



Provider News

A Newsletter for Highmark Blue Cross
Blue Shield West Virginia Providers

Welcome to Highmark Blue Cross Blue Shield West Virginia

An exciting change has taken place for our company as we move into 2011. On Jan. 17, 2011, our company name officially changed to Highmark Blue Cross Blue Shield West Virginia ("Highmark West Virginia") from Mountain State Blue Cross Blue Shield.

This change results from the almost 11-year affiliation our company has had with Pennsylvania-based Highmark Inc. Our affiliation with Highmark, which started in 1999 and became permanent in 2004, has helped us to remain competitive within our industry, enhanced our service to providers and members, become more cost effective through shared investment in systems and capabilities and enhanced many of our operational areas. This name



change has always been a part of the affiliation plan and is the next important step in continuing to position Highmark West Virginia for future success.

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February 2011



Welcome to Highmark Blue Cross Blue Shield West Virginia

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It is important to note that only our name is changing. Our commitment and service to you remains at the same high level to meet your needs. Our members will continue to carry their Mountain State Blue Cross Blue Shield Identification Cards for an undefined period of time, but will gradually be transitioned to new ID Cards bearing our new company name and logo.

Because you frequently rely on accessing our web site to obtain important information, you should also note

that our web address has changed to www.highmarkbcbswv.com.

If you have any questions regarding this information, please contact your assigned External Provider Relations Representative.

We recognize and appreciate the key role you have in providing service to Highmark West Virginia members.

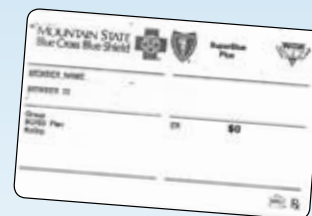
Reminder Regarding NIA Authorizations

Effective Jan. 1, 2011, National Imaging Associates, Inc. (NIA) began providing utilization management services for non-emergent, high-tech outpatient radiology services rendered to members enrolled in Highmark Blue Cross Blue Shield West Virginia commercial health plans, including SuperBlue® Plus PPO, SuperBlue Select Point of Service (POS), Steel, West Virginia Small Business Plan (WVSBP) and Highmark Health Insurance Company (HHIC) FreedomBlueSM PPO Medicare Advantage Plan.

Physicians are reminded that **NIA authorizations are not required for the following:**

- ▶ Traditional Indemnity product

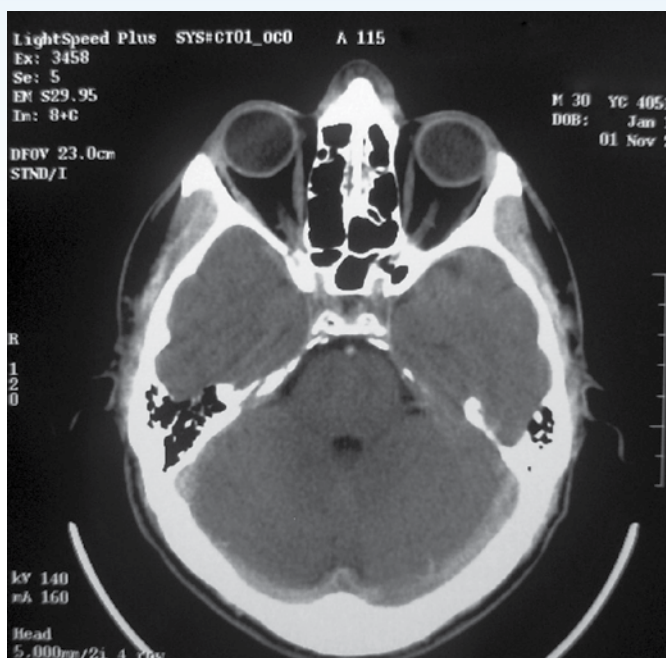
- ▶ BlueCard members (members with Blue Cross Blue Shield coverage from another state, including Highmark Pennsylvania)
- ▶ Federal Employee Program (FEP) members
- ▶ Members with group coverage through United Mine Workers of America (for dates of service on or after March 1, 2011)



Please DO NOT Request NIA authorization via NaviNet® or by telephone for the members listed above.

NIA authorizations **are required for HHIC FreedomBlue PPO members** — those from West Virginia whose coverage is through HHIC as well as those from Pennsylvania with Highmark-based coverage. Please note that if you are a Highmark West Virginia Medicare Advantage-contracted provider and are providing imaging services for Pennsylvania FreedomBlue PPO members with Highmark-based coverage (members with alpha prefixes FEM and FER), you must request the NIA authorization by telephone, as requests for these members cannot be processed through NaviNet.

For more information, see Page 4 of the August 2010 issue of [Provider News](#).



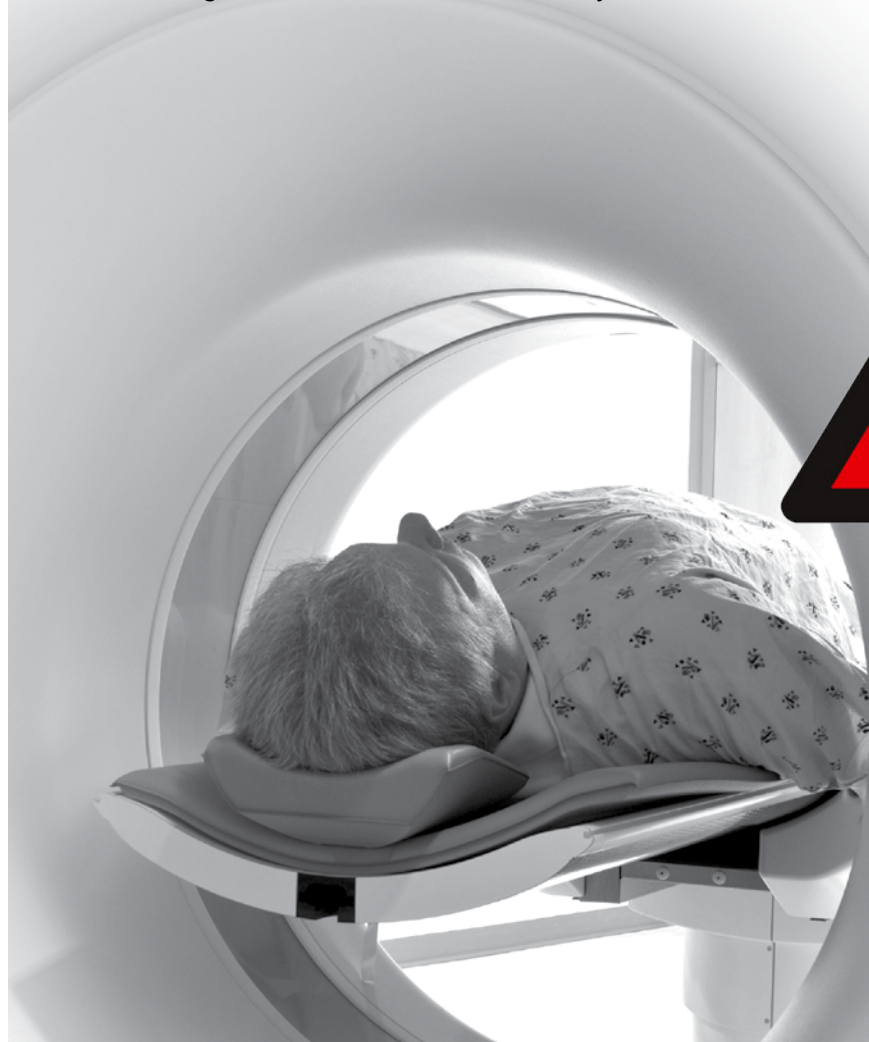
Medical Imaging News

Radiation Safety Awareness Program

Radiation exposure from medical imaging is a rapidly growing patient safety issue. Patients are now exposed to nearly six times more radiation from medical diagnostic tests than they were in 1980. Evidence is mounting that an individual's risk of developing a cancer is linked to exposure to ionizing radiation above a certain threshold. There are predominantly three tests that are believed to deliver the most significant dosages of ionizing radiation: CT scanning, PET scanning and myocardial perfusion imaging, also referred to as a nuclear stress test. To safeguard our members, and assist our network physicians in doing the same, Highmark West Virginia is developing a Radiation Safety Awareness Program, to be launched later this year,

and will be supported by National Imaging Associates (NIA) Inc., our nationally recognized radiology benefits manager.

As a value-added service, we will identify for you, the ordering physician, those members who have been exposed to a threshold amount of ionizing radiation. The patient's level of radiation exposure will not impact the preauthorization or decision-making process for requested imaging studies. Also, members undergoing treatment for cancer diagnoses, and those age 65 and older, will not be included in this program. Watch for more information in an upcoming issue of *Provider News* and on the NaviNet® Plan Central page.



Highmark West Virginia to Apply Multiple Procedure Payment Reduction to Certain Diagnostic Imaging Procedures

The Centers for Medicare & Medicaid Services has added certain procedure codes to its payment reduction rules for reimbursing the technical component of multiple diagnostic imaging procedures performed for the same patient during the same session.

Effective June 13, 2011, Highmark West Virginia will add these procedure codes to family 02, 06 or 10.

Family 02 – CT and CTA (Chest/Thorax/Abdomen/Pelvis)

Code	Terminology
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
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)

Family 06 – MRI and MRA (Spine)

Code	Terminology
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)

Family 10 – MRI and MRA (Upper Extremities and Joints)

Code	Terminology
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)

Key Dates Approaching for Implementing Electronic Requirements

for NaviNet, EFT and Paperless EOB and Remittance Advice

Highmark West Virginia continues to move forward with implementing requirements that network practitioners must enroll in NaviNet® and receive paperless EOB statements and EFT by June 30, 2011. These electronic transactions provide enhanced protection of both member and practitioner data and provide you with faster reimbursement.

For providers who enroll in the EFT process, you will be required to receive a paperless EOB either by accessing NaviNet or by enrolling in the 835 HIPAA format as the means of receiving your EOB or Remittance advice. Beginning in March 2011 and upon enrollment, the paper version will no longer be provided and mailed to you.

This conversion process is being conducted in three phases:

- 1. Phase I:** Effective Oct. 1, 2010, all new assignment accounts and practitioners who are participating with Highmark West Virginia were automatically enrolled in NaviNet, the free, easy, online solution linking physician offices with Highmark West Virginia and other health plans. These practitioners will also be required to receive EFT and paperless EOB statements.
- 2. Phase II:** March 31, 2011, all practitioners currently enrolled with NaviNet will be required to receive EFT and paperless EOB statements.
- 3. Phase III:** June 30, 2011, all practitioners doing business with Highmark West Virginia will be required to receive NaviNet, EFT and paperless EOB statements.

Initially, there will be four NaviNet transactions that will be mandated with this implementation.



Those transactions are verification of benefits and eligibility, authorization submission, claims status inquiry and claims status investigations through the NaviNet portal.

As the NaviNet requirements are enforced, you must use NaviNet as your primary servicing resource. Therefore, if you call customer service without first having utilized NaviNet for your inquiry, Customer Service will instruct you to access NaviNet for those required transactions. The Customer Service area should only be contacted for assistance if you feel NaviNet did not properly address your inquiry.

The Provider Relations Representatives will be conducting the necessary outreach to those providers who are not complying with the requirements. If you need access to or training for NaviNet, please contact your Provider Relations Representative.

Optimize Your Time! Submit/Manage Authorizations Electronically

Submitting authorizations electronically — rather than by telephone — gives you the freedom and convenience of adjusting your schedule to complete other tasks. You can view authorizations and referrals in real-time online, regardless of whether it was entered via NaviNet®, or submitted by telephone or fax to HMS Care Management. (Remember, you must be either the “referred to” or the “referred from” provider to view the status of a submitted authorization request.)

Highmark West Virginia Gives Providers a Hand with Technology

The thought of adopting and implementing technology can be scary sometimes, especially when it affects how we do business.

At Highmark West Virginia, our message to providers is: Fear not, because we're here to help.

As the health care industry continues to evolve, technology is playing an increasingly prominent role in how business is conducted – technology that is capable of reducing a practice's administrative burden, increasing data security, providing real-time information, lowering costs and improving cash flow.

Most importantly, the cumulative result of these innovative tools is better, more efficient care.

As a company at the forefront of the industry's transformation, Highmark West Virginia realizes that we're all in this together. And that's why we're eager to help our member practices adopt helpful technology. At www.highmarkbcbswv.com, for example, our Provider Resource Center includes information about how to integrate technological tools into your practice.

The Provider Resource Center also has details about Real-Time tools. Available to providers through NaviNet, Real-Time tools can be used to estimate a member's financial responsibility before a service is performed, or to submit claims, have them processed and receive a response in seconds. And providers who use convenient tools such as Electronic Funds Transfer and paperless Explanation of Benefits statements can expedite reimbursement from Highmark West Virginia.

Although implementing technology can present initial challenges, adopting the technology ultimately will benefit all stakeholders – providers, patients and insurers.

And remember – Highmark West Virginia is here to support you every step of the way.



Key dates for going paperless

Highmark West Virginia reminds providers that paper transactions are being eliminated this year. In support of the HITECH Act, HIPAA and environmental initiatives, all business will be conducted electronically by the end of 2011.

- ▶ By March 31, 2011, practitioners enrolled in NaviNet but not Electronic Funds Transfer and paperless Explanation of Benefits statements will be required to do so.
- ▶ By June 30, 2011, all practitioners will be required to enroll in NaviNet, EFT and paperless EOB statements.

Those who already use NaviNet, EFT and paperless EOB statements will continue to conduct business as usual.

If you have questions about the transition to paperless, contact your Highmark West Virginia Provider Relations Representative.



2011 Benefit Changes

for Federal Employees Health Benefits Program (FEP) Members

Effective Jan. 1, 2011, several changes have been made to the Federal Employees Health Benefits Plan (FEP) under Standard Option and Basic Option for 2011. FEP is the health care plan that covers U.S. government workers. Included are changes to FEP members' deductibles, out-of-pocket maximums, coinsurance and copayments. **An important change to note:** FEP will no longer require Prior Approval for outpatient professional or outpatient facility Mental Health and Substance Abuse (MHSA) treatment under the Standard and Basic Options. This applies

to services incurred on or after Jan. 1, 2011. Previously, prior approval was required.

To learn more about the FEP benefit changes for 2011, visit www.fepblue.org, where you can download the 2011 Benefit Plan Brochure. In the brochure, see Section 2, "How we change for 2011," on Page 9. In addition, providers who have access to the Highmark West Virginia-sponsored NaviNet® system can check FEP members' benefits and eligibility via NaviNet.

Eligibility Rosters to be Eliminated

Because very few primary care physicians are using the SuperBlue® Select Point of Service eligibility roster, and because more in-depth and current member data is available in other functions on NaviNet®, the eligibility rosters will be eliminated by April. Moving forward, please use the NaviNet *Eligibility and Benefits* function in conjunction with your practice patient lists to obtain more robust patient information.



Pediatric Immunization Administration Procedure Codes

Changed on Jan. 1, 2011

On Jan. 1, 2011, four pediatric immunization administration CPT codes (90465, 90466, 90467, 90468) were deleted as part of the 2011 HCPCS update. Prior to Jan. 1, 2011, physicians reported these codes when face-to-face counseling of the patient and family were provided during the administration of a vaccine.

The following procedure codes have replaced CPT codes 90465-90468, effective Jan. 2, 2011:

- **90460** – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

- **90461** – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure.)

Use codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. These new codes enable providers to report each vaccine component separately. Codes 90460 and 90461 must be reported in addition to the vaccine and toxoid codes 90476 – 90749. Below are examples of how to report vaccine and immunization administration codes.

Vaccine Administered	Vaccine CPT Code	New Immunization Administration CPT Codes
DTaP (three vaccine components)	90700	90460 90461, 90461
HepB and Hib (two vaccine components)	90748	90460, 90461
Polio (IPV) (one component)	90713	90460



Use the appropriate multiple number of service code when reporting 90460 and 90461. In the example, report 90460 with a multiple number of services 3 and 90461 with a multiple number of services 3.

For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471 – 90474.

If you have questions about the new codes, please call Provider Service.

HIPAA 005010 and ICD-10 News

Common Coding Errors on HIPAA 005010 Electronic Claims: Learn What You Can Do to Avoid Having Your Transaction Rejected

Highmark West Virginia is now accepting 837 electronic claim transactions in Version 005010 format, and we have noticed some common coding errors arising in providers' claim submissions. Whether you are currently submitting claims in the Version 005010 format, or soon will be, you are encouraged to review the following tips and reminders and to contact your Highmark West Virginia trading partner to ensure that these common errors can be avoided. Doing so will minimize the chances that your claims will be rejected.

Listed below are a few of the common coding errors Highmark West Virginia has identified to date:

- ▶ **Nine-digit ZIP codes:** You must provide a **full** nine-digit ZIP code for billing provider and service facility locations on all claim submissions. When the full nine-digit ZIP code is required, spaces or zeroes aren't valid in the last four digits of the ZIP code. Providers, facilities and ancillary providers can make changes to their addresses, including ZIP code, by completing the Provider Reimbursement Change Form. Click here to obtain a copy of the form: (<https://www.highmarkbcbswv.com/PDFFiles/Provider-Reimbursement-Change-Form.pdf>)

The completed Provider Reimbursement Change Form should be faxed to 304-424-7713.

