All Providers Should Now Be Enrolled in NaviNet®, EFT and Paperless EOB Statements

As part of several steps Highmark West Virginia is taking to eliminate paper transactions with our contracted practitioners in support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, all practitioners doing business with Highmark West Virginia are now required to enroll in NaviNet, EFT and paperless EOB statements.

The deadline to do so was June 30, 2011. In the August 2010 issue and subsequent issues of Provider News and in a letter dated Dec. 1, 2010, we outlined the three-phase conversion process to paperless EOB statements and EFT. The deadline for Phase I was Oct. 1, 2010. In Phase II, all practitioners currently enrolled with NaviNet should have enrolled in EFT and paperless EOB statements by March 31, 2011.

In Phase III, by June 30, 2011, all practitioners doing business with Highmark West Virginia were required to enroll in NaviNet, EFT and paperless EOB statements. To access the EFT enrollment form, click here. If you have not already done so, please contact your Provider Relations representative for assistance in enrollment in NaviNet, EFT and paperless EOB statements.

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June 2011
To stay healthy, members must be able to see their physicians when needed. To support this goal, we are sharing with you Highmark’s expectations for accessibility of primary care physicians (PCPs), medical specialists and behavioral health specialists. The standards set forth specific timeframes in which network providers should respond to member needs, based on symptoms. Please note the standard for in-office waiting time is now within 15 minutes of the patient’s scheduled appointment time.

### PCP AND MEDICAL SPECIALIST EXPECTATIONS

<table>
<thead>
<tr>
<th>Patient’s Need</th>
<th>Performance Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency/life-threatening care</strong></td>
<td></td>
</tr>
<tr>
<td>• Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)</td>
<td>Immediate response</td>
</tr>
<tr>
<td><strong>Urgent care appointments</strong></td>
<td></td>
</tr>
<tr>
<td>• An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury or condition (e.g., high fever, persistent vomiting/diarrhea)</td>
<td>Office visit within 1 day (24 hours)</td>
</tr>
<tr>
<td><strong>Regular and routine care appointments</strong></td>
<td></td>
</tr>
<tr>
<td>• Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain)</td>
<td>Office visit within 2-7 days</td>
</tr>
<tr>
<td>• Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams)</td>
<td>Office visit within 30 days</td>
</tr>
<tr>
<td><strong>After-hours care</strong></td>
<td></td>
</tr>
<tr>
<td>• Access to practitioners after the practice's regular business hours</td>
<td>24 hours a day/seven days a week Prac</td>
</tr>
<tr>
<td></td>
<td>titioners are expected to return calls within 30 minutes</td>
</tr>
<tr>
<td><strong>In-office waiting time</strong></td>
<td></td>
</tr>
<tr>
<td>• Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.</td>
<td>Within 15 minutes</td>
</tr>
</tbody>
</table>

### BEHAVIORAL HEALTH SPECIALIST EXPECTATIONS

<table>
<thead>
<tr>
<th>Patient’s Need</th>
<th>Performance Standard</th>
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<tbody>
<tr>
<td><strong>Care for a life-threatening emergency</strong></td>
<td></td>
</tr>
<tr>
<td>• Immediate intervention is required to prevent death or serious harm to patient or others</td>
<td>Immediate response</td>
</tr>
<tr>
<td><strong>Care for a non-life-threatening emergency</strong></td>
<td></td>
</tr>
<tr>
<td>• Rapid intervention is required to prevent acute deterioration of the patient’s clinical state that compromises patient safety</td>
<td>Care within six hours</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td></td>
</tr>
<tr>
<td>• Timely evaluation is needed to prevent deterioration of patient condition</td>
<td>Office visit within 48 hours</td>
</tr>
<tr>
<td><strong>Routine office visit</strong></td>
<td></td>
</tr>
<tr>
<td>• Patient’s condition is considered to be stable</td>
<td>Office visit within 10 business days</td>
</tr>
<tr>
<td><strong>After-hours care</strong></td>
<td></td>
</tr>
<tr>
<td>• Access to practitioners after the practice's regular business hours</td>
<td>24 hours a day/seven days a week Prac</td>
</tr>
<tr>
<td></td>
<td>titioners are expected to return calls within 30 minutes</td>
</tr>
</tbody>
</table>

Please mark your calendar now to attend the 2011 Statewide Provider Workshop at the Days Hotel in Flatwoods on Monday, Sept. 19, 2011. We will be mailing out more information and registration details regarding the workshop. Also watch for details on the NaviNet® Plan Central page.
As noted in recent issues of Provider News, the Health Care Eligibility Benefit Inquiry and Response (270/271), Claim Status Request and Response (276/277) and Health Care Services Request for Review and Response (278) transactions will be available in Version 005010 on July 1, 2011.

Effective July 1, 2011, Highmark West Virginia will accept both 004010 and 005010 versions of these transactions.

This change primarily affects providers who need to convert from Version 004010 to Version 005010. For providers who are not currently utilizing all of the Inquiry Transactions, these changes offer benefits and improvements that may encourage greater use of these transactions.

**Availability**
- Only approved Version 005010 transaction formats will be used as of Jan. 1, 2012.
- Version 004010 inquiry formats will be available through Dec. 31, 2011. However, they will no longer be accepted after this date.
- The updated Highmark West Virginia Companion Guide for these transactions became available during the 2nd Quarter of 2011.

**Service Type Codes on the 270 Inquiries and Responses**
- The addition of the new Service Type Codes enables providers to ask for more specific benefits so they only receive member eligibility that is relevant to the services they provide.
- The Service Type Codes give payers the opportunity to return more specific eligibility information. Version 005010 transactions require a minimum response to an eligibility request.
- The use of more specific Service Type Codes on inquiries ensures more consistent data across all payers.

**Key Changes**

Depending on your practice management software vendor, your screen presentation or reports may not be impacted; however, the software must be upgraded to Version 005010. Here are a few changes of note for Version 005010:

**270/271 Transaction Changes**
- Definition of Subscriber is one having a unique ID
- Requirement that data elements needed for Subscriber Identification on subsequent transactions (278, 837, etc.) be returned on the 271
- Additional Service Type Codes

**276/277 Transaction Changes**
- Improved inquiry-tracking identifiers, including a specific element for reporting the Patient Account Number
- Removed sensitive patient information data that was not necessary for the transaction’s business use

**278 Transaction Changes**
- Added event Level Detail
- Expanded service Level Detail
- Rejection Reasons — Moved to an external source
- Reconsideration Process — Now included

**Followup**
Keep in mind, your practice management software vendor manages how your office views the data returned from Highmark West Virginia and how that data could potentially impact your office functions. Please follow up with your vendor now to find out when your office will be converted to the new 005010 format and what changes your office can expect.
Providers are encouraged to consult their electronic billing service, practice management software vendor or clearinghouse to ensure that they are preparing to support all Version 005010 transactions by Jan. 1, 2012.

Impacts to NaviNet® Users
For those providers using NaviNet to submit inquiries to Highmark West Virginia, there should be no immediate impacts to you regarding the transition.

Are You Ready for ICD-10?

Although more than two years away, the ICD-10 compliance date of Oct. 1, 2013 will come fast! Now is the time to prepare to ensure that your practice is ready for this important deadline. Following are some key questions to ask that will help to assess your readiness:

• Have you developed a plan for making the necessary changes to your office operations?

• Have you identified what training is needed? Who in your office needs to be trained? And when will that training be needed?

• Who determines and applies diagnosis and procedure codes in your practice? What will they need in order to use the new codes?

• What are the new diagnosis and procedure descriptions and codes that are equivalent to the medical conditions that are most frequently encountered in your office? If no one in your office can answer this question, you should consider giving at least one staff member the responsibility to learn about ICD-10 and how it will impact your practice.

• Have you identified how ICD-10 will impact your claims coding and billing services?

• Will your practice expect Highmark West Virginia and other payers to process test claims prior to the Oct. 1, 2013 compliance date?

Are you still not sure how to get started? Updates and reference information to help with the transition can be found on the Centers for Medicare & Medicaid Services (CMS) website. Highmark West Virginia has also previously published information on getting ready for ICD-10 in recent issues of Provider News and Policy Review & News (PRN), which are available online in our Provider Resource Center.
Radiation Awareness and Medical Imaging:
Balancing Benefits Physicians Can See with Risks They May Not

Medical imaging has given medicine a powerful tool for diagnosing a host of diseases. It is credited with allowing earlier detection of numerous disease processes. Medical imaging has no doubt revolutionized the way certain diseases are detected and treated and has had a measurable impact in successful treatment of and improving survival in illnesses that were once almost universally fatal.

In light of these advances, it is no surprise that physicians’ use of medical imaging — including advanced medical imaging that requires ionizing radiation — has risen dramatically in recent years.

In addition to the increased use of advanced imaging for scheduled tests, the use of computed tomography in the emergency setting and the launch of multi-detector CT units has brought concerns of how to quantify and manage an individual’s cumulative “medical” radiation exposure. Although enhanced technology has shortened imaging acquisition times, the per-scan radiation exposure of today’s multi-detector CT scans may be higher than earlier units.

Increased Imaging and Increased Exposure
All of those factors have raised the issue of what increased exposure to ionizing radiation means in the long term?

The Food and Drug Administration and the National Academy of Science each have expressed concerns about the long-term effects of repeated exposure to ionizing radiation.1 In 2010, the FDA announced it will require manufacturers of high-grade medical imaging devices to include safety controls to prevent excessive radiation doses. The controls would alert providers if they are using a higher-than-recommended dose. The FDA is also considering best-practice measures that will be tied to the accreditation status of hospitals and imaging centers.

