CapsuleNews℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

BlueCross BlueShield of Montana
Live Smart. Live Healthy.
An Independent Licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Second Quarter 2008

BCBSMT Conversion Factors Increase

2008 Compensation Updates Effective May 1

Blue Cross and Blue Shield of Montana (BCBSMT) increased the physician and anesthesiology conversion factors effective May 1, 2008. The Resourced-Based Relative Value Scale (RBRVS) conversion factor increased to $58.85, and the anesthesiology conversion factor increased to $53.00.

In the RBRVS system, physician services are assigned units of value, known as Relative Value Units (RVU), based on the resources (physician's work, the practice expense, and professional liability insurance) required to provide the services. The RVU is multiplied by the BCBSMT conversion factor to determine the BCBSMT allowable fee for most services (or codes). Compensation is then the BCBSMT allowable fee or the actual charge submitted on the claim, whichever is less.

Payment for the administration of anesthesia is made based on the American Society of Anesthesiology methodology. The compensation method for physicians and certified registered nurse anesthetists is a base and time unit calculation (base units plus time units multiplied by the conversion factor). Anesthesia time is reported in minutes, and each 15-minute increment equals one unit.

More information about provider compensation is available at www.bcbsmt.com. Click on Providers and then Provider Policies to review all BCBSMT provider compensation policies.

[Continued on page 2]

Inside This Issue

From the Network Administrator 3
Medical Policy 4
Regular Business 5
BlueCard®
- BlueCard Claims Submission
- BlueCard Provider Satisfaction Survey Options

TriCare/TriWest
- Helpful Tips for Submitting TriCare Claims
- TriCare Offers New Autism Services Demonstration Project
- Letter From the President and CEO

Other Business
- Change in Processing of CPT Codes 7889 and 78891
- BCBSMT Access and Availability Standards
- Asymtomatic Postmenopausal Status – V4981
- BCBSMT Provider Manual Updated
- Overpayment Recovery Business Process Change

Fraud
Health Insurance Fraud News Briefs ... 13
Health Care Services
New Provider Development Representative Joins HCS 14
Participating Providers
March 17 to May 31, 2008 15

www.bcbsmt.com

[Continued from page 1]

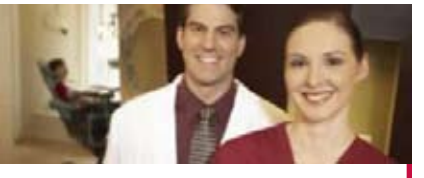
Compensation Updates

BCBSMT changed its business processes, which will result in shifting the time for the annual compensation update from March 1 of each year to May 1. We made this change because unpredictability in when the "Final Rule" in the *Federal Register* is published has not allowed sufficient time for analysis and implementation of the new fee schedule. BCBSMT will be changing the update to May 1 for the following compensation schedules:

- Anesthesia
- RVU-based (either CMS, St. Anthony, or manually calculated comparing to an RVU-based code)
- Clinical lab
- Durable medical equipment, prosthetics, orthotics, and supplies

We will continue to perform the Vaccine and Drug compensation update on January 1 and July 1 of each year.

If you have questions, contact your Provider Network Representatives at 1-800-447-7828, extension 3600 or email at HCS-X3600@bcbsmt.com.



BCBSMT Spring Provider Workshops Well Received

An Opportunity To Meet Your Representatives

Paul Pedersen
Network Administrator
Health Care Services

Health Care Services (HCS) provider representatives hosted provider workshops throughout the state in April and May. Over 250 people from all over Montana were presented with information about NPI, the new BCBSMT physician conversion factor, BlueCard, and new business process changes being implemented to make every provider and member interaction with BCBSMT more efficient.

We also shared our new mission to help people lead healthier lives, and we are not promoting this message just with a preventive benefit. BCBSMT has established wellness programs for our groups (including our own) to educate employees about simple steps they can take that will improve overall health, prevent disease, and promote exercise as the best preventive medicine for many of today's illnesses.

A large portion of the presentation was dedicated to new business processes and online services designed to make getting information specific to your practice efficient and easy. Step-by-step instructions were shown for registering on our website to received claims, benefits, eligibility, and provider claims registers direct to your desktop. Updated information on place of service, Medicare crossover claims, electronic claims for small provider offices, and tips to submitting claims that will pass on the first pass rounded out the day's presentation.

If you have suggestions for improvement or content for our next round of provider workshops this fall, contact your Provider Network Service Representatives at hcs-x3600@bcbsmt.com or at 1-800-447-7828, Extension 3600.

The Capsule News is a quarterly publication for Montana health care providers. Any material in the Capsule News may be reproduced with proper credits.

Send Comments Or Questions To:
Michael McGuire, Editor
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604
406-444-8412 voice
406-447-3570 FAX
mmcguire@bcbsmt.com

Medical Policy

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

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

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

The following new and revised medical policies were approved in May, and approved with an effective date listed in the policy. You may call BCBSMT at 1-800-447-7828 to request a copy.

Medical Policies Index

Click to go to Medical Policy

New Policies

- Transplant: Heart and Heart/Lung Transplant
- Transplant: High-Dose Chemotherapy and Hematopoietic Stem-Cell Support to Treat Hodgkin's and Non-Hodgkin's Lymphomas
- Transplant: High-Dose Chemotherapy and Hematopoietic Stem-Cell Support to Treat Leukemia
- Transplant: High-Dose Chemotherapy and Hematopoietic Stem-Cell Support to Treat Solid Tumors in Adults
- Transplant: High-Dose Chemotherapy and Hematopoietic Stem-Cell Support to Treat Solid Tumors in Children
- Transplant: High-Dose Chemotherapy and Hematopoietic Stem-Cell Support to Treat Malignancies and Diseases
- Transplant: Liver Transplant
- Transplant: Lung and Lobar Lung Transplant
- Transplant: Nonmyeloblative Allogeneic Transplant of Hematopoietic Stem-Cell for Treatment of Malignancy
- Transplant: Single or Tandem Course of High-Dose Chemotherapy Plue Hematopoietic Stem-Cell Support for Multiple Myeloma
- Ixabepilone (Ixempra) Injection
- Durable Medical Equipment (DME), Prosthetic and Orthopedic Items

Revised Policies

- Appeals Process for Experimental/Investigational and Medical Necessity Denials
- Genetic Testing for Inherited BRCA1 or BRCA2 Mutations
- Paraspinal Surface Electromyography – SEMG
- Thermography
- Topographic Brain Mapping

BlueCard® 6

- BlueCard Claims Submission
- BlueCard Provider Satisfaction Survey Options

TriCare/TriWest 8

- Helpful Tips for Submitting TriCare Claims
- TriCare Offers New Autism Services Demonstration Project
- Letter From the President and CEO

Other Business 11

- Change in Processing of CPT Codes 78890 and 78891
- BCBSMT Access and Availability Standards
- Asymtomatic Postmenopausal Status – V4981
- BCBSMT Provider Manual Updated
- Overpayment Recovery Business Process Change

Fraud 13

- Health Insurance Fraud News Briefs

Health Care Services 14

- New Provider Development Representative Joins HCS

BlueCard®

BlueCard® Claims Submission

Editors Note: The first quarter 2008 Capsule News inadvertently listed the Montana Children's Health Insurance Plan (CHIP) as a product excluded from the BlueCard program. Montana CHIP claims are processed through the BlueCard program when out-of-state members receive services in Montana and when Montana CHIP members travel out of state. Out of state services must be prior authorized unless urgent or emergent.

The BlueCard Program provides a valuable service that allows you to file claims through BCBSMT for members from other BCBS Plans, both domestic and international. You may also obtain prior authorization for services from members' BCBS Home Plan. However, it is important for patients to know that ultimately it is their responsibility to seek prior authorization. If you assist the member with this, ask to be transferred to the utilization review area when you call BlueCard Eligibility (**1-800-676-BLUE**). To file a claim for the member:

1. Make a copy of the front and back of the member's ID card. Look for the three-character alpha prefix that precedes the member's ID number on the ID card.
2. Call BlueCard Eligibility at 1-800-676-BLUE (2583) to verify membership and coverage.
3. **Submit all out of state member claims to BCBSMT with the alpha prefix**. BCBSMT electronically routes the claim to the member's BCBS Plan. The member's Plan then processes the claim and approves payment. BCBSMT will send a check along with your weekly Provider Claims Register. Do not ask for payment up front from the out of state member.

Do not resubmit claims because they will be denied as duplicates. The member's plan should not be contacting you directly unless you filed a paper claim directly with that plan. If the member's Plan contacts you to send them another copy of the member's claim, refer them to BCBSMT.

In some cases, a member's BCBS Plan may suspend a claim because medical records or additional information is necessary. When resolution of a claim requires additional information from your office, BCBSMT may either ask for the information or give the member's plan permission to contact your office directly.

If members contact your office, instruct them to contact their BCBS plan. Refer them to the front or back of their ID card for a Customer Service number.

Medical Records

When medical records are required to process a claim, requests will come from BCBSMT, which will work with the member's Blue plan. Do not send medical records with claims unless you are asked to do so. Unsolicited claim attachments may cause claim payment delays. Direct any questions regarding medical records or the status of your claims to 1-800-447-7828, Extension 8622.

Ancillary Medical Service Providers

If you are a health care provider who offers products, materials, informational reports, or remote analyses or services, and are not present in the same physical location as a patient, you are considered an ancillary medical service provider under the BlueCard Program. Examples include, but are not limited to, prosthesis manufacturers, durable medical equipment suppliers, independent or chain laboratories, or telemedicine providers. Ancillary medical service providers for members from multiple Blue Plans should use the following claim filing guidelines:

- If you have a contract with the member's plan, file with that plan
- If you normally send claims to the direct provider of care, follow normal procedures If you do not normally send claims to the direct provider of care and you do not have a contract with the member's plan, file the claim with BCBSMT

[Continued on page 7]

[BlueCard continued from page 6]

Coordination of Benefits (COB)

COB ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility.

If, after calling BlueCard Eligibility or through other means, you discover the member has a COB provision in the benefit plan and BCBSMT is the primary payer, submit the claim along with information regarding COB to BCBSMT. If you do not include the COB information with the claim, the member's BCBS plan or the insurance carrier will need to investigate the claim, and this will delay payment or result in a post-payment adjustment.

Medicare Supplement (Medigap Claims)

Always file Medicare supplemental claims with the Medicare contractor first to ensure that crossover claims are forwarded appropriately. Always include the following:

- The complete Medicare HIC number
- The patient's complete BCBS plan identification number, including the three-character alpha prefix
- The BCBS plan name as it appears on the patient's ID card

Do not submit claims to BCBSMT and Medicare simultaneously. File with Medicare first and wait until the Explanation of Medical Benefits (EOMB) or payment advice is received from Medicare. If the claim automatically crosses over to the member's home plan, there is no need to file a claim with BCBSMT.

If the claim has not crossed over to the member's home plan, send a paper claim along with the Medicare EOMB to BCBSMT. BCBSMT, or the member's BCBS plan, will pay you the Medicare supplemental benefits. If assignment is not accepted, the member will be paid, and you may bill the member.

Note: *Some Medicare supplemental benefits will be paid by other plans. However, continue to submit claims to BCBSMT.*

More information is available in the BCBSMT Provider Manual, Chapter : BlueCard out of state claims published online at www.bcbsmt.com. Call 1-800-447-7828, Extension 8622, if you have questions.

BlueCard® Provider Satisfaction Survey Options

