for allergy tests in excess of the established upper limits, except in extraordinary circumstances. When submitting documentation to Pennsylvania Blue Shield to establish the need for tests in excess of these limits, include the following:

- A copy of the patient's history and physical examination report, including the completed allergen “check-off” sheet, if available;
- A copy of the test results;
- Any other pertinent documentation.

Radiology/ultrasound

X-ray combination coding

Report multiple diagnostic studies of the same general body area performed at the same time under a combination code where available. For example:

- Separate charges reported for codes 72100 (radiologic examination, spine, lumbosacral anteroposterior and lateral) and 72120 (radiologic examination, spine, lumbosacral, bending views only, minimum of four views) should be reported under code 72114 (radiologic examination, spine, lumbosacral anteroposterior and lateral, complete, including bending views).

Reinterpretation of X-ray

Blue Shield pays for only one interpretation of any given X-ray. When reporting the professional component of an X-ray, the health care professional must perform a complete interpretation of the X-ray that includes a detailed written report of the results for the patient's records.

- A re-interpretation of that same X-ray by another physician is not eligible for payment as a distinct and separate service.

Stress films and weight bearing X-rays

Pennsylvania Blue Shield does not provide additional payment for stress films of an extremity or joint or for weight bearing X-ray studies when performed in conjunction with a conventional X-ray study of the same body area.

- When you perform only stress films or weight bearing X-rays, report the appropriate code for a limited X-ray of the area.

Routine screening tests

Coverage for routine screening tests or services for asymptomatic patients varies according to the terms of the individual Blue Shield contract.

Listed below are the codes you should report for asymptomatic patients:

<u>Code</u>	<u>Terminology</u>
G0102	Prostate cancer screening; digital rectal examination
G0103	Prostate cancer screening; prostate specific antigen test (PSA), total
G0104	Colorectal cancer screening; flexible sigmoidoscopy
G0106	Colorectal cancer screening; screening sigmoidoscopy, barium enema
G0107	Colorectal cancer screening; fecal occult blood test one - three simultaneous determinations
G0120	Colorectal cancer screening; screening colonoscopy, barium enema
G0122	Colorectal cancer screening; barium enema
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

Code	Terminology
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under physician supervision
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by a physician
S0601	Screening proctoscopy
S0605	Digital rectal examination, annual
W9310	Electrocardiogram, routine ECG with at least 12 leads, routine service, asymptomatic patient
W9315	Cardiovascular stress test, asymptomatic patient
X4530	Proctosigmoidoscopy; routine service, asymptomatic patient
Y7608	Mammography, asymptomatic patient; unilateral
76092	Mammography, asymptomatic patient; bilateral
Z8030	General health screen panel, asymptomatic patient
Z8100	Urinalysis; routine service, asymptomatic patient
Z8246	Cholesterol, serum; asymptomatic patient
Z8502	Blood count; hemogram, automated, and differential WBC (CBC), asymptomatic patient
Z8503	Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices), asymptomatic patient
Z8555	Blood count; hematocrit, asymptomatic patient
Z8557	Blood count; hematocrit and hemoglobin (Hct and Hgb) asymptomatic patient;
Z8558	Blood count; hemoglobin, colorimetric, asymptomatic patient
Z8628	Hemagglutination inhibition tests (HAI), each (e.g., rubella, viral), asymptomatic patient
Z8658	Skin test; tuberculosis, tine test, asymptomatic patient

Miscellaneous services

Physician assistant services

Blue Shield covers licensed physician assistant (PA) services when the PA is employed by and is acting under the direct, personal supervision of a doctor.

- Blue Shield cannot pay a PA directly. Instead, we pay either the participating doctor or the patient (for services provided by a non-participating doctor). We pay the same amount as we would for services personally performed by the reporting doctor.
- Pennsylvania Blue Shield does not pay for assistant surgery performed by a PA. An assistant surgeon must actively assist in the surgery. To “actively assist” means the assistant surgeon must assist in the actual performance of the surgical procedure. In the event the surgeon is unable to continue, the assistant surgeon should be able to complete the surgery.
- Blue Shield will not pay the doctor for supervision of a PA acting in the capacity of a surgical assistant at an operation that the supervising doctor personally performs. Supervision of the PA’s services is considered an integral part of the doctor’s surgical fee. Therefore, participating or preferred providers cannot bill the patient separately for the supervision of the PA.