In 2005, a National Academy of Sciences report underscored that any level of ionizing radiation may have carcinogenic effects. The American College of Radiology published a white paper in 2007, on “Radiation Dose in Medicine,” that outlines several steps and interventions to help address the issue of ionizing radiation exposure from medical imaging.2

Statistics lend credence to those concerns.

- In recent testimony to a U.S. House of Representatives subcommittee, Rebecca Smith-Bindman, MD, of the University of California, San Francisco, estimated that one in five individuals in the U.S. undergoes a CT scan every year.

(Continued on next page)
The number of CT scans performed annually in the U.S. has risen from around 3 million in 1980 to more than 62 million today. Because CT scans involve much higher doses of radiation than standard X-rays, the general population is experiencing a marked increase in radiation exposure. One CT chest scan carries as much radiation as about 400 chest X-rays, according to the FDA. Epidemiologic studies indicate that the radiation dose from even two or three CT scans results in a statistically detectable increase in the risk of cancer, especially in children — who are most vulnerable. Lifetime risk of cancer due to CT scans is now estimated to be as much as one percent, according to Dr. Smith-Bindman.

The BEIR VII study of 2004, the latest in a series of reports from the National Research Council’s Committee on the Biological Effects of Ionizing Radiation (BEIR), addresses the health effects of exposure of human populations to low-dose, low-LET (linear energy transfer) ionizing radiation. This study serves as a major source of information for evaluating health risks from exposure to ionizing radiation and particularly for developing quantitative estimates of risk.

The BEIR studies were of survivors of the atomic bombings in Hiroshima and Nagasaki, workers in the nuclear industry and patients who had received radiation treatment for acne and thyroid cancer.

BEIR VII found:
- There are intimate links between the dose-dependent induction of DNA damage in cells, the appearance of gene or chromosomal mutations through DNA damage misrepair and the development of cancer.
- The radiation causes free radical “ions” that may break DNA strands.
- When repairs to the damage are attempted, there can be mistakes that lead to mutations and translocations.
- These errors of repair can lead to development of cancer decades later.

Cardiac Computed Tomography Angiography (CCTA) — The Dilemma of High Diagnostic Value with High Radiation
Since the dramatic increase in popularity of the 64-detector row cardiac computed tomography angiography (CCTA) about five years ago, various studies have shown CCTA to provide high diagnostic accuracy for detection of obstructive coronary artery disease compared with invasive angiography. However, studies have also shown these devices to expose patients to significantly higher levels of radiation than other medical imaging techniques. A study featured in the January 2009 issue of the Journal of the American Medical Association concluded that a CCTA examination was the equivalent of 600 chest X-rays.

The challenge facing the medical community is finding ways to use these remarkable technologies in the most effective and safest manner possible to avoid unnecessary radiation exposure for patients.
Radiation Awareness and Medical Imaging

(Continued from page 6)

Steps for Mitigating Radiation Exposure
The International Commission of Radiological Protection's Publication 87 and the ACR White Paper of Radiation Dose in Medicine offer several strategies for equipment operators as well as ordering physicians and radiologists to reduce ionizing radiation exposure from advanced medical imaging.

Operators

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<tr>
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<tbody>
<tr>
<td>Reduce/limit the scan volume with CTs. Avoid unnecessary overlapping of images. Reduce the pitch factor with spiral CTs.</td>
</tr>
<tr>
<td>Use z-filtering with multi-slice CT units.</td>
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<tr>
<td>Reduce milliamp second values (radiation intensity).</td>
</tr>
<tr>
<td>Use automatic exposure control by adapting scanning parameters to the patient cross section.</td>
</tr>
<tr>
<td>Shield superficial organs, such as eyes, thyroid and breast (bismuth shields).</td>
</tr>
<tr>
<td>Separate factors for children.</td>
</tr>
<tr>
<td>Use partial rotation techniques for head CTs.</td>
</tr>
<tr>
<td>Become familiar with and use the CT manufacturer’s radiation dose-reduction techniques.</td>
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Ordering Physicians and Radiologists

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<tr>
<th>Ordering Physicians and Radiologists</th>
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<tr>
<td>Assess the risk-benefit of the study being performed. Make appropriate, stepwise use of investigative studies. Before ordering a study, consider whether the study’s results will impact patient management.</td>
</tr>
<tr>
<td>Consider non-ionizing tests for initial investigation before advanced imaging.</td>
</tr>
<tr>
<td>Ensure that qualified medical personnel perform the medical imaging studies.</td>
</tr>
<tr>
<td>Do not repeat CT exams unless clinically indicated or if other approaches can be utilized.</td>
</tr>
<tr>
<td>Obtain a prior history of the patient’s ionizing radiation imaging studies and communicate that information to the radiologist.</td>
</tr>
<tr>
<td>Carefully consider risk-benefit of chest and abdomen/pelvis CT imaging in girls and young women, due to radiation dose to breasts and ovaries.</td>
</tr>
<tr>
<td>Ensure sound technique when administering advanced imaging studies.</td>
</tr>
<tr>
<td>Develop clinical care pathways for CTs, particularly with regard to imaging of patients with uncomplicated headaches, chest pain and nephrolithiasis.</td>
</tr>
<tr>
<td>Establish specific thresholds for cumulative dose of ionizing radiation for each patient.</td>
</tr>
<tr>
<td>Calculate each patient’s cumulative dose of ionizing radiation and report to practitioners when thresholds are reached.</td>
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Highmark West Virginia Radiation Safety Awareness Program to Support Physicians in Monitoring Cumulative Radiation in Patients

One limitation physicians and radiologists face when trying to determine a patient’s prior radiation exposure can be a lack of imaging records for that patient. Information for a patient who has had an imaging procedure ordered by another physician in the past may not be readily available. To assist providers with this issue, Highmark West Virginia has teamed with National Imaging Associates to offer the Highmark West Virginia Radiation Safety Awareness Program beginning Aug. 22, 2011.

The program tracks CT, PET and nuclear cardiology modalities in the inpatient and outpatient settings while the patient is a Highmark West Virginia member. It utilizes claims history to monitor a patient’s lifetime accumulated radiation exposure. Other tests included in the lifetime radiation calculation include all ionizing diagnostic imaging tests, angiography, bone density tests, diagnostic nuclear medicine and any imaging study with a millisieverts (mSv) dosage greater than 0.5.

For the Highmark West Virginia program, at-risk patients are considered to be those with cumulative radiation (Dose Limit) exposure equal to, or exceeding, 50 millisieverts (mSv), a level that has been identified as causing a statistically (epidemiologically) significant increased risk of developing radiation-associated cancers. Exposure is based on the standard average dose per study. When a new radiologic study that utilizes ionizing radiation is ordered for an at-risk patient, a peer-to-peer consultation is offered between the ordering physician and an NIA physician to discuss alternatives.

The program’s goals include:
• Informing providers of a patient’s prior exposure history
• Enhancing patient safety
• Reducing future cancer risk by utilizing imaging radiation appropriately

The program features a claims-based, patient-specific radiation exposure accumulator that advises providers if their patient already has high-level exposure to radiation at the time a new CT, PET or nuclear cardiology test is ordered. When a patient is flagged, as the ordering physician, you will be notified when you request a preauthorization by telephone, or through a notification presented during the imaging authorization function on NaviNet. At that time, you will be offered an NIA peer discussion should you want to discuss the case with another physician. In addition, a Dose Limit Threshold Notification will also be sent via fax or mail with the authorization or adverse determination letter. Providers can also view additional educational information on Highmark West Virginia’s Radiation Safety Awareness Program page, which can be found on our Provider Resource Center. The page can be accessed via NaviNet® or at www.highmarkbcbswv.com.

Some other important features of the program are as follows:
• The program does not apply to patients with a cancer diagnosis or to those ages 65 and older.
• The patient’s lifetime radiation exposure calculation does not impact medical necessity decisions; the information is only intended to assist the provider in managing radiation exposure for their patient.
• Data provides a balanced view of the risks and benefits of imaging studies with ionizing radiation.
• Radiation exposure information is intended for ordering physicians only and is not provided to the Highmark West Virginia members.
• The program’s elements are consistent with national standards and positions of professional societies.

Additional information about the program can be found on the Highmark West Virginia Provider Resource Center NIA link. Select NIA, then Radiation Safety Awareness.

References:
1. FDA Aims to Rein in Radiation Based Medical Scans, Associated Press, Feb. 9, 2010
3. Computed Tomography – An Increasing Source of Radiation Exposure, Brenner, David J., PhD, DSc; and Hall, Eric J., DPhil, DSc; N Engl J Med 2007; 357:2277-84
ATTENTION DOCTORS OF CHIROPRACTIC:

Use NaviNet® to Authorize Imaging Services Included in the Radiology Management Program

If you are a Highmark West Virginia NaviNet-enabled provider, you can now use NaviNet to request Prior Authorizations through National Imaging Associates, Inc. (NIA) for non-emergency room, outpatient imaging services covered under the Radiology Management Program. Doctors of Chiropractic recently obtained the ability to make these requests via NaviNet.

The program requires providers to request an authorization through NIA prior to ordering the following selected imaging services: CT scans, MRI and MRA scans, PET scans and myocardial perfusion imaging/nuclear cardiology services. Also, stress echocardiography requires Prior Notification.

