PRN
Policy Review & News

Important information about Highmark Blue Cross Blue Shield June 2011
www.highmarkbcbs.com

In This Issue

MA

Look for this symbol for all Medicare Advantage related information

News

National Correct Coding Initiative edits to be used for Medicare Advantage claims

MA

This change applies to only Highmark Blue Cross Blue Shield's Medicare Advantage products—FreedomBlue℠ PPO and SecurityBlue℠ HMO. It does not affect Highmark's commercial products.

For claims processed on or after Oct. 15, 2011, Highmark Blue Cross Blue Shield will begin to use the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits for its Medicare Advantage business rather than Highmark procedure code combination edits.

Highmark's claim processing system contains various edits to appropriately adjudicate claims. One such edit is procedure code combinations. Highmark's procedure code combinations are based on code terminology and/or guidelines from the applicable code governing entity. Procedure codes may be governed by the American Medical Association, CMS, or the Blue Cross and Blue Shield Association. Some codes represent a combination of two or more "components." These components may also be represented by individual codes. If component codes are reported separately, they may be combined into the combination or "total" procedure code.

Highmark's code combination edits are the same in many instances as CMS NCCI edits; however, there are some differences. Therefore, for Medicare Advantage claims, processing and reimbursement differences may be realized. This change is being implemented to more closely align Medicare Advantage processing with national Medicare processing.

UCR and PremierBlue Shield reimbursement changes approved

The Pennsylvania Insurance Department has approved Highmark Blue Cross Blue Shield's request to adjust UCR Level II and PremierBlue℠ Shield reimbursements for anesthesia, select surgical, diagnostic, and evaluative services including, but not limited to, musculoskeletal, eye, behavioral health, allergen immunotherapy, and digestive procedures. These changes may also affect Keystone Health Plan West (KHPW) reimbursements.

Highmark will increase allowances for the specific services with dates of service on or after July 1, 2011.

Highmark will decrease allowances for a minimal number of services for dates of service on or after Sept. 26, 2011.

The allowances for CT studies of the abdomen and pelvis combined, procedure codes 74176, 74177, and 74178, will also increase with this update. The allowances will be based upon additional data collection and analysis, and have yet to be finalized.

Fees available via NaviNet

When the adjustments are in effect (see dates on Page 2), you may access the reimbursement adjustment information online in these convenient ways:

- Visit the Provider Resource Center through NaviNet®. Simply hover on *Administrative Reference Materials*, and click on *Fee Updates* to view the complete list of fee adjustments. (Fees are not published on the public Provider Resource Center.)

When the adjustments are in effect, you can also use these online tools:

- On NaviNet, hover on *Allowance*, then select *Allowance Inquiry* to determine pricing for specific procedure codes by plan or product type.

- Also on NaviNet, you can hover on *Allowance*, and select *Frequently Billed Codes*. This function initiates a report request that provides you with a quicker means of retrieving the most frequently billed codes or procedure codes based on the specialty represented by the selected billing provider and plan.

- Via NaviNet's Resource Center, you can download the full KHPW and/or PremierBlue Shield fee schedule. Simply click on *Administrative Reference Materials*, and you'll find the links on the bottom half of the page.

If your practice does not have NaviNet access, please contact your Provider Relations representative for assistance.

Multiple procedure payment reduction on technical component of some diagnostic imaging services – merging the families of codes explained

Highmark Blue Cross Blue Shield currently applies a multiple procedure payment reduction to certain diagnostic imaging services when two or more services performed on contiguous body parts are performed for the same patient, on the same day. The contiguous body parts are grouped into eleven families. The reduction applies when two or more services within a family are reported. This reduction affects only the technical component allowance.

Highmark's reduction mirrored the reduction of the Centers for Medicare & Medicaid Services (CMS) until Jan. 1, 2011, when CMS consolidated the eleven diagnostic families into a single family. Effective Sept. 26, 2011, Highmark will also consolidate all families into one.

Beginning Sept. 26, 2011, when more than one service in the following list is performed for the same patient during the same session, Highmark will pay for the highest priced procedure in full. Highmark will reduce the technical component allowance of each additional procedure by 50 percent.

This change applies to Medicare Advantage (FreedomBlue[SM] PPO and SecurityBlue[SM] HMO), UCR, PremierBlue[SM] Shield, and Keystone Health Plan West products.

Code	Description
70336	Magnetic resonance (eg, proton) imaging, tempormandibular joint(s)
70450	Computed tomography, head or brain; without contrast material
70460	Computed tomography, head or brain; with contrast materials
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
70482	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s)and further sections
70486	Computed tomography, maxillofacial area; without contrast material
70487	Computed tomography, maxillofacial area; with contrast material(s)
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections
70490	Computed tomography, soft tissue neck; without contrast material
70491	Computed tomography, soft tissue neck; with contrast material(s)
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
70496	Computed tomographic angiography, head, with contrast material(s),including noncontrast images, if performed, and image postprocessing
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)

Code	Description
70542	Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; with contrast material(s)
70543	Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences
70544	Magnetic resonance angiography, head; without contrast material(s)
70545	Magnetic resonance angiography, head; with contrast material(s)
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences
70547	Magnetic resonance angiography, neck; without contrast material(s)
70548	Magnetic resonance angiography, neck; with contrast materials
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration
71250	Computed tomography, thorax; without contrast material
71260	Computed tomography, thorax; with contrast material(s)
71270	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
71550	Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)
71551	Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)
71552	Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72125	Computed tomography, cervical spine; without contrast material
72126	Computed tomography, cervical spine; with contrast material

Code	Description
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72128	Computed tomography, thoracic spine; without contrast material
72129	Computed tomography, thoracic spine; with contrast material
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
72131	Computed tomography, lumbar spine; without contrast material
72132	Computed tomography, lumbar spine; with contrast material
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
72192	Computed tomography, pelvis; without contrast material
72193	Computed tomography, pelvis; with contrast material(s)
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
72195	Magnetic resonance (e.g., proton) imaging, pelvis; without contrast material(s)

Code	Description
72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)
73200	Computed tomography, upper extremity; without contrast material
73201	Computed tomography, upper extremity; with contrast material(s)
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)
73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
73223	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)
73700	Computed tomography, lower extremity; without contrast material
73701	Computed tomography, lower extremity; with contrast material(s)
73702	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
73718	Magnetic resonance (eg, proton) imaging, lower extremity, other than joint; without contrast material(s)
73719	Magnetic resonance (eg, proton) imaging, lower extremity, other than joint; with contrast material(s)
73720	Magnetic resonance (eg, proton) imaging, lower extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences

Code	Description
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)
73723	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
74176	Computed tomography, abdomen and pelvis; without contrast material
74177	Computed tomography, abdomen and pelvis; with contrast material(s)
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by contrast material(s) and further sequences
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences

Code	Description
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing
76604	Ultrasound, chest (includes mediastinum), real time with image documentation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
76776	Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)
76870	Ultrasound, scrotum and contents
77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
77059	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral

Attention cardiologists, hematologists/oncologists, and neuroscientists: Highmark accepting candidates for CPMC advisory subcommittees

Highmark Blue Cross Blue Shield is accepting new members for its three Clinical Policy Management Committee (CPMC) advisory subcommittees.

These specialty subcommittees—cardiology, hematology/oncology, and the neurosciences (including psychiatry)—serve as an advisory to the CPMC by providing recommendations about the development of new, or the modification of existing, medical policies.

