PRN

Policy Review & News

Important information about Highmark Blue Shield
www.highmarkblueshield.com

April 2005

In This Issue

BC **Look for this symbol for all BlueCard® related information**

News

Some Blue members carry health care debit cards as high-deductible health plans grow in popularity

BC Increased cost sharing (like higher deductibles) is a growing trend. So, don't assume patients have first-dollar coverage.

For member convenience, some Blue Plans now offer their members a health care debit card (also known as a "stored value card")—a new card with value-added features to help providers collect the member's cost-sharing amount, for example, copayment, coinsurance, etc.

Although they are called a "debit card" and may actually have the word "debit" imprinted on them, members do not have a PIN and can't swipe the card as a debit transaction. It's swiped as a credit transaction; however, no credit line is attached to it. Rather, the card stores a predetermined balance that the member accesses during his or her benefit year.

HIGHMARK® BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

When a member presents a health debit card, it helps you simplify your administration process by potentially reducing bad debt, reducing paper work for billing statements, minimizing bookkeeping and patient account functions for handling cash and checks, and avoiding unnecessary claim payment delays.

The cards allow members to pay for out-of-pocket costs using funds from their Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). Some cards, like those carried by some Highmark Blue Shield members who are enrolled in a high-deductible health plan, are "stand-alone" cards to cover out-of-pocket costs. While others, like those issued by some other Blue Plans, may combine the card to serve as both the health debit card and the member identification card. You may occasionally see these combination cards when treating BlueCard® members.

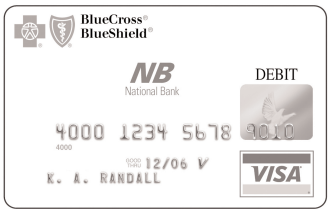
For more information about Highmark Blue Shield's high-deductible health plans, please see the December 2004 issue of **Behind the Shield**, available online in the Provider Resource Center at **www.highmarkblueshield.com**.

It's easy to recognize—just look for the familiar logos

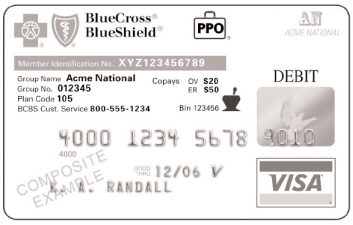
The card will have the logo from a major credit card, such as MasterCard® or Visa®. And, in some instances, other Blue Plans are including the nationally recognized Blue logos on the card. (At this time, Highmark Blue Shield's health debit cards do not carry the Blue Shield logo.)

Here is a sample health debit card that does not include the Blue logos. Highmark Blue Shield currently offers this card to its members, including those enrolled in its high-deductible health plans.

Sample health debit card that includes the Blue logos:



Sample combined card that serves as both a health debit card and member identification card:



Note: These sample identification card images were provided by the Blue Cross Blue Shield Association. They represent those issued by out-of-area Blue Plans.

It's easy to use

The cards include a magnetic strip so you can swipe the card at the point of service to collect what the member owes. With the health debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature card.

Helpful tips

- Ask members for their current member health insurance identification card. It's a good idea to regularly obtain new photocopies of the front and back of their card. Having the current card will enable you to submit claims with the appropriate member information (including alphabetical prefix) and avoid unnecessary claims payment delays.
- Check Highmark Blue Shield member eligibility and benefits through NaviNet^{SM}. For BlueCard members, you can use NaviNet or call (800) 676-BLUE (2583) to verify eligibility and benefits.
- If the member presents a health debit card, be sure to verify the copayment or deductible amount before processing payment.
- Please do not use the card to process full payment upfront. You should charge only the allowable amount for covered services.

NaviNet is a registered service mark of NaviMedix, Inc.

Blue Shield rejects claims that are not in HIPAA-mandated electronic format

Beginning May 26, 2005, Highmark Blue Shield will no longer accept claim transactions that are not in the HIPAA-mandated electronic format. Blue Shield will reject non-compliant electronic claim transactions for all payers that it receives on or after May 26, 2005.

Blue Shield will require all providers, their billing services and clearinghouses to use only HIPAA-mandated (004010A1) formats for submitting electronic claim transactions.

Blue Shield is currently determining the date for when it will discontinue the transmission of non-compliant Electronic Remittance Advices (ERAs). Watch for more information about this in an upcoming issue of **PRN**.

If you have questions about how to submit your electronic claims, call EDI Operations at (800) 992-0246.