Obesity

Claims reporting services performed in conjunction with a diagnosis of “obesity” are not eligible for payment.

In general, 20 to 30 percent above “ideal” bodyweight, according to standard life insurance tables, constitutes obesity. Morbid obesity is further defined as a condition of consistent and uncontrollable weight gain that is characterized by a weight that is at least 100 pounds or 100 percent over ideal weight or a body mass index (BMI) of 35 or greater.

BMI is a method used to quantitatively evaluate body fat by reflecting the presence of excess adipose tissue. BMI is calculated by dividing measured bodyweight in kilograms by the patient’s height in meters squared. The normal BMI is 20-25 kg/m².

Claims reporting surgical services (for example, gastric stapling and gastric bypass surgery) for the treatment of “morbid obesity” are generally eligible for payment under standard Blue Shield contracts.

Non-covered services

Pennsylvania Blue Shield provides benefits according to the terms of the individual member’s Blue Shield contract. Services that are specifically excluded under the contract may be billed to the patient.

Examples of services that are not covered under most Blue Shield contracts:

- Artificial insemination;
- Corneal microsurgery for the correction of myopia or hyperopia;
- In vitro fertilization;
- Routine neonatal circumcision.

Physical therapy

Physical therapy is a covered service when performed with the expectation of restoring the patient’s level of function that has been lost or reduced by injury or illness.

However, physical therapy is not eligible when performed repetitively to maintain a level of function.

Spinal manipulation

Procedure codes S8901-S8905 represent spinal manipulation including decision-making based on subjective and objective findings of patient status and preparatory and post-service physical modalities.

- Only one spinal manipulation encounter is eligible for payment per day.
- Codes S8901-S8905 apply to spinal manipulation performed by a health care professional of any specialty or discipline.
- Spinal manipulation is not covered under standard Pennsylvania Blue Shield contracts. Therefore, participating or preferred providers may bill patients for these procedures.

Manipulation therapy is a covered service when performed with the expectation of restoring the patient’s level of function that has been lost or reduced by injury or illness.

However, manipulation therapy is not eligible when performed repetitively to maintain a level of function.

Rhythm strip

A rhythm strip is considered an inherent part of the following studies and does not warrant separate payment in addition to that study:

- Echocardiogram;

- Electrocardiogram;
- Master two-step;
- Stress test (cardiac or pulmonary).

Consequently, when a rhythm strip is reported in conjunction with any of these tests, Blue Shield will pay only for the appropriate study (for example, 93000, 93015).

Resting ECG and stress testing

A resting ECG is an inherent part of cardiac stress testing and does not warrant separate payment in addition to that for the stress test.

Consequently, when you report a resting ECG in conjunction with a cardiac stress test, Blue Shield will pay only for the cardiac stress test.

Electrocardiogram reinterpretations

An attending or admitting physician who interprets an ECG will not be reimbursed in non-emergency cases when the ECG is interpreted by another physician, such as a staff physician, whose duties include the interpretation of ECGs.

In non-emergency cases, Pennsylvania Blue Shield views reinterpretation of an ECG as integral to the attending or admitting physician's medical care. Therefore, a participating doctor cannot bill the patient separately for these reinterpretations.

However, if the patient's condition requires immediate interpretation of the ECG (emergency treatment), Blue Shield can pay the attending or admitting physician as well as the hospital-staff physician who also interprets the ECG.

Report emergency ECG interpretations by adding modifier "YC" to the appropriate ECG procedure code.

Procedures of questionable current usefulness

Procedures of questionable current usefulness (POQCU) are procedures that are no longer routinely paid by Pennsylvania Blue Shield.

A POQCU is classified as:

- 1) A procedure of unproved value or of dubious current efficacy;
- 2) Redundant when performed in conjunction with other procedures; or
- 3) Unlikely to yield information of value in the patient's treatment course.

If you provide information to Pennsylvania Blue Shield that satisfactorily documents the medical necessity of a POQCU, we will pay for the procedure.

