Blue Cross Blue Shield of Montana

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THE CAPSULE NEWS

First Quarter 2007

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

NPI - GET IT. SHARE IT. USE IT.

NPI Deadline May 23, 2007

The Department of Public Health and Human Services set the National Provider Identifier (NPI) as a standard identifier for health care providers under HIPAA mandates. If you deliver health care and conduct HIPAA standard transactions (claims, referrals, etc.) electronically, you are required to obtain an NPI. You will need an NPI even if you use a vendor or clearinghouse to transmit HIPAA standard transactions on your behalf. If you do not conduct electronic HIPAA standard transactions, HIPAA does not require that you obtain an NPI, but the Centers for Medicare and Medicaid Services (CMS) and other payers may.

You must have your NPI by May 23, 2007. However, BCBSMT encourages you to apply as soon as possible because you will not be able to use your old BCBSMT, Medicare, Medicaid, and UPIN numbers after that date. BCBSMT will reject electronic claims without an NPI after May 23, 2007.

Only two months remain until the NPI compliance date—are you ready to use your NPI? A recent survey conducted by the Workgroup for Electronic Data Interchange (WEDI) indicates that providers should be moving from the enumeration stage into the implementation stage to ensure NPI readiness by the May 23, 2007 compliance date. It is estimated that it may take up to 120 days to complete the work needed to implement the NPI into your current business practices.

The following steps will assist you in your preparation:

1. **Have you applied for your NPI(s)?** Not only should individual providers have NPIs, but organizations should have NPIs also.
2. **Have you received your software application updates, upgrades, and/or changes relevant to NPI?** Be sure that the updates not only address HIPAA transactions, but also include the CMS-1500 and UB-04 claim form changes.

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Inside This Issue

FROM THE EDITOR

THE VIEW DEPENDS UPON YOUR PERSPECTIVE

Michael McGuire
Provider Communications Developer
Health Care Services

I hope you are enjoying the newly designed Capsule News. Our goal in Health Care Services is to provide you with a professional, easy-to-read, and highly informative publication to help you conduct business with BCBSMT and the Blues system. My philosophy is simple; deliver a quality newsletter that efficiently educates the reader. We can spend a considerable amount of time just reading about our professional lives so all of us in Health Care Services want the Capsule News to be the most reliable source of information about BCBSMT. But the Capsule News is not the means to an end.

The Provider Services website at www.bluecrossmontana.com has just about every tool you will need to do business with BCBSMT. Not only can you find issues of the Capsule News back to 2000, the BCBSMT Provider Manual easily explains claims filing, benefits, claims, and eligibility services, the BlueCard® program, managed care, payment and appeals, and coordination of benefits.

The entire BCBSMT medical policy is available alphabetically, by chapter, or you can search by specific key words. New policies are separated from existing policies and anyone can submit comments on any policy at any time directly to the medical policy coordinator.

Secure Services allows you to check claims payment, verify eligibility, and review member benefits in a safe and secure environment Monday through Saturday from 6 a.m. to 10 p.m. and Sunday from 9 a.m. to 6 p.m. Secure Services allows you to ask questions at your convenience.

The website also includes links to our online provider directory, provider compensation policies, prior authorization and claim forms, best-practice databases, and the BCBSMT physician fee schedule. We have published a lot of good information based upon the questions providers routinely ask BCBSMT, but is it the right information in the right format?

To answer that question, I could embark on a scientific provider survey to determine the statistical probability of what defines quality, but that's boring. I would much rather hear directly from you. Whether by mail, e-mail, phone, fax, or carrier pigeon, tell me what you need that you are currently not getting from the Capsule News, website, provider manual, or Secure Services. If it's complicated or just an idea, call me and we can talk about it.

Together, we might even come up with a better idea.

Send comments or questions to:

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NPI, *Continued on from cover*

3. **Have you communicated your NPI(s) to health plans and other organizations you work with?** As outlined in current regulation, all covered providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes including designation of an ordering or referring physician.

4. **Do you know the readiness of your trading partners (such as health plans, third-party administrators, and clearinghouses)?** It's important to work with your trading partners to know their readiness with NPI and how it impacts you.

5. **Have you started testing the NPI, both internally and externally?** Not only do you need to test the HIPAA transactions such as 837 claims, but if you process 835 Remittance Advice, test your system to ensure that it can process the NPI appropriately. Also, if you submit paper claims, be sure that the data is printed in the correct fields.

6. **Have you educated your staff on what the NPI is and the use of it?** It's important that staff who use the NPI in their day-to-day work, such as verification of eligibility, be aware of the NPI and the provider identifiers that it replaces. Your staff may have to update your policies and procedures.

7. **Have you implemented the NPI into your business practices?** Once testing is complete, changes will go into production. Prior to this, make sure your trading partners are ready to process with the NPI only.

Given all the steps above, will you be ready by May 23, 2007?

Incorporated Individual Providers

Individual health care providers are eligible for an Entity Type 1 (Individual) NPI classification. If individuals form corporations, these corporations are considered organizational providers. Organizational providers are eligible for an Entity Type 2 (Organization) NPI. If either of these health care providers (the individual or the corporation) are covered providers (i.e., providers that send electronic transactions) under HIPAA, the NPI Final Rule requires them to obtain NPIs.

Providers should remember that the NPI enumerator can only answer and/or address the following:

1. Status of an application;
2. Forgotten or lost NPI;
3. Lost NPI notification letter (i.e., for those providers enumerated via paper or web-based applications);
4. Trouble accessing NPPES;
5. Forgotten password and/or user ID;
6. Need to request a paper application; and
7. Need clarification on information that is to be supplied in the NPI application.

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at *CustomerService@NPIenumerator.com*. Take note that the NPI Enumerator's operation is closed on federal holidays.

BCBSMT is preparing its systems to comply with the HIPAA NPI rule, and to ensure a smooth transition in May 2007. We need to know the NPI numbers for all providers submitting claims to BCBSMT. Send a copy of your NPI validation to:

Deb Stewart
Health Care Services
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604
FAX: 406-447-3570
E-mail: dstewart@bcbsmt.com

HCFA-1500 and CMS-1500 Claim Forms

The new CMS-1500 claim form is available at most office supply stores, and accommodates NPI reporting. CMS mandated its use effective April 1, 2007. Both forms will be accepted from January 2, 2007 to March 30, 2007. Effective April 1, 2007, only the CMS-1500 form will be accepted. All rebilling of claims should use the new form even though earlier submissions may have been on the old form.

The major difference between the old and the new forms is the split provider identifier fields. The split fields enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field. A sample of the new form is included on page 4.

UB-92 and UB-04 Claim Form

The new UB-04 claim form is available, and while most of the data usage descriptions and allowable data values have not changed, many UB-92 data locations have changed. The new form incorporates the NPI, taxonomy, and additional codes.

Both forms will be accepted from March 1 to May 22, 2007. Effective May 23, 2007, only the UB-04 form will be accepted. All rebilling of claims should use the new form even though earlier submissions may have been on the old form. A sample of the new form is included on page 4.

If you have already sent in your NPI validation form, thank you. If you have questions about NPI and BCBSMT provider identification numbers, contact your Provider Network Service Representative (see inside back cover).

NPI - CLAIM FORM SAMPLES

CMS-1500 Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

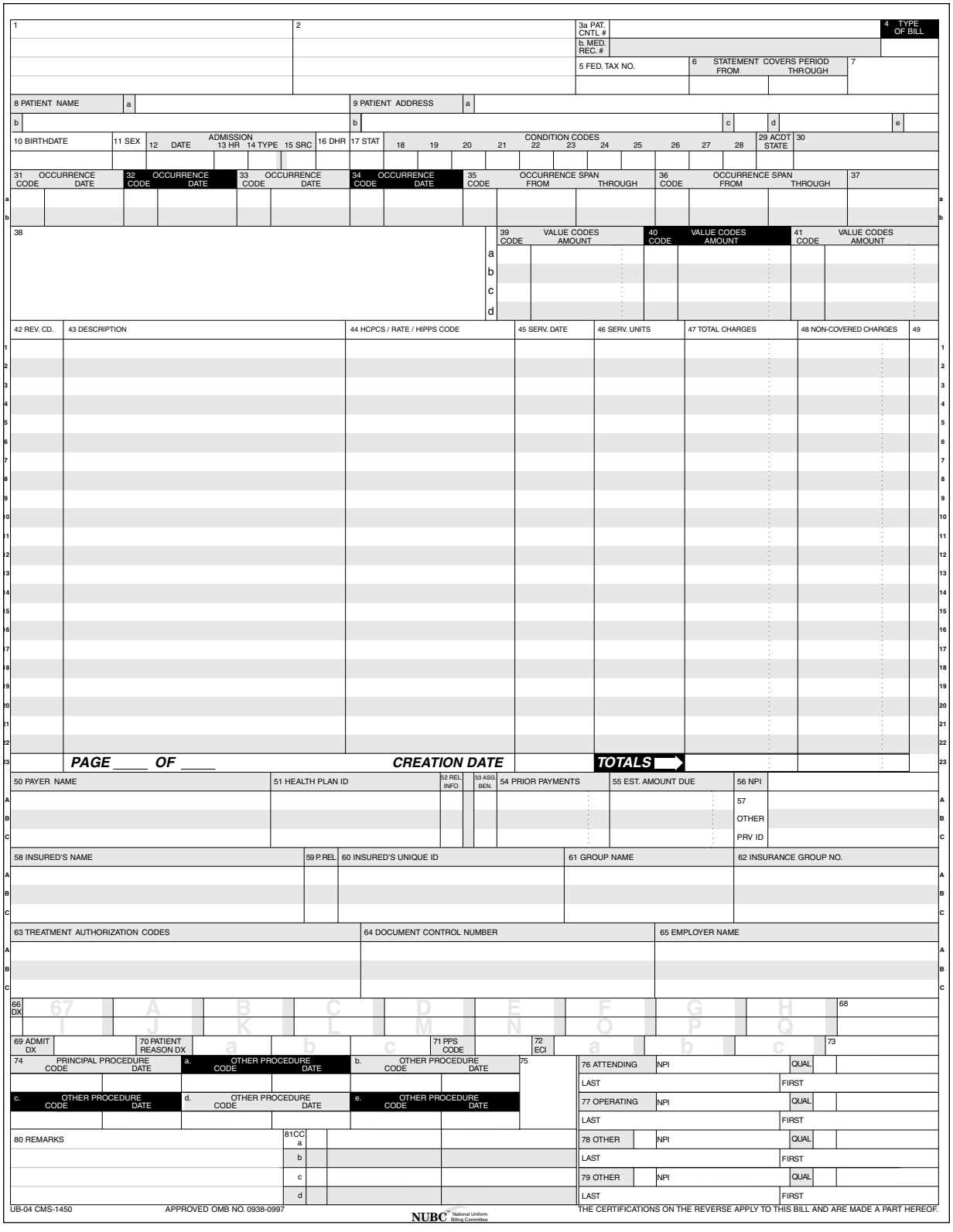
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UB-92 Claim Form



MEDICAL POLICIES

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.

Federal mandate prohibits denial of any drug, device, or biological product fully approved by the FDA as investigational for the Federal Employee Program. In these instances, coverage of FDA-approved technologies are reviewed on the basis of medical necessity alone.

The Medical and Compensation Physician's Committee met in January 2007, 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 and you may call BCBSMT at 1-800-447-7828 to request a copy. All medical policies are available online at www.bluecrossmontana.com.

MEDICAL POLICIES INDEX

New Policies

Revised Policies

BED OR MATTRESS, PRESSURE REDUCING (INCLUDING AIR-FLUIDIZED BED)

Chapter: Durable Medical Equipment
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION

Pressure reducing support surfaces are designed for members with limited or no mobility who are confined to a bed most or all of the day and are prone to developing pressure ulcers over bony prominences. They include:

Group 1: Mattress Overlay or Mattress — Designed to be placed on top of a standard hospital or home mattress and may consist of air, gel, water or foam. Codes E0180-E0187, E0196-E0199, E0371-E0373, A4640.

Group 2: Special Mattresses (alone or fully integrated into a bed) — A power pressure reducing mattress characterized by alternating pressure, low air loss, or powered flotation without low air loss and is used to reduce friction and shear. It can be placed directly on a hospital bed frame.

Group 3: Air-Fluidized Bed — An air-fluidized bed, also called a static high-air-loss bed, is a device using warm air under pressure to set small ceramic beads in motion which simulates the movement of fluid. When placed on the air-fluidized bed, the member's body weight is evenly distributed over a large surface area, which creates a sensation of "floating."

POLICY

Prior authorization is recommended for a Group 2 and 3 bed or mattress. Call the BCBSMT Customer Service Department 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.

Prior authorization is NOT recommended for a Group 1 mattress overlay or mattress. However, individual and group contracts recommend prior authorization of durable medical equipment if the cost is $500 or more.

Medically Necessary

Group 2 — BCBSMT considers a special mattress alone or fully integrated into a bed (E0193, E0277, E0371-E0373) medically necessary when the following criteria are met:

- The member has multiple stage II pressure ulcers located on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least one month, which has included the use of an appropriate Group 1 support surface and the ulcers have worsened or remained the same over the past month; or
- The member has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis; or
- The member has a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis. The member has had flap or skin graft surgery within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility within the past 30 days.

Group 3 — BCBSMT considers an air-fluidized bed (E0194) medically necessary when the following criteria are met:

- The member has a stage III (full thickness tissue loss extending to subcutaneous tissue and muscle) or stage IV (deep tissue destruction exposing underlying muscle or bone) pressure sore;
- The member is bedridden or chair-bound as a result of severely limited mobility;
- The member would require institutionalization in the absence of an air-fluidized bed;
- The air-fluidized bed is ordered in writing by the member's attending physician based upon a comprehensive assessment and evaluation after conservative treatment has been tried without success for at least one month;
- A trained adult caregiver is available to assist the member with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air fluidized bed on a monthly basis; and
- All other alternative equipment has been considered and ruled out including, but not limited to, gel flotation pads, egg crate mattresses, and pressure pads and pumps.

Note: Coverage for an air-fluidized bed is limited to equipment only. Benefits do not include services of a caregiver or for architectural adjustments such as electrical or structural improvement.

Not Medically Necessary

BCBSMT considers the use of an air-fluidized bed not medically necessary under the following circumstances:

- The member has coexisting pulmonary disease (e.g., atelectasis, pneumonia, ARDS, and inhalation injury). The lack of firm back support makes coughing ineffective, dry air inhalation thickens pulmonary secretions, and the head of bed cannot be elevated.
- The member requires treatment with moist wound dressings (the drying effect of air-fluidized beds counteracts the moist dressing);
- Unstable spinal cord injured members; and
- Traction (i.e., cervical, skin, or limb).

Non-Covered

BCBSMT considers the following retail mattress as non-covered because they can be purchased without a physician's order. The retail mattresses include, but are not limited to, the following:

- TEMPUR-PEDIC™;
- Sleep Number®; and
- Air Mattress.

MEDICAL POLICIES—NEW POLICIES

WHEELCHAIRS AND WHEELCHAIR ACCESSORIES

Chapter: Durable Medical Equipment
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION

For members who are non-ambulatory or have limited ambulation, a wheelchair is expected to significantly improve or restore a member's ability to perform or participate in activities of daily living (ADL) in the home setting. Wheelchairs are described in the Healthcare Common Procedure Coding System (HCPCS) with one code for the wheelchair base and additional codes for options and accessories. Which base and other options chosen is influenced by:

- How the wheelchair will be used;
- The member's size or level of disability; and
- Specific features that will be incorporated into the chair (e.g. a heavy-duty base with additional electronic features may be needed to support a power tilt and/or recline option).

POLICY

Standard member insurance policy language states that durable medical equipment must be primarily used to serve a medical purpose rather than for comfort or convenience. If BCBSMT finds that non-standard and/or deluxe wheelchair equipment is not medically necessary, the member should be referred for case management. BCBSMT may apply the reimbursement available for standard equipment toward the purchase of deluxe or non-standard equipment.

Prior authorization is recommended for power wheelchairs and non-standard wheelchair options as indicated below. Call the BCBSMT Customer Service Department 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.

Prior authorization is not recommended for the rental or purchase of a standard manual wheelchair (except when used as a back-up to an electric wheelchair.

NOTE: When a member already has a power-operated vehicle, consideration for a power wheelchair will be made on a case-by-case basis. Refer to the medical policy: Power Operated Vehicles, (page 10).

Medical Necessity Criteria for Power Wheelchairs

The medical necessity criteria below do not apply to the rental or purchase of a standard manual wheelchair. BCBSMT applies the following criteria to the purchase or rental of a power wheelchair:

- Other mobility assistive devices (e.g., canes, walkers, crutches, POV, manual wheelchair) will not sufficiently resolve functional mobility limitations in the home;
- The home environment will support the use of a power wheelchair;
- A power wheelchair is needed for long-term use (e.g., a minimum of six months);
- A health care provider has verified the member has demonstrated the ability to safely operate a motorized wheelchair in the home setting;
- The member is expected to be mobile for at least two hours per day;
- The member is non-ambulatory and has severe weakness, pain, deformity or limitations in endurance, coordination or range of motion of the upper extremities resulting in the inability to effectively operate a manual wheelchair; and
- The ability to participate in one or more activities of daily living (e.g., toileting, feeding, dressing, grooming, bathing) is significantly impaired due to mobility-related limitations which:
  - Prevent accomplishing activities of daily living entirely or within a reasonable time frame; and
  - Place the patient at heightened risk of morbidity or mortality secondary to attempts to participate in activities of daily living.

Manual Back-Up Wheelchair

A manual back-up wheelchair is considered medically necessary when either of the two criteria is met:

- The member's motorized wheelchair cannot be used in areas essential for access; or
- The member's motorized wheelchair cannot be transported by the usual available transportation.

Not Medically Necessary (Power Wheelchairs)

BCBSMT considers a power wheelchair not medically necessary when:

- The member is capable of ambulation within the home but requires a wheelchair for movement outside the home.
- The primary benefit of the wheelchair is for the convenience of the member or to perform leisure or recreational activities and is not necessary for performance of activities of daily living.
- The wheelchair is used for the convenience of the caregiver.

Medical Necessity Criteria for Non-Standard Wheelchair Options

In addition to the specific criteria listed below, BCBSMT considers all wheelchair options and accessories medically necessary only when both of the following criteria are met:

- The option/accessory is necessary for the member to perform activities of daily living; and
- The option/accessory is not primarily for the purpose of allowing the member to perform leisure or recreational activities.

A. Back and Seating Systems

- A custom fabricated seating system, back and/or seat module, is considered medically necessary when all of the following criteria are met:
  - The member has a significant spinal deformity and/or severe weakness of the trunk muscles;
  - The member's need for prolonged sitting tolerance, postural support to permit functional activities, or pressure reduction cannot be met adequately by a prefabricated seating system; and

WHEELCHAIRS, *continued on page 9*

WHEELCHAIRS, *continued from page 8*

  - The member is expected to be in a wheelchair at least two hours per day.

- A manual fully reclining back or manual Tilt-In-Space wheelchair or wheelchair option (E1014, E1050, E1060, E1070, E1083, E1084, E1085, E1086, E1087, E1088, E1089, E1090, E1092, E1093, E1161, E1226, E1231, E1232, E1233, and E1234) is considered medically necessary if the member spends at least two hours per day in the wheelchair and has one or more of the following conditions/needs:
  - Quadriplegia;
  - Fixed hip angle:
    - Trunk or lower extremity casts/braces that require the reclining back feature for positioning;
    - Excess extensor tone of the trunk muscles; and
    - The need to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is difficult.
- Power tilt and/or recline features (E1002, E1003, E1004, E1005, E1006, E1007, and E1008) and powered seat cushions (E2610) are considered medically necessary when all of the following criteria are met:
  - The member is confined to the wheelchair;
  - The member cannot operate a manual tilt and can operate a power tilt/recline; and
  - The member is left alone for periods of two or more hours during the day or does not have someone readily available to assist with needed positioning (e.g., in a work or school setting).

B. Miscellaneous Power Wheelchair Options and Accessories

- A headrest with mounting hardware (E0955) is considered medically necessary when one of the following criteria is met:
  - The member has weak neck muscles and needs a headrest for support; or
  - The member has a reclining back on the wheelchair.
- A safety belt/pelvic strap (E0978) and a wheelchair tray table (E0950) attached to the wheelchair for proper positioning and support are medically necessary if the member has weak upper body muscles, upper body instability, or muscle spasticity.
- An anti-rollback device (E0974) and an anti-tipping device (E0971) is considered medically necessary if the member self-propels and needs the device because of ramps.
- Up to two batteries (E2360, E2361, E2362, E2363, E2364, E2365) are considered medically necessary at any one time for a power wheelchair.
- A battery charger (E2366) is included with a power wheelchair base and is considered medically necessary only as a replacement.

Non-Covered

Wheelchair Options and Accessories

BCBSMT considers the following wheelchair options and accessories non-covered:

- An electronic interface (E2351) to allow a speech-generating device to be operated with the power wheelchair control interface (speech generating devices are non-covered in most member insurance policies);
- Power assist devices for manual wheelchairs (E0986);
- Power assisted wheelchairs (K0009);
- A power seat elevation feature (E2300);
- Power wheelchair attendant control (E2331);
- If a wheelchair has an electrical connection device (E2310 or E2311) and the sole function of the connection is for a power seat elevation or a power wheelchair attendant control, it is considered not medically necessary; and
- A dual mode battery charger (E2367).

Standing Systems (deluxe upgrades)

BCBSMT considers the following standing systems non-covered:

- Power standing systems (E2301); and
- A standing wheelchair or all-in-one wheelchair/stander (e.g., Permobile and Lifestand). It has not been shown to have significant benefit compared with separate wheelchair and stander (E1399).

MEDICAL POLICIES—NEW POLICIES

POWER OPERATED VEHICLES (POV)

Chapter: Durable Medical Equipment
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION
A power operated vehicle (POV) is a three- or four-wheeled vehicle used for non-highway use. It is sometimes referred to as a "scooter."

POLICY
Prior authorization is recommended. To authorize, call the BCBSMT Customer Service Department 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: When a member already has a power wheelchair, consideration for a power operated vehicle will be made on a case-by-case basis. Refer to the medical policy: Wheelchairs and Wheelchair Accessories, (page 8).

Medically Necessary
BCBSMT considers a POV medically necessary when all of the following criteria are met:

- The member is unable to move around in their residence without the use of a wheelchair;
- The member is unable to operate a manual wheelchair;
- The member is capable of safely operating the controls for the POV;
- The member can transfer safely in and out of the POV; and
- The member has adequate trunk stability to safely ride in the POV.

Not Medically Necessary
BCBSMT considers a POV not medically necessary when:

- The member is capable of ambulation within the home but requires a POV for movement outside the home; and
- The primary benefit of the POV is to allow the member to perform leisure or recreational activities.

PHARMACOGENOMICS (E.G., CYTOCHROME P450)

Chapter: Medicine: Tests
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION
Pharmacogenomics is the study of how an individual's genetic inheritance affects the body's response to drugs. Pharmacogenomic researchers have focused their efforts on testing for DNA sequence variations or polymorphisms (genotyping) in key drug-metabolizing enzymes such as the cytochrome p450 (CYP450) family to determine why some individuals either don't respond to drug therapy or have severe adverse drug reactions.

Diagnostic genotyping tests for some CYP450 enzymes are now available. Some tests are offered as in-house laboratory services, which do not require FDA approval but must meet general laboratory quality standards for high complexity testing. Recently, the AmpliChip (Roche Molecular Systems, Inc.) was cleared for marketing by the Food and Drug Administration (FDA). The AmpliChip tests for 29 polymorphisms and mutations of the CYP2D6 gene and 2 polymorphisms for the CYP2C19 gene. CYP2D6 metabolizes approximately 25% of all clinically used medications (e.g., dextromethorphan, beta-blockers, antiarrhythmics, antidepressants, and morphine derivatives), including many of the most prescribed drugs. CYP2C19 also metabolizes several important types of drugs including proton-pump inhibitors, diazepam, propranolol, imipramine, and amitriptyline.

Researchers speculate genotyping may help direct early selection of the most effective drug or dose, and/or avoid drugs or doses likely to cause toxicity. For example, warfarin, some neuroleptics and tricyclic antidepressants have narrow therapeutic windows. The potential severity of the disease requires immediate and adequate therapy yet prescribing physicians use cautious dosing protocols to avoid serious adverse events. Genotyping might speed the process of achieving a therapeutic dose and avoid significant adverse events. However, many other non-genetic factors influence drug efficacy and toxicity including age, liver function, disease states, nutrition, smoking, ethnicity, and drug-drug interactions.

It is also important to realize that many drugs are metabolized to varying degrees by more than one enzyme, either within or outside the CYP450 family. In addition, interaction between different metabolizing genes, interaction of genes and environment, and interaction between different non-genetic factors also influence CYP450-specific metabolizing functions. Identification of a variant in a single gene in the metabolic pathway may be insufficient to explain individual differences in metabolism and consequent efficacy or toxicity in all but a small proportion of drugs.

POLICY
BCBSMT considers genotyping to determine cytochrome p450 (CYP450) genetic polymorphisms investigational because it is not yet possible to translate pharmacogenetic parameters into therapeutic recommendations. While studies show promising associations between genotype and clinical parameters or outcomes, none study the prospective use of genotyping to direct patient management and determine the effect on outcomes.

CYSTIC FIBROSIS TESTING

Chapter: Maternity/Gyn/Reproduction
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION

The cloning of the cystic fibrosis (CF) gene, CFTR, in 1989 provided the opportunity to screen individuals without a family history of the disease to identify carriers at risk for producing affected children. Shortly thereafter, the American College of Medical Genetics (ACMG) and the American College of Obstetricians and Gynecologists (ACOG), in conjunction with the National Human Genome Research Institute, formed a Steering Committee to develop guidelines for CF carrier screening.

While there are hundreds of different mutations in the CFTR gene that can cause CF, the Steering Committee recommends the standard screening test include the 25 disease causing mutations known to have an allele frequency of greater than 0.1% in the general U.S. population. These 25 mutations detect greater than 80% of CF alleles and are considered sufficient to justify efficient and cost-effective screening.

ACOG recommends either concurrent screening (testing both partners simultaneously) or sequential screening (testing one partner and the second partner only if the first partner is identified as a carrier). Specifically, ACOG recommends screening be offered to:

- Individuals with a family history of CF;
- Reproductive partners of individuals who have CF;
- Couples in whom one or both partners are Northern European or Ashkenazi Jewish and are pregnant or are planning a pregnancy; and
- Members in other ethnic groups who are at lower risk and for whom testing is less sensitive (Table 1).

Table 1: Chance To Have A Child With Cystic Fibrosis Based On Ethnicity

Ethnic Group Of Both Partners	Carrier Frequency	Detection Rate	One Partner Negative
Ashkenazi Jewish	1 in 3,300	97%	1 in 93,000
European Caucasian	1 in 3,300	90%	1 in 25,000
African American	1 in 17,000	69%	1 in 48,000
Hispanic American	1 in 9,000	57%	1 in 18,000
Asian American	1 in 32,000	30%	1 in 46,000

Adapted from Lyon E, Miller C. Current challenges in cystic fibrosis screening. Arch Pathol Lab Med 2003;127:1138.

POLICY

Prior authorization of CF screening is recommended. To authorize, call the BCBSMT Customer Service Department 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 allows sequential testing (testing one partner and the second partner only if the first partner is identified as a carrier) for the 25 alleles with greater than a 0.1% probability of causing CF (see standard mutation panel below) for:

- Couples who are pregnant or are planning a pregnancy; and
- Members presenting with symptoms of CF with a negative sweat chloride test.

Standard Mutation Panel (http://www.acmg.net/resources/policies/pol-005.asp)					
ΔF508	Δ1507	G542X	G551D	W1282X	N1303K
R553X	621+1G→T	R117H	1717-1G→A	A455E	R560T
R1162X	G85E	R334W	R347P	711+1G→T	1898+1G→A
2184delA	1078delT	2789+5G→A	3659delC	I148T	3120+1G→A
3849+10kbC→T					

Reflex Test

I506V,[a] 1507V,[a] F508C[a]
5T/7T/9T[b]

[a] Benign variants. This test distinguishes between a CF mutation and these benign variants. I506V, I507V, and F508C are performed only as reflex tests for unexpected homozygosity for ΔF508 and/or ΔI507.

[b] 5T in *cis* can modify R117H phenotype or alone can contribute to congenital bilateral absence of vas deferens (CBAVD); 5T analysis is performed only as a reflex test for R117H positives.

MEDICAL POLICIES—NEW POLICIES

ESOPHAGEAL PH MONITORING

Chapter: Medicine: Tests
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION

Acid reflux, also known as gastroesophageal reflux disease (GERD), is the cause of a number of medical conditions, including heartburn, acid regurgitation peptic esophagitis, and Barrett's esophagus. It also contributes to esophageal stricture, some cases of asthma, posterior laryngitis, chronic cough, dental erosions, chronic hoarseness, pharyngitis, subglottic stenosis or stricture, nocturnal choking, and recurrent pneumonia. GERD is usually diagnosed by clinical history and endoscopy.

Twenty-four-hour esophageal pH monitoring using catheter-based systems are an established technology primarily used in patients with GERD that have not responded symptomatically to medical therapy (including proton pump inhibitors), or in patients with refractory extraesophageal symptoms.

Esophageal monitoring is done through a tube with a pH electrode attached to its tip, which is then passed to 5 cm above the upper margin of the lower esophageal sphincter (LES). The electrode is attached to a data logger worn on a waist belt or shoulder strap. Every instance of acid reflux as well as its duration and pH is recorded, indicating gastric acid reflux over a 24-hour period.

More recently, a catheter-free, temporarily implanted device (Bravo™ pH Monitoring System, Medtronic) has been approved by the FDA for the purposes of esophageal monitoring. Using endoscopic or manometric guidance, the capsule is temporarily implanted in the esophageal mucosa using a pin. The capsule records pH levels for up to 48 hours and transmits them via radio frequency telemetry to a receiver worn on the patient's belt. Data from the recorder is uploaded to a computer for analysis.

POLICY

Medically Necessary

BCBSMT considers 24-hour esophageal pH monitoring using a catheter-based system medically necessary and does not recommend prior authorization.

Prior authorization is recommended for catheter-free 48-hour wireless esophageal monitoring. To authorize, call the BCBSMT Customer Service Department 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 catheter-free 48-hour wireless esophageal monitoring medically necessary as an alternative to conventional catheter-based 24-hour esophageal monitoring when one or more of the following criteria are met:

- The member is unable to tolerate a catheter-based pH monitoring system (this must be documented in the patient record); and/or
- The member is having an esophagoscopy on the same day as the pH monitoring.

Rationale

The catheter-free 48-hour wireless system provides increased convenience to the patient and 48 hours of monitoring, as compared to 24 hours of monitoring with conventional systems. It is unclear whether these features afford additional health benefits. For example, in one study, successful 24-hour pH studies were completed in 96% of patients and 36- to 48-hour studies were completed in 89% of subjects. Capsules required endoscopic removal in 4% of subjects. Without any comparison to those receiving conventional pH monitoring, it is not known whether the use of a wireless system results in more successful studies. Any increase in successful studies would need to be balanced against the need for an additional endoscopic procedure to remove a capsule in 4% of the patients. How an increased length of monitoring time (up to 48 hours) might benefit patient management is unknown.

X-Stop (Interspinous Process Distraction/ Decompression Device)

Chapter: Surgery - Procedures
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION
On November 21, 2005, the FDA approved the X STOP® Interspinous Process Decompression System (St. Francis Medical Technologies, Inc.). The X STOP® implant is used to relieve symptoms of lumbar spinal stenosis. It is inserted between the spinous processes through a 4 to 8 cm incision under local anesthesia with intravenous sedation or general anesthesia. The supraspinous ligament is maintained and assists in holding the implant in place. The surgery does not include any laminotomy, laminectomy, or faraminotomy at the time of insertion. The implant acts as a spacer between the spinous processes, maintaining the flexion of just that spinal interspace. It is not fixed to any bony structures and does not result in fusion.

FDA approval is based solely on evaluation of 24-month data of 191 patients in a randomized, controlled clinical trial. Information on patient outcomes after 24 months is not available. The manufacturer (St. Francis Medical Technologies, Inc.) has agreed to conduct a post-market approval study to evaluate the long-term safety and effectiveness of X STOP®. Safety and effectiveness data will be assessed at baseline and annually through five years postoperatively. The study is expected to include 240 patients at up to eight clinical sites where all participating spine surgeons have completed a company-sponsored physician-training program.

POLICY
Prior authorization is recommended for the X STOP® implant. To authorize, call BCBSMT Customer Service Department 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 X STOP® implant medically necessary when all of the following criteria are met:

- When the X STOP is implanted at one or two lumbar levels and operative treatment is indicated at no more than two levels (implant at the L5/S1 level is excluded);
- The member age is 50 years or older;
- Diagnosis of lumbar spinal stenosis (confirmed by X-Ray, MRI, and/or CT evidence of thickened ligamentum flavum, narrowed lateral recess and /or central canal narrowing);
- Suffering from neurogenic intermittent claudication (pain and cramping in the legs);
- Have moderately impaired physical function;
- Obtain relief from symptoms of leg/buttock/groin pain when in a flexed position, with or without back pain; and
- The member has tried non-operative treatments for at least 6 months without adequate relief from pain (e.g., activity modification, medications such as non-steroidal anti-inflammatory drugs, physical therapy, or epidural steroid injections).

Contraindications

- Spinal anatomy or disease preventing implantation of the device or causing the device to be unstable in situ, including, but not limited to, the following:
  - Significant instability of the lumbar spine (e.g., isthmic spondylolisthesis or degenerative spondylolisthesis greater than grade 1.0 on a scale of 1 to 4);
  - An ankylosed segment of the affected level(s);
  - Acute fracture of the spinous process or pars interarticularis; and
  - Significant scoliosis (Cobb angle greater than 25 degrees).
- Cauda equina syndrome, defined as neural compression causing nerogenic bowel or bladder dysfunction;
- Diagnosis of severe osteoporosis, defined as bone mineral density more than 2.5 standard deviations below the mean of adult normals, when one or more fragility fractures is present;
- Active systemic infection or infection localized to the site of implantation;
- An allergy to titanium or titanium alloy; and
- The safety and effectiveness of the X STOP® implant have not been studied in patients with the following conditions:
  - Axial back pain without leg, buttock, or groin pain;
  - Symptomatic lumbar spinal stenosis at more than two levels;
  - Prior lumbar spine surgery;
  - Significant peripheral neuropathy;
  - Acute denervation secondary to radiculopathy;
  - Paget's disease;
  - Vertebral metastases;
  - Morbid obesity;
  - Pregnancy;
  - A fixed motor deficit;
  - Angina;
  - Active rheumatoid arthritis;
  - Peripheral vascular disease; and
  - Advanced diabetes or any other systemic disease that may affect the patient's ability to walk.

Investigational
BCBSMT evaluates coverage of the X STOP® implant according to the FDA criteria listed above. If all of the criteria are not met, or the member has one or more contraindications, BCBSMT considers the X STOP® implant investigational.

MEDICAL POLICIES—REVISED POLICIES

ERECTILE DYSFUNCTION (IMPOTENCE)

Chapter: Medicine: Treatments
Upcoming/Revised Policy
Effective Date: May 1, 2007

POLICY
The initial diagnostic testing to determine the causative factor(s) of erectile dysfunction (ED) is considered medically necessary. Treatment of ED caused by psychogenic factors is non-covered in most member insurance policies.

Prior authorization for treatment of erectile dysfunction is recommended. To authorize, call the BCBSMT Customer Service Department 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
Treatment for ED caused by organic disease, surgical procedures, or injury is considered medically necessary. Examples include, but are not limited to, the following:

- Severe diabetes mellitus with neuropathy;
- Peripheral vascular disease in the pelvis or extremities;
- Post priapism;
- Spinal cord injuries;
- Injuries to the genital or lower urinary tract;
- Severe fractures of the pelvis which result in injury to the bladder, urethra, and/or pelvic nerves;
- Aortic surgery;
- Radiation or surgery of the genital or lower urinary tract (includes radical cystectomy for carcinoma, and prostatectomy);
- Removal of the rectum; and
- Any surgery which may interfere with the pelvic nerves.

Medical Treatment
BCBSMT considers the following medical treatments medically necessary when one or more of the medically necessary criteria above are met:

- Oral drug therapy is used as a first-line therapy based on efficacy, side effect profile, and ease of use. When allowed by member contract, a total of eight tablets per month are covered (e.g., Viagra, Cialis, and Levitra);
- Intracavernosal injection therapy (ICI) is used when oral therapy fails (e.g., Phentolamine, Papaverine, Alprostadil, and Caverjet);
- Intra-urethral administration of alprostadil (prostaglandin E1 analogue/MUSE therapy) as a "needle less" alternative in patients with ED who don't respond to first-line treatments or when they are contraindicated;
- Externally applied prosthesis (e.g., vacuum device); and
- Testosterone replacement when there is a demonstrated deficiency.

Surgical Treatment
BCBSMT considers the following surgical treatments medically necessary when one or more of the medically necessary criteria above are met:

- Penile prosthesis implantation;
- Services related to the surgical correction of complications following the insertion of a penile prosthesis; and
- Arterial revascularization in men with normal corporeal venous function who have arteriogenic erectile dysfunction secondary to pelvic or perineal trauma.

Investigational
Vascular surgery—including, but not limited to, penile revascularization surgery and penile arterial by-pass surgery (PABG) for organic impotence—is considered "investigational." Current medical literature reports that despite short-term improvement, most cases result in long-term failure. Therefore, the efficacy of these procedures for the treatment of organic impotence has not been established.

HORMONE PELLET IMPLANTATION

Chapter: Drugs
Upcoming/Revised Policy
Effective Date: May 1, 2007

POLICY
Investigational
BCBSMT considers the following investigational because they are not FDA approved:

- Implantable estradiol pellets; and
- Implantable testosterone pellets for women.

Medically Necessary
Prior authorization is recommended. Call the BCBSMT Customer Service Department 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 implantable testosterone pellets medically necessary in males with congenital or acquired endogenous androgen deficiency or absence.

COSMETIC PROCEDURES

Chapter: Surgery - Procedures
Upcoming/Revised Policy
Effective Date: May 1, 2007

POLICY

BCBSMT considers these procedures to be cosmetic including, but not limited to, the following:

- "Lifts" including, but not limited to, the buttocks, thighs, arm, or face;
- Ear and body piercing;
- Excision, glabellular, and frown lines;
- Mastopexy (a surgical procedure to raise and reshape sagging breasts);
- Neck tuck;
- Tattoo removal;
- Calf, pectoral, bicep, and tricep augmentation; and
- Liposuction of any area of the body including, but not limited to, the abdomen, hips, thighs, calves, arms, buttocks, back, neck, or face.

Many procedures are usually of a cosmetic nature but may, on occasion, be medically necessary for non-cosmetic reasons.

Note: BCBSMT reviews services for "possible cosmetic" procedures either because of the diagnosis or the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code(s) submitted on a claim.

Prior authorization is recommended for procedures that may be considered medically necessary for non-cosmetic reasons. To authorize, call the BCBSMT Customer Service Department 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. Additionally:

- Claims are subject to review of information such as photos, operative reports, office notes, diagnosis, medical necessity, consultant reports, or other pertinent information;
- If non-covered cosmetic surgery is performed at the same operative period as a covered surgical procedure, benefits are provided for the covered surgical procedure only;
- Complications arising from a non-covered service (e.g., cosmetic) are an exclusion of most member insurance policies; and
- Occasionally, a member has a congenital anomaly that does not result in a functional impairment but is severely disfiguring. Individual consideration for treatment will be given in these cases. Examples include the cranio-facial anomalies associated with Crouzon's syndrome and Treacher-Collins syndrome.

The following may be considered medically necessary for non-cosmetic reasons:

Breast Augmentation/Reconstruction—Refer to the medical policy Reconstructive Breast Surgery/Management of Breast Implants.

Breast Reduction—Refer to the medical policy Reduction Mammoplasty (breast reduction).

Chemical Peel and Dermabrasion—Refer to the medical policy Chemical Peels, Dermabrasion and Microdermabrasion.

Chest Deformities—Pectus Excavatum or Carinatum (pectus excavatum, also known as sunken or funnel chest, and pectus carinatum, also known as "pigeon breast") are congenital chest wall deformities in which some ribs and the sternum grow abnormally. Corrective surgery is based on documentation of one or more of the following medical necessity criteria including, but not limited to, the following:

- Reduction in exercise tolerance;
- Shortness of breath on exertion;
- Upper respiratory tract infections;
- Lower respiratory tract infections;
- Precordial pain;
- Palpitations;
- Asthma;
- Fatigability; and
- Inability to breathe deeply.

If the surgery for pectus excavatum or carinatum is performed to improve appearance or due to psychological factors, it is considered cosmetic.

Chin Implants—Chin implants are considered cosmetic. A possible exception is a rare case of hemi-atrophy of the face or a hypoplastic situation, which is asymmetrical. Chin implants are considered on case-by-case basis.

Ear Reconstruction (Otoplasty)—Otoplasty is considered cosmetic. However, there are cases where this is considered medically necessary because of a functional impairment.

Eye Muscle Surgery (Strabismus - "crossed eyes" or "lazy eye" - Surgery)—Treatment of pathologic causes of strabismus or diplopia (double vision) is considered medically necessary. Benefits are only allowed if the surgery will result in improved vision.

Eyelid Surgery (Blepharoplasty/Blepharoptosis, Ptosis repair)

- When surgery is performed to improve appearance in the absence of a functional abnormality, it is considered cosmetic.
- When upper lid surgery is considered medically necessary, a brow lift is also covered.
- Unless functional impairment such as entropion (inward rolling of the eyelid) or ectropion (a outward turning or sagging of the eyelid) can be demonstrated, lower-lid blepharoplasty is considered cosmetic.
- Medically necessary indications for reconstructive blepharoplasty include, but are not limited to, the following:
  - Severe cases of entropion or ectropion when documented with photographs;
  - Pseudoptosis causing visual impairment. In this condition, the upper-lid skin becomes

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MEDICAL POLICIES—REVISED POLICIES

COSMETIC , *continued from page 15*

redundant and lax to such an extent that it "hoods" the eye, restricting the patient's upward gaze and blocking peripheral vision. When the upper-lid skin rests on the eyelashes, and forward gaze is impaired, corrective surgery is medically necessary when documented by:
  - A visual field study interpreted by the physician who performed the study;
  - A document stating the eyelid is causing visual impairment or globe exposure; and
  - Preoperative photographs.
- Hooding of the lateral upper eyelids may be aggravated by redundancy and ptosis (drooping) of the skin of the lateral forehead and eyebrows. This is an exaggerated effect of aging. A brow lift with the excision of excess forehead or anterior scalp skin may be required to suspend the brows in a more normal position and relieve the ptosis and visual obstruction;
- True ptosis with dermatochalasis. Dermatochalasis (excessive skin redundancy) may mask the presence of ptosis. Correction of dermatochalasis is an integral part of ptosis treatment to restore vision.
- Primary essential (idiopathic) blepharospasm. The condition is characterized by severe squinting secondary to uncontrollable spasms of the periorbital muscles. Treatment includes extended blepharoplasty with wide resection of the orbicularis oculi muscle complex;
- Cranial nerve palsy (Partial or complete palsy of the facial (VII) nerve or the oculomotor (III) nerve). For lesions involving the temporal branch of the facial nerve, treatment consists of reconstructive blepharoplasty with or without brow lift. Third-nerve palsy may require frontalis fascial suspension to obtain an adequate eyelid opening; and
- Thyroid disease. Symptoms associated with thyroid disease can include unilateral or bilateral upper eyelid retraction and proptosis (protruding eye). Occasionally reconstructive blepharoplasty is necessary to prevent corneal exposure and erosion

Face Transplant—Face transplants are considered on a case-by-case basis.

Forehead Reduction—Forehead reduction is considered cosmetic. There is an extremely rare case where this could be done in conjunction with a blepharoplasty, but this would be considered on a case-by-case basis.

Gynecomastia, Surgical treatment—Gynecomastia is defined as the benign enlargement of the male breast, due to either increased adipose tissue, glandular tissue, fibrous tissue, or a combination of all three. It may be associated with any of the following:

- An underlying hormonal disorder (e.g., conditions causing either estrogen excess or testosterone deficiency such as liver disease or an endocrine disorder);
- A side effect of certain drugs (e.g., estrogens, androgens, marijuana, Tagamet, or Spironolactone);
- Obesity;
- Adolescent gynecomastia, which consists of transient, bilateral breast enlargement; or
- Gynecomastia of aging related to the decreasing levels of testosterone and relative estrogen excess.

BCBSMT considers mastectomy for gynecomastia a medically necessary option in a male over age 18, or 18 months after the end of puberty, when associated with any of the following conditions:

- Androgen deficiency;
- Chronic liver disease;
- Klinefelter's syndrome;
- Adrenal tumors;
- Brain tumors; and
- Testicular tumors.

BCBSMT considers mastectomy for gynecomastia not medially necessary if:

- The tissue removed is not glandular breast tissue but is related to obesity. The use of liposuction to perform breast reduction is considered cosmetic because it involves the removal of adipose tissue, not breast tissue.
- The breast hyperplasia is the result of drug treatment that can be discontinued.

Hair Loss (Alopecia)—The initial evaluation and diagnosis is not cosmetic. Treatment for male or female pattern baldness or hair thinning is cosmetic. Hair transplants are generally considered cosmetic. However, BCBSMT provides:

- Individual consideration for a hair transplant for a pediatric patient whose hair follicles have been destroyed by infection or fungus and the scalp would still provide a suitable bed for hair transplant; and
- Medically necessary treatment of hair loss caused by a disease condition, such as alopecia areata, and cicatricial alopecia.

Hair removal—The initial evaluation and diagnosis of hirsutism is not cosmetic. Electrolysis, laser, waxing, or other products and procedures designed for hair removal for men or women is considered cosmetic. Coverage for laser hair removal may be considered medically necessary when done secondary to pseudofolliculitis barbae and other hair follicle disorders.

Lipectomy—surgical removal of a lipoma (a benign tumor just below the skin consisting mostly of fat cells) is considered medically necessary. Liposuction is considered cosmetic except under individual consideration by the Medical Review Department for indications including, but not limited to, the following:

- Lipomas greater than 250 grams.

COSMETIC , *continued on page 17*

COSMETIC , *continued from page 16*

Panniculectomy (abdominoplasty, or "tummy tuck")—Panniculectomy is the surgical removal of excessive abdominal fat and skin. BCBSMT considers this a cosmetic procedure. However, individual consideration is given for coverage when a panniculectomy is done for patients who have had significant weight loss (refer to the Morbid Obesity, Management Of medical policy) and have one or more of the following complicating factors:

- Inability to walk normally;
- Chronic pain;
- Dermatitis, ulceration, or infection created by the abdominal skin folds; and/or
- The size of the panniculus would be such that it covers the pubic area or the genitalia.

Only one panniculectomy will be allowed per lifetime. It is recommended that the patient reach 120% of ideal weight before having a panniculectomy. If, after significant weight loss, the patient has a panniculectomy and then goes on to lose additional weight resulting in the need for a further panniculectomy, BCBSMT will not cover the second procedure.

Rhinoplasty (nose surgery)—When nasal surgery is performed solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities, the procedure is considered cosmetic. Rhinoplasty is generally not considered cosmetic when it is performed to improve nasal respiratory function and repair defects caused by trauma (e.g., dislocated nasal bone fractures and turbinate hypertrophy).

Scar Treatment—Scar treatment is considered cosmetic except when there is documentation of functional problems and symptoms such as pain, inflammation, impaired mobility, and itching. Individual consideration will be given in these cases and in cases when the scarring is the result of an accident. Treatment of old acne scars is considered cosmetic.

Skin Disorders—The initial evaluation and diagnosis of the following skin disorders is not considered cosmetic. Treatment, however, is considered cosmetic:

Dyschromia—Mottling or skin discoloration.

Poikiloderma—Increased pigmentation of the skin associated with widened capillaries (telangiectasia) often on the neck and chest.

Rosacea—The most visually apparent symptoms of rosacea (e.g., erythema, papules, pustules, telangiectasias, and rhinophyma) may be cosmetically disconcerting to patients. Non-pharmacologic treatment of rosacea including, but not limited to, laser and light therapy, dermabrasion, chemical peels, surgical debulking, and electrosurgery is performed solely for cosmetic reasons. There are no known clinical factors arising from rosacea that warrant non-pharmacologic treatment. While rosacea is progressive and chronic, the clinical manifestations do not impact the health status of the patient.

Individual consideration will be given for Rhinophyma that obstructs nasal passages. Rhinophyma has also been related to an increase in basal and squamous cell carcinoma. However, there is insufficient evidence to demonstrate any association with, or increase in, carcinoma in patients with rosacea. The probability of developing a nasal obstruction, or basal or squamous cell carcinoma, is not sufficient to warrant preventive removal of rhinophymatous tissue.

Spider Veins—Treatment of superficial telangiectatasias and asymptomatic varicosities are considered cosmetic. Refer to the medical policy Varicose Veins, Treatment Of.

Tattooing—Tattooing is generally considered cosmetic with the exception of nipple tattooing by a tattoo technician (artist) for approved areolar reconstruction when billed by the surgeon.

Varicose Veins Treatment—Refer to the medical policy Varicose Veins, Treatment Of.

Vitiligo—Vitiligo is not cosmetic. Psoralens Ultraviolet A (PUVA) or Excimer (X-Trac) treatment done in the physician's office for vitiligo is not cosmetic.

Wrinkle Removal (Rhytidectomy)—Wrinkle removal is considered cosmetic except in cases where documentation supports a functional impairment.

MEDICAL POLICIES—REVISED POLICIES

DENTAL: GENERAL ANESTHESIA IN A HOSPITAL, OUTPATIENT, OR SURGICENTER FACILITY

Chapter: Dental
Upcoming/Revised Policy
Effective Date: May 1, 2007

DESCRIPTION
Most office dental procedures involve the use of a local, injectible anesthesia. Conscious sedation and general anesthesia are not routinely used in most dental procedures but may be used to treat children or mentally or physically disabled patients. The following definitions are from the Montana Board of Dentistry:

Conscious Sedation means a minimally depressed level of consciousness in which the patient breathes normally without assistance, retains protective reflexes, and responds to physical stimulation or verbal command in a manner appropriate to the patient's cognitive level. Conscious sedation is not a form of general anesthesia, and brief interludes of unconsciousness during conscious sedation do not bring conscious sedation within the scope of general anesthesia.

General Anesthesia means a state of unconsciousness intentionally produced by anesthetic agents, with absence of pain sensation over the entire body and a greater or lesser degree of muscular relaxation. The drugs producing this state can be administered by inhalation, intravenously, intramuscularly, or via the gastrointestinal tract. General anesthesia is divided into:

- Full general anesthesia, which means a level of consciousness in which the patient is without intact protective reflexes, is unable to maintain an airway, and is incapable of rational response to query or command; and
- Light general anesthesia, which means a level of consciousness in which the patient breathes normally without assistance and retains protective reflexes throughout most of the procedure.
- "General anesthetic" means any recognized anesthetic agent, sedative, hypnotic, tranquilizer, or narcotic used in sufficient prescribed dosages for the purpose of inducing general anesthesia.
- The term does not include a nitrous oxide and oxygen mixture or any other anesthetic administered to produce conscious sedation.

POLICY
Prior authorization is recommended when general anesthesia is needed for a dental procedure. To authorize, call the BCBSMT Customer Service Department 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 coverage for general anesthesia for dental procedures provided in an outpatient hospital or surgery center setting when the following medical necessity criteria are met:

- The general anesthesia will be covered under the medical benefits of the contract;
- The dental services provided are subject to dental benefits;
- The general anesthesia must be administered by an anesthesiologist, a certified registered nurse anesthetist, or another licensed health care professional, and not the attending dental provider; and
- When the member's mental or physical condition prohibits the service being done in an office setting. The determination will be based on medical necessity and the conditions covered may include, but are not limited to, the following:
  - A child five years of age or under (e.g., until the child's sixth birthday); and
  - A medical or mental condition that requires monitoring during dental procedures including, but not limited to, the following:
    - Coronary disease;
    - Asthma;
    - Chronic Obstructive Pulmonary Disease (COPD);
    - Heart failure; and
    - Developmental disability.

Other conditions are considered on a case-by-case basis.

VISION THERAPY--ORTHOPTIC TRAINING

Chapter: Vision
Upcoming/Revised Policy
Effective Date: May 1, 2007

POLICY
Prior authorization of vision therapy is recommended. To authorize, call the BCBSMT Customer Service Department 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 up to seven sessions of vision therapy medically necessary for the treatment of the following conditions:

- Convergence insufficiency (378.83);
- Active Meniere's disease, cochleovestibular (386.01);
- Esotropia (378.0);
- Exotropia (378.1 - 378.18); and
- Strabismus - (378.2 - 378.9).

Investigational
BCBSMT considers vision therapy investigational for treatment including, but not limited to, the following:

- Dyslexia;
- Learning disabilities;
- Reading disorders;
- Attention deficit disorder;
- Visual rehabilitation after traumatic brain injury or stroke; and
- Vision improvement for refractive errors.

VISION, *continued on page 19*

VISION, *continued from page 18*

The available evidence does not support the conclusion that orthoptic treatment improves reading comprehension for people who have a reading disorder nor does it demonstrate that visual anomalies cause learning disabilities or are even more common among persons who have learning disabilities. If, as a few studies suggest, atypical eye movements are associated with learning disabilities, they may be secondary or compensatory to an information-processing deficit. This suggests the possibility that orthoptic training could be detrimental by disrupting a compensatory mechanism.

PATENT FORAMEN OVALE (PFO) CLOSURE DEVICES

Chapter: Surgery - Procedures
Upcoming/Revised Policy
Effective Date: May 1, 2007

Effective October 31, 2006, the two transcatheter devices (CardioSEAL Septal Occlusion System and Amplatzer PFO Device) previously approved by the FDA to treat a PFO are being voluntarily withdrawn from the market. Both devices had previously received humanitarian device approval (a category of FDA approval applicable to devices designed to treat a patient population of less than 4,000 patients). Both device manufacturers exceeded their implantation limits. Under the humanitarian device exemption, clinical trials to validate effectiveness of the device were not required.

Both manufacturers now plan to move forward with clinical trials to gain FDA approval in patients with recurrent cryptogenic stroke due to presumed paradoxical embolism through a PFO 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 the BCBSMT Customer Service Department 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 will consider coverage for implantation of a patent foramen ovale closure device only for members enrolled in an investigational device exemption (IDE) center trial and when the following medical necessity criteria are met:

- BCBSMT recommends evaluation by both a cardiologist and a neurologist to determine the alternatives, benefits, and risks of surgery to close a patent foramen ovale.
- 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; and
- The member is enrolled in an investigational device exemption (IDE) center trial.

Investigational

BCBSMT considers closure of a PFO investigational in 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, and right ventricular infarction);
- Migraine headaches accompanied by aura;
- Post-traumatic fat embolism syndrome with cerebral embolism by way of PFO; and
- The member is not enrolled in an IDE center trial.

VARICOSE VEINS, TREATMENT OF

Chapter: Surgery - Procedures
Upcoming/Revised Policy
Effective Date: May 1, 2007

POLICY

Medically Necessary

BCBSMT considers the following medically necessary modalities to treat symptomatic varicose veins:

- Surgical treatment of the saphenous vein by ligation and stripping; and
- Stab phlebectomy to treat residual veins as an adjunct to or following laser or radiofrequency ablation (this does not include co-existing spider (reticular) veins not related to the venous system, which has been surgically treated).

Prior authorization is recommended for the following procedures. To authorize, call the BCBSMT Customer Service Department 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.

Endoluminal radiofrequency ablation or endovascular laser ablation as an alternative to saphenous vein ligation and stripping. The following patient selection criteria apply:

- Doppler ultrasonographic documentation of saphenofemoral junction incompetence and great saphenous vein reflux;
- Non-aneurysmal saphenous veins;
- Maximum saphenous vein diameter of 12 mm; and
- Absence of vein tortuosity, which would impede catheter advancement.

Coverage for sclerotherapy or stab plebectomy to treat symptomatic varicose veins is limited to members with complications of venous disease including, but not limited to the following:

- Ulceration;
- Edema;
- Sclerosis;
- Subcutaneous fibrosis; and
- Varicose dermatitis.

VERICOSE, *continued on page 20*

MEDICAL POLICIES—REVISED POLICIES

VERICOSE, *continued from page 19*

Cosmetic
BCBSMT considers the treatment of asymptomatic varicosities, reticular veins, and superficial telangiectatasias (spider veins) cosmetic.

Investigational
BCBSMT considers the following treatments investigational:

- Sclerotherapy as the sole treatment of varicose tributaries without associated ligation of the saphenofemoral junction and stripping of the saphenous vein; and
- Sclerotherapy of the greater saphenous vein with or without associated ligation of the saphenofemoral junction.

Non-Covered
BCBSMT considers sclerosing agents not approved by the FDA non-covered.

RANGE OF MOTION MEASUREMENTS

Chapter: Medicine: Tests
Upcoming/Revised Policy
Effective Date: May 1, 2007

Per CPT Assistant, CPT code 95851 is intended to report range of motion measurements. Code 95851 may be reported for each extremity measured (excluding the hand) or for each trunk section measured (e.g., cervical, thoracic, and lumbar). A written report of the physician's interpretation of the results is required.

POLICY
Covered
BCBSMT range of motion measurements are covered when done in conjunction with physical medicine procedures.

Non-Covered
BCBSMT considers range of motion measurements inclusive when done in conjunction with the selection, design, alteration, or fabrication of orthotics.

SURGICAL TRAY

Chapter: Surgery - Administrative
Upcoming/Revised Policy
Effective Date: May 1, 2007

Description
A surgical tray is a set of reusable or disposable instruments kept in a sterile package to be opened and used for certain surgical techniques.

POLICY
BCBSMT considers a surgical tray (A4550) inclusive of a surgical, evaluation and management, or other procedure code. Additional compensation for a surgical tray will not be allowed for medical services. Additional compensation for a surgical tray will be allowed for dental oral surgery procedures billed using Current Dental Terminology (CDT) codes. Refer to the policy Dental: Surgical Trays

Rationale
From 1999 to 2002, the Relative Value Units (RVU) assigned by the Centers for Medicare and Medicaid Services for HCPCS code A4550 have decreased to zero. This change was accompanied by a steady increase in the resource based practice expenses component of surgical procedures. The cost of the surgical tray is fully included in the RVUs assigned to surgical procedures.

Reimbursement of CDT codes billed for dental office procedures is not based on RVU. Therefore, the above logic does not apply when these codes are billed.

SURGICAL SUITES, IN OFFICE

Chapter: Surgery - Administrative
Upcoming/Revised Policy
Effective Date: May 1, 2007

POLICY
BCBSMT does not reimburse for an in-office surgical suite when the procedure performed is routinely performed in an office setting, and when the in-office surgical suite is a licensed freestanding surgical center.

Refer to the dental policy General Anesthesia in a Hospital, Outpatient, or Surgicenter Facility.

RETIRED POLICIES

Retired policies are no longer considered active policies. Retired policies address services that fit one or more of the following criteria:

- The issue might be better addressed through other mechanisms such as member contracts or as a compensation policy;
- The service is considered obsolete; and
- The issue is no longer of interest to BCBSMT.

Once a policy is retired, it is available upon request but is not available electronically. The following policies are retired:

- Torsion Braces;
- Suture Removal;
- Ovulation Prediction Kits;
- Chorionic Villus Sampling; and
- Home Monitoring Devices (HomMed).

REGULAR BUSINESS

QNXT CONVERSION BEGINS ON MARCH 1

During March and April, we will convert more groups and members to our QNXT core operating system. To prepare for this activity, the membership and claims payment freeze begins on March 17 and should be completed in 10 to 14 days. This freeze affects only the members that are being converted. We will continue to run normal pay cycles for members on our old system and for members already converted to the new system. As you can see in Table 1, which lists the number of members being converted in each county, we have significantly reduced the size of this conversion to ensure a smooth transition. In fact, it is approximately 70% smaller than the last conversion.

Converted members will receive new identification (ID) cards that will have new system-generated health plan ID numbers that are system-generated; we will no longer use social security numbers. You must submit BCBSMT claims with the new member ID number, so be sure to ask members for their most current ID card. New member eligibility information may not be available online in Secure Services, and you will receive a message telling you to contact Customer Service to obtain accurate eligibility information.

BCBSMT is working hard to make this a seamless transition for your office, but you may experience some delay in claims processing during the conversion, and we appreciate your patience. Our members, groups, and providers are the foundation of our company, and we want to provide the best service possible.

Beginning April 1, our extended Customer Service Department hours will be 8 a.m. to 6 p.m. Monday through Friday so that we are more accessible during the system transition. You may contact our Customer Service Department at 1-800-447-7828.

At the same time, we are committed to mitigating the impact this process may have on you and your facility or practice. We will provide you with periodic interim payments upon request. Just call Health Care Services at 1-800-447-7828, extension 3600 to request a payment.

TABLE 1

Approximately 12,400 members are being converted to the new system. These numbers represent members in groups and not members with claims.

COUNTY	MEMBERS
Beaverhead	82
Big Horn	32
Blaine	24
Broadwater	15
Carbon	106
Carter	0
Cascade	3,215
Chouteau	134
Custer	180
Daniels	31
Dawson	74
Deer Lodge	125
Fallon	8
Fergus	45
Flathead	514
Gallatin	1,242
Garfield	14
Glacier	0
Golden Valley	11
Granite	18
Hill	130
Jefferson	129
Judith Basin	17
Lake	73
Lewis & Clark	1,189
Liberty	4
Lincoln	42
Madison	37
McCone	2
Meagher	4
Mineral	5
Missoula	516
Musselshell	3
Park	405
Petroleum	0
Phillips	43
Pondera	72
Powder River	6
Powell	31
Prairie	7
Ravalli	569
Richland	44
Roosevelt	20
Rosebud	11
Sanders	21
Sheridan	23
Silver Bow	721
Stillwater	22
Sweet Grass	14
Teton	197
Toole	54
Treasure	5
Valley	22
Wheatland	5
Wibaux	9
Yellowstone	1,142

BRAIN AND SPINE MRI/CT PRIOR AUTHORIZATION FAX NUMBER UPDATE

If you currently use the online prior authorization forms for brain and spine MRIs and CTs, note that the fax number has changed to 444-8451. Forms are available online at www.bluecrossmontana.com. Click on Provider Services, then Prior Authorize.

Prior authorization is recommended for scans of the brain and spine when ordered by primary care physicians and non-physician professional providers. Typically, records are not necessary when using BCBSMT prior authorization forms, but simply stating "backache" and "headache" does not provide enough information. When records are requested, it is to support medical necessity.

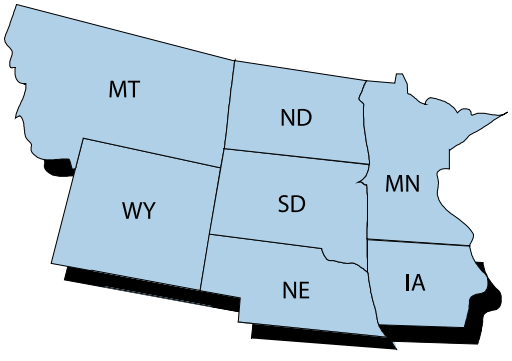
More information about the prior authorization process is published in Chapter 3: Benefit Management, and the prior authorization forms are also available in Appendix A of the BCBSMT Provider Manual published at www.bluecrossmontana.com. Click on Provider Services, then Provider Manuals. MRI and CT medical policies are also online. Click on Provider Services, then Medical Policy.

If you have any questions, call Customer Service at 1-800-447-7828, or call your Provider Network Service Representative (see inside back cover).

MEDICAREBLUE PPO AND PRESCRIPTION DRUG PLANS ENTER SECOND YEAR

MedicareBlue℠ PPO
A Medicare Advantage Plan

The Medicare Advantage regional PPO product, MedicareBlue PPO, is entering its second year of providing medical and prescription drug benefit plans for members 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 has an extensive network of physicians, specialists, hospitals, and pharmacies, and 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. 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

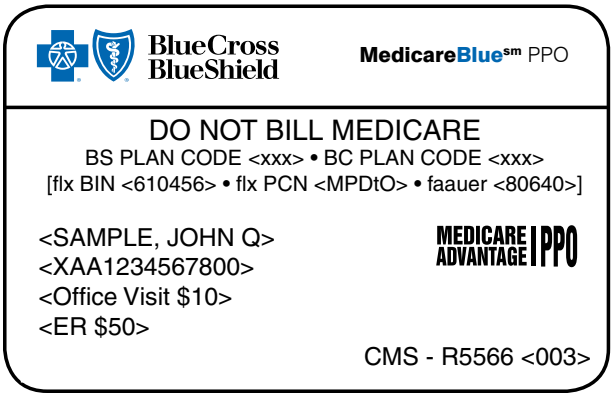
MEDICAREBLUE, *continued on page 24*

REGULAR BUSINESS

MEDICAREBLUE, *continued from page 23*

Member ID Cards

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. An example of the MedicareBlue PPO identification card is shown below. Remember 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

Benefit Plans

MedicareBlue PPO is a Preferred Provider Organization medical benefit plan that includes both Medicare Part C and Medicare Part D prescription drugs. There is no need to select a primary care physician and referrals are not required. MedicareBlue PPO offers all the original benefits of Medicare but with more coverage (including preventive benefits) at a lower monthly premium. MedicareBlue PPO offers the freedom for members to choose their own doctors and hospitals.

MedicareBlue Rx is a stand-alone Medicare Part D Prescription Drug Plan that helps members pay for prescription drugs. It covers a broad range of generic and brand name medications and features a large national network of more than 53,000 independent and chain pharmacies.

Complete MedicareBlue PPO and MedicareBlue Rx benefit information is available at www.yourmedicaresolutions.com (click on *Plan Options*).

If you have questions about network participation and/or your Medicare Advantage provider contract, contact your Provider Network Service 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 www.yourmedicaresolutions.com *(*click on *For Providers)*.

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 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:

- CHIP;
- Caring Program for Children;
- Federal Employee Program;
- Medicare Risk; and
- 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.

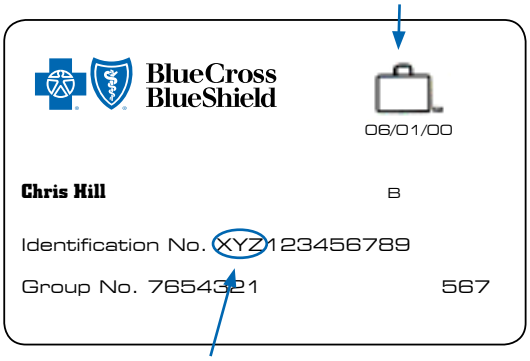
Identification Cards With No Alpha Prefix

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.

The blank suitcase logo may appear anywhere on the front of the ID card.



The easy-to-find alpha prefix identifies the member's Blue Cross and Blue Shield Plan.

BLUECARD, *continued on page 26*

REGULAR BUSINESS

BLUECARD, *continued from page 25*

Health Debit Cards

Some members may have a Blue Cross and/or Blue Shield health care debit card with value-added features to assist your office with collecting member cost-sharing amounts. Using the new cards can help simplify the payment process and help you:

- Reduce bad debt;
- Reduce paper work for billing statements;
- Minimize bookkeeping and patient-account functions for handling cash and checks; and
- Avoid unnecessary claim payment delays.

Stand-Alone Debit Cards and Combined Debit and Member ID Cards

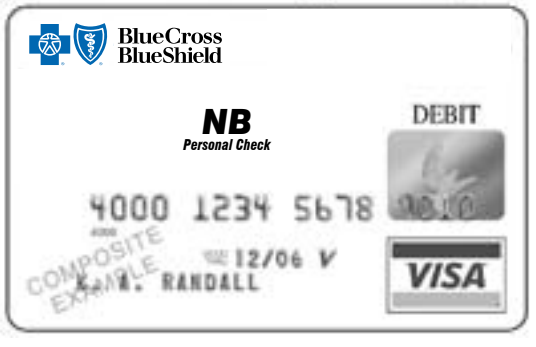
The card allows members to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), or Flexible Spending Account (FSA). Some cards are "stand-alone" debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number.

The card will have the nationally recognized Blue Cross and/or Blue Shield logos, along with the logo from a major debit card logo such as MasterCard® or Visa®.

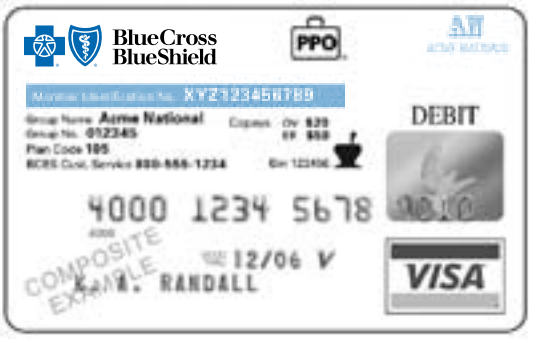
The cards include a magnetic strip so providers can collect any deductibles, copayment, or coinsurance through any debit card swipe terminal. Funds are deducted automatically from the member's appropriate HRA, HSA, or FSA account.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements and can also use their cards via phone to process payments. In addition, members are more likely to carry their current ID cards because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment. The cost is the same as the current cost you pay to swipe any other signature debit card.

Sample Stand-Alone Debit Card



Sample combined Debit Card and Member ID Card



How to Identify International Members

Occasionally, you may see identification cards from foreign BCBS plan members. These ID cards will also contain three-character alpha prefixes. Treat these members the same as domestic BCBS plan members.

To verify membership, call 1-800-676-BLUE (2583)

Operators are available to assist you during regular weekday business hours (7 a.m. – 10 p.m. EST). They will ask for the alpha prefix shown on the member's ID card and will connect your office directly to the appropriate membership and coverage unit at the member's BCBS Plan.

Keep in mind that BCBS plans are located throughout the country and may operate on a different time schedule than BCBSMT. If calling after hours, a recorded message will state normal business hours and you may be transferred to a voice response system linked to enrollment and benefits.

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.

CAI UPDATE: FLUOROSCOPY SEPARATE COMPENSATION ADDITIONS

Additional codes (in bold) have been added to the Claims Accuracy Initiative programming allowing for additional compensation for fluoroscopy. BCBSMT allows separate compensation for CPT codes 76000-76005 when submitted with the following CPT codes:

10022, 20525, 20610, 20670, 20680, 23350, 24220, 25246, 25565, 26505, 26650, 27093, 27095, 27096, **27370**, 27648, 32002, 33967, 36597, 62270, 62272, 62273, 62282, **62281**, **62284**, 62287, **62290**, 62310, 62311, 62318, 62350, 63650, 64421, 64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484, 64517, 64520, 64530, 64622, 64623, 64626, 64627, 64680, 64681, 73222, 73722, **76831**, and 77778.

Fluoroscopic guidance is considered an integral component for most procedures. However, separate compensation is allowed for the listed procedures because of the increased risk associated with these procedures. BCBSMT considers fluoroscopic guidance with all other procedures a common fundamental component.

If you have questions, call Customer Service at 1-800-447-7828, or call your Provider Network Service Representative (see inside back cover).

BCBSMT PROVIDER MANUAL UPDATED

The BCBSMT Provider Manual is updated and published at www.bluecrossmontana.com. The manual is continually reviewed for clarity and style with the goal of providing simple and direct instructions. A summary of recent changes include:

1. Updated HCS contact information (1-2 and 1-3).
2. Simplified credentialing (1-6) and re-credentialing (1-7) descriptive language.
3. Removed the following services from Recommended Prior Authorization (3-3):
   - Ambulatory home uterine monitoring.
   - Brachytherapy for prostate cancer.
   - Chorionic villus sampling (if patient is under 35 years old).
   - Selective posterior rhizotomy for spasticity with cerebral palsy.
4. Changed Pain Pump (external) to Pain Pump (internal) (3-3).
5. Added closing statement to Recommended Prior Authorization (3-3): "Prior authorization recommendations are listed in medical policy."
6. Deleted information about archived policies in Medical Policy Maintenance. Deleted the statement, "The message on each retired policy will read Policy No Longer Active" from retired policies. Added the following statements to retired policies' bulleted list (3-8):
   - There is minimal claims activity.
   - The service is considered a standard of care.
7. Updated Department of Corrections phone number to 1-406-846-1320, extension 2254.
8. Deleted Health First Direct from Joint Venture Provider Network (8-1).
9. Added the following to Coordination of Benefits introduction (11-1): BCBSMT does not coordinate benefits for individual benefit plans.
10. Reorganized the Managed Care chapter referral requirements for Blue Select and Self-Funded Groups (8-1 through 8-12).

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 or content, contact Mike McGuire at mmcguire@bcbsmt.com or call 1-800-447-78258, extension 8412.

2006 PROVIDER SATISFACTION SURVEY RESULTS

BCBSMT completed its annual provider satisfaction survey during October and November 2006. The Myers Group in Snellville, GA administrated the survey. 1,400 providers were randomly selected from over 4,000 participating providers, and 276 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 73.1% in 2006 compared to 80.7% in 2005. 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 decreased by 7.6%.

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

PROVIDER SURVEY, *continued on page 28*

REGULAR BUSINESS

PROVIDER SURVEY, *continued from page 27*

	Survey Item Others	BCBSMT Box Score	2006 Top Box Score	2005 Top Box Score	2004 Top Box Score	2003 Top Box Score
1	Responsiveness and courtesy of Provider relation's representatives.	BCBSMT	58.0%	65.0%	50.9%	61.0%
		Others	25.7%	25.7%	20.2%	21.0%
2	Timeliness to answer questions and/or resolve problems.	BCBSMT	46.3%	59.4%	46.5%	52.9%
		Others	23.0%	19.8%	18.0%	15.6%
3	Frequency and effectiveness of provider representative visits.	BCBSMT	26.9%	36.1%	17.7%	25.8%
		Others	13.3%	12.3%	5.3%	9.1%
4	Quality of provider orientation process.	BCBSMT	28.6%	37.7%	22.3%	29.7%
		Others	11.0%	14.3%	6.7%	7.9%
5	Reasonableness of paperwork and documentation.	BCBSMT	30.2%	42.2%	24.5%	34.5%
		Others	15.2%	14.9%	10.0%	16.6%
6	Usefulness of BCBSMT's New Provider Workshop Format.	BCBSMT	37.5%	39.9%	35.8%	39.1%
		Others	na	na	na	na
7A	Usefulness of Capsule News.	BCBSMT	39.3%	39.9%	30.4%	39.3%
		Others	na	na	na	na
7B	Usefulness of Provider Manuals.	BCBSMT	30.5%	36.6%	27.6%	39.8%
		Others	na	na	na	na
7C	Usefulness of Provider Contracts.	BCBSMT	25.5%	35.1%	27.1%	34.7%
		Others	na	na	na	na
7D	Usefulness of Provider Directories.	BCBSMT	29.8%	43.7%	30.0%	43.0%
		Others	na	na	na	na
8	The health plan's administration of the PCP's specialist referrals.	BCBSMT	29.7%	30.3%	21.0%	26.6%
		Others	15.6%	16.1%	13.5%	16.7%
9	The health plan's facilitation of clinical care for patients.	BCBSMT	33.5%	40.0%	23.7%	30.1%
		Others	17.5%	16.5%	12.2%	13.7%
10	The health plan's support of physician relationship with patients.	BCBSMT	28.3%	34.3%	22.2%	29.3%
		Others	15.8%	16.5%	14.3%	14.8%
11	Degree to which prevention and wellness are covered/encouraged.	BCBSMT	26.2%	28.0%	23.1%	27.3%
		Others	8.8%	11.1%	14.3%	11.9%
12	The health plan's support of appropriate clinical care for patients.	BCBSMT	31.6%	36/6%	22.0%	33.5%
		Others	14.6%	15.0%	13.9%	15.4%
13	The health plan's support concerning medical management.	BCBSMT	25.3%	30.9%	21.5%	26.9%
		Others	12.9%	13.8%	10.7%	12.1%
14	Accuracy of claims processing.	BCBSMT	47.9%	21.7%	49.4%	50.0%
		Others	23.2%	23.2%	21.4%	22.7%
15	Timeliness of claims processing.	BCBSMT	50.2%	61.7%	52.6%	57.0%
		Others	14.7%	15.1%	15.9%	18.1%
16	Ease of using health plan's provider	BCBSMT	48.4%	60.4%	47.3%	60.0%
		Others	22.1%	23.9%	15.9%	29.2%
17	Would you recommend BCBSMT to other patients?	BCBSMT	88.1%	86.7%	77.5%	35.9%
18	Would you recommend BCBSMT to other physicians?	BCBSMT	80.1%	87.8%	75.5%	34.5%
19	Overall satisfaction with BCBSMT.	BCBSMT	73.1%	80.7%	67.0%	72.8%
		Others	61.8%	60.1%	57.8%	58.4%

2007 PHYSICIAN FEE SCHEDULE

As was reported in the last Capsule News, the conversion factor for BCBSMT participating physicians increases to $57.70, and the conversion factor for participating anesthesiologists and CRNAs increases to $52.00, effective March 1, 2007. The new physician fee schedule is available at www.bluecrossmontana.com. Click on *Provider Services* and then *Fee Schedule*.

BCBSMT has updated and published its provider compensation policies at www.bluecrossmontana.com that define the compensation methodology for all providers submitting claims to BCBSMT. Click on *Provider Services*, then Provider Policies. If you do not have access to the Internet, call the Customer Service Department for a copy of the policies applicable to your provider type.

Medicare Budget Neutrality Adjustor

BCBSMT has received questions as to whether or not BCBSMT is going to implement the Medicare budget neutrality adjustor. As a result of Medicare's five-year review, the final rule in the federal register significantly increases the Relative Value Unit (RVU) work component for evaluation and management (E&M) services. This change reflects the recommendations of the Relative Value Update Committee (RUC) of the American Medical Association. Subsequently, Medicare implemented a budget neutrality adjustor that is applied to the work RVUs for all CPT codes.

This means that Medicare calculates a negative adjustment (-10.1%) to make the all payments budget neutral. This is not published in Addendum B of the federal register. However, this budget neutrality adjustor is part of the formula for payment and not part of the published RVUs. **BCBSMT will not apply the budget neutrality adjustor to claims payment.**

Transitional and Fully Implemented RVUs

Medicare is adopting a new methodology for determining practice expense RVUs, but will phase in the changes over a four-year period. BCBSMT uses the transitioned RVU values and not the fully implemented RVU values found on the 2007 National Physician Fee Schedule Relative Value File.

If you have any questions, call Customer Service at 1-800-447-7828, or call your Provider Network Service Representative (see inside back cover).

CHILDREN'S HEALTH INSURANCE PLAN CLARIFICATION

The Children's Health Insurance Plan (CHIP) is now fully administered by the Department of Public Health and Human Services effective October 1, 2006. BCBSMT provides third-party administrative services including claims processing and customer service.

Providers of acupuncture, chiropractic, home health, hospice care, medical equipment, oxygen supplies, and skilled nursing and extended care providers are not allowed to participate in the CHIP network as was published in the fourth quarter 2006 Capsule News.

We apologize for any confusion this may cause. If you have questions about the CHIP provider network, contact your Provider Network Representative (see inside back cover).

More information about CHIP claims, eligibility, and co-payments is available in chapter five of the BCBSMT provider manual published at www.bluecrossmontana.com. Click on *Provider Services* and then *Provider Manuals*.

PARTICIPATING PROVIDERS

NOVEMBER 2, 2006 TO FEBRUARY 2, 2007

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.

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

Sandra L Bailey, DO	Great Falls	Obstetrics and Gynecology
Julie W. Bliss, PT	Great Falls	Physical Therapy
Beverly L. Braak, MD	Missoula	Obstetrics and Gynecology
James I. Bucher, MD	Kalispell	Anesthesiology
Bryn L. Burnham, DO	Billings	Family Medicine
Central Montana Birth Center , PLLP	Great Falls	Birthing Center
Theodore J. Chase, PA	Helena	Physician Assistant
Charles H. Christensen, DO	Great Falls	Pediatrics
Patricia M. Cole, MD	Whitefish	Family Medicine
Tara L. Cooper, PA-C	Billings	Physician Assistant
Kimberly S. Damrow, MD	Helena	Internal Medicine
Laurel H Desnick, MD	Livingston	Internal Medicine
Chad R Dickemore, DPM	Hamilton	Podiatry
Eric J. Exelbert, MD	Missoula	Pediatrics
Lynda M. Fichtner, LCSW	Missoula	Licensed Clinical Social Worker
Scott M. Foss, DC	Libby	Chiropractic
Betty K. Fox Sterling, LCPC	Bozeman	Licensed Clinical Professional Counselor
Randall K. Gibb, MD	Billings	Obstetrics and Gynecology
Sara M. Hagedorn, MPT	Bozeman	Physical Therapy
Michael J. Hannan, DO	Kalispell	Anesthesiology
Susan M Hobbs, NP	Great Falls	Nurse Practitioner
Cindy R Holt, MD	Missoula	Pediatrics
Shad R. James, PT	Belgrade	Physical Therapy
Martin D. Katz, MD	Livingston	Family Medicine
Michael S. Kornish, MD	Hamilton	Family Medicine
Michael A. Kremkau, MD	Missoula	Emergency Medicine
Anthony W Lambert, DC	Missoula	Chiropractic
Jeffrey H Lin, MD	Kalispell	Pulmonary Disease
Mary Louise Louder, DO	Billings	Family Medicine
Michael L Mahoney, MD	Libby	Family Medicine
Ernest K. Mar, MD	Great Falls	Physical Medicine & Rehabilitation
Michele C. Marler, MD	Shelby	Family Medicine
Phil C. McLain, MD	Cut Bank	Family Medicine
Shaun L. McQueen, DDS	Billings	Dentist
Larry D. Melia, MD	Missoula	Internal Medicine
Michelle A. Moler, PT	Stevensville	Physical Therapy
Mark E. Morin, MD	Sidney	Ophthalmology
Robert J. Murphy, PA-C	Great Falls	Physician Assistant
Craig R. Nicholson, MD	Fort Benton	Family Medicine
Drake A. Paul, MD	Missoula	Pediatrics
Daniel L. Pierce, MD	Missoula	Emergency Medicine
Lance W. Pysher, MD	Hamilton	Radiology

PARTICIPATING PROVIDERS, *continued on page 31*

PARTICIPATING PROVIDERS

PARTICIPATING PROVIDERS, *continued from page 30*

Andrew M Rashkow, MD	Great Falls	Internal Medicine
Paul R. Reeb, MD	Whitefish	Family Medicine
Brent J. Reich, MD	Billings	Anesthesiology
Thomas S. Reich, MD	Great Falls	Otolaryngology
Jeffrey J. Rentz, MD	Billings	Surgery, General
Charlie E. Richardson, MD	Cut Bank	Surgery, General
Edwin J. Rodriguez, MD	Worden	Family Medicine
Sonja R. Samsoondar, MD	Glendive	Pediatrics
Rodney J. Schmidt, PA-C	Kalispell	Physician Assistant
Lanny Roy Schneider, PA	Billings	Physician Assistant
George M. Seal, MD	Great Falls	Urology
Hannah A. Sexton, PA	Livingston	Physician Assistant
Chad G. Smith, DPM	Billings	Podiatry
Nathan B. Smith, PA-C	Missoula	Physician Assistant
Joan F. Sorenson, MD	Billings	Pediatrics
Jeanne W. Sticht, MD	Helena	Anesthesiology
Margaret K. Stockwell, MD	Helena	Family Medicine
Daniel G. Tailleur, MD	Miles City	Family Medicine
John H. True, MD	Havre	Orthopaedics
Chun-Ju Wang, DO	Missoula	Physical Medicine & Rehabilitation
Matthew E. Wolpoe, MD	Billings	Otolaryngology

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

Brian L. Abbott, MD	Great Falls	Pediatric Hematology-Oncology
Constance F. Albrecht, LCPC	Bozeman	Licensed Clinical Professional Counselor
Michael L. Allen, DDS	Columbia Falls	Dentist
Marilyn C. Barrick, PHD	Gardiner	Psychology
Julie W Bates, CNM	Kalispell	Certified Nurse Midwife
Don J. Benton, NP	Miles City	Nurse Practitioner
Tracy G. Benzing, DPM	Billings	Podiatry
Edward P. Bergin, MD	Sidney	Surgery
Mary Beth Bergman, LCPC	Great Falls	Licensed Clinical Professional Counselor
Jeffrey L. Bern, MD	Ennis	Family Medicine
Norma Bilbool, MD	Billings	Physical Medicine & Rehabilitation
Phillip Wayne Blaich, PA-C	Malta	Physician Assistant
Robin L. Boland, FNP	Great Falls	Nurse Practitioner
Vonna Branam, FNP	Billings	Nurse Practitioner
Neil S Bricco, LCPC	Belgrade	Licensed Clinical Professional Counselor
Danny J. Browning, PA	Glasgow	Physician Assistant
James C. Bull, MD	Great Falls	Urology
Charles T. Burton, MD	Billings	Dermatology
Edward J. Callaghan, MD	Missoula	Pathology
Nicholas M. Campbell, MD	Townsend	Family Medicine
Penny J Carpenter, LCPC	Livingston	Licensed Clinical Professional Counselor
Karla Rae Carr, OT	Billings	Occupational Therapy
Rita Charles, CRNA	Helena	Certified Registered Nurse Anesthestist
Martin D. Cheatle, PHD	Missoula	Psychology
John P. Chesson, MD	Great Falls	Urology
Carolyn J. Chiappetta, LCPC	Thompson Falls	Licensed Clinical Professional Counselor
James F. Cleary, MD	Livingston	Family Medicine
Nora D. Cohoe, SP	Ronan	Speech Therapy
Emily M. Copps, PA	Whitefish	Physician Assistant
Sandra D. Cruickshank, FNP	Billings	Nurse Practitioner
Amanda J. Cuff, OT	Billings	Occupational Therapy
David B. Culp, FNP	Hamilton	Nurse Practitioner
John H. Engebretson, LCPC	Miles City	Licensed Clinical Professional Counselor
Howard J. Feldman, MD	Great Falls	Cardiovascular Disease
Barbara J. Fiaschetti, LCPC	Kalispell	Licensed Clinical Professional Counselor

PARTICIPATING PROVIDERS, *continued on page 32*

PARTICIPATING PROVIDERS

PARTICIPATING PROVIDERS, *continued from page 31*

Guy S. Fischer, DC	Big Sky	Chiropractic
Bruce D. Fisher, DPM	Havre	Podiatry
Bradford L. Frank, DDS	Great Falls	Dentist
Theresa M. Ghekiere-Richardson, LCPC	Great Falls	Licensed Clinical Professional Counselor
Jolene M. Gibbs, PT	Kalispell	Physical Therapy
Timothy J. Gibbs, PT	Kalispell	Physical Therapy
Barbara A. Gleason, PT	Great Falls	Physical Therapy
Annette Grefe, MD	Billings	Neurology w Special Qualifications in Child Neurology
David M. Groot, LCSW	Billings	Licensed Clinical Social Worker
Jodi Groot, CNS	Billings	Clinical Nurse Specialist
Ryan T. Gunlikson, MD	Kalispell	Surgery
Kurt S Gustavson, DPM	Great Falls	Podiatry
Traci L. Hallett, PT	Great Falls	Physical Therapy
Marcia J Hanks, CNM	Missoula	Certified Nurse Midwife
Susan L. Hartman, SP	Kila	Speech Therapy
William O. Haug, MD	Billings	Family Medicine
Jonathan T. Haven, PT	Missoula	Physical Therapy
Robert L. Hawks, OD	Bozeman	Optometry
Richard L. Hogan, DDS	Miles City	Dentist
Sheila R. Horton, PT	Billings	Physical Therapy
Richard C. Howland, MD	Havre	Orthopaedics
Philip A. Huffman, MD	Havre	Internal Medicine
Cecil T. Jackson, CRNA	Dillon	Certified Registered Nurse Anesthestist
M. Heather Jackson, PSYD	Bozeman	Psychology
Gregory T. Jacobs, DO	Billings	Emergency Medicine
Gregory M. Johnson, DDS	Great Falls	Dentist
Michael L. Kelsey, PT	Missoula	Physical Therapy
Stephanie L. Kerbel, SLP	Bozeman	Speech Therapy
Brooke R. Kimzey, SLP	Polson	Speech Therapy
Gloria C. Kornish, PA-C	Missoula	Physician Assistant
Barbara K. Lange, OT	Oxnard	Occupational Therapy
Joshua Leblang, LCPC	Whitefish	Licensed Clinical Professional Counselor
Michael E. Lefever, DO	Butte	Family Medicine
Sheree Smith Leo, LCPC	Box Elder	Licensed Clinical Professional Counselor
Michael W. Linderman, LCPC	Thompson Falls	Licensed Clinical Professional Counselor
Shaina H. Long, PA	Livingston	Physician Assistant
Rodney T Lutes, PA-C	Kalispell	Physician Assistant
RaeAnn H. Magyar, MD	Bozeman	Internal Medicine
Brittney A. Matheson, PA	Missoula	Urgent Care
Joseph M. McClain, MD	Great Falls	Surgery, Cardiovascular
Patrick J. McGree, MD	Butte	Family Medicine
Fred G. McMurry, MD	Billings	Surgery, Neurological
Kathryn Adcox Meade, LCPC	Great Falls	Licensed Clinical Professional Counselor
Robert K. Merchant, MD	Havre	Pulmonary and Critical Care
Jo A. Miller, PA-C	Circle	Physician Assistant
Amy A. Moran, OT	Helena	Occupational Therapy
Elliot M. Morris, MD	Polson	Gastroenterology
Heather E. Morrison, CRNA	Helena	Certified Registered Nurse Anesthestist
John I. Moseley, MD	Billings	Surgery, Neurological
George C. Nadasi, PhD	Kalispell	Psychology
Tim Nordstrom, LCSW	Red Lodge	Licensed Clinical Social Worker
Northwest MT MRI, LLC	Kalispell	Radiology Center
Chima C. Nwaukwa, MD	Great Falls	Cardiovascular Disease
Steven L. Ogilvie, DPM	Missoula	Podiatry
Cheryl A. Olson-McMillan, NP	Missoula	Nurse Practitioner
Cathie S. Osmun, PA-C	Miles City	Physician Assistant
James H. Oury, MD	Missoula	Surgery, Cardiovascular
William Ownbey, OT	Missoula	Occupational Therapy

PARTICIPATING PROVIDERS, *continued on page 33*

PARTICIPATING PROVIDERS

PARTICIPATING PROVIDERS, *continued from page 32*

Christopher L. Paris, MD	Billings	Ophthalmology
Jim Paulsen, LCSW	Billings	Licensed Clinical Social Worker
Carolyn S. Peterson, SLP	Libby	Speech Therapy
Mary T. Pierce, LCSW	Thompson Falls	Licensed Clinical Social Worker
Anita M. Plann, LCPC	Wolf Point	Licensed Clinical Professional Counselor
Elizabeth Denise Quinlan, MD	Glasgow	Orthopaedics
Quincy L. Ribellia, DC	Laurel	Chiropractic
Erik R. Riessen, MD	Helena	Internal Medicine
Mary A Riley, LCSW	Billings	Licensed Clinical Social Worker
James S. Rogers, MD	Malta	Surgery
Jennifer L Rosquist, MD	Missoula	Pediatrics
Claudia Roy, DC	Laurel	Chiropractic
Michael J. Saltzman, MD	Bozeman	Urology
Ruth L. Sampson, MD	Missoula	Endocrinology, Diabetes, & Metabolism
Connie Sue Scarpine, PA	Thompson Falls	Physician Assistant
Thomas E. Schultz, CRNA	Glasgow	Certified Registered Nurse Anesthestist
Krista K. Scott, PT	Polson	Physical Therapy
Frank C. Seitz, PHD	Bozeman	Psychology
Nancy Seldin, LPC	Missoula	Licensed Clinical Professional Counselor
Jacqueline B. Sherman, PhD	Lewistown	Psychology
Nancy Siegel, PT	Frenchtown	Physical Therapy
Sheryl L. Simkins, PT	Bozeman	Physical Therapy
Marshall D. Sklar, MD	Great Falls	Radiation Oncology
Peggy Smith, LCPC	Red Lodge	Licensed Clinical Professional Counselor
Walker Smith, LCPC	Missoula	Licensed Clinical Professional Counselor
Cheri L. Sorg-Hackler, SLP	Bozeman	Speech Therapy
Joseph G. Steffens, MD	Dillon	Pathology
James L. Stobie, DDS	Condon	Dentist
Carolyn R. Suden, LCPC	Great Falls	Licensed Clinical Professional Counselor
Donna J. Suden, LCPC	Forsyth	Licensed Clinical Professional Counselor
Richard Terra, LCSW	Great Falls	Licensed Clinical Social Worker
Craig W. Tolleson, MD	Helena	Psychiatry
Steven A. Torcoletti, PT	Missoula	Physical Therapy
Robin Lynn Treptow, PHD	Great Falls	Pediatric Psychology
Shelly J. Tuller, PA-C	Roundup	Physician Assistant
Teresa S. Turnbull, NP	Stevensville	Nurse Practitioner
Kari Sue Wagner, LCPC	Helena	Licensed Clinical Professional Counselor
Karmen L. Walker, PT	Manhattan	Physical Therapy
P. Leslie Walker, PHD	Kalispell	Psychology
Steven F. Wallace, MD	Missoula	Pediatrics
Michael Wang, MD	Miles City	Pathology
Cory D. Warner, PT	Billings	Physical Therapy
Heather S. Watts, PT	Billings	Physical Therapy
Kathy E Westerly, LCPC	Ronan	Licensed Clinical Professional Counselor
Amy J. Williams, PhD	Missoula	Licensed Clinical Professional Counselor
Brett A Williams, MD	Great Falls	Surgery, Thoracic
Nicole Y. Winbush, MD	Billings	Family Medicine
David Andrew Wolfe, DPM	Billings	Podiatry
Barry E. Yaskus, DDS	Stevensville	Dentist
H L Yaskus, DDS	Stevensville	Dentist
Elizabeth M. Zaluski, LCPC	Butte	Licensed Clinical Professional Counselor

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

Steven F. Arnold, NP	Shelby	Nurse Practitioner
Danny M Aune, LCSW	Bozeman	Licensed Clinical Social Worker
Rodney Babcock, DC	Anaconda	Chiropractic
Kelly G Bagnell, MD	Polson	Obstetrics and Gynecology
Sandra L Bailey, DO	Great Falls	Obstetrics and Gynecology

PARTICIPATING PROVIDERS, *continued on page 34*

PARTICIPATING PROVIDERS

PARTICIPATING PROVIDERS, *continued from page 33*

Cheryl L. Baker, MD	Missoula	Obstetrics and Gynecology
Hallie A. Banzinger, PhD	Missoula	Psychology
Gelene M. Berkram, FNP	Shelby	Nurse Practitioner
Greg G Bourdon, PA-C	Anaconda	Physician Assistant
Daniel Brzozowski, LCSW	Missoula	Licensed Clinical Social Worker
James I. Bucher, MD	Kalispell	Anesthesiology
Bryn L. Burnham, DO	Billings	Family Medicine
Robert Caldwell, MD	Butte	Psychiatry
Timothy W Carte, MD	Polson	Pediatrics
Patricia M. Cole, MD	Whitefish	Family Medicine
Tara L. Cooper, PA-C	Billings	Physician Assistant
Sandra K Cox, MD	Kalispell	Psychiatry
Shane A Cutting, DC	Missoula	Chiropractic
Kimberly S. Damrow, MD	Helena	Internal Medicine
Del Denton, LAC	Billings	Licensed Addiction Counselor
Laurel H Desnick, MD	Livingston	Internal Medicine
Timothy P Donovan, MD	Missoula	Emergency Medicine
Jennell C. Duey, MD	Billings	Family Medicine
Kevin G Eichhorn, MD	Missoula	Emergency Medicine
Eric J. Exelbert, MD	Missoula	Pediatrics
Tony A Fantozzi, PA	Kalispell	Physician Assistant
Linda L Fegan, LCSW	Missoula	Licensed Clinical Social Worker
Betty K. Fox Sterling, LCPC	Bozeman	Licensed Clinical Professional Counselor
Laura Gaetano, PT	Bozeman	Physical Therapy
James P Gardner, MD	Missoula	Emergency Medicine
Lawren P. Gladen, LCSW	Missoula	Licensed Clinical Social Worker
Don E. Goeke, LCSW	Missoula	Licensed Clinical Social Worker
Christopher A. Graham, PA	Billings	Physician Assistant
Warren H Guffin, MD	Missoula	Emergency Medicine
Sara M. Hagedorn, MPT	Bozeman	Physical Therapy
Michael J. Hannan, DO	Kalispell	Anesthesiology
Jami L Hansing, DC	Helena	Chiropractic
Linda R Hanson, PA-C	Boulder	Physician Assistant
Dana M. Headapohl, MD	Missoula	Occupational Medicine
Susan M Hobbs, NP	Great Falls	Nurse Practitioner
Cindy R Holt, MD	Missoula	Pediatrics
R Stephen Irwin, MD	Polson	Family Medicine
Deann R Johnson, PT	Butte	Physical Therapy
Martin D. Katz, MD	Livingston	Family Medicine
Wade R. King, NP	Billings	Nurse Practitioner
Bernadette L. Kneefe, LCSW	Missoula	Licensed Clinical Social Worker
Alaina L. Knight, LCPC	Bozeman	Licensed Clinical Professional Counselor
Michael A. Kremkau, MD	Missoula	Emergency Medicine
Chad J. Krezelok, OD	Bozeman	Optometry
Anthony W Lambert, DC	Missoula	Chiropractic
Tana R Leander, LCSW	Kalispell	Licensed Clinical Social Worker
Jeffrey H Lin, MD	Kalispell	Pulmonary Disease
Libbi S Martino, CNM	Kalispell	Certified Nurse Midwife
Jodi M. Martz, LCPC	Butte	Licensed Clinical Professional Counselor
Anne S Maxwell, NP	Livingston	Nurse Practitioner
Natalie B. McGillen, LCPC	Butte	Licensed Clinical Professional Counselor
Michele C. McKinnie, PSYD	Bozeman	Psychology
Kimberly J. Meier, DC	Billings	Chiropractic
Michelle A. Moler, PT	Stevensville	Physical Therapy
Kirsten L. Morissette, MD	Hardin	Family Medicine
Marilyn J. Murphy, LCPC	Missoula	Licensed Clinical Professional Counselor
Gary J Muskett, MD	Missoula	Emergency Medicine
Jerry L. Nordstrom, LCSW	Billings	Licensed Clinical Social Worker
June O'Connor, LCPC	Butte	Licensed Clinical Professional Counselor

PARTICIPATING PROVIDERS, *continued on page 8*

PARTICIPATING PROVIDERS

PARTICIPATING PROVIDERS, *continued on page 8*

Tomomi Ogata-Schure, LCPC	Bozeman	Licensed Clinical Professional Counselor
Diane S. Page, LCSW	Butte	Licensed Clinical Social Worker
Steven W Palmieri, DO	Polson	Family Medicine
Craig J Panos, MD	Polson	Family Medicine
Drake A. Paul, MD	Missoula	Pediatrics
Heather M. Pfeiffer, FNP	Columbia Falls	Nurse Practitioner
Daniel L. Pierce, MD	Missoula	Emergency Medicine
Scott A. Pierce, LCSW	Missoula	Licensed Clinical Social Worker
Susan E Price- Saylor, LCSW	Anaconda	Licensed Clinical Social Worker
Lance W. Pysher, MD	Hamilton	Radiology
Jessica Randazzo, MSW	Hamilton	Licensed Clinical Social Worker
Andrew M Rashkow, MD	Great Falls	Internal Medicine
Daniel P Rausch, MD	Polson	Family Medicine
Brent J. Reich, MD	Billings	Anesthesiology
Thomas S. Reich, MD	Great Falls	Otolaryngology
Monica L. Rekiel, LCPC	Missoula	Licensed Clinical Professional Counselor
Jeffrey J. Rentz, MD	Billings	Surgery
Aleece P. Reynolds, LCSW	Great Falls	Licensed Clinical Social Worker
Traci Lynn Richards, LCSW	Butte	Licensed Clinical Social Worker
Charlie E. Richardson, MD	Conrad	Surgery, General
Eileen Robbins, APRN	Libby	Clinical Nurse Specialist
Lura K. Robison, NP	Dillon	Nurse Practitioner
Edwin J. Rodriguez, MD	Billings	Family Medicine
Debra J. Ruggiero, PHD	Stevensville	Psychology
Beth A. Salusso, PT	Butte	Physical Therapy
George M. Seal, MD	Great Falls	Urology
Randale C Sechrest, MD	Missoula	Orthopaedics
David C. Segerstrom, LCSW	Kalispell	Licensed Clinical Social Worker
Hannah A. Sexton, PA	Livingston	Physician Assistant
Sharon A Shaw, LCSW	Livingston	Licensed Clinical Social Worker
George Sinelnik, MD	Missoula	Emergency Medicine
Karen F. Skonord, NP	Kalispell	Nurse Practitioner
Pamela L Skonord, PT	Kalispell	Physical Therapy
Nathan B. Smith, PA-C	Missoula	Physician Assistant
Sound Health Imaging	Helena	Radiology Center
St. James Healthcare	Butte	Hospital
Rebekah J Stamp, MPT	Hamilton	Physical Therapy
John V. Stephens, MD	Kalispell	Physical Medicine & Rehabilitation
Margaret K. Stockwell, MD	Helena	Family Medicine
Libby K Sutherland, LCPC	Kalispell	Licensed Clinical Professional Counselor
Daniel G. Tailleur, MD	Miles City	Family Medicine
Pamela J. Vecchio, FNP	Hamilton	Nurse Practitioner
Kelsey Wadsworth, PT	Bozeman	Physical Therapy
Robert S. Wagenaar, MD	Anaconda	Family Medicine
Joseph D. Walsh, LCPC	Billings	Licensed Clinical Professional Counselor
Chun-Ju Wang, DO	Missoula	Physical Medicine & Rehabilitation
Becky J. Wells, PA-C	Ennis	Physician Assistant
Mark G. Weston, MD	Missoula	Emergency Medicine
Matthew E. Wolpoe, MD	Billings	Otolaryngology

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

Charles B. Anderson, MD	Helena	Neurology
Julie W Bates, CNM	Kalispell	Certified Nurse Midwife
Tracy G. Benzing, DPM	Billings	Podiatry
Norma Bilbool, MD	Billings	Physical Medicine & Rehabilitation
Julia M. Bolding, MD	Great Falls	Rheumatology
Neil S Bricco, LCPC	Belgrade	Licensed Clinical Professional Counselor
James C. Bull, MD	Great Falls	Urology

PARTICIPATING PROVIDERS, *continued on page 36*

PARTICIPATING PROVIDERS

PARTICIPATING PROVIDERS, *continued from page 35*

Charles T. Burton, MD	Billings	Dermatology
Frank J Cardiello, APRN	Helena	Clinical Nurse Specialist
R. Jeffery Christopher, PT	Polson	Physical Therapy
Emily M. Copps, PA	Whitefish	Physician Assistant
Sandra D. Cruickshank, FNP	Billings	Nurse Practitioner
Amanda J. Cuff, OT	Billings	Occupational Therapy
David B. Culp, FNP	Hamilton	Nurse Practitioner
Jose C. DeSouza, MD	Butte	Endocrinology, Diabetes, & Metabolism
Susan J. Effertz, MD	Great Falls	Rheumatology
Howard J. Feldman, MD	Great Falls	Cardiovascular Disease
Kristi J. Fischer, PT	Billings	Physical Therapy
Bruce D. Fisher, DPM	Havre	Podiatry
Jolene M. Gibbs, PT	Kalispell	Physical Therapy
Timothy J. Gibbs, PT	Kalispell	Physical Therapy
Barbara A. Gleason, PT	Great Falls	Physical Therapy
Annette Grefe, MD	Billings	Neurology w Special Qualifications in Child Neurology
Ryan T. Gunlikson, MD	Kalispell	Surgery
Traci L. Hallett, PT	Great Falls	Physical Therapy
Marcia J Hanks, CNM	Missoula	Certified Nurse Midwife
William O. Haug, MD	Billings	Family Medicine
Beth R. Henning, SLP	Billings	Speech Therapy
William T Highfill, MD	Polson	Cardiovascular Disease
Patricia Holl, DC	Billings	Chiropractic
Sheila R. Horton, PT	Billings	Physical Therapy
Richard C. Howland, MD	Havre	Orthopaedics
Philip A. Huffman, MD	Havre	Internal Medicine
William L Hull, DO	Helena	Cardiovascular Disease
William R. Hunt, PA	Whitefish	Physician Assistant
Gregory T. Jacobs, DO	Billings	Emergency Medicine
Marlene N. Johnson, LCPC	Billings	Licensed Clinical Professional Counselor
Debra A. Lang, PsyD	Bozeman	Psychology
Michael E. Lefever, DO	Butte	Family Medicine
Shaina H. Long, PA	Livingston	Physician Assistant
Rodney T Lutes, PA-C	Kalispell	Physician Assistant
Jacqueline J. McAdam, MPT	Butte	Physical Therapy
Amy K. McKerrow, MD	Kalispell	Urology
Fred G. McMurry, MD	Billings	Surgery, Neurological
Jonathan F Mercer, MD	Kalispell	Urology
Robert K. Merchant, MD	Havre	Pulmonary and Critical Care
Matthew R. Moog, MD	Missoula	Anesthesiology
Amy A. Moran, OT	Helena	Occupational Therapy
Elliot M. Morris, MD	Polson	Gastroenterology
John I. Moseley, MD	Billings	Surgery, Neurological
George C. Nadasi, PhD	Kalispell	Psychology
Northwest MT MRI, LLC	Kalispell	Radiology Center
Elizabeth A. O'Connor, NP	Great Falls	Nurse Practitioner
Steven L. Ogilvie, DPM	Missoula	Podiatry
James H. Oury, MD	Missoula	Surgery, Cardiovascular
William Ownbey, OT	Missoula	Occupational Therapy
David B. Powell, LCSW	Livingston	Licensed Clinical Social Worker
Erik R. Riessen, MD	Helena	Internal Medicine
James S. Rogers, MD	Havre	Surgery
Jennifer L Rosquist, MD	Missoula	Pediatrics
Connie Sue Scarpine, PA	Thompson Falls	Physician Assistant
Krista K. Scott, PT	Polson	Physical Therapy
Walker Smith, LCPC	Missoula	Licensed Clinical Professional Counselor
Marlene K Stauffer, LCPC	Kalispell	Licensed Clinical Professional Counselor
Mona M. Stenberg, LCPC	Livingston	Licensed Clinical Professional Counselor

PARTICIPATING PROVIDERS, *continued on page 37*

PARTICIPATING PROVIDERS

PARTICIPATING PROVIDERS, *continued from page 36*

Robin Lynn Treptow, PHD	Great Falls	Pediatric Psychology
Teresa S. Turnbull, NP	Stevensville	Nurse Practitioner
Robert J. Vincent, MD	Hamilton	Urgent Care
Robert S. Wagenaar, MD	Helena	Family Medicine
Kari Sue Wagner, LCPC	Helena	Licensed Clinical Professional Counselor
P. Leslie Walker, PHD	Kalispell	Psychology
Steven F. Wallace, MD	Missoula	Pediatrics
Cory D. Warner, PT	Billings	Physical Therapy
Heather S. Watts, PT	Billings	Physical Therapy
Christine E. Wike, MPT	Helena	Physical Therapy
Brett A Williams, MD	Great Falls	Surgery, Thoracic
Derek J. Williams, MD	Helena	Family Medicine
Nicole Y. Winbush, MD	Billings	Family Medicine
David Andrew Wolfe, DPM	Billings	Podiatry
Elizabeth M. Zaluski, LCPC	Butte	Licensed Clinical Professional Counselor

Reduce Administrative Costs

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Bringing Service Into Perspective

Health-e-Web, Inc. (HeW) is a Montana-based company committed to reducing health care costs by offering premier clearinghouse, consulting, and other services that help health care providers operate more efficiently. HeW's enhanced products and services ensure that you are taking full advantage of administrative savings offered by HIPAA.

To learn more about what HeW has to offer, call us at 1-877-565-5457, or visit our website at www.health-e-web.net.

To Better Serve You

1-800-447-7828, Extension 3600

The Health Care Services (HCS) department at BCBSMT has implemented changes to better serve you. Three Provider Service Representatives have been dedicated to provide education, answer general contracting questions, and resolve complex claim issues for health care providers. Many of you already know Jenifer Sampson, who has been with HCS for several years. Sheri French and Leah Martin recently joined HCS from Customer Service, and all three have extensive knowledge of BCBSMT and the Montana medical community.

Contact Jenifer, Leah, or Sheri at 1-800-447-7828, extension 3600, for new provider contracts and provider contract questions, BCBSMT provider ID number and NPI questions, credentialing and re-credentialing status, provider workshops, and complex claims issues beyond the scope of Customer Service. If they are unavailable at the time of your call, your message will be returned within 24 hours.

Please continue to contact Customer Service at 1-800-447-7828 for routine benefits, eligibility, and claims questions. You may also register with Secure Services at www.bluecrossmontana.com to view benefits, eligibility and claims information online. Secure Services is designed to answer the questions you have when it's convenient for you!

BCBSMT EXPANDING ANTI-FRAUD EFFORT IN 2007

With the BCBSMT Special Investigation Unit (SIU) approaching its tenth year of existence, an expanded effort to increase the productivity of the unit is taking place in 2007. National studies estimate that 3 to 10% of the nation's annual health care is potentially fraudulent resulting in estimated annual losses of $51 to $170 **billion**. During the last decade, the BCBSMT SIU has received over 3,400 fraud referrals resulting in the investigation of over 600 cases with more than 230 of these cases reported to law enforcement or regulatory agencies. This activity has resulted in millions of dollars in fraud-related savings and numerous prosecutions.

Who Commits Healthcare Fraud?

Anyone. In addition to investigating activity in more than a dozen states besides Montana, the SIU has also investigated cases in several foreign countries. Specific to Montana, however, subjects of investigation have included providers from virtually every specialty of the medical field, inpatient and outpatient facilities, provider personnel, billing companies, employer groups, insured members, agents, attorneys, and even criminal rings. Schemes range from false information on applications, false information on claims, billing for services not rendered, misrepresentation of identity, prescription fraud, and much more.

What BCBSMT is Doing to Improve the Fight Against Health Care Fraud

BCBSMT recently added additional personnel to the SIU and will continue to respond to fraud-related referrals in addition to conducting proactive audits to identify areas known to be prone to fraudulent activity. Special emphasis is currently being placed on pharmaceutical fraud, member eligibility, and false claims. In addition, the SIU will implement an expanded awareness campaign designed to help the public identify fraudulent activity and provide information on how to report questionable activity. Providers can also expect to see a new program designed to enlist their help in identifying health care fraud. Once fraud is identified, the SIU works with virtually every branch of state and federal law enforcement, as well as numerous regulatory agencies.

Join us in helping to protect the system from the greedy minority who profit from fraud and drive up premiums. If you're 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 me direct 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 18 years, has received the DPHHS Inspector General's Integrity Award for his work in health care fraud, and currently serves 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, visit the BCBSMT anti-fraud website at www.stopfraud.bcbsmt.com.

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