



BlueCross BlueShield of Montana

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THE CAPSULE NEWSSM

SMService Marks of Blue Cross and Blue Shield of Montana

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

FIRST QUARTER 2006

SAVE FOR FUTURE REFERENCE



SYSTEM CONVERSION CONTINUES

CLAIMS INVENTORY DROPS SIGNIFICANTLY IN JANUARY

The conversion to the new claims processing system (QNXT) continues and claims inventory decreases each day. BCBSMT is running payment cycles at least three times per week for all providers. Progress is being made daily due to the extra efforts from all BCBSMT staff working long hours in the evenings, weekends, and holidays. Extra resources have been assigned to high-priority and critical issues.

MEMBERSHIP AND BILLING

The conversion of member files, new enrollments, new benefit periods, and group billing has caused most payment delays. Front-end claims processing is entirely dependent upon having member benefits and enrollment established for existing and new members. A claim will begin to process when members and benefits are programmed in the system. Then premium income must be received and properly accounted for to begin paying claims according to the member contract. Until premium income is balanced, claims suspend for member premium updates.

Hundreds of membership and billing details account for most of the claims inventory with membership and billing escalated to the highest priority in January.

CLAIMS INVENTORY

On December 16, 2005, claims inventory peaked at just over 80,000 and by January 20, 2006, BCBSMT claims inventory was about 38,000. Over-aged claims were up to 38,000 and were reduced to 10,000 by January 20. As of press time, approximately \$50 million has been paid in January with over \$38 million from the new claim system. There are still issues within the claims system but BCBSMT is almost paying the same claims volume prior to conversion.

FINANCIAL ASSISTANCE

BCBSMT is committed to mitigating the impact this process is having on physicians, hospitals, and other health care providers. To that end, we are happy to provide periodic interim payments (PIP) to any of our BCBSMT participating providers to alleviate potential negative cash flow situations they may face. A phone call to any of the Health Care Services External Team (see inside back cover) is all that is necessary for a physician, hospital, or other health care provider to apply for a PIP.

If you have questions, contact Customer Service at 1-800-447-7828 or your provider network representatives (see inside back cover).

SAVE FOR FUTURE REFERENCE

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MEDICAL
POLICY

Medical policies are developed through consideration of peer-reviewed medical literature, Federal Drug Administration (FDA) approval status, accepted standards of medical practice in Montana, the Blue Cross and Blue Shield Association Technology Evaluation Center assessments, other Blue Cross and Blue Shield plan policies, and the concept of medical necessity.

The purpose of medical policy is to guide **coverage** decisions and is not intended to influence **treatment** decisions. Providers are expected to make treatment decisions based on their medical judgment. BCBSMT recognizes the rapidly changing nature of technological development and welcomes comments on all medical policies. When using medical policy to determine whether a service, supply, or device will be covered, member contract language will take precedence over medical policy if there is a conflict.

The Medical and Compensation Physician's Committee met in September 2005, and approved the following **NEW** and **REVISED** medical policy with an effective date as listed on the policy. Note that only the "Policy" section is included in revised policies, and if the policy change is minor, only that portion of the policy is included. References used in policy development are not included. You can review all medical policies online at www.bluecrossmontana.com.

REVISED POLICY

CAROTID ARTERY
STENTING/ANGIOPLASTY,
EXTRACRANIAL

Chapter: Surgery - Procedures

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

Carotid angioplasty has been investigated as a less invasive alternative to open carotid endarterectomy (CEA), which is used to revascularize the carotid arteries in patients with significantly obstructing carotid atherosclerosis (stenosis). Carotid angioplasty is rarely performed without stent placement. The procedure typically takes 20-40 minutes and is performed with the patient fully awake. During the procedure catheters, micro-catheters, balloons, and other devices are inserted through the femoral artery and into the carotid artery. Most practitioners also use a distally placed embolic protection device designed to reduce the risk of peri-procedural stroke caused by thromboembolic material dislodged during the procedure.

In August 2004, the U. S. Food and Drug Administration (FDA) approved the first stents (ACCULINK and RX ACCULINK) and cerebral protection filters (ACCUNET and RX ACCUNET) manufactured by Guidant Corporation for use in carotid arteries.

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

Coverage is limited to procedures performed using FDA approved carotid artery stenting systems and embolic protection devices and is consistent with Medicare guidelines. BCBSMT considers carotid artery stenting medically necessary when **both** of the following criteria are met:

- The patient has symptomatic carotid artery stenosis (CAS) greater than or

equal to 70%. The degree of CAS should be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70% by angiography, then CAS should not be done.

- The patient is at high risk for carotid endarterectomy. High-risk patients are defined as having significant comorbidities and/or anatomic risk factors (e.g., recurrent stenosis and/or previous radical neck dissection), and would be poor candidates for CEA in the opinion of a surgeon. Significant comorbid conditions include, but are not limited to, the following:
 - Congestive heart failure class III or IV.
 - Left ventricular ejection fraction less than 30%.
 - Unstable angina.
 - Contralateral carotid occlusion.
 - Recent myocardial infarction.
 - Previous CEA with recurrent stenosis.
 - Prior radiation treatment to the neck.

CODING

37215 - Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection.

37216 - without distal embolic protection.

0075T - Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous; initial vessel.

0076T - each additional vessel.

FIRST QUARTER 2006

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ANODYNE AND OTHER SKIN CONTACT MONOCHROMATIC INFRARED ENERGY (MIRE) THERAPIES

Chapter: Therapies

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

The Anodyne Professional Therapy System (which received FDA approval in 1994) is one of several monochromatic infrared energy (MIRE) devices available. It received FDA marketing approval in 1994. MIRE devices have been investigated as a treatment of multiple conditions including cutaneous ulcers, diabetic neuropathy, musculoskeletal and soft tissue injuries (e.g., temporomandibular disorders, tendonitis, capsulitis and myofascial pain).

MIRE therapy is delivered through pads containing infrared diodes that emit pulsed near-infrared irradiation. The pads are placed on the skin for 30 to 45 minute per session. Ongoing therapy is necessary.

The mechanism of action is unknown. It is proposed that light from the diodes is absorbed by hemoglobin in the blood, causing the release of nitric oxide, a potent vasodilator that increases circulation and the concentration of nutrients and oxygen to promote healing and reduce pain.

POLICY

BCBSMT considers the use of MIRE devices, including the Anodyne Professional Therapy System, investigational.

CODING

HCPCS Codes

E0221 - Infrared heating pad system.

CPT Codes

97026 - Application of a modality, infrared.

SPECT (SINGLE PHOTON EMISSION COMPUTED TOMOGRAPHY) SCANS

Chapter: Radiology

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

SPECT scanning, referred to as FDG-SPECT, metabolic SPECT or PET using a gamma camera, is a general term describing imaging techniques in which a SPECT gamma camera is used. SPECT cameras are conventionally used to provide scintigraphic studies such as bone scans or cardiac thallium studies. When used in conjunction with FDG, specially equipped SPECT cameras can provide images reflecting the metabolic activity of tissues, similar to PET scanning. However, because of technical issues there are questions regarding the diagnostic performance of FDG-SPECT in comparison to PET scanning.

See the BCBSMT medical policy, Positron Emission Tomography (PET).

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers FDG-SPECT scanning medically necessary:

- As a technique to evaluate myocardial viability in patients with known coronary artery disease.
- When used prior to surgery for intractable epilepsy.

INVESTIGATIONAL

BCBSMT considers FDG-SPECT scanning to be investigational for several reasons including, but not limited to, the following:

- Cardiac applications other than as

a technique to evaluate myocardial viability in patients with known coronary artery disease (e.g., evaluation of coronary artery perfusion defects).

- As a technique to evaluate patients with known or suspected malignancies.
- The evaluation of neurological disorders, dementias, psychiatric disorders, or motor neuron disorders.

CODING

HCPCS Codes

G0231 - PET, whole body, for staging and characterization of colorectal metastatic cancer; gamma cameras only.

G0232 - PET, whole body, for staging and characterization of lymphoma; gamma cameras only.

G0233 - PET, whole body, for recurrence of melanoma or melanoma metastatic cancer; gamma cameras only.

G0234 - PET, whole body, for solitary pulmonary nodule following CT for initial staging of pathologically diagnosed non-small cell lung cancer; gamma cameras only.

S8085 - FDG imaging using dual-head coincidence detection system (non-dedicated PET scan).

CPT Codes

78464 - Myocardial perfusion imaging; tomographic (SPECT), single study.

78465 - Myocardial perfusion imaging; tomographic (SPECT), multiple studies.

78606 - Brain imaging, complete, with vascular flow.

78607 - Brain imaging, complete study; tomographic (SPECT).

CORONARY ARTERY EVALUATION: CONTRAST-ENHANCED COMPUTED TOMOGRAPHIC ANGIOGRAPHY (CTA)

Chapter: Radiology

Upcoming Policy

Effective Date: May 1, 2006

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MEDICAL POLICY

DESCRIPTION

Contrast-enhanced computed tomographic angiography (CTA) is used to evaluate coronary artery disease (CAD) instead of conventional angiography. It is a non-invasive imaging test using intravenously administered contrast material and high-resolution, high-speed CT machinery to obtain detailed volumetric images of blood vessels. Two different CT technologies can achieve high-speed CT imaging: electron beam CT (EBCT, also known as ultrafast CT) and helical CT scanning (also referred to as spiral CT scanning). It has been proposed CTA may be helpful to rule out the presence of CAD and avoid invasive coronary angiography in patients with a very low clinical likelihood of significant CAD.

Evaluation of CAD, either through conventional angiography or CTA, is done to determine whether hemodynamically significant stenosis is present. Symptomatic lesions with greater than 50-70% diameter stenosis are generally considered significant and often result in revascularization procedures when viable myocardium is present.

Another potential use for CTA is exploring the role of nonsignificant plaques (e.g. those associated with less than 50% stenosis). It is postulated that plaques considered unstable may undergo rupture or erosion and lead to acute myocardial infarction. CTA may be better than conventional angiography at visualizing the presence and composition of these plaques. However, how this information to guide patient management has not been established.

POLICY

BCBSMT considers contrast-enhanced computed tomographic angiography for coronary artery evaluation investigational.

CODING

CPT Codes

71275 - Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing.

NEW CODES EFFECTIVE JANUARY 1, 2006:

0144T - Computed tomography, heart, without contrast material.

0145T - Computed tomography, heart, without contrast material followed by contrast material(s) and further sections.

0146T - Computed tomography, heart, without contrast material followed by contrast material(s) and further sections without quantitative evaluation of coronary calcium.

0147T - Computed tomography, heart, without contrast material followed by contrast material(s) and further sections with quantitative evaluation of coronary calcium.

0148T - Computed tomography, heart, without contrast material followed by contrast material(s) and further sections.

0149T - Computed tomography, heart, without contrast material followed by contrast material(s) and further sections.

0150T - Computed tomography, heart, without contrast material followed by contrast material(s) and further sections in congenital heart disease.

0151T - Computed tomography, heart, without contrast material followed by contrast material(s) and further sections function evaluation.

0152T - Computer aided detection.

HCPCS Codes

S8093 - Computed tomographic angiography, coronary arteries, with contrast material(s).

REVATIO (SILDENAFIL CITRATE)

Chapter: Drugs

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

Revatio is FDA approved to treat patients with pulmonary arterial hypertension (PAH) to improve their exercise ability. PAH is characterized by dangerously high blood pressure in the blood vessels that lead from the heart to the

lungs and is estimated to affect approximately 100,000 people worldwide. Sildenafil citrate is also the active drug in Viagra, which is approved by the FDA to treat erectile dysfunction.

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

The intent of this policy is to restrict reimbursement for Revatio to the FDA approved treatment of PAH.

COVERED

BCBSMT considers the use of Revatio covered when used to treat patients with PAH.

NON-COVERED

BCBSMT considers the use of Revatio non-covered when used to treat patients with erectile dysfunction.

CONTRAINDICATIONS

Revatio potentiates the hypotensive effects of nitrates and is contraindicated in patients using organic nitrates regularly or intermittently (e.g., nitroglycerin and isordil). Coverage is allowed when the prescribing provider documents adequate communication with the patient regarding the risks.

CODING

J3490 - Unclassified drugs

VENTAVIS (ILOPROST) INHALATION SOLUTION

Chapter: Drugs

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

Ventavis (iloprost) inhalation solution was approved by the FDA August 24, 2005, to treat the symptoms of pulmonary arterial hypertension (PAH) in adults 18 years and older with New York

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Heart Association (NYHA) Class III or IV heart failure.

PAH – increased pressure in the main artery carrying blood from the right ventricle of the heart to the lungs – occurs when the smaller blood vessels in the lungs become resistant to blood flow causing the right ventricle to work harder to pump blood through the lungs.

Iloprost is a synthetic prostacyclin analogue that dilates both systemic and pulmonary arterial vascular beds, which decreases the pressure in the vessels resulting in increased supply of blood to the lungs and reduced workload of the heart. In controlled trials, Iloprost improved a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration.

Iloprost inhalation should be administered only via the I-Neb ADD System or ProDose AAD System 6 to 9 times per day (no more than every 2 hours) during waking hours according to individual need and tolerability. The maximum daily does evaluated in clinical studies for U.S. approval was 45 mcg.

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers the use of Iloprost medically necessary when **all** of the following criteria are met:

- Diagnosis of pulmonary arterial hypertension.
- 18 years of age or older.
- NYHA Class III or IV.

ZOMETA (ZOLEDRONIC ACID) INJECTION

Chapter: Drugs

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

Zometa (zoledronic acid) injection is part of a class of drugs called bisphosphonates that are used to improve bone strength in many diseases associated with bone resorption, such as cancer. The principal action of Zometa is to inhibit bone resorption. Although the mechanism is not completely understood, Zometa inhibits the increased osteoclastic (bone breakdown) activity and skeletal calcium release induced by various stimulatory factors released by tumors. This osteoclastic hyperactivity is the underlying mechanism resulting in hypercalcemia of malignancy (tumor-induced hypercalcemia) and metastatic bone disease.

Zometa is indicated in the treatment of hypercalcemia of malignancy for patients with multiple myeloma or documented bone metastases from solid tumors. It is given in conjunction with standard antineoplastic therapy. Treatment for patients with prostate cancer is indicated only after documented progression of disease following treatment with at least one hormonal therapy.

The safety and efficacy of Zometa in the treatment of hypercalcemia associated with hyperparathyroidism or other non-tumor related conditions have not been established.

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers the use of Zometa medically necessary for the treatment of patients with any of the following conditions:

- Hypercalcemia of malignancy.
- Diagnosis of multiple myeloma.
- Documented bone metastases from a solid tumor in conjunction with standard antineoplastic therapy.

- **Limitation:** Treatment for patients with prostate cancer is indicated only after documented progression of disease following treatment with at least one hormonal therapy.
- Treatment of osteoporosis in patients intolerant of oral bisphosphonate therapy. To receive coverage of this off-label use, documentation must include:
 1. A T-score of at least -2.5.
 2. A significant adverse reaction that precludes further use of at least two oral agents used to treat osteoporosis.
- Drug-induced osteopenia secondary to androgen-deprivation therapy in prostate cancer patients (prophylaxis). (USPDI August 2005).

INVESTIGATIONAL

BCBSMT considers the use of Zometa investigational to treat, including but not limited to, the following:

- To treat osteoporosis (see exception above). Osteoporosis therapy is covered under the pharmacy benefit.
- To prevent metastases in patients with solid tumors. Superiority to oral bisphosphonates has not been established for this indication.
- Hypercalcemia associated with hyperparathyroidism.
- Hypercalcemia associated with non-tumor related conditions.
- Use in pediatric patients.

CODING

J3487 - Zoledronic acid, 1 mg injection.

VAGUS NERVE STIMULATION (VNS)

Chapter: Medicine: Treatments

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

In 1997, FDA approved a vagus nerve stimulation (VNS) device for use in conjunction with drugs or surgery “as

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an adjunctive treatment of adults and adolescents over 12 years of age with medically refractory partial-onset seizures". Medically refractory seizures are defined as seizures that occur in spite of therapeutic levels of antiepileptic drugs or seizures that cannot be treated with therapeutic levels of antiepileptic drugs because of intolerable adverse effects of these drugs.

Seizures (with or without a loss of consciousness) are defined as paroxysmal disorders of the central nervous system characterized by abnormal cerebral neuronal discharge. They are sub-classified into:

- Those with a generalized onset beginning throughout the brain.
- Those with a partial onset having a discrete focal onset. There are three principal subtypes of partial-onset seizures:
 1. Simple partial do not involve alteration of consciousness but may have observable motor components or may solely be a subjective sensory or emotional phenomenon.
 2. Complex partial seizures are partial-onset seizures that involve an alteration of consciousness.
 3. Partial onset seizures with secondary generalization: These seizures begin on one side of the brain then spread to the other side. This results in a generalized tonic-clonic seizure and a complete loss of consciousness.

Surgery for implantation of a vagal nerve stimulator involves wrapping two spiral electrodes around the left vagus nerve within the carotid sheath. The electrodes are connected to an infraclavicular generator pack. The stimulator may be programmed in advance to stimulate at regular times or on demand by patients or family by placing a magnet against the subclavicular implant site. While the mechanisms for the antiepileptic effects of VNS are not fully understood, the basic premise is that vagal visceral afferents have a diffuse central nervous system projection, and activation of these pathways has a widespread effect on neuronal excitability.

On July 15, 2005, the FDA approved the VNS Therapy System "for the adjunctive long-term treatment of chronic or recurrent depression for patients 18 years of age or older who are experiencing a major depressive episode and have not had an adequate response to four or more adequate antidepressant treatments". The FDA has additionally required the manufacturer to conduct post-approval studies on the effectiveness of the treatment.

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers the use of a vagus nerve stimulator medically necessary for the following:

- As a treatment of medically refractory partial-onset seizures in patients for whom surgery is not recommended (e.g., bilateral or unresectable foci or no identified structural abnormality) or for whom surgery has failed.

INVESTIGATIONAL

BCBSMT considers the use of a vagus nerve stimulator investigational to treat, including but not limited to, the following:

- Seizures other than partial-onset seizures.
- Refractory depression (The currently available evidence is not sufficient to determine the efficacy of VNS therapy for this condition or to define the patient population that might be helped by this modality).
- Headaches.
- Essential tremor.

CODING

CPT Codes

64553 - Percutaneous implantation of neurostimulator electrodes; cranial nerve.

64573 - Incision for implantation of neurostimulator electrodes; cranial nerve.

64585 - Revision or removal of neurostimulator electrodes.

64590 - Insertion or replacement of peripheral neurostimulator pulse generator or receiver (Medicare).

64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver (Medicare).

95970 - Electronic analysis of implanted neurostimulator pulse generator system (Medicare).

95971 - Simple spinal cord or peripheral neurostimulator with intraoperative or subsequent programming (Medicare).

95974 - Cranial nerve neurostimulator analysis and programming.

95975 - each additional 30 minutes after the first hour.

HCPCS Codes

E0752 - Implantable neurostimulator electrode, each.

TOTAL HIP RESURFACING

Chapter: Surgery - Procedures

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

Hip resurfacing can be categorized as partial hip resurfacing (a femoral shell is implanted over the femoral head) and total hip resurfacing (consisting of an acetabular and femoral shell). This policy addresses total hip resurfacing and does not address medically necessary partial hip resurfacing of the femoral component only.

Total hip resurfacing has been proposed as an alternative to total hip arthroplasty in patients with a broad range of hip pathologies (e.g., osteoarthritis, rheumatoid arthritis, post-traumatic arthritis, advanced avascular necrosis, congenital hip dysplasia). Young patients who would potentially outlive a total hip prosthesis may benefit from total hip resurfacing as a time-buying procedure

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to delay the need for total hip arthroplasty. Proposed advantages include preservation of the femoral neck and femoral canal, thus facilitating revision or conversion to a total hip replacement. Total hip resurfacing has undergone various modifications in design, composition, and implantation techniques over the past several decades. Currently, FDA has approved one device for total hip resurfacing. The Beuchel-Pappas Integrated Total Hip Replacement is composed of a ceramic femoral component and a polyethylene acetabular component. Metal-on-metal designs are currently undergoing investigation as a part of the FDA approval process including, but not limited to, the Conserve-Plus (Wright Medical Technology) and DePuy ASR System.

POLICY

BCBSMT considers total hip resurfacing investigational. Currently, there are no long term studies showing total hip resurfacing devices are superior or equal to the standard total hip arthroplasty devices.

CODES

27299 - Unlisted procedure, pelvic or hip joint.

Note: CPT 27130 (arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft) should not be used to report total hip resurfacing.

WIRELESS CAPSULE ENDOSCOPY

Chapter: Medicine - Tests

Upcoming Policy

Effective Date: May 1, 2005

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DESCRIPTION

Wireless capsule endoscopy is currently being used to explore obscure sources of bleeding in the small bowel. The device is a disposable, pill-sized camera, which includes a light source, radio transmitter, and battery. After the device is swal-

lowed, it transfers pictures to a recorder carried by the patient. The recorder can be removed after 6 hours and the video images viewed. The device passes naturally from the body with the stool and is not recovered or reused.

FDA approved the device, called the Given Diagnostic Imaging System, for use along with – not as a replacement for – other endoscopic and radiological evaluations of the small bowel. The capsule was not studied for use in the large intestine since the battery has an expected life of eight hours, which is not long enough to photograph the entire gastrointestinal tract.

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers the use of wireless capsule endoscopy medically necessary when **all** of the following criteria are met:

- The patient has documented heme positive stool and anemia.
- The source of gastrointestinal bleeding is suspected to be from the small bowel and standard endoscopic and radiologic evaluations have failed to identify the source (e.g., upper endoscopy, colonoscopy, push enteroscopy, or radiologic procedure).
- The device used is FDA approved.

NOT MEDICALLY NECESSARY

BCBSMT considers the use of wireless capsule endoscopy not medically necessary for:

- The confirmation of lesions or pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileum).
- Patients with hematemesis who do not meet the medical necessity criteria above.

- More than one service per period of illness.

INVESTIGATIONAL

BCBSMT considers the use of wireless capsule endoscopy investigational for routine colon cancer screening.

CODING

91110 - Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report.

PATENT FORAMEN OVALE (PFO) CLOSURE DEVICES

Chapter: Surgery - Procedures

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

A patent foramen ovale (PFO) is a remnant of fetal circulation and may be detected in 10% to 15% of the adult population. PFOs are typically clinically insignificant and not associated with right to left shunting of blood. However, they may be associated with paradoxical embolus, in which an embolus from the venous circulation gains access to the arterial circulation through a PFO, resulting in a stroke or transient ischemic attack (TIA). Therefore, there has been interest in surgical closure of a PFO in patients with a history of embolic stroke of unknown cause. The benefit of the procedure is to prevent a possible recurrent non-cardiac event, typically cerebral ischemia. Alternatives to surgery include chronic coumadin therapy.

The two most common transcatheter devices approved by the FDA as a treatment of PFO include:

- CardioSEAL Septal Occlusion System.
- Amplatzer PFO Device.

Both devices received humanitarian device approval (a category of FDA approval applicable to devices designed to treat a patient population of less than 4,000 patients). Clinical trials to

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validate effectiveness of the device are not required. The labeled indications limit the use of these devices to closure of PFO in patients with recurrent cryptogenic stroke due to presumed paradoxical embolism through a PFO, and for patients who have failed conventional drug therapy (anticoagulants). Cryptogenic stroke is defined as a stroke occurring in the absence of a potential cardiac, pulmonary, vascular, or neurological source.

POLICY**Prior authorization is recommended.**

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT recommends evaluation by both a cardiologist and a neurologist to determine the alternatives, benefits, and risks of surgery to close a PFO. BCBSMT considers closure of a PFO through a transcatheter approach using an FDA approved device medically necessary when the following criteria are met:

- The patient has a history of stroke or transient ischemic attack due to presumed paradoxical embolism through a PFO.
- No other cause of stroke or transient ischemic attack has been identified.

INVESTIGATIONAL

BCBSMT considers closure of a PFO investigational in the following off-label indications including, but not limited to, the following:

- Divers who have a PFO who are at risk of clinical events related to paradoxical embolism through a PFO during decompression.
- Systemic deoxygenation due to right-to-left shunting through a PFO in the absence of severe pulmonary hypertension (e.g., platypnea orthodeoxia, right ventricular infarction).
- Migraine headaches accompanied by aura.

- Post-traumatic fat embolism syndrome with cerebral embolism by way of PFO.

CODING

93580 - Percutaneous transcatheter closure of congenital interatrial communication with implant.

TRANSCATHETER ARTERIAL EMBOLIZATION FOR CANCER TREATMENT

Chapter: Medicine: Treatments

Upcoming Policy

Effective Date: May 1, 2006

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DESCRIPTION

Transcatheter arterial chemoembolization (TACE) has been investigated to treat resectable, unresectable, and recurrent hepatocellular carcinoma and to treat liver metastases most commonly from colorectal cancer. Chemoembolization requires hospitalization for placement of a hepatic artery catheter via the femoral artery through which a viscous material containing one or more antineoplastic agents is injected. "Bland embolization" is embolization without chemotherapy. Radioactive isotopes may also be included in the material injected for localized radiotherapy. This is covered in the medical policy: Selective Internal Radiation Therapy for Primary and Metastatic Tumors of the Liver.

The rationale for TACE is that it delivers effective local doses while possibly minimizing systemic toxicities associated with oral or intravenous chemotherapy. Also, the viscous material and the chemotherapy may exert synergistic effects (cytotoxicity from the chemotherapy potentiated by anoxia in the infarcted region). Typically, only one lobe of the liver is treated during a single session, with subsequent embolization procedures scheduled from five days to six weeks later. In addition, since the embolized vessel recanalizes, chemoembolization can be repeated as many times as necessary.

Response to treatment and other out-

comes are strongly influenced by the number and size of the tumor(s), location relative to major vessels, and presence of concurrent liver disease (e.g., cirrhosis, hepatitis). The influence of these and other clinical characteristics on prognosis have given rise to at least 4 staging systems. Outcome within any prognostic category can still be highly variable, which raises questions regarding the validity of the results.

The preponderance of evidence based on randomized, prospective, controlled clinical trials does not support the conclusion that chemoembolization improves survival in hepatocellular carcinoma. No randomized, prospective, controlled clinical trials have been performed to assess survival benefit in patients with hepatic metastasis.

Treatment alternatives include resection when possible and chemotherapy administered systemically or by hepatic artery infusion, which involves continuous infusion of chemotherapy with an implanted pump and does not use embolic material.

POLICY**INVESTIGATIONAL**

BCBSMT considers the use of transcatheter hepatic arterial embolization investigational including, but not limited to, the following:

- Treatment of liver metastases.
- Primary or salvage treatment for newly diagnosed or recurrent hepatocellular carcinoma.
- Bridge to liver transplantation in patients with hepatocellular carcinoma.
- Treatment of any other carcinoma.

CODING

37204 - Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation).

75894 - Transcatheter therapy, embolization, radiological supervision and interpretation.

REMICADE (INFLIXIMAB)

Chapter: Drugs

Effective Date: May 1, 2006

Medical Policy is on-line at www.bluecrossmontana.com

DESCRIPTION

Remicade (Infliximab) is a chimeric monoclonal antibody that binds specifically to human tumor necrosis factor alpha (TNF-alpha). TNF has a broad spectrum of biologic activities. TNF is a key mediator of inflammation, and it is produced in response to infection and immunologic injury. Excess activation of TNF can result in severe inflammation and tissue damage while inhibition of TNF may alleviate symptoms and prevent disease progression in diseases characterized by high TNF expression. Elevated concentrations of TNF-alpha have been found in the joints of rheumatoid arthritis (RA) patients and in the stools of Crohn's disease patients. The following drugs inhibit the activity of TNF:

- Enbrel (etanercept): self-administered via subcutaneous injection.
- Humira (adalimumab): self-administered via subcutaneous injection.
- Thalidomide: oral.
- Remicade: IV infusion in doses from 3 mg/kg up to 10 mg/kg (The dosage interval depends on the disease being treated and ranges from every four to eight weeks).

The FDA first approved Remicade in the United States in August 1998 for the treatment of moderate to severe Crohn's disease in patients with an inadequate response to conventional therapy. Since then, the FDA has approved the following additional uses:

- Used with methotrexate for the treatment of RA in patients who have had an inadequate response to methotrexate alone (November 1999).
- For maintaining clinical remission in patients with moderate to severe Crohn's disease who have had an inadequate response to conventional therapy (2002).
- To treat ankylosing spondylitis (December 20, 2004).
- To treat psoriatic arthritis (May 17, 2005).
- To treat ulcerative colitis (September 16, 2005).

Given that elevated levels of TNF-alpha have been implicated in many inflammatory diseases, there has been interest in expanding the use of Remicade to a variety of off-label indications.

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

FDA APPROVED INDICATIONS

BCBSMT considers Remicade medically necessary when used to treat:

- Moderate to severe Crohn's disease in patients who have had an inadequate response to conventional therapy.
 - Dosing: 5 mg/kg at 0, 2, and 6 weeks.
 - Maintenance therapy: 5 mg/kg every 8 weeks.
- Fistulizing Crohn's disease to reduce the number of draining enterocutaneous and rectovaginal fistulas and for maintaining fistula closure.
 - Dosing: 5 mg/kg at 0, 2 and 6 weeks.
 - Maintenance therapy: 5 mg/kg every 8 weeks.
- Moderate to severe rheumatoid arthritis in patients with an inadequate response to methotrexate (use is approved only in combination with methotrexate).
 - Dosing: 3 mg/kg with similar doses at 2 and 6 weeks.
 - Maintenance therapy: 3 mg/kg every 8 weeks. For patient with an incomplete response, dosing up to 10 mg/kg every 8 weeks or treating as often as every 4 weeks.
- Psoriatic arthritis in patients who have had an inadequate response to conventional therapy.
- Ankylosing spondylitis in patients who have had an inadequate response

to conventional therapy.

- Moderate to severe ulcerative colitis to reduce signs and symptoms, achieve clinical remission and mucosal healing, and eliminate corticosteroid use for patients who have had an inadequate response to conventional therapy.

OFF- LABEL INDICATIONS

BCBSMT considers Remicade medically necessary when used to treat:

- Plaque psoriasis when patients have failed prior psoralen-PUVA therapy or other systemic therapies.

INVESTIGATIONAL

BCBSMT considers Remicade investigational to treat disorders including, but not limited to, the following:

- Juvenile rheumatoid arthritis.
- Pediatric patients with Crohn's disease (18 years or younger).
- Sjogrens syndrome.
- Treatment of psoriatic skin lesions (other than plaque psoriasis).
- Fibromyalgia.
- Scleroderma.

CONTRAINDICATIONS

Contraindications include, but are not limited to, the following:

- Patients with moderate or severe (NYHA Class III/IV) congestive heart failure.
- Patients with CHF of any class at doses greater than 5 mg/kg.
- Patients should be treated for latent tuberculosis infection prior to treatment with Remicade.
- Patients who have resided in regions where histoplasmosis or coccidioidomycosis is endemic. The risk versus benefit of treatment with Remicade should be carefully weighed.
- Patients with an active, clinically important infection.
- Patients with pre-existing or recent onset of central nervous system demyelinating or seizure disorder.

MEDICAL
POLICYALLERGY TESTING AND
TREATMENT

Chapter: Medicine: Tests

Effective Date: May 1, 2006

POLICY

MEDICALLY NECESSARY
ALLERGY TESTING

BCBSMT considers the following allergy tests medically necessary in the diagnosis of the allergic patient:

Direct Skin Test

BCBSMT considers direct skin testing using FDA approved antigens only:

- Percutaneous (scratch, prick, or puncture).
- Intracutaneous (intradermal).
- The number of tests required may vary widely from patient to patient (depending upon the patient's history). Rarely are more than 60 percutaneous or 15 intracutaneous tests required.

Serial Endpoint Testing (SET)

Serial endpoint testing (SET) is a form of intradermal skin testing that uses increasing doses of antigen to determine the concentration at which the reaction changes from negative to positive (endpoint). The test has been used for diagnosing allergic disorders and is a potential alternative to other diagnostic tests such as skin prick testing or in vitro testing for this purpose. SET has also been used to guide the initiation of immunotherapy by using the endpoint dilution as the starting antigen dose.

SET testing billing guidelines include:

- Per CPT guidelines, bill code 95027 for SET testing services.
- Per the June 1997 *CPT Assistant* guidelines, one unit is allowed for each antigen tested. For example, if skin end point titration is performed on two allergens with nine dilutions of each allergen, report two units of CPT code 95027.
- The antigen list is required with the claim to correctly process claims. Claims submitted without the antigen

list are denied as needing records to process.

Note: The following antigens are non-covered for direct skin test and SET:

- Bacterial antigens (often referred to as mixed respiratory vaccine are not FDA approved.
- Fungal intradermal skin testing (referred to as TOE) is not FDA approved to detect IgE mediated sensitivity by intradermal skin tests.
- Food antigens should not be tested intradermally because they cause false positive reactions, and the results are unreliable. There is also a greater likelihood of anaphylaxis for intradermal tested foods. There is no purpose for this testing because patients should not receive immunotherapy containing foods.

Patch Test (Application Test)

This testing modality identifies allergens causing contact dermatitis. The suspected allergens are applied to the patient's back under dressings and examined for evidence of delayed hypersensitivity reactions at 24, 48, and 72 hours.

Photo Patch Test

This test reflects contact photosensitization. A patch of skin is applied with the suspected sensitizer for 48 hours. If no reaction occurs, the area is exposed to a dose of ultraviolet light sufficient to produce inflammatory redness of the skin. If the test is positive, a more severe reaction develops at the patch site than on surrounding skin.

Specific IgE In Vitro Tests
(blood test)

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized. Include records supporting the use of IgE testing in members 10 years and older. Claims submitted without documentation are denied.

The following tests detect antigen-specific IgE antibodies in the patient's blood:

- Radioallergosorbent Test (RAST) CPT 86003.
- Multiple Radioallergosorbent Tests (MAST) CPT 86005.
- Fluorescent Allergosorbent Test (FAST) CPT 86003.
- Enzyme-linked Immunosorbent Assay (ELISA) CPT 86003.

They are considered medically necessary:

- When direct skin testing is impossible due to extensive dermatitis.
- When patients have marked dermatographism.
- When patients are unable to discontinue medication such as tricyclic antidepressants, Prednisone, or beta blockers that interfere with skin testing.
- In children less than ten years of age.

In addition, these IgE in vitro tests are only compensated when testing for suspected allergens and not when used as a multiple allergy-screening tool.

Total Serum (blood) IgE
Concentration

This testing modality is not indicated in most allergic patients but may be indicated for patients suspected of having allergic bronchopulmonary aspergillosis, immune deficiency disease characterized by increased IgE levels (e.g., Wiskott-Aldrich syndrome, hyper-IgE staphylococcal abscess syndrome), IgE myeloma, or pemphigoid.

CERTAIN BRONCHIAL
CHALLENGE TESTS

Histamine or methacholine is used to perform this test when it is necessary to determine if the patient has hyper-responsive airways. Volatile chemicals are used to perform the test when the allergy is encountered in an occupational setting. If dust, ragweed, or other common allergens are the suspected cause of the problem, this test is not medically necessary since skin tests can be used in these situations.

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Double Blind Food Challenge Test

With this test, the patient ingests the food to which sensitivity is suspected. Both the patient and the physician are "blind". This is usually done at home, but in some instances of extreme suspected hypersensitivity, it may be performed in a hospital setting.

INVESTIGATIONAL ALLERGY TESTING

BCBSMT considers the following allergy tests investigational in the diagnosis of the allergic patient:

1. Conjunctival challenge test (ophthalmic mucous membrane test).
2. Cytotoxic food test (also known as leukocytotoxic test).
3. Food allergen-specific IgG or IgG subclass antibody testing (86001).
 - Food allergen-specific IgG may be found in many normal and allergic individuals. There is insufficient evidence that the presence or quantity of food allergen-specific IgG produced as a result of natural exposure is related to allergic disease. The measurement of subclass specific IgG antibodies to foods has been inconsistent between various studies. Therefore, food-specific IgG or IgG antibodies has no recognized diagnostic value.
4. Leukocyte histamine release test (LHRT).
5. Nasal challenge test.
6. Passive transfer or P-K (Prausnitz-Kustner) test (obsolete--replaced by allowed Radioallergosorbent Tests).
7. Provocation-neutralization tests for food or food additive allergies, inhalant allergens, pollen, and environmental chemicals.
 - The test is performed by giving the member a dose of an extract of one of these substances by intracutaneous injection, subcutaneous injection, or sublingual drop. The member records any subjective sensations appearing during the next 10 minutes. Any report by the member constitutes

a "positive" test result (evidence for allergy to the substance).

8. Rebeck skin window test.
9. Direct skin testing for bacterial, fungal, and food antigens.

INVESTIGATIONAL ALLERGY TREATMENT

BCBSMT considers sublingual immunotherapy (SLIT) investigational. This methodology involves the use of FDA approved allergenic extracts administered orally. The FDA has not approved oral administration of allergenic extracts.

This service should be billed using CPT code 95199 with a description of the service provided in box 19 of the HCFA 1500 form. Per CPT, the reporting of allergy immunotherapy is per antigen administered in a single injection. Codes 95115- 95170 should not be reported for sublingual therapy.

IN VITRO FERTILIZATION

Chapter: Maternity/Gyn/Reproduction

Effective Date: May 1, 2006

POLICY

This policy covers treatment for in-vitro fertilization. Standard diagnostic tests for infertility are covered unless the member contract excludes treatment of infertility. Prior authorization is recommended for drugs used to treat infertility.

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

Note: Few contracts cover in-vitro fertilization. Contracts that cover in-vitro fertilization vary in the number of attempts allowed per lifetime. If allowed, the following medical policy criteria must also be met:

- The patient has a diagnosis of male, female, or combined infertility.
- The underlying cause of infertility has failed to respond to appropriate drug therapy, surgical intervention, or artificial insemination.

- The patient with the diagnosis of infertility is the covered member.

NON-COVERED

BCBSMT considers the following non-covered:

- Services for harvesting of oocyte from donor source, other than the covered member including, but not limited to, the following:
 - Drugs used to stimulate ovulation.
 - Ultrasounds.
 - Anesthesia.
 - Surgery.
 - Medical supplies.
 - Donor sperm.
 - In vitro fertilization services following an elective sterilization procedure.
 - Cryopreservation and storage of ova for future use.
 - Cryopreservation and storage of sperm for future use.

HERCEPTIN (TRASTUZUMAB)

Chapter: Drugs

Effective Date: May 1, 2006

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers the use of Herceptin medically necessary in patients with completely resected breast cancer whose tumor over-expresses the HER-2 protein and who meet either of the following criteria:

- The patient has node positive disease, **or**
- The patient has high-risk breast cancer defined as:
 - tumor greater than 1 cm in diameter (the tumor is estrogen receptor negative).
 - tumor greater than 2 cm in diam-

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ter (the tumor is estrogen receptor positive).

DURATION OF THERAPY

There is data to support the use of adjuvant Herceptin therapy for one year, and prior authorization is for one year. There is inadequate data to determine benefit for longer than one year, but it is being studied in the HERA trial.

INVESTIGATIONAL USES

Off-label uses of Herceptin are considered investigational as a treatment for other malignancies including, but not limited to, the following:

- Non-small cell lung.
- Ovarian.
- Prostate.
- Head and neck.
- Esophageal.
- Gastric.
- Pancreatic.
- Colorectal.

LENSES AND FRAMES AFTER CATARACT SURGERY

Chapter: Vision

Effective Date: May 1, 2006

POLICY**COVERED**

Most patients require a change in their corrective lenses following cataract surgery. BCBSMT compensates for corrective lenses when the member's vision prescription is altered by the cataract surgery. The claim is processed from the medical benefit and is in addition to the standard, non-accommodating intraocular lens implanted at the time of surgery. Frames are provided only when the member does not have frames prior to cataract surgery.

For patients who are unable to have the standard intraocular lens implanted during cataract surgery, BCBSMT allows, **on a one-time basis only**, two contact lenses and one pair of glasses following surgery. The claim is processed from the medical benefit.

NON-COVERED

BCBSMT considers the accommodating IOL non-covered. However, compensation up to the cost of a standard plastic intraocular lens is allowed when patients having cataract surgery choose to upgrade to the accommodating intraocular lens.

POSITRON EMISSION TOMOGRAPHY (PET)

Chapter: Radiology

Effective Date: May 1, 2006

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY CARDIAC APPLICATIONS

BCBSMT considers PET scans for the following cardiac applications medically necessary:

- Myocardial perfusion to diagnose coronary artery disease when used instead of, but not in addition to, single photon emission computed tomography (SPECT) or following an inconclusive SPECT.
- Myocardial viability in patients with severe left ventricular dysfunction as a technique to determine candidacy for a revascularization procedure.

MEDICALLY NECESSARY ONCOLOGIC APPLICATIONS

Note: Limitation of PET scan coverage by cancer diagnoses is based on Medicare criteria for coverage.

BCBSMT considers PET scans for the evaluation of malignancy medically necessary for the following malignancies and when one or more of the additional criteria are met:

1. **Solitary Pulmonary Nodules:** Characterization.
2. **Non-Small Cell Lung Cancer:** Diagnosis, staging, and restaging.

3. **Esophageal Cancer:** Diagnosis, staging, and restaging.

4. **Colorectal Cancer :** Diagnosis, staging, and restaging. Also for determining the location of tumors if rising CEA level suggests recurrence.

5. **Lymphoma:** Diagnosis, staging, and restaging.

6. **Melanoma:** Diagnosis, staging, and restaging. Non-covered for evaluating regional nodes.

7. **Breast Cancer:** As an adjunct to standard imaging modalities for staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis. As an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated.

8. **Head and Neck Cancers (excluding CNS and thyroid):** Diagnosis, staging, and restaging.

9. **Thyroid Cancer:** Restaging of recurrent or residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin greater than 10 ng/ml and negative I-131 whole body scan performed.

ADDITIONAL CRITERIA

Diagnosis: PET is covered only in clinical situations where the results may assist in avoiding an invasive diagnostic procedure, or the results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. For most solid tumors, a tissue diagnosis is made prior to PET scanning.

Staging and Restaging: PET is covered for the following clinical situations:

- The stage of the cancer remains in doubt after completion of a standard diagnostic workup including biopsy and conventional imaging such as computed tomography, magnetic resonance imaging, or ultrasound.
- The use of PET is considered reason-

Medical Policy is on-line at www.bluecrossmontana.com

able and necessary if it could potentially replace one or more conventional imaging studies when it is expected that the conventional study information is insufficient for the clinical management of the patient.

- Clinical management of the patient would differ depending on the stage of the cancer identified.
- PET is covered for restaging after the completion of treatment to:
 - Detect residual disease.
 - Detect suspected recurrence.
 - Determine the extent of a known recurrence.

Monitoring: Restaging only occurs after a course of treatment is completed. PET is not covered for the following:

- Use of PET to monitor tumor response during a planned course of therapy (e.g., when no change in therapy is being contemplated) is not covered. For example, BCBSMT will not cover a PET scan after two weeks of a planned six-week course of chemotherapy.
- Long-term treatment with drugs such as Tamoxifen is not considered a course of therapy for breast cancer patients.

OTHER MEDICALLY NECESSARY APPLICATIONS

BCBSMT considers PET scans medically necessary for the evaluation of the following:

1. For the diagnosis and treatment of mild cognitive impairment (MCI) and early dementia in patients who meet all of the following criteria:
 - Documented cognitive decline of at least six months.
 - Who meet the diagnostic criteria for both Alzheimer's disease and fronto-temporal dementia.
 - Have been evaluated for specific alternate neurodegenerative diseases or causative factors and the cause of the clinical symptoms remains uncertain.
2. When used in the assessment of selected patients with refractory epileptic seizures who are candidates for

surgery. Appropriate candidates for FDG (2-[fluorine-18]-floro-2-deoxy-d-glucose) PET Scans for epileptic seizure patients are those patients who meet the following criteria:

- Have complex partial seizures that have failed to respond to medical therapy.
- Have been advised to have a resection of a suspected epileptogenic focus located in the region of the brain accessible to surgery.
- Conventional techniques for seizure localization have been tried and provided data that suggest a seizure focus but are not sufficiently conclusive to permit surgery.
- The purpose of the PET examination should be to avoid subjecting the patient to extended pre-operative electroencephalographic recording with implanted electrodes.

INVESTIGATIONAL

BCBSMT considers PET scans for any disease or condition not listed above, investigational. The progress of PET scan technology continues to change rapidly. BCBSMT extends our willingness to update medical policy when research demonstrates effectiveness.

AUTOLOGOUS CHONDROCYTE TRANSPLANTATION

Chapter: Surgery - Procedures

Effective Date: May 1, 2006

POLICY

Prior authorization is recommended.

To authorize, call BCBSMT Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451. A retrospective review will be performed if services are not prior authorized.

BCBSMT considers autologous chondrocyte transplantation for the treatment of cartilage defects medically necessary when all of the following criteria are met:

- Age 15-45 years.
- Weight is less than 150% of ideal using the Metropolitan Life Indices.

- Presence of disabling pain and/or knee locking.
- Focal articular cartilage defect down to subchondral bone on a load-bearing surface of the medial and/or lateral femoral condyle or trochlea.
- Size of the defect is less than 7 mm in depth, less than 6 cm in length, and area ranging from 1.6 to 10 cm².
- Stable knee with intact meniscus and normal joint space on x-ray.
- No active inflammatory or other arthritis, clinically and by x-ray.
- Failure of conservative therapy (minimum of two months of physical therapy) as well as other traditional surgical interventions (e.g., micro-fraction, drilling, abrasion).
- A cooperative patient for post-operative weight bearing restrictions and activity restrictions together with a potential for completion of post-operative rehabilitation.

CHIROPRACTIC CARE

Chapter: Therapies

Effective Date: May 1, 2006

POLICY

BCBSMT covers chiropractic services only when performed with the expectation of restoring the member's level of function that has been lost or reduced by injury or illness. Members must have a significant acute health problem in the form of a neuro-musculoskeletal condition necessitating treatment. The manipulative services rendered must have a direct therapeutic relationship to the patient's condition, and once the maximum therapeutic benefit has been achieved, ongoing maintenance therapy is not covered.

DOCUMENTATION REQUIREMENTS

The maintenance of adequate and accurate clinical records is a requirement for all physicians and hospitals. Chiropractors must use Medicare/Medicaid clinical documentation guidelines available on the American Chiropractic Association website. Documentation should be complete and legible to reviewers other than

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the author, include positive and negative findings, and be recorded in a timely manner. The Administrative Rules of Montana governing Chiropractors state that all records must be legible and contain at a minimum:

- Date(s) of service.
- Pertinent history.
- Relevant symptomology.
- Physical findings.
- Diagnostic test results.
- Clinical assessment.
- Treatment procedures.
- Patient progress.

BCBSMT requires the following documentation for records review:

- The precise level of subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine or extremity.
- Submitted documentation must contain sufficient data to substantiate the diagnosis and need for treatment on each date of service.
- Records for therapeutic services require documentation of time spent.
- Documentation for all services must be legible and signed by the health care provider (e.g., date(s) of service and diagnosis [not a list of symptoms]).

To substantiate medical necessity:

- It is essential to report the most complete and precise diagnosis(es) on the claim form.
- Service(s) billed should be appropriate for the diagnosis.
- Documentation in the clinical record (e.g., physical findings and historical data) should confirm the diagnosis and support the medical necessity and appropriateness of the service billed.
- Documentation should be available for each service billed.

COVERED SERVICES

- Chiropractic manipulation (CPT codes 98940 – 98943) with appropriate diagnosis(es).
- Therapeutic procedures (CPT codes

97110, 97112, 97116, 97124, 97140, and 97530).

- Myofascial release (CPT code 97140).
- Physical medicine and rehabilitation (CPT codes 97012 – 97035).
- Diagnostic x-ray coverage to the yearly maximum of the member's contract.
- Initial evaluation and management of a new patient, subject to the criteria for new patient exams, (CPT codes 99201 – 99205) in addition to a manipulation code (CPT codes 98940 – 98943).
- Established patient evaluation and management (CPT codes 99211 – 99215) in addition to a manipulation code (CPT codes 98940 – 98943) in the following instances:
 - First encounter of an episode of illness (i.e., new complaint, an exacerbation of an old injury).
 - There is a separately identifiable condition.
 - A re-evaluation of a patient not responding to treatment.
 - An evaluation for referral.
- Unlisted evaluation and management services (CPT code 99499). Records are required.
- Pool therapy (CPT code 97113) will be reviewed for medical necessity after four visits.
- Unlisted services (CPT code 97139 or 97039) may or may not be compensated depending on the service. Include a description in Box 19 of the HCFA/CMS billing claim form. Claims are denied if there is no description included.
- Chiropractors who are also licensed acupuncturists may bill for acupuncture (CPT code 97780). Compensation is made only if the member contract covers acupuncture services, and it is billed under the acupuncture provider ID number.
- Fitting of orthotics (CPT code 97760). Compensation is made only if the member contract covers orthotic services.

NON-COVERED SERVICES

- Group therapy (CPT code 97150).
- Hubbard tank (CPT code 97036).
- Oscillating waterbed therapy (CPT code 97139 – unlisted code).
- Nutritional supplements and therapy provided by the chiropractor.
- Vertebral Axial Decompression (VAX-D) Therapeutic Table (HCPCS code S9090).
- Maintenance therapy.
- Supplies.
- Instrumentation that does not improve diagnostic accuracy, enhance clinical management, or improve patient outcomes, including but not limited to:
 - Cineradiography or videofluoroscopy (CPT code 76120).
 - Surface electromyography (SEMG) (CPT code 96002-96004).
 - Computerized inclinometry.
 - Dermothermography (CPT Codes 93760 and 93762).

NOT MEDICALLY NECESSARY

Maintenance Therapy: A treatment plan seeks to prevent disease, promote health, and prolong and enhance the quality of life. Therapy is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is considered not medically necessary.



Secure Services

- **CLAIMS STATUS**
- **ELIGIBILITY**
- **BENEFITS**

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Regular Business



HOW THE BLUECARD PROGRAM WORKS

The BlueCard Program is a national program that enables members traveling or living in another Blue Cross Blue Shield (BCBS) Plan's area to receive the same benefits and BCBS provider access. The BlueCard Program allows health care providers to submit claims for members from other BCBS Plans, including international BCBS Plans, directly to BCBSMT. BCBSMT is the primary point of contact for most claims-related questions.

The BlueCard Program links participating health care providers and the independent BCBS Plans across the country and around the world through a single electronic network for claims processing and compensation. Over 53,000 out-of-state members living in Montana have claims processed through the BlueCard Program.

PRODUCTS AND SERVICES INCLUDED IN THE BLUECARD PROGRAM

The BlueCard Program applies to all inpatient, outpatient, and professional claims. Traditional, Preferred Provider Organization (PPO), Point-of-Service (POS), and HMO products are included in the BlueCard Program.

PRODUCTS AND ACCOUNTS EXCLUDED FROM THE BLUECARD PROGRAM

The following products are excluded under the BlueCard Program:

- BlueCHIP.
- Caring Program for Children.
- Federal Employee Program.
- Medicare Risk.
- Stand-alone dental and prescription drugs.

Some Medicare supplement plans will be **paid** by other plans, but continue to

submit claims to BCBSMT.

EXCEPTIONS TO BLUECARD CLAIMS SUBMISSION

Rare exceptions may arise in which BCBSMT requires you to file the claim directly with the member's BCBS Plan. Some of these exceptions include, but are not limited to, the following:

- The ID card does not include an alpha prefix. (The claim is from an exempt plan such as FEP. **Follow the claims filing instructions noted on the card.**)
- A temporary processing issue at BCBSMT, the member's Blue Plan, or both that prevents processing of the claim through the BlueCard Program.

MEMBER ELIGIBILITY

When members from other Blue Cross and Blue Shield Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the alpha prefix, a blank suitcase logo, except, for eligible PPO members, in which case, PPO will appear in a suitcase logo.

ALPHA PREFIX

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route out-of-state claims. The alpha prefix identifies the BCBS Plan or national account to which the member belongs, and is critical for confirming a patient's membership and coverage.

There are two types of alpha prefixes: plan-specific and account-specific.

1. **Plan-Specific** alpha prefixes are assigned to every plan and start with X, Y, Z or Q. The first two letters indicate the plan while the third letter identifies the member's product.
 - First character (X, Y, Z or Q)
 - Second character (A-Z)
 - Third character (A-Z)
2. **Account-Specific** alpha prefixes are assigned to centrally processed national accounts. National accounts

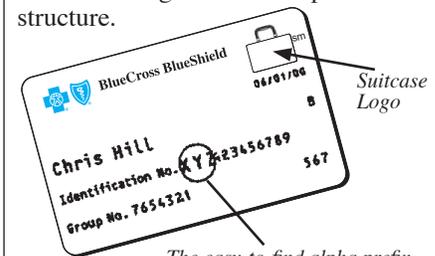
are employer groups that have offices or branches in more than one area but offer uniform benefit coverage to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z, or Q. Typically, a national account alpha prefix will relate to the name of the group. All three letters are used to identify the national account.

IDENTIFICATION CARDS WITH NO ALPHA PREFIX

Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Look for instructions or a telephone number on the back of the member's ID card for information on how to file claims. If that information is not available, call Customer Service at 1-800-447-7828.

SUITCASE LOGO

A suitcase logo on a member's ID card means the patient has BCBS traditional, PPO, or HMO benefits delivered through BlueCard. Some plans may adjust benefits according to the home plan's benefit structure.



More information about filing out-of-state claims is available in the BCBSMT Provider Manual at www.bluecrossmontana.com. Contact Customer Service at 1-800-447-7828, extension 8622, or your Provider Network Service Representative (see inside back cover) for questions about out-of-state claims.

BLUECARD® PROGRAM — NEW MEDICARE CROSSOVER CONSOLIDATION PROCESS

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to the local Medicare

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intermediary. When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier (this may be different from the local Blue Plan). Check the member's ID card for additional verification. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership, coverage, and to facilitating prompt payment.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to BCBSMT.
- If the remittance indicates that the claim was not crossed over, submit the claim to BCBSMT with the Medicare remittance advice.
- For claim status inquiries, contact BCBSMT BlueCard Program Customer Service Team at 1-800-447-7828, extension 8622.

To simplify and streamline claims submission, the Centers for Medicare and Medicaid Services is now consolidating its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA). Under this program, the COBC automatically forwards most Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Blue Plans are implementing the Medicare crossover consolidation process System-wide and will continue to do so over the next few months. Once the consolidated crossover process is fully implemented, you should experience an increased level of *one-stop* billing for your Medicare primary claims.

This change may affect the timing of the secondary payment from the

Blue Plan. The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan after the Medicare intermediary processes the claims. This process may take up to 14 business-days, and the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. It may take an additional 14-30 business days for you to receive payment from the Blue Plan.

If you submitted the claim to BCBSMT and have not received a response to your initial claim submission, do not submit another claim. Sending another claim actually slows down the claim payment process and creates confusion for the member. You should review the automated resubmission cycle on your claim system, wait 30 days, and/or check claims status before resubmitting.

If you have questions, call BCBSMT BlueCard Program Customer Service Team at 1-800-447-7828, extension 8622.

HIPAA

APS CASE MANAGEMENT AND HIPAA PRIVACY REGULATIONS

APS Healthcare provides case management services for most BCBSMT members. Medical Management staff at BCBSMT received notice from APS that a few providers declined to speak with case managers because of HIPAA privacy restrictions. BCBSMT has a business associate agreement in place and protected health information can be shared because case management is classified as health care operations.

If you have questions, contact the BCBSMT privacy official at 1-800-447-7828, extension 8409.

GOT INFO?

www.bluecrossmontana.com



FLUORIDE VARNISH APPLICATIONS

BlueCHIP will now compensate for fluoride varnish applications (D2101 and D2103) by medical providers. This change is an effort to improve oral health and prevent dental caries in children enrolled in the Children's Health Insurance Plan (CHIP). CHIP will continue to reimburse dental providers for this service through the Department of Public Health and Human Services.

Fluoride varnish is a protective coating painted on teeth to help prevent cavities, and it has a higher fluoride concentration than current gels, foams, rinses, and pastes. Varnish is also safer because less material is swallowed during application. It is not recommended for children who are not likely to develop cavities, drink fluoridated water, or receive other routine fluoride treatments.

If you have questions, call Customer Service at 1-800-447-7828.



FAX:

1-406-447-3570

MAIL:

Send change of information to
BCBSMT, Attn: HCS,
PO Box 4309, Helena, MT 59604

E-MAIL:

The Provider Network Specialist
at www.bluecrossmontana.com.
Click on *Provider Services* then
Service Teams.

NPI

NATIONAL PROVIDER IDENTIFIER TRANSITION DATES

BCBSMT is preparing its technical and business systems to comply with the HIPAA National Provider Identifier (NPI) rule, which calls for the use of NPIs in all electronic transactions by May 23, 2007. Critical to the success of the NPI project is our ability to coordinate BCBSMT activities with those of the health care community to avoid payment related problems for providers and members. To date, BCBSMT established the following NPI transition milestones:

JANUARY 1, 2006 — DECEMBER 31, 2006

NPIs can be submitted along with your BCBSMT provider number on all standard electronic transactions. Electronic transactions submitted with only an NPI number will not be processed. BCBSMT verifies the NPI number for electronic claims transaction submitted with NPIs. More information will be published in future Capsule News.

JANUARY 1, 2007 — MAY 23, 2007

Standard electronic transactions can be submitted only with an NPI. However, electronic claims can be submitted with BCBSMT provider numbers only or both NPI and BCBSMT provider numbers. The NPI verification will continue during this period.

MAY 23, 2007

All standard electronic transactions must not contain BCBSMT provider ID numbers. Although not specified in the NPI rule, BCBSMT has adopted a policy requiring all paper claims be submitted with NPI numbers. Claims submitted with a BCBSMT provider ID number after May 23, 2007 will be returned. Effective October 2, 2006, Medicare claims can be submitted only with an NPI, but because BCBSMT will not be ready to process NPI only claims until

January 1, 2007, providers are urged not to submit NPI only claims to Medicare. BCBSMT will encounter payment problems for members with BCBSMT Medicare secondary insurance coverage. Health care providers are encouraged to apply for NPIs as early as possible because this will afford providers and BCBSMT ample time to test NPI claims processing. Providers may apply for an NPI at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. Mail a copy of the NPI validation to:

BCBSMT
Attention: Deb Stewart/HCS
P.O. Box 4309
Helena, MT 59604

UB-92 CLAIM FORM

The National Uniform Billing Committee unveiled the new UB-04 form at its May 12, 2005 meeting. The UB-04 is scheduled to replace the UB-92 beginning March 1, 2007. Health plans, clearinghouses, and other health care vendors should be ready to accept the new UB-04 form and data set March 1, 2007.

From March 1 to May 22, 2007, providers can use the UB-04 or UB-92 forms and data set specifications. The UB-92 is officially discontinued May 23, 2007, and only the UB-04 form should be used. Any claims resubmitted must use the new UB-04 form from this date forward even though earlier submissions may have been on the old UB-92. More information is available at <http://www.nubc.org>.

CMS-1500 CLAIM FORM

The National Uniform Claim Committee has proposed a new version of the HCFA-1500 paper claim form. The proposed form has a number of enhancements including the placement of the NPI field. Health plans, clearinghouses, and other health care vendors should be ready to accept the new CMS-1500 form and data set by October 1, 2006. Providers can use either the current HCFA-1500 form or the proposed CMS-1500 form from October 1, 2006 to February 1, 2007.

The current HCFA-1500 form will be discontinued February 1, 2007, and only

the proposed CMS-1500 form should be used. Any claims resubmitted must use the proposed CMS-1500 form from this date forward even though earlier submissions may have been on the current HCFA-1500 form. More information is available at <http://www.nucc.org>.

If you any questions about NPI and BCBSMT provider identification numbers, contact your Provider Network Service Representative (see inside back cover).

Deb... We need those NPI forms!



Please Help Deb... Send her a copy of your National Provider Identifier validation form to:

Deb Stewart, Health Care Services,
Blue Cross Blue Shield of Montana
P.O. Box 4309, Helena, MT 59604

Health
HeWeb

- Low-cost claims billing software
- HIPAA transaction and code set compliant
- Montana based electronic claims clearinghouse
- Connectivity to over 900 payers

For more information on how HeW can help you, visit our website at www.health-e-web.net.

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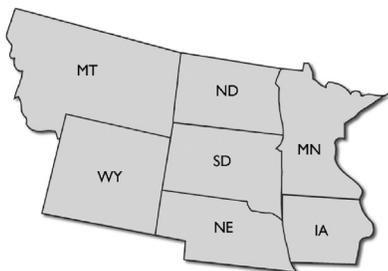


MedicareBlueSM PPO

A Medicare Advantage Plan

MEDICAREBLUE PPO AND PRESCRIPTION DRUG PLANS OPERATIONAL

Effective January 1, 2006, the Medicare Advantage regional PPO product, MedicareBlue PPO, began operations. MedicareBlue PPO offers benefit plans for members including plans offering medical coverage only and plans offering both medical and prescription drug (Part D) coverage. MedicareBlue PPO has an extensive network of physicians, specialists, hospitals, and pharmacies in Montana, Wyoming, South Dakota, North Dakota, Minnesota, Iowa, and Nebraska. This coalition of Blue Plans is known as the Northern Plains Alliance.



MedicareBlue PPO is federally regulated by the Centers for Medicare and Medicaid Services (CMS). Most state health plan requirements are pre-empted for MedicareBlue PPO and are not applicable.

AmeriHealth in Pennsylvania manages claims and appeals processing functions including provider and member services. Blue Cross and Blue Shield of Minnesota

performs all medical management functions for MedicareBlue PPO members, and local Blue Cross and Blue Shield Plans manage provider contracting, sales, and marketing. For your convenience, the MedicareBlue PPO Provider Guide is available online at yourmedicaresolutions.com.

CLAIMS, ELIGIBILITY, AND BENEFIT INFORMATION

Contact AmeriHealth at 1-888-457-3009 Monday-Friday, 8:00 a.m. to 6:00 p.m. central or mountain standard time to check claim status, verify eligibility, and confirm benefit information. Send written correspondence to:

Provider Service
P.O. Box 8556
Philadelphia, PA 19101-8556

MEMBER ID CARDS

	MedicareBlue SM PPO
DO NOT BILL MEDICARE	
BS PLAN CODE <XXX> • BC PLAN CODE <XXX> [Rx BIN <610455> • RxPCN <MPD19> • Issuer <60840>]	
<SAMPLE, JOHN Q> <XAA1234567800> <Office Visit \$10> <ER \$50>	MEDICARE ADVANTAGE PPO
CMS - R5566 <003>	

<p>Customer Service: <1-888-457-3009> or TTY users should call <1-888-457-3005> Hours of Operation: <Monday-Friday 8:00 a.m.-6:00 p.m. Central and Mountain Time>.</p> <ul style="list-style-type: none"> • Please present this card at the time of service. • Medicare limiting charges apply. • Submit all claims to your local Blue Cross and Blue Shield Plan. • To locate a MedicareBlue PPO Provider: Call <1-800-610-BLUE> or Call Customer Service at <1-888-457-3009> or Access Searchable Directory at <www.YourMedicareSolutions.com>. • For NURSE phone care and advice 24 hours a day, call <1-800-622-9524>. <p>Providers: Submit all claims to your local Blue Cross and Blue Shield Plan. For admission notifications call <1-800-XXX-XXXX>. Provider Service: <1-888-457-3009>.</p> <p><small>Your MedicareBlue PPO coverage is provided by only one of the following plans, depending on your state of residence: Wellmark Blue Cross and Blue Shield of Iowa; Blue Cross and Blue Shield of Minnesota; Blue Cross and Blue Shield of Montana; Blue Cross and Blue Shield of Nebraska; Blue Cross Blue Shield of North Dakota; Wellmark Blue Cross and Blue Shield of South Dakota; and Blue Cross Blue Shield of Wyoming. Independent licensees of the Blue Cross and Blue Shield Association.</small></p>

Although each member should present an ID card upon request for services, the card cannot fully ensure current eligibility. Providers are encouraged to contact AmeriHealth to obtain eligibility. Member to read both sides carefully for

any special claims, benefit, or customer service information.

Alpha prefixes for each state are as follows:

State	Alpha Prefix
Iowa	IAZ
Minnesota	XZW
Montana	MMY
North Dakota	NDA
Nebraska	YEA
South Dakota	SDZ
Wyoming	WYA

MEDICAL MANAGEMENT

Medical management programs are designed to ensure appropriate utilization of health care resources and define and agree upon standards of care. MedicareBlue PPO medical management programs include prior authorization, pre-admission notification for inpatient admissions, and case management services. The medical management process is a review only for medical necessity. Payment for services is still subject to all other terms of the member's benefit package as determined by CMS.

For health care support, contact Blue Cross and Blue Shield of Minnesota at 1-866-537-7702. Send written correspondence to:

Medical Management
P.O. Box 64265, Route R4-18
St. Paul, MN 55164-0560

ESSENTIAL	MedicareBlue PPO Essential	MedicareBlue PPO Essential Plus Rx 1
Services from Network Providers	\$25 per office visit \$25 per specialist visit \$500 per hospital stay	\$25 per office visit \$25 per specialist visit \$500 per hospital stay
Emergency Room	\$50 co-pay (waived if admitted)	\$50 co-pay (waived if admitted)
Inpatient Hospital	\$500 for each Medicare-covered stay	\$500 for each Medicare-covered stay
Ambulance	\$100 co-pay	\$100 co-pay
Out-of-Pocket Maximum	\$2,900 in-network \$7,100 out-of-network	\$2,900 in-network \$7,100 out-of-network
Out-of-Network Services	40% coinsurance	40% coinsurance
Outpatient Surgery	\$150 per visit	\$150 per visit
Preventive Benefits	No co-pay for clinic/ diagnostic lab services, pneumonia and flu vaccines, and most cancer screenings	No co-pay for clinic/ diagnostic lab services, pneumonia and flu vaccines, and most cancer screenings
Drug Options	No Coverage	Rx 1: Two Level Formulary \$5 / \$24

BENEFIT PLANS

Each state in the Northern Plains Alliance offers two benefit plans with or without prescription drug coverage. Medicare eligible members can choose from MedicareBlue PPO Essential or MedicareBlue PPO Enhanced. There is no need to select a primary care physician and referrals are not required. MedicareBlue PPO offers more coverage (including preventive benefits) at a lower monthly premium, and both plans offer the freedom for members to choose their own doctors and hospitals.

Rx 1 drug plans are as follows:

- After the \$250 deductible, members pay \$5 for Level 1 formulary generic drugs and \$24 for Level 2 formulary preferred drugs.
- After total yearly drug costs reach \$2,250, members pay 100% for all prescription drugs.
- After total yearly out-of-pocket drugs costs reach \$3,600, members pay the greater of: \$2 for generic or multi-source preferred brand and \$5 for all other drugs, or 5% of the drug costs.

Rx 2 drug plans are as follows:

- There is no deductible.
- Members pay \$5 for Level 1 formulary generic drugs, \$20 for Level 2 formulary preferred drugs, and 50% for level 3 formulary brand drugs.
- After total yearly out-of-pocket drugs costs reach \$2,250, members pay 100% for all prescription drugs.
- After total yearly out-of-pocket drugs costs reach \$3,600, members pay the greater of: \$2 for generic or multi-source preferred brand and \$5 for all other drugs, or 5% of the drug costs.

If you have questions about network participation and/or your Medicare Advantage provider contract, contact your Provider Network Development Representative (see inside back cover). Contact AmeriHealth at 1-888-457-3009 Monday-Friday, 8:00 a.m. to 6:00 p.m. central or mountain standard time to check claim status, verify eligibility, and confirm benefit information. A MedicareBlue PPO Provider Guide is available at yourmedicaresolutions.com (For Providers).

ENHANCED	MedicareBlue PPO Enhanced	MedicareBlue PPO Enhanced Plus Rx 1 or Rx 2
Services from Network Providers	\$10 per office visit \$10 per specialist visit \$100 per hospital stay	\$10 per office visit \$10 per specialist visit \$100 per hospital stay
Emergency Room	\$50 co-pay (waived if admitted)	\$50 co-pay (waived if admitted)
Inpatient Hospital	\$100 for each Medicare-covered stay	\$100 for each Medicare-covered stay
Ambulance	\$100 co-pay	\$100 co-pay
Out-of-Pocket Maximum	\$1,000 in-network \$5,000 out-of-network	\$1,000 in-network \$5,000 out-of-network
Out-of-Network Services	20% coinsurance	20% coinsurance
Outpatient Surgery	\$50 per visit	\$50 per visit
Preventive Benefits	No co-pay for clinic/ diagnostic lab services, pneumonia and flu vaccines, and most cancer screenings	No co-pay for clinic/diagnostic lab services, pneumonia and flu vaccines, and most cancer screenings
Drug Options	No Drug Option	Rx 1: Two Level Formulary \$5 / \$24 Rx 2: Three Level Formulary \$5 / \$20 / 50%

MEDICARE ADVANTAGE PROVIDER GUIDE
yourmedicaresolutions.com/for_providers

Regular Business



MEDICARE PART B ADVANCED BILLING SEMINAR

Medicare Part B is hosting an advanced billing seminar at the Red Lion Colonial Hotel in Helena April 19, 2006. The cost is \$45.00 per person and includes lunch and seminar materials. Check in is from 7:30 a.m. — 8:30 a.m. and includes a continental breakfast.

The general session is from 8:30 a.m. — 11:45 a.m. for all providers and includes a panel discussion. Afternoon sessions include:

Provider Based Clinics, Rural Health Clinics, Federally Qualified Health Clinics (12:45 p.m. — 2:30 p.m. and 2:15 p.m. — 4:30 p.m.). This session is for hospital-owned clinics meeting Medicare Part A criteria for CMS approved Designated Provider Based Clinics, Rural Health Clinics, and Federally Qualified Health Clinics. Medicare Part A and B will be present.

Medicare and the Paperless Society (12:45 p.m. — 2:30 p.m. and 2:15 p.m. — 4:30 p.m.). This is an interactive session navigating Medicare related websites and learning about their value to providers.

CEU credits are being requested, and you can register for the seminar at www.medicare.bcbsmt.com. If you have questions, call 1-877-567-7203.

OVER/UNDER

INCORRECT PAYMENT ADJUSTMENTS

Overpayments and underpayments may be adjusted within one year after the date of payment. The one-year time period

does not apply to:

- The BlueCard program.
- Medicare claims.
- Other Party Liability (e.g., Workers' Compensation, third-party liability insurers, automobile medical payers, and/or other insurance).
- Fraud investigations.
- Groups for whom BCBSMT administers benefits (e.g., State of Montana, Montana Automobile Dealers Association, University System, etc.) have the discretionary authority to render the final decision on overpayments and underpayments beyond the one-year time period.

Corrections automatically are adjusted from future payments. However, patient and claim information *is not* carried over to the next provider claims register/remit. Automatic reversals are necessary for the timely processing of claims because of the large volume of adjusted claims during processing. Reversals expedite payment to all providers involved in the claim because neither party is waiting for returned payments and reprocessing of claims that require additional paperwork and time is unnecessary.

BCBSMT highly recommends that providers adjust patient account records from each weekly Provider Claims Register.

Overpayment and Underpayment Process

Step	Description
1	BCBSMT becomes aware of an overpayment or underpayment when the provider notifies BCBSMT, a claims audit identifies an overpayment or underpayment and/or from a denied or corrected claim.
2	Customer Service initiates an adjustment to correct the claim.
3	The adjustment will automatically reprocess the claim to pay the correct amount (There is no need to re-submit the claim).
4	The overpayment will be reversed from the following PCR check, and the underpayment will appear as an adjustment on the following PCR.



CLARIFYING THE SPECIALTY CARE REFERRAL PROCESS

The following information provides clarification for requesting a referral from TriWest when a second specialist is needed. Two examples of the specialist-to-specialist referral process are:

1. A primary care manager refers a member to a cardiologist who determines cardiovascular surgery is necessary. The cardiologist submits a request to TriWest for a referral to a cardiovascular surgeon. The cardiologist's consult report indicates the need for a second specialist. The consult report keeps the primary care manager aware of the need for a second specialist and the member's condition, but there is no need for the member to return to their primary care manager to obtain the referral.
2. A primary care manager refers a member to a cardiologist who determines the beneficiary has tested positive for Type II Diabetes. In this case, the member is directed back to their primary care manager who requests a referral from TriWest to the appropriate physician.

If additional services are required for the same diagnosis, the specialist can request a referral to a second network specialist. If it is not the same diagnosis, the member is directed back to their primary care manager because the services required are not be within the scope of the initial specialist.

For further information on the referral process, Medical Necessity Review List, or consult tracking, call 1-888-TRIWEST (1-888-874-9378) or visit www.triwest.com.



QUESTIONS?

CALL BCBSMT HEALTH CARE SERVICES 1-800-447-7828



MONTANA TRICARE PROVIDER SEMINAR INVITATION

Register online for TRICARE Provider Seminars at www.triwest.com

CHECK ONE:	SEMINAR TYPE:	DATE	TIME	LOCATION / ROOM	CITY	ZIP CODE	RESPOND BY:
	Medical / Surgical	Wednesday, May 10, 2006	9:30 AM D 11:30 AM	Mary Alice Fortin Center at Deaconess Hospital HCC B & D 2800 10 th Avenue N	Billings	59107	Wednesday, May 3, 2006
	Medical / Surgical	Wednesday, May 10, 2006	1:30 PM D 3:30 PM	Mary Alice Fortin Center at Deaconess Hospital HCC B & D 2800 10 th Avenue N	Billings	59107	Wednesday, May 3, 2006
	Medical / Surgical	Tuesday, May 16, 2006	9:00 AM D 11:00 AM	St. Patrick Hospital Conference Center #1, Broadway Building 500 W. Broadway Street	Missoula	59802	Tuesday, May 9, 2006
	Medical / Surgical	Tuesday, May 16, 2006	1:00 PM D 3:00 PM	St. Patrick Hospital Conference Center #1, Broadway Building 500 W. Broadway Street	Missoula	59802	Tuesday, May 9, 2006
	Medical / Surgical	Thursday, May 18, 2006	9:00 AM D 11:00 AM	Best Western Helena Great Northern Hotel Iron Horse Ballroom 835 Great Northern Boulevard	Helena	59601	Thursday, May 11, 2006
	Medical / Surgical	Wednesday, May 31, 2006	9:00 AM D 11:00 AM	Benefis Healthcare E D Dufresne Auditorium 1101 26 th Street South	Great Falls	59405	Wednesday, May 24, 2006
	Behavioral Health	Wednesday, May 31, 2006	1:00 PM D 3:00 PM	Benefis Hospital/Dufresne Room 1101 26 th Street South	Great Falls	59405	Wednesday, May 24, 2006
	Medical / Surgical	Thursday, June 1, 2006	9:00 AM D 11:00 AM	Best Western Butte Plaza Inn Lobby Conference Room 2900 Harrison Avenue	Butte	59701	Thursday, May 25, 2006

REGISTRATION REQUIRED

By registering online, you will receive an email confirmation and a reminder notice prior to scheduled seminar. If you do not have Internet access, copy this page and fax your registration to (866) 867-7925. Bring your email confirmation to enter a drawing for a small prize.

List ALL Attendees:	
Provider/Group Name:	
Provider/Group Address (Including City, State, Zip Code):	
List ALL Tax ID #'s represented or provide separate list:	
Contact Name & Phone Number:	
Email Address:	

Check www.triwest.com prior to attending the seminar to verify the location. If you have questions, email pseminar@triwest.com or call (602) 644-5584.

Regular Business**2005****PROVIDER SATISFACTION SURVEY RESULTS**

BCBSMT completed its annual provider satisfaction survey during October and November 2005. The Myers Group in Snellville, GA administrated the survey. 1,400 providers were randomly selected from over 4,000 participating providers, and 516 responded to the 3-wave mail survey. The survey measures 19 attributes to assist BCBSMT in developing a comprehensive plan for improving and maintaining provider satisfaction.

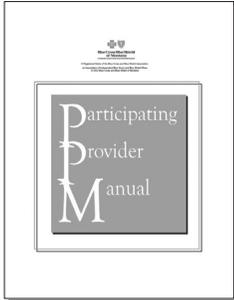
The Top Box (excellent and very good response options) scores for overall health plan satisfaction is 80.7% compared to 67.0% in 2004, 72.8% in 2003, 79.6% in 2002, and 64.8% in 2001. However, the ratings for BCBSMT are significantly higher than the provider ratings for other plans in all surveyed attributes. Compared to last year's BCBSMT Top Box scores, the overall satisfaction with BCBSMT increased by 13.7%.

The table below illustrates the BCBSMT rating compared to other plans and previous year's scores.

	Survey Item	BCBSMT	2005 Top Box Score	2004 Top Box Score	2003 Top Box Score	2002 Top Box Score
		Others				
1	Responsiveness and courtesy of Provider relation's representatives.	BCBSMT <i>Others</i>	65.0% 25.7%	50.9% 20.2%	61.0% 21.0%	64.9% 25.9%
2	Timeliness to answer questions and/or resolve problems.	BCBSMT <i>Others</i>	59.4% 19.8%	46.5% 18.0%	52.9% 15.6%	58.0% 17.7%
3	Frequency and effectiveness of provider representative visits.	BCBSMT <i>Others</i>	36.1% 12.3%	17.7% 5.3%	25.8% 9.1%	31.2% 9.0%
4	Quality of provider orientation process.	BCBSMT <i>Others</i>	37.7% 14.3%	22.3% 6.7%	29.7% 7.9%	35.1% 9.4%
5	Reasonableness of paperwork and documentation.	BCBSMT <i>Others</i>	42.2% 14.9%	24.5% 10.0%	34.5% 16.6%	35.7% 13.0%
6	Usefulness of BCBSMT's Provider Workshops.	BCBSMT <i>Others</i>	39.9% <i>na</i>	35.8% <i>na</i>	39.1% <i>na</i>	34.9% <i>na</i>
7A	Usefulness of Capsule News.	BCBSMT <i>Others</i>	39.9% <i>na</i>	30.4% <i>na</i>	39.3% <i>na</i>	37.2% <i>na</i>
7B	Usefulness of Provider Manuals.	BCBSMT <i>Others</i>	36.6% <i>na</i>	27.6% <i>na</i>	39.8% <i>na</i>	32.4% <i>na</i>

7C	Usefulness of Provider Contracts.	BCBSMT	35.1%	27.1%	34.7%	29.6%
		<i>Others</i>	<i>na</i>	<i>na</i>	<i>na</i>	<i>na</i>
7D	Usefulness of Provider Directories.	BCBSMT	43.7%	30.0%	43.0%	37.8%
		<i>Others</i>	<i>na</i>	<i>na</i>	<i>na</i>	<i>na</i>
8	The health plan's administration of the PCP's specialist referrals.	BCBSMT	30.3%	21.0%	26.6%	29.5%
		<i>Others</i>	<i>16.1%</i>	<i>13.5%</i>	<i>16.7%</i>	<i>16.0%</i>
9	The health plan's facilitation of clinical care for patients.	BCBSMT	40.0%	23.7%	30.1%	35.1%
		<i>Others</i>	<i>16.5%</i>	<i>12.2%</i>	<i>13.7%</i>	<i>14.9%</i>
10	The health plan's support of physician relationship with patients.	BCBSMT	34.3%	22.2%	29.3%	32.3%
		<i>Others</i>	<i>16.5%</i>	<i>14.3%</i>	<i>14.8%</i>	<i>14.9%</i>
11	Degree to which prevention and wellness are covered/encouraged.	BCBSMT	28.0%	23.1%	27.3%	27.2%
		<i>Others</i>	<i>11.1%</i>	<i>14.3%</i>	<i>11.9%</i>	<i>11.4%</i>
12	The health plan's support of appropriate clinical care for patients.	BCBSMT	36/6%	22.0%	33.5%	34.1%
		<i>Others</i>	<i>15.0%</i>	<i>13.9%</i>	<i>15.4%</i>	<i>12.4%</i>
13	The health plan's support concerning medical management.	BCBSMT	30.9%	21.5%	26.9%	33.2%
		<i>Others</i>	<i>13.8%</i>	<i>10.7%</i>	<i>12.1%</i>	<i>11.2%</i>
14	Accuracy of claims processing.	BCBSMT	58.5%	49.4%	50.0%	58.4%
		<i>Others</i>	<i>23.2%</i>	<i>21.4%</i>	<i>22.7%</i>	<i>23.1%</i>
15	Timeliness of claims processing.	BCBSMT	61.7%	52.6%	57.0%	63.8%
		<i>Others</i>	<i>15.1%</i>	<i>15.9%</i>	<i>18.1%</i>	<i>10.0%</i>
16	Ease of using health plan's provider claims payment register.	BCBSMT	60.4%	47.3%	60.0%	55.9%
		<i>Others</i>	<i>23.9%</i>	<i>15.9%</i>	<i>29.2%</i>	<i>21.4%</i>
17	Would you recommend BCBSMT to other patients?	BCBSMT	86.7%	77.5%	35.9%	37.9%
18	Would you recommend BCBSMT to other physicians?	BCBSMT	87.8%	75.5%	34.5%	36.1%
19	Overall satisfaction with BCBSMT.	BCBSMT	80.7%	67.0%	72.8%	79.6%
		<i>Others</i>	<i>60.1%</i>	<i>57.8%</i>	<i>58.4%</i>	<i>55.5%</i>

Regular Business



BCBSMT PROVIDER MANUAL UPDATED

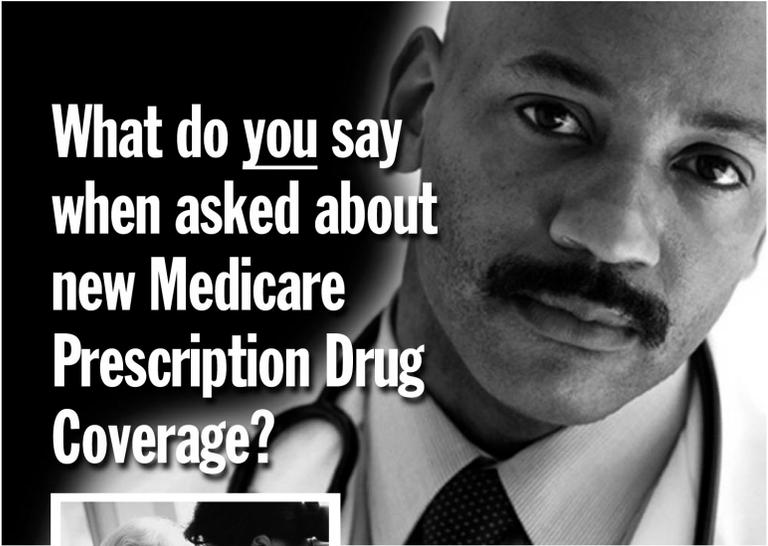
The BCBSMT Provider Manual is updated and published at www.bluecrossmontana.com. The manual is consistently reviewed for sentence structure and style with the goal of simple and direct instructions. A summary of changes includes:

1. Deleted reference to employee zip codes (59999) from IVR instructions (1-1).
2. Deleted reference to tax ID required from IVR instructions (1-1).
3. Deleted Internal Team central region Network Specialist (1-3, 1-4).
4. Deleted ERISA section (1-7). No operational instructions. Information only.
5. Deleted Participating Providers (1-6). Contract information and separate contract claims filing information is referenced in Chapter 5: FEP, Caring, BlueCHIP, and DOC Claims and Chapter 8: Managed Care.
6. Added phone extension of new privacy officer (1-7).
7. Updated credentialing standards. (1-8 through 1-13).
 - Updated TriCare credentialing requirements (1-9).
 - Updated physician and podiatrist education requirements (1-10).
 - Deleted CRNA education requirements (1-11).
 - Deleted nurse practitioner supervising physician requirements (1-12).
8. Added Secure Services hotline extension 8524 (2-1).
9. Added YDP alpha prefix information (2-3).
10. Added Appendix A: Provider Forms

- Neck/Spine MRI/CT Prior Authorization Form
- Brain MRI/CT Prior Authorization Form
- IV Therapy Prior Authorization Form
- Managed Care Referral Form
- Change of Status Form
- TriWest Credentialing Form

- BCBSMT Dental Claim Form

If you do not have Internet access and would like a copy, contact your Provider Network Service Representative (see inside back cover). If you have suggestions for improvements, contact Mike McGuire at mmcguire@bcbsmt.com or call 1-800-447-78258, extension 8412.



What do you say when asked about new Medicare Prescription Drug Coverage?



Beginning in January all your Medicare patients can get help from Medicare with their prescription drug costs. We want to help you answer questions you might get from your Medicare and Medicaid patients. There are local resources available for your patients to go to for more help.

- Visit www.medicare.gov to get personalized information through to Medicare Rx Plan Finder. Your patients should have their Medicare information, list of medicines and address of their local pharmacy with them before they start.
- Call 1-800-677-1116 or visit www.eldercare.gov to find local counselors.
- Call 1-800-Medicare to speak to a counselor.

If you need more information for your practice, go to www.cms.hhs.gov/medlearn/drugcoverage.asp.

Help is Here
24/7
1-800-MEDICARE
TTY 1-877-486-2048
www.medicare.gov

MedicareRx
Prescription Drug Coverage



MEDICARE ADVANTAGE PROVIDER GUIDE
yourmedicareolutions.com/for_providers

DID YOU KNOW?

Did you know that BCBSMT processed 84,575 more claims in 2005 than in 2004?

Month	2004	2005
January	290,722	299,093
February	279,176	292,866
March	341,499	357,934
April	304,908	303,130
May	288,751	314,527
June	300,038	323,810
July	291,782	277,383
August	302,899	301,294
September	286,875	289,889
October	295,675	256,526
November	270,846	319,998
December	297,262	298,568
Total	1,063,968	1,068,748

CLAIMS

UNIT OF SERVICE DENIALS

Customer service is receiving inquiries regarding claims that have been denied on the new system because the units of service reported do not match the date span submitted. Most of these denials are for psychotherapy services (90801-90899) and anesthesia qualifying circumstances codes 99100-99140. Most CPT codes are one unit on a single date unless the code specifies more than one unit is applicable (i.e., each additional unit or each 15 minutes).

PSYCHOTHERAPY CODES

Per CPT description, individual psychotherapy codes 90804-90829 are time directed (20-30 minutes, 45-50 minutes, and 75-80 minutes). Submit only one unit of service with the code applicable to the length of the session. Psychotherapy codes for group/family therapy are not time directed, so submit the code with one unit of service regardless of how long the session lasts. Multiple units submitted per date are denied for inappropriate units. If an individual

psychotherapy session lasts longer than 90 minutes, submit the appropriate 75-80 minute code with one unit and modifier 22 accompanied by documentation supporting a prolonged session.

When inappropriate units for these codes are reported on the old system, programming is set to compensate based on the units appropriate for the code and not the reported units. Because of this programming, providers are correctly compensated although they may not be aware that the units were billed incorrectly.

ANESTHESIA QUALIFYING CIRCUMSTANCE CODES

Per American Society of Anesthesiology, qualifying circumstances codes 99100-99140 are not time directed services but are reported in addition to the administration of the anesthesia service code. Do not report the associated base unit for the qualifying circumstance code. The correct base units for these codes are programmed into the system for correct application of anesthesia compensation logic (total base units multiplied by the conversion factor).

For examples, when code 99140 (two base units) is reported on the old claims processing system with two units, the system does not consider the units submitted, and applies the correct anesthesia compensation (the conversion factor multiplied by two additional base units).

The new claims system does not have this programming and requires correct coding of units. Submitting more than one unit splits the claim line and charge into multiple units resulting in lower compensation. For example, when code 99140 is reported with 2 units, the line is split into two lines, and the charge is divided evenly between the two lines. One line is allowed with anesthesia compensation logic applied, and one line is considered a duplication of services and denied. Correctly submitting 99140 with one unit enables appropriate anesthesia compensation (the conversion factor multiplied by two base units).

CODES DEFINING MULTIPLE SERVICES

A code that encompasses multiple services not performed on the same date

should be submitted as one unit with a single date. For example code 59425 (antepartum care) does not specify the number of services or dates. The code describes four to six visits and is compensated as one service. Therefore, submit claims with the date of the last visit and one unit of service. The claims processing system is not able to process these codes when reported as:

- One unit of service and a date span encompassing the 4th through the 6th visits.
- A date span and six units of service.
- One date of service and six units of service.

DATE SPAN AND UNITS OF SERVICE

When billing for multiple days, the units of service must match the date span reported. For example, code 99233 is performed 01/01/06, 01/03/06, 01/04/06 and 01/05/06. To match the units of service to the date span, submit the claim accordingly:

Line 1:

01/01/06, code 99233 with one unit.

Line 2:

01/03/06 – 01/05/06, code 99233 with three units.

or, Line 1:

01/01/06, code 99233 with one unit.

Line 2:

01/03/06, code 99233 with one unit.

Line 3:

01/04/06, code 99233 with one unit.

Line 4:

01/05/06, code 99233 with one unit.

If you have questions, contact customer service at 1-800-447-7828 or your provider representatives (see inside back cover).



CLAIMS STATUS

ELIGIBILITY

BENEFITS

www.bluecrossmontana.com

Regular Business**vs.****Same ingredients.****Cheaper price.**

**Which
would you
choose?**

Buy Generic.**Safe. Effective.****FDA approved.****Ask your pharmacist.**

**Blue Cross Blue Shield
of Montana**

An Independent Licensee of the Blue Cross and Blue Shield Association



® Registered Marks of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.

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www.bluecrossmontana.com

RVU**RVU UPDATE: CMS WEBSITE RESTRUCTURE**

The fourth quarter 2005 Capsule News published instructions to obtain updated Centers for Medicare and Medicaid Services (CMS) relative value units (RVU). Since then, CMS redesigned their website and the links to the RVU updates are no longer valid. To obtain the RVU updates at <http://www.cms.hhs.gov>, click on:

1. Medicare.
2. Physician Fee Schedule (listed under Medicare Fee-for-Service Payment).
3. PFS Relative Value Files (on the left).

You must have January 2006 UnZIP software installed on your computer to download the 2-megabyte files.

RFI**BCBSMT QUALITY FOCUSED SHARED SAVINGS INITIATIVE**

The BCBSMT Quality-Focused Shared Savings Initiative is designed to support professional and facility providers who are willing to critically examine and improve their medical care delivery. A Request for Information (RFI) is now available, and providers may obtain a copy by calling Jeanne at 1-800-447-7828, extension 8957.

Responses are due by 5 p.m. April 30, 2006, and can be delivered to 560 North Park Avenue in Helena, or mailed to:

Blue Cross and Blue Shield of Montana
Provider Compensation/Jeanne
P.O. Box 4309
Helena, MT 59604

It has to be Blue

www.bluecrossmontana.com

Provider Services

- Find a Doctor
- Provider Manuals
- Provider Policies
 - *Physician Fee Schedule*
- Medical Policy
- Pharmacy
- Dental
- Service Teams

News & Reports

- Capsule News
- HEDIS Reports

Forms

- Prior Authorize
- Claim Forms
- Credentialing

Useful Links

- Best Practices
- Transplant Net
- Medicare - MT
- FAQ



Download the BCBSMT Formulary to your PDA
AND
Download the BCBSMT Part D Formulary at epocrates.com



PHARMACY AND THERAPEUTICS COMMITTEE

BCBSMT held its quarterly Pharmacy and Therapeutic (P&T) Committee meeting on February 1, 2006. Participating physicians from various specialties were either present or teleconferenced for the meeting. The P&T committee's purpose is to review, discuss, and make decisions regarding pharmaceutical drugs and their formulary status with the goal of high-quality, low-cost drugs on the formulary. If you have any questions, contact Tina Wong at 1-800-447-7828, extension 8843.

FIRST QUARTER 2006 CHANGES TO THE FORMULARY

At the February P&T Committee meeting, eight new drugs were reviewed for formulary placement. Effective immediately, the following changes were made to the BCBSMT drug formulary that is used for the majority of its business. We encourage physicians to reference the formulary when prescribing medications for BCBSMT members.

Drug	Therapeutic Class	Formulary Status
Actoplus Met	Insulin Sensitizers and Combos	Formulary
Aptivus	Antiretrovirals	Formulary
Asmanex	Steroid Inhalants	Non-Formulary
Lyrica	Misc. Anticonvulsants	Non-Formulary
Naglazyme	Metabolic Modifiers	Non-Formulary
Nevanac	Misc. Ophthalmics	Non-Formulary
Rozerem	Selective Melatonin Receptor Agonists	Non-Formulary
Zemplar	Metabolic Modifier	Non-Formulary

NEW SPECIALTY PHARMACY PROVIDER

In late 2005, Express Scripts, Inc., (owner of CuraScript Pharmacy) purchased Priority Healthcare. CuraScript Pharmacy is now a preferred provider in our specialty pharmacy network that includes Priority Healthcare. You will notice different company information on pharmacy prior authorization forms and other pharmacy correspondence.



Participating Providers

The online provider directory is updated daily at www.bluecrossmontana.com. BCBSMT encourages providers to review their information and report any errors or changes.



The following pages list new and terminated providers for the Traditional Participating Provider Network and the Joint Venture Managed Care Provider Network. **Note:** If a participating provider changes locations, they may be listed below as a new participating provider because new effective dates for the new location are entered into the network management system.

November 2, 2005 to February 1, 2006

Blue Cross and Blue Shield of Montana welcomes these new participating providers to its Traditional Network.

Christine A. Adams, LCSW Bozeman..... Lic. Clin. Social Worker
 Jay R. Armstrong, PT Bozeman.....Physical Therapy
 Rollin W. Bearss, MDGreat Falls..... Urology
 Thomas G. Berbos, MD Helena..... Ophthalmology
 Big Sky Diagnostics.....Butte..... Radiology Center
 James P. Blasingame, MD..... Kalispell..... Orthopaedics
 Christian S. Breburda, MD Billings..... Internal Medicine
 Joy C. Burk, MD.....Great Falls.....Pediatrics
 Delaney J. Carlson, DC.....Bigfork.....Chiropractic
 James M. Cooper, MD Cut Bank...Obstetrics and Gynecology
 David I. Croteau, MDStevensville..... Family Practice
 Gordon M. Dean, DC.....Forsyth.....Chiropractic
 Ann M. Doll, CNM.....Great Falls..... Certified Nurse Midwife
 Dana C. Ducote, MDBigfork..... Family Practice
 Meredith C. Duvall, FNPButte..... Nurse Practitioner
 Derek Gilbert, MDHarlowton..... Family Practice
 D. J. Harboway, DDS.....Great Falls..... Dentist
 Mark J. Haynes, DC.....Billings.....Chiropractic
 Heather L. Heggem, PABillings..... Physician Assistant
 Erin B. Holm, PT Helena..... Physical Therapy
 Shaikh Rabiul Hoque, MD.....Great Falls..... Internal Medicine
 Scott R. Jahnke, DO.....Kalispell.....Physical Medicine
 & Rehabilitation
 Kari L. Jones, MD.....Missoula.....Pediatrics
 Torbjorn I. Joretteg, MDCondon..... Cardiovascular Disease
 Thomas C. Key, MDGreat Falls.....Neonatal-Perinatal
 Medicine
 Debra J. Klein, MDKalispell...Obstetrics and Gynecology
 Mary Z. Kleschen, MDMissoula..... Family Practice
 Terry L. Lanes, MDButte.....Psychiatry
 Niall Patrick Madigan, MD.....Whitefish..... Cardiovascular Disease
 Jules W. Marsh, MDKalispell..... Family Practice
 Daniel R. Mattson, CRNAButte..... Certified Registered
 Nurse Anesthetist
 Sandra S. McIntyre, MD.....Dillon..... Internal Medicine

Heidi A. McNulty, DOMissoula..... Family Practice
 Jonathan F. Mercer, MD..... Kalispell..... Urology
 Sharon A. Mulvehill, MDBillings..... Family Practice
 Edwin E. Peters, MDMissoula.....Pediatrics
 Curtis B. Pickert, MDMissoula.....Pediatrics
 Timothy R. Price, PTKalispell.....Physical Therapy
 Quincy L. Ribellia, DCLaurel.....Chiropractic
 Tracy E. Rogers, PA.....Kalispell..... Physician Assistant
 Claudia Roy, DCLaurel.....Chiropractic
 Chad D. Russell, DDSThree Forks..... Dentist
 Nicholas R. Sams, DCBillings.....Chiropractic
 Jason J. Schmidt, MDKalispell..... Family Practice
 Cornelia Simunic, NPCut Bank..... Nurse Practitioner
 Ronald P. Skipper, MDLewistown..... Surgery
 George T. Stafford, MD Havre..... Surgery
 Jerome R. Stewart, DOBillings..... General Practice
 Amy B. Sullivan, NP..... Helena..... Nurse Practitioner
 James D. Swift, MD.....Missoula.....Pediatrics
 Jane E. Taylor, PAThompson Falls..... Nurse Practitioner
 Jay D. Taylor, MD..... Conrad..... Family Practice
 Joel B. Territo, DCWhitefish.....Chiropractic
 Craig W. Tolleson, MD Helena.....Psychiatry
 Kathleen R. Trapp, MD.....Townsend..... Family Practice
 Troy D. Wagner, PABillings..... Physician Assistant
 Karmen L. Walker, PTBozeman..... Physical Therapy
 James Bryce Wiley, PA-CBozeman..... Physician Assistant
 Mark A. Wilson, DCMissoula.....Chiropractic
 Roberta E. Wilson, OT.....Corvallis..... Occupational Therapy
 Anne M. Yeakey, MDMissoula.....Pediatrics

The following providers are no longer participating with the Blue Cross and Blue Shield of Montana Network.

Lynne M. Boone, OT Helena..... Occupational Therapy
 Warren D. Bowman, MDBillings..... Internal Medicine
 Timothy D. Browne, MD..... Polson..... Orthopaedics
 Nicholas M. Campbell, MD.....Townsend..... Family Practice
 Patricia Carlson, LCSW..... Emigrant..... Lic. Clin. Social Worker

Virginia Ellen Ceynar, PA..... Sidney..... Physician Assistant
 Kirk L. Christianson, DDS.....Billings..... Dentist
 Deane Cowan, LCPC..... Bozeman..... Lic. Clin. Prof. Counselor
 Shannon Lee Crossler, LCPC..... Chinook..... Lic. Clin. Prof. Counselor
 Donald F. Findon, PT.....Billings..... Physical Therapy
 William S. Fitterman, DO.....Glendive..... Internal Medicine
 Wayne Frederickson, DDS.....Livingston..... Dentist
 Fay Friede, LCPC..... Chinook..... Lic. Clin. Prof. Counselor
 Raul S. Garcia, PA-C.....Billings..... Physician Assistant
 Erin R. Hamlin, PA-C.....Billings..... Physician Assistant
 Lance F. Hamlin, PA-C.....Billings..... Physician Assistant
 Karl J. Hapcic, MD..... Bozeman..... Plastic Surgery
 Gordon E. Harrison, DC..... Hardin.....Chiropractic
 John S. Hunt, MD..... Bozeman.....Oncology
 Vernon T. Jenkins, DC.....Gardiner.....Chiropractic
 Patrick (Rick) F Johnson, LCPC..... Bozeman..... Lic. Clin. Prof. Counselor
 John W. Jost, DMD..... Helena..... Dentist
 Theresa Kaufman-McGeary, OT.....Missoula..... Occupational Therapy
 Kathryn A. Kelley, LCPC..... Helena..... Lic. Clin. Prof. Counselor
 Carol A. Korizek-McKenzie, LCPC.....Billings..... Lic. Clin. Prof. Counselor
 Theodore K. Kulaga, DDS.....Livingston..... Dentist
 Jerome P. La Valley, DDS.....Livingston..... Dentist
 John H. Layer, MD..... Kalispell..... Internal Medicine
 Johnson E. Loh, MD.....Livingston..... Internal Medicine
 Timothy R. Lund, DDS..... Bozeman..... Dentist
 Philip M. Mamalakis, LCPC.....Missoula..... Lic. Clin. Prof. Counselor
 Beverly J. McGowan, FNP..... Cut Bank..... Nurse Practitioner
 Scott David McKee, MD..... Dillon..... Internal Medicine
 Thomas McKenzie, LCSW..... Helena..... Lic. Clin. Social Worker
 Bruce D. Mikesell, MD.....Missoula..... Family Practice
 Jeannie M. Muir-Padilla, MD.....Billings..... Pathology
 Stephen S. Nagy, MD..... Helena..... Psychiatry
 Maria K. Nash, PT.....Missoula..... Physical Therapy
 Ann M. Neutgens, OD..... Bozeman..... Optometry
 Neva M. Oliver, NP.....Missoula..... Nurse Practitioner
 Robert Parrott, DO.....Missoula..... Family Practice
 Garr T. Phelps, DDS..... Deer Lodge..... Dentist
 Debra Lynn Retzlaff, OT.....Butte..... Occupational Therapy
 Robert James Rollins, MD..... Havre..... Pulmonary and
 Critical Care
 Beverly G. Rooley, NP.....Stevensville..... Nurse Practitioner
 Dean Sullivan, DDS.....Billings..... Dentist
 Laura G. Taffs, LCPC..... Helena..... Lic. Clin. Prof. Counselor
 Karen E. Thornton, PT.....Great Falls..... Physical Therapy
 Debra L. Tubbs, LCSW..... Wolf Point..... Lic. Clin. Social Worker
 Richard A. Wells, DO..... Thompson Falls..... Family Practice
 Sandra K. Whaley-Olson, PHD.....Billings..... Psychology
 Deloit R. Wolfe, DDS.....Missoula.....Orthodontics

Blue Cross and Blue Shield of Montana welcomes these new Joint Venture Network providers.

Christine A. Adams, LCSW..... Bozeman..... Lic. Clin. Social Worker
 Kyle E. Austin, PA..... Kalispell..... Physician Assistant
 Linda Barone, LCPC..... Kalispell..... Lic. Clin. Prof. Counselor
 Big Sky Diagnostics.....Butte..... Radiology Center
 David C. Boharski, FNP..... Kalispell..... Nurse Practitioner
 Judy Bolewicz, OT..... Bozeman..... Occupational Therapy
 John M. Brandon, LCPC.....Lakeside..... Lic. Clin. Prof. Counselor
 Karl E. Buechsenschuetz, DO.....Missoula..... Orthopaedics
 Delaney J. Carlson, DC.....Bigfork.....Chiropractic
 Robert A. Clary, DO..... Shelby..... Family Practice
 Annette C. Comes, MD..... Lewistown..... Family Practice
 Sharon W. Dillon, LCSW.....Missoula..... Lic. Clin. Social Worker
 Dana C. Ducote, MD.....Bigfork..... Family Practice
 Meredith C. Duvall, FNP.....Butte..... Nurse Practitioner
 Cindy K. Feddes, FNP..... Bozeman..... Nurse Practitioner
 Mary K. Fouhy-Thurston, NP..... Bozeman..... Nurse Practitioner
 Megan M. Gittings, NP..... Helena..... Nurse Practitioner
 Michael G. Goodman, MD..... Kalispell.....Oncology
 Kim D. Hackl, CRNA..... Bozeman..... Certified Registered
 Nurse Anesthetist
 Carlin C. Hale, LCPC..... Kalispell..... Lic. Clin. Prof. Counselor
 Mark J. Haynes, DC.....Billings.....Chiropractic
 Beth R. Henning, SLP.....Billings..... Speech Therapy
 Shaikh Rabiul Hoque, MD.....Great Falls..... Internal Medicine
 Linda G. Hosek, PT.....Whitefish..... Physical Therapy
 Scott R. Jahnke, DO..... Kalispell..... Physical Medicine
 & Rehabilitation
 Kari L. Jones, MD.....Missoula..... Pediatrics
 Katie E. Jones, FNP..... Billings..... Nurse Practitioner
 Torbjorn I. Joretteg, MD..... Condon..... Cardiovascular Disease
 Margaret S. Kearney, LCSW..... Polson..... Lic. Clin. Social Worker
 Debra J. Klein, MD..... Kalispell..... Obstetrics and Gynecology
 Mary Z. Kleschen, MD.....Missoula..... Family Practice
 Kevin B. Krieg, DC.....Missoula.....Chiropractic
 Patricia J. Lane, PT.....Great Falls..... Physical Therapy
 Carmen F. Lousen, LCPC.....Missoula..... Lic. Clin. Prof. Counselor
 Niall Patrick Madigan, MD.....Whitefish..... Cardiovascular Disease
 Edward J. Madler, MD..... Kalispell..... Anesthesiology
 Gerianne R. Marchion, LCPC..... Anaconda..... Lic. Clin. Prof. Counselor
 Marias Medical Center..... Shelby..... Hospital
 Marian J. McIntyre, LCSW.....Butte..... Lic. Clin. Social Worker
 Sandra S. McIntyre, MD..... Dillon..... Internal Medicine
 Jonathan F. Mercer, MD..... Kalispell..... Urology
 Dana B. Miquelle, LCPC..... Bozeman..... Lic. Clin. Prof. Counselor
 Marie Mitchell, NP..... Bozeman..... Nurse Practitioner
 Sharon A. Mulvehill, MD.....Billings..... Family Practice

Martina J. Nelson, LCPC.....Libby..... Lic. Clin. Prof. Counselor
 Dennis L. Peet, LCSW.....Kalispell..... Lic. Clin. Social Worker
 Edwin E. Peters, MD.....Missoula.....Pediatrics
 Curtis B. Pickert, MD.....Missoula.....Pediatrics
 Timothy R. Price, PT.....Kalispell.....Physical Therapy
 Shari L. Rogler, CRNA.....Dillon..... Certified Registered
 Nurse Anesthetist
 Jason J. Schmidt, MD.....Kalispell..... Family Practice
 George T. Stafford, MD..... Havre.....Surgery
 Lance L. Stewart, MD.....Shelby..... Family Practice
 Jennifer A. Strine, PA.....Thompson Falls..... Physician Assistant
 Mary B. Sturhan, LCPC.....Libby..... Lic. Clin. Prof. Counselor
 James D. Swift, MD.....Missoula.....Pediatrics
 Jane E. Taylor, PA.....Thompson Falls..... Nurse Practitioner
 Jay D. Taylor, MD.....Conrad..... Family Practice
 Kristin R. Veneman, DO.....Whitefish.....Pediatrics
 Ellen Vogelsang, SLP.....Helena.....Speech Therapy
 James Bryce Wiley, PA-C.....Bozeman..... Physician Assistant

Anne M. Yeakey, MD.....Missoula.....Pediatrics
 Patrice L. Yowell, LCPC.....Missoula..... Lic. Clin. Prof. Counselor
 Amy J. Zuroff, SLP.....Bozeman.....Speech Therapy

The following providers are no longer participating with the Joint Venture Provider Network.

Robert A. Babbitt, PAC.....Columbia Falls..... Physician Assistant
 Timothy D. Browne, MD.....Polson..... Orthopaedics
 Charles T. Burton, MD.....Great Falls..... Dermatology
 Joseph D. Chopyak, PA-C.....Butte..... Physician Assistant
 John H. Layer, MD.....Kalispell..... Internal Medicine
 Jeannie M. Muir-Padilla, MD.....Billings..... Pathology
 Robert James Rollins, MD.....Havre..... Pulmonary and
 Critical Care
 Beverly G. Rooley, NP.....Stevensville..... Nurse Practitioner
 Eric W. Rudd, MD.....Hamilton..... Orthopaedics
 Gordon Steven Wallace, LCPC.....Billings..... Lic. Clin. Prof. Counselor
 Richard A. Wells, DO.....Thompson Falls..... Family Practice

PROVIDER SERVICES

Provider Services

- Find a Doctor
- Provider Manuals
- Povidner Policies
 - *Physician Fee Schedule*
- Medical Policy
- Pharmacy
- Dental
- Service Teams

News & Reports

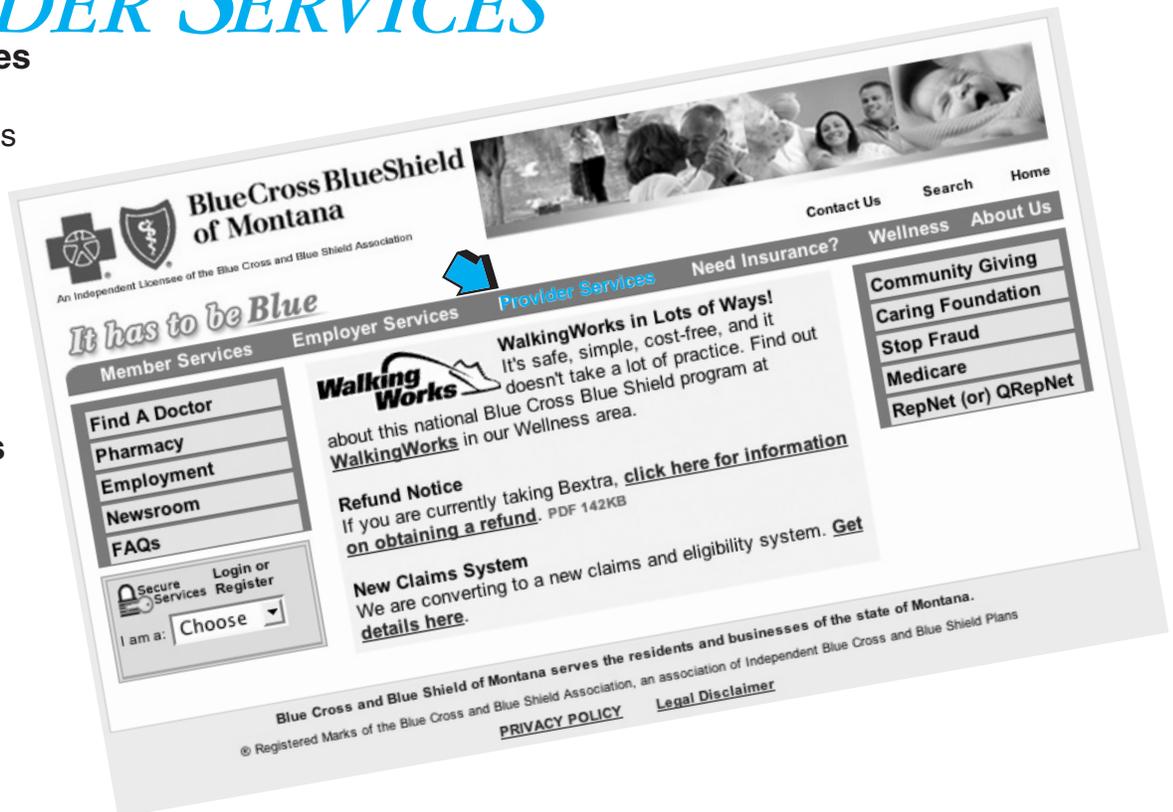
- Capsule News
- HEDIS Reports

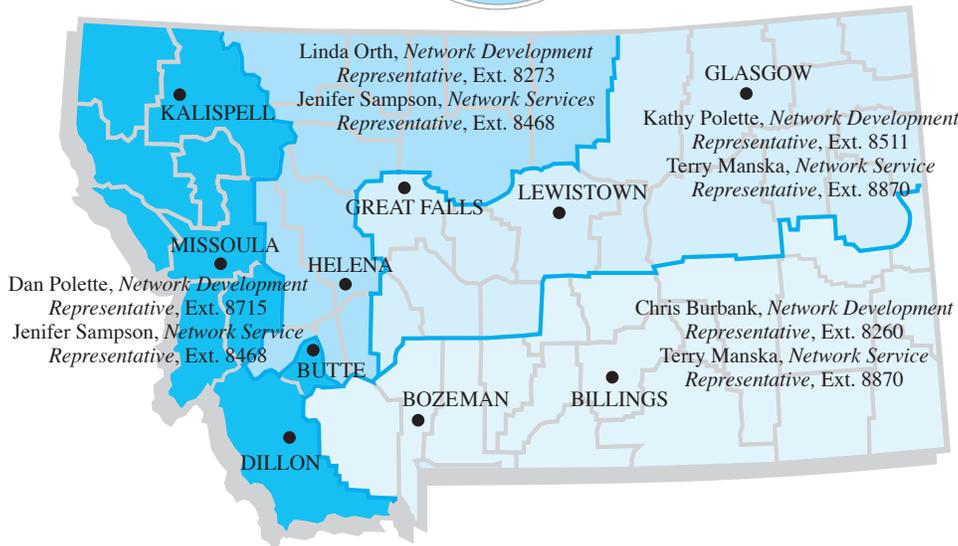
Forms

- Prior Authorize
- Claim Forms
- Credentialing

Useful Links

- Best Practices
- Transplant Net
- Medicare - MT
- FAQ

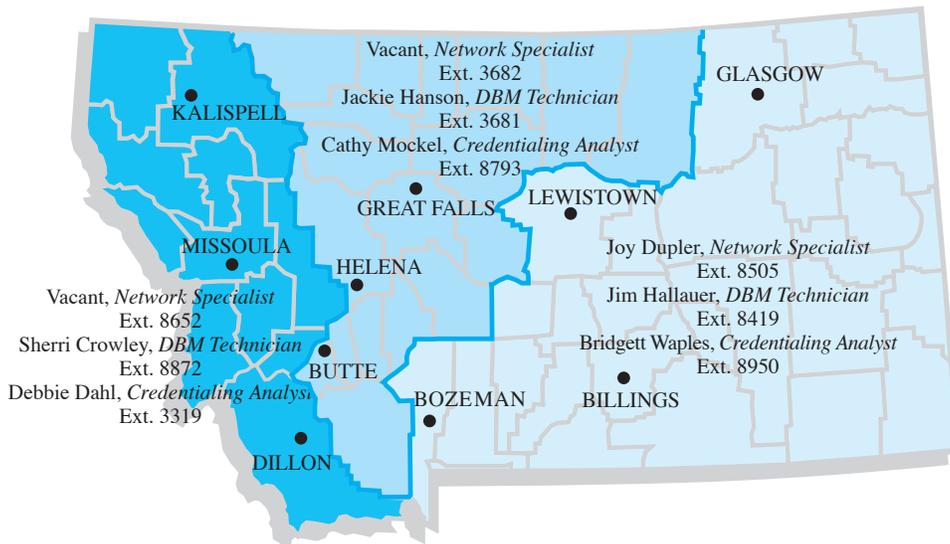




The **External Team** consists of Network Development Representatives and Network Service Representatives who travel to provider offices in their respective areas.

- **Network Development Representatives** negotiate provider and facility contracts and address contractual issues relevant to all lines of business.
- **Network Service Representatives** assist provider offices to resolve recurring problems and continuing education.

Contact the External Team if you have any questions concerning office visits, billing with the BCBSMT ID number according to contract, product information, provider workshops, and any other contracting or operational issues beyond the scope of Customer Service



The **Internal Team** consists of Provider Relations Specialists, Database Maintenance Technicians, and Credentialing Analysts who expedite the data processes necessary to manage the BCBSMT provider networks.

- **Provider Relations Specialists** are responsible for processing provider contracts and correspondence and/or supporting the External Team.
- **Data Base Maintenance Technicians** maintain provider databases for all lines of business, resolve provider claims' edits, and assign provider identification numbers.
- **Credentialing Analysts** are responsible for processing provider credentialing applications and correspondence and for maintaining the credentialing database.

Contact the Internal Team if you have any questions concerning address, tax ID or Social Security Number, on-call list, and any questions concerning a provider's listing in BCBSMT directories.

1-800-447-7828

FRAUD

INTERESTING STATISTICS RELATED TO HEALTHCARE FRAUD

In 2003, over 4 billion claims were processed nationally totaling over \$1.7 trillion in healthcare costs (a 7.7% increase over calendar year 2002). The National Health Care Anti-Fraud Association (NHCAA) estimates the nation's health care expenditures – at least 3% (\$51 billion) in calendar year 2003 – is lost to fraud. Other estimates by government and law enforcement agencies calculate losses as high as 10% of the annual costs.

To fully comprehend the annual financial value attached to fraud (using the NHCAA 3% estimate):

- The average family loses more than \$950 to healthcare fraud each year.
- Healthcare fraud costs more than 10 times what is lost to identity theft (\$5 billion).
- Healthcare fraud costs as much as 100 times what is lost to credit card fraud (\$788 million).

Using a figure of \$80 billion lost to insurance fraud each year, the Coalition Against Insurance Fraud estimates the amount lost to healthcare fraud into perspective by comparing it to what else

could be purchased with \$80 billion. In addition to consumers paying hundreds of additional dollars in higher premiums, the money could:

- Fund the entire U.S. space program for five years.
- Pay for more than twice the gold stored at Fort Knox.
- Make insurance fraud a Fortune 10 company – if fraud was a company.
- Pay for college tuition for 12 million undergraduates each year.
- Fund AIDS treatment, prevention, and research for the next eight years.

As you can see, the amount of money lost to healthcare fraud is staggering. If you are aware of someone who may be committing insurance fraud, be a part of the solution and report it to the appropriate insurer or law enforcement agency. You can contact the BCBSMT Special Investigations Unit at 1-406-444-8211, or access our website at www.stopfraud.bcbsmt.com.

Karl Krieger currently serves as a BCBSMT Special Investigator, is a Certified Fraud Examiner, and an Accredited Health Care Fraud Investigator. Karl has been employed by BCBSMT for over 17 years, has received the DPHHS Inspector General's Integrity Award for his

work in health care fraud, and currently serves as President on the Board of Directors for the Big Sky Chapter of the Association of Certified Fraud Examiners. Karl can be reached at 1-800-447-7828, extension 8211, or by email at kkrieger@bcbsmt.com. For more information, refer to the BCBSMT anti-fraud website at www.stopfraud.bcbsmt.com.



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