Blue Shield reviews all claims for a POQCU on an individual basis. Some examples of POQCU include:

<u>Code</u>	<u>Procedure</u>
27080	Coccygectomy;
44680	Intestinal plication;
61490	Craniotomy for lobotomy.

The *PTM* identifies all POQCUs.

Diagnostic studies with computer analysis or generation of automated data

Pennsylvania Blue Shield will not pay a separate charge for computer analysis or generation of automated data performed in conjunction with a diagnostic medical study. These are considered to be an integral part of the diagnostic study and are not covered as separate and distinct services.

Psychiatric/psychological services

Generally, individual psychotherapy (codes 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845, 90875, 90876) and a psychiatric or psychological visit are not performed on the same day. In those cases where individual psychotherapy and a psychiatric/psychological visit are reported on the same day, Blue Shield will make payment for only one service.

It is only in exceptional cases that multiple visits or multiple psychotherapy sessions (same modality) are necessary on the same day. Therefore, when multiple visits or psychotherapy sessions are reported to Blue Shield, payment will be made for only one visit or psychotherapy session. However, payment may be made for psychiatric/psychological treatment consisting of different modalities (for example, family or group vs. individual psychotherapy) when performed on the same day. Additionally, payment may be made for psychological testing/central nervous system assessments/tests (codes 96100, 96105, 96111-96117) and psychiatric or psychological treatment (for example, visit or psychotherapy) when performed on the same day.

A comprehensive or interval history of a patient's complaint or illness (codes 90801, 90802), when used to assist in psychiatric diagnosis and treatment planning, is an eligible service regardless of the source of information. When the patient is comatose or withdrawn and uncommunicative due to a mental disorder, a history may be obtained by interviewing the patient's family and close associates. However, family counseling (90846, 90887) is not reimbursable as part of the physician's personal services to the patient. Family counseling is generally not eligible for reimbursement.

Family psychotherapy (code 90847) primarily involves the physician's treatment of the patient's condition, and not the treatment of each family member's problems. Therefore, this code represents a complete family session, payable only for the patient. These codes should not be used for other family members involved in family psychotherapy.

As with all other professional services, Blue Shield pays for psychiatric or psychological services in accordance with the individual member's contract. Therefore, the guidelines explained above are applicable when those services are covered under the member's contract.

Chemotherapy

Coverage for chemotherapy services is generally provided in any place of service when:

- The treatment is administered by or under the supervision of a doctor for treatment of a malignant disease; and
- FDA-approved antineoplastic agents are used.

In addition, payment may be made for drugs administered as part of a rescue form, or antidote for, severe toxic reactions to the antineoplastic agent. For example, leucovorin given as an antidote following high-dose methotrexate therapy is covered.

Payment may be made for oral antiemetic drugs (Q0163-Q0181) when used as full replacement for intravenous antiemetic drugs as part of a cancer chemotherapeutic regimen.

- Procedure codes Q0166 and Q0180 should not exceed a 24-hour dosage regimen.
- The remaining codes should not exceed a 48-hour dosage regimen.

When drugs are administered in an outpatient or inpatient hospital setting, the drug is a hospital expense.

- However, payment can be made for the administration of the antineoplastic drug when the doctor personally administers the drug, or when he supervises an employee who is performing the administration.

Eligible methods of administration include intravenous, intra-arterial, intramuscular, intracavitary and oral routes.

- When multiple drugs are given by the same route of administration, during the same session, only one administration fee will be reimbursed.
- When multiple drugs are given by **different** routes of administration, each route can be paid.

Miscellaneous reimbursement issues

Employment and supervision information

Under Pennsylvania Blue Shield's standard contracts, the services of a non-licensed person (for example, a nutritionist) are not eligible for payment, regardless of employment or supervision status.

Pennsylvania Blue Shield recognizes services performed by the following providers, duly licensed and acting within the authority of their licenses:

- Audiologists
- Certain certified registered nurses
- Doctors of chiropractic
- Clinical laboratories
- Dentists
- Doctors of medicine
- Doctors of osteopathy
- Nurse midwives
- Optometrists
- Physical therapists
- Podiatrists
- Psychologists
- Speech pathologists, and
- Teachers of the hearing impaired.