Blue Shield changes claims status notice procedure

Beginning April 15, 2005, you'll notice these changes to claim receipt and status notifications:

- If Highmark Blue Shield has not processed and paid a paper claim within 10 days of receipt, it will send the provider a paper notification advising that the claim has been received. Blue Shield will not send paper notices to providers with access to the Accounts Receivable (A/R) Dashboard functionality on NaviNet^{SM} because they have continuous access to claims status information.

  The A/R Dashboard functionality on NaviNet takes claims information from various Blue Shield resources and displays it in a single application. Its rollout to NaviNet-enabled practices is under way and should be completed later in 2005.

- Electronic claim providers will continue to receive electronic acknowledgements of claim receipt. They will not receive additional paper claim receipt notifications.

- If a claim has not processed and paid within 28 days and the provider does not have access to the A/R Dashboard functionality, Blue Shield will send a paper notification advising the provider of the claim's status and reason for the delay. Blue Shield will send additional paper notifications every 45 days thereafter until the claim has been processed. Blue Shield will not send paper notices to providers with access to the A/R Dashboard functionality on NaviNet since they have continuous access to claims status information.

Blue Shield gives priority to claims submitted electronically, typically finalizing them in seven to 10 days. Usually, Blue Shield finalizes paper claims in 21 to 27 days.

If you submit paper claim forms and/or do not have access to NaviNet, and you'd like to learn more about the benefits of electronic claims filing, please contact your Provider Relations representative.

Electronic claims submission is easier than ever

Highmark Blue Shield is committed to working with providers to make electronic claims submission as simple and convenient as possible. Blue Shield has made tremendous progress over the past few years, and if you're not keeping up with the latest capabilities, you may be filing paper claims unnecessarily.

So, avoid the extra expense of producing paper claims, copying documents and paying postage. Tell your billing staff and/or computer software vendors that these three claim reporting functions can be submitted to Blue Shield electronically:

- secondary claims
- attachments
- adjustments

Secondary claims

When Blue Shield is the secondary payer, it does not require a copy of the primary insurer's Explanation of Benefits. This is true even when Medicare is the primary insurer. All you need to do is submit an 837 transaction with complete primary payer payment data in the appropriate fields.

Attachments

Blue Shield encourages the electronic submission of all claims and discourages sending attachments on a routine basis. When additional documentation is necessary to process a claim, Blue Shield will request the data at that time. However, if you believe that paper documentation, for example, medical records, is needed to support your claim, you can still file the claim electronically.

Just submit an 837 transaction and use the Paperwork (PWK) Segment to report the type and transmission code of the attachment. When reporting the "Type of Attachment," avoid using the generic attachment code "OZ," as this may delay processing. To indicate the attachment transmission method, report one of these "Attachment Transmission" codes:

- AA—available on request at provider site
- BM—by mail

  Send to:
  PWK Additional Documentation
  PO Box 890176
  Camp Hill, Pa. 17089-0176

- FX—by fax

  Send to (717) 302-3686

You can find the fax cover sheet online at **www.highmarkblueshield.com**. Click on the Provider Resource Center in the lower right corner, hover on Electronic Data Interchange (EDI) Services, and click on Specifications. The cover sheet is the last link on the page.

Be sure to send your attachments at the same time as the 837 transaction.

Adjustments

You can also request claim adjustments electronically—either through NaviNet^{SM}, or through an 837 transaction. Please note, however, that the 837 transaction is not automated for Replace and Void functions. Therefore, professional providers (1500 billers) may find NaviNet easier to use for adjustments.

Avoid rejected claims: submit accurate member data

Make sure you submit your claims with accurate, complete and current patient information to avoid rejected claims. Highmark Blue Shield rejects invalid claim submissions so that it maintains compliance with HIPAA confidentiality requirements. Blue Shield will accept claims only if there is a complete match with the member's identifying data.

When Blue Shield rejects claims because of invalid member indentification information, it will not send an Explanation of Benefits form to the member. The patient will not know that their claim has been rejected. You must resubmit the rejected claim with corrected information for a final determination.

Do not bill the member if the claim is rejected. You should notify them of any patient liability only after the claim is successfully processed.

To make sure you report the correct patient information on your claims, please verify this information with the patient at the time of each service:

- current member identification number (this number may be up to 16 characters, including a three-digit alphabetical prefix)
- patient's full name (use the patient's proper name, for example, Margaret not Peggy, Robert not Bob)
- patient's date of birth
- current address
- relationship to insured

You can also verify this information through NaviNet^{SM} or the Provider Service Center.