Highmark's CPMC is responsible for medical policy decisions. Each CPMC subcommittee will review the analysis and recommendations of Highmark's Medical Policy department for the development of policy guidelines for new and evolving technologies that are evidence based and in a discipline directly linked to the subcommittee's designated medical specialty. The subcommittee will make a recommendation to the CPMC either accepting, with or without modifications, the Medical Policy department's analysis and recommendation, or they will reject the analysis and recommendation.

Subcommittee member qualifications

CPMC subcommittee members must be Highmark network participating providers practicing in the community and at academic centers. Subcommittee members must be board certified in their medical specialty.

How to apply

If you would like to apply for appointment to the CPMC subcommittee, please send an e-mail detailing your current medical practice activities and location, along with a resume or curriculum vitae, to **cpmc@highmark.com**. Please respond by Aug. 15, 2011.

Highmark will notify you by Oct. 24, 2011 if you are selected to serve on a CPMC subcommittee.

Review

Reporting and documentation requirements explained for central nervous system assessments or mental, neuro-cognitive, and speech testing

Procedure codes 96101, 96102, 96105, 96116, 96118, 96119, and 96125 are timed procedures. These codes describe face to face assessments by the hour.

If the testing takes more than 31 minutes, report one unit. Report two units if the testing lasts longer than 90 minutes (but less than 151 minutes of service). Assessments taking 151 minutes (two hours and 31 minutes) should be reported as three units of service.

When you bill more than one unit, the medical record should include clocked start and stop times with a cumulative calculation recorded in the record.

Report code 96118 when additional time is needed to include other clinical data in the report, for example, the technician reports or computer administered reports.

Highmark Blue Cross Blue Shield recommends that you do not report codes 96118 and 96119 on the same day as codes 96101 and 96102. If you do report these codes together, the medical record should indicate distinct testing techniques and beginning and end times. You should avoid reporting time for duplicating information included in psychological testing. You can report these codes only if you are personally administering at least one of the tests face to face. Testing over a number of days should be submitted with the days span when submitting more than four units for these face to face codes.

Highmark does not consider electronic questionnaires, for example, code 96103 for computerized testing, face to face testing. If self administered tests or self-scoring tests, for example, Holmes & Rahe Social Readjustment Rating Scale or the Folstein Mini-Mental Exam, are included in the clinical interview, do not report them separately.

While some tests can be administered in minutes, for example, MCI Screening, you should also consider time spent in reviewing the record, meeting with the patient to prepare them for the test or doing analysis and interpretation. Psychiatrists may bill using an evaluation and management code (visit or consults) instead of 90801.

Neuropsychological or neurobehavioral testing (codes 96116, 96118, 96119, 96120) include a mental status examination, family interview, behavioral observation, and psychometric testing. Psychometric testing components of these codes can take extended times. The clinical record should document dates and times of code components for testing. Testing in excess of four hours should be submitted using date spans.

Policy

Highmark Blue Cross Blue Shield's medical policy guidelines for all of its medical-surgical and Medicare Advantage products are available online in the Provider Resource Center through NaviNet® or at **www.highmarkbcbs.com**. *An alphabetical, as well as a sectional index, is available on the Medical Policy page. You can search for a medical policy by entering a key word, policy number, or procedure code.*

*In **PRN**, the Medicare Advantage icon* MA *indicates Medicare Advantage medical policy-related information.*

Place of service designations: more medical policies to include

Highmark Blue Cross Blue Shield is adding place of service designations to the following medical policies on the indicated dates.

Policy number	Policy topic	Place of service	Effective date
S-60	Artificial Hearts and Ventricular Assist Devices	Inpatient	Sept. 26, 2011
S-66	Minimally Invasive Coronary Artery Bypass Surgery	Inpatient	Sept. 26, 2011
S-118	Small Bowel/Liver and Multivisceral Transplantation	Inpatient	Oct. 10, 2011
S-144	Islet Cell Transplantation	Inpatient	Oct. 10, 2011
S-189*	Transforaminal Epidural Injection	Outpatient	Oct. 10, 2011
S-198	Acellular Dermal Grafts for Reconstruction	Inpatient	June 6, 2011

*Please see the "Additional guidelines" section for more information about Medical Policy S-189.

Additional guidelines

Highmark will consider each person's unique clinical circumstances when a service that is typically performed in an outpatient setting is requested to be performed inpatient.

In addition to those policies listed on Page 12, Medical Policy S-189—Transforaminal Epidural Injection—is typically an outpatient procedure that is eligible for coverage only as an inpatient procedure under special conditions including, but not limited to, current therapeutic anticoagulation therapy.

Clinical pathology consultation services now covered

Beginning Oct. 3, 2011, Highmark Blue Cross Blue Shield will consider consultative clinical pathology services eligible for payment if all of the following requirements are met.

The consultative services must:

- Be requested by the patient's attending physician
- Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient
- Result in a written narrative report included in the patient's medical record
- Require the exercise of medical judgement by the consulting physician

A clinical pathology consultation is a service, including a written report, performed by a pathologist in response to a request from an attending physician in relation to a test result requiring additional medical interpretive judgement.

Clinical pathology consultation services require specific medical record documentation

When you perform clinical pathology consultation services, please indicate in the patient's medical records that the service was actually performed, was performed at the level reported, and was reasonable and necessary.

Use the following codes, as appropriate, to report clinical pathology consultation services:

80500—clinical pathology consultation; limited, without review of patient's history and medical records

80502—clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records

Highmark determines coverage for clinical pathology consultations according to individual or group customer benefits.

Ipilimumab eligible for treating unresectable or metastatic melanoma

Ipilimumab (Yervoy™), a monoclonal antibody, blocks a molecule known as cytotoxic T-lymphocyte antigen or CTLA-4. Highmark Blue Cross Blue Shield covers ipilimumab for the treatment of unresectable or metastatic melanoma.

If ipilimumab is used for other indications, including the following conditions, Highmark considers it experimental or investigational:

- Patients with active autoimmune disease, or
- Patients receiving systemic immunosuppression for organ transplantation

A participating, preferred, or network provider may bill the member for the non-covered service.

The recommended dose of ipilimumab is 3 mg/kg administered intravenously over 90 minutes every three weeks for a total of four doses.

Withhold scheduled dose of ipilimumab for any moderate immune-mediated adverse reactions or for symptomatic endocrinopathy. For patients with complete or partial resolution of adverse reactions (Grade 0-1), and who are receiving less than 7.5 mg prednisone or equivalent per day, resume ipilimumab at a dose of 3 mg/kg every three weeks until administration of all four planned doses or 16 weeks from first dose, whichever occurs earlier.

Permanently discontinue ipilimumab for any of the following:

- Persistent moderate adverse reactions or inability to reduce corticosteroid dose to 7.5 mg prednisone or equivalent per day
- Failure to complete full treatment course within 16 weeks from administration of first dose
- Severe or life-threatening adverse reactions, including any of the following:

- Colitis with abdominal pain, fever, ileus, or peritoneal signs; increase in stool frequency (seven or more over baseline), stool incontinence, need for intravenous hydration for more than 24 hours, gastrointestinal hemorrhage, and gastrointestinal perforation
- AST or ALT greater than five times the upper limit of normal or total bilirubin greater than three times the upper limit of normal
- Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full thickness dermal ulceration, or necrotic bullous, or hemorrhagic manifestations
- Severe motor or sensory neuropathy, Guillian-Barre syndrome, or myasthenia gravis
- Severe immune-mediated reactions involving any organ system, for example, nephritis, pneumonitis, pancreatitis, non-infectious myocarditis
- Immune-mediated ocular disease that is unresponsive to topical immunosuppressive therapy

Assess patients for signs and symptoms of enterocolitis, dermatitis, neuropathy, and endocrinopathy and evaluate clinical chemistries including liver function tests and thyroid function tests at baseline and before each dose.