Authorization numbers are issued and include either an “N” or “R” prefix. Highmark West Virginia requires authorization numbers to ensure appropriate reimbursement. Denials of coverage of services may be issued based on medical necessity and/or appropriateness determinations.

Requesting authorizations for selected outpatient, non-emergency room imaging tests is fast and easy with NaviNet’s Authorization Submission function. Simply hover on the Authorization Submission link, click Authorization Submission from the fly-out menu, and enter the member ID number and date of service. Then choose the procedure category (CT, MRI, etc.) and the service (head, neck, etc.) from the dropdown menus and enter the billing provider information. Follow the remaining prompts and/or enter information in the remaining required fields and click the Submit button.

Once you’ve provided all of the standard required information, you’ll see NIA’s clinical criteria for the scan being ordered. If your request meets the clinical criteria, an authorization number will be provided.

Using NaviNet is the preferred way to request authorizations. If not NaviNet enabled, providers may call NIA.

If you have questions about the Radiology Management Program, please access the Highmark West Virginia Radiology Management Program link on the Provider Resource Center on NaviNet or the Highmark West Virginia website at www.highmarkbcbswv.com. If you have questions about using NaviNet, please contact your Provider Relations representative.
RADIOLOGY MANAGEMENT PROGRAM UPDATE:

Find Clinical Criteria for Imaging Scans Quickly and Easily Online via Provider Resource Center

Highmark West Virginia’s Radiology Management Program was implemented in 2005 to promote quality and appropriateness of outpatient, non-emergency imaging scans for Highmark West Virginia members. As part of the program, Highmark West Virginia and National Imaging Associates, Inc. (NIA) make the clinical criteria for specific imaging scans easily accessible online so you can see the guidelines that are used when making decisions on imaging authorizations.

Based on American College of Radiology guidelines and reviewed by Highmark West Virginia’s Care and Case Management Committee to assure appropriateness, the NIA clinical criteria are accessible to you through Highmark West Virginia’s online Provider Resource Center (which is available via NaviNet® or through the Providers tab on our website). On the Resource Center, simply click on the Highmark West Virginia Radiology Management Program link and then on Clinical Guidelines, which links you to NIA’s website.

On the NIA website, select Highmark West Virginia as the health plan in the first dropdown menu, and then select the type of imaging study (MRI, CT, etc.) from the second dropdown menu. A third dropdown menu will appear, requiring you to select the specific exam, such as Lumbar Spine MRI or Hip CT.

The clinical criteria for the selected scan will then be displayed. (Note: You may need to disable pop-up blockers on your web browser to allow the clinical criteria to be displayed.)

Bookmark or Print Clinical Criteria for Quick Access
To provide fast access to the clinical criteria for the imaging scans you order most often, you may consider bookmarking this page on the NIA website; bookmarking the online document that displays and contains the actual clinical criteria; or printing the clinical criteria to keep it within easy reach. Printing the criteria also may save time when it comes to ordering groupings of tests for the same patient.

NaviNet® Offers the Fastest, Easiest Way to Request Authorizations
Using NaviNet is still the quickest and easiest way to request and receive authorizations for your Highmark West Virginia patients, including when it comes to authorizations for outpatient, non-emergency imaging scans. Currently, more than two-thirds of imaging authorization requests are submitted this way, and approval is usually provided in minutes in most cases.

For more information about Highmark West Virginia’s Radiology Management Program, visit the Highmark West Virginia Radiology Management Program link on our Provider Resource Center.
CAQH to Become Highmark West Virginia’s Sole Credentialing System, Effective Oct. 17, 2011

As previously communicated, Highmark West Virginia has been moving toward use of the online Universal Provider Datasource, developed by CAQH, to replace other, less efficient methods of provider credentialing — namely paper-based credentialing. CAQH’s Universal Provider Datasource offers a single, national system that eliminates the need for multiple credentialing applications for participating health plans. Through this online service, practitioners complete one standardized application to meet the needs of Highmark West Virginia and other participating health plans and health care organizations.

Effective Oct. 17, 2011, Highmark West Virginia will eliminate the use of paper credentialing applications and will fully transition to the CAQH Universal Provider Datasource as our exclusive provider credentialing system. NaviNet® recredentialing functions also will be shut down as of this date, making CAQH the single credentialing system for Highmark West Virginia providers.

Beginning Oct. 17, 2011, all Highmark West Virginia network providers must use CAQH Universal Provider Datasource for credentialing and recredentialing. If you don’t have Internet access, you can contact the CAQH Help Desk, toll-free, at 1-888-599-1771 for other options to complete the online application. If you are a CAQH-participating practitioner with a CAQH ID, please visit www.caqh.org and log into the Universal Provider Datasource to review and re-attest to your CAQH application.

Be sure to add Highmark West Virginia as an authorized plan, or grant global authorization.

If you are an initial applicant, please visit Highmark West Virginia’s Provider Resource Center to complete a CAQH ID Request form so you can begin the credentialing process with CAQH. To access the form, click on Provider Forms and then Provider Applications. A link to the form is found within the text under the second bullet. (Complete the form by providing your information in the blue [required] fields; after you submit your form successfully, Highmark West Virginia will retain an electronic copy in its database, and you will receive a confirmation e-mail containing your CAQH ID, which will enable you to complete the CAQH Universal Provider Datasource credentialing process by visiting www.caqh.org.)

If you are already in our provider network, Highmark West Virginia will supply you with a CAQH ID when you are up for recredentialing so you can complete the recredentialing process with CAQH.

See Highmark West Virginia Provider Manual for Participation Rules; Credentialing/Recredentialing Criteria and Procedures; and Medical Record Criteria

Network providers should consult the Highmark West Virginia Provider Manual for information outlining the health plan’s network participation rules; credentialing/credentialing criteria and procedures; 24/7 coverage; and medical record criteria. The manual is available at www.highmarkbcbswv.com.

Select the Providers tab, then Highmark West Virginia, then Provider Manual.

Information on these vital topics can be found in chapters 2 and 3 of the manual.
2011 Lab Fee Schedule Update
As previously communicated by Special Bulletin on March 31, 2011, Highmark West Virginia has been evaluating updates to the Lab Fee Schedule by analyzing Ingenix RVUs, the CMS Lab Fee Schedule and other market methodologies for reimbursing lab services.

Effective July 1, 2011, the Highmark West Virginia Lab Fee Schedule will move to a 120 percent multiplier of the West Virginia CMS Lab Fee Schedule. This update will apply to all codes that CMS includes as part of the Lab Fee Schedule. Please note that this change will include the reimbursement for Venipuncture code 36415. This methodology change will result in fees decreasing from the previous schedule.

This transition will create administrative simplification for both the provider community and Highmark West Virginia in calculating lab service reimbursement. This change will also align Highmark West Virginia’s reimbursement methodology for lab services with the market methodology norm of other payers in the state of West Virginia.

If you have questions regarding this notice, please contact your assigned External Provider Relations representative or visit the Highmark West Virginia website at www.highmarkbcbswv.com.

Highmark West Virginia to Implement MS-DRG Grouper Version 28 Effective 7/1/2011
As previously communicated in the April 2011 Provider News, 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 have been sent additional information detailing this conversion.

2011 RBRVS Reimbursement Updates
As previously communicated in the April 2011 Provider News, Highmark West Virginia has finalized the review of the changes made by CMS to its 2011 RBRVS schedule. As a result of this review, Highmark West Virginia has concluded that adopting the changes would have a negative financial impact to the provider network. Consistent with the Special Bulletin from March 31, Highmark West Virginia will not adopt the 2011 CMS RVUs for July 1, 2011. The current Highmark West Virginia Fee Schedule (using CMS 2009 RVUs) will continue in effect.

The Highmark West Virginia Fee Schedule will continue to use the 2009 CMS RBRVS value to include the West Virginia Geographic Practice Cost Index (GPCI) for all professional network providers in West Virginia and bordering counties.

An example regarding the RBRVS calculation for our commercial business using the CMS WV GPCI related to the RVU work, practice expense and malpractice component is provided below.

The GPCI values for West Virginia are:
• Work = 1.0
• Practice Expense = 0.827
• Malpractice = 1.353

The formula for 2009 fee schedule payment amount is as follows:
• 2009 Non-Facility Pricing Amount = [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Highmark West Virginia Market Factor
• 2009 Facility Pricing Amount = [(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Highmark West Virginia Market Factor

If you have any questions regarding this information, please contact your assigned External Provider Relations representative or visit the Highmark West Virginia website at www.highmarkbcbswv.com.

Change in Reimbursement for Code 93613 (Intracardiac Electrophysiologic 3-Dimensional Mapping) Effective Nov. 1, 2011
Effective Nov. 1, 2011, the current total component and technical component will be removed, and the professional component reimbursement fee will then be applied to the fee for 93613.
Highmark Inc. is working with 13 physician practices throughout Western and Central Pennsylvania and West Virginia on a pilot program that establishes patient-centered medical homes (PCMH) in which physicians take greater accountability for coordinating care for their patients. The program began on June 1, 2011. The 13 practices include 29 different locations, 160 physicians and will include about 45,000 members.

“The PCMH concept is one where a practice-based care team led by the primary care physician (PCP) coordinates all the care for the patient. This approach means working with the patients and their families across care settings to support their care decision making and to assist in coordinating the care experience,” said Robert Nielsen, MD, a primary care physician with Anville Family Practice. The practice is in Lebanon County, PA, and is participating in the pilot project.