- ▶ **Reporting anesthesia services:** Submit **both** the anesthesia code at the line level and the corresponding surgical code at the claim level for any claim in which the anesthesia code is a "Not Otherwise Specified" or "Not Otherwise Classified" code. If the claim level surgical code is missing, the claim will be rejected.
- ▶ **Billing provider address:** Highmark West Virginia will reject electronic claims containing a P.O. Box or "lockbox" as the billing provider address. The billing provider address must be a physical address.

Highmark West Virginia uses the mailing address it has on file for any mailings — not the address that is submitted on the claim.

- ▶ **Billing Provider Taxonomy Code:** When the billing provider's National Provider Identifier (NPI) is associated with more than one Highmark West Virginia-Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI.

For additional information on changes related to the 005010 mandate, refer to the June 2010, August 2010, October 2010 and December 2010 issues of *Provider News*.

Prepare Now

These common coding errors represent just a few of the changes that are a result of the HIPAA 005010 mandate that you may need to discuss with your practice management software vendor in order to be fully prepared and compliant with the 005010 mandate. Highmark West Virginia encourages electronic claims submitters to act now to ensure that their claim submission software is ready prior to the compliance date of Jan. 1, 2012.

Have Questions?

If you have any questions regarding how Highmark West Virginia is working to become compliant with the Version 005010 transaction formats, contact your Highmark West Virginia Provider Relations Representative. Questions specific to the Version 005010 authorization process or electronic claim transactions can be addressed to Highmark West Virginia's EDI Operations department by calling, toll-free, 1-800-992-0246.

Also, watch *Provider News* and the NaviNet® Plan Central page for more information and updates about the 005010 mandate.

ICD-10 Milestones for Provider Preparation

Thirty-two months — nearly three years — may normally sound like a lot of time. But for provider practices to plan, prepare, train and implement changes in advance of the ICD-10 Oct. 1, 2013, compliance date, 32 months will pass by very quickly.

There are many support and reference materials being published to help provider practices plan and execute the tasks that need to be accomplished to ensure successful preparation for ICD-10. The Workgroup for Electronic Data Interchange (WEDI), for example, has an estimated timeline for preparing for ICD-10 on its web site (www.wedi.org). Provider practices are encouraged to review information from authoritative sources like WEDI to help them plan their own preparations for ICD-10.

CAUTION: When researching timelines, be advised to look closely at the tasks and how they are defined or used. Task definitions vary, and this affects the estimated target dates. For example, one source may combine Impact Analysis with

Developing Requirements. Another may combine Design, Development and Internal Testing. When tasks are combined, target dates are typically extended, potentially giving a false sense of timing for completion of intermediate tasks.

While there is no single official timeline, the following are a few general points to remember when building your own timeline and gauging your progress:

- ▶ **Impact Analysis:** This is a very critical task and should be completed as soon as possible. It will identify the overall tasks and effort for preparation and drive the planning and implementation schedule. Target dates for completing this task vary greatly. Some sources indicate this task is already past due. Others have a target date as late as January 2012. The right target date depends on the size and complexity of your practice. You will need to start by asking some basic questions, such as “Who applies diagnosis

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ICD-10 Milestones for Provider Preparation

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codes to claims in your office?” and “At what point are the codes applied?” Other such questions may include “Are there forms, systems or other tools that assist in coding claims that must change” and “Does your billing system include any logic or references that must change?”

- ▶ Industry sources strongly suggest reserving all or much of 2013 (prior to October 1, of course) for external testing with payers, software vendors, etc. You will need to think about what degree of testing you want to perform to ensure that your claims and records are captured and reported correctly and are processed correctly by your patient's health plans.

To comply with the external testing target, internal testing should be completed by the end of 2012.

- ▶ **Training:** Industry sources recommend that coder training occur within six to nine months of implementation. However, some individuals in a practice (i.e., those involved in planning and preparing for ICD-10) may require training much

earlier. The timing is based on their involvement and the implementation plan for a particular practice. Initial “training” should include key office personnel becoming familiar with how the ICD-10 codes will impact the services provided by your practice so that you can have meaningful discussions about the new codes.

And lastly, while there is an increasing amount of information being made available about preparing and planning for ICD-10, when reviewing this information, provider practices are reminded that their own implementation plans are dependent on the nature of their own practice and the resources they have available to them.

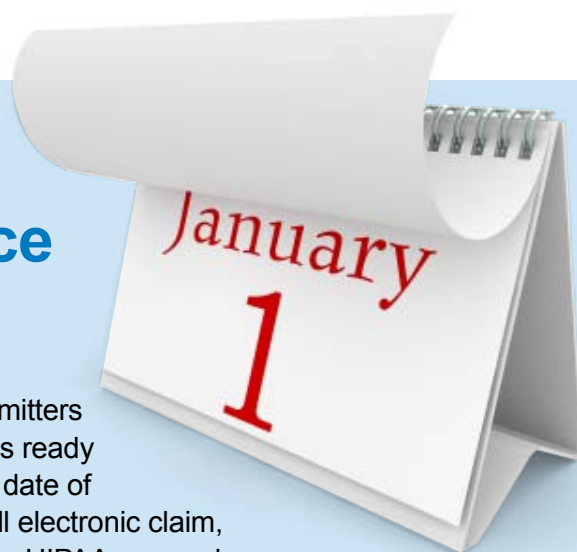
Thirty-two months will go by very quickly. Therefore, contact your practice management system vendor today to establish a comprehensive strategy to successfully make the transition leading up to the Oct. 1, 2013, ICD-10 compliance date. **Now** is the time to begin preparations to ensure this transition goes smoothly.

REMINDER:

HIPAA 005010 Compliance Date is 1/1/12

Highmark West Virginia encourages electronic claims submitters to act now to ensure that their claim submission software is ready and fully compliant prior to the HIPAA 005010 compliance date of Jan. 1, 2012. Please remember that, as of Jan. 1, 2012, all electronic claim, remittance, eligibility and claim status transactions between HIPAA-covered entities that aren't compliant with the HIPAA 005010 electronic format will be rejected and returned to the sender.

Providers should contact their practice management software vendor, billing service or clearinghouse **immediately** to learn what they need to do to become compliant. Highmark West Virginia encourages electronic claims submitters to act now to ensure that their claim submission software is ready for this important change by Jan. 1, 2012.



Medicare Advantage News

Help Your Older Patients Benefit from Physical Activity

Many older patients are afraid that exercise will result in injury or increase their pain, especially if they have a chronic disease like diabetes, heart disease or arthritis. As a physician, you can encourage them to increase their flexibility, balance and strength through moderate exercise.

Simple activities like yard work, brisk walking, dancing, swimming and biking can increase muscle tone and flexibility. Highmark Health Insurance Company (HHIC) FreedomBlueSM PPO Medicare Advantage members can also benefit from the SilverSneakers[®] program, a special exercise program for seniors offered at local fitness centers.

Highmark West Virginia and HHIC offer an *Rx for Improving Physical Activity* prescription pad that provides suggestions for improving activity levels and acts as a takeaway reminder for your older patients. The pads will be distributed by your Highmark West Virginia Provider Relations Representative during one of his/her future visits. When you need more, just contact your Provider Relations Representative.



REMINDER:

Medicare Advantage Members Must Obtain Insulin Pumps, Supplies and Insulin for Their Insulin Pumps from DMEPOS Vendors

Highmark West Virginia reminds providers that Highmark Health Insurance Company (HHIC) FreedomBlueSM PPO Medicare Advantage members are to obtain insulin pumps, pump supplies and insulin for their insulin pumps only from durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) providers —

not from retail pharmacies. When these items are improperly obtained at a retail pharmacy, it results in the claims being incorrectly billed.

In the retail pharmacy setting, the insulin is packaged the same way for dispensing via pumps as it is for self-administration via a syringe. So, if

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Reminder: Medicare Advantage Members Must Obtain Insulin Pumps, Supplies and Insulin for Their Insulin Pumps from DMEPOS Vendors

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Medicare Advantage members obtain insulin from a retail pharmacy, the pharmacy doesn't know which dispensing method is being used to administer the insulin. Ultimately, it results in these supplies being incorrectly billed under Medicare Part D instead of Medicare Part B.

To prevent future problems, when prescribing insulin pumps, supplies and insulin for insulin

pumps, please remind your HHIC FreedomBlue PPO patients to purchase these items only from durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) providers — not from retail pharmacies. To help you in this regard, Highmark West Virginia is developing a brief flier that your practice will be able to give members, along with the prescription. Please watch the NaviNet® Plan Central page for a link to the flier.

Prevent 1099 Errors: Identify Billing Provider Correctly

In the December 2010 issue of *Provider News*, Highmark Blue Cross Blue Shield West Virginia published an article titled "Valid billing provider NPI required on all claims." To assist you further, below is additional information about the correct reporting of the Billing Provider National Provider Identifier (NPI) and impacts to IRS Form 1099s.

Each year Highmark West Virginia receives numerous requests from providers to make corrections to their miscellaneous income statement (form 1099-Misc). The majority of these requests are for income to be moved from an individual provider's Social Security number to the group's Employer Identification number (EIN).

Highmark West Virginia has found that most of these 1099s are incorrect because the claims submitted identify the billing provider incorrectly. The submitted claim lists the performing provider in the billing provider field, so claims and payments are processed incorrectly. When this happens, the 1099 form is then issued to the individual because the Tax Identification Number associated with the claim payment is the number carried by Highmark West Virginia for the performing provider.

To guarantee that your 1099 is correct, make sure that your billing agent is using the correct group NPI on all claims—electronic or paper. For the 1099 to be correctly processed to the group, all claims must be paid to the group.

As a reminder, after 1099s are issued in January of each year, Highmark West Virginia will not make changes to a 1099 if the claims were submitted with the performing provider incorrectly listed as the billing provider. If you suspect your 1099 may be incorrect for the 2011 filing year, please contact Highmark West Virginia now to review your current 1099. Correcting this now will ensure you receive an accurate 1099 for the 2011 tax filing season.

Note: Highmark West Virginia discourages the use of Social Security numbers instead of business tax identification numbers whenever it requests a provider's tax identification number. A provider who chooses to submit his or her Social Security Number as a tax identification number hereby acknowledges, understands, and agrees that Highmark West Virginia will treat the Social Security Number in the same manner in which it handles other providers' business Tax Identification Numbers and shall not be liable to such provider for any intentional or unintentional disclosures of such Social Security Number.

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Prevent 1099 Errors: Identify Billing Provider Correctly

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Here is a detailed matrix that will show you how to submit your claims:

Common Naming Convention	Blue Cross Blue Shield Terminology	CMS-1500 (08/05) Paper Claim Form Box Number	837 Professional Version 4010 Mapping	837 Professional Version 5010 Mapping
Billing Provider name	Assignment account (AA) or group name	33	Loop 2010AA Billing Provider name NM103	Same as 4010
Billing Provider address	AA or group address	33	Loop 2010AA Billing Provider address N3 and N4	Same as 4010
Billing Provider Tax Identification Number	AA or group Tax Identification Number	25	Loop 2010AA Billing Provider secondary identification REF02	Loop 2010AA Billing Provider Tax Identification REF02
Billing Provider National Provider Identifier (NPI)	AA or group NPI	33a (unshaded area)	Loop 2010AA Billing Provider Name NM109	Same as 4010
Billing Provider specialty information	AA or group Taxonomy Code	33b (shaded area) Report PXC (ID Qualifier) and Taxonomy Code*	Loop 2000A Billing Provider specialty information	Same as 4010
Rendering Provider name	Performing provider name (individual person who performed the service)	Not applicable	Loop 2310B Rendering Provider name NM103, NM104, NM105. Use when the Provider performing the service is different than the Billing Provider (Loop 2010AA NM1)	Same as 4010
Rendering Provider specialty information	Performing Provider Taxonomy Code	24J, upper line (shaded area). In box 24I (ID Qual.), upper line (shaded area), report PXC.*	Loop 2310B Rendering Provider specialty information	Same as 4010
Rendering Provider NPI	Performing Provider NPI	24J, lower line (unshaded area)	Loop 2310B Rendering Provider NM109	Same as 4010

* When the billing or rendering provider's NPI is associated with more than one Highmark West Virginia-contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark West Virginia.

If you'd like to request a review of your 1099, please call a 1099 specialist at 866-425-8275, Option 5.

Contracting/ Reimbursement Update

2011 Lab Fee Schedule Update

As previously communicated, Highmark West Virginia is evaluating updates to its Lab Fee Schedule. Highmark West Virginia is currently analyzing the Medicare Fee Schedule, Ingenix RVUs and evaluation/reduction of the Highmark West Virginia Market Conversion Factor used for laboratory services. As Highmark West Virginia finalizes plans for the update, we will provide additional information to our provider community.

West Virginia Small Business Plan (WVSBP) Update

Throughout calendar year 2011, using PEIA pricing for the West Virginia Small Business Plan (WVSBP), Highmark West Virginia will update all fee schedules within two months of receipt of the appropriate information from the PEIA. These fee schedules include RBRVS, DMEPOS, Clinical Lab, Drugs and Biologicals, among others.

Medical Benefit Dental Fee Schedule Update

As previously communicated, Highmark West Virginia will be updating the Dental fee schedule for those procedures covered under a member's medical benefits on May 1, 2011. The revision of fees will result in increases and decreases to numerous codes.

An example of an increase is code D7955 (Repair of maxillofacial soft and/or hard tissue defect). Reimbursement for this code will increase from \$631 to \$1,692.

An example of a decrease is code D7220 (Removal of impacted tooth, soft tissue). Reimbursement for this code will decrease from \$224 to \$179.

Highmark West Virginia to Implement MS-DRG Grouper Version 28, Effective 7/1/2011

For hospital discharges on and after July 1, 2011, Highmark West Virginia will be converting from MS-DRG Grouper Version 27 to MS-DRG Grouper Version 28 for hospitals reimbursed by the DRG method. This update will allow for both the hospital and Highmark West Virginia to achieve administrative simplification and align Highmark West Virginia's grouper version with Medicare. Hospitals affected by this change will be sent additional information detailing this conversion.

2011 RBRVS Reimbursement Updates

The annual 2011 RBRVS physician fee schedule update will be effective July 1, 2011. Highmark West Virginia is currently reviewing and analyzing the CMS changes. As Highmark West Virginia finalizes plans for the annual update, we will provide an update to our provider community. The new codes for 2011 were added effective Jan. 1, 2011.

Anesthesia Crosswalk 2011 Update

Highmark West Virginia has received the Anesthesia Crosswalk 2011 from the ASA. Below are changes which were implemented on Feb. 28, 2011, for Highmark West Virginia commercial lines of business and Highmark Health Insurance Company (HHIC) FreedomBlueSM PPO. The first chart below identifies new CPT codes as of Jan. 1, 2011.

The second chart identifies CPT codes existing prior to Jan. 1, 2011, where there was a change from the Anesthesia Crosswalk from 2010 to the current 2011 version.

2011 New Codes			
NEW CPT CODES	Description	CPT Anes Code	Base Unit Value
22552	Spinal Surgery	00670	13
31296	Nasal Surgery	00160	5
31297	Nasal Surgery	00160	5
33620	Cardiac Surgery	00560	15

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Contracting/Reimbursement Update

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2011 New Codes			
NEW CPT CODES	Description	CPT Anes Code	Base Unit Value
33621	Cardiac Surgery	00560	15
37220	Vascular surgery	01924	6
37221	Vascular surgery	01924	6
37224	Vascular surgery	01924	6
37226	Vascular surgery	01924	6
37227	Vascular surgery	01924	6
37228	Vascular surgery	01924	6
37229	Vascular surgery	01924	6
37230	Vascular surgery	01924	6
37231	Vascular surgery	01924	6
43228	Endoscopic procedure	00540	12
43334	Esophageal surgery	00540	12
43336	Esophageal surgery	00540	12
43337	Esophageal surgery	00540	12
43755	Laparoscopic procedure	00740	5
43756	Placement of tube	00740	5
53860	Female surgery	00910	3
66175	Eye Surgery	00140	5

2011 Revisions to Existing Codes			
Existing Code	Description	CPT Anes Code	Base Unit Value
26111	Hand/finger surgery	00400	3
26115	Hand/finger surgery	00400	3
33234	Pacemaker removal	00520	6
33235	Pacemaker removal	00006	6
50230	Kidney surgery	00862	7
57109	Female surgery	00904	7
63650	Spinal Surgery	01936	5
64479	Injection procedure	01936	5
64483	Injection procedure	01936	5
64714	Nerve surgery	00630	8
97597	Skin Debridement	00300	5

MEDICAL POLICY UPDATES

As an added enhancement to our Provider News, Mountain State Blue Cross Blue Shield communicates Medical Policy updates in each issue.

Our medical policies are also available online through NaviNet® or at www.highmarkbcbswv.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 keyword, policy number or procedure code.

Recent updates or changes are as follows:

More Medical Policies Include Place of Service Designations

Highmark Blue Cross Blue Shield West Virginia is including place of service designations on seven additional medical policies. For more details, please see "Place of service designations added to some medical policies" on Page 20 in the August 2010 Provider News.