Report ipilimumab (Yervoy) with procedure code J3590—unclassified biologicals. When you report J3590, please provide the name of the drug and dosage in the procedure code description field of the electronic claim or the narrative section of the paper claim.

Highmark determines coverage for ipilimumab according to individual or group customer benefits.

Intravenous anesthetics as treatment of chronic neuropathic pain not covered

Beginning Sept. 26, 2011, Highmark Blue Cross Blue Shield considers intravenous infusion of anesthetics, for example, ketamine or lidocaine, used to manage chronic neuropathic pain experimental or investigational; therefore, it is not covered. Highmark does not cover lidocaine or ketamine for this off-label indication because there is a lack of scientific evidence regarding their effectiveness. A participating, preferred, or network provider may bill the member for the non-covered service.

Report lidocaine hydrochloride with procedure code J2001—injection, lidocaine HCI for intravenous infusion, 10 mg.

Use code J3490—unclassified drugs—to report ketamine hydrochloride. When you report code J3490, please provide the name of the drug and dosage in the procedure code description field of the electronic claim or the narrative section of the paper claim.

Physician certification and recertification of home health services: new coverage guidelines explained

Highmark Blue Cross Blue Shield will pay for covered home health services that a home health agency (HHA) provides if a physician certifies that:

- The home health services are medically necessary because the individual is confined to his or her home and needs intermittent skilled nursing care, physical therapy and/or speech-language pathology services, or continues to need occupational therapy. Where a patient's sole skilled service need is for skilled oversight of unskilled services, the physician must include a brief narrative describing the clinical justification of this need as part of the certification and recertification, or as a signed addendum to the certification and recertification,
- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician, and
- The services are or were furnished while the individual was under the care of a physician.

Effective Oct. 10, 2011, Highmark will require that prior to certifying a patient's eligibility for the home health benefit the certifying physician must document that he or she, or an allowed professional provider has had a face-to-face encounter with the patient. The initial certification is incomplete without them.

Face-to-face encounter

The certifying physician must document that he or she or an allowed professional provider had a face-to-face encounter with the patient.

Other professional providers may perform the face-to-face encounter and inform the certifying physician regarding the clinical findings exhibited by the patient during the encounter. However, the certifying physician must document the encounter and sign the certification. In addition to the physician, professional providers who are allowed to perform the face-to-face encounter are:

- A nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician in accordance with state law
- A certified nurse-midwife as authorized by state law
- A physician assistant under the supervision of the certifying physician

Report face-to-face encounters with the most appropriate evaluation and management service that accurately reflects the level of care provided.

Encounter documentation requirements

- The documentation must include the date when the physician or allowed professional provider saw the patient, and a brief narrative composed by the certifying physician who describes how the patient's clinical condition, as seen during that encounter, supports the patient's homebound status and need for skilled services.
- The certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. It may be written or typed.
- It is acceptable for the certifying physician to dictate the documentation content to one of the physician's support personnel to type. It is also acceptable for the documentation to be generated from a physician's electronic health record.
- It is unacceptable for the physician to verbally communicate the encounter to the HHA, where the HHA would then document the encounter as part of the certification for the physician to sign.

Timeframe requirements

- The encounter must occur no more than 90 days before the home health start of care date or within 30 days after the start of care.
- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed professional provider must see the patient again within 30 days after the start of care. Specifically, if a patient saw the certifying physician or allowed professional provider within the 90 days prior to start of care, another encounter would be needed if the patient's condition had

changed to the extent that standards of practice would indicate that the physician or the allowed professional provider should examine the patient to establish an effective treatment plan.

Exceptional circumstances

When a home health patient dies shortly after the start of care, before the face-to-face encounter occurs, if it has been determined that a good faith effort existed on the part of the HHA to facilitate or coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.

If the following conditions are met, an encounter between the home health patient and the attending physician who cared for the patient during an acute or post-acute stay can satisfy the face-to-face encounter requirement.

- A physician who attended to the patient in an acute or post-acute setting, but does not follow the patient in the community (such as a hospitalist) may certify the need for home health care based on his or her contact with the patient, and establish and sign the plan of care. The acute or post-acute physician would then transfer or hand off the patient's care to a designated community-based physician who assumes care for the patient, or

- A physician who attended to the patient in an acute or post-acute setting may certify the need for home health care based on his or her contact with the patient, initiate the orders for home health services, and transfer the patient to a designated community-based physician to review and sign off on the plan of care.

Recertifications for home health services

When services are continued for a period of time, the physician must recertify at intervals of at least once every 60 days that there is a continuing need for services. The physician should also estimate how long services will be needed.

The recertification should be obtained at the time the plan of care is reviewed since the same interval (at least once every 60 days) is required for the review of the plan.

The physician must recertify that the individual continues to meet the guidelines for home health services.

Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertifications are up to the individual HHA.

Highmark determines coverage for home health services according to individual or group customer benefits.

ERCC1 analysis for non-small cell lung cancer not covered

Highmark Blue Cross Blue Shield considers excision repair cross-complementing factor 1 (ERCC1) analysis for non-small cell lung cancer (NSCLC) experimental or investigational—it is not covered. There is insufficient clinical evidence to support the routine use of this test in the care of NSCLC patients. Further studies are needed. A participating, preferred, or network provider may bill the member for the non-covered service.

Use procedure code 88360—morphometric analysis, tumor immunohistochemistry (eg, her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual—to report this service.

The excision repair cross-complementing factor 1 gene is a critical gene in the cell's ability to repair damage to DNA. The ERCC1 gene expression has been investigated in various cancers including non-small cell lung cancer. ERCC1 plays a key role in the nucleotide excision repair of the DNA and has been shown to possibly play a role in the repair of the damage produced by the use of cisplatin and other platin drugs.

ERCC1 gene expression analysis for NSCLC is performed clinically using immunohistochemistry. The antibody 8F1, which recognizes the ERCC1 protein, is used to assess ERCC1 levels within tumor cells present in tissue sections obtained from lung biopsy or tumor resection.

Small bowel or liver and multivisceral transplantation coverage guidelines explained

Highmark Blue Cross Blue Shield will consider a small bowel or liver transplant or multivisceral transplant medically necessary for pediatric and adult patients with intestinal failure (characterized by loss of absorption and the inability to maintain protein-energy, fluid, electrolyte, or micronutrient balance), who have been managed with long-term total parenteral nutrition (TPN) and who have developed evidence of impending end-stage liver failure.

Candidates should meet these criteria:

- Adequate cardiopulmonary status

- Absence of significant infection that could be exacerbated by immunosuppressive therapy, for example, chronic active viral hepatitis B, hepatitis C, and human immunodeficiency virus
- No history of malignancy within five years of transplantation, excluding nonmelanomatous skin cancers
- Documentation of patient compliance with medical management

Transplant contraindications

Absolute contraindications for small bowel, liver, or multivisceral transplant recipients include, but are not limited to:

- Metastatic cancer
- Ongoing or recurring infections that are not effectively treated
- Serious cardiac or other ongoing insufficiencies that create an inability to tolerate transplant surgery
- Serious conditions that are unlikely to be improved by transplantation as life expectancy can be finitely measured
- Demonstrated patient noncompliance, which places the organ at risk by not adhering to medical recommendations
- Potential complications from immunosuppressive medications that are unacceptable to the patient
- AIDS (diagnosis based on CDC definition of CD4 count, 200 cells/mm^3) unless the following are noted:
    - CD4 count greater than 200 cells/mm^3 for longer than six months
    - HIV-1 RNA undetectable
    - On stable anti-retroviral therapy longer than three months
    - No other complications from AIDS, for example, opportunistic infection, including aspergillus, tuberculosis, coccidioide-mycosis, resistant fungal infections, Kaposi's sarcoma, or other neoplasm

- Meeting all other criteria for small bowel or multivisceral transplantation

Highmark considers retransplantation in individuals with graft failure of an initial small bowel, small bowel or liver, or multi-visceral transplant, due to either technical reasons or hyperacute rejection medically necessary**.**

Highmark considers retransplantation in individuals with chronic rejection or recurrent disease medically necessary when the individual meets the criteria in Highmark Medical Policy S-118.