Under Highmark West Virginia’s new approach to care, PCP reimbursement will be modified to provide compensation to help fund the practice’s transformation to a patient-centered medical home. Fundamental to the model is the implementation of care coordination, patient information transfer and clinical outcomes-based reporting.

“We are confident that these practices will improve patient care for Highmark West Virginia members,” said Mary Goessler, MD, medical director of Quality Management at Highmark West Virginia. “We believe by significantly improving communications and patient information exchange between primary care physicians, specialists and hospitals, coupled with working more closely with patients in coordinating care and establishing self-management goals, we will realize a sustained improvement in care quality and patient outcomes. Over time, our goal is to slow the growth of care costs.”

When a patient is transitioned from one care setting to the next, communication breakdowns can result in medication errors, duplicate tests and services and lack of proper patient followup. Through better management and coordination of care, Highmark West Virginia anticipates fewer hospital readmissions and reduced emergency room visits — a costly place to receive care. “One of the key elements of the PCMH is that information technology is used appropriately and in a meaningful way to support optimal patient care, patient education and enhanced communication,” Dr. Goessler said. “This approach will enable physicians to communicate more efficiently with the many caregivers whom they speak with on behalf of patients. It will be easier to track records, maintain various registries and check compliance.”

Highmark West Virginia anticipates this new delivery model will help to improve and sustain optimal clinical outcomes and begin to positively impact health care cost trends. It will be considered for broader implementation throughout the Highmark West Virginia primary care network after data of the two-year pilot is assessed.
2011 Benefit Updates & Reminders

For Federal Employees Health Benefits Program (FEP) Members

Because of changes made at the first of the year to the Federal Employees Health Benefits Plan (FEP) for 2011, we would like to take this opportunity to provide you with some additional updates and reminders regarding these changes. FEP is the health care plan that covers United States government workers.

Addressed in this article is information about the Geriatric Care initiative; dental co-payments; observation stays; charging facility co-payments for an office visit; and the Generic Dispensing Rate (GDR) initiative.

Geriatric Care Initiative
This year, the first of the “baby boom” generation turns 65. Older adults will soon become our fastest-growing age group, and this shift poses challenges. The Center for Disease Control (CDC), among other agencies, has highlighted a scarcity of providers specifically trained to meet the needs of this population. As part of the Geriatric Care initiative, we want to ensure that we continue to focus on increasing the number of physicians in our networks who are board certified or have training in geriatric care. We will actively pursue quality geriatrics-specialized non-participating providers to participate in our networks, while encouraging network internists and family and general practitioners to pursue board certification in geriatrics.

Observation Stays
For Blue Cross Blue Shield FEP members, claims for the care received are paid based on the type of care the provider bills, the provider’s network status and the member’s benefits. Standard Option members will be responsible for at least 15 percent of the Plan’s allowance for all the services provided, which can be considerably more than the $250 co-payment they would be responsible for if admitted to the hospital as an inpatient versus receiving outpatient observation. Because of the variations of what our members may pay in regard to hospital stays, we are encouraging all providers to help educate our members about their admission status in a hospital setting. By doing so, our members will better understand what expenses they may or may not be responsible for during their stay.

Dental Co-Payments
For the 2011 benefit year, changes were made to the Basic Option dental co-payment, increasing the member cost-share from $20 to $25 for the covered services under the Service Benefit Plan. It has been brought to our attention that many of the providers within our dental provider network are unaware of the increase, therefore creating issues for our members who may be using an incentive card program such as MyBlue Wellness to cover this expense. We would like to remind you of the increase of $5 for the Basic Option member co-payment for 2011 in order to prevent our members from having to provide additional documentation for these services if a wellness incentive card is used.

Charging Facility Co-Payments for an Office Visit
We would like to clarify that if an enrollee visits a doctor whose office is located in a facility (such as a hospital), the enrollee should only be charged the doctor’s co-payment. In some instances, our enrollees are being charged the hospital co-payment in addition to the doctor’s co-payment. Please make note of this so that our members are not charged more than they are responsible for.

Generic Dispensing Rate (GDR)
To assist your patients with the overall cost of their medications, consider the benefits and cost savings associated with prescribing generic medication. It is important to educate your patients that generic drugs typically cost 50 percent to 70 percent less than brand-name drugs, have the same active ingredients, quality and strength, and must meet the same strict FDA manufacturing standards as brand-name drugs. Another way of saving money is to prescribe a generic alternative for a particular drug when a generic equivalent is not available. As a provider, inform your patients the difference between brand-name drugs versus generic drugs and assure them that generic drugs are both safe and effective.

To learn more about the FEP Health Benefits Plan for 2011, visit www.fepblue.org to download the 2011 Benefit Plan Brochure. Additionally, providers who have access to the Highmark West Virginia-sponsored NaviNet® system can check FEP members’ benefits and eligibility via NaviNet.
Instructions for Ancillary and Telemedicine Claims Filing

Highmark Blue Cross Blue Shield West Virginia defines an ancillary provider as independent clinical laboratories, durable/home medical equipment and supply providers and specialty pharmacies. A remote provider is any of the above, located outside a Blue Plan’s service area with which the Blue Plan may contract under its license agreement solely for services rendered in its service area and which are considered local providers.

Claims for ancillary services are to be filed to the local Blue Plan of the provider. The local Plan, as defined for ancillary services, is the Plan in whose service area the ancillary services are rendered. If a remote provider contract is in place with the local Plan, the claim must be filed to the local Plan, and it would be considered a participating provider claim. However, if a remote provider contract is not in place with the local Plan, the claim must be filed to the local Plan, and it would be considered a nonparticipating provider claim.

For an independent clinical laboratory, the local Plan is defined as the Plan in whose service area the specimen was drawn. The local Plan for durable/home medical equipment is the one whose service area the equipment was shipped to or purchased, at a retail store. For specialty pharmacy services, the local Plan includes the one in whose service area the ordering physician is located.

It is the host Plan’s responsibility to notify the provider to file the claim with the local Plan as described for ancillary claims. In the event a Plan incorrectly receives an ancillary claim directly from a provider, the Plan should return the claim to the provider with instructions to file the claim to the local Plan as described for ancillary claims.

Telemedicine is considered to be the transmitting and receiving of a patient’s clinical data via electronic communication for the purpose of analysis and interpretation. It includes, but is not limited to, telephonic services, internet services and radiology. In regard to claims filing for telemedicine, current licensee agreements prohibit Blue Plans from contracting with providers outside the Plan’s service area except where specifically allowed under the rules. Telemedicine providers are not considered remote providers and, therefore, the remote provider exception does not apply.

Report Place of Service 20 for Urgent Care

Effective July 22, 2011, Highmark Blue Cross Blue Shield West Virginia will begin to recognize urgent care as a separate identifiable place of service for claims processing purposes. The national place of service value for reporting urgent care is 20. Only practices acting in the capacity of an urgent care center should use place of service 20.

To ensure the most accurate claims processing result, please use the most appropriate place of service, for example, office (11), retail office site (17), urgent care (20) or outpatient (22). You can find a complete list of valid national place of service values on the Centers for Medicare & Medicaid Services’ website at www.cms.gov/PlaceofServiceCodes/03_POSDatabase.asp.
HCPCS 2011 Revision Listing
Clarifies Terminology for Drug Screening Procedure Code G0431

Procedure Code G0431 (drug screening) was included on the 2011 HCPCS Revision Listing with revised terminology. The Centers for Medicare & Medicaid Services (CMS) has issued terminology clarification that indicates Procedure Code G0431 describes all screening for multiple drug classes per patient encounter. CMS also established a new code — G0434 — to report qualitative point-of-care drug screen testing and to limit billing for such testing to one time per patient encounter.

With this terminology change, Highmark West Virginia will increase the fee for G0431, which should now typically only be reported once per day, effective May 16, 2011. See chart for the new code descriptions/fee information.

Revised Code Descriptions

- **G0431** – Drug screen, qualitative; multiple drug classes by high-complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
- **G0434** – Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter

Fee Information

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<tr>
<th>Procedure Code</th>
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<th>Highmark West Virginia Fee, Effective 5/16/2011</th>
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EDI Has New Fax Number

Electronic Data Interchange (EDI) has a new fax number: **304-424-7713**

When faxes are received at the old fax number, providers and their staff will be contacted with the new number. We will also advise providers and their office staff of the new fax number when we speak to them.
Effective July 22, 2011, Highmark Health Insurance Company (HHIC) to Recognize CMS Anesthesia Base Unit Values for 10 Procedure Codes

A follow-up reminder to the NaviNet® Plan Central announcement posted in April 2011: Highmark Health Insurance Company (HHIC) applies anesthesia base units to procedure codes to determine reimbursement, and these base units are obtained from the American Society of Anesthesiologists (ASA). The Centers for Medicare and Medicaid Services (CMS) also publishes anesthesia base units on their website. For the most part, CMS anesthesia base units are the same as the ASA’s; however, for certain anesthesia procedure codes, the CMS base unit’s value is different. Beginning July 22, 2011, for those anesthesia procedure codes where there is a variance from the ASA base units value, HHIC will recognize the CMS anesthesia base units value for Medicare Advantage claims. Listed here are the 10 anesthesia procedure codes for which there is currently a difference in the anesthesia base unit’s value.