Highmark West Virginia will add place of service designations to these medical policies on June 13, 2011:

Policy number	Policy topic	Place of service
G-24*	Obesity	Outpatient
S-93	Percutaneous (Transluminal) Balloon Valvuloplasty	Inpatient
S-109	Transcatheter Arterial Chemoembolization	Inpatient
S-122	Heart Transplantation	Inpatient
S-125	Heart/Lung Transplantation	Inpatient
S-155	Gastric Electrical Stimulation, Gastric Pacing	Inpatient
S-170*	Infrared Coagulation of Hemorrhoids	Outpatient

Note: For more information about those policies annotated with an asterisk, please see the "Additional guidelines" section below.

Additional guidelines

Highmark West Virginia will consider each person's unique clinical circumstances with respect to requests for coverage of inpatient services typically performed in an outpatient setting.

In addition to the policies listed above, some of those circumstances are provided in the following examples:

- ▶ Medical Policy G-24, Obesity
The adjustable gastric lapband procedure is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances, including but not limited to, patients with:
- ▶ Significant cardiac co-morbidity
 - myocardial infarction
 - coronary artery disease
 - congestive heart failure
 - previous coronary artery bypass graft or stent
 - significant valvular disease
 - previous valve repair or replacement
 - abnormal stress test
 - significant arrhythmia requiring postoperative monitoring
 - any patient taking digoxin or plavix
- ▶ Significant pulmonary co-morbidity
 - DVT or PE
 - emphysema
 - COPD
 - severe restrictive defect
 - significant dyspnea on exertion
 - poorly controlled asthma
- ▶ Poorly controlled diabetes
- ▶ Anticoagulant therapy

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- ▶ Known coagulopathy
- ▶ Diabetic patients with BMI > 60
- ▶ Medical Policy S-170, Infrared Coagulation of Hemorrhoids
Infrared coagulation of hemorrhoids is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances including, but not limited to, patients with active bleeding, hematocrit <25 percent, platelets <60,000, or INR>2.

Watch for more announcements about place of services additions to Highmark West Virginia's medical policies in upcoming issues of *Provider News*.

Corrections to October 2010 *Provider News*: Place of Service Designation Included on Certain Medical Policies

In "Place of service designations included on certain medical policies" on Pages 17-19 in the October 2010 *Provider News*, certain information was incorrect.

Highmark West Virginia is now providing you with the following corrections:

Policy number	Policy topic	Place of service	Effective date
S-40*	Implantable Infusion Pump	Outpatient	June 13, 2011
S-77*	Endometrial Ablation	Outpatient	Feb. 21, 2011
S-81	Congenital Cleft Palate Repair (Place of service removed)	N/A	N/A
S-106*	Treatment of Urinary Incontinence/ Periurethral Bulking Agents	Outpatient	Feb. 21, 2011
S-129*	Mastectomy and Reconstructive Surgery	Inpatient Outpatient	June 13, 2011

S-130*	Cryosurgery of the Liver	Outpatient	Feb. 21, 2011
S-143*	Donor Leukocyte Infusion for Hematologic Malignancies that Relapse after allogeneic Stem Cell transplant	Outpatient	Feb. 21, 2011
S-181*	Coronary Revascularization	Inpatient Outpatient	Feb. 21, 2011

Here are examples of circumstances that would allow a service that is typically performed in the outpatient setting to be performed inpatient:

- ▶ S-40, Implantable Infusion Pump
The implantation of an infusion pump is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the need to titrate medication to achieve control of symptomatology and the need for on-going monitoring for potential complications related to the specific medication being administered.
- ▶ S-77, Endometrial Ablation
Endometrial ablation is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, current therapeutic anticoagulant therapy or a hematocrit <25%, hemoglobin <8.3 g/dL.
- ▶ S-106, Treatment of Urinary Incontinence/ Periurethral Bulking Agents
Treatment of urinary incontinence with periurethral bulking agents is typically an outpatient procedure.
- ▶ S-129, Mastectomy and Reconstructive Surgery
When performed for non-cancer diagnoses or independent of the mastectomy or the breast reconstruction flap, nipple/areola reconstruction, nipple tattooing, preparation of moulage

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for custom breast implants, augmentation mammoplasty, reduction mammoplasty, and mastopexy are typically outpatient procedures that are only eligible for coverage as inpatient procedures in special circumstances, including, but not limited to, current therapeutic anticoagulation therapy or when performed in conjunction with a service typically performed in the inpatient setting.

► **S-130, Cryosurgery of the Liver**

Cryosurgery of the liver is typically an eligible outpatient procedure which may be eligible for coverage when performed in an inpatient setting only when special conditions exist, including, but not limited to, patients with intractable pain or jaundice with INR>2.

► **S-143, Donor Leukocyte Infusion for Hematologic Malignancies that Relapse after Allogeneic Stem Cell Transplant**

Donor leukocyte infusion for hematologic malignancies that relapse after allogeneic stem cell transplant is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, chemotherapy related complications such as T >100.4, hematocrit <18%, hemoglobin <6.0 g/dL.

► **S-181, Coronary Revascularization**

Percutaneous coronary revascularization is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, unstable angina; and, under special conditions, including but not limited to, current therapeutic anticoagulation therapy, severe pulmonary co-morbidity, insulin-dependent diabetes with unstable blood sugar.

**Corrections to December 2010 *Provider News*:
Place of Service Designations Included on
Certain Medical Policies**

In "Place of service designations included on certain medical policies" on Page 15 in the December 2010 *Provider News*, certain information was incorrect.

Highmark West Virginia is now providing you with the following corrections:

Policy number	Policy topic	Place of service	Effective date
S-75*	Extracorporeal Photopheresis	Outpatient	May 23, 2011
S-114*	Uterine Artery Embolization for Uterine Fibroids	Outpatient	May 23, 2011

Here are examples of circumstances that may allow a service that is typically performed in the outpatient setting to be performed inpatient:

► **S-75, Extracorporeal Photopheresis**

Extracorporeal photopheresis is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances including, but not limited to, current therapeutic anticoagulant therapy or for patients experiencing symptoms of acute rejection of the transplanted organ.

► **S-114, Uterine Artery Embolization for Uterine Fibroids**

Uterine artery embolization for uterine fibroids is typically an outpatient procedure that is only eligible for coverage as an inpatient procedure in special circumstances including, but not limited to, current therapeutic anticoagulant therapy or a hematocrit <25 percent, hemoglobin <8.3 g/dL.

**Intraoperative Neurophysiology Monitoring
Eligibility Outlined**

Highmark West Virginia considers intraoperative neurophysiology monitoring (INM) an eligible service when it's performed by an eligible provider (see eligible provider requirements) for any of these specific indications:

► **Intracranial surgery**

- Cerebral vascular aneurysms
- Surgical management or embolization of intracranial arteriovenous malformations
- Arteriography, during which there is a test occlusion of the carotid artery
- Clipping of intracranial anterior or posterior circulation aneurysm
- Resection of brain tissue close to the primary motor or other eloquent cortex and requiring brain mapping

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- Protection of cranial nerves
 - Resection of tumors that affect optic, trigeminal, facial, auditory nerves
 - Resection of cavernous sinus tumors
 - Resection of epileptogenic brain tissue or tumor
 - Excision of posterior fossa tumor involving any motor cranial nerve, cranial nerve nuclei, or neural (motor/sensory) pathway
 - Surgery for intracranial tumor where there is risk of injury to brain vascular supplies
 - Posterior fossa decompression for chiari malformation
 - Surgery for basal ganglia movement disorders
 - Surgery for intractable movement disorders
 - Microvascular cranial nerve decompression
 - Surgery for glomus jugulare tumor
 - Implantation of electrodes for deep brain stimulation
- Orthopedic surgery
- Leg lengthening procedures, where there is traction on the sciatic nerve or other nerve trunks
 - Revision of total hip replacement
 - Hip resurfacing
 - Repair of pelvic and acetabular fracture
 - Placement of sacroiliac screw fixation
 - Total arthroscopic shoulder repair
 - Open shoulder repair
 - Thermal shoulder capsulorraphy
 - Removal of first rib for management of thoracic outlet syndrome
- Otolaryngologic procedures
- Parotidectomy when there is risk of injury to the facial nerve and its branches
 - Thyroidectomy when there is risk of injury to the recurrent and superior laryngeal nerves
 - Partial or radical neck dissection
 - Revision mastoidectomy
 - Tympanomastoidectomy
 - Translabyrinthine excision of acoustic neuromas
- Vestibular nerve section
 - Facial nerve decompression
 - Repair of middle fossa cerebrospinal fluid leak
 - Endolymphatic shunt for Meniere's Disease
 - Oval or round window graft
- Peripheral nerve surgery
- Excision of neuromas of peripheral nerves of brachial plexus, when there is risk to major sensory or motor nerves
 - Brachial plexus reconstruction
- Robotic-assisted procedures
- Preservation of recurrent laryngeal nerves during robotic-assisted thyroidectomy
 - Prevention of brachial plexus or other peripheral nerve injury during robotic-assisted laparoscopic hysterectomy
- Spinal procedures
- Surgery for arteriovenous malformation of spinal cord
 - Correction of scoliosis or kyphosis, or deformity of spinal cord involving traction on the cord
 - Surgery for degenerative spinal disorders
 - Decompressive procedures on the spinal cord or cauda equina carried out for myelopathy or claudication where the function of the spinal cord or spinal nerves and associated vascular supplies and/or spinal nerve roots are at risk for iatrogenic injury
 - Spinal instrumentation requiring pedicle screw anchoring or insertion, interbody fusion cages, or distraction devices where there is risk of injury to the spinal cord or nerve roots
 - Protection of the spinal cord where work is performed in close proximity to the spinal cord as in the placement or removal of hardware or where there have been previous surgical interventions
 - Placement of spinal cord stimulator in the cervical or thoracic spine
 - Surgery for spinal stabilization due to traumatic injury or disease
 - Surgery for spinal cord tumors, for example, cauda equina excision
 - Surgery for spinal dysraphism

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- Surgical treatment for syringomyelia
- Excision of primary or metastatic spinal bone tumor

- ▶ Vascular, cardiovascular or endovascular procedures
 - Surgery of the aortic arch, its branch vessels, or thoracic aorta, when there is a risk of cerebral ischemia
 - Distal aortic procedures, in which there is a risk of ischemia to the spinal cord
 - Carotid artery surgery, including carotid endarterectomy
 - Resection of carotid body tumor
 - Procedures requiring circulatory arrest with hypothermia, (not including surgeries performed under circulatory bypass, for example, coronary artery bypass or ventricular aneurysms)
 - Arteriography, during which there is a test occlusion of the artery
 - Therapeutic embolization for aneurysm, arteriovenous malformation, or fistula
 - Transluminal angioplasty

Eligible provider requirements

Highmark West Virginia considers INM an eligible service when it's performed by either a licensed physician, or an INM-certified technician.

Highmark West Virginia will consider the actual interpretation of INM data eligible only when it's performed by a licensed physician (MD or DO). The physician must be performing the service in real time. The physician may be in the operating room suite or at a remote site with the monitoring data relayed via digital transmission or closed circuit television. When digital transmission or closed circuit television is used, there must be the ability for continuous or immediate contact with the operating surgeon to ensure that information about the patient's status can be immediately communicated. The interpreting physician must be someone other than the operating physician. The written interpretation of the INM data must be documented within the patient's medical record.

Medical Necessity Criteria for Percutaneous Balloon Valvuloplasty Modified

Effective June 13, 2011, Highmark West Virginia will consider percutaneous balloon valvuloplasty medically necessary for these indications:

- ▶ Pulmonic balloon valvotomy for pulmonary stenosis (ICD-9 CM diagnosis codes 424.3, 746.02)

Highmark West Virginia may consider percutaneous balloon valvuloplasty medically necessary in symptomatic patients or for patients with right ventricular to pulmonary artery peak gradient of 40 mm Hg or greater.

- ▶ Aortic balloon valvotomy for aortic stenosis (ICD-9-CM diagnosis codes 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 746.3)

Highmark West Virginia may consider percutaneous aortic balloon valvuloplasty medically necessary for adolescent patients and young adults in their early twenties with aortic stenosis and who meet any one of the following criteria:

- Symptoms of angina, syncope, and dyspnea on exertion, with catheterization peak gradient ≥ 50 mm Hg.
- Catheterization peak gradient > 60 mm Hg.
- New-onset ischemic or repolarization changes on EKG at rest or with exercise (ST depression, T-wave inversion over left precordium) with a gradient > 50 mm Hg.
- Catheterization peak gradient > 50 mm Hg if the patient wants to play competitive sports or desires to become pregnant.
- For palliative use in children with congenital critical aortic valve stenosis, until the child is old enough to have a valve replacement.

Highmark West Virginia may consider percutaneous aortic balloon valvuloplasty medically necessary for adult patients with aortic stenosis as a bridge to surgery in hemodynamically unstable patients who are at high risk for aortic valve replacement.

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- ▶ Mitral balloon valvotomy for mitral valve stenosis (ICD-9 CM diagnosis codes 394.0, 394.2, 396.0, 396.1, 396.8, 746.5)

Highmark West Virginia may consider percutaneous balloon valvuloplasty medically necessary for patients with mitral valve stenosis who meet any of these criteria:

- Symptomatic patients (NYHA functional Class II, III, or IV), with moderate or severe mitral stenosis and valve morphology favorable for percutaneous balloon valvotomy in the absence of left atrial thrombus or moderate to severe mitral regurgitation.
- Asymptomatic patients with moderate or severe mitral stenosis (moderate or severe mitral stenosis is defined as mitral valve area ≤ 1.5 cm²) and valve morphology favorable for percutaneous balloon valvotomy who have pulmonary hypertension (pulmonary artery systolic pressure >50 mm Hg at rest or 60 mm Hg with exercise) in the absence of left atrial thrombus or moderate to severe mitral regurgitation.
- Patients with NYHA functional Class III-IV symptoms, moderate or severe mitral stenosis (moderate or severe mitral stenosis is defined as mitral valve area ≤ 1.5 cm²), and a nonpliable calcified valve who are at high risk for surgery in the absence of left atrial thrombus or moderate to severe mitral stenosis.
- Members in the second and third trimesters of pregnancy in whom balloon valvuloplasty would be expected to achieve hemodynamic and symptomatic improvement with minimal risk to the mother and fetus.
- Members with favorable valve anatomy and a cumulative score of eight or less on echocardiographic criteria, for example, a pliable, non-calcified valve with mild subvalvular disease and no or mild mitral regurgitation.

How to report percutaneous balloon valvuloplasty
Use the following codes, as appropriate, to report percutaneous balloon valvuloplasty:

- ▶ 92986—percutaneous balloon valvuloplasty; aortic valve
- ▶ 92987—percutaneous balloon valvuloplasty; mitral valve

- ▶ 92990—percutaneous balloon valvuloplasty; pulmonary valve

If a percutaneous balloon valvuloplasty does not meet Highmark West Virginia's medical necessity criteria, Highmark West Virginia will deny it as 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.

Segmental Pneumatic Appliance for Use with Pneumatic Compressor No Longer Covered for the Trunk or Chest

On June 13, 2011, Highmark West Virginia will begin to consider a segmental pneumatic appliance used with a pneumatic compressor for the treatment of lymphedema of the trunk or chest experimental or investigational.

Even though these devices have received FDA approval, there is a lack of long-term studies demonstrating the effectiveness of these devices for the treatment of truncal or chest edema. Therefore, they are not eligible for reimbursement. A participating, preferred, or network provider may bill the member for the denied device.

Report the following codes, as appropriate, when you bill for segmental pneumatic appliances for the trunk or chest:

- ▶ E0656—segmental pneumatic appliance for use with pneumatic compressor, trunk
- ▶ E0657—segmental pneumatic appliance for use with pneumatic compressor, chest

Refer to Highmark West Virginia Medical Policy Bulletin E-7 for further information on Pneumatic Compression Devices.

Highmark West Virginia determines coverage for durable medical equipment according to individual or group customer benefits.

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Cryosurgical Ablation and Radiofrequency Ablation of Renal Tumors Coverage Criteria Revised

Cryosurgical ablation of renal tumors

As of June 13, 2011, Highmark West Virginia considers renal cryosurgery eligible for select patients with small renal cell carcinoma less than 4cm when any of the following criteria is met:

- ▶ Individuals who are considered high-risk surgical candidates;
- ▶ Individuals with renal insufficiency, as defined by a glomerular filtration rate of less than or equal to 60 ml/min/m²; or
- ▶ Individuals with one kidney.

Radiofrequency ablation of renal tumors

Beginning June 13, 2011, Highmark West Virginia covers radiofrequency ablation (RFA) of renal cell carcinoma for patients with small renal tumors less than 4cm when either of the following criteria is met:

- ▶ Preservation of kidney function is necessary, that is, the patient has one kidney or renal insufficiency defined by a glomerular filtration rate of less than 60 ml/min/m², and standard surgical approach, that is, resection of renal tissue, is likely to substantially worsen kidney function; or
- ▶ The patient is not considered a surgical candidate.

Highmark West Virginia considers renal cryosurgery and RFA of renal tumors reported for any other indications not medically necessary. Therefore, they are not covered. A participating, preferred, or network provider may not bill the member for the denied service unless the provider 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.