If Blue Shield rejects the claim, it will be reflected on your remittance. You must verify the patient's information before you resubmit the claim. Please do not bill the member for the service(s) you performed until the member's enrollment has been verified and the claim has been resubmitted and processed.

More information available by electronic inquiry transactions

BC

Highmark Blue Shield and the other Blue Plans have enhanced the information returned electronically when a provider inquires through a 270 (eligibility) or 276 (claim status) HIPAA transaction.

Background

The Health Insurance Portability and Accountability Act (HIPAA) mandated the use of standard electronic transactions between covered entities, including providers and payers. Many providers have been taking advantage of the efficiencies made possible by these transactions, especially those dealing with patient eligibility and claim status. To make these electronic tools even more valuable to providers, the Blue Cross Blue Shield Association (BCBSA) is spearheading a program of upgrades to the information returned through these transactions by its member Plans. The BCBSA required a Jan. 1, 2005 deadline for all Plans to complete this work.

To support providers in their need for timely information, the BCBSA has also announced that by the end of 2005, these electronic response transactions will be processed in "real-time" rather than "batch" mode. This change will reduce the amount of time required to return a response to the inquiring provider.

Impact

271 (Eligibility Response) transactions

As of Jan. 1, 2005, these data elements are returned through the electronic eligibility transaction (271) when a provider sends an electronic eligibility transaction (270) to any Blue Plan:

- patient first, last name
- patient date of birth
- patient gender code
- effective date of coverage
- effective date—other party liability related
- insurance type code
- insurance narrative
- copayment information (network and out-of-network) for:
    - PCP office visit (OV)
    - specialist OV
    - urgent care
    - inpatient (IP) and outpatient (OP) hospital
    - emergency room
    - IP and OP mental health
- deductible information (both family and individual, regardless of the specific question asked)
- coinsurance information (both network and out-of network, from the viewpoint of the patient, regardless of the specific question asked)

277 (Claim Status Response) transactions

Blue Shield has expanded the claim status response transaction (277) to allow for the return of both claim-level and line-level status information on pending and finalized claims.

Eligibility and benefit inquiries through NaviNet℠

The Eligibility and Benefits Inquiry within NaviNet includes a separate selection for out-of-area (BlueCard®) members. These inquiries are routed to other Blue Plans through a process known as BlueExchange. When a BlueExchange inquiry is submitted through NaviNet, Blue Shield converts the data entered into a 270 transaction. The response is returned as a 271 transaction. Therefore, as of Jan. 1, 2005, users can expect to receive from all Plans, at a minimum, the data listed on Page 8 on every valid inquiry.

Claim inquiries through NaviNet

NaviNet continues to support claim status inquiries for both local and out-of-area members. As of April 18, 2005, a separate BlueExchange (out-of-area) claim status selection will be available. When a BlueExchange claim inquiry is submitted through NaviNet, Blue Shield converts the request to a 276 transaction. Blue Shield then returns the response as a 277 transaction.

You can review the status of out-of-area claims through the original claim status inquiry selection. Always include the member's alphabetical prefix along with their identification number when submitting an inquiry. The claim detail will show data as presented within Blue Shield's claim system.

Please keep your billing staff and/or billing vendor informed of these enhancements

Blue Shield encourages you to share this information with your billing staffs and/or vendors.

How to correct common rejections on electronic claims

Highmark Blue Shield has identified the most common rejections generated on the 277 claim acknowledgement report.

The acknowledgement report is usually available within 24 hours of the file submission. You can find the rejection codes in the STC segment of the 277 claim acknowledgement report.

If you have questions about where to locate the rejection codes within your file, please contact your software vendor.

Here are the common rejections and how to resolve them:

Rejection code	Description of rejection	What to look for within the claim
24/41	No affiliation between billing provider number and the trading partner	Verify that the billing provider number being reported is correct. There should be no alpha characters or leading zeros.

Rejection code	Description of rejection	What to look for within the claim
		If the number being submitted is correct, contact EDI Operations at (800) 992-0246 for assistance.
116	Claim being sent to incorrect payer	This usually occurs when a Personal Choice claim is sent under the Highmark Blue Shield payer code 54771. If the patient's identification number has a prefix of QCA, QCB or QCM, send the claim under payer code 54704 for Personal Choice.
130/77	Facility identification number invalid or missing	A facility number or tax identification number is required for all services performed in a facility, for example, inpatient, outpatient, emergency room, nursing home. The number reported must be the six-digit Blue Shield facility identification number or the nine-digit tax identification number. Do not report leading zeros or alpha characters.
130/82	Rendering provider number missing or invalid	The number reported must be the individual provider number of the physician who saw the patient.