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New Telephone Number for Senior Provider Relations Representative Mary DeLaRosa

Please note the new telephone number for Senior Provider Relations representative Mary DeLaRosa. Her new number is 304-347-7799. You can also contact Ms. DeLaRosa at mary.delarosa@highmark.com. She represents providers in the following territories:

- Boone
- Fayette
- Greenbrier
- Logan
- McDowell
- Mercer
- Monroe
- Mingo
- Nicholas
- Pocahontas
- Summers
- Wyoming
- Pike, KY
- Alleghany, VA
- Bath, VA
- Bland, VA
- Buchanan, VA
- Craig, VA
- Giles, VA
- Highland, VA
- Tazewell, VA
- Raleigh
- Webster
Annual Wellness Visits Now Covered for Medicare/Medicare Advantage Beneficiaries

In accordance with prevention initiatives included in the Patient Protection and Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) began as of Jan. 1, 2011 to provide an Annual Wellness Visit (AWV) benefit for Medicare beneficiaries, including those enrolled in Medicare Advantage plans.

The new AWV extends but does not replace the existing Initial Preventive Personal Examination (IPPE) — also known as the “Welcome to Medicare Visit” — that has been provided since 2009 to new beneficiaries within 12 months of their enrolling in Medicare. The new AWV is not covered during the first 12 months of a beneficiary’s initial enrollment in Medicare.

The Medicare AWV and IPPE preventive visits are both important aspects of Highmark West Virginia’s overall wellness and prevention initiatives, and Highmark West Virginia believes that it is important for network physicians to conduct these assessments for our Medicare Advantage (FreedomBlueSM PPO) members. Highmark West Virginia and CMS are providing educational materials to promote the annual visits to beneficiaries and providers, as well as offering guides for providers on billing for services.

In the AWV, a health professional will perform the following Personalized Prevention Plan Services (PPPS) for an eligible beneficiary:

- establishing a medical/family history
- establishing a list of current providers and suppliers
- measuring height, weight, body mass index (or waist circumference, if appropriate), blood pressure and other routine measurements as deemed appropriate, based on the beneficiary’s medical/family history
- detecting any cognitive impairment
- reviewing physical and mental health risk factors
- reviewing potential risk factors for depression, including current or past experiences with depression or other mood disorders, by using an appropriate screening instrument for persons without a current diagnosis of depression (The health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.)
- reviewing the individual’s functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire (The health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.)
- establishing a written screening schedule as appropriate, such as a five-to-10-year checklist based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, as well as the individual’s health status, screening history and age-appropriate preventive services covered by Medicare

AWV SUPPORT MATERIALS

Highmark Offers Physical Activity Rx Pads for Providers

The AWV is an appropriate time to discuss with Medicare Advantage patients the benefits of physical activity in older adults. To assist providers, Highmark has developed the “Rx for Improving Physical Activity” prescription pad, which is available in pads of 50. Providers can request supplies through their Highmark Provider Relations representative.

(Continued on next page)
Annual Wellness Visits Now Covered for Medicare/Medicare Advantage Beneficiaries (Continued from page 18)

- establishing a list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits

- furnishing personalized health advice and referrals, where appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management; or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition

A health professional may also offer guidance about services regarding voluntary advanced care planning, where appropriate, with the agreement of the beneficiary.

The AWV may also include other elements that are determined to be appropriate by the Secretary of Health and Human Services, through the National Coverage Determination process.

For more information, see Help Your Older Patients Benefit from Physical Activity in Issue 1, 2011 of Behind the Shield.

CMS Releases Three New Medicare-covered Preventive Services Quick Reference Information Charts

As an aid in conducting Annual Wellness Visits (AWVs) for Medicare Advantage beneficiaries, the Centers for Medicare and Medicaid Services (CMS) has released three new quick reference information charts for Medicare-covered preventive services, available through the Preventive Services (www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp) page on the CMS website.

The quick reference charts provide information to help Medicare Fee-For-Service health care professionals and their staffs in recommending and providing Medicare-covered preventive services and screenings. All components of the examinations also apply to Medicare Advantage members; however, these claims may be processed differently than under Original Medicare.

The three quick reference charts are:

**The ABCs of Providing the Initial Preventive Physical Examination** (www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf); identifies the elements of the Initial Preventive Personal Examination (IPPE — the “Welcome to Medicare Visit”), as well as providing coverage and coding information, and a set of FAQs

**The ABCs of Providing the Annual Wellness Visit** (www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf); identifies the elements of the AWV, as well as coverage and coding information, and FAQs

**Medicare Preventive Services** (www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf); provides frequency parameters, coding and member copayment/coinsurance and deductible information on the variety of preventive services and screenings covered by Medicare

For additional information about preventive services, please access the Medicare Learning Network (MLN) Preventive Services Educational Products web page at www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.

**ATTENTION PCPs AND SPECIALISTS:**

Upcoming Medicare Advantage Provider Office Medical Record Reviews to Begin in June

To ensure that Highmark West Virginia remains in compliance with Centers for Medicare and Medicaid Services requirements, registered nurses will soon be calling or faxing selected PCP and specialist provider offices to request an appointment to review the medical records of certain FreedomBlue℠ PPO patients. The review process was scheduled to begin in June. If your practice is selected for a review, you will receive a letter in advance that will provide more details to help you prepare. Please watch your mail for this important information.
Attention Primary Care Practices:
Voluntary In-home Health Assessments for Selected Highmark Medicare Advantage Members Begin July 1, 2011

As part of our ongoing quality and medical management initiatives, Highmark West Virginia periodically conducts voluntary health assessments on our Medicare Advantage membership. For 2011, Highmark West Virginia has partnered with Leprechaun LLC to perform these voluntary in-home health assessments. Selected members will be contacted between July 1, 2011, and the end of this year to participate in this initiative.

Members are not obligated to participate in the assessment. Members can opt to have the findings and recommendations from the assessment shared directly with their primary care physician. This initiative is in no way meant to replace the care you provide through your regular visits with the patient. We believe that by gathering health-related information we can provide members with health education regarding Highmark West Virginia programs and services that best meet their health care needs.

Please note that the privacy and security of our members’ protected health information is our highest priority and will be maintained in accordance with Highmark West Virginia’s business associate agreements.

Billing Guidelines for Tdap and Tetanus-only Vaccine Administration

It is important that providers understand how to appropriately bill for Medicare-covered immunizations in order for the member to receive coverage under the appropriate benefit category. Prescription drugs that are covered under the member’s Part D benefit cannot be paid by the Plan under the medical (Part B) portion of their benefit plan.

For this reason network physicians are reminded of the following:

With regard to the use of immunizations, the Centers for Medicare and Medicaid Services (CMS) Medicare Benefit Policy Manual (IOM 100-02), Chapter 15, Section 50.4.4.2, states: “Vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation against such diseases as smallpox, polio, diphtheria, etc.) is not covered. However, pneumococcal, hepatitis B, and influenza virus vaccines are exceptions to this rule.”

- These policies also apply to Highmark Health Insurance Company (HHIC) Medicare Advantage FreedomBlue℠ PPO members.
- In the event of exposure, physicians must use the AT modifier when billing either tetanus or Tdap administration. Failure to use the AT modifier will result in a claim denial and members cannot be billed because it was a billing oversight that caused the denial.
- Tetanus or Tdap provided for preventive care must be billed with a GA modifier signifying that the member has been informed that the service will not be covered under the medical (Part B) benefit. Members can pay the physician privately and submit the receipt for reimbursement under their Part D prescription drug plan. Reimbursement will be based on the member’s Part D plan benefits and cost sharing.

For more information, including appropriate indications and limitations of coverage for Tdap and tetanus-only vaccines, please refer to HHIC Medicare Advantage Medical Policy I-8. To access HHIC Medicare Advantage Medical Policies, visit the online Provider Resource Center via NaviNet® or through the Providers tab at www.highmarkbcbswv.com. Then, click on Highmark West Virginia, where you will find a subsequent link titled Medical Policy. Next, use the Search Medicare Advantage Medical Policies link, under which you can search for Medicare Advantage Medical Policy I-8.
Highmark West Virginia’s

Advanced Illness Services Program

Highmark West Virginia now offers the Advanced Illness Services (AIS) program as part of its Medicare Advantage plans. The program will provide 100 percent coverage for as many as 10 outpatient care visits by AIS network hospice providers to promote quality of care for members with progressive, life-limiting illness.

The program’s focus is controlling pain and symptoms, providing emotional support, facilitating decision-making related to care and coordinating services. Highmark West Virginia is offering the program to ensure that members with life-limiting illness have access to the uniquely trained professionals who provide these services.

Under the program, AIS network hospice and/or palliative care physicians, nurses, social workers and/or home health aides will visit members for whom their doctor attests that death could occur within one year. Members who might enroll are those with cancer, heart disease, end-stage kidney disease, stroke or advanced frailty.

AIS participation guidelines

Members may receive services within their home or a health care or assisted-living facility.

- Members are not required to be homebound or meet a skilled level of care to be eligible for services.
- Participation is voluntary.

AIS and hospice

Advanced Illness Services are primarily consultative, and members receiving these services are eligible to continue to receive curative and other covered services available through their health plan. When curative treatments become ineffective and/or a member no longer wants to continue them, hospice may become the care choice.