How to report cryosurgical ablation and RFA of renal tumors

Use the following procedure codes, as appropriate, to report cryosurgical ablation or RFA of renal tumors:

- ▶ 50250—ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed
- ▶ 50542—laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed
- ▶ 50592—ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency
- ▶ 50593—ablation, renal tumor(s), unilateral, percutaneous, cryotherapy

Desensitization for Heart Transplant Coverage Guidelines Explained

Sensitization is problematic in human orthotopic heart transplantation (OHT) because identification of a crossmatch-negative donor extends the candidates time on the waiting list and increases the risk of rejection. Even if the crossmatch is negative, sensitized OHT recipients have significantly lower survival and experience earlier and more severe cardiac rejection episodes. The development of donor-specific antibodies post-OHT also has a deleterious effect on the outcome of such operations.

Highmark West Virginia is adopting the following recommendations published by **The International Society of Heart and Lung Transplantation**. Highmark West Virginia is adding these new coverage guidelines to Highmark West Virginia Medical Policy I-25, Desensitization of Heart and Kidney Transplant.

Recommendations for the risk-assessment and prophylaxis strategies for allosensitized heart transplant candidates are:

Class IIa:

1. A complete patient sensitization history, including previous panel reactive antibody (PRA) determinations, blood transfusions, pregnancies, implant of homograft materials, previous transplantation, and use of a ventricular assist device is required to assess the risk of heart allograft anti-body-mediated rejection.

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2. A PRA \geq 10 percent indicates significant allosensitization. It should raise the question as to whether therapies aimed at reducing allosensitization should be instituted to minimize the need for a prospective donor or recipient crossmatch.
3. The results of the retrospective donor recipient crossmatch may be considered to make decisions regarding immunosuppressive therapy.

Class IIb:

1. Desensitization therapy should be considered when the calculated PRA is considered by the individual transplant center to be high enough to significantly decrease the likelihood for a compatible donor match or to decrease the likelihood of donor heart rejection where unavoidable mismatches occur.
2. Choices to consider as desensitization therapies include IV immunoglobulin (Ig) infusion, plasmapheresis, either alone or combined, rituximab, and in very selected cases, splenectomy.

If the use of a desensitization treatment protocol does not meet Highmark West Virginia's coverage guidelines or is used for any other transplant other than heart or renal, Highmark West Virginia considers it experimental or investigational. In this case, it is not covered. A participating, preferred, or network provider may bill the member for the non-covered service.

Highmark West Virginia determines coverage for desensitization therapy according to individual or group customer benefits.

Ozurdex Covered for Treating Non-Infectious Uveitis Affecting the Posterior Segment of the Eye

Highmark West Virginia will cover Ozurdex® for the Food and Drug Administration approved indication of the treating non-infectious uveitis that affects the posterior segment of the eye. The FDA has also approved Ozurdex for the treatment of macular edema following branch retinal vein occlusion or central retinal vein occlusion.

If Ozurdex is used for any other indication, Highmark West Virginia will consider it experimental or investigational; therefore, it is not covered. A participating, preferred, or network provider may bill the member for the non-covered implant.

Report Ozurdex with procedure code J7312— injection, Dexamethasone, intravitreal implant, 0.1 mg.

Highmark West Virginia determines coverage for Ozurdex according to individual or group customer benefits.

Oncotype DX Recurrence Score Assay Eligible for Certain Breast Cancer Patients

Effective June 13, 2011, Highmark West Virginia covers the Oncotype DX Recurrence Score Assay for predicting recurrence of breast cancer for patients who meet these criteria:

- ▶ Hormone-receptor-positive,
- ▶ HER2-negative,
- ▶ Node-negative or not greater than 2 mm axillary node metastasis, and
- ▶ Size of 0.6–1 cm and moderate or poorly differentiated or unfavorable features or size larger than 1 cm.

The patient and the physician must also discuss the potential results of the test before testing. They must also agree to use the results to guide decisions as to whether or not adjuvant chemotherapy will be used.

Highmark West Virginia considers all other indications for the 21-gene RT-PCR assay, that is, Oncotype DX, including determination of recurrence risk in breast cancer patients who are lymph node-positive experimental or investigational. A participating, preferred, or network provider may bill the member for the denied test.

Use code S3854—gene expression profiling panel for use in the management of breast cancer treatment—to report the Oncotype DX Recurrence Score Assay.

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Patient age, tumor size, histology, status of the axillary lymph nodes, histologic type, and hormone receptor status are the conventional methods of determining prognosis in breast cancer. However, patients with the same set of risk factors can have markedly different prognoses. For example, not all patients with larger breast primaries or positive axillary lymph nodes are destined to progress to metastatic disease, and yet adjuvant chemotherapy is routinely recommended in all of these patients. A set of more sensitive and specific risk factors would improve patient selection criteria for adjuvant therapy and other aspects of the treatment of breast cancer.

Recently, there has been interest in examining gene expression in tumor tissue as a prognostic factor. For example, RNA can be isolated from tumor tissue, used to generate complementary RNA, which is then labeled and allowed to hybridize to microarrays that can contain up to 25,000 human genes. Positive results are detected by fluorescent intensities. Patterns of genetic expression can then be compared to outcome databases to identify specific patterns that are associated with prognosis. The Oncotype DX™ is an example of this technology.

Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Coverage now Includes Parkinsonian and Other Disabling Tremors

Effective Jan. 31, 2011, Highmark West Virginia expanded its coverage for stereotactic radiosurgery and stereotactic body radiation therapy to include patients with Parkinsonian and other essential or disabling tremors that are refractory to conventional therapy and/or who are not candidates for open surgical procedures.

Xiaflex Covered for Adults with Dupuytren's Contracture

When Xiaflex (collagenase, clostridium histolyticum) is a benefit, Highmark West Virginia will cover it for treating adult patients with Dupuytren's contracture with a palpable cord.

Treatment of Dupuytren's contracture consists of an injection of 0.58 mg collagenase into a palpable Dupuytren's cord with a contracture of a metacarpophalangeal joint or a proximal interphalangeal joint followed approximately 24 hours

after the injection by manipulation of the finger if contracture persists.

Injections and finger extension procedures may be administered up to three times per cord at approximately 4-week intervals.

If Xiaflex is used for any other diagnosis, Highmark West Virginia will consider it experimental or investigational. It is not covered in this instance. A participating, preferred, or network provider may bill the member for the non-covered drug.

Report Xiaflex with procedure code J0775—injection, collagenase, clostridium histolyticum, 0.01 mg.

Highmark West Virginia determines coverage for Xiaflex according to the individual or group customer benefits.

External Counterpulsation Covered for Disabling Angina

Highmark West Virginia covers external counterpulsation (ECP), procedure code G0166, for patients who:

1. have been diagnosed with disabling angina (Class III or Class IV, Canadian Cardiovascular Society Classification score or equivalent classification), and
2. who are not readily amenable to surgical intervention.

Effective June 13, 2011, Highmark West Virginia will pay for ECP only when the patient meets criteria Nos. 1 and 2 and one of the following diagnosis codes are reported:

- ▶ ICD-9-CM diagnosis code 413.0 — angina decubitus
- ▶ ICD-9-CM diagnosis code 413.1 — Prinzmetal angina
- ▶ ICD-9-CM diagnosis code 413.9 — other and unspecified angina

If ECP is reported for any other indication, Highmark West Virginia will deny it as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied ECP unless he or

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she has given advance written notice, informing the member that the ECP 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 ECP. The signed agreement should be maintained in the provider's records.

A full course of therapy usually consists of up to 35 treatments.

Use code G0166—external counterpulsation, per treatment session—to report this procedure.

Highmark West Virginia Covers Gastric Electrical Stimulation for Gastroparesis

Beginning June 13, 2011, a medical director will consider gastric electrical stimulation or gastric pacing for coverage on an individual consideration basis. The medical director will base his or her coverage determination on the Food and Drug Administration's (FDA) approval for members for whom gastroparesis is refractory to medical management.

Gastric electrical stimulation is FDA approved as a Humanitarian Device Exemption for the treatment of chronic, intractable (drug refractory) nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology.

Highmark West Virginia considers gastric electrical stimulation not medically necessary as an initial treatment for gastroparesis. If the medical director does not approve gastric electrical stimulation, Highmark West Virginia will deny it as 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.

A Humanitarian Use Device may only be used in facilities that have established a local institutional review board (IRB) to supervise clinical testing of devices. The IRB must approve the use of the device to treat or diagnose the specific disease. Highmark

West Virginia may request documentation of IRB approval to ensure compliance with the FDA-labeled indications. This documentation must be available upon request.

Reporting gastric electrical stimulation: procedure codes and diagnosis code

Use the following codes, as appropriate, to report this service:

- ▶ 43647—laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
- ▶ 43648—laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
- ▶ 43881—implantation or replacement of gastric neurostimulator electrodes, antrum, open
- ▶ 43882—revision or removal of gastric neurostimulator electrodes, antrum, open

Use codes 95980-95982, as appropriate, to report electronic analysis of implanted neurostimulator pulse generator system, gastric neurostimulation pulse generator/transmitter; intraoperative, with programming or subsequent electronic analysis with or without reprogramming.

Report gastroparesis with ICD-9-CM diagnosis code 536.3.

Lumizyme Coverage Guidelines Outlined

Highmark West Virginia will provide coverage for alglucosidase alfa (Lumizyme®) for patients ages 8 years and older with late-onset (non-infantile) Pompe disease (GAA deficiency) who do not have evidence of cardiac hypertrophy.

The safety and effectiveness of Lumizyme have not been evaluated in controlled clinical trials in infantile-onset patients, or in late (non-infantile) onset patients less than 8 years of age.

The recommended dosage of Lumizyme is 20 mg/kg body weight administered every two weeks as an intravenous infusion.

If Lumizyme is used for any other condition, Highmark West Virginia considers it experimental or investigational. It is not covered. A participating,

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

Report Lumizyme with procedure code J0220—Alglucosidase alfa, 10 mg.

Highmark West Virginia determines coverage for Lumizyme according to individual or group customer benefits.

Keratoprosthesis Covered for Select Criteria

Highmark West Virginia considers the Boston keratoprosthesis (Boston KPro) covered for the treatment of corneal blindness for these indications:

- ▶ The cornea is severely opaque and vascularized with vision less than 20/400 in the affected eye and lower than optimal vision in the opposite eye;
- ▶ There is documentation of two or more prior failed corneal transplants;
- ▶ The patient should be able to be compliant with postoperative care; and
- ▶ The patient does not have end-stage glaucoma or retinal detachment.

Highmark West Virginia will cover keratoprosthesis when it's reported with one of the following ICD-9-CM diagnosis codes:

- ▶ 369.00-369.08
- ▶ 369.60-369.69
- ▶ 371.00
- ▶ 371.03
- ▶ 996.51
- ▶ 996.69
- ▶ 996.79
- ▶ 996.89

If a keratoprosthesis is used for any other indications, Highmark West Virginia considers it experimental or investigational. A participating, preferred, or network provider may bill the member for the denied keratoprosthesis.

Highmark West Virginia considers keratoprosthesis procedures using an artificial cornea device other

than the Boston KPro experimental or investigational. In these instances, it is not covered. A participating, preferred, or network provider may bill the patient for the non-covered service.

Use procedure code 65770—keratoprosthesis—to report this service.

Use procedure code L8609—artificial cornea—to report the artificial cornea.

Keratoprosthesis is an artificial cornea that is intended to provide vision to patients with severe bilateral cornea disease (such as prior failed corneal transplants, chemical injuries, or certain immunological conditions). This is usually a procedure of last resort in patients not likely to benefit from a corneal transplant or other conventional treatment.

Oncotype DX, Colon Cancer Assay Considered Investigational

Highmark West Virginia considers the use of multi-gene assays for predicting recurrence in colon cancer, for example, Oncotype DX, experimental or investigational. The evidence to date is insufficient to permit conclusions concerning the effect of the 12-gene expression test on health outcomes. A participating, preferred, or network provider may bill the member for the denied test.

Use procedure code 89240—unlisted miscellaneous pathology test—to report multigene assays for predicting recurrence in colon cancer. When you report code 89240, please include a description of the test performed, for example, Oncotype DX, in the narrative section of the electronic or paper claim.

The Oncotype DX® Colon Cancer Assay (Genomic Health, Inc., Redwood City, California) analyzes the expression of a panel of 12 genes from a formalin-fixed paraffin embedded tumor (FPET) specimen using a technique called RT-PCR. A high-throughput, real-time RT-PCR method was developed to analyze the expression of select genes simultaneously. This method is sensitive, precise, reproducible, and has a wide dynamic range. RT-PCR is a mature technology that is routinely used in several clinical applications, including the broadly adopted Oncotype DX Breast Cancer Assay as well as viral load testing for HIV.

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To quantify gene expression, RNA is extracted from manually micro-dissected, FPET tumor tissue and subjected to DNase I treatment. Total RNA content is measured and the absence of DNA contamination is verified. Reverse transcription is performed and is followed by quantitative TaqMan® (Roche Molecular Systems, Inc.) RT-PCR reactions in 384-well plates. The expression of each of seven cancer-related genes is measured in triplicate and then normalized relative to a set of five reference genes.

The Oncotype DX Colon Cancer Assay provides an individualized Recurrence Score that is intended to give patient-specific information to help decide which stage II colon cancer patients should be most appropriately considered for post-surgical chemotherapy. The Recurrence Score is based upon the quantitative expression of the seven cancer genes, normalized to the five reference genes. The Recurrence Score includes seven genes identified as consistently and significantly associated with recurrence free interval in the 1,851 patients from the development studies. These genes include the cell cycle group (Ki-67, MYBL2, C-MYC), the stromal group (FAP, INHBA, BGN), and GADD45B. The pre-specified Recurrence Score gene panel was validated in 1,436 stage II colon cancer patients with tissue from the QUASAR trial.

Negative Pressure Wound Therapy Pumps Eligible for Select Diagnosis Codes

Highmark West Virginia currently covers negative pressure wound therapy (NPWT) pumps for ulcers and wounds in the home and inpatient setting.

Effective June 13, 2011, Highmark West Virginia will cover powered NPWT pumps and related supplies for the following eligible diagnoses (please report the corresponding ICD-9-CM diagnosis codes so that Highmark West Virginia may determine eligibility).

- ▶ For stage III and IV pressure ulcers: 707.23, 707.24
- ▶ For diabetic ulcer of lower extremity, other than pressure ulcer: 249.00-249.91, 250.00-250.93 or 648.00-648.01, and one of the following: 707.10, 707.11, 707.12, 707.13, 707.14, 707.16 or 707.19
- ▶ For venous ulcer of lower extremity, other than pressure ulcer: 454.0, 454.2
- ▶ For arterial insufficiency with ulcer: 440.23, or codes 459.31 or 458.81, and one of the following: 707.10, 707.11, 707.12, 707.13, 707.14, 707.16, or 707.19

- ▶ Complications of a surgically created wound: 998.31-998.32, 998.59, 998.83
- ▶ Open wound of upper or lower limb, complicated: 880.10-880.19, 881.10-881.12, 884.1, 890.1, 891.1, 892.1, 894.1

If the NPWT device and related supplies are supplied for any other diagnosis, Highmark West Virginia will consider the device and related supplies not medically necessary. A participating, preferred, or network provider may not bill the member for the denied NPWT device and related supplies unless he or she has given advance written notice, informing the member that the device and related supplies 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 NPWT device and related supplies. The signed agreement should be maintained in the provider's records.

Use the following codes, as appropriate, to report the NPWT and related supplies:

- ▶ 97605—negative pressure wound therapy, (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
- ▶ 97606—negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
- ▶ A6550—wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories
- ▶ A7000—canister, disposable, used with suction pump, each
- ▶ E2402—negative pressure wound therapy electrical pump, stationary or portable

Refer to Highmark West Virginia Medical Policy E-31 for further guidelines on NPWT devices.

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Highmark West Virginia determines coverage for durable medical equipment according to individual or group customer benefits.

Ranibizumab Covered for Macular Edema Following Retinal Vein Occlusion

Highmark West Virginia will provide coverage for ranibizumab (Lucentis®) for macular edema following retinal vein occlusion (central and branch).

Highmark West Virginia also covers ranibizumab for neovascular (wet) age-related macular degeneration.

If ranibizumab is used for any other diagnosis, Highmark West Virginia considers it experimental or investigational; therefore, it is not covered. A participating, preferred, or network provider may bill the member for the non-covered drug.

The recommended dosage regimen for ranibizumab is 0.5 mg (0.05 mL) to be administered by intravitreal injection once a month (approximately 28 days).

Report ranibizumab with procedure code J2778—Ranibizumab, 0.1 mg.

Highmark West Virginia determines coverage for ranibizumab according to individual or group customer benefits.

Highmark West Virginia Changes Infrared Photocoagulation of Hemorrhoids Coverage Guidelines

Effective June 13, 2011, Highmark West Virginia considers infrared photocoagulation (IRC) medically necessary for the treatment of hemorrhoidal disease in patients with Grade I or Grade II internal hemorrhoids (ICD-9-CM diagnosis code 455.2) that remain symptomatic (usually bleeding or prolapse) despite conservative, medical management of at least six weeks duration. IRC may occasionally be used in patients with symptomatic Grade III internal hemorrhoids.