Rejection code	Description of rejection	What to look for within the claim
		Do not report leading zeros or alpha characters.
130/85	Billing provider number missing or invalid	The number reported must be the group number. If the provider is not part of a group then report the individual provider number. Do not report leading zeros or alpha characters.
247	Line information	This is not a rejection code. This is used to identify that there is a rejection within the claim. The rejection code will follow the 247, for example, 130/77, 255, 116.
255	Invalid diagnosis code	Verify that the reported diagnosis is valid for the date of service. As of Oct. 1, 2004, HIPAA guidelines require that the most specific diagnosis code be reported. If the diagnosis code has a fifth digit, it must be reported.

If you need more information about the rejection codes please contact EDI Operations at (800) 992-0246, Monday–Friday, 8 a.m.–5 p.m. EST.

How to report antepartum care

These guidelines apply if you manage a patient's antepartum care but do not perform the delivery:

You can report only one antepartum code per member. Do not report a combination of all three antepartum codes.

- If you are billing for one to three antepartum visits, report the appropriate evaluation and management code(s).

Example:

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H PERFORMING PROVIDER
09012003	09032003	11		99213			255	00	3	

It is not necessary to report the actual number of visits in the number of services field or the range of dates the patient was seen. Report either procedure code 59425 or 59426 with a "1" in the number of services field. The date of service should be the date of the fourth visit (code 59425) or the date of the seventh visit (code 59426).

Highmark Blue Shield reimburses codes 59425 and 59426 on a global payment basis rather than a per-visit-fee basis.

- If you are billing for four to six antepartum visits, report code 59425—antepartum care only; 4-6 visits.

Example of incorrect reporting for code 59425:

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H PERFORMING PROVIDER
11012003	03052004	11		59425			390	00	6	

Example of correct way to report code 59425:

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H PERFORMING PROVIDER
11012003	11012003	11		59425			390	00	1	

- If you are billing for seven or more antepartum visits, report code 59426—antepartum care only; 7 or more visits.

Example of incorrect reporting for code 59426:

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H PERFORMING PROVIDER
11012003	06052004	11		59426			520	00	13	

Example of the correct way to report code 59426:

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C T O S	D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES		G DAYS OR UNITS	H PERFORMING PROVIDER
11012003	11012003	11		59426			520	00	1	

If you do not report the correct date of service for the antepartum care (codes 59425 and 59426) Blue Shield may delay the processing of your claims or may reject the claims unnecessarily.

Policy

Blue Shield covers minimally invasive hip and knee arthroplasty

Highmark Blue Shield now pays for minimally invasive hip arthroplasty as an alternative to standard hip arthroplasty.

You can use procedure code 27299 to report minimally invasive hip arthroplasty. When you report code 27299, please provide a complete description of the service you performed by entering "minimally invasive hip arthroplasty" in the narrative section of the electronic or paper claim.

Minimally invasive knee arthroplasty covered

Blue Shield also pays for minimally invasive knee arthroplasty.

Use procedure code 27599 to report minimally invasive knee arthroplasty. When you report code 27599, provide a complete description of the service you performed by entering "minimally invasive knee arthroplasty" in the narrative section of the electronic or paper claim.

Coverage of ultrasound to assess and treat infertility explained

Highmark Blue Shield will pay for a complete nonobstetric ultrasound study to evaluate patients for infertility before initiating any medical or surgical treatment.

Blue Shield will also pay for ultrasound studies performed after the infertility treatment has started. However, it is not always medically necessary to perform additional complete ultrasound studies during the treatment. Blue Shield will pay for limited ultrasound studies reported during an infertility treatment unless there is a clinical reason for a complete ultrasound.

Conception may not always result from a fertility enhancing treatment. If the patient pursues further medical or surgical treatment for infertility, Blue Shield will cover another complete ultrasound study to reassess the patient's status before a new episode of infertility treatment begins.

If the infertile patient chooses to pursue a method of assisted fertilization, for example, artificial insemination, in vitro fertilization, or any other method, Blue Shield considers all subsequent ultrasound studies part of the assisted fertilization program. Blue Shield will only reimburse ultrasound studies performed in connection with an assisted fertilization program when the member's benefits specifically include assisted fertilization.