- Hospice care is a Medicare benefit. It is a form of palliative care that seeks to alleviate symptoms and improve quality of life when life expectancy is six months or less.
- When a member is in an active hospice election period, the Medicare Advantage plan no longer is responsible for payment of Medicare-covered services related to the member’s terminal condition or payment of services unrelated to the terminal condition.
- During an active hospice election period, the Medicare Advantage plan would continue to cover supplemental or extra benefits not covered by Medicare, such as vision and dental.
- Members who are hospice patients, under the Medicare hospice benefit, will not be enrolled in AIS. If a member is enrolled in hospice and revokes the hospice election, that member would be eligible for AIS.
- AIS participants will not be required to enroll in hospice. Hospice is voluntary and based on the wishes of a member and/or the member’s family.

Because AIS is offered by AIS network hospice providers, the services are not considered duplicative of traditional home health services. It is possible that a home health agency may provide a service to a member on the same day as an AIS network provider, thereby staying within Medicare rules that prohibit billing two home health services on the same day.

(Continued on next page)
Qualifications for contracted AIS providers

- Medicare-certified hospice providers
- 24/7 coverage
- “Some” level of accreditation (i.e., ACHC, CHAP, JCAHO)
- National Hospice and Palliative Care Organization (NHPCO) membership
- “Some” level of palliative care certification (i.e., MD, RN/CRNP)

All team members providing AIS are in the employ of Medicare-certified hospices, which facilitates a seamless transition to hospice if that becomes the member’s choice.

Referrals and authorization

- Referrals to AIS may be made by a patient’s PCP or specialty provider, family members, self, community case managers, internal Highmark West Virginia case manager or others.
- A referral is not required.
- Authorization is required.
- A physician must attest he/she “would not be surprised if the patient died within a year” as per CPT II code 1150F. Attestation serves as medical necessity.

Provider directory

The providers who are privileged to provide in-network AIS will be noted in an AIS provider directory available on the Highmark West Virginia Provider Resource Center and on NaviNet®.

Role of Highmark West Virginia case managers

Case managers experienced in palliative/hospice care engage members, family/caregivers and physicians to facilitate discussions about options at the end of life. The case manager monitors provision of AIS services to confirm the member’s needs are being met.

Covered services

There is a lifetime limit of 10 visits (any combination of the services noted at right) over an unlimited period.

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**Clinical Social Worker Visits**

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**Home Visits (Physician/Nurse Practitioner)**

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**Medical Team Conference, Direct (Face-to-Face) Contact with Patient and/or Family**

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**Medical Team Conference, Without Direct (Face-to-Face) Contact with Patient and/or Family**

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**Care Plan Oversight Services**

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**Home Health Procedures/Services**

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Highmark West Virginia Collaborates With Navigenics

A new generation of personalized wellness powered by genetic knowledge will be offered to Highmark West Virginia members and individuals through a collaboration between Highmark West Virginia and Navigenics, a pioneer in the application of genetic knowledge to improve individual health.

Through this program, Highmark West Virginia aims to apply an integrated approach to health and wellness that is personalized for individuals based upon their genetic risks. Navigenics selects only health conditions where genetic insight can guide an individual to an informed plan of action. Results are coupled with access to a board-certified genetic counselor, the ability to coordinate with personal physicians and the tools and resources to understand steps to address the identified health risks in conjunction with an individual’s overall health profile.

The personalized wellness program will be offered through Highmark West Virginia’s group customer relationships in order for employers to provide a personalized option of health and wellness to their employees. The program will also be offered to individuals through an educational conversation with a trained specialist at six Highmark Direct store locations in Pennsylvania.

For more details, click here to read a press release. You can also visit the Navigenics website: Click here and view the For Physicians section near the bottom of the page.

Preventive Health Guidelines Available Online

Highmark West Virginia Quality Management and participating network physicians annually review and update the Preventive Health Guidelines and Clinical Practice Guidelines, which are distributed to the practitioner community as a reference tool to encourage and assist you in planning your patients’ care. To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit www.highmarkbcbswv.com and click on the Providers tab at top right. You’ll find the guidelines under News & Bulletins, then Health Watch. The Preventive Guidelines include:

- adult (under and over 65)
- pediatrics
- prenatal/perinatal

Welcome to Our Newest Group

City of Wheeling
Effective Date: 7/1/11
Number of Employees and Retirees: 1,079
Group Locations: Wheeling
Product Type: PPO
Alpha Prefix: ZPN
Highmark Inc. Receives Multicultural Health Care Distinction

Highmark Inc. was recently recognized with a Distinction in Multicultural Health Care by the National Committee for Quality Assurance (NCQA), an independent organization that accredits health plans for demonstrated commitment to improving the quality of health care for their members.

In both of Highmark Inc.'s accredited products, “Health Plan — Commercial HMO” and “Health Plan — Medicare HMO,” Highmark Inc.'s overall score was 95.5 out of a possible 100 points.

This is the first year that the NCQA has recognized health plan efforts to improve multicultural health as a distinct category. Highmark Inc. underwent a voluntary review, reflecting the health plan's commitment to addressing health care disparities and improving health care quality for all of our members.

Receiving this Distinction in Multicultural Health Care puts Highmark Inc. in the top tier of plans nationwide. Highmark Inc. is the third health plan and the first Blue Cross Blue Shield plan to achieve this distinction.

“This recognition comes as no surprise,” says Rhonda Moore Johnson, MD, Highmark Inc.'s medical director of Health Equity and Quality Services. “This is the fruit of years of organizational effort and reflects Highmark Inc.'s commitment to learn more about our members, improve our members' health and create healthier communities. We have solidly built an evidence-based framework that is focused on reducing health care disparities and improving quality of care and the care experience for all. We offer our providers resources and tools they can use to better serve the needs of all of our members, in ways that are culturally and linguistically appropriate.”

Highmark Inc. was particularly recognized by the NCQA for:
- making the reduction of health care disparities a corporate strategic goal
- successfully collecting and analyzing data about race, ethnicity and language
- developing a program targeting disparities in heart disease and diabetes among its African-American members

Highmark Inc.'s approach is comprehensive. All Highmark Inc. medical directors have gone through cultural competency training — along with more than 1,000 Highmark Inc. clinical staff and customer service representatives. Nearly all of Highmark Inc.'s 19,000 employees participate in ongoing diversity and inclusion training. A multidisciplinary committee, the Health Equity Committee, oversees all programs and practices touching on multicultural health, to ensure that a focus on health equity is embedded into Highmark Inc.'s culture.

The NCQA Distinction in Multicultural Health Care Program utilizes evidence-based standards and guidelines that assess how a managed care organization:
- directly and indirectly collects and analyzes data on race/ethnicity and language from members and practitioners
- monitors access and availability of language services
- monitors cultural responsiveness of practitioner networks
- provides culturally and linguistically appropriate service programs
- monitors and acts to reduce health care disparities

For more information about Highmark Inc.'s health equity and quality services, please visit: www.HighmarkInc.com/hmk2/about/newsroom/presskits/costquality.shtml.
Attention PCPs: Announcing Change to Coverage for Developmental Screenings

Effective May 23, 2011, for services provided beginning October 1, 2010, Highmark Inc. now includes coverage for up to five (5) developmental screenings for children from birth to age 36 months when billed separately from a pediatric visit. The Highmark West Virginia 2011 Pediatric Preventive Schedule: Ages 0 through 6 Years has been updated to reflect this change.

This change is retroactive to Oct. 1, 2010, for all non-grandfathered individual policies, and beginning with the group's first plan year after Oct. 1, 2010, for non-grandfathered group products. For all grandfathered group products, this change will become effective on May 23, 2011. Highmark Inc. will adjust eligible claims for these services that were previously denied for dates of service between Oct. 1, 2010 and May 23, 2011. These claims will be adjusted automatically and there is no action required by providers.

For additional information, including instructions for billing for developmental screenings, please see the Special Bulletin titled Attention PCPs: Announcing Change to Coverage for Developmental Screenings in the News & Bulletins section under the Providers tab at www.highmarkbcbswv.com.

Highmark Inc. Will Sponsor National Veterans Wheelchair Games in Pittsburgh Aug. 1-6

The Veterans Wheelchair Games are the largest annual wheelchair sports events in the world and are expected to attract more than 600 wheelchair athletes to Pittsburgh when the games are held there from Aug. 1 through Aug. 6. All of these wheelchair athletes are military veterans with spinal cord injuries and amputations. The veterans come from the U.S., Great Britain and Puerto Rico and range from newly injured soldiers who served in Iraq and Afghanistan to World War II veterans.

Highmark Inc. is sponsoring the five-day, 17-event competition as part of its mission to encourage a culture where inclusion — with a focus on what an individual is able to do, not what he or she is unable to do — is valued. Not only is Highmark Inc. the largest financial sponsor of the event, but the company is also asking employees to volunteer their time at the events.