If IRC of hemorrhoids is reported for any other indications, Highmark West Virginia will deny it as 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.

Use procedure code 46930—destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)—to report IRC of hemorrhoids. Report code 46930 only once per operative session regardless of the number of hemorrhoids treated.

Highmark West Virginia will pay a physician or group only once per patient per global period (90 days), no matter how many IRC treatment sessions occur. Because patients treated with IRC may require additional treatments, it may be considered medically necessary to report this service a maximum of twice in a twelve-month period. It is not appropriate to report IRC as a staged procedure. After this, if IRC treatment has not satisfactorily resolved symptoms, then another method of treatment should be used.

IRC is one of several minimally invasive treatments used in the management of hemorrhoidal disease. While hemorrhoids are a normal part of the anal canal, when they become congested or enlarged and/or move, they can cause symptoms such as bleeding, pruritis, prolapse, and/or pain. Hemorrhoids below the dentate line are classified as external; above the dentate line they are classified as internal. Most clinicians use the grading system established by Banov in 1985:

- ▶ Grade I – internal hemorrhoids that bleed but do not prolapse
- ▶ Grade II – internal hemorrhoids that prolapse and reduce spontaneously, with or without bleeding
- ▶ Grade III – internal hemorrhoids that prolapse and require manual reduction
- ▶ Grade IV – internal hemorrhoids that are prolapsed and cannot be manually reduced (these may include both internal and external components)

Also considered grade IV are acutely thrombosed, incarcerated hemorrhoids.

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IRC delivers pulses of infrared light through a hand-held applicator to the base of a hemorrhoid. This causes thermal coagulation and tissue necrosis, with the development of scar tissue. Blood flow is reduced, the hemorrhoid shrinks, and the mucosa becomes fixed to the underlying tissue, decreasing prolapse. Multiple hemorrhoids can be treated at one time.

Coverage Criteria for Proteomics-Based Testing for the Evaluation of Ovarian Masses Outlined

Highmark West Virginia considers the use of the OVA1 test medically necessary as part of the preoperative evaluation of patients older than age 18 years who have ovarian masses for which surgery is indicated and whose initial independent and radiological evaluation does not indicate the mass is malignant.

Highmark West Virginia considers all other uses of the OVA1 test experimental or investigational, including but not limited to:

- ▶ Screening for ovarian cancer
- ▶ Selecting patients for surgery for an proven benign adnexal mass
- ▶ Evaluation of patients with clinical or radiologic evidence of malignancy
- ▶ Evaluation of patients with nonspecific signs or symptoms suggesting possible malignancy
- ▶ Postoperative testing and monitoring to assess surgical outcome and/or to detect recurrent malignant disease following treatment

In these instances, a participating, preferred, or network provider may bill the member for the denied test.

Use procedure code 84999—unlisted chemistry procedure—to report proteomics-based testing for the evaluation of ovarian (adnexal) masses. When you report code 84999, please include a description of the test performed, for example, OVA1, in the narrative section of the electronic or paper claim.

Proteomics-based testing for the evaluation of ovarian (adnexal) masses, for example, the OVA1 test , (Vermillion, Inc., Fremont, California) is a qualitative serum test that combines immunoassay results for five analytes (CA 125, prealbumin,

apolipoprotein A-1, beta2 microglobulin, and transferrin) into a single numerical score. It is intended to be used in women older than 18 years with adnexal masses who are planning to have surgery for disease that is considered benign using routine clinical and radiologic evaluation. In this patient subset, the test serves as an aid to further assess the likelihood that malignancy is present.

Sleeve Gastrectomy Now Eligible for Select Criteria

Highmark West Virginia now covers sleeve gastrectomy as a first stage of a two-stage procedure or as a sole definitive procedure for the super obese patient when all of the following patient selection criteria are met:

Adult patient selection criteria

- ▶ The patient has a BMI of 50 kg/m2 or greater
- ▶ The patient is at least 18 years of age or older, and
- ▶ The patient has received non-surgical treatment, for example, dietitian or nutritionist consultation, low calorie diet, exercise program, and behavior modification, and those attempts at weight loss have failed.
- ▶ The patient must participate in and meet the criteria of a structured nutrition and exercise program. This includes dietitian or nutritionist consultation, low calorie diet, increased physical activity, behavioral modification, and/or pharmacologic therapy. These program requirements must be documented in the patient's medical record.

This structured nutrition and exercise program must meet all of these criteria:

- a. The nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dietitians and/or nutritionists, and
- b. The nutrition and exercise program(s) must be for a total of 6 continuous months or longer in duration, and

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- c. The nutritional and exercise program must occur within two years before the surgery, and
 - d. The patient's participation in a structured nutrition and exercise program must be documented in the medical record by an attending physician who supervised the patient's progress. A physician's summary letter is not sufficient documentation. Documentation should include medical records of the physician's on-going assessments of the patient's progress throughout the course of the nutrition and exercise program. For patients who participate in a structured nutrition and exercise program, medical records documenting the patient's participation and progress must be available for review.
- ▶ The patient must complete a psychological evaluation performed by a licensed mental health care professional and be recommended for bariatric surgery. The patient's medical record documentation should indicate that all psychosocial issues have been identified and addressed.
 - ▶ Patient selection is a critical process requiring psychiatric evaluation and a multidisciplinary team approach. The member's understanding of the procedure and ability to participate and comply with life-long follow-up and the life-style changes, for example, changes in dietary habits, and beginning an exercise program, are necessary to the success of the procedure.

If the patient does not meet all of the patient selection criteria for bariatric surgery, Highmark West Virginia will deny the surgery as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied surgery unless he or she has given advance written notice, informing the member that the surgery 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 surgery. The signed agreement should be maintained in the provider's records.

Report sleeve gastrectomy with procedure code 43775—laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy).

Include the following appropriate ICD-9-CM diagnosis code(s) when your report sleeve gastrectomy:

- ▶ 278.01—morbid obesity
- ▶ V85.43—body mass index 50.0-59.9, adult
- ▶ V85.44—body mass index 60.0-69.9, adult
- ▶ V85.45—body mass index 70 and over, adult

Highmark West Virginia determines coverage for the surgical treatment of morbid obesity according to individual or group customer benefits.

Liver Transplantation to be Covered for Additional Indications

Highmark West Virginia covers liver transplantation for adult patients with end-stage organ failure due to irreversibly damaged livers.

Beginning June 13, 2011, Highmark West Virginia will pay for liver transplantation for the following additional indications for adolescents and adults with either:

- ▶ A Model of End-stage Liver Disease (MELD) score greater than 10; or
- ▶ Who are approved for transplant by the United Network for Organ Sharing (UNOS) Regional Review Board, and
- ▶ For children less than 12 years of age who meet the transplanting institution's selection criteria.

Without an institution's selection criteria, Highmark West Virginia will consider liver transplantation medically necessary for adolescents and adults with a MELD score greater than 10 or who are approved by the UNOS Regional Review Board, and for children who meet the medical necessity indications.

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Medically necessary indications (Note: this is not an all inclusive list):

► Cholestatic diseases

- biliary atresia
- familial cholestatic syndromes
- primary biliary cirrhosis
- primary sclerosing cholangitis with development of secondary biliary cirrhosis

► Hepatocellular diseases

- alcoholic cirrhosis
- chronic active hepatitis with cirrhosis (hepatitis B or C)
- cryptogenic cirrhosis
- idiopathic autoimmune hepatitis
- post necrotic cirrhosis due to hepatitis B surface antigen negative state

► Malignancies

- Primary hepatocellular carcinoma confined to the liver when all of the following criteria are met:
 - a. Any lung metastases have been shown to be responsive to chemotherapy; and
 - b. Member is not a candidate for subtotal liver resection; and
 - c. Member meets UNOS criteria for tumor size and number; and
 - d. There is no identifiable extrahepatic spread of tumor to surrounding lymph nodes, abdominal organs, bone ,or other sites; and
 - e. There is no macrovascular involvement.
- Hepatoblastomas in children when all of these criteria are met:
 - a. Member is not a candidate for subtotal liver resection; and
 - b. Member meets UNOS criteria for tumor size and number; and

- c. There is no identifiable extrahepatic spread of tumor to surrounding lungs, abdominal organs, bone ,or other sites. (Note: spread of hepatoblastoma to veins and lymph nodes does not disqualify a member for coverage of a liver transplant.)

- epithelioid hemangioendotheliomas
- intrahepatic cholangiocarcinomas
- large, unresectable fibrolamellar hepatocellular carcinomas
- Metastatic neuroendocrine tumors (carcinoid tumors, apudomas, gastrinomas, glucagonomas) in persons with severe symptoms and with metastases restricted to the liver, who are unresponsive to adjuvant therapy after aggressive surgical resection including excision of the primary lesion and reduction of hepatic metastases

► Vascular diseases

- Budd-Chiari syndrome
- veno-occlusive disease

► Metabolic disorders and metabolic liver diseases with cirrhosis (Note: this is not an all-inclusive list):

- Alpha 1-antitrypsin deficiency
- hemochromatosis
- inborn errors of metabolism
- protoporphyria
- Wilson's disease

► Miscellaneous

- familial amyloid polyneuropathy
- polycystic disease of the liver

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- portopulmonary hypertension (pulmonary hypertension associated with liver disease or portal hypertension) in persons with a mean pulmonary artery pressure by catheterization of less than 35 mm Hg
- toxic reactions (fulminant hepatic failure due to mushroom poisoning, acetaminophen (Tylenol) overdose, etc.)
- trauma
- hepatopulmonary syndrome when these selection criteria are met:
 - a. arterial hypoxemia (PaO₂ less than 60 mm Hg or AaO₂ gradient greater than 20 mm Hg in supine or standing position); and
 - b. chronic liver disease with non-cirrhotic portal hypertension; and
 - c. intrapulmonary vascular dilatation (as indicated by contrast-enhanced echocardiography, technetium-99 macroaggregated albumin perfusion scan, or pulmonary angiography)

Liver retransplantation

Highmark West Virginia considers liver transplantation in individuals with graft failure of an initial liver transplant, due to either technical reasons or hyperacute rejection medically necessary.

Highmark West Virginia considers retransplantation in individuals due to either chronic rejection or recurrent disease medically necessary if the individual meets the general selection criteria.

Liver transplantation classified as experimental for certain situations

Highmark West Virginia considers liver transplantation experimental or investigational for the following situations:

- ▶ Bioartificial liver transplantation
- ▶ Ectopic or auxiliary liver transplantation
- ▶ Hepatocellular transplantation

- ▶ Malignancies other than those listed as covered above
- ▶ Xenotransplantation

Liver transplantation absolute contraindications

Highmark West Virginia considers liver transplantation not medically necessary for patients with the following absolute contraindications (Note: this is not an all inclusive list):

- ▶ Metastatic cancer
- ▶ Ongoing alcohol and/or drug abuse (evidence for abstinence may vary among liver transplant programs, but generally a 3 month minimum is required)
- ▶ 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, 200cells/mm³) unless the following are noted:
 - CD4 count greater than 200 cells/mm³ for greater than 6 months
 - HIV-1 RNA undetectable
 - on stable anti-retroviral therapy greater than 3 months
 - no other complications from AIDS, for example, opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections, Kaposi's sarcoma or other neoplasm

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If liver transplantation does not meet Highmark West Virginia's coverage criteria, Highmark West Virginia will deny it as 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.

Use the following codes, as appropriate, to report liver transplantation:

47133 47135 47136 47140 47141 47142
47143 47144 47145 47146 47147

Refer to Highmark West Virginia Medical Policy S-121 for further guidelines on liver transplantation.

Highmark West Virginia to Stop Covering Interferential Stimulator

As of June 13, 2011, Highmark West Virginia no longer covers an interferential stimulator. Because there is not enough quality evidence from well-designed trials and peer-reviewed literature that indicate improved health outcomes, Highmark West Virginia now classifies interferential stimulators as experimental or investigational. A participating, preferred, or network provider may bill the member for the denied device.

Highmark West Virginia did cover an interferential stimulator, when it was prescribed by a physician for home use for:

- ▶ Symptomatic relief and management of chronic pain;
- ▶ Reduction of edema; or
- ▶ Improvement in range of motion

For more information about interferential stimulation, please review Highmark West Virginia Medical Policy E-45.

Gilenya First Dose Reporting Guidelines Explained

On Sept. 22, 2010, the Food and Drug Administration (FDA) approved Gilenya®, a sphingosine 1-phosphate receptor modulator indicated for the treatment of patients with relapsing forms of multiple sclerosis, to reduce the frequency of clinical exacerbations and to delay the accumulation of physical disability.

The recommended dose of Gilenya is 0.5 mg orally once daily. Gilenya doses higher than 0.5 mg are associated with a greater incidence of adverse reactions without additional benefit.

Gilenya's prescribing information indicates there is a risk for decrease in heart rate and/or atrioventricular conduction after the first dose. The precautions include observation of all patients for signs and symptoms of bradycardia for six hours after the first dose.

Report this observation with procedure code H0033—oral medication administration, direct observation. H0033 represents six hours of direct observation of the administration of Gilenya. H0033 would typically be billed only once per day.

When patients are registered with the Novartis Gilenya Support Program, they receive services that include a free starter product that's delivered to the patient's first-dose observation site. You should not report charges for the first oral dose that is provided by the manufacturer.

Please refer to Highmark West Virginia Pharmacy Policy J-135, Gilenya (fingolimod), for coverage guidelines.

Highmark West Virginia determines coverage for Gilenya according to individual or group customer benefits.

Transcatheter Arterial Chemoembolization Coverage Guidelines Revised

Effective, June 13, 2011, Highmark West Virginia considers transcatheter arterial chemoembolization (TACE) eligible for these indications:

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- ▶ Treatment of hepatocellular cancer or cholangiocarcinoma that is unresectable but confined to the liver and not associated with portal vein thrombosis.
- ▶ Treatment of liver metastasis in symptomatic patients with metastatic neuroendocrine tumors, or metastatic colon cancer who are not candidates for surgical resection.
- ▶ Treatment of liver metastasis in patients with liver-dominant metastatic uveal melanoma.
- ▶ As a bridge to transplant in patients with hepatocellular cancer where the intent is to prevent further tumor growth and to maintain a patient's candidacy for liver transplant.

When using TACE as a bridge to transplant the following criteria apply:

- ▶ Single tumor less than 5 cm or no more than three (3) tumors less than 3 cm in size
- ▶ Absence of extra hepatic disease or vascular invasion
- ▶ Child-Pugh score of either A or B

Highmark West Virginia considers TACE experimental or investigational when the above criteria are not met, including, but not limited to, palliative treatment of either primary or secondary malignant disease of the liver that is not associated with a specific liver-related symptom. A participating, preferred, or network provider may bill the member for the denied service.

Use procedure code 37204—transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck—to report this service.

TACE is a treatment modality for unresectable hepatic malignancies. Similar to hepatic arterial infusions, this technique exploits the selective blood supply to the neoplastic lesions provided by the hepatic artery. Chemoembolization is performed by introducing a vascular occlusion agent combined with

cytotoxic drugs into the hepatic artery, which results in dual ischemic and cytotoxic insult to the tumor.

Microprocessor-Controlled Ankle-Foot Prostheses Considered Investigational

Effective June 13, 2011, Highmark West Virginia will consider the microprocessor-controlled ankle or foot prostheses, code L5973, experimental or investigational. A participating, preferred, or network provider may bill the member for the non-covered device.

The microprocessor-controlled ankle or foot prostheses is a system for lower-extremity amputees. Examples include the Proprio Foot and the iPED. With sensors in the feet that determine the direction and speed of the foot's movement, a microprocessor controls the flexion angle of the ankle, allowing the foot to lift during the swing phase and potentially adjust to changes in force, speed, and terrain during the step phase. The intent of the technology is to make ambulation more efficient and prevent falls in patients ranging from the young active amputee to the elderly diabetic patient.

Denosumab Coverage Guidelines Explained

Prolia™ (denosumab) is the first FDA-approved biologically derived agent to treat bone loss caused by osteoporosis. Denosumab, a human IgG2 monoclonal antibody, is indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture.

Highmark West Virginia will apply the following criteria for determining coverage for denosumab:

- ▶ Denosumab is being used to treat osteoporosis and to prevent fractures in postmenopausal women who have a documented bone mineral density T-score <-2.5 establishing the diagnosis of osteoporosis, and
- ▶ The member is taking daily calcium and vitamin D supplements, and
- ▶ The member does not have underlying cause for secondary osteoporosis such as hyperthyroidism, hyperparathyroidism, hypogonadism, chronic estrogen deficiency state (for example, menopause before age 45, bilateral

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oophorectomy), vitamin D deficiency, chronic liver disease, or chronic kidney disease, and

- ▶ The member is intolerant to or has a contraindication to at least two osteoporotic therapies, one of which must be a bisphosphonate, (that is, Actonel®, Fosamax®). Contraindications to bisphosphonate therapy include hypocalcemia, esophageal ulcerations, esophageal stricture, Barrett's esophagitis, active ulcers, and an inability to stand or sit upright for 30 minutes. Other therapies include a selective estrogen receptor modulator, that is, Evista®, calcitonin, or hormone replacement therapy with estrogens, or
- ▶ The member has a documented failure with at least one bisphosphonate (that is, Actonel, Fosamax, Boniva). Failure will be defined as:
 - New osteoporotic fracture despite at least 6 months of bisphosphonate therapy, or
 - A T-Score ≤ -3.0 despite at least 12 months of bisphosphonate therapy.