In some instances, Blue Shield will pay for covered services performed under the personal supervision of an eligible provider by a licensed health care practitioner in his or her employment.

“Personal supervision” means that the provider must be in the immediate vicinity so he or she can personally assist in the procedure or take over the patient's care if necessary. Availability of the provider by telephone or radio contact does not constitute direct personal supervision.

Criteria for employment of a licensed health care practitioner

Blue Shield recognizes an employment relationship between a provider and a licensed health care practitioner — and therefore pays for covered services — only if all of the following criteria are met:

- The employer has the power to hire and fire.
- The employer has the power to direct the work done by the health care practitioner, and has ultimate responsibility for the manner of his or her performance.
- The employer pays wages and fringe benefits, and establishes the level of compensation.
- The employer is personally responsible for withholding federal income tax and social security contributions and is personally responsible for making contributions for the health care practitioner under the Pennsylvania Unemployment Compensation Act, and is personally responsible for insuring the health care practitioner's liability under the Pennsylvania Workers' Compensation Act.
- There is no compensation received by any hospital for the services of the health care practitioner during the period of employment under the employer.

Purchased services

Purchased services are defined by Blue Shield as services reported by one doctor, but actually performed by another doctor or entity, such as an independent physiological laboratory (IPL).

- These services usually involve the technical and professional components of diagnostic tests performed by different entities (two doctors or a doctor and an IPL or other entity).
For example, it is common to find radiological and diagnostic medical procedures split in this manner.
- You may report the total procedure when the technical component is purchased. However, it is unacceptable to report a purchased professional component, either independently or as part of the total service.

Here are some sample billing arrangements:

- 1. An acceptable arrangement:** A doctor purchases the technical component of a diagnostic service from another doctor, IPL or other entity. He then interprets the results of the test and reports the total procedure.
- 2. An unacceptable arrangement:** A doctor purchases both the technical and professional components of a diagnostic service from another doctor, IPL or other entity. The doctor then reports the total service, but has not actually performed any professional service for the patient.
- 3. An unacceptable arrangement:** A doctor owns specialized equipment and performs only the technical portion of the test. The doctor purchases a professional interpretation from another specialist and then reports the total service. Since the reporting doctor has not performed any professional service for the patient, this billing arrangement is unacceptable.

It is not acceptable for a doctor to purchase professional services from an independent contractor and report these services to Blue Shield. Blue Shield defines an “independent contractor” as a doctor who performs a professional service for another doctor, but who is neither an employee nor a partner of the “purchasing” doctor.

“Status of patient” vs. “place of service”

Pennsylvania Blue Shield classifies services performed on one of its members as “inpatient” or “outpatient,” based on the status of the patient — not on the place where the service was performed. When a member who is an inpatient in a hospital is taken outside of that hospital to receive services (for example, to a mobile MRI or CT unit or to a doctor's office) and then is returned to the hospital without being discharged, these services are considered inpatient.

Definition of medical necessity

Pennsylvania Blue Shield defines “medical necessity” as a need for a particular item or service, required for the diagnosis or treatment of disease, injury or defect.

- For Blue Shield to consider a service as medically necessary, there must be active symptomatology or evidence of the disease, injury or defect, and the need for the services must be documented in the patient’s records. Blue Shield will deny payment when there is no identifiable relationship between the reported service and the diagnosis or symptoms reported.
- A limited or comprehensive health screening of any kind or any periodic examination that is initiated for reasons other than symptomatology is not eligible for payment. In addition, Blue Shield will not reimburse services performed at the request of the patient or at the suggestion of the doctor without symptomatology or evidence of disease.
- This determination also takes into account the need for the frequency and/or level of the services reported.

Referred services

If you report referred services to Pennsylvania Blue Shield and receive payment, you are responsible for checking the medical necessity of those services. The fact that another doctor referred the patient to you does not relieve you of the obligation to assess medical necessity.

The Regulations for Participating Doctors require that covered services performed for Blue Shield members be reported only if medically necessary. The documentation for the medical necessity of the service must be present in the patient’s records and be available for review, if required. If the documentation is not available or does not justify the need for the service, Blue Shield will request a refund.

When reporting services, please be sure to complete Block 19 – “Name of referring physician or other source” on the 1500A claim form.