Highmark considers living donor multivisceral transplants and all other multivisceral transplants in adults or children not medically necessary.

Highmark considers small bowel or liver or multivisceral transplantation performed for any other condition or for patients presenting with an absolute contraindication not medically necessary.

Highmark considers transplantation for patients presenting with an absolute contraindication, and who do not meet the medical necessity criteria not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement should be maintained in the provider's records.

Fetal surgery coverage to include treatment of myelomeningocele, coverage criteria revised for other conditions

On July 18, 2011, Highmark Blue Cross Blue Shield will begin to cover fetal surgery for the treatment of myelomeningocele under these conditions:

- The fetus is less than 26 weeks' gestation, and
- Myelomenigocele is present with an upper boundary located between T1 and S1 with evidence of hindbrain herniation

Highmark considers in utero repair of myelomeningocele experimental or investigational in these situations:

- Fetal anomaly unrelated to myelomeningocele, or

- Severe kyphosis, or
- Risk of preterm birth, for example, short cervix or previous preterm birth, or
- Maternal body mass index of 35 or more

A participating, preferred, or network provider may bill the member for the denied fetal surgery.

Use code S2404—repair, myelomeningocele in the fetus, procedure performed in utero—to report in utero repair of myelomeningocele.

Additional coverage criteria to be applied to fetal surgery in October 2011

Highmark covers fetal surgery for the following conditions:

- Vesico-amniotic shunting as a treatment of urinary tract obstruction
- Either open in-utero resection of malformed pulmonary tissue or placement of a thoraco-amniotic shunt as a treatment of either congenital cystic adenomatoid malformation, or extralobar pulmonary sequestration
- In utero repair of sacrococcygeal teratoma

Beginning Oct. 10, 2011, Highmark will adopt the following additional coverage criteria for fetal surgery:

- Vesico-amniotic shunting as a treatment of urinary tract obstruction may be considered medically necessary in fetuses that have:
    - Evidence of hydronephrosis due to bilateral urinary tract obstruction, and
    - Progressive oligohydramnios, and
    - Adequate renal function, and
    - No other lethal abnormalities or chromosomal defects
- Open in utero resection of malformed pulmonary tissue or placement of a thoraco-amniotic shunt may be considered medically necessary when:

- Congenital cystic adenomatoid malformation or bronchopulmonary sequestration is identified, and
- The fetus is at 32 weeks' gestation or less, and
- There is evidence of fetal hydrops, placentomegaly, and/or the beginnings of severe pre-eclampsia, that is, the maternal mirror syndrome, in the mother

- In utero removal of sacrococcygeal teratoma may be considered medically necessary when:
  - The fetus is at 32 weeks' gestation or less, and
  - There is evidence of fetal hydrops, placentomegaly, and/or the beginnings of severe pre-eclampsia, that is, maternal mirror syndrome, in the mother

If fetal surgery is performed for any other indications, Highmark will consider it experimental or investigational. A participating, preferred, or network provider may bill the member for the denied fetal surgery.

Fetal surgery procedure codes

Report fetal surgery with the following code(s), as appropriate:

59076—fetal shunt placement, including ultrasound guidance

S2401—repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero

S2402—repair, urinary tract obstruction in the fetus, procedure performed in utero

S2403—repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero

S2405—repair of sacrococcygeal teratoma in the fetus, procedure performed in utero

Coverage changes for laser treatment of psoriasis

Highmark Blue Cross Blue Shield considers excimer and pulsed dye laser medically necessary for treating mild to moderate localized plaque psoriasis affecting 10 percent or less of the body area for persons who have failed to adequately respond to three or more months of topical treatments, including at least three of the following with or without standard non-laser ultraviolet actinotherapy:

- Anthralin,
- Corticosteroids, for example, betamethasone dipropionate ointment and fluocinonide cream,
- Keratolytic agents, for example, lactic acid, salicylic acid, and urea,
- Retinoids, for example, tazarotene,
- Tar preparations, and/or
- Vitamin D derivatives, for example, calcipotriene

Highmark also covers excimer and pulsed dye laser for treating vitiligo of the face and hands.

Highmark considers no more than thirteen treatments per course and three courses per year medically necessary. If the person fails to respond to an initial course of laser therapy, additional courses are not considered medically necessary.

Highmark considers combination use of pulsed dye laser and ultraviolet B experimental or investigational for the treatment of persons with localized plaque psoriasis. A participating, preferred, or network provider may bill the member for the denied service.

Highmark considers the use of ultraviolet light therapy and home therapy not medically necessary for all other diagnoses and when the coverage criteria are not met. A participating, preferred, or network provider may not bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement should be maintained in the provider's records.

Belimumab coverage guidelines and reporting instructions outlined

Highmark Blue Cross Blue Shield covers belimumab (Benlysta®), a B-lymphocyte stimulator-specific inhibitor, for the treatment of adult patients (age 18 years or older) with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy.

A systemic lupus erythematosus standard of care treatment regimen may comprise any of the following (alone or in combination): corticosteroids, antimalarials, non-steroidal anti-inflammatory drugs, and immunosuppressives.

The recommended dosage regimen is 10 mg/kg at two-week intervals for the first three doses and at four-week intervals thereafter. This drug should be administered as an intravenous infusion.

Highmark considers the use of belimumab for all other indications experimental or investigational, and therefore, not covered, including:

- Patients with active central nervous system lupus, or
- Patients with severe lupus nephritis, active nephritis, or requiring hemodialysis, or
- Patients currently being treated with biologics or intravenous cyclophosphamide

A participating, preferred, or network provider may bill the member for the non-covered service.

How to report belimumab

If belimumab is administered on or after July 1, 2011, report it with procedure code Q2044—injection, Belimumab, 10 mg. For reporting belimumab administered before July 1, 2011, use code J3590—unclassified biologicals. When you report code J3590, please provide the name of the drug and dosage in the procedure code description field of the electronic claim or the narrative section of the paper claim.

Highmark determines coverage for belimumab according to individual or group customer benefits.

Highmark to cover minimally invasive coronary artery bypass surgery

Currently there are variations on techniques that are classified as "minimally invasive" coronary artery bypass graft (CABG) surgery. The surgery can be done under direct vision, with a mini-sternotomy or a mini-thoracotomy approach. These types of direct procedures have been termed minimally invasive direct coronary artery bypass (MIDCAB). MIDCAB is performed without cardiopulmonary bypass by slowing the heart rate to 40 beats per minute to minimize motion in the surgical field.

The surgery can also be performed endoscopically with the use of robotics, whereby the internal structures are visualized on a video monitor, and the entire procedure is performed without direct visualization of the operative field. Cardiopulmonary bypass may or may not be used with this technique. Using this approach, theoretically, all sides of the heart can be approached. In many instances, only a single bypass of the LAD artery is performed, although multivessel bypass of the left and right coronary artery has been performed.