Effective June 13, 2011, Highmark West Virginia will consider the use of denosumab for any other indication experimental or investigational. In these instances, it is not covered. A participating, preferred, or network provider may bill the member for the non-covered drug.

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

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

New Criteria for Urinary Bladder Tumor Markers Issued

Highmark West Virginia will consider the following urinary bladder tumor markers medically necessary as an adjunct in the initial diagnosis of bladder cancer only in conjunction with current standard diagnostic procedures:

- ▶ BTA *stat*, BTA TRAK (procedure codes 86294, 86316)

- ▶ NMP22, NMP22 BladderChek (procedure codes 86294, 86316)

- ▶ UroVysion (procedure codes 88120, 88121)

Highmark West Virginia considers the ImmunoCyt urinary bladder tumor marker (procedure code 88346) experimental or investigational when it's used to diagnose bladder cancer. A participating, preferred, or network provider may bill the member for the denied test.

Bladder cancer monitoring

Highmark West Virginia will consider the following urinary bladder cancer tumor markers medically necessary as an adjunct in the monitoring of bladder cancer only in conjunction with current standard diagnostic procedures:

- ▶ BTA *stat*, BTA TRAK
- ▶ ImmunoCyt
- ▶ NMP22, NMP22 BladderChek
- ▶ UroVysion

Screening for bladder cancer in asymptomatic patients

Highmark West Virginia considers the use of urinary bladder cancer tumor markers for screening for bladder cancer in asymptomatic patients experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Highmark West Virginia considers the use of all other bladder cancer tumor markers in the diagnosis, monitoring, or screening for bladder cancer experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Multifunction CardioGram Not Covered

Highmark West Virginia considers Multifunction CardioGram (MCG) as a technique to improve the sensitivity of a resting ECG to detect coronary artery disease (CAD) and ischemia experimental or investigational. A participating, preferred, or network provider may bill the member for the denied MCG.

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MCG, an internet-based system, is designed to assist physicians in diagnosing quantitative early detection of CAD ischemia, recent or remote myocardial infarction, localized or regional ischemia, and global ischemia.

Use procedure code 0206T—algorithmic analysis, remote, of electrocardiographic-derived data with computer probability assessment, including report—to report MCG.

Treatment of Gaucher Disease Coverage Guidelines Outlined

Highmark West Virginia covers alglucerase (Ceredase®), imiglucerase (Cerezyme®), and velaglucerase alfa (VPRIV™) as indicated for use as a long-term enzyme replacement therapy for pediatric and adult patients with a confirmed diagnosis of Type I Gaucher disease. Highmark West Virginia covers alglucerase, imiglucerase, or VPRIV when one or more of the following conditions exist:

- ▶ Anemia with hemoglobin of:
 - 10 grams or less for females
 - 12 grams or less for males
- ▶ Thrombocytopenia of 50,000 platelets or less and/or documented episodes of thrombocytopenic bleeding
- ▶ Multiple bony lesions involving marrow and/or cortex (must be more than three bone lesions in number) and/or pathologic fracture of bone
- ▶ Significant hepatomegaly or splenomegaly in association with thrombocytopenia

Effective June 13, 2011, if these drugs are used for any other indications, Highmark West Virginia considers them experimental or investigational. They are not covered. A participating, preferred, or network provider may bill the member for the non-covered drug.

Highmark West Virginia determines coverage for these drugs according to individual or group customer benefits. Ceredase, Cerezyme, or VPRIV is not reimbursable under the prescription drug benefit.

Ceredase, Cerezyme, and VPRIV procedure codes
Report Ceredase (alglucerase) with procedure code J0205—Alglucerase, 10 units

Report Cerezyme (imiglucerase) with procedure code J1786—Imiglucerase, 10 units

Report VPRIV (velaglucerase alfa) with procedure code J3385—Velaglucerase alfa, 100 units

Monitoring Procedures Performed in Conjunction with Administration of Anesthesia Not Paid Separately

If certain monitoring procedures are reported on the same day as the administration of anesthesia, Highmark West Virginia will consider them an integral part of the anesthesia. Highmark West Virginia will not pay for these monitoring procedures as distinct and separate services.

Effective June 13, 2011, if the services listed below are reported on the same day as anesthesia, Highmark West Virginia will combine the charges and will pay for only the anesthesia. The services are not eligible for separate payment. A participating, preferred, or network provider may not bill the member separately for these services in this case.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ▶ ECG or EKG monitoring (procedure codes 93000-93010, 93040-93042)
- ▶ Administration of fluids and/or blood (procedure codes 36430-36460)
- ▶ Respiratory functions, for example, oxygen maintenance (procedure codes 94680-94750, 94770)
- ▶ Oximetry (procedure codes 94760, 94761)
- ▶ Temperature
- ▶ Blood pressure
- ▶ Capnography
- ▶ Mass spectrometry (procedure codes 83788, 83789)

Preoperative and postoperative visits are part of Highmark West Virginia's global anesthesia allowance.

Dynamic Low-Load Prolonged-Duration Stretch Devices Eligible for Treating an Injured Knee, Elbow, Wrist or Finger

Highmark West Virginia considers dynamic low-load prolonged-duration stretch (LLPS) devices (including but not limited to Dynasplint Systems, LMB Pro-glide, EMPI Advance Ultraflex, and Advanced Biomedics) medically necessary for use on the knee, elbow, wrist, or finger in any of these clinical settings:

- ▶ As an addition to physical therapy in the subacute injury or post-operative period (≥ 3 weeks but ≤ 4 months after injury or operation) in patients with signs and symptoms of persistent joint stiffness or contracture:
 - a. For an initial period of up to 4 months; and
 - b. If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be demonstrated; or
- ▶ In the subacute injury or post-operative period (≥ 3 weeks but ≤ 4 months after injury or operation) in a patient whose limited range of motion poses a meaningful (as judged by the physician) functional limitation, and who has not responded to other therapy (including physical therapy);
 - a. For an initial period of up to 4 months; and
 - b. If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be demonstrated; or
- ▶ In the acute post-operative period for patients who have undergone additional surgery to improve the range of motion of a previously affected joint:
 - a. For an initial period of up to 4 months; and
 - b. If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be demonstrated; or

- ▶ For patients unable to benefit from standard physical therapy modalities because of an inability to exercise:

- a. For an initial period of up to 4 months; and
- b. If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be demonstrated.

If there is no significant improvement after 4 months of use, Highmark West Virginia considers dynamic LLPS devices for the knee, elbow, wrist, or finger not medically necessary under any circumstances including but not limited to, for patients unable to benefit from standard physical therapy modalities because of an inability to exercise. A participating, preferred, or network provider may not bill the member for the denied device unless he or she has given advance written notice, informing the member that the device 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 device. The signed agreement should be maintained in the provider's records.

These devices will pay according to Highmark West Virginia's usual payment methodology for durable medical equipment (DME). While some items of DME are for purchase only, numerous DME items can be rented or purchased. If rented, the total rental payments may not exceed the allowable purchase price of the item.

Highmark West Virginia determines coverage for DME according to individual or group customer benefits.

How to report dynamic LLPS devices

Report the following procedure codes, as appropriate, for dynamic LLPS devices for the knee, elbow, wrist, or finger:

- ▶ E1800—dynamic adjustable elbow extension/flexion device, includes soft interface material
- ▶ E1802—dynamic adjustable forearm pronation/supination device, includes soft interface material

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- ▶ E1805—dynamic adjustable wrist extension/flexion device, includes soft interface material
- ▶ E1810—dynamic adjustable knee extension/flexion device, includes soft interface material
- ▶ E1812—dynamic knee, extension/flexion device with active resistance control
- ▶ E1820—replacement of soft interface material, dynamic adjustable extension/flexion device
- ▶ E1825—dynamic adjustable finger extension/flexion device, includes soft interface material

Highmark West Virginia Expands Breast MRI Coverage

Highmark West Virginia expanded its coverage criteria for MRI of the breast on Dec. 27, 2010.

Highmark West Virginia's coverage for MRI of the breast now includes:

- ▶ Patients who are a first-degree relative of a BRCA carrier, but who have not been tested, and
- ▶ Those who have a lifetime risk of breast cancer of 20-25 percent or more as defined by standard breast cancer risk assessment models, such as the Gail Model, BRCAPRO, the Claus Model, or the Tyrer-Cuzick Model.

Certain Lift Devices Not Covered

Effective June 13, 2011, Highmark West Virginia will not cover the following lift devices:

- ▶ Patient lifts used primarily to move a patient in or out of the bathtub (procedure code E0625-patient lift, bathroom or toilet, not otherwise classified)
- ▶ Auto lifts (used to lift a wheelchair into a car, truck or van) (procedure code E1399)
- ▶ Wheelchair lifts or ramps, for example, Wheel-O-Vator lift, (provides access to stairways or car trunks) (procedure code E1399)
- ▶ Ceiling lifts (patient lifts mounted on tracks that are attached to the ceiling) (procedure code E0640-patient lift, fixed system, includes all components/accessories)

- ▶ Platform lifts, stair lifts, and stairway elevators (procedure code E1399)

When your report code E1399, please provide a complete description of the item you provided in the narrative section of the electronic or paper claim.

Because these items do not meet Highmark West Virginia's definition of durable medical equipment or are considered home modifications, Highmark West Virginia will deny them as non-covered. A participating, preferred, or network provider may bill the member for the denied service.

Highmark West Virginia determines coverage for durable medical equipment according to individual or group customer benefits.

Please refer to Highmark West Virginia Medical Policy E-8 for more information on patient lifts.

Stelara Eligible for Treating Plaque Psoriasis

Stelara® (ustekinumab), a human interleukin -12 and -23 antagonist, is indicated as monotherapy for the treatment of adult patients (18 years or older) with moderate to severe plaque psoriasis.

Highmark West Virginia will provide coverage for Stelara when the patient:

- ▶ Has plaque psoriasis that has been present for more than six months with a minimum body surface involvement of 10 percent (In patients with severe disease, localized psoriasis in sensitive areas such as palmar, plantar, and genitalia would meet the 10 percent body surface involvement definition.), and
- ▶ Has failed to adequately respond to standard systemic agents, for example, methotrexate, cyclosporine, or
- ▶ Has failed to adequately respond to standard phototherapy, for example, PUVA, UVB.

Effective June 13, 2011, if ustekinumab is used for any other indication, Highmark West Virginia will consider it experimental or investigational. A participating, preferred, or network provider may bill the member for the non-covered drug.

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Report ustekinumab with procedure code J3357— injection, Ustekinumab, 1 mg.

Highmark West Virginia determines coverage for ustekinumab according to individual or group customer benefits.

Highmark West Virginia Expands Heart Transplantation Coverage Guidelines

Highmark West Virginia considers heart transplantation a covered service for these indications:

Adult clinical indications

- ▶ Terminal cardiac disease (New York Heart Classification III and IV with an estimated life expectancy of less than 12 months)
- ▶ Age - ideally up to 65 years of age
- ▶ Normal, expectantly reversible renal and hepatic function
- ▶ Absence of infection
- ▶ A pulmonary vascular resistance less than six Wood Units and a transpulmonary gradient less than 15 mm Hg that is not responsive to a prostaglandin E infusion
- ▶ Absence of pulmonary infarction in the preceding 4 weeks
- ▶ Blood type compatibility
- ▶ Lymphocyte cross match compatibility in cases where panel reactive antibody level indicates its necessity
- ▶ Absence of coexisting systemic illness that may limit life expectancy or compromise recovery

Pediatric clinical indications

- ▶ Patients with heart failure with persistent symptoms at rest who require one or more of the following:
 - Continuous infusion of intravenous inotropic agents,

- Mechanical ventilator support, or
- Mechanical circulatory support.

▶ Patients with pediatric heart disease with symptoms of heart failure who do not meet the above criteria but who have:

- Severe limitation of exercise and activity (if measurable, such patients would have a peak maximum oxygen consumption <50 percent predicted for age and sex),
- Cardiomyopathies or previously repaired or palliated congenital heart disease and significant growth failure attributable to the heart disease,
- Near sudden death and/or life-threatening arrhythmias untreatable with medications or an implantable defibrillator,
- Restrictive cardiomyopathy with reactive pulmonary hypertension,
- Reactive pulmonary hypertension and potential risk of developing fixed, irreversible elevation of pulmonary vascular resistance that could preclude orthotopic heart transplantation in the future,
- Anatomical and physiological conditions likely to worsen the natural history of congenital heart disease in infants with a functional single ventricle, or
- Anatomical and physiological conditions that may lead to consideration for heart transplantation without systemic ventricular dysfunction.

Absolute contraindications include:

- ▶ Known malignancy, including metastatic cancer,
- ▶ Recent malignancy with high risk of occurrence,
- ▶ Untreated systemic infection making immunosuppression unsafe, including chronic infection; or

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- ▶ Other irreversible end-stage disease not attributed to heart disease

Relative contraindications include:

- ▶ Pulmonary hypertension that is fixed as evidenced by pulmonary vascular resistance greater than five Woods units, or trans-pulmonary gradient greater than or equal to 16 mm/Hg*,
- ▶ Severe pulmonary disease despite optimal medical therapy, not expected to improve with heart transplantation*,
- ▶ History of cancer with a moderate risk of recurrence,
- ▶ Systemic disease that could be exacerbated by immunosuppression, or
- ▶ Psychosocial or dependence affecting ability to adhere to therapy conditions

*Some patients may be candidates for combined heart-lung transplantation (see Highmark West Virginia Medical Policy S-125).

Contraindications to heart transplantation include:

- ▶ Active sepsis or multi-organ failure, (patients can be considered for transplantation after line sepsis has been treated successfully for one week with intravenous antibiotics)
- ▶ Active ulcer disease
- ▶ Drug or alcohol addiction
- ▶ Morbid obesity
- ▶ High risk of life-threatening non-compliance:
 - Inability to make strong commitment to transplantation
 - Cognitive impairment severe enough to limit comprehension of medical regimen
 - Psychiatric instability severe enough to jeopardize incentive for adherence to medical regimen

- Failure to establish stable address or telephone number

- Previous demonstration of repeated non-compliance with medication or follow-up

- ▶ Severe diabetes mellitus with end-organ damage
- ▶ Severe peripheral vascular disease
- ▶ Pulmonary function (FEV, FVC) <60 percent or history of chronic bronchitis
- ▶ Creatinine clearance <40-50 ml/min
- ▶ Bilirubin >2.5 mg/dl. transaminases >2X normal
- ▶ Pulmonary artery systolic pressure >60 mmHg
- ▶ Mean transpulmonary gradient >15mmHg
- ▶ Pulmonary disease of a chronic, restrictive, or obstructive nature requiring either prednisone or frequent bronchodilator therapy.
- ▶ Human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) (diagnosis based on CDC definition of CD4 count, 200cells/mm3) unless the following are noted:
 - CD4 count greater than 200 cells/mm3 for greater than 6 months;
 - HIV-1 ribonucleic acid (RNA) undetectable;
 - On stable anti-retroviral therapy greater than 3 months;
 - No other complications from AIDS, such as opportunistic infection, for example, aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections, or neoplasms, for example, Kaposi's sarcoma, non-Hodgkin's lymphoma.

Heart retransplantation

Highmark West Virginia considers retransplantation in individuals with graft failure of an initial heart transplant, due to hyperacute reaction, chronic rejection, rejection refractory to immunosuppressive therapy, moderate graft vasculopathy and graft coronary artery disease with severe ischemia of heart graft medically necessary.

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Report these procedure codes, as appropriate, for these services:

- ▶ 33940—donor cardiectomy (including cold preservation)
- ▶ 33944—backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation
- ▶ 33945—heart transplantation, with or without recipient cardiectomy

Bi-Directional Static Progressive Stretch Devices and Patient-Actuated Serial Stretch Devices Are Experimental

Highmark West Virginia considers bi-directional static progressive (SP) stretch devices experimental or investigational. A participating, preferred, or network provider may bill the member for the denied devices.

Report the following procedure codes, as appropriate for bi-directional SP stretch devices for the ankle, toe, and shoulder:

- ▶ E1801—static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
- ▶ E1806—static progressive stretch wrist device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
- ▶ E1811—static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
- ▶ E1816—static progressive stretch ankle device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
- ▶ E1818—static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all components and accessories

- ▶ E1821—replacement soft interface material/cuffs for bi-directional static progressive stretch device

- ▶ E1841—static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories

Highmark West Virginia considers patient-actuated serial stretch (PASS) devices, for example, ERMI Knee, MPJ, or Elbow Extensionator® ERMI Knee/Ankle or Shoulder Flexionator®, experimental or investigational. A participating, preferred, or network provider may bill the member for the denied devices.

Please use the not otherwise classified code E1399 when you report PASS devices. When you use code E1399 to report these devices, please include the terminology “patient-actuated serial stretch (PASS) devices” in the narrative section of the electronic or paper claim.