Report these procedure codes for nonobstetric ultrasound studies:

76830—ultrasound, transvaginal

76856—ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete

76857—ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (eg, for follicles)

Hippotherapy is considered investigational

Because the effectiveness of hippotherapy has not been established, Highmark Blue Shield considers it experimental or investigational. It is not eligible for payment. A participating, preferred, or network provider can bill the member for the denied service.

Use procedure code S8940—equestrian/hippotherapy, per session—to report this service.

Hippotherapy, also referred to as equine movement therapy, is a type of physical medicine service using a horse. The purpose of hippotherapy is to improve equilibrium in patients with spastic cerebral palsy.

Manipulation services guidelines clarified

Highmark Blue Shield covers manipulation services when they're performed to restore the patient's level of function that has been lost or reduced by injury or illness. Blue Shield determines coverage for manipulation of all body regions according to individual or group customer benefits.

Here are the applicable manipulation procedure codes:

98925-98929—osteopathic manipulations

98940-98943—chiropractic manipulations

Please follow these guidelines when you provide manipulation services:

- Blue Shield considers physical medicine procedures and modalities that are performed only to relax and prepare the patient for the manipulation procedure as part of the manipulation procedure. Blue Shield will not

pay separately for these services when they're performed on the same day as the manipulation. Examples include the application of hot or cold packs (97010), massage (97124), and manual therapy techniques (97140).

- When codes 97010, 97124 and 97140 are performed on a separate body region, unrelated to the manipulation procedure, Blue Shield may consider them for separate payment. Report modifier 59 with codes 97010, 97124 and 97140 to indicate that a separate body area has been treated.
- Code 97140 is based on time. Each unit represents 15 minutes. Please remember to record the total length of time for which manual therapy techniques are performed in the patient's medical records.
- Blue Shield will not cover manipulation when it's reported repeatedly to maintain a level of function. Report such services with code S8990.
- Report the service performed. When you perform a manipulation service, do not report evaluation and management services.
- Although Blue Shield does not require the review of treatment plans, please maintain the treatment plans in the patient's medical record.

Reporting guidelines for endoscopic procedures and related services outlined

Please follow these guidelines when you report endoscopic procedures and related services:

- A diagnostic endoscopy is always included as part of a surgical endoscopic procedure. For example, code 43200 is included as part of codes 43201 through 43232.
- An endoscopy with polypectomy includes the biopsy performed at the same surgical site. Do not report the endoscopic biopsy separately. For example, code 43202 is included as part of code 43216.
- When a single endoscopic technique is performed on different surgical sites, report the code once. For example, if multiple esophageal polyps are removed by snare technique, report code 43217 one time. If different endoscopic techniques are performed on separate sites, you can report multiple endoscopy codes. For example, you can report codes 43216 and 43217 when polyps are removed from different sites by the different techniques represented by these codes.

Certain surgical procedures are exempt from multiple surgery reductions

When multiple surgical procedures are performed by a surgeon during a single operative session, Highmark Blue Shield allows its full fee for the highest paying procedure. It typically reduces the fees for the additional procedures by 50 percent.

Modifier 51 exempt procedures are exception

There are exceptions. Blue Shield does not apply reductions to those surgical procedures listed on the AMA's CPT Appendix E (CPT Codes Exempt from Modifier 51). For these procedures, Blue Shield allows 100 percent of their payment levels, even when they're performed with other surgeries.

Modifier 57 reporting guidelines explained

Report modifier 57—decision for surgery—when you perform an evaluation and management service that results in the initial decision to perform surgery, whether on the day of the procedure or another day.

Add modifier 57 to the appropriate level of evaluation and management service.

Treatment for hyperhidrosis eligible for certain conditions

Highmark Blue Shield considers treatment of primary hyperhidrosis, including topical aluminum chloride, botulinum toxin, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands, eligible only in the small subset of patients with documented medical complications such as skin maceration with secondary infection.

In the absence of documented medical complications, Blue Shield considers treatment for primary hyperhidrosis not medically necessary. In these instances, it is not covered. A participating, preferred, or network provider cannot bill the member for the denied service.

Blue Shield will pay for botulinum toxin type A, BOTOX®, only in the treatment of primary axillary hyperhidrosis in patients with documented medical complications such as skin maceration with secondary infection. If BOTOX is used to treat palmar, plantar, or facial hyperhidrosis or primary axillary hyperhidrosis in the absence of documented medical complications, Blue Shield considers it not medically necessary. It is not eligible for coverage. A participating, preferred, or network provider cannot bill the member for the denied BOTOX.