Highmark Blue Cross Blue Shield will begin to cover MIDCAB graft surgery on Sept. 26, 2011.

Highmark considers other techniques for minimally invasive coronary artery bypass graft surgery, that can include the use of robotics and those not performed under direct visualization, experimental or investigational. A participating, preferred, or network provider may bill the member for the non-covered surgery.

Use the following procedure code(s), as appropriate, to report MIDCAB procedures:

Code	Terminology
S2205	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini sternotomy surgery, performed under direct vision; using arterial graft(s), single arterial graft
S2206	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini sternotomy surgery, performed under direct vision; using arterial graft(s); two coronary arterial grafts
S2207	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini sternotomy surgery, performed under direct vision; using venous graft only, single coronary venous graft
S2208	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini sternotomy surgery, performed under direct vision; using single arterial and venous graft(s), single venous graft
S2209	Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini sternotomy surgery, performed under direct vision; using two arterial grafts and single venous graft
33999	Unlisted procedure, cardiac surgery

When you report code 33999, please include a complete description of the service you performed in the procedure code description field of the electronic claim or the narrative section of the paper claim.

Please read Highmark Medical Policy S-66 for more information on MIDCAB surgery. Highmark's Medical Policy S-50 explains the robotic surgical technique.

Procedure codes 37600, 37618, 46744, 61697, and 64910 eligible for co-surgery

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

37600—ligation; external carotid artery

37618—ligation, major artery (eg, post-traumatic, rupture); extremity

46744—repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach

61697—surgery of complex intracranial aneurysm, intracranial approach; carotid circulation

64910—nerve repair, with synthetic conduit or vein allograft (eg, nerve tube), each nerve

Please remember, other Highmark medical policies may affect the eligibility of these codes.

Video EEG covered for some indications

Highmark Blue Cross Blue Shield covers video electroencephalographic (EEG) monitoring when:

- The diagnosis cannot be made by neurological examination, standard EEG studies, or ambulatory cassette EEG monitoring
- Routine surface EEG is not diagnostic of a seizure disorder
- Seizure activity is observed clinically but not captured by routine EEG
- Seizure activity captured on routine EEG does not yield sufficient qualitative or quantitative data to determine a treatment regimen
- Antiepileptic drug withdrawal is needed
- Non-neurological causes of symptoms, for example, syncope and cardiac arrhythmias, have been ruled out
- Differentiating epileptic events from nonepileptic seizures such as psychogenic seizures

- Individual with intractable epilepsy is being evaluated for surgical intervention
- Seizure monitoring of a neonate or child is needed to develop or modify treatment

If video EEG is used for any other indications, Highmark will deny it as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied services unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement should be maintained in the provider's records.

Report procedure code 95951—monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for presurgical localization), each 24 hours—for video EEG.

Occipital nerve stimulation considered investigational

Effective Sept. 26, 2011, Highmark Blue Cross Blue Shield will consider occipital nerve stimulation (ONS) experimental or investigational. A participating, preferred, or network provider may bill the member for the denied ONS service.

Highmark will not cover ONS for any condition including, but not limited to, chronic headache, chronic migraine headache, or cluster headache. The U.S. Food and Drug Administration (FDA) has not cleared any ONS device for treating headaches.

Because there is no specific ONS procedure code, please use the following CPT codes, as appropriate, to report this service:

61885—insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

61886—insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays

64553—percutaneous implantation of neurostimulator electrodes; cranial nerve

64568—incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

64569—revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator

64570—removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

64999—unlisted procedure, nervous system

When you report code 64999, please include a complete description of the service you performed, along with the term "occipital nerve stimulation" in the procedure code description field of the electronic claim or the narrative section of the paper claim.

For more information about ONS, please read Highmark Medical Policy Z-70, available Sept. 26, 2011.

More coverage criteria to be applied to implantable infusion pumps

Highmark Blue Cross Blue Shield is updating its coverage criteria for implantable infusion pumps. The new guidelines will become effective on Sept. 26, 2011.

As of Sept. 26, 2011, Highmark will pay for the surgical implantation of an infusion pump for the following Food and Drug Administration (FDA) approved usages. The administered medications must be approved by the FDA for the route of administration and the medical condition.

Anti-spasmodic drugs

Highmark considers an implantable infusion pump medically necessary when it's used to intrathecally administer anti-spasmodic drugs, for example, baclofen, to treat chronic intractable spasticity in persons who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- A failed six-week trial of non-invasive methods of spasticity control, such as oral anti-spasmodic drugs, either because these methods fail to adequately control the spasticity or produce intolerable side effects, and
- A favorable response to a trial intrathecal dosage of the anti-spasmodic drug prior to pump implantation

Highmark considers intrathecal baclofen (Lioresal®) medically necessary for:

- The treatment of intractable spasticity caused by spinal cord disease, spinal cord injury, or multiple sclerosis
- Persons who require spasticity to sustain upright posture, balance in locomotion, or increased function

Please indicate in the member's medical record that the spasticity was unresponsive to other treatment methods and that the oral form of baclofen was ineffective in controlling spasticity or that the member could not tolerate the oral form of the drug. The medical record should also document that there was a favorable response to the trial dosage of the baclofen.

A trial of oral baclofen is not a required prerequisite to intrathecal baclofen therapy in children ages 12 years old or less due to the increased risk of adverse effects from oral baclofen in this group.

Opioid drugs for the treatment of severe chronic intractable pain

Highmark considers an implantable infusion pump medically necessary when it's used to administer opioid drugs, for example, morphine, intrathecally, intravenously, or epidurally for treatment of severe, chronic, intractable pain in persons who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- For the treatment of non-malignant pain, for example, pain not associated with cancer. Documentation in the medical record must indicate the failure of six months of other conservative treatment modalities (pharmacologic, surgical, psychological, or physical) if appropriate and not contraindicated.
- For the treatment of malignant pain, for example, pain associated with cancer. Strong opioids or other analgesics in adequate doses, with a fixed schedule (not prn) dosing, have failed to relieve pain, or have intolerable side effects to systemic opioids, or other analgesics have developed.
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal or epidural catheter to substantiate adequately acceptable pain relief (defined as at least a 50 percent reduction in pain), the degree of side effects (including effects on the activities of daily living), and acceptance.

Intra-arterial injection of chemotherapeutic agents

Highmark considers implantable infusion pumps medically necessary for the administration of intrahepatic or intra-arterial chemotherapy for patients with unresectable primary liver cancer, colorectal cancer with metastases limited to the liver, and head or neck cancers.

Contraindications to implantable infusion pumps

Highmark considers implantable infusion pumps not medically necessary for persons with the following contraindications to implantable infusion pumps:

- An active infection that may increase the risk of the implantable infusion pump,
- Body size is insufficient to support the weight and bulk of the device,
- Known allergy or hypersensitivity to the drug being used, for example, oral baclofen, morphine, etc., or
- Other implanted programmable devices where the crosstalk between devices may inadvertently change the prescription

Highmark considers implantable infusion pumps experimental or investigational for all other uses, for example, heparin for thromboembolic disease, insulin for diabetes, antibiotics for osteomyelitis. Highmark also considers drug delivery directly into the neural tissue or ventricle spaces of the brain via the implantable infusion pump experimental or investigational. If an implantable infusion pump is provided by any other method of delivery or for any condition not included in the coverage criteria, or is not FDA-approved, Highmark considers it experimental or investigational. In these instances, the implantable infusion pump is not covered. A participating, preferred, or network provider may bill the member for the non-covered service.