Knee Orthosis Coverage Criteria Modified

Highmark West Virginia is modifying its knee orthosis coverage criteria (Highmark West Virginia Medical Policy O-28). The new coverage criteria will become effective on June 13, 2011.

Highmark West Virginia will begin to deny claims for code L1847-knee orthosis, double upright with adjustable joint with inflatable air support chamber-as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied knee orthosis unless he or she has given advance written notice, informing the member that the device 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 device. The signed agreement should be maintained in the provider's records.

Use code L4002 to report replacement components. Highmark West Virginia will not pay separately for replacement components that are provided at the same time as the initial issue of a base orthosis. In this instance, a participating, preferred, or network provider may not bill the member for the replacement components.

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Therapeutic Paravertebral Facet Joint Nerve Block Eligible for Treating Chronic Pain

Highmark West Virginia considers diagnostic and therapeutic paravertebral facet joint nerve blocks (procedure codes 64490, 64491, 64492, 64493, 64494, 64495, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T) eligible services when they're performed for the assessment and treatment of chronic pain (pain lasting more than 3 months despite appropriate conservative treatment) for patients with any of these conditions:

- ▶ Cervical spondylosis without myelopathy
- ▶ Cervical spondylosis with myelopathy
- ▶ Thoracic spondylosis without myelopathy
- ▶ Lumbosacral spondylosis without myelopathy
- ▶ Spondylosis with myelopathy, thoracic region
- ▶ Spondylosis with myelopathy, lumbar region
- ▶ Cervicalgia
- ▶ Lumbago
- ▶ Sprains and strains of the cervical, thoracic, and lumbar areas of the neck and back
- ▶ Sciatica
- ▶ Sacroiliitis

Conservative treatment includes physical therapy and pharmacotherapies such as non-steroidal anti-inflammatory drugs, muscle relaxants and non-narcotic analgesics.

Highmark West Virginia Adds More Coverage Guidelines for Additional Braces and Supports
Effective June 13, 2011, Highmark West Virginia will determine coverage for braces and supports according to these additional guidelines.

Supportive back brace

Following a strain or sprain, supportive back braces (back supports, lumbosacral supports, support vests) are used support an injured site of the back.

The main effect is to support the injured muscle and reduce discomfort.

Highmark West Virginia will consider a supportive back brace medically necessary for *any* of the following indications:

- ▶ To facilitate healing following an injury to the spine or related soft tissues,
- ▶ To facilitate healing following a surgical procedure on the spine or related soft tissue (see "Postoperative back brace" section),
- ▶ To reduce pain by restricting mobility of the trunk, or
- ▶ To support weak spinal muscles and/or a deformed spine.

Highmark West Virginia considers supportive back braces not medically necessary if they're used for any other indications. A participating, preferred, or network provider may not bill the member for the non-covered supportive back brace.

The following additional criteria apply to custom-fitted and custom-fabricated back braces.

- ▶ Highmark West Virginia considers a custom-fitted back brace (a prefabricated back brace modified to fit a specific member) medically necessary where there is a failure, contraindication, or intolerance to an unmodified, prefabricated (off-the-shelf) back brace.
- ▶ Highmark West Virginia considers a custom-fitted back brace medically necessary as the initial brace after surgical stabilization of the spine following traumatic injury.
- ▶ Highmark West Virginia considers a custom-fabricated back brace (individually constructed to fit a specific member from component materials) medically necessary if there is a failure, contraindication, or intolerance to a custom-fitted back brace.

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If a custom-fitted or custom-fabricated back brace does not meet these criteria, Highmark West Virginia will consider it not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered brace.

Postoperative back brace

Highmark West Virginia will consider postoperative back braces medically necessary to facilitate healing when applied within 6 weeks after a surgical procedure on the spine or related soft tissue.

Highmark West Virginia considers a postoperative back brace used to immobilize the spine following laminectomy with or without fusion and metal screw fixation medically necessary. This brace promotes healing of the operative site by maintaining proper alignment and immobilization of the spine. If a postoperative back brace is used for any other indications, Highmark West Virginia will deny it as not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered brace.

Inflatable lumbar supports

Inflatable lumbar supports do not meet Highmark West Virginia's definition of covered durable medical equipment (DME) because they are not durable (not made to withstand prolonged use) and because they are not mainly used in the treatment of disease or injury or to improve body function lost as the result of a disease or injury. A participating, preferred, or network provider may bill the member for the non-covered inflatable lumbar support.

Protective body socks

Protective body socks do not meet Highmark West Virginia's definition of covered DME because they are not made to withstand prolonged use. A participating, preferred, or network provider may bill the member for the non-covered protective body socks.

Cast-braces (also called fracture braces)

► Comfort, non-therapeutic

Highmark West Virginia considers comfort, non-therapeutic cast-braces medically necessary DME after a fracture or surgery. These braces are

often used after the patient has been in a walking cast. They are usually removable. Highmark West Virginia considers comfort, non-therapeutic cast-braces not medically necessary if they're used for other indications. A participating, preferred, or network provider may not bill the member for the non-covered brace.

Highmark West Virginia covers molded casts, for example, the Cam Walker. They allow the user to remove the cast to bathe the affected extremity and can also be used when a fracture is slow to heal or is non-healing. The use of these removable casts replaces monthly cast changes. A removable cast of this type offers no therapeutic advantages over a non-removable cast.

► Functional cast-brace

Highmark West Virginia considers functional cast-braces medically necessary after a fracture or surgery. These have become the standard brace for certain fractures, including tibial-femoral fractures. The functional cast-brace is used after a short period of standard fracture treatment using a non-weight bearing or partial weight-bearing cast, or immediately after surgery. It allows protected weight bearing, and motion of the joints above and below the fracture. The joints are moved earlier, contractures are prevented, and early healing is affected due to the weight bearing. Examples include PTB cast brace, PTB fracture brace, molded ankle-foot orthosis (MAFO) fracture brace with pelvic band, or Achilles tendon hinged brace.

If a functional cast-brace is used for any other indication, Highmark West Virginia considers it not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered brace.

Rehabilitation braces

Highmark West Virginia will consider post-operative and post-injury braces medically necessary when applied within 6 weeks of surgery or injury.

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If a rehabilitation brace is used for any other indications, Highmark West Virginia considers it not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered brace.

Cervical (neck) braces

Highmark West Virginia considers cervical (neck) braces medically necessary DME for members with a neck injury and other appropriate indications. An example is the Philadelphia Cervical Collar.

Cervical foam neck collars do not meet Highmark West Virginia's definition of covered durable medical equipment because they are not durable, and not made to withstand prolonged use. A participating, preferred, or network provider may bill the member for the non-covered cervical foam neck collar.

Childhood hip braces

Highmark West Virginia considers specialized hip braces medically necessary for children with hip disorders to stabilize the hip and/or to correct and maintain hip abduction. Examples include the Pavlik Harness, Frejka Pillow Splint, and the Friedman Strap.

If these hip braces are used for any other indications, Highmark West Virginia considers them not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered brace.

Braces for congenital defects

Highmark West Virginia will consider orthopedic braces medically necessary in the treatment of congenital defects. Highmark West Virginia also considers replacement braces medically necessary when the member has outgrown the previous brace or because his or her condition has changed such as to make the previous brace unusable. This includes scoliosis braces.

Highmark West Virginia may consider a cervical-thoracic-lumbar-sacral or thoracic-lumbar-sacral orthosis medically necessary for the treatment of scoliosis in juvenile and adolescent patients at high-risk of progression that meets these criteria:

- ▶ Idiopathic spinal curve angle between 25 and 40 degrees, and

- ▶ Spinal growth has not been completed (Risser grade 0-3; no more than 1 year post-menarche in females), or
- ▶ Idiopathic spinal curve angle greater than 20 degrees, and
- ▶ There is documented increase in the curve angle, and
- ▶ At least 2 years growth remain (Risser grade 0 or 1, pre-menarche in females)

If the use of an orthosis for the treatment of scoliosis does not meet Highmark West Virginia's criteria, Highmark West Virginia considers it not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered device.

Wheaton brace

Highmark West Virginia considers a Wheaton Brace medically necessary DME when it's used to treat metatarsus adductus in infants. It replaces the need for serial casting.

If a Wheaton brace is used for any other indications, Highmark West Virginia considers it not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered brace.

Splints and immobilizers

Certain orthopedic problems are routinely treated with splints or splint-like devices. Highmark West Virginia considers the following medically necessary:

- ▶ Acromio-clavicular splint (also called a Zimmer splint)
- ▶ Carpal tunnel splints
- ▶ Clavicle splint (also called a figure-8 splint)
- ▶ Denis Browne Splint for children with clubfoot or metatarsus valgus to maintain and correct abduction
- ▶ Dynasplints (please see Highmark West Virginia Medical Policy O-10, Dynamic Splinting Devices, for specific coverage guidelines)

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- ▶ Finger splints
- ▶ Shoulder immobilizer

Unna boots

Highmark West Virginia considers unna boots medically necessary only for non-fracture care.

Unna boots have no proven value when used in conjunction with fracture treatment. They can be used to treat sprains and torn ligaments, provide protection for other soft tissue injuries, and may be used after certain surgical procedures as a protective cover to promote healing. Occasionally they are used in the first days after a fracture before a cast is put on.

Air casts

Highmark West Virginia considers air casts medically necessary for the treatment of fractures or other injuries, that is, sprains, torn ligaments. Air casts (air splints) are used as an alternative to plaster casts to immobilize an elbow, ankle, or knee.

If an air cast is used for any other indications, Highmark West Virginia considers it not medically necessary. A participating, preferred, or network provider may not bill the member for the non-covered air casts.

Miscellaneous covered services

Highmark West Virginia considers casting of a sprain and casting following surgical procedures medically necessary.

Fiberglass versus plaster casts

The casting material used in fracture care can be either fiberglass or plaster. The choice of material is dictated by the individual situation and is left to the discretion of the treating physician.

Devices that do not meet Highmark West Virginia's medical necessity guidelines will be denied as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied device unless he or she has given advance written notice, informing the member that the device 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.

Please review Highmark West Virginia Medical Policy O-8, Braces and Supports, for a list of associated ICD-9-CM diagnosis codes.

Heart and Lung Transplantation Coverage Criteria Expanded

Highmark West Virginia considers heart and lung transplantation a covered service for select patients with end-stage cardiac and pulmonary disease for the following conditions:

- ▶ Irreversible primary pulmonary hypertension with heart failure
- ▶ Eisenmenger complex with irreversible pulmonary hypertension and heart failure
- ▶ Non-specific severe pulmonary fibrosis
- ▶ Cystic fibrosis with severe heart failure
- ▶ Chronic obstructive pulmonary disease with heart failure
- ▶ Pulmonary fibrosis with uncontrollable pulmonary hypertension or heart failure
- ▶ Emphysema with severe heart failure

Contraindications for heart or lung transplantation include:

- ▶ Systemic or multisystem disease:
 - Persons with potential multi-system diseases such as systemic sclerosis (scleroderma) or other collagen vascular diseases such as systemic lupus erythematosus must be carefully evaluated to ensure that their disease is primarily confined to the lung.

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- Persons with diabetes must be carefully evaluated to rule out significant diabetic complications such as nephropathy, neurology, or retinopathy.

- ▶ Active malignancy
- ▶ Active extrapulmonary infections, including hepatitis B and C, and immunodeficiency virus
- ▶ Active pulmonary fungal infections
- ▶ Irreversible renal or hepatic dysfunction
- ▶ Mechanical ventilation
- ▶ Chronic high-dose steroid therapy (>20mg prednisone or equivalent per day)
- ▶ Current drug, alcohol, or tobacco abuse
- ▶ Unstable psychological profile
- ▶ Body weight outside 20 percent of ideal range
- ▶ Prior thoracotomy or sternotomy
- ▶ Gastrointestinal disease, for example, bleeding peptic ulcer, diverticulitis, chronic hepatitis, active or recurrent pancreatitis
- ▶ Progressive neuromuscular disease
- ▶ Severe musculoskeletal disease with debilitating thoracic involvement
- ▶ Refractory uncontrolled hypertension
- ▶ Untreated or unstable cerebrovascular disease

Heart and lung transplantation procedure codes

Report the following procedure codes, as appropriate, for heart and lung transplantation services:

- ▶ 33930—donor cardiectomy-pneumonectomy (including cold preservation)
- ▶ 33933—backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft

from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation

- ▶ 33935—heart-lung transplant with recipient cardiectomy-pneumonectomy
- ▶ 33944—backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation

Dynamic Low-Load Prolonged-Duration Stretch Devices for the Ankle, Toe and Shoulder are Experimental

Highmark West Virginia considers dynamic low-load prolonged-duration stretch (LLPS) devices for the ankle, toe, and shoulder experimental or investigational for all indications including, but not limited to, the management of chronic joint stiffness or chronic or fixed contractures.

Highmark West Virginia does not cover these devices because there is a lack of scientific evidence regarding their effectiveness for these indications. A participating, preferred, or network provider may bill the member for the denied devices.

Report the following procedure codes, as appropriate, for dynamic LLPS devices for the ankle, toe, and shoulder:

- ▶ E1815—dynamic adjustable ankle extension/flexion device, includes soft interface material
- ▶ E1830—dynamic adjustable toe extension/flexion device, includes soft interface material
- ▶ E1840—dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material

Highmark West Virginia Updates Cardiac Event Detection Monitoring Guidelines

Highmark West Virginia considers cardiac event detection monitoring eligible for payment when it's reported for these conditions:

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- ▶ Palpitations (ICD-9-CM diagnosis code 785.1);
- ▶ Dizziness (ICD-9-CM diagnosis code 780.4);
- ▶ Syncope and collapse (ICD-9-CM diagnosis code 780.2); and
- ▶ Other transient symptoms that could be due to arrhythmia (ICD-9-CM diagnosis codes 426.82, 426.9, 427.60, 427.89, 427.9)

Highmark West Virginia considers cardiac event detection monitoring not medically necessary for any other indications. 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, in advance of receiving the service. The signed agreement should be maintained in the provider's records.

Highmark West Virginia will allow payment once in a thirty day period regardless of the number of events or recordings which occurred. If charges are billed more frequently within the thirty-day period, Highmark West Virginia considers them part of the global allowance—they are not eligible for separate reimbursement. A participating, preferred, or network provider may not bill the member separately for additional monitoring during the thirty day period.

Eye X-Rays Performed Before MRI Eligible for Certain Patients

Highmark West Virginia covers an eye X-ray (procedure code 70030) when it's performed before an MRI to evaluate a patient with a known, documented, or suspected contact with magnetic metal or metallic fragments (ICD-9-CM diagnosis codes 360.50-360.59, 376.6, V90.10, and V90.11).

If an eye X-ray is performed before an MRI for any other condition, Highmark West Virginia will deny the X-ray as 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, in advance of receiving the service. The signed agreement should be maintained in the provider's records.

Face-to-Face Prolonged Physician Services Coverage Guidelines Changed

As of Feb. 21, 2011, Highmark West Virginia no longer considers the following prolonged physician services with direct face-to-face patient contact an integral part of a physician's medical care:

- ▶ 99354—prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour.
- ▶ 99355—prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes.
- ▶ 99356—prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; first hour.
- ▶ 99357—prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; each additional 30 minutes.

When provided, Highmark West Virginia will pay for prolonged physician services (procedure codes 99354, 99355, 99356, 99357) in addition to the office or other outpatient evaluation and management service. In these instances, it is not necessary to report the 25 modifier—significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

Please include documentation in the patient's medical record that supports the additional time spent involving direct (face-to-face) patient contact that is beyond the usual service.

Endoscopic Radiofrequency Ablation of the Esophagus Covered for Certain Conditions

Highmark West Virginia considers radiofrequency ablation (RFA) medically necessary when it's performed using an FDA approved device, for example, HALO System from BARRX Medical, Inc.,

(Continued on next page)

for treating Barrett's esophagus in members with low - or high-grade dysplasia.

The diagnosis of low-grade and high-grade dysplasia should be confirmed by two pathologists before RFA is performed.

Highmark West Virginia considers RFA experimental or investigational for all indications or conditions other than low - or high- grade dysplasia—it is not covered. A participating, preferred, or network provider may bill the member for the non-covered RFA.

More data are required concerning the use of RFA for the eradication of nondysplastic Barrett's esophagus. Longer follow-up is needed to show that eradication will persist, and that the benefits will outweigh potential complications in these patients who show a lower rate of progression to adenocarcinoma than those with dysplasia.

Surveillance guidelines following radiofrequency ablation of dysplastic Barrett's esophagus

The following surveillance intervals are generally recommended following an ablation procedure for patients with dysplastic Barrett's esophagus:

High-grade dysplasia

- ▶ Esophagogastroduodenoscopy (EGD) and 4-quadrant biopsies every 1-2 cm every 3 months for the first year
- ▶ EGD every 6 months for the second year
- ▶ EGD yearly after the second year if Barrett's esophagus with no dysplasia or squamous epithelium is found

Low-grade dysplasia

- ▶ Esophagogastroduodenoscopy every 6 months for the first year and then yearly for patients without dysplasia in whom two carefully performed endoscopic examinations a year apart have shown no evidence of disease progression, the surveillance interval may be extended up to 3 years.