The events will take place at the David L. Lawrence Convention Center, University of Pittsburgh and other venues throughout Pittsburgh.
As an added enhancement to our Provider News, Highmark Blue Cross Blue Shield West Virginia 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:

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

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

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

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

This change applies to Highmark West Virginia and all Medicare Advantage products.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70336</td>
<td>Magnetic resonance (eg, proton) imaging, tempormandibular joint(s)</td>
</tr>
<tr>
<td>70450</td>
<td>Computed tomography, head or brain; without contrast material</td>
</tr>
<tr>
<td>70460</td>
<td>Computed tomography, head or brain; with contrast materials</td>
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<tr>
<td>70470</td>
<td>Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections</td>
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<td>70480</td>
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<td>Computed tomography, maxillofacial area; without contrast material</td>
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<td>70488</td>
<td>Computed tomography, maxillofacial area; with contrast material, followed by contrast material(s) and further sections</td>
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<tr>
<td>70490</td>
<td>Computed tomography, soft tissue neck; without contrast material</td>
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<tr>
<td>70491</td>
<td>Computed tomography, soft tissue neck; with contrast material(s)</td>
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<tr>
<td>70492</td>
<td>Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>70496</td>
<td>Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing</td>
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<td>Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)</td>
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<td>Magnetic resonance angiography, neck; without contrast material(s)</td>
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<td>70548</td>
<td>Magnetic resonance angiography, neck; with contrast materials</td>
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<td>70549</td>
<td>Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences</td>
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<td>70551</td>
<td>Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material</td>
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<tr>
<td>70552</td>
<td>Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)</td>
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<tr>
<td>70553</td>
<td>Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences</td>
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<tr>
<td>70554</td>
<td>Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration</td>
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<td>Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)</td>
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<td>70556</td>
<td>Magnetic resonance angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing</td>
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<td>71275</td>
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<tr>
<td>71550</td>
<td>Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)</td>
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<tr>
<td>71551</td>
<td>Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)</td>
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<tr>
<td>71552</td>
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<td>72126</td>
<td>Computed tomography, cervical spine; with contrast material</td>
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<td>72127</td>
<td>Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections</td>
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<td>72128</td>
<td>Computed tomography, thoracic spine; without contrast material</td>
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<td>Computed tomography, thoracic spine; with contrast material</td>
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<td>Code</td>
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<tr>
<td>72130</td>
<td>Computed tomography, thoracic spine; without contrast material(s) and further</td>
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<td></td>
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<td>72131</td>
<td>Computed tomography, lumbar spine; without contrast material</td>
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<td>72132</td>
<td>Computed tomography, lumbar spine; with contrast material</td>
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<td>Computed tomography, lumbar spine; without contrast material, followed by</td>
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<td>contrast material(s) and further sections</td>
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<td>72141</td>
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<td>72142</td>
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<td>with contrast material</td>
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<td>72146</td>
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<tr>
<td>72147</td>
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<tr>
<td>72148</td>
<td>Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar;</td>
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<tr>
<td>72149</td>
<td>Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar;</td>
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<td>with contrast material</td>
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<tr>
<td>72156</td>
<td>Magnetic resonance (eg, proton) imaging, spinal canal and contents, without</td>
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<td>contrast material, followed by contrast material(s)</td>
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<td>72157</td>
<td>Magnetic resonance (eg, proton) imaging, spinal canal and contents, without</td>
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<td>contrast material, followed by contrast material(s)</td>
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<tr>
<td>72158</td>
<td>Magnetic resonance (eg, proton) imaging, spinal canal and contents, without</td>
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<td></td>
<td>contrast material, followed by contrast material(s)</td>
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<tr>
<td>72159</td>
<td>Magnetic resonance angiography, spinal canal and contents, with or without</td>
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<td>contrast material(s)</td>
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<td>72191</td>
<td>Computed tomographic angiography, pelvis; with contrast material(s),</td>
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<tr>
<td></td>
<td>including noncontrast images, if performed, and image postprocessing</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>73223</td>
<td>Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences</td>
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<td>73225</td>
<td>Magnetic resonance angiography, upper extremity, with or without contrast material(s)</td>
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<td>73700</td>
<td>Computed tomography, lower extremity; without contrast material</td>
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<tr>
<td>73701</td>
<td>Computed tomography, lower extremity; with contrast material(s)</td>
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<tr>
<td>73702</td>
<td>Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections</td>
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<tr>
<td>73706</td>
<td>Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing</td>
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<td>73718</td>
<td>Magnetic resonance (eg, proton) imaging, lower extremity, other than joint; without contrast material(s)</td>
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<td>Magnetic resonance (eg, proton) imaging, lower extremity, other than joint; with contrast material(s)</td>
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<td>73725</td>
<td>Magnetic resonance angiography, lower extremity, with or without contrast material(s)</td>
</tr>
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<td>74150</td>
<td>Computed tomography, abdomen; without contrast material</td>
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<tr>
<td>74160</td>
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<td>74170</td>
<td>Computed tomography, abdomen; without contrast material and further sections</td>
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<tr>
<td>74176</td>
<td>Computed tomography, abdomen and pelvis; without contrast material</td>
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<tr>
<td>74177</td>
<td>Computed tomography, abdomen and pelvis; with contrast material(s)</td>
</tr>
<tr>
<td>74178</td>
<td>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</td>
</tr>
<tr>
<td>74181</td>
<td>Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)</td>
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<tr>
<td>74182</td>
<td>Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)</td>
</tr>
<tr>
<td>74183</td>
<td>Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by contrast material(s) and further sequences</td>
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<tr>
<td>74185</td>
<td>Magnetic resonance angiography, abdomen, with or without contrast material(s)</td>
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<tr>
<td>74261</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material</td>
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<tr>
<td>74262</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed</td>
</tr>
<tr>
<td>75557</td>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material</td>
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<tr>
<td>75559</td>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging</td>
</tr>
<tr>
<td>75561</td>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences</td>
</tr>
</tbody>
</table>

(Continued on next page)
Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging

Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium

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)

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)

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)

Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Ultrasound, chest (includes mediastinum), real time with image documentation

Ultrasound, abdominal, real time with image documentation; complete

Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)

Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete

Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited

Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation

Saline infusion sonohysterography (SIS), including color flow Doppler, when performed

Ultrasound, pelvic (nonobstetric), real time with image documentation; complete

Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)

Ultrasound, scrotum and contents

Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral

Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral

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

Highmark West Virginia recommends that you do not report codes 96118 and 96119 on the same day as codes 96101 and 96102. If you do report these codes together, the medical record should indicate distinct testing techniques and beginning and end times. You should avoid reporting time for duplicating information.

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

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

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

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

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

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

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

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

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

**Place of service designations: more medical policies to include**

Highmark West Virginia is adding place of service designations to the following medical policies on the indicated dates.

<table>
<thead>
<tr>
<th>Policy number</th>
<th>Policy topic</th>
<th>Place of service</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-60</td>
<td>Artificial Hearts and Ventricular Assist Devices</td>
<td>Inpatient</td>
<td>Sept. 26, 2011</td>
</tr>
<tr>
<td>S-118</td>
<td>Small Bowel/Liver and Multivisceral Transplantation</td>
<td>Inpatient</td>
<td>Oct. 10, 2011</td>
</tr>
<tr>
<td>S-144</td>
<td>Islet Cell Transplantation</td>
<td>Inpatient</td>
<td>Oct. 10, 2011</td>
</tr>
</tbody>
</table>

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

**Additional guidelines**

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

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

**Clinical pathology consultation services now covered**

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

The consultative services must:

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

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

**Clinical pathology consultation services require specific medical record documentation**

When you perform clinical pathology consultation services, please indicate in the patient’s medical records that the service was actually performed, was

(Continued on next page)
performed at the level reported, and was reasonable and necessary.

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

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

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

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

**Iplilimumab eligible for treating unresectable or metastatic melanoma**

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

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

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

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

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

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

Permanently discontinue ipilimumab for any of the following:

- Persistent moderate adverse reactions or inability to reduce corticosteroid dose to 7.5 mg prednisone or equivalent per day
- Failure to complete full treatment course within 16 weeks from administration of first dose
- Severe or life-threatening adverse reactions, including any of the following:
  - Colitis with abdominal pain, fever, ileus, or peritoneal signs; increase in stool frequency (seven or more over baseline), stool incontinence, need for intravenous hydration for more than 24 hours, gastrointestinal hemorrhage, and gastrointestinal perforation
  - AST or ALT greater than five times the upper limit of normal or total bilirubin greater than three times the upper limit of normal
  - Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full thickness dermal ulceration, or necrotic bullous, or hemorrhagic manifestations
  - Severe motor or sensory neuropathy, Guillain-Barre syndrome, or myasthenia gravis
  - Severe immune-mediated reactions involving any organ system, for example, nephritis, pneumonitis, pancreatitis, non-infectious myocarditis
  - Immune-mediated ocular disease that is unresponsive to topical immunosuppressive therapy

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

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

Highmark West Virginia determines coverage for ipilimumab according to individual or group customer benefits.
Intravenous anesthetics as treatment of chronic neuropathic pain not covered

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

Report lidocaine hydrochloride with procedure code J2001—Injection, lidocaine HCl for intravenous infusion, 10 mg.

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

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

Highmark West Virginia will pay for covered home health services that a home health agency (HHA) provides if a physician certifies that:

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

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

Face-to-face encounter

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

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

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

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

Encounter documentation requirements

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

**Timeframe requirements**

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

**Exceptional circumstances**

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

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

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

**Recertifications for home health services**

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

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

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

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

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

**ERCC1 analysis for non-small cell lung cancer not covered**

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

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

The excision repair cross-complementing factor 1 gene is a critical gene in the cell’s ability to repair damage to DNA. The ERCC1 gene expression has been investigated in various cancers including non-small cell lung cancer. ERCC1 plays a key role in the nucleotide excision repair of the DNA and has been shown to possibly play a role in the repair of the damage produced by the use of cisplatin and other platin drugs.
ERCC1 gene expression analysis for NSCLC is performed clinically using immunohistochemistry. The antibody 8F1, which recognizes the ERCC1 protein, is used to assess ERCC1 levels within tumor cells present in tissue sections obtained from lung biopsy or tumor resection.