An implantable infusion pump is intended to provide long-term continuous or intermittent drug infusion. Possible routes of administration include intravenous, intra-arterial, subcutaneous, intraperitoneal, intrathecal, and epidural. Primary uses are delivery of chemotherapy agents and analgesics.

Refer to Highmark Medical Policy S-40 for more information about implantable infusion pumps.

Interspinous distraction devices classified as experimental, not covered

Highmark Blue Cross Blue Shield considers the implantation of interspinous distraction devices, for example, X-STOP® Interspinous Process Decompression (IPD), X-STOP® PEEK IPD System, ExtenSure Bone Allograft Interspinous Spacer, experimental or investigational. A participating, preferred, or network provider may bill the member for the denied device.

Report procedure code 0171T or 01712T for interspinous distraction devices:

0171T—insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level

0172T—insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level

Lumbar spinal stenosis (LSS) refers to the narrowing of the lumbar spinal canal that may result in painful compression of a nerve and/or blood vessel(s) supplying the nerve. Symptoms of neurogenic intermittent claudication such as leg, buttock, or groin pain, with or without back pain may be experienced. Non-surgical treatments, for example, activity modification, medications, physical therapy, epidural steroid injections, are usually used before considering surgery. If symptoms fail to improve with non-surgical treatments, decompressive surgery, for example, laminectomy, facetectomy, multi-level laminotomies, fenestration, distraction laminoplasty, and microscopic decompression, with or without fusion, may be necessary.

The development of interspinous distraction devices has emerged as an alternative treatment for LSS. These devices are intended to restrict painful motion while otherwise enabling normal motion of the spine. It is implanted between the spinous processes of the lumbar spine, using a minimally invasive procedure. The device is designed to act as a spacer between the spinous processes, maintaining flexion and limiting extension of the lumbar spine. This prevents nerve impingement, and relieves symptoms of pain.

Sacroiliac joint injections not covered

Beginning Oct. 10, 2011, Highmark Blue Cross Blue Shield will consider arthrography of the sacroiliac joint experimental or investigational. Highmark will also consider injections into the sacroiliac joint for diagnostic or therapeutic purposes or for the treatment of acute, subacute, or chronic back pain or radicular syndromes experimental or investigational. A participating, preferred, or network provider may bill the member for the denied services.

Report the following procedure codes, as appropriate, for sacroiliac joint injections:

27096—injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid

73542—radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation

77003—fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction

G0260—injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

How to report auditory brainstem implants

Please use NOC code L8699—prosthetic implant, not otherwise specified—to report auditory brainstem implants. When you report code L8699 for an auditory brainstem implant, please include the term "auditory brainstem implant" in the procedure code description field of the electronic claim or the narrative section of the paper claim.

Tocilizumab coverage guidelines explained

Highmark Blue Cross Blue Shield covers tocilizumab (Actemra®), an interleukin-6 (IL-6) receptor inhibitor, for treating:

- Adult (18 years of age or older) patients with moderate to severe active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor antagonist therapies, for example, infliximab, etanercept, etc.

- Patients two years of age and older with active systemic juvenile idiopathic arthritis

Tocilizumab may be used alone or in combination with methotrexate or other disease modifying anti-rheumatic drugs (DMARDs), for example, sulfasalazine, azathioprine, etc. When used in combination with DMARDs or as monotherapy the recommended starting dose is 4 mg/kg followed by an increase to 8 mg/kg based on clinical response.

It is recommended that tocilizumab not be initiated in patients with an absolute neutrophil count below 2000/mm^3, platelet count below 100,000 mm^3, or who have ALT or AST above 1.5 times the upper limit of normal. Tocilizumab doses exceeding 800 mg per infusion are not recommended.

Report tocilizumab (Actemra) with procedure code J3262—injection, Tocilizumab, 1 mg.

If tocilizumab is used for any other indication, Highmark considers it experimental or investigational. A participating, preferred, or network provider may bill the member for the non-covered service.

Highmark determines coverage for tocilizumab according to individual or group customer benefits.

Massage therapists services covered under certain circumstances

As of Jan. 1, 2011, Highmark Blue Cross Blue Shield will pay for certain covered services performed by a licensed massage therapist who is employed and supervised by an eligible professional provider.

Highmark does not reimburse massage therapists directly. The eligible professional provider or professional provider group must submit claims for services performed by the supervised, employed, and licensed massage therapist. Highmark will pay the eligible participating, preferred, or network professional provider, or professional provider group that employs the licensed massage therapist.

The massage therapist must be licensed by the Commonwealth of Pennsylvania and must be performing services within the scope of his or her license.

“Supervision" means that the eligible professional provider must be immediately available physically or by electronic means, for example, telephone, radio, telecommunications, in the event his or her assistance or oversight is required in the care of the patient. All supervision must be in accordance with the state licensure or certification requirements of the performing licensed or certified health care practitioner.

Highmark determines coverage for massage therapy services according to individual or group customer benefits.

Coverage criteria explained for Xgeva

Highmark Blue Cross Blue Shield covers denosumab (Xgeva®), a RANK ligand (RANKL) inhibitor, for the prevention of skeletal-related events in adult patients (age 18 and older) with bone metastases from solid tumors.

Highmark considers the use of denosumab for any other indication experimental or investigational including the prevention of skeletal-related events in patients with myeloma. A participating, preferred, or network provider may bill the member for the non-covered service.

The recommended dose of denosumab is 120 mg every four weeks as a subcutaneous injection.

Report denosumab with procedure code J3590—unclassified biologicals. When you report code J3590, please provide the name of the drug and dosage in the procedure code description field of the electronic claim or the narrative section of the paper claim.

Highmark determines coverage for denosumab according to individual or group customer benefits.

New artificial hearts and ventricular assist devices coverage guidelines defined

Highmark Blue Cross Blue Shield provides coverage for artificial hearts and ventricular assist devices (VAD). Beginning Sept. 26, 2011, Highmark will further define its coverage criteria for artificial hearts and VADs with the following.

Highmark covers artificial hearts and VADs only if they've received approval from the Food and Drug Administration (FDA) for that purpose, and if they're used in accordance with the FDA approved usages.

Covered indications for VADs include:

- Postcardiotomy ventricular dysfunction
- Treatment of right heart failure following insertion of an implantable left ventricular device

- Treatment of cardiogenic shock following cardiac transplantation
- Bridge-to-transplant

  The patient must meet all of the following criteria for Highmark to cover a VAD used as a bridge-to-transplant. The patient must be:

  - a candidate for cardiac transplantation,
  - in imminent risk of dying before donor heart procurement, and
  - dependent on, or incomplete response to, continued vasopressor support

  Highmark may consider FDA-approved VADs, including humanitarian device exemptions (HDE), medically necessary as a bridge to heart transplantation in children when used in accordance with the FDA's HDE requirements when all of the following are met:

  - age five–16
  - body surface area ≥ 0.7 m^2 and < 1.5 m^2
  - in New York Heart Association (NYHA) Class IV end-stage, that is, left ventricular, heart failure refractory to medical therapy
  - listed candidate for cardiac transplantation

  Pediatric VADs are contraindicated in children who meet any one of the following. In this instance, Highmark considers the pediatric VAD not medically necessary.

