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THE CAPSULE NEWS SM

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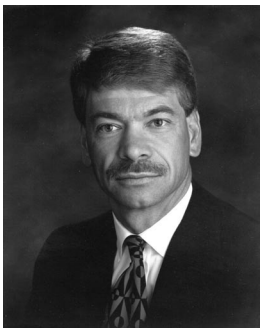
A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS SECOND QUARTER 2004

SAVE FOR FUTURE REFERENCE

SAVE FOR FUTURE REFERENCE



Mark A. Burzynski

Vice President
Health Care Management

Professional Participating CONVERTER INCREASES Effective December 2004

Effective December 1, 2004, Blue Cross and Blue Shield of Montana (BCBSMT) will increase its professional participating provider converters. With 2005 rapidly approaching, BCBSMT thought this advance notice could possibly assist practices in their cash planning for the next year. Although often overlooked as a component of compensation, BCBSMT will continue to process claims on a weekly basis and allow all professional providers to submit BCBSMT and Medicare claims at no charge.

Normally codes compensated based on the RBRVS methodology are updated annually by BCBSMT on March 1st. Inasmuch as BCBSMT is increasing the conversion factor for RBRVS codes on December 1, 2004, the 2005 RVUs will also be updated as of that date, unless the RBRVS updates are not available. BCBSMT will notify you if such delay occurs.

PHYSICIAN CONVERTER INCREASE

BCBSMT will increase its professional participating converter to $56.01 for its traditional products. Like the previous converter of $54.50, the new converter will be applied in accordance with BCBSMT compensation policies and procedures. This also increases all non-physician professional provider compensation since non-physicians are paid a percentage of the physician allowable fee.

ANESTHESIOLOGY CONVERTER INCREASE

BCBSMT will increase its professional participating converter to $44.00 (for ASA based codes) and $56.01 (for RBRVS based codes) for its traditional products. Like the previous converters of $40.35 and $54.50, the new converters will be applied in accordance with BCBSMT compensation policies and procedures.

CERTIFIED REGISTERED NURSE ANESTHETIST PERCENTAGE INCREASE

BCBSMT will increase its professional participating converter to $44.00 (for ASA based codes) and $56.01 (for RBRVS based codes) for its tradi-

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continued from cover

tional products. Like the previous converters of $40.35 and $54.50, the new converters will be applied in accordance with BCBSMT compensation policies and procedures. However, as of December 1, 2004, BCBSMT will modify its compensation policy regarding Certified Registered Nurse Anesthetists (CRNAs), so that CRNAs will be compensated at one hundred percent (100%) of the allowed compensation for anesthesiologists.

The new converters and CRNA policy will be instituted as of December 1, 2004, which will allow BCBSMT the time to notify groups of its intentions, to build them into premiums, and to reprogram its claims systems. Normally BCBSMT adjusts its compensation levels as of March 1st each year, but BCBSMT is going to institute this increase in advance of that date given malpractice cost pressures many physicians are feeling and to thank the ninety-three percent of the physicians that participate in its networks.

BCBSMT and its groups are indebted to Montana professionals participating in BCBSMT networks because that participation helps keep health care coverage affordable. This is critical in Montana, which ranks 44th in per capita income and has an uninsured rate in excess of twenty percent. It is also critical because sixty percent of small businesses in Montana do not offer coverage to their employees. Providers, employers, and insurers must be committed to providing this fundamental security to as many Montanans as possible.

Should you have any questions, comments, and/or concerns, do not hesitate to contact your BCBSMT representative (see the inside back cover). More information concerning provider compensation is available at www.bluecrossmontana.com. Click on *Providers*, then *Provider Policies*.

CLAIMS PROCESSING SYSTEM CONVERSION

The BCBSMT conversion to its new claims processing system is proceeding well. The new system, called QNXT, will provide additional electronic safeguards for further protection of personal health information as required under the Health Insurance Portability and Accountability Act.

The conversion to the new system will be in three separate *rolls* as specific groups or products transition onto the new system. The first roll, which includes both managed care and traditional products (approximately 15,000 members), is scheduled to begin in September 2004.

Following are some of the changes you will see. Any other changes will be available at the BCBSMT website at www.bluecrossmontana.com or will be sent to you by direct mail. During the conversion, you may experience a slowdown in claims processing time for the members that are converted to the new system. We do appreciate your patience.

PROVIDER CLAIMS REGISTERS AND PAYMENT CYCLES

As groups and products are converted to the new system, your office will receive a new QNXT Provider Claims Remit form that is similar to the current LRSP Provider Claims Register. Until the system conversion is complete, you will receive two provider claims documents (one from LRSP and one from QNXT) listing the status of claims submitted to BCBSMT. An example of the new Provider Claims Remit form is shown below.

Instead of value function codes with the explanation on a separate page, you will see two sets of messages. There may be line messages appearing under a claim line if applicable. There may also be claim messages at the bottom of the claim information that apply to the entire claim.

Additionally, the modifier portion of the Provider Claims Remit has been

continued next page

PROVIDER CLAIMS REMIT

Provider Name: PROFJVPAREOCCUPTHER001, TEST
Provider Number: MTPRV0000006932

Page 1 of 1
Check Number: 258

Patient Name / Patient Account	Line Number	Health Plan ID / Dates From	To	POS	Claim ID / NOS	Proc Code	Modifiers	Charges Submitted	Allowed Charges	Contract Adjustment (-)	Patient Responsible For	Contract Adjustment (+) or Prepaid Service	Paid
LNAME005, FNAME002 M		00500000002			04036E00163								
	1	03/04/2002	03/04/2002	11	1	99215		168.00	0.00	168.00	0.00	0.00	
	2	03/04/2002	03/04/2002	11	1	L3000		230.00	0.00	230.00	0.00	0.00	
							CLAIM TOTAL:	$398.00	$0.00	$398.00	$0.00	$0.00	
		Line 1. - Service billed is not an approved service for this provider Line 2. - This service/supply is not a benefit of the member's contract.											
LNAME050, FNAME000 M		05000000000			04026E00135								
	1	07/15/2003	07/15/2003	11	1	97005		50.00	0.00	50.00	0.00	0.00	
	2	07/15/2003	07/15/2003	11	1	97535		50.00	38.45	11.55	20.00	0.00	
		Services have been processed according to the Outpatient Therapy section of the member's contract for Joint Venture Participating Provider.											
							CLAIM TOTAL:	$100.00	$38.45	$61.55	$20.00	$0.00	
		Line 1. - This service provided is an exclusion of the member's contract.											
LNAME050, FNAME001 F		05000000001			04026E00136								
	1	09/07/2003	09/07/2003	11	1	L3980		300.00	227.72	72.28	227.72	0.00	
		Services have been processed according to the Orthopedic Devices section of the member's contract											
							CLAIM TOTAL:	$300.00	$227.72	$72.28	$227.72	$0.00	

Claim Message

Line Message

SECOND QUARTER 2004

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The *Capsule News* is a quarterly publication for Montana health care providers. Any material in the *Capsule News* may be reproduced with proper credits. Correspondence concerning this publication should be addressed to: Mike McGuire, Editor, P.O. Box 4309, Helena, Montana 59604.

BlueCross BlueShield of Montana

expanded to allow up to five modifiers.

The QNXT provider payments will process as follows:

- Claims for professional providers will continue to process on Friday with the payments mailed the following Monday.
- Claims for facility providers (hospitals and other institutions) will now process on Friday with payment mailed on the following Monday.
- Claims for allied providers (providers not eligible to contract with BCBSMT) will continue to process on Tuesday with the payments mailed on Wednesday.
- Capitation will continue to be processed the first Wednesday of the month and mailed on Thursday to managed care primary care physicians receiving capitation.
- Payment for non-participating provider claims will continue to be sent to the member.

MEMBER ID NUMBERS

What is currently referred to as the Subscriber or Member ID number will be called the Health Plan ID number on QNXT. All members converting to the QNXT system will receive a new ID card. As new BCBSMT members are enrolled on the QNXT system, they will be assigned a system generated Health Plan ID number. Providers are encouraged to make a copy of the front and back of the Health Plan ID card.

MEMBER ELIGIBILITY

If a new member's coverage becomes effective during the transition to QNXT, they may not appear in the on-line eligibility system. However, Membership and Customer Service have developed procedures to provide accurate eligibility information for new members. There should be a very small number of new members enrolling during this first conversion.

MODIFIERS 50 AND 51

As was published in the third quarter 2003, page 13, any secondary procedure that is done bilaterally should be billed on two separate lines with a 51 modifier on each line. Do not report the bilateral secondary procedure on one line with both modifiers 50 and 51. Reporting the service on separate lines will ensure that your office will continue to be compensated 50 percent for one side as a secondary procedure and 50 percent for the contralateral side as a secondary procedure. A bilateral primary procedure may continue to be reported on one line with a 50 modifier. (see examples below).

Example One	Report on Claim
29881 bilateral	Line 1 – 29881-50
29873 bilateral	Line 2 – 29873-RT, 51
	Line 3 – 29873-LT, 51

Example Two	Report on Claim
31255 bilateral	Line 1 – 31255-50
30520	Line 2 – 30520-51
31267 bilateral	Line 3 – 31267-LT, 51
	Line 4 – 31267-RT, 51
31288 bilateral	Line 5 – 31288-LT, 51
	Line 6 – 31288-RT, 51

BCBSMT is working very hard to minimize the impacts of this conversion. As each roll progresses, further communication will be sent so that your office will have all available information. Should you have any questions or concerns, please do not hesitate to contact Customer Service at 1-800-447-7828.

2nd SECOND OPINION

By Stephen S. Nagy, M.D., Helena

WHAT CAN I SAY TO MY PATIENTS ABOUT TREATMENT WITH ANTIDEPRESSANTS?

On March 22, 2004, the FDA issued a Public Health Advisory titled, "Worsening Depression and Suicidality in Patients Being Treated with Antidepressant Medications." On the same day, they issued an FDA Talk Paper that discussed cautions for the use of antidepressants in adults and children. These statements followed public meetings to discuss suicidality in teens treated with antidepressants.

The FDA statements have received significant publicity, and the practicing physician may receive intense questioning by concerned patients. This short paper is to review some important points that may be helpful if this issue arises. The full text of these papers can be read at www.fda.gov/cder/drug/antidepressants/antidepressanstPHA.htm **and** www.fda.gov/cder/drug/antidepressants/default.htm

It is important to understand that the most effective therapy for depression is a combination of psychotherapy and antidepressant medications, that many people have had their lives changed for the better through the use of antidepressant medications, and that the risk of side-effects is low with this group of meds. In many cases, depression will continue throughout a lifetime without antidepressant treatment, with the attendant cost in human suffering and lost human potential. That said, there are four concerns that every clinician should keep in mind when treating patients with antidepressants:

First, before the introduction of the selective serotonin antidepressants, standard teaching about treating depression with tricyclic antidepressants (TCAs) included a caution for the prescribing physician that the most dangerous time for the patient was in the first one to two weeks of treatment, because patients often felt more energy before they felt less depressed. When the first selective serotonin reuptake inhibitor (SSRI) antidepressant Prozac™ was being reviewed for approval by the FDA, one of the issues assessed was whether this antidepressant would also have an increased risk of suicide early in treatment, and studies showed that it had less tendency to do this than the TCAs. As more and more SSRIs were approved, this caution seems to have faded from the list of standard treatment concerns, but it is clear that clinicians need to keep this in mind because any antidepressant may have this potential in a given patient, even though the statistical risk of this happening is quite low.

A second concern is that SSRIs can rarely cause akathisia, a syndrome of motor restlessness that the patient feels as a combination of high anxiety and a need to keep moving. While this symptom is most commonly associated with conventional dopamine-blocking antipsychotics, it is extremely uncomfortable and may cause a depressed patient to conclude that there is no hope, and thus lead to a suicide attempt.