Blue Shield considers iontophoresis and axillary liposuction experimental or investigational when they're used to treat primary hyperhidrosis. The medical effectiveness of iontophoresis and axillary liposuction has not been established. Blue Shield also does not cover iontophoretic devices used in the home for treatment of primary hyperhidrosis. When Blue Shield denies these services or devices, a participating, preferred, or network provider can bill the member for the services or devices.

Hyperhidrosis is a condition involving excessive perspiration, beyond a level required to maintain normal body temperature in response to heat or exercise.

Subfascial endoscopic perforator surgery considered investigational

Highmark Blue Shield will stop providing reimbursement for subfascial endoscopic perforator surgery (SEPS) on July 18, 2005.

There is not enough scientific evidence to prove the effectiveness of SEPS in comparison to surgical treatment of the superficial venous system alone. Therefore, Blue Shield considers SEPS experimental or investigational. A participating, preferred, or network provider can bill the member for the denied surgery.

Use procedure code 37500—vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)—to report this service.

SEPS, a minimally invasive procedure, is used to interrupt incompetent perforator veins that connect the deep venous system of the leg with the superficial venous system. It is used to treat chronic venous insufficiency.

Additional procedures eligible for co-surgery

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

22840—posterior non-segmental instrumentation (eg, harrington rod technique), pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation

23395—muscle transfer, any type, shoulder or upper arm; single

23405—tenotomy, shoulder area; single tendon

33249—insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator

34803—endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)

49200—excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas

58356—endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed

58565—hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

62350—implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump; without laminectomy

63050—laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments

63051—laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)

63295—osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (list separately in addition to code for primary procedure)

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

New FDA-approved drugs to be reimbursed at 95 percent of AWP

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

These reimbursement rates will remain in effect for one year from the date the drug is approved by the FDA. After the one-year introductory period expires, Blue Shield will price the drug or biological at 85 percent of the AWP.

Here is a new drug that Blue Shield will price at 95 percent of the AWP for one year.

Drug name:	Abraxane (Paclitaxel Protein-bound)
FDA approval:	Jan. 7, 2005
Effective date:	Jan. 7, 2005
Revision date:	Jan. 7, 2006

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 and modifiers now available

Here are new procedure codes and modifiers and the dates they became available:

Code	Terminology	Effective date
K0670	Addition to lower extremity prosthesis endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type	4/1/2005
K0671	Portable oxygen concentrator, rental	4/1/2005
S0142	Colistimethate sodium, inhalation solution administered through DME, concentrated form, per mg	4/1/2005
S0143	Aztreonam, inhalation solution administered through DME, concentrated form, per gram	4/1/2005
S0197	Prenatal vitamins, 30-day supply	4/1/2005
S0595	Dispensing new spectacle lenses for patient supplied frame	4/1/2005
S0625	Retinal telescreening by digital imaging of multiple different fundus areas to screen for vision-threatening conditions, including imaging, interpretation and report	4/1/2005
S3005	Performance measurement; evaluation of patient self-assessment, depression	4/1/2005
S8434	Interim postoperative orthotic device for upper extremity, custom made	4/1/2005
S8940	Equestrian/hippotherapy, per session	4/1/2005

Modifier	Terminology	Effective date
QR	Item/service in Medicare study	1/1/2005
RD	Drug provided to the beneficiary but not administered	1/1/2005

Deleted codes

Highmark Blue Shield has deleted these codes:

Code	Terminology	Date deleted
S0016	Amikacin sulfate, per 500 mg	4/1/2005
S0107	Injection, omalizumab, 25 mg	4/1/2005
S0158	Injection, laronidase, 0.58 mg	4/1/2005
S0159	Injection, agalsidase beta, 35 mg	4/1/2005
S8004	Radioimmunopharmaceutical localization of targeted cells; whole body	4/1/2005
50978	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)	12/31/2004

Notes

Notes

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 (866) 731-2896. You may also continue to send information by completing the coupon below.

Coupon for changes to provider information

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

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

Name _____ Provider ID number _____

Electronic media claims source number _____

Please make the following changes to my provider records:

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Tax ID number _____

Specialty _____

Provider's signature _____ Date signed _____

PRN

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Acknowledgement

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Policy Review & News

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