Report endoscopic RFA of the esophagus with code 43499, as appropriate. When you report unlisted

code 43499, please include the words "endoscopic radiofrequency ablation of the esophagus" in the narrative field of the electronic or paper claim.

RFA is a type of treatment for Barrett's esophagus that uses radiofrequency energy to remove the diseased esophageal lining, without harming the underlying tissue layers.

The RFA system, for example, the HALO system from BÂRRX Medical, Inc., consists of two components: an energy generator and an ablation catheter. The generator provides rapid (that is, less than 1 second) delivery of a predetermined amount of radiofrequency energy to the catheter. Both the circumferential and focal ablation catheters are inserted into the esophagus with an endoscope, using standard endoscopic techniques. The HALO⁹⁰ catheter is plate-based and used for focal ablation of areas of Barrett's esophagus up to 3 cm. The HALO³⁶⁰ uses a balloon catheter that is sized to fit the individual esophagus, and is inflated to allow for circumferential ablation. RFA is generally performed as an outpatient procedure using standard endoscopic techniques under conscious sedation. Radiofrequency ablation can be performed every 6 weeks as necessary until the dysplasia is ablated.

Transcranial Magnetic Stimulation Considered Investigational for all Conditions

Highmark West Virginia considers transcranial magnetic stimulation (TMS) experimental or investigational.

Highmark West Virginia will not cover TMS when it's performed for any condition, including depression, because there is insufficient evidence in medical literature to support the effectiveness. A participating, preferred, or network provider may bill the member for the denied TMS.

Please use the following codes, as appropriate, to report TMS:

90867-Therapeutic repetitive transcranial magnetic stimulation treatment; planning

90868-Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management per session

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Ankle-Foot and Knee-Ankle-Foot Orthosis Coverage Guidelines to Change

Highmark West Virginia is revising its coverage criteria for ankle-foot and knee-ankle-foot orthosis (Highmark West Virginia Medical Policy O-24).

Beginning June 13, 2011, Highmark West Virginia will deny routinely provided replacement components, for example, soft interfaces, without regard to whether the original item is worn out, as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied item unless he or she has given advance written notice, informing the member that the item 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 item. The signed agreement should be maintained in the provider's records.

Certain products may have both covered and non-covered uses and must be coded based on the patient's condition. For example, when used as a brace for the treatment of an orthopedic condition, please report walking boots with code L4360 or L4386. However, when walking boots are used solely for the prevention or treatment of a lower extremity ulcer of pressure reduction, report the walking boots with code A9283.

The code for a Charcot's restraint orthotic walker—L4631—includes all additions including straps and closure. You may not report additional codes with code L4631. Please include ICD-9-CM diagnosis code 713.5—arthropathy associated with neurological disorders—when you submit claims for L4631.

December 2010 *Provider News* clarification: Select special services not eligible for separate reimbursement

The following is a reprint of "Select special services not eligible for separate reimbursement" that appeared in the December 2010 *Provider News*. Revised information is indicated in blue italics.

Highmark West Virginia will include the allowance for select special services in *its payment for* the basic service that is performed on the same date.

Therefore, if any of the services listed are reported with a basic service *and the charges are itemized*, Highmark West Virginia will *combine the charges and will pay for only the basic service*.

The following codes describe the specific circumstance under which a basic service is performed. These codes do not represent separately identifiable services.

- ▶ **99050**—services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.
- ▶ **99051**—service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.
- ▶ **99053**—service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service.
- ▶ **99056**—service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service.
- ▶ **99058**—service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.
- ▶ **99060**—service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.

In addition, when these special services codes are reported independently they are not eligible for reimbursement because they do not represent separately identifiable services, but rather adjunctive services or the circumstances during which a basic service was rendered. A participating, preferred, or network provider may not bill the member for the denied special service.

If you bill an evaluation and management (E/M) service procedure code and a special services code (99050, 99051, 99053, 99056, 99058, or 99060), do not append modifier 25 to the E/M procedure code. Codes 99050, 99051, 99053, 99056, 99058,

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and 99060 do not describe separately identifiable services, but rather adjunctive services or the circumstances during which the basic service was rendered.

SuperDimension Bronchus System Coding

The American Medical Association established code 31627-bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure(s))-on January 1, 2010 for reporting SuperDimension Bronchus System.

Beginning June 13, 2011, Highmark West Virginia will process code 31627 in accordance with Highmark West Virginia Medical Policy Z-24 guidelines that indicate this service is experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

Report Codes 94774-94777 Only Once Every 30 Days

This article was initially published in the December 2010 Provider News with a typographical error. The revised article is copied below. There has been no change in the intent of the article.

The procedure code descriptions for 94774-94777, pediatric home apnea monitoring event recording, specify a "per 30-day period of time." Therefore, when you submit home apnea monitoring services with codes 94774-94777, bill these services only once every 30 days.

If you report codes 94774-94777 more than once every 30 days, Highmark Blue Cross Blue Shield West Virginia will deny the excessive services as not covered. A participating, preferred or network provider may not bill the member for the denied service.

Here are the descriptions for codes 94774-94777:

- ▶ **94774** — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, physician review, interpretation and preparation of a report

- ▶ **94775** — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitor attachment only (includes hook-up, initiation of recording and disconnection)
- ▶ **94776** — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitoring, download of information, receipt of transmission(s) and analyses by computer only
- ▶ **94777** — pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; physician review, interpretation and preparation of report only

Correction to the December 2010 Provider News. The following article was published in the December newsletter. A few revisions have been made to the text. Please see below for the revised article.

Medical Policy Bulletin: S-55 (Surgical Treatment of Varicose Veins) Echosclerotherapy fee includes Ultrasound Guidance.

Effective: May 23, 2011

Highmark West Virginia includes the reimbursement for the ultrasound in the fee for echosclerotherapy. Therefore, when you report code 76937, 76942, or 76998 in addition to code S2202, Highmark West Virginia will not make an additional allowance for the ultrasound guidance.

Beginning May 23, 2011, if you bill these services separately, Highmark West Virginia will deny them as not covered. A participating, preferred, or network provider may not bill the member separately for these services.

You may report modifier 59 with the injection and/or ultrasound services to identify them as significant, separately identifiable services from the echosclerotherapy. When you report the 59 modifier, you must document in the patient's medical records that an injection and/or ultrasound service was provided independently.

Medicare Advantage **MEDICAL POLICY UPDATES**

Medicare Advantage Eliminates Least Costly Alternative Determinations on Feb. 4, 2011

As of Feb. 4, 2011, Medicare Advantage will no longer make partial payment for services associated with least costly alternative (LCA) determinations. The Centers for Medicare & Medicaid Services (CMS) has issued instructions that partial payment may no longer be made, as of Feb. 4, 2011, for claims based on an LCA determination.

Medicare Advantage has identified the following Medicare Advantage medical policies as those containing least costly alternative guidelines and, therefore, impacted by this CMS direction.

Note: This list contains an alphabetical listing of policies, along with the related Medicare Advantage Medical Policy number.

- ▶ Ankle-Foot/Knee-Ankle-Foot Orthoses – O-24
- ▶ Canes and Crutches – E-69
- ▶ Cervical Traction Devices – E-70
- ▶ Commodes – E-71
- ▶ Enteral Nutrition – O-3
- ▶ External Breast Prostheses – O-18
- ▶ External Infusion Pumps – E-17
- ▶ Glucose Monitors – E-15
- ▶ Hospital Beds – E-63
- ▶ Knee Orthoses – O-28
- ▶ Manual Wheelchairs – E-52
- ▶ Nebulizer Equipment and Related Drugs – E-32
- ▶ Patient Lifts – E-8
- ▶ Pneumatic Compression Devices – E-7
- ▶ Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea – E-20
- ▶ Power Mobility Devices – E-60
- ▶ Respiratory Assist Devices – E-34
- ▶ Seat Lift Mechanisms – E-49
- ▶ Surgical Dressings – E-75
- ▶ Therapeutic Shoes for Persons with Diabetes – O-17
- ▶ Tracheostomy Supplies – O-20

- ▶ Urological Supplies – O-27
- ▶ Walkers – E-76
- ▶ Wheelchair Options and Accessories – E-56
- ▶ Wheelchair Seating – E-55

Medicare Advantage is revising these Medicare Advantage Medical Policy bulletins and will publish them on its website.

The following new guidelines will apply:

- ▶ If the medical policy currently states an item will always be paid based on the allowance for the LCA (if the criteria for the less costly item are met), Medicare Advantage will deny claims for that item as not medically necessary. (This is considered a Type 1 LCA denial.)
- ▶ If the medical policy currently states 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), Medicare Advantage will deny that item as not medically necessary if all of the additional coverage criteria for that item are not met. (This is considered a Type 2 LCA denial.)

Medicare Advantage 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, Medicare Advantage will deny claims without a KX modifier (and with a GA, GY, or GZ modifier).

- ▶ For capped rental DME items, elimination of LCA determinations will apply only to claims in which the date of service (DOS) 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 DOS before Feb. 4, 2011, Medicare Advantage will adjudicate subsequent claims for that item using the LCA determination for the duration of that rental period.

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- ▶ If Medicare Advantage 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 Medicare Advantage 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.

Medicare Advantage will consider services not medically necessary if they do not meet the medical necessity guidelines documented on the Medicare Advantage policies. 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

For more information on the elimination of the LCA, please see the DME MAC Jurisdiction A website at http://www.medicarenhic.com/dme/medical_review/mr_bulletin_current.shtml



Medicare Advantage Does Not Pay Separately for Monitoring Procedures Performed with Anesthesia Administration

Effective June 13, 2011, if the monitoring procedures listed below are reported on the same day as anesthesia, Medicare Advantage will combine the charges and will pay for only the anesthesia. Medicare Advantage considers these services an integral part of the anesthesia administration. A provider may not bill the member separately for these services in this case.

Examples of monitoring procedures performed during the administration of anesthesia or for purposes of intraoperative anesthesia management are:

- ▶ ECG or EKG monitoring (procedure codes 93000-93010, 93040-93042)
- ▶ Administration of fluids and/or blood (procedure codes 36430, 36440)
- ▶ Respiratory functions, for example, oxygen maintenance (procedure codes 94680-94690, 94770)
- ▶ Oximetry (procedure codes 94760, 94761)
- ▶ Temperature
- ▶ Blood pressure
- ▶ Capnography

Preoperative and postoperative visits are part of Medicare Advantage's global anesthesia allowance.

You may report modifier 59 with a non-evaluation and management (E/M) service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient's record must support its use in accordance with CPT guidelines.



Medicare Advantage Covers Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome

Medicare Advantage covers dermal injections for the treatment of facial lipodystrophy syndrome (LDS).

Dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA), and then only in HIV-infected members when LDS caused by antiretroviral HIV treatment is a significant contributor to the member's depression.

Medicare Advantage does not cover dermal fillers that are not approved by the FDA for the treatment of LDS.

If dermal fillers are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments, Medicare Advantage will consider them cosmetic. In this instance, Medicare Advantage will deny the dermal fillers as not covered. A provider may bill the member for the non-covered dermal filler.

Please report the injection of dermal fillers with procedure code Q2026, Q2027, or G0429.

When you report the injection of a dermal filler, please include ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (lipodystrophy).

Correction to the December 2010 Provider News. The following two Medicare Advantage articles were published in the December newsletter with an effective date of April 18, 2011. The effective date for both Medicare Advantage articles has been changed to May 23, 2011. Please see below for the revised article.



Medical Policy Bulletin: N-197 (Coverage of Kidney Disease Patient Education Services) Coverage for Kidney Disease Patient Education Services
Effective: May 23, 2011

As of May 23, 2011, Medicare Advantage will provide coverage for kidney disease education (KDE) services for members diagnosed with Stage IV chronic kidney disease - CKD (severe decrease in GFR; GFR value of 15-29 ml/min/1.73 m²), who have received a referral from the physician managing the member's kidney condition. KDE services should be tailored to meet the needs of the individual member involved, designed to provide members opportunities to actively participate in the choice of therapy, and provide comprehensive information regarding:

- ▶ Management of comorbidities, including for the purpose of delaying the need for dialysis;
- ▶ Prevention of uremic complications; and
- ▶ Each option for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-facility, dialysis access options, and transplantation);

Payment will be made for KDE services that meet the following conditions:

- ▶ No more than 6 sessions of KDE services are provided in a member's lifetime,
- ▶ Sessions billed in increments of 1 hour (In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than 1 hour still constitutes 1 session.),

- ▶ Sessions furnished either individually or in a group setting of 2 to 20 individuals (who need not all be members of the Plan), and
- ▶ Furnished, upon the referral of the physician managing the member's kidney condition, by a qualified person meaning a:
 - physician, physician's assistant, nurse practitioner, or clinical nurse specialist;

Reasons of Noncoverage

KDE services provided for conditions other than chronic kidney disease, Stage IV (severe) will be considered not medically necessary. A provider cannot bill the member for the denied service unless the provider 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, in advance of receiving the service. The signed agreement, in the form of a Pre-Service Denial Notice, should be maintained in the provider's records.

Claims reporting more than 6 KDE sessions will be denied.

Payment will not be made for a professional claim and institutional claim for KDE services when both are reported on the same date of service.

Qualified persons that provide KDE services must develop outcomes assessments that are designed to measure the member's knowledge about CKD and its treatment. The assessment must be administered to the member during a KDE session and be made available upon request.

KDE reporting guidelines

Here are the procedure and diagnosis codes you should use to report KDE services:

G0420 - Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour

G0421 - Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour

ICD-9-CM diagnosis code 585.4 – Chronic kidney disease, Stage IV (severe)



**Medical Policy Bulletin: O-17
(Therapeutic Shoes for Persons with Diabetes) Medicare Advantage revises coverage criteria for therapeutic shoes for persons with diabetes
Effective: May 23, 2011**

Medicare Advantage revised the coverage criteria for therapeutic shoes for persons with diabetes. The following guidelines will become effective May 23, 2011.

Medicare Advantage will cover therapeutic shoes, inserts and/or modifications to therapeutic shoes if all of these criteria are met:

1. The patient has diabetes mellitus (ICD-9-CM diagnosis codes 249.00-250.93), and
2. The certifying physician has documented in the patient's medical record one or more of the following conditions:
 - a. previous amputation of the other foot, or part of either foot,
 - b. history of previous foot ulceration of either foot,
 - c. history of pre-ulcerative calluses of either foot,
 - d. peripheral neuropathy with evidence of callus formation of either foot,
 - e. foot deformity of either foot, or
 - f. poor circulation in either foot, and
3. The certifying physician has certified that indications (1) and (2) are met and that he or she is treating the patient under a comprehensive plan of care for their diabetes and that the patient needs diabetic shoes.

The following additional criteria are effective May 23, 2011:

In order to meet criterion No. 2, the certifying physician must either:

- ▶ Personally document one or more of criteria a – f in the medical record of an in-person visit within six months before delivery of the shoes or inserts and before or on the same day as signing the certification statement, or
- ▶ Obtain, initial or sign, date (before or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within six months before delivery of the shoes or inserts, and that documents one or more of criteria a–f.

The requirement that the in-person visit(s) be within 6 months before delivery of the shoes or inserts is effective for claims with dates of service on or after May 23, 2011.

The certifying physician must:

- ▶ have an in-person visit with the patient during which diabetes management is addressed within six months before delivery of the shoes or inserts, and
 - ▶ sign the certification statement on or after the date of the in-person visit and within three months before the delivery of the shoes or inserts.
4. The supplier must conduct and document an in-person evaluation of the patient before selecting the specific items that will be provided.
 5. At the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient.

If criteria Nos. 1-5 are not met, Medicare Advantage will deny the therapeutic shoes, inserts, and/ or modifications as not covered. When codes for therapeutic shoes are billed without a KX modifier, Medicare Advantage will deny them as not covered. The provider may bill the member for the non-covered item.

The certification statement is not sufficient to meet the requirement for documentation in the medical record.

Depending on the items ordered, both the evaluation and delivery could occur on the same day if the supplier had both a sufficient array of sizes and types of shoes or inserts and adequate equipment on site to provide the items that meet the beneficiary's needs. Both components of the visit (criteria Nos. 4 and 5) must be clearly documented.

There must be an in-person visit with the prescribing physician within six months before delivery of the shoes or inserts.

The only products that may be billed using code A5512 are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor web site.

There are two categories of products that are billed with code A5513:

- ▶ Inserts that are custom fabricated by a manufacturer or central fabrication facility and then sent to someone other than the patient. These items may be billed with code A5513 only if they are listed on the PDAC web site.
- ▶ Inserts that are custom fabricated from raw materials that are dispensed directly to the patient by the entity that fabricated the insert. These items do not have to be listed on the PDAC web site to be billed with code A5513. However, the supplier must provide a list of the materials that were used and a description of the custom fabrication process on request.

If an insert is not included in one of these categories of items, it must be billed with code A5510 or A9270 (non-covered item).

Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Review can be found on the PDAC web site or by contacting the PDAC.

For additional information, see Medicare Advantage Medical Policy O-17, Therapeutic Shoes for Persons with Diabetes.





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Highmark Blue Cross Blue Shield West Virginia Provider News
Post Office Box 1353
Charleston, WV 25325
or call
Provider Relations
Toll-Free 1-800-798-7768

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