Small bowel or liver and multivisceral transplantation coverage guidelines explained

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

Candidates should meet these criteria:

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

Transplant contraindications

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

- Metastatic cancer
- Ongoing or recurring infections that are not effectively treated
- Serious cardiac or other ongoing insufficiencies that create an inability to tolerate transplant surgery
- Serious conditions that are unlikely to be improved by transplantation as life expectancy can be finitely measured

- Demonstrated patient noncompliance, which places the organ at risk by not adhering to medical recommendations
- Potential complications from immunosuppressive medications that are unacceptable to the patient
- AIDS (diagnosis based on CDC definition of CD4 count, 200 cells/mm³) unless the following are noted:
  - CD4 count greater than 200 cells/mm³ for longer than six months
  - HIV-1 RNA undetectable
  - On stable anti-retroviral therapy longer than three months
  - No other complications from AIDS, for example, opportunistic infection, including aspergillus, tuberculosis, coccidioido-mycosis, resistant fungal infections, Kaposi's sarcoma, or other neoplasm
  - Meeting all other criteria for small bowel or multivisceral transplantation

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

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

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

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

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

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

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

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

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

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

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

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

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

Highmark West Virginia covers fetal surgery for the following conditions:

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

- In utero repair of sacrococcygeal teratoma

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

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

- Open in utero resection of malformed pulmonary tissue or placement of a thoraco-amniotic shunt may be considered medically necessary when:
  - Congenital cystic adenomatoid malformation or bronchopulmonary sequestration is identified, and
  - The fetus is at 32 weeks’ gestation or less, and
  - There is evidence of fetal hydrops, placentomegaly, and/or the beginnings of severe pre-eclampsia, that is, the maternal mirror syndrome, in the mother

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

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

**Fetal surgery procedure codes**

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

(Continued on next page)
59076—fetal shunt placement, including ultrasound guidance

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

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

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

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

Coverage changes for laser treatment of psoriasis

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

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

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

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

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

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

Belimumab coverage guidelines and reporting instructions outlined

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

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

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

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

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

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

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

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

Highmark West Virginia to cover minimally invasive coronary artery bypass surgery

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

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

Highmark West Virginia will begin to cover MIDCAB graft surgery on Sept. 26, 2011.

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

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

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

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


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

Highmark West Virginia considers these additional procedure codes eligible for payment for co-surgery:

- 37600—ligation; external carotid artery
- 37618—ligation, major artery (eg, post-traumatic, rupture); extremity
- 46744—repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach

(Continued on next page)
61697—surgery of complex intracranial aneurysm, intracranial approach; carotid circulation

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

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

**Video EEG covered for some indications**

Highmark West Virginia covers video electroencephalographic (EEG) monitoring when:

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

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

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

**Occipital nerve stimulation considered investigational**

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

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

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

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

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

64553—percutaneous implantation of neurostimulator electrodes; cranial nerve

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

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

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

64999—unlisted procedure, nervous system

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

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

**More coverage criteria to be applied to implantable infusion pumps**

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

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

**Anti-spasmodic drugs**

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

- A failed six-week trial of non-invasive methods of spasticity control, such as oral anti-spasmodic drugs, either because these methods fail to adequately control the spasticity or produce intolerable side effects, and

- A favorable response to a trial intrathecal dosage of the anti-spasmodic drug prior to pump implantation

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

- The treatment of intractable spasticity caused by spinal cord disease, spinal cord injury, or multiple sclerosis

- Persons who require spasticity to sustain upright posture, balance in locomotion, or increased function

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

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

**Opioid drugs for the treatment of severe chronic intractable pain**

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

- For the treatment of non-malignant pain, for example, pain not associated with cancer. Documentation in the medical record must indicate the failure of six months of other conservative treatment modalities (pharmacologic, surgical, psychological, or physical) if appropriate and not contraindicated.

- For the treatment of malignant pain, for example, pain associated with cancer. Strong opioids or other analgesics in adequate doses, with a fixed schedule (not prn) dosing, have failed to relieve pain, or have intolerable side effects to systemic opioids, or other analgesics have developed.

- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal or epidural catheter to substantiate adequately acceptable pain relief (defined as at least a 50 percent reduction in pain), the degree of side effects (including effects on the activities of daily living), and acceptance.

**Intra-arterial injection of chemotherapeutic agents**

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

(Continued on next page)
**Contraindications to implantable infusion pumps**

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

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

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

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

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

**Interspinous distraction devices classified as experimental, not covered**

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

Report procedure code 0171T or 0172T for interspinous distraction devices:

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

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

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

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

**Sacroiliac joint injections not covered**

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

Report the following procedure codes, as appropriate, for sacroiliac joint injections:
27096—injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid

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

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

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

How to report auditory brainstem implants

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

Tocilizumab coverage guidelines explained

Highmark West Virginia covers tocilizumab (Actemra®), an interleukin-6 (IL-6) receptor inhibitor, for treating:

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

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

It is recommended that tocilizumab not be initiated in patients with an absolute neutrophil count below 2000/mm³, platelet count below 100,000/mm³, or who have ALT or AST above 1.5 times the upper limit of normal. Tocilizumab doses exceeding 800 mg per infusion are not recommended.

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

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

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

Coverage criteria explained for Xgeva

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

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

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

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

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

New artificial hearts and ventricular assist devices coverage guidelines defined

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

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

Covered indications for VADs include:

- Postcardiotomy ventricular dysfunction
- Treatment of right heart failure following insertion of an implantable left ventricular device
- Treatment of cardiogenic shock following cardiac transplantation
- Bridge-to-transplant

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

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

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

- age five–16
- body surface area ≥ 0.7 m² and < 1.5 m²
- in New York Heart Association (NYHA) Class IV end-stage, that is, left ventricular, heart failure refractory to medical therapy
- listed candidate for cardiac transplantation

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

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

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

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

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

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

- any medical condition that, if corrected, would improve heart function
- any condition that could result in a poor surgical risk
- prior cardiac transplant, left ventricular reduction, or cardiomyoplasty
- stroke, impaired cognitive function, history of severe cerebral vascular disease
- severe end organ damage
- irreversible left ventricular congestive failure:
  - awaiting a donor heart for transplantation
  - on the hospital’s transplant list

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

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

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

**Total artificial hearts**

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

**Covered indications:**

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

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

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

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

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

The following conditions generally exclude patients for heart transplant:

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

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

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

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

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

Microsurgical technique no longer a covered service

Highmark West Virginia currently provides coverage for use of a surgical microscope.

Effective Oct. 3, 2011, Highmark West Virginia will no longer provide an additional allowance for microsurgical technique.

Use code 69990-Microsurgical techniques, requiring use of operating microscope to report this service.

When a doctor reports code 69990, it will be denied as non-covered since this code is not representative of the surgical procedure being performed. A participating, preferred, or network provider cannot bill the member for the denied service.

For additional information please refer to Highmark West Virginia Medical Policy Bulletin S-50.
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.

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

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

Medicare Advantage covers a pneumatic or hydraulic polycentric hip joint, code L5961, for patients whose functional level is three or above.

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

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

Comments on these new medical policies?

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

Write to us at medicalpolicy@highmark.com.

CODING UPDATES

Codes S3628 and S9075 deleted June 30, 2011

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

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

S9075—smoking cessation treatment

New codes available July 1, 2011

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>0262T</td>
<td>Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach</td>
</tr>
<tr>
<td>0263T</td>
<td>Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest</td>
</tr>
<tr>
<td>0264T</td>
<td>Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest</td>
</tr>
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(Continued on next page)
<table>
<thead>
<tr>
<th>Code</th>
<th>Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>0265T</td>
<td>Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy</td>
</tr>
<tr>
<td>0266T</td>
<td>Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)</td>
</tr>
<tr>
<td>0267T</td>
<td>Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)</td>
</tr>
<tr>
<td>0268T</td>
<td>Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)</td>
</tr>
<tr>
<td>0269T</td>
<td>Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)</td>
</tr>
<tr>
<td>0270T</td>
<td>Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)</td>
</tr>
<tr>
<td>0271T</td>
<td>Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)</td>
</tr>
<tr>
<td>0272T</td>
<td>Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)</td>
</tr>
<tr>
<td>0273T</td>
<td>Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode therapy start/stop times each day); with programming</td>
</tr>
<tr>
<td>0274T</td>
<td>Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic</td>
</tr>
<tr>
<td>K0741</td>
<td>Portable gaseous oxygen system, rental, includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing for cluster headaches</td>
</tr>
<tr>
<td>K0742</td>
<td>Portable oxygen contents, gaseous, 1 month's supply = 1 unit, for cluster headaches, for initial months supply or to replace used contents</td>
</tr>
<tr>
<td>K0743</td>
<td>Suction pump, home model, portable, for use on wounds</td>
</tr>
<tr>
<td>K0744</td>
<td>Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less</td>
</tr>
<tr>
<td>K0745</td>
<td>Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches</td>
</tr>
<tr>
<td>K0746</td>
<td>Absorptive wound dressing for use with suction pump, home model, portable, pad size, greater than 48 square inches</td>
</tr>
<tr>
<td>Q2041</td>
<td>Injection, von willebrand factor complex (human), wilate, 1 i.u. vWF:RCo</td>
</tr>
<tr>
<td>Q2042</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
</tr>
<tr>
<td>Q2043</td>
<td>Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion</td>
</tr>
<tr>
<td>Q2044</td>
<td>Injection, belimumab, 10 mg</td>
</tr>
</tbody>
</table>
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Highmark Blue Cross Blue Shield West Virginia Provider News
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or call
Provider Relations
Toll-Free 1-800-798-7768

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