  - are younger than five years old,
  - have right ventricular failure,
  - have a blood-clotting (primary coagulopathy) or platelet disorder such as hemophilia or Von Willebrand's disease,
  - have a known allergy or sensitivity to the blood thinner heparin, or
  - have anatomical anomalies that would prevent surgical connection of the outflow graft to the ascending aorta

Only one VAD has approval from the FDA for the pediatric population. The DeBakey VAD® Child device has FDA approval (HDE process) for use in children ages five to 16 years who are awaiting a heart transplant, that is, as a bridge to transplant.

- Destination therapy—defined as permanently implanting a device for patients who are not considered candidates for a heart transplant and have end-stage heart failure (an alternative to heart transplantation).

  All of the following criteria must be met for Highmark to cover a VAD used as destination therapy:

  - the device has received FDA approval for a destination therapy indication
  - the member has NYHA Class III or IV end-stage ventricular heart failure and is not a candidate for heart transplant
  - the member has failed to respond to optimal medical management (including beta-blockers, and angiotensin-converting enzyme inhibitors if tolerated) for at least 45 of the last 60 days, or has been balloon pump dependent for seven days, or has been IV inotrope dependent for 14 days
  - the member has a left ventricular ejection fraction less than 25 percent
  - the member has demonstrated functional limitation with a peak oxygen consumption of less than or equal to 14 ml/kg/min
  - the member is at least 18 years of age

  The exclusion criteria are:

  - any medical condition that, if corrected, would improve heart function
  - any condition that could result in a poor surgical risk
  - prior cardiac transplant, left ventricular reduction, or cardiomyoplasty
  - stroke, impaired cognitive function, history of severe cerebral vascular disease
  - severe end organ damage

- irreversible left ventricular congestive failure:
    - awaiting a donor heart for transplantation
    - on the hospital's transplant list

The TandemHeart (CardiacAssist) is a covered device specifically designed for short-term stabilization of patients in the postoperative setting. This device is unique in that it allows for percutaneous access through the femoral vein, permitting rapid deployment. In addition, it is the first ventricular assist device that uses continuous axial flow, as opposed to pulsatile flow.

Use code 33999 to report prolonged extracorporeal percutaneous transseptal VAD. When you report code 33999, please provide a complete description of the procedure you performed in the procedure code description field of the electronic claim or the narrative section of the paper claim.

Highmark considers the use of non-FDA approved or cleared VAD experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Total artificial hearts

The total artificial heart (TAH) replaces the native ventricles and is attached to the pulmonary artery and aorta; the native heart is typically removed. Highmark covers TAHs only if they have received approval from the FDA for that purpose, and the TAHs are used in accordance with the following FDA approved usages.

Covered indications:

Highmark may consider TAHs with FDA-approved devices medically necessary as a bridge to heart transplantation for patients:

- With biventricular failure who have no other reasonable medical or surgical treatment options,
- Who are not eligible for other univentricular or biventricular support devices, and
- Are currently listed as heart transplantation candidates, and are not expected to survive until a donor heart can be obtained

Highmark considers the use of TAHs as destination therapy experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Highmark does not cover the use of non-FDA approved or cleared implantable TAHs because it considers them experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Contraindications for bridge to transplant ventricular assist devices and total artificial hearts

The following conditions generally exclude patients for heart transplant:

- Chronic irreversible hepatic, renal, or respiratory failure
- Systemic infection
- Coagulation disorders
- Inadequate psychosocial support

Due to potential problems with adequate function of the VAD or TAH, implantation is also contraindicated in patients with uncorrected valvular disease.

If an FDA approved artificial heart and/or VAD does not meet the coverage criteria, Highmark will consider it not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement should be maintained in the provider's records.

Refer to Highmark Medical Policy S-60 for additional information on artificial hearts and VADs.

Artificial hearts and VADs are devices that either replace all or part of a human heart, or assist the heart in performing its pumping function. Artificial hearts may be used as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant. VADs are used as a temporary method of supporting heart functions.

Medicare Advantage Policy

Medicare Advantage eliminated least costly alternative determination on Feb. 4, 2011

MA

As of Feb. 4, 2011, Highmark Blue Cross Blue Shield's Medicare Advantage products—FreedomBlue℠ PPO and SecurityBlue℠ HMO—will no longer make partial payment for services associated with least costly alternative (LCA) determinations.

Highmark is making this change because the Centers for Medicare & Medicaid Services (CMS) announced that as of Feb. 4, 2011, partial payment may no longer be made for claims based on an LCA determination.

The following new guidelines apply:

- Type 1 LCA denial: if the Highmark Medicare Advantage medical policy currently states that an item will always be paid based on the allowance for the LCA (if the criteria for the less costly item are met), Highmark will deny claims for that item as not medically necessary.

- Type 2 LCA denial: if the Highmark Medicare Advantage medical policy currently states that an item will be paid in full if specific additional coverage criteria are met, but will be paid based on the allowance for the LCA if the additional coverage criteria for the billed item are not met (and if the criteria for the less costly item are met), Highmark will deny that item as not medically necessary if all of the additional coverage criteria for that item are not met.

  Highmark will pay the claim in full if the additional coverage criteria are met.

  If a KX modifier is required to attest to the additional coverage criteria being met, Highmark will deny claims without a KX modifier (and with a GA, GY, or GZ modifier).

- For capped rental durable medical equipment (DME) items, elimination of LCA determinations will apply only to claims in which the date of service for the initial rental month is on or after Feb. 4, 2011. If an LCA determination is made on an item with an initial rental month date of service before Feb. 4, 2011, Highmark will adjudicate subsequent claims for that item using the LCA determination for the duration of that rental period.

- If Highmark denies an item in full because LCA is eliminated, partial payment based on LCA will not be possible through the appeals process.

- For items that were previously paid based on an LCA determination, suppliers can receive partial payment at the time of initial determination if they elect to bill using one of the upgrade modifiers, GK or GL.

Note: If Highmark denies a base code for a DME item, a prosthesis, or an orthosis as not medically necessary, it will also deny all related accessories, supplies, additions, and drugs as not medically necessary.

If services do not meet the Medicare Advantage medical necessity guidelines, Highmark will deny them as not medically necessary. A provider may not bill the member for the denied service unless he or she has given advanced written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement, in the form of a Pre-service Denial Notice, should be maintained in the provider's records.

Medicare Advantage covers pneumatic or hydraulic polycentric hip joint for functional level of three or above

MA

Highmark Blue Cross Blue Shield's Medicare Advantage products, FreedomBlue℠ PPO and SecurityBlue℠ HMO, cover a pneumatic or hydraulic polycentric hip joint, code L5961, for patients whose functional level is three or above.

Functional level three is described as having the ability or potential for ambulation with variable cadence. This is typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

When you submit a claim for a pneumatic or hydraulic polycentric hip joint (code L5961), you must include modifier K0, K1, K2, K3, or K4, indicating the expected patient functional level. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records. The simple entry of a K modifier in those records is not sufficient. There must be information about the patient's history and current condition that supports the designation of the functional level by the prosthetist.

Isolated ultrafiltration for management of fluid overload eligible for certain indications

MA

Highmark Blue Cross Blue Shield is issuing new coverage criteria for isolated ultrafiltration for management of fluid overload in cardiac disease for its Medicare Advantage products—FreedomBlue[SM] PPO and SecurityBlue[SM] HMO.

Effective June 6, 2011, Highmark considers isolated ultrafiltration medically necessary for:

- Temporary (up to eight hours) isolated ultrafiltration for treating patients with fluid overload who have failed diuretic therapy
- Extended (longer than eight hours) isolated ultrafiltration for treating patients with fluid overload who have failed diuretic therapy and require hospitalization

Due to the cardiovascular and cerebrovascular risk profiles of patients with severe congestive heart failure (CHF), it is anticipated that temporary and extended isolated ultrafiltration will be performed in a hospital (either inpatient or outpatient) to allow the presence of both ICU level care and a cardiopulmonary resuscitation team to respond and provide Advanced Cardiac Life Support should a complication occur in the delivery of this treatment. Highmark also considers this service medically necessary when it's performed in an outpatient dialysis facility.

Patients must exhibit signs and symptoms of fluid overload as evidenced by at least three of the following:

- Physical findings of fluid overload, that is, significant peripheral edema, ascites, trunkal edema, or jugular venous distention
- Moderately severe dyspnea
- Eight percent above dry weight
- Elevated BNP supportive of CHF or radiographic evidence of CHF

and

Are judged by the provider to have an inadequate diuretic response in the setting of volume overload as evidenced by one of the following:

- Optimal loop diuretic dose

- Concurrent use of two or more moderately dosed diuretic classes, for example, furosemide and metolazone
- Two or more hospitalizations in a six month time period
- Rehospitalization for fluid overload within 30 days

It is considered medically necessary to perform no more than three treatments within a 60 day period.

Use NOC code 90999—unlisted dialysis procedure, inpatient or outpatient—to report this service. When you report code 90999, please include a complete description of the service you performed in the procedure code description field of the electronic claim or the narrative section of the paper claim.

If the isolated ultrafiltration services do not meet the medical necessity criteria, Highmark will consider them not medically necessary. A provider may not bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, before receiving the service. The signed agreement, in the form of a Pre-service Denial Notice, should be maintained in the provider's records.

Isolated ultrafiltration is an extracorporeal therapy that's used to safely and selectively filter out excess plasma water and sodium. It restores normal fluid balance when the patient has fluid overload.

Isolated ultrafiltration is an extracorporeal therapy in which a small amount of blood is initially withdrawn from the patient using specialized venous access catheters. The blood next passes continuously through a special filter and, by using a form of mechanical filtration called ultrafiltration, leads to the production of isotonic fluid. This fluid has a high concentration of sodium and water with the remaining blood being reinfused back to the patient. The rate of isotonic fluid removal is determined by the clinician, based on the clinical state of the patient.

MRA coverage criteria revised for Medicare Advantage

MA

On Oct. 3, 2011, Highmark Blue Cross Blue Shield will revise its coverage guidelines for magnetic resonance angiography (MRA) for its Medicare Advantage products—FreedomBlue℠ PPO and SecurityBlue℠ HMO.

Currently, covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest.

Highmark limits its coverage of MRA units to those that have received FDA premarket approval. Such units must also be operated within the parameters specified by the approval. In addition, the services must be reasonable and necessary for the diagnosis or treatment of the specific patient involved.

The following indications are the revisions to current coverage guidelines for the anatomic area specified.

Head and neck

MRA is performed on patients with conditions of the head and neck for which surgery is anticipated and may be found to be appropriate based on the MRA. These conditions include, but are not limited to, tumor, aneurysms, vascular malformations, vascular occlusion, or thrombosis. Within this broad category of disorders, medical necessity is the underlying determinant of the need for an MRA in specific diseases. The medical records should clearly justify and demonstrate the existence of medical necessity.

MRA is appropriately used to verify the presence of a condition, suspected because of findings from another test (usually an imaging study). For example, a patient who presents with a transient ischemic attack should not undergo MRA simply because he or she might have a lesion that is amenable to surgery. However, if that patient has a carotid bruit and is found by Doppler study to have carotid stenosis, an MRA may be appropriate to evaluate the stenotic section of artery for surgical intervention. Please note that the anticipated surgery may be a percutaneous procedure such as carotid angioplasty with stent insertion.

Another patient may present with a headache. It is not appropriate to proceed directly to MRA to rule out the possibility of an intracranial aneurysm. However, if that patient was found to have a clinically significant amount of blood in the cerebrospinal fluid, or the patient demonstrated signs and symptoms strongly suggesting an unruptured intracranial aneurysm, an MRA (or cerebral angiogram) may be appropriate. Please note that the anticipated surgery may be a percutaneous procedure such as carotid angioplasty with stent insertion.

Abdomen and pelvis

Highmark would not consider an MRA of the abdomen for evaluation of possible renal artery stenosis medically necessary without some evidence consistent with renovascular hypertension. Such evidence might include:

- A history of early or late onset of hypertension, hypertension refractory to medication, or worsening renal function,
- The presence of a renal artery bruit,
- Laboratory tests (elevated serum renins, increasing creatinine), or
- Other radiologic tests (ultrasound, captopril scintigraphy, or other imaging showing small kidney or unequal kidney sizes)

Cardiac MRA for velocity flow mapping

Highmark considers cardiac velocity flow mapping medically reasonable and necessary for quantitative assessment of the following pre and post repair of the structural defects:

- Magnitude of cardiac shunt fractions in patients with atrial septal defect, ventricular septal defect, or patent ductus arteriosus
- Valvular regurgitation fractions in patients with valvular regurgitation of insufficiency
- Grading of valvular, subvalvular, for example, hypertrophic cardiomyopathy, supravalvular, or great vessel stenosis
- Evaluation of differential flow of the pulmonary arteries in patients with Tetrology of Fallot

If Highmark denies an MRA study as not medically necessary, a provider may not bill the member for the denied service unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility before receiving the service. The signed agreement, in the form of a Pre-service Denial Notice, should be maintained in the provider's records.

Comments on these new medical policies?

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

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

Codes

Codes S3628 and S9075 deleted June 30, 2011

The following two procedure codes will be deleted on June 30, 2011:

S3628—placental alpha microglobulin-1 rapid immunoassay for detection of rupture of fetal membranes

S9075—smoking cessation treatment

New codes available July 1, 2011

Here are 24 new codes that will be available for your reporting purposes on July 1, 2011:

Code	Terminology
0262T	Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)

Code	Terminology
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode therapy start/stop times each day); with programming
0274T	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic
0275T	Percutaneous laminotomy/laminectomy (intraluminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar
K0741	Portable gaseous oxygen system, rental, includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing, for cluster headaches

Code	Terminology
K0742	Portable oxygen contents, gaseous, 1 month's supply = 1 unit, for cluster headaches, for initial month's supply or to replace used contents
K0743	Suction pump, home model, portable, for use on wounds
K0744	Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less
K0745	Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches
K0746	Absorptive wound dressing for use with suction pump, home model, portable, pad size, greater than 48 square inches
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco
Q2042	Injection, hydroxyprogesterone caproate, 1 mg
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
Q2044	Injection, belimumab, 10 mg

About this newsletter

PRN (Policy, Review & News) is the bimonthly newsletter for most health care professionals (and office staff) who participate in our networks and submit claims to Highmark using the 837P HIPAA transaction or the CMS 1500 form.

PRN focuses only on medical policy and claims administration updates, including coding guidelines and procedure code revisions, and is the sole source for this information. For all other news, information and updates, be sure to read **Behind the Shield**, available on the Provider Resource Center at **www.highmarkbcbs.com**.

Contents Vol. 2011, No. 3

Contents Vol. 2011, No. 3

Would you rather receive this newsletter electronically through your e-mail? If so, go to the Provider Resource Center and sign up for electronic delivery of PRN through the e-Subscribe link.

Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the **Current Procedural Terminology**, as contained in CPT-2011, Copyright 2010, by the American Medical Association. **PRN** includes CPT descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.