A third concern is that patients may think of treatment of depression as similar to treatment for an infectious disease and conclude that when their symptoms abate, they can stop the medication and continue to do well. Of course, this is not true. And, when SSRIs are stopped abruptly, the rapid withdrawal of any SSRI can potentially cause a discontinuation syndrome characterized by confusion and clouding of consciousness, ataxia, widespread muscle and bone pain, and peculiar sensations similar to electric shocks that seem to start in the cranium and zip down into the body. If the patient has not been educated about the need for treatment that lasts for months after symptoms are resolved, and the need to taper off of SSRIs because of this syndrome, they may also react with despair and suicidal actions. Although certain SSRIs tend to provoke this syndrome more commonly than others, it can occur with the abrupt cessation of any SSRI.

A fourth concern has to do with making the correct diagnosis. Bipolar patients complain only of depressive symptoms, and the clinician needs to assume that any patient complaining of depression is bipolar until proven otherwise. This is because treatment with antidepressant monotherapy may precipitate a manic episode, with irritability, racing thoughts, and impulsive behavior. Using the Mood Disorder Questionnaire, available online, and in a padded form from several pharmaceutical manufacturers, can help the physician make the correct diagnosis and initiate treatment that will hopefully do no harm.

It is wise for the physician to educate the patient about potential adverse events gently before starting treatment to help the patient identify side-effects that might arise; to see the patient frequently to assess tolerability to antidepressants and therapeutic effect; to ask the patient to call the office if they feel worse in any way; and to review the diagnosis periodically to be sure that bipolar illness is not overlooked. There is great hope for depressed patients to have an improved quality of life if treated with the newer antidepressants, and these medications can be safe and effective when used with caution and regular visits to monitor response to treatment.

MEDICAL POLICY

The Medical and Compensation Physician's Committee met during the first quarter of 2004 and approved the following New and Revised medical policies. Effective dates are listed on each policy.

Only the "Policy" section is included in revised policies. When the policy change is minor, just that portion of the policy is included. Medical policy is available online at www.bluecrossmontana.com.

NEW POLICIES

RAPTIVA (EFALIZUMAB)

Chapter: Drugs
Upcoming/Revised Policy
Effective Date: August 1, 2004

Original Effective Date: August 1, 2004
Current Effective Date: August 1, 2004

DESCRIPTION

Approved by the Food and Drug Administration (FDA) in October 2003, Raptiva (efalizumab) is an immunosuppressive recombinant humanized IgG1 monoclonal antibody used to treat patients with chronic moderate to severe plaque psoriasis. Severe psoriasis is classified by the National Psoriasis Foundation as involving greater than or equal to 10% of the body surface area. Psoriasis occurs when new skin cell growth rapidly accelerates, resulting in thick, scaly, red patches on the skin. Raptiva works by selectively and reversibly blocking the activation, reactivation and trafficking of T-cells that lead to the development of these symptoms. It is administered as a single once-weekly, subcutaneous injection and patients may self-inject after training by a healthcare professional.

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers the use of Raptiva medically necessary when used:

- To treat chronic moderate to severe plaque psoriasis (present for at least 6 months and involving at least 10% of the body surface area) **AND**
- For a treatment period of not more than 1 year **AND**
- At a dosage of 1 mg/kg administered subcutaneously once weekly **AND**
- Patient is 18 years or older **AND**
- When more cost effective alternatives such as phototherapy, photochemotherapy, topical agents and at least one systemic agent have been ineffective or are contraindicated.

INVESTIGATIONAL

BCBSMT considers the use of Raptiva investigational:

- When used to treat other conditions.
- When given more frequently than once weekly or in dosages greater than 1 mg/kg.

AMEVIVE (ALEFACEPT)

Chapter: Drugs

Original Effective Date: June 1, 2004
Current Effective Date: June 1, 2004

DESCRIPTION

Amevive is classified as a immunosuppressive dimeric fusion protein and is used to treat severe* chronic plaque psoriasis in patients with an inadequate response to other therapies. It is FDA approved for use in adults who are candidates for systemic therapy or chemotherapy and is administered weekly for 12 weeks - either intramuscularly or intravenously. A second 12 week course may be given. Published safety and efficacy data beyond two cycles of treatment are not available.

*The National Psoriasis Foundation classifies severe psoriasis as psoriasis covering greater than 10% of the body surface area .

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized. Prior authorization will be for 12 weeks of treatment. If a second 12-week course is needed, it must also be prior authorized.

BCBSMT considers the use of Amevive medically necessary to treat patients with:

- Functional impairment due to severe chronic plaque psoriasis **AND**
- CD4+ T lymphocyte counts above the lower limit of normal.

At least three of the following conservative treatments must have been tried and found to be not effective, contraindicated or not tolerated due to documented clinical side effects:

- Topical agents (eg. coal tar, calcipotriene, tazarotene, antralin, salicylates)
- Topical corticosteroids
- Phototherapy (eg. sunlight, ultraviolet light B (UVB) or psoralen plus ultraviolet light A (PUVA)
- Chemophototherapy (eg. PUVA plus methotrexate or oral retinoids)
- At least one systemic agent (eg. methotrexate, oral retinoids, cyclosporine) approved for the treatment of psoriasis.

INVESTIGATIONAL

Treatment over 24 weeks.

IRESSA (GEFITINIB)

Chapter: Drugs

Original Effective Date: June 1, 2004
Current Effective Date: June 1, 2004

DESCRIPTION

Cancer of the lung and bronchus is the leading cause of cancer death in both men and women in the United States. In May 2003, Iressa (Gefitinib) tablets were approved to treat locally advanced or metastatic non-small cell lung cancer under the FDA's accelerated approval program. This program is intended to allow patients suffering from life-threatening diseases early access to promising new drugs. An essential part of the accelerated approval process is continued study of the drug after its introduction to the market. There are currently no controlled trials demonstrating a clinical benefit for Iressa, such as improved survival or improvement in disease-related symptoms.

MEDICAL POLICY

Iressa is approved as a single agent treatment for patients with advanced non-small cell lung cancer whose cancer has continued to progress despite treatment with platinum-based and docetaxel chemotherapy, the standard of care currently being used to treat this disease.

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers the use of Iressa medically necessary when **ALL** of the following criteria are met:

- Diagnosis of locally advanced or metastatic non-small cell lung cancer.
- Failure of both platinum-based and docetaxel based chemotherapy regimens.
- When used as a stand-alone treatment.
- Daily dosage of 250 mg (higher doses didn't demonstrate a better response in trials and caused increased toxicity).
- Age over 18 years (safety and effectiveness in pediatric patients has not been studied).

REVISED POLICES

AMNIOCENTESIS

Chapter: Maternity/Gyn/Reproduction

Original Effective Date: October 1, 1990
Current Effective Date: August 1, 2004

POLICY

MEDICALLY NECESSARY

BCBSMT considers amniocentesis medically necessary in the following circumstances:

- Pregnancies where the woman will be 35 years of age or over at the expected time of delivery;
- A previous pregnancy has resulted in the birth of a child with a chromosomal (e.g., Down's syndrome) or genetic abnormality, or major malformation;
- A chromosomal or genetic abnormality is known to exist in either parent;
- A history of chromosomal or genetic abnormality is present in a blood relative;
- There is a history of multiple (three or more) spontaneous abortions in this marriage or in a previous mating of either spouse;
- The fetus is at an increased risk for a hereditary error of metabolism detectable in vitro;
- For the determination of fetal sex in pregnancies at risk for x-linked hereditary disorders (e.g., hemophilia, Duchenne muscular dystrophy, x-linked mental retardation, x-linked hydrocephalus, etc.);
- The fetus is at an increased risk for neural tube defect (family history or elevated maternal serum alpha-fetoprotein level);
- The fetus is at risk for Downs Syndrome (abnormal serum test eg., triple screen)
- Abnormal triple screen blood test;
- When used to assess fetal lung development;
- When used in the assessment of hemolytic disease of the newborn.

NOT MEDICALLY NECESSARY

Amniocentesis performed purely for sex determination in the absence of documented increased risk for a x-linked disorder is considered not medically necessary.

VERTEBRAL AXIAL DECOMPRESSION - VAX-D

Chapter: Medicine: Treatments

Senior Staff Approval Date: January 21, 1999
Original Effective Date: May 1, 1999
Current Effective Date: August 1, 2004

POLICY

BCBSMT considers vertebral axial decompression therapy methods investigational. These methods include, but are not limited to, VAX-D, IDD, or DRS.

VISION THERAPY - ORTHOPTIC TRAINING

Chapter: Vision

Senior Staff Approval Date: November 26, 1996
Original Effective Date: January 1, 1996
Current Effective Date: August 1, 2004

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers vision therapy medically necessary in the treatment of:

- Convergence insufficiency

INVESTIGATIONAL

BCBSMT considers vision therapy investigational for treatment of several conditions, including, but not limited to:

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

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.

CHELATION THERAPY

Chapter: Therapies

Senior Staff Approval Date: December 3, 1997
Original Effective Date: January 15, 1998
Current Effective Date: August 1, 2004

POLICY

Prior authorization is recommended (a retrospective review will be done if

services are not prior authorized).

BCBSMT considers chelation therapy medically necessary in the treatment of the following:

- Control of ventricular arrhythmias or heart block associated with digitalis toxicity.
- Emergency treatment of hypercalcemia.
- Hemosiderosis, whether idiopathic or due to chronic anemia/transfusions, or serious iron toxicity (serum Fe level 350 ug/dL or above with evidence of GI symptoms or 500 ug/dL or above in any symptomatic patient). Deferoxamine is commonly used for this indication.
- Wilson's disease (hepatolenticular degeneration)
- Lead poisoning

The Merck Manual, Seventeenth Edition, lists the following chelating drugs and their indications for use. Dosage recommendations are also provided in the Merck Manual but are not included here. (see chart below)

BCBSMT considers chelation therapy investigational in the treatment of several conditions, including, but not limited to:

- Multiple sclerosis
- Arthritis
- Hypoglycemia
- Diabetes
- Arteriosclerosis (e.g. coronary artery disease, cerebrovascular disease, or peripheral vascular disease.)

Chelating Drug	Indication
Edetate calcium disodium (calcium disodium edathamil)	Cadmium, chromium, cobalt, copper, copper salts, lead, manganese, nickel, radium selenium, tungsten, uranium, vanadium, zinc, zinc salts
Dimercaprol	Antimony, arsenic, bichromates, bismuth, chromates, chromic acid, chromium trioxide, copper salts, gold, mercury, nickel tungsten, zinc salts
Penicillamine	Bichromates, cadmium, chromates, chromic acid, chromium trioxide, cobalt, copper salts, lead mercury, nickel, zinc salts
Succimer	Lead problems in children with blood lead levels >45 ug/dl (>2.15 umol/L); increasingly used for occupational lead, arsenic, and mercury problems in adults

TRETINOIN - RENOVA, VITAMIN A, RETIN A

Chapter: Drugs

Senior Staff Approval Date: May 1, 1990
Original Effective Date: May 1, 1990
Current Effective Date: August 1, 2004

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized. Authorization duration will be for the prescribed treatment course or up to one year, whichever is less.

MEDICALLY NECESSARY

BCBSMT considers the use of Tretinoin (Retin-A) medically necessary to treat the following:

- Acne vulgaris
- Actinic keratosis (Considered as chemoprevention in patients at high risk of basal or squamous cell carcinomas.)
- Bullous congenital ichthyosifosis
- Lamellar ichthyosis
- Dariers disease
- Molluscum
- Pityriasis rubra pilaris
- Verruca plantaris
- Verruca planae juvenilis
- Xeroderma

NOT MEDICALLY NECESSARY

BCBSMT consider the use of Tretinoin (Retin-A) cosmetic when used to treat:

- Photodamaged skin characterized by decreased clarity, progressive wrinkling, hyperpigmentation, roughness, and lack of tone.
- Hypertrophic scars, keloids, acne scars
- Striae
- Melasma
- Keratosis Pilaris
- Acanthosis Nigricans

INVESTIGATIONAL

BCBSMT considers the use of Tretinoin investigational in the treatment of some conditions, including, but not limited to:

- Rosacea
- Wound healing
- Alopecia areata

STEREOTACTIC RADIOFREQUENCY PALLIDOTOMY

Chapter: Surgery - Procedures

Original Effective Date: January 1, 1997
Current Effective Date: August 1, 2004

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers stereotactic radiofrequency unilateral pallidotomy medically necessary in patients with the following:

- Diagnosis of idiopathic Parkinson's disease.
- Previously responsive to levodopa therapy but now medically intractable.
- Presence of severe bradykinesia, tremor, dystonia, rigidity, or marked "on-off" fluctuations.
- No evidence of dementia.

MEDICAL POLICY

INVESTIGATIONAL

BCBSMT considers bilateral radiofrequency pallidotomy investigational.

GAIT ANALYSIS

Chapter: Medicine: Tests

Original Effective Date: July 1, 1990
Current Effective Date: August 1, 2004

DESCRIPTION

Gait analysis, or motion analysis, is the quantitative laboratory assessment of coordinated muscle function, typically of human walking. At its core is videotaped observation of patient walking. Videos can be observed from several visual planes at slow speed, allowing detection of movements not detectable at normal speed. Joint angles can be measured, and various time-distance variables can be measured including step length, stride length, cadence, and cycle time. Movement data are compiled by computer from cameras oriented in several planes, and the movement data are processed so that the motion of joints and limbs can be assessed in three dimensions. The range and direction of motion of a particular joint can be isolated from all the other simultaneous motions that are occurring during walking. Graphic plots of individual joint and limb motion as a function of gait phase can be generated.

The Electrodynogram™ is one of many technologies used in gait analysis. It is a computerized diagnostic device that quantitatively measures and times the weight-bearing forces exerted on the feet and legs. Electromyography (EMG) measures the timing and intensity of muscle contractions. It is used to determine whether a certain muscle's activity is normal.

Gait analysis is proposed as a tool:

- To define outcomes or end points for physical therapy.
- To assist in the design, selection, or alteration of prosthetic or orthotic devices.
- As an aid in surgical planning, primarily for cerebral palsy.
- To plan rehabilitative strategies for a variety of disorders.

POLICY

BCBSMT considers gait analysis investigational.

SPEECH THERAPY

Chapter: Therapies

Senior Staff Approval Date: March 26, 1996
Original Effective Date: March 26, 1996
Current Effective Date: August 1, 2004

The Speech Therapy policy was clarified as follows. The remainder of the policy is unchanged.

Speech therapy benefits are contract specific. Member contract language takes precedence over medical policy when there is a conflict. Most contracts deny coverage for speech therapy services when the member is eligible for services through a State or Federal agency (e.g. the school system).

Prior authorization is recommended if speech therapy services are recommended after the initial evaluation. A retrospective review will be done if services are not prior authorized.

An initial speech therapy evaluation (CPT 92506) is eligible for coverage without prior authorization. Only one speech therapy evaluation (CPT 92506) will be allowed per member for a course of treatment.

COSMETIC PROCEDURES (TITLE CHANGED FROM COSMETIC SURGERY)

Chapter: Surgery - Procedures

Original Effective Date: January 1, 1988
Current Effective Date: August 1, 2004

The following addition was made to the Cosmetic Procedures medical policy. The remainder of the policy is unchanged.

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

MAGNETIC RESONANCE IMAGING (MRI) OF THE BREAST

Chapter: Radiology

Senior Staff Approval Date: August 30, 2003
Original Effective Date: August 30, 2003
Current Effective Date: August 1, 2004

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers MRI of the breast medically necessary:

- When used as a diagnostic tool to confirm silicone breast implant rupture in symptomatic patients. (See "Reconstructive Breast surgery/Management of Breast Implants")
- For detection of suspected occult breast primary tumor with axillary nodal adenocarcinoma
- As a screening technique for breast cancer in women with:
  - A known BRCA1 or BRCA2 mutation, (See Genetic Testing for Inherited BRCA1 or BRCA2 Mutations), or
  - At high-risk of BRCA1 or BRCA2 mutation due to a known presence of the mutation in relatives, or
  - With a pattern of breast cancer history in multiple first-degree relatives, often occurring at a young age and with bilaterality.

INVESTIGATIONAL

BCBSMT considers MRI of the breast investigational in the following instances:

- Routine screening to detect breast cancer.
- As a technique to determine whether a breast lesion identified by clinical exam, mammography, or ultrasound is benign or malignant.
- To evaluate whether multicentric

disease is present in patients with clinically localized breast cancer.

BIOFEEDBACK

Chapter: Mental Health

Medical Directors Approval Date: July 1, 1990
Original Effective Date: October 1, 1990
Revised Date(s): March 17, 2004
Current Effective Date: June 1, 2004

DESCRIPTION

Biofeedback is a training procedure aimed at helping achieve control over a physiologic process. The central feature involves providing auditory or visual signals from a monitoring device. These signals are the feedback that signify activity from a physiologic variable that is supposed to be related to a given disorder.

Biofeedback is often administered concurrently with relaxation training. Biofeedback treatment regimens begin with a training phase in which feedback is received from the monitoring device. After success in controlling the physiologic variable and/or clinical symptoms is achieved, a long-term maintenance phase is initiated. During maintenance, the subject is often expected to learn to control the condition without feedback.

The various forms of biofeedback differ in the physiologic information fed back to the subject. For example, electromyographic (EMG) biofeedback is used to treat tension headaches, and thermal biofeedback is used to treat migraines.

Neurofeedback is a type of feedback that uses the electroencephalogram (EEG) as a source of feedback data. It is used to train subjects to modify or control their brain function and has been used in the treatment of a variety of disorders such as:

- Attention deficit/hyperactivity disorder
- Learning disabilities, seizure disorders
- Substance abuse-related disorders
- Panic and anxiety disorders
- Depression
- Stress management
- Sleep disorders

POLICY

BCBSMT will consider reimbursement for biofeedback when used to treat mental/nervous illness.

INVESTIGATIONAL

BCBSMT considers neurofeedback investigational.

INTRADISCAL ELECTROTHERMAL THERAPY (IDET)

Chapter: Surgery - Procedures

Medical Directors Approval Date: October 27, 2000
Original Effective Date: January 1, 2001
Revised Date(s): March 17, 2004
Current Effective Date: June 1, 2004

POLICY

BCBSMT considers intradiscal electrothermal annuloplasty investigational.

RATIONALE

There are no convincing studies in the published, peer-reviewed literature that report the long-term outcomes of intradiscal thermal annuloplasty. Randomized, double-blind, placebo controlled studies are considered particularly important in addressing the outcomes of the treatment of chronic low back pain; similar to any therapy for pain, a placebo effect can be significant. In addition, the basic scientific rationale underlying the therapy is still preliminary. For example, the etiology of the patient's pain may be related to microinstability or to mechanical or chemical sensitization of the annular nocioceptors. It is unknown how thermal annuloplasty may affect these possible etiologies. The long-term effects of such treatment are also unknown.

RESPIRATORY SYNCYTIAL VIRUS - IMMUNE PROPHYLAXIS

Chapter: Drugs

Medical Directors Approval Date: January 21, 1999
Original Effective Date: May 1, 1999
Revised Date(s): November 13, 2002, February 11, 2004
Current Effective Date: June 1, 2004

POLICY

Preauthorization is recommended.

Prophylactic use of Synagis® or RespiGam® is eligible for coverage for infants at high risk for RSV disease as follows:

- All infants born at 28 weeks or less gestation and are less than one year of age prior to the onset of RSV season.
- Infants born between 29-32 weeks gestation and are less than 6 months old prior to the onset of RSV season.
- Infants less than 2 years of age at onset of the RSV season with chronic lung disease (CLD), formerly designated bronchopulmonary dysplasia (BPD), requiring medical therapy within the previous six months.
- Infants 2 years or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD). (Only palivixumab is approved for this indication)

Prophylactic use of Synagis® or RespiGam® for infants born at 32 to 35 weeks who do not meet the above criteria will be considered on an individual case basis. Based on the guidelines from the American Academy of Pediatrics, at least two of the following criteria must be met:

- Smoker in the household.
- Infant in day care.
- Crowded household.
- School aged siblings.
- Severe neuromuscular disease.
- Congenital abnormalities of the airways.

NOT MEDICALLY NECESSARY

BCBSMT considers the prophylactic use of Synagis or Respigam medically unnecessary:

- In children over 2 years of age at the onset of the RSV season.
- For the treatment of active RSV infections. (If a patient experi-

MEDICAL POLICY

ences a breakthrough RSV infection, prophylaxis should continue through the RSV season).

INVESTIGATIONAL

Other indications for immune prophylaxis for RSV are considered investigational, including but not limited to, adults and children who do not meet the above criteria who have:

- Immunodeficiencies
- Cystic fibrosis (There are insufficient data to determine the effectiveness of the vaccine in this population.)
- RSV vaccine
- Prevention of nosocomial RSV disease in hospitalized infants.

CHROMOSOME TESTING WITH PREGNANCY LOSS

Chapter: Maternity/GYN/Reproduction

Original Effective Date: July 30, 1997
Revised Date(s): February 11, 2004, Added codes May 13, 2004
Current Effective Date: June 1, 2004

POLICY

Prior authorization is recommended. A retrospective review will be done if services are not prior authorized.

BCBSMT considers chromosome testing of the products of conception, fetus or stillborn infant medically necessary under one of the following conditions:

- Three consecutive fetal losses, any trimester.
- A second or third trimester fetal loss with noted fetal abnormalities.
- A second or third trimester fetal loss when maternal causes (i.e., incompetent cervix) are not suspected.

BCBSMT considers chromosome testing on the parents who are covered members who have a pregnancy loss under one of the following conditions:

- Three consecutive fetal losses, any trimester.
- Previous fetal loss if chromosome abnormalities were found.

CHEMOTHERAPY ADMINISTRATION - PROFESSIONAL COMPONENT

Chapter: Drugs

Original Effective Date: October 1, 1990
Revised Date(s): May 14, 2003, February 11, 2004
Current Effective Date: June 1, 2004

The following change was made to the Chemotherapy Administration – Professional Administration medical policy. The remainder of the policy remains unchanged.

Chemotherapy IV push technique (CPT code 96408) is allowed once per day for each drug administered.

CHEMICAL PEELS, DERMABRASION AND MICRODERMABRASION

Chapter: Medicine: Treatments

Medical Directors Approval Date: May 19, 1999
Original Effective Date: August 5, 1999
Revised Date(s): February 11, 2004
Current Effective Date: June 1, 2004

POLICY

Medically Necessary

BCBSMT considers epidermal chemical peels or microdermabrasion medically necessary to treat patients under 40 years of age with active resistant comedomyl acne.

Prior authorization is recommended for patients over 40 years of age. A retrospective review will be done if services are not prior authorized.

BCBSMT will allow up to four epidermal peels or microdermabrasion treatments per year for patients with active acne who are over 40 years of age when the following criteria are met:

- Active acne that has persisted despite treatment with topical comedolytic agents.
- Office records will be requested and must include:
  - Documentation of all therapies
  - Pre-treatment photographs
- Treatment beyond 4 sessions will require further documentation.

COSMETIC

BCBSMT considers treatment with dermal or epidermal chemical peels cosmetic when used to treat:

- Photoaged skin
- Wrinkles
- Acne scarring

RETIRED POLICIES

The following policies are retired which means they are no longer scheduled for review and are not considered active policies:

1. Tubal Ligation
2. ACTH in the Long Term Treatment of Multiple Sclerosis
3. Assistant for Arthroscopically Aided Anterior Cruciate Ligament (ACL) Repair, Augmentation or Reconstruction
4. Esophageal pH Monitoring
5. Low Osmolar Contrast Media – Non-Ionic
6. Lung Transplant, Single and Double
7. Outpatient Private Duty Nursing
8. Port Wine Stain Birthmarks
9. Prenatal Genetics Testing
10. Self-Inflicted Injury
11. Signal-Averaged Electrocardiography (SAECG)
12. Tracheoplasty
13. Alzheimer's Disease

Regular Business

Dr. Mary Sims

MRI/CT PRIOR AUTHORIZATION: WHO IS RESPONSIBLE?

by Mary Sims, M.D.

When BCBSMT first instituted the policy of prior authorization for CT and MRI of the brain and spine, a decision had to be made as to who would be financially responsible for scans performed that did not meet medical necessity criteria. On the one hand, many people go to their doctors and insist on having scans that are not really necessary. On the other hand, providers may order unnecessary scans for various reasons. Another complicating factor is that the doctor ordering the unnecessary scan may not be the provider who is penalized if the scan is performed.

The best solution to this problem is to have providers work collaboratively in deciding what imaging studies are appropriate and useful in any given clinical situation. All too often, radiologists serve only to interpret scans after the fact. A better arrangement is one in which the radiologist becomes an imaging consultant, helping other providers decide the best way to obtain the information they need from radiological studies.

BCBSMT set up such an arrangement for CT and MRI with St. Peter's Hospital in Helena, Bozeman MRI, and Northwest Imaging, which provides the consultancy for Kalispell Regional Hospital and HealthCenter Northwest. One of the advantages of this arrangement is that providers referring to these facilities do not need to prior authorize these studies. Additionally, BCBSMT members benefit by having only the most appropriate radiology tests performed, and neither providers nor members are at financial risk for having payments for costly scans denied. Even in locations where BCBSMT does not have an official pre-screening arrangement with radiologists, providers are urged to collaborate with radiologists and specialists to make the most informed decisions possible.

If pre-screening of CT and MRI scans is not performed, someone ends up paying for scans that do not meet medical policy. Initially, these costs were passed on the provider, but in February 2004, financial responsibility shifted to the member. So far, most providers are helping to protect their patients from financial harm by prior authorizing their CT and MRI scans of the brain and spine.

If every non-emergency brain or spine CT/MRI were pre-screened or prior authorized, members would know beforehand whether BCSBSMT intended to pay for the scan or whether the member would need to pay for it out of pocket. Your responsibility as providers is, at the very least, to let your patients know that CT or MRI scans of the brain and spine, as with all expensive procedures, might be subject to benefit limitations and that prior authorization is highly recommended.

When requesting a prior authorization, you should use the new prior-authorization forms to allow for faster processing. The form clearly states the type of scan recommended for a given clinical situation and also states which indications are readily approved. If the case at hand does not precisely fit any of the clinical situations listed, it must be described in the section labeled "If none of the above . . ." A reason must be given for making an exception to our policy, and supporting records must be submitted to ensure rapid turn-around of the request.

QUESTIONS AND ANSWERS ON MRI/CT PRIOR AUTHORIZATION

The following frequently asked questions was added to the Magnetic Resonance Imaging (MRI) of the Brain and Spine medical policy and to the Computerized Axial Tomography Scan (CAT Scan or CT Scan) of the Brain and Spine medical policy. (Note that in the following, the term MRI is used. In the actual CAT scan policy, MRI is changed to CT.

Q: I need to have an emergency scan. Do I need prior authorization?

A: Patients sent from the emergency room or from within the hospital to have a scan are not required to obtain prior authorization. Outpatients' scans require prior authorization.

Q: Why are you recommending prior authorization of MRI scans of the brain and spine?

A: BCBSMT performed a selective audit of these scans compared with the American College of Radiology guidelines and found a high number of scans were being performed unnecessarily in Montana. We provided training to providers on the guidelines but did not see any improvement in the number of scans performed. We did, however, see improvement at St. Peter's Hospital where the radiologists were pre-screening the imaging studies. Therefore, to eliminate the need for prior authorization, we encourage providers to set up a pre-screening arrangement.

Q: What scans should I prior authorize?

A: Only MRI scans that involve the brain and spine require prior authorization.

Q: Which providers should obtain prior authorization for scans?

A: All providers, including primary care providers, who are not medical or osteopathic doctors should obtain prior authorization for MRI scans of the brain and spine. Primary care providers include general medicine, internal medicine, family practice, pediatric, and gynecological doctors.

Q: Which providers are not being asked to obtain prior authorization?

A: Medical and osteopathic physician specialists are not being asked to obtain prior authorization for MRI scans of the brain and spine. Scans obtained emergently are not subject to review at this time. Also, scans being performed at St. Peter's hospital in Helena, Bozeman MRI in

continued next page

Regular Business

Bozeman, Northwest Imaging, HealthCenter Northwest, or Kalispell Regional Hospital in Kalispell do not need to be prior authorized, regardless of the provider specialty, because these facilities perform their own pre-screening.

Q: Why are you only asking primary care and non-MD/DO providers to prior authorize?

A: The intent of BCBSMT is to encourage dialogue among all clinicians and radiologists about the appropriate type of imaging for any given clinical situation. We have limited resources to apply to this issue, and we need to narrow the focus of our intervention.

Q: Our radiologist/radiology group would like to pre-screen MRI scans as St. Peter's Hospital currently does. To whom should we speak?

A: Our corporate medical director, Dr. Roy Arnold, is in charge of pre-screening contracts.

Q: I already order scans very conservatively. Why should I be asked to prior authorize?

A: BCBSMT will be tracking each provider's compliance with the American College of Radiology guidelines. If the provider stays within the guidelines consistently, that provider may be exempted from prior authorization in the future.

Q: What are the consequences of not obtaining prior authorization when recommended?

A: MRI scans of the brain and spine that are not prior authorized, when prior authorization was recommended, will be reviewed after the fact for medical necessity. If the scan is deemed not medically necessary, the member must pay the full price for the service.

Q: I had a scan done because my doctor said that I should, and now I have to pay for it because you say it's not medically necessary. What can I do about this?

A: Your member contract states that services found to be not medically necessary are not covered benefits and that the costs of non-covered services are the responsibility of the member. Prior authorization for high-cost tests and procedures is always a good idea to avoid this type of problem. If you disagree with the determination that this service was not medically necessary, you have the right to appeal. Please refer to the back of your Explanation of Benefits form for details on your appeal rights and how to appeal.

CLAIMS

ADDITIONAL INFORMATION FOR CLAIMS PROCESSING

Occasionally, additional information is required by BCBSMT to accurately process a claim according to the member contract and/or BCBSMT claims processing standards. This information may include the name or amount of the drug given or a description of certain medical supplies. There are also instances when the medical record used in a claim review does not support the diagnosis or the service being billed.

When this happens, the provider claims register and the member Explanation of Benefits will indicate the charges associated with those services are denied and the charges are the provider's responsibility. The claim will be reprocessed when the additional information is received.

If you have any questions, contact customer service.

BLUECHIP

BCBSMT PARTICIPATION NOT REQUIRED FOR BLUECHIP

Medical service providers who are not enrolled in the BCBSMT Participating Provider Network, Federal Employee Program, Montana HealthLink, or managed care joint venture networks can still participate in the BlueCHIP provider network. More information about what provider types and specialties are permitted to participate in BCBSMT provider networks is available online at www.bluecrossmontana.com. Click on *Providers, Provider Policies*, then scroll down to *Administrative Policies*.

CODE GRACE

DELETED CODE GRACE PERIOD ENDING IN 2005

Effective January 1, 2005, BCBSMT will no longer have a 90-day grace period accepting deleted CPT, HCPCS, and ASA procedure codes. The HIPAA transaction and code set regulations require usage of the medical code set valid at the time the service is provided. Therefore, deleted codes submitted with dates of service after January 1, 2005, will no longer be accepted.

BCBSMT encourages providers to obtain updated coding manuals and to subscribe to the services available to receive updates to coding changes. For any questions, contact the provider network service representative for your area. (see inside back cover).

HIPPA

HIPAA HELPER: FAX COVER SHEETS

To fax claims, provider claims registers, and/or medical records, a cover sheet much be attached with the department and first name (if possible) of the BCBSMT representative. Many faxes are received from provider offices without a cover sheet, and this requires significant research to determine who is the recipient working with what provider office. Fax cover sheets should include an office and contact name, return phone number, and appropriate disclaimer language. In addition, any PHI on the documents that is not relevant to the action being taken must be marked out.

BCBSMT departments perform visual inspections of areas with fax machines and printers to ensure PHI is not readily available to anyone walking through the department. All employees have received training on how to appropriately send and receive PHI and are prepared to quickly respond to faxes sent to BCBSMT.

For any questions about sending or receiving information, contact Customer Service or your provider network service representative. (See inside back cover).

S8301

S8301 INFECTION CONTROL SUPPLIES

Effective July 1, 2004, HCPCS code S8301, Infection Control Supplies, Not Otherwise Specified, should be used to report this service. Previously, oral surgeons and other dental service providers were instructed to use code D9999, Unspecified Adjunctive Procedure, By Report, and a written description was required. Using this new code will eliminate the need to submit a written description of the service.

This is not a covered service but reporting the service is appropriate if providers wish to do so. For any questions, call Customer Service or your provider network service representative (See inside back cover).

Linda McGillen
BCBSMT Communications Director

BCBSMT ANNOUNCES NEW CORPORATE COMMUNICATIONS DIRECTOR

Linda McGillen was recently named Corporate Communications Director of BCBSMT in Helena. Prior to joining BCBSMT, McGillen spent 24 years in a variety of management and staff positions, including Director of Investor and Media Relations, with the Montana Power Company and Touch America in Butte. She was also an adjunct instructor of technical and scientific writing at Montana Tech in Butte for 12 years.

At BCBSMT, McGillen will be the primary media contact and will oversee the company's public relations function. She also will be responsible for advertising and other internal and external commu-

Regular Business

nications. She can be reached at (406) 444-8931.

McGillen was active in the Butte Chamber of Commerce and served for three years as chairperson of the Chamber's Ambassadors. She served on the Northwest Hydro Association Board and was also the Montana representative on the Northwest Utilities Underground Locating Center Board.

A native of Anaconda, McGillen, and her husband, Paul, have two grown children and four grandchildren. She will reside in Helena.

ALPHA

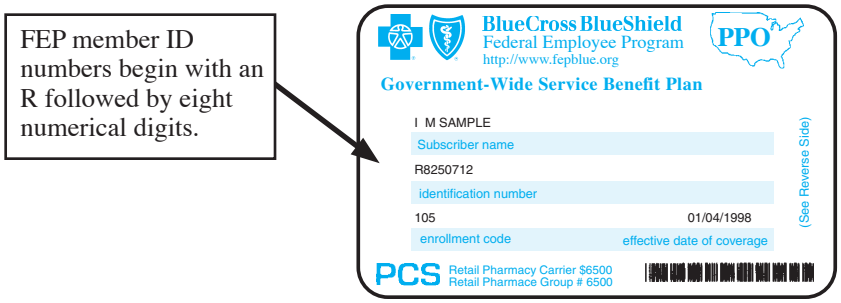
ALPHA PREFIXES AND ID NUMBERS: THE FEP DIFFERENCE

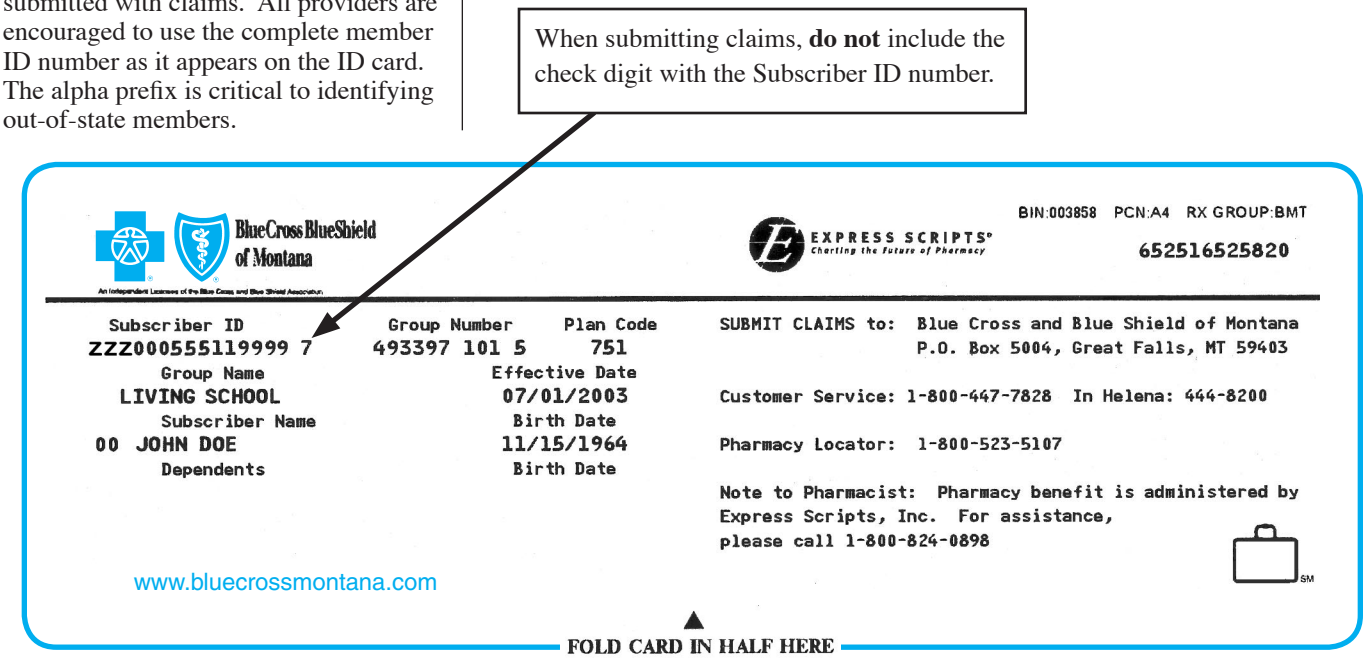
A majority of insurance ID cards use an alphanumeric number to identify members insured by a health plan. These numbers are often represented as ZZZ000555119999 7. The first three letters are the alpha prefix identifying the plan. The second three numbers are zero fills followed by the nine-digit social security number. The last number is known as a check digit, and it is not to be submitted with claims. All providers are encouraged to use the complete member ID number as it appears on the ID card. The alpha prefix is critical to identifying out-of-state members.

FEP
FEDERAL EMPLOYEE PROGRAM

For Federal Employee Program (FEP) members, a large number of behavioral health providers are only sending in the member's social security number when asking for a review of treatment plan or prior authorization. FEP does not use the social security number or three letter alpha prefix to identify members. Instead, FEP member ID numbers begin with an R followed by eight numerical digits. All claims received by BCBSMT are transmitted to FEP headquarters in Washington, D.C. for verification of eligibility and adjudication. When approved, BCBSMT processes the claim. Eligibility, verification, claims processing, or prior authorization approval cannot occur with the FEP member's social security number.

More information can be found in the recently updated BCBSMT *Participating Provider Manual*. Refer to Chapter Five, FEP, Caring and BlueCHIP Claims for information on member ID numbers, claims filing, and FEP claim processing guidelines. The manual is also online at www.bluecrossmontana.com. Additional questions may be directed to Customer Service or to your provider network service representative (see the inside back cover).





CLAIMS ACCURACY INITIATIVE

CAI UPDATE

SERVICE

Modifier 55 – Post Op Care Only

CLAIMS ACCURACY INITIATIVE

Effective September 1, 2004, BCBSMT will require providers of Post-Operative Care Only Services to submit claims in accordance with Medicare billing guidelines by appending modifier 55 to the surgical procedure code for which the post-operative care is being provided. Previously, except for Medicare prime members, providers were requested to submit Post-Operative Care Only Services with the appropriate level evaluation and management code for each visit.

RATIONALE

Modifier 55 is appropriately reported when the surgeon has appended modifier 54 to the procedure indicating the provision of surgical care only. Appending modifier 55 to the surgical procedure code includes all post-op care services. BCBSMT compensation for modifier 55 is 20 percent of the complete procedure.

The following information is a reiteration of previously published material. Because of a large volume of calls and reviews, BCBSMT wants to clarify the following information.

CPT CODE

90780-90781 IV Infusion For Therapy/ Diagnosis

96410-96414 Chemotherapy Administration

CLAIMS ACCURACY INITIATIVE

Effective March 1, 2003, BCBSMT will compensate IV infusion therapy for pre-medication when billed concurrently with chemotherapy infusion only when the following drugs are provided:

1. Rituximab
2. Paclitaxel
3. Paclitaxel with Carboplatin
4. 5FU with Leucovorin
5. Doxorubicin with cyclophosphamide
6. Etoposide with Cisplatin

To ensure claims process correctly, use modifier 99 for IV infusion therapy codes 90780-90781, and if not billing for the above mentioned drugs on the same claim, provide the drug names or J codes in box 19 on the HCFA 1500 claim form.

RATIONALE

Reporting both intravenous therapies represents a duplication of services. If therapy was provided by the physician, or under direct supervision, and the IV therapy was used to deliver medication such as an anti-emetic and not simply hydration, separate compensation will be allowed. However, separate compensation will be allowed only when the above chemotherapy agents are provided.

CPT CODE

76000-76005 Fluoroscopy

CLAIMS ACCURACY INITIATIVE

BCBSMT will allow separate compensation for CPT codes 76000-76005 when submitted with CPT codes 20610, 23350, 24220, 25246, 27093, 27095, 27096, 27648, 62270, 62272, 62290, 62310, 62311, 62318, 64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484, 64517, 64520, 64622, 64623 and 64680.

RATIONALE

Fluoroscopic guidance is considered an integral component of most procedures. However, BCBSMT has determined that separate compensation will be allowed with large joint injections and the above listed spinal procedures because of the increased risks associated with these procedures. BCBSMT considers fluoroscopic guidance with all other procedures an integral component that is commonly carried out as part of the overall service.

BILLING NOTE REGARDING GLOBAL SURGICAL PACKAGE SERVICES

BCBSMT CAI processing standards are aligned with the Complete Global Service Data for Orthopaedic Surgery. As such, BCBSMT has adopted their position statement in regards to unbundling. Per the American Academy of Orthopaedic Surgeons, it is unethical to separate from the global service package. Services which are a necessary part of the surgical procedure should not be billed individually. BCBSMT will retroactively adjust any claims where this billing practice has occurred.

PREVENTIVE MEDICINE AND PROBLEM-FOCUSED E&M SERVICES

On January 1, 2002, BCBSMT began to allow the billing of both a preventive medicine Evaluation and Management (E&M) service on the same day as an established or new patient E&M service when both of the E&M services are part of the same encounter. Reporting of the E&M service should be significant enough to require additional work to perform the key components of the problem-focused E&M service. An insignificant problem or abnormality that is encountered in the process of performing the preventive medicine E&M should not be reported separately.

Claims will be compensated according to the members' benefits. For example, if a member does not have a benefit for an annual or routine examination, this service will not be compensated by BCBSMT. However, the problem-oriented services would be allowed subject to the terms and limitations of the member contract. If the member has the preventive care benefit, BCBSMT will compensate up to the allowable fee for the E&M code with the highest RVU value.

If you have questions concerning CAI, contact your Provider Network Service Representative for your area and continue to contact Customer Service for individual claim review. If you have issues concerning a particular code set, send comments in writing with supporting documentation and excerpts from specialty societies to:

Blue Cross Blue Shield of Montana
Attention: Medical Director
P.O. Box 4309
Helena, MT 59604

Regular Business

HISTORY in Review

COVERING AMERICA: 75 YEARS AND COUNTING

Birth of the Brands

BLUE CROSS

- In 1929, the prototype prepaid hospital plan upon which Blue Cross Plans were later based was created at Baylor University in Dallas, Texas.
- Baylor University hired Justin Ford Kimball, a Texas businessman and former school superintendent, to develop a financing plan for teachers that would budget against future hospital costs.
- A group of more than 1,300 Dallas school teachers were assured up to 21 days of hospital care with a small donation of 50 cents a month to Baylor University Hospital.
- In 1934, E.A. Van Steenwyk, head of the newly formed Hospital Service Association (later to be known as Blue Cross of Minnesota) commissioned a Viennese artist, Joseph Binder, to paint a poster with the Blue Cross Symbol on it. It was the first time the Blue Cross symbol was used. Soon, the Blue Cross began to show up in other parts of the country and became the unifying symbol among the newly emerging Plans.
- In 1946, the Blue Cross Commission was formed as the early national organization of Blue Cross Plans.

BLUE SHIELD

- During the early part of the 20th century, what would evolve to be Blue Shield was growing out of lumber and mining camps in the Pacific Northwest. Serious injuries and chronic conditions were common among workers employed in these hazardous jobs.
- Employers wanted to provide medical care for their workers, so they made arrangements to pay local physicians a monthly fee for their services. These pioneer programs provided the basis for what would become the *modern* Blue Shield Plans.
- In 1939, Carl Metzger, who helped launch the Rochester Blue Cross Plan before becoming the head of the Buffalo Blue Shield Plan, wanted to create an image that would distinguish the new medical service plan. The result was an image inspired by the U.S. Army Medical Corps insignia and the image of a serpent associated with Greek mythology. This image, with the Blue Shield, would come to represent the Blue Shield Plans across the country.
- In 1947, Associated Medical Care Plans was formed as the first national organization of Blue Shield Plans.

Covering America

RAPID ENROLLMENT

- By 1939, just 10 years since its inception, Blue Health Plans' enrollment had grown from 1,000 to 3 million individuals.
- In 1996, Blue Cross and Blue Shield Plans' PPO, POS, and HMO enrollment reached 34.6 million, surpassing the 31.7 million members in traditional coverage.
- In 2003, Blue Cross and Blue Shield System-wide enrollment reaches an all-time high. More than 88 million Americans — nearly one in three — have BCBS coverage.

PRIVATE AND PUBLIC SECTOR PARTNERSHIPS

- *Labor:* In 1950, nearly 7 million workers received health benefits through their workplace. By 1954, that number had grown to 12 million workers and 17 million dependents. Today, Blue Cross and Blue Shield Plans continue to work closely with labor groups and provide health benefits to more union workers, retirees, and their families than any other national carrier. Today, collective bargaining contracts account for approximately 15 percent of the Blue Cross and Blue Shield System's national enrollment.
- *Federal Employee Program:* On September 28, 1959, Congress enacted the Federal Employees Health Benefits Act. Even without a formal federal program in place, Blue Cross and Blue Shield Plans across the country had enrolled nearly 33 percent of the federal workforce and their families through what were called collector groups. From the first open enrollment in 1960 to today, FEP has maintained its leadership position and now covers around 52 percent of those eligible — more than 4.2 million federal employees, retirees, and their families.
- *Medicare:* On July 1, 1966, the arrival of a special form flashed over a Blue Cross private network to the Social Security Administration's record center and marked the official beginning of a new federal health insurance program for the nation's elderly and disabled. Launching a massive program like Medicare would have been prohibitive without the established Blue Cross and Blue Shield infrastructure. This event also marked a new role for the Blue Cross and Blue Shield System. In the five years following Medicare's inception, Blue Cross processed 63.4 million claims totaling approximately $19.2 billion. In 2001, the Blue System continued to process the overwhelming majority of Medicare claims totaling $163 billion.
- *TEC Program:* The Blue Cross Blue Shield Association founded the Technology Evaluation Center (TEC) pioneering the development of scientific criteria for assessing medical technologies. In 1997, TEC was designated as one of 12 Evidence-based Practice Centers (EPC) to receive a contract from the Agency for Healthcare Research and Quality. The findings of the EPCs serve as the foundation for organizations to develop clinical practice guidelines as well as tools and strategies for improving the quality of healthcare services they provide.

Download the BCBSMT formulary to your PDA @ epocrates.com

Pharmacy

More pharmacy information available at www.bluecrossmontana.com

STEP THERAPY PROGRAM IMPLEMENTATION

Effective July 1, 2004, BCBSMT will implement two different step therapy programs for Cox-2 Inhibitors and Non-steroidal anti-inflammatory drugs. Members currently receiving these drugs will not be impacted, and the program will be for members obtaining new prescriptions for Cox-2 Inhibitors and Non-steroidal anti-inflammatory drugs. These programs will help ensure members are receiving the most appropriate drug therapy while helping to reduce member out-of-pocket costs.

In both programs, a member will have had previous experience with two generic drugs before being eligible to receive a Celebrex, Vioxx, Bextra, Arthrotec, Ponstel, or Mobic prescription. The Cox-2 Inhibitor program requires members 65 years of age or older, or with a claims history of warfarin (Coumadin), dicumarol, an oral corticosteroid, or a brand COX-2 within the last 130 days, to be excluded. There are other risk factors that are considered too. Physicians may call Express Scripts at 1-800-417-8164 to authorize coverage of a 2nd line product. Physicians may be contacted by pharmacies to prescribe a first line product.

If you have any questions, please call Tina Wong at 1-800-447-7828 ext. 8843.

BLUE CROSS BLUE SHIELD OF MONTANA THERAPEUTIC SUBSTITUTIONS

Therapeutic Substitution Program	Affected Drug(s)	1st Line Product(s)	Exceptions
COX-2 Inhibitors	Bextra Celebrex Vioxx	Diclofenac, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Meclofenamate, Nabumetone, Naproxen, Oxaprozin, Piroxicam, Sulindac, Tolmentin	Patients concurrently on Proton Pump Inhibitor (PPI)
Branded Single-Source NSAIDs	Arthrotec Ponstel Mobic	Diclofenac, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Meclofenamate, Nabumetone, Naproxen, Oxaprozin, Piroxicam, Sulindac, Tolmentin	

PHARMACY AND THERAPEUTICS COMMITTEE

BCBSMT held its quarterly Pharmacy and Therapeutic (P&T) Committee meeting on April 21, 2004. Participating BCBSMT physicians from various specialties were either present or teleconferenced for the meeting. The P&T committee's purpose is to review, discuss, and make decisions regarding pharmaceutical drugs and their formulary status with the goal of high quality, low cost drugs on the formulary. If you have any questions, please call Tina Wong at 1-800-447-7828 ext. 8843.

continued next page

Pharmacy *continued*

SECOND QUARTER 2004 CHANGES TO THE FORMULARY

During the April 21, 2004, P&T Committee meeting, eleven new drugs were reviewed for formulary placement. Effective immediately, the following drug changes were made to the BCBSMT *Drug Formulary* that is used for the majority of its business. BSBSMT encourages physicians to reference the formulary when prescribing medications for BCBSMT members.

Drug	Therapeutic Class	Formulary Status
Ciprodex Otic	Otic Combinations	Formulary
Effexor XR*	Other Antidepressants	Formulary
Femring	Vaginal Estrogens	Non-Formulary
Flomax*	Prostatic Hypertrophy Agents	Non-Formulary
Inspra	Selective Aldosterone Receptor	Non-Formulary
Lexiva	Antiretrovirals	Formulary
Namenda	Antidementia	Formulary
Paxil CR	SSRI	Formulary
Proscar*	Prostatic Hypertrophy Agents	Non-Formulary
Raptiva	Antipsoriatics	Non-Formulary with Prior Authorization
Seasonale	Combination Oral Contraceptives	Non-Formulary
Stalevo	Antiparkinsonian Dopaminergic	Formulary
Uroxatral	Prostatic Hypertrophy Agents	Formulary
Zavesca	Agents for Gaucher Disease	Formulary
Zomig Nasal Spray	Serotonin Agonists	Formulary

*Change effective 7/1/2004

Participating Providers

The on-line Provider Directory is updated daily at www.bluecrossmontana.com. BCBSMT encourages providers to review their on-line file and report any errors or changes.

The following pages list new providers for its traditional participating provider network and the Joint Venture managed care provider network. Also included are providers who are no longer participating with these networks.

February 1, 2004 to June 1, 2004

Blue Cross and Blue Shield of Montana welcomes these new participating providers.

Megan W Adkins, FNP	Hamilton	Nurse Practitioner
Christina Marie Aksamit, PT	Missoula	Physical Therapy
Christopher F Andersen, PT	Hamilton	Physical Therapy
Jon A. Anderson, MD	Livingston	Radiology
Loy L. Anderson, MD	Great Falls	Family Practice
Raymone Jean Annau, NP	Great Falls	Nurse Practitioner
Rodney Babcock, DC	Anaconda	Chiropractic
Jennifer R. Beverly, PA-C	Billings	Physician Assistant
Christopher A. Boor, PT	Bozeman	Physical Therapy
Kevin W. Bozarth, MD	Bozeman	Radiology
Scott A. Briggs, DC	Helena	Chiropractic
Patricia A. Calkin, MD	Great Falls	Psychiatry
Cosmetic Surgical Arts	Missoula	Surgery Center
Jennifer L. Cruise, MD	Great Falls	Family Practice
Julie Ann Czywczynski, PA-C	Bozeman	Physician Assistant
Julie Ann Czywczynski, PA-C	Livingston	Physician Assistant

Stephanie W. Doster, OT	Columbia Falls	Occupational Therapy
Patricia I. Era, MSN	Great Falls	Nurse Practitioner
Evergreen Health Care	Livingston	Speech Therapy
Evergreen Health Care	Livingston	Occupational Therapy
Evergreen Health Care	Livingston	Physical Therapy
Fallon Medical Complex	Baker	Occupational Therapy
Fallon Medical Complex	Baker	Speech Therapy
Fallon Medical Complex	Baker	Physical Therapy
Corby C. Freitag, MD	Billings	Urgent Care
Joseph M. Gassenberg, MD	Helena	Family Practice
Diane D. Goedde, NP	Billings	Nurse Practitioner
Marilyn F. Grams, MD	Billings	Geriatric Medicine
Bruce Frank Gray, MD	Kalispell	Radiology
Karl J. Hapcic, MD	Bozeman	Plastic Surgery
Lourie L. Helmer, LCPC	Billings	Lic. Clin. Prof. Counselor
Anne B. Helsby, LCPC	Billings	Lic. Clin. Prof. Counselor
Pandi Lee Highland, LCSW	Great Falls	Lic. Clin. Social Worker
Lance R. Hinther, MD	Missoula	Dermatology
Todd C. Hull, PA-C	Billings	Physician Assistant
James G. Jensen, LCPC	Billings	Lic. Clin. Prof. Counselor
Mark E. Jergens, MD	Hamilton	Emergency Medicine
James D. Johnson, Psyd	Havre	Psychology
Christina S. Keener, NP	Butte	Nurse Practitioner
Stephanie L. Kerbel, SLP	Bozeman	Speech Therapy
Richard S. Kozakiewicz, MD	Chester	Family Practice
Mary Ellen Krivonen, SP	Billings	Speech Therapy
Jennifer A. Krueger, PA-C	Anaconda	Physician Assistant
Joel M. Lavoie, DDS	Butte	Dentist
Shailini K Lavoie, DDS	Butte	Dentist
Linda C. Law, MD	Kalispell	Family Practice
James Tolbert Maddux, MD	Missoula	Cardiovascular Disease
Kathryn Manning, SLP	Bozeman	Speech Therapy
Mark D. Marilley, MD	Missoula	Gastroenterology
Terah M.L. McClain, DC	Helena	Chiropractic
John H. Meyer, MD	Bozeman	Anesthesiology
Kevin M. Minix, PA-C	Bozeman	Physician Assistant
Roque Miramontes, PA-C	Livingston	Physician Assistant
Michael P. Moran, MD	Hamilton	Family Practice
Michelle E. Morgan, PT	Helena	Physical Therapy
Stephanie S. Morup, PA-C	Billings	Physician Assistant
Dean Allen Nelson, DO	Libby	Urgent Care
Nancie L. Nordwick, MD	Helena	Pediatrics
Christina M. Quijano, MD	Billings	Psychiatry
Geoff C. Ramsay, DC	Missoula	Chiropractic
Connie S. Reichelt, FNP	Big Sandy	Nurse Practitioner
Sherry A. Reid, MD	Bozeman	Neurology
Kristen (Kelli) Richardson, PT	Billings	Physical Therapy
Virginia I. Rightmier, LCSW	Billings	Lic. Clin. Social Worker
RNH Medical Supply	Missoula	Medical Equipment
Karl F. Rosston, LCSW	Helena	Lic. Clin. Social Worker
John E. Russo, MD	Scobey	General Practice
Scott A. Sample, DO	Billings	Cardiovascular Disease
Mary C. Seitz, PA-C	Havre	Physician Assistant
David W. Silk, MD	Helena	Emergency Medicine
Robert Henry Slover II, MD	Billings	Pediatric Endocrinology
Adam W. Smith, PA	Butte	Physician Assistant
Kanyon R. Smith, DC	Whitefish	Chiropractic
Nancy M. Smith, LCSW	Superior	Lic. Clin. Social Worker
Jake S. Starr, DMD	Deer Lodge	Dentist
Gary Steinbach, PT	Belgrade	Physical Therapy
Suzanne R. Swietnicki, MD	Havre	Obstetrics and Gynecology
Julie Telfer, LCSW	Missoula	Lic. Clin. Social Worker
Desiree Van Blaricom, PT	Deer Lodge	Physical Therapy
Elizabeth M. White, MD	Kalispell	Internal Medicine
James Bryce Wiley, PT	Billings	Physical Therapy
Jerald D. Wiley, DC	Great Falls	Chiropractic
Raymond Delano Williams, MD	Shelby	Surgery, General
Michael R. Younker, DO	Billings	Allergy & Immunology
Timothy J. Zellmer, DDS	Great Falls	Dentist
Timothy J. Zellmer, DDS	White Sulphur Springs	Dentist

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

Alan R. Belknap, MD	Butte	Radiology
Lynda M. Bieber, NP	Philipsburg	Nurse Practitioner
Big Sky Safety and Medical Supply	Billings	Medical Equipment
James W. Bonds, MD	Livingston	Surgery, General
Scot J. Bowen, DC	Colstrip	Chiropractic
Scot J. Bowen, DC	Hardin	Chiropractic
Patrice R. Butler, LCPC	Darby	Lic. Clin. Prof. Counselor
Gregory J. Chapman, DC	Missoula	Chiropractic
Brian R. Chisdak, MD	Billings	Oral & Maxillofacial Surgery
Clare L. Chisholm, LCPC	Whitefish	Lic. Clin. Prof. Counselor
John M. Conn, MD	Butte	Surgery
Christopher W Conner, MD	Great Falls	Plastic Surgery
Clifford W. Davis, PA-C	Great Falls	Physician Assistant
Marilyn L. Davis, PA	Great Falls	Physician Assistant
Karen Day, LCPC	Bozeman	Lic. Clin. Prof. Counselor
Terry D. Dennis, MD	Billings	Internal Medicine
William D. Dilworth, LCSW	Cut Bank	Lic. Clin. Social Worker
Dan R. Duncan, PA	Butte	Physician Assistant
James A. Dusing, MD	Helena	Emergency Medicine

continued next page

Wendy L. Flansburg, CNM	Great Falls	Certified Nurse Midwife
Peter J. Gioia, MD	Missoula	Psychiatry
Lynn Graham, PT	Livingston	Physical Therapy
Patricia J. Grena, DO	Thompson Falls	Family Practice
John W. Harlan, MD	Missoula	Plastic Surgery
Donald P. Harrell, MD	Missoula	Orthopaedics
Francis W. Harris, CRNA	Miles City	Cert. Reg. Nurse Anesthestist
Devon Hartman, NP	Butte	Nurse Practitioner
Devon Hartman, NP	Helena	Nurse Practitioner
Fred Hesser, PA	Miles City	Physician Assistant
Brett Hollis, NP	Missoula	Nurse Practitioner
Richard Horswill, LCPC	Bozeman	Lic. Clin. Prof. Counselor
Bernadette M. Hunter, LCPC	Missoula	Lic. Clin. Prof. Counselor
Gregory D. Hutton, DO	Missoula	Family Practice
Institute of Facial Surgery	Missoula	Surgery Center
Maureen S. Jamieson, CRNA	Butte	Cert. Reg. Nurse Anesthestist
Johnston Pharmacy	Plentywood	Medical Equipment
Timothy Johnston, NP	Whitefish	Nurse Practitioner
Mary Jozwiak, MD	Billings	Internal Medicine
Timothy J. Katsma, PA	Polson	Physician Assistant
Lee Anne Landenberger, LCSW	Superior	Lic. Clin. Social Worker
Mark Chad Leslie, PT	Missoula	Physical Therapy
Joy M. MacPherson, LCPC	Bozeman	Lic. Clin. Prof. Counselor
Christine Mahkuk, LCPC	Butte	Lic. Clin. Prof. Counselor
Kristine A. Marsh, LCSW	Boulder	Lic. Clin. Social Worker
Kathleen Mattucci, MSW	Billings	Lic. Clin. Social Worker
Herbert Kenneth McFadden, MD	Whitefish	Internal Medicine
Loren E. McKerrow, MD	Helena	Ophthalmology
Frederick G. Miller, DO	Conrad	Internal Medicine
Richard M. Natelson, MD	Kalispell	Obstetrics and Gynecology
Paul K. Overland, MD	Butte	Ophthalmology
Paul K. Overland, MD	Hamilton	Ophthalmology
Paul K. Overland, MD	Missoula	Ophthalmology
Lawrence R. Palazzo, MD	Glasgow	Obstetrics and Gynecology
James Patenaude, LCPC	Billings	Lic. Clin. Prof. Counselor
J. Richard Rees, MD	Deer Lodge	Surgery, Thoracic
J. Richard Rees, MD	Philipsburg	Surgery, Thoracic
Mary Ann Riley, MD	Miles City	Family Practice
Tony J. Rizzo, LCPC	Great Falls	Lic. Clin. Prof. Counselor
James W. Rogers, PT	Butte	Physical Therapy
Loren L. Rogers, DPM	Missoula	Podiatry
Kenton L. Sanders, MD	Helena	Internal Medicine
Fred Searle, CRNA	Dillon	Cert. Reg. Nurse Anesthestist
Caleb T. Stolte, PT	Kalispell	Physical Therapy
Caleb T. Stolte, PT	Whitefish	Physical Therapy
Carol P. Taylor, CNM	Coram	Certified Nurse Midwife
Nancy A. Thibault, DPM	Florence	Podiatry
Gary F. Walter, MD	Missoula	Internal Medicine
Gail Wheatley, PT	Great Falls	Physical Therapy
Jean K. Williams, NP	Kalispell	Nurse Practitioner
Jean K. Williams, NP	Missoula	Nurse Practitioner
Michael W. Woods, MD	Missoula	Orthopaedics
Kathleen M. Yapuncich, MD	Billings	Pediatrics

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

Megan W. Adkins, FNP	Hamilton	Nurse Practitioner
Eric R. Anacker, MD	Great Falls	Internal Medicine
Loy L. Anderson, MD	Great Falls	Family Practice
Linh P. Barinowski, PA	Kalispell	Physician Assistant
Dayna K. Begley, NP	Dillon	Nurse Practitioner
Betty J. Boyce, PT	Havre	Physical Therapy
Anne W. Brucker, MD	Miles City	Internal Medicine
Susan E. Burton, CNM	Butte	Certified Nurse Midwife
Oscar E. Busso, MD	Miles City	Internal Medicine
Robert Caldwell, MD	Helena	Psychiatry
Patricia A. Calkin, MD	Great Falls	Psychiatry
Patricia Carrick, FNP	Dillon	Nurse Practitioner
Joseph D. Chopyak, PA-C	Butte	Physician Assistant
Stephen Wayne Coon, PT	Butte	Physical Therapy
Jennifer L. Cruise, MD	Great Falls	Family Practice
Mary Lou Dees, PT	Havre	Physical Therapy
Wanda S. Diekhans, LCPC	Fort Benton	Lic. Clin. Prof. Counselor
Wanda S. Diekhans, LCPC	Great Falls	Lic. Clin. Prof. Counselor
Jerome Dunst, MD	Polson	Radiology
Carl J. Eby, LCPC	Billings	Lic. Clin. Prof. Counselor
Alyne E. Eickert, PT	Billings	Physical Therapy
Alyne E. Eickert, PT	Laurel	Physical Therapy
Patricia I. Era, MSN	Great Falls	Nurse Practitioner
Corby C. Freitag, MD	Billings	Urgent Care
Nickie D. Frisch, LCSW	Billings	Lic. Clin. Social Worker
Deborah M. Garrity, MD	Great Falls	Pediatrics
Barbara A. Gleason, PT	Great Falls	Physical Therapy
Sarah Lynn Googe, MD	Sheridan	Family Practice
Bruce Frank Gray, MD	Kalispell	Radiology
Kimberley T. Grover, PT	Seeley Lake	Physical Therapy
Eugenie T. Haight, MD	Dillon	Internal Medicine
Traci L. Hallett, PT	Great Falls	Physical Therapy
Mary J. Harsh, PHD	Helena	Psychology
Kevin J. Helvik, PT	Helena	Physical Therapy
Todd C. Hull, PA-C	Billings	Physician Assistant
Mark E. Jergens, MD	Hamilton	Emergency Medicine
James D. Johnson, Psyd	Havre	Psychology
Tamara L. Kittelson-Aldred, OT	Missoula	Occupational Therapy
Curtis L. Kostelecky, DC	Havre	Chiropractic
Richard S. Kozakiewicz, MD	Chester	Family Practice
Mary Ellen Krivonen, SP	Billings	Speech Therapy

Valerie A. Kurtzhalts, NP	Kalispell	Nurse Practitioner
Linda C. Law, MD	Kalispell	Family Practice
Vicki L. Lay, APRN	Billings	Nurse Practitioner
Sandra M. Lippy, LCSW	Billings	Lic. Clin. Social Worker
Leta A. Livoti, LCSW	Thompson Falls	Lic. Clin. Social Worker
Deborah K. Meeks, FNP	Fort Benton	Nurse Practitioner
Katina P. Mendis, LCPC	Billings	Lic. Clin. Prof. Counselor
Myrna J. Mentikov, PA-C	Billings	Physician Assistant
Michael P. Moran, MD	Hamilton	Family Practice
Judy Munsell, NP	Kalispell	Nurse Practitioner
Jeananne Murphy, LCPC	Anaconda	Lic. Clin. Prof. Counselor
Judith Elaine Neal, NP	Kalispell	Nurse Practitioner
Raymond C. Nelson, MD	Thompson Falls	General Practice
Frank E. Pawlak, NP	Philipsburg	Nurse Practitioner
Christina M. Quijano, MD	Billings	Psychiatry
Renee H. Ratliff, LCPC	Havre	Lic. Clin. Prof. Counselor
Jim P. Reynolds, CCDC	Billings	Cert. Chemical Dependency Counselor
Kristen (Kelli) Richardson, PT	Billings	Physical Therapy
Steven F. Sacry, PA-C	Dillon	Physician Assistant
Steven F. Sacry, PA-C	Whitehall	Physician Assistant
Same Day Surgery Center	Bozeman	Surgery Center
Ellen Savage Cole, LCPC	Chinook	Lic. Clin. Prof. Counselor
Ellen Savage Cole, LCPC	Havre	Lic. Clin. Prof. Counselor
Renee M. Schoening, LCPC	Deer Lodge	Lic. Clin. Prof. Counselor
Natalie F. Sea Burger, LCPC	Bozeman	Lic. Clin. Prof. Counselor
Mary C. Seitz, PA-C	Havre	Physician Assistant
Jacqueline B. Sherman, PhD	Lewistown	Psychology
Robert Henry Slover II, MD	Billings	Pediatric Endocrinology
Kanyon R. Smith, DC	Whitefish	Chiropractic
Wanda Smith, LCPC	Billings	Lic. Clin. Prof. Counselor
Elie J. Soueidi, PA-C	Billings	Physician Assistant
Sheri L. Stroppel, PT	Hamilton	Physical Therapy
Michele R. Susie, FNP	Anaconda	Nurse Practitioner
Suzanne R. Swietnicki, MD	Havre	Obstetrics and Gynecology
Clark O. Taylor, MD	Missoula	Maxillofacial Surgery
Clark O. Taylor, MD	Missoula	Oral Surgery
Teresa S. Turnbull, NP	Stevensville	Nurse Practitioner
Julie M. Turunen, LCSW	Missoula	Lic. Clin. Social Worker
Christine L. Wagner, LCSW	Thompson Falls	Lic. Clin. Social Worker
Elizabeth A. Walter, MD	Billings	Psychiatry
Charles L. Whitaker, PA-C	Kalispell	Physician Assistant
Elizabeth M. White, MD	Kalispell	Internal Medicine
James Bryce Wiley, PT	Billings	Physical Therapy
Page M. Zieske, LCPC	Billings	Lic. Clin. Prof. Counselor

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

Alan R. Belknap, MD	Butte	Radiology
Joan M. Bond, PA-C	Missoula	Physician Assistant
Clare L. Chisholm, LCPC	Whitefish	Lic. Clin. Prof. Counselor
Christopher W. Conner, MD	Great Falls	Plastic Surgery
Terry D. Dennis, MD	Billings	Internal Medicine
Christine E. Drivdahl-Smith, MD	Miles City	Family Practice
Charlotta L. Eaton, MD	Billings	Nephrology
Mary Ann Evans, MD	Great Falls	Psychiatry
Wendy L. Flansburg, CNM	Great Falls	Certified Nurse Midwife
Susan J. Gallo, MD	Miles City	Family Practice
Patricia J. Grena, DO	Thompson Falls	Family Practice
Brett Hollis, NP	Missoula	Nurse Practitioner
Jennifer Kay Johnson, LCPC	Kalispell	Lic. Clin. Prof. Counselor
Mary Jozwiak, MD	Billings	Internal Medicine
Timothy J. Katsma, PA	Polson	Physician Assistant
Lee Anne Landenberger, LCSW	Superior	Lic. Clin. Social Worker
Mark Chad Leslie, PT	Missoula	Physical Therapy
Jan K. Lintz, PA-C	Thompson Falls	Physician Assistant
Michael J. Mitchell, MD	Anaconda	Family Practice
Richard M. Natelson, MD	Kalispell	Obstetrics and Gynecology
Douglas G. Nebeker, DC	Billings	Chiropractic
Killeen B. Nielsen, FNP	Butte	Nurse Practitioner
Kenton L. Sanders, MD	Helena	Internal Medicine
Caleb T. Stolte, PT	Kalispell	Physical Therapy
Caleb T. Stolte, PT	Whitefish	Physical Therapy
Gary F. Walter, MD	Missoula	Internal Medicine
Kathleen D. White, PA	Kalispell	Physician Assistant
Jean K. Williams, NP	Kalispell	Nurse Practitioner
Michael W. Woods, MD	Missoula	Orthopaedics
Kathleen M. Yapuncich, MD	Billings	Pediatrics

FAX:

1-406-447-3570

MAIL:

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

E-MAIL:

The Provider Network Specialist at www.bluecrossmontana.com. Click on *Providers*, then *Geographic Regions*.

BCBSMT HEALTH CARE SERVICES 1-800-447-7828

HEALTH CARE SERVICES REORGANIZES AREA RESPONSIBILITIES

Health Care Services (HCS), commonly known as Provider Relations, has realigned its staff regional assignments to better serve the Montana medical community. This transition of area responsibility aligns provider representatives and internal support staff with the provider population distributed throughout Montana.

Since the middle to latter part of the 1990s, HCS has been servicing providers and their staff according to joint venture boundaries that divided the state into three regions, Montana Health (West), MontanaCare (Central), and the former YCHP joint venture (East). Each region has an Internal and an External Team dedicated to assisting provider offices with the day-to-day BCBSMT business operations. In the reorganization, the Internal and External Teams have been assigned counties slightly different from the previous joint venture regions to balance the number of provider offices and hospitals among the teams.

The External Team consists of Network Development and Network Service Representatives who travel to provider offices in their respective areas. Network Development Representatives negotiate provider and facility contracts and address contractual issues relevant to all lines of business. Network Service Representatives assist provider offices with resolving recurring problems and continuing education. If you have any questions concerning office visits, workshops, billing with your BCBSMT ID according to contract, product information or any other issues beyond the scope of Customer Service, contact your provider representative listed on the map on page 23.

The Internal Team consists of Provider Relations Specialists, Database Maintenance Technicians, and Credentialing Analysts that expedite the data processes necessary to manage the BCBSMT provider networks. Provider Relations Specialists are responsible for processing provider contracts, correspondence, and supporting the External Team. Data Base Maintenance Technicians maintain provider databases for all lines of business, resolve provider claims' edits, and assign provider identification numbers. Credentialing Analysts are responsible for processing provider credentialing applications, correspondence, and credentialing database maintenance. If you change your address, tax ID or Social Security Number, or on-call list, or you have any questions concerning your listing in the provider directories, contact the appropriate Internal Team member listed on the map on page 23.

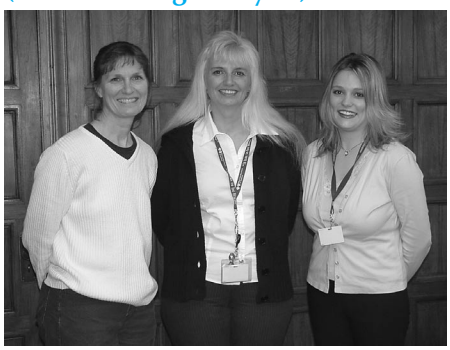
EXTERNAL TEAM (Development and Service Representatives)

L to R: Kathy Polette, Jenifer Sampson, Dan Polette, Chris Burbank, Terry Manska, Team Coach Linda Orth

INTERNAL TEAM (Specialists and Database Maintenance Technicians)

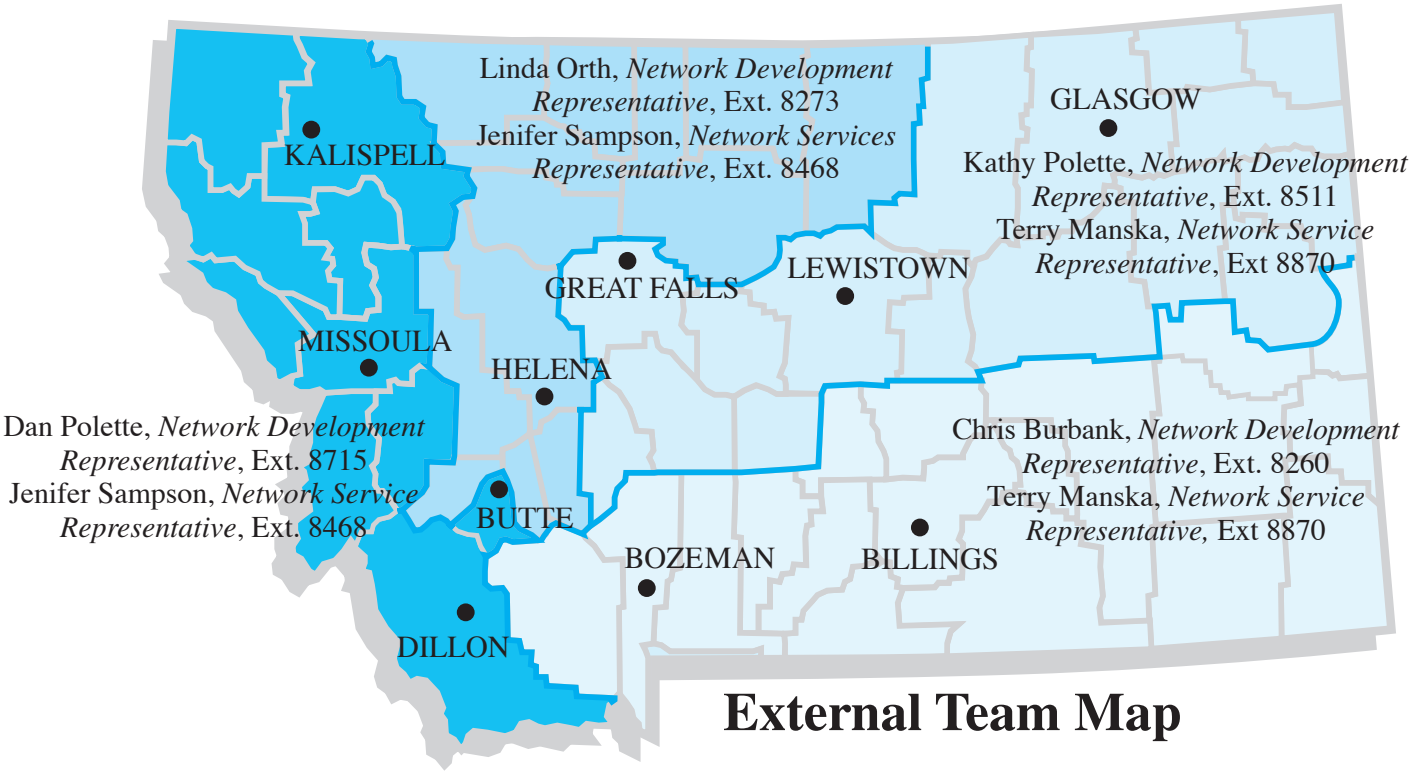
L to R: Jim Hallauer, Amy Salle, Tom Strong, Louise Elbrecht, Bridgett Waples, Joy Dupler, Team Coach Deb Stewart

INTERNAL TEAM (Credentialing Analysts)

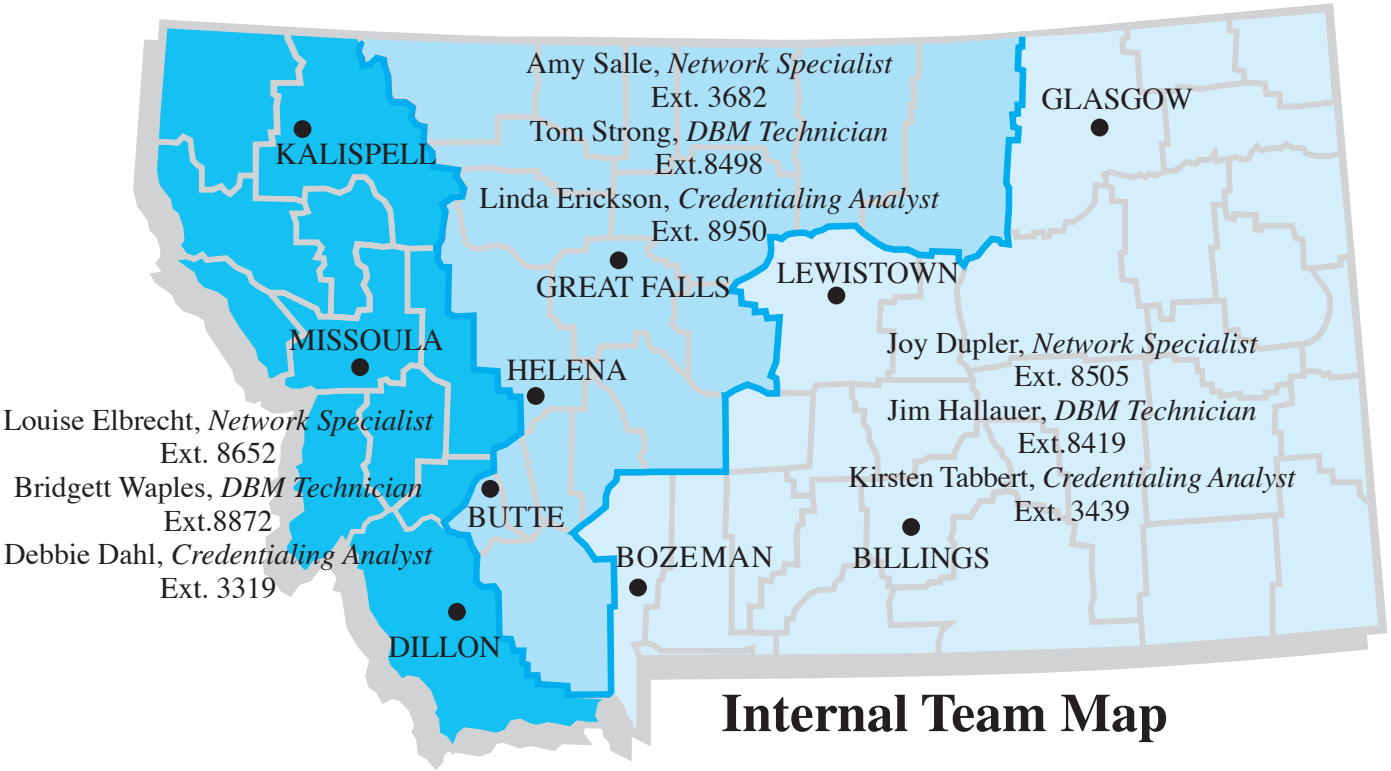


L to R: Linda Erickson, Debbie Dahl, Kristen Tabbert

BCBSMT HEALTH CARE SERVICES
1-800-447-7828



External Team Map



Internal Team Map

FRAUD

BORDERLINE MEDICINE: ALTERNATIVE CLINICS IN TIJUANA

Karl Krieger, CFE, AHFI

BCBSMT has investigated questionable claims from alternative Mexican clinics for years. These clinics promote expensive, unproven treatments that often put a patient's medical health, as well as their family's financial well being, at risk.

Case in point: In a February 24, 2002, story, the *San Diego Union Tribune* documented the saga of several patients who sought treatment from the American Metabolic Institute (AMI), including a 6-year-old boy who suffered from a rare and deadly cancer. The boy had been receiving treatment at AMI for three months when his doctors presented CAT scans to the parents that purportedly showed their child's cancer had disappeared. However, as the boy's condition continued to deteriorate, the family took him to a traditional hospital where it was confirmed his body was still riddled with cancer. Two days later, after $90,000 in treatment at AMI, the boy died. Unfortunately, the ending to this story is not uncommon.

On May 19, 2004, agents from the FBI and the Internal Revenue Service arrested personnel from AMI following a 64-count indictment on charges of insurance and tax fraud. AMI allegedly set up a billing company in San Diego designed to bill insurance claims for patients as if they received traditional treatment from an American hospital. The indictment also accuses the hospital's operators of violating banking laws by withdrawing hundreds of thousands of dollars in cash from their accounts in transactions of $9,900, just below the $10,000 level that triggers federal reporting.

If you have a patient considering treatment at an alternative Mexican clinic, please warn them that BCBSMT conducts a detailed investigation of each claim, and benefits are generally not available. Many of these patients risk their chances for recovery treatment by choosing unproven alternative therapies.

Karl Krieger currently serves as a BCBSMT Special Investigator, is a Certified Fraud Examiner, and an Accredited Health Care Fraud Investigator. Karl has been employed by BCBSMT for over 15 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, refer to the BCBSMT anti-fraud website at www.stopfraud.bcbsmt.com.

1-800-621-0992

stopfraud.bcbsmt.com

IT AFFECTS ALL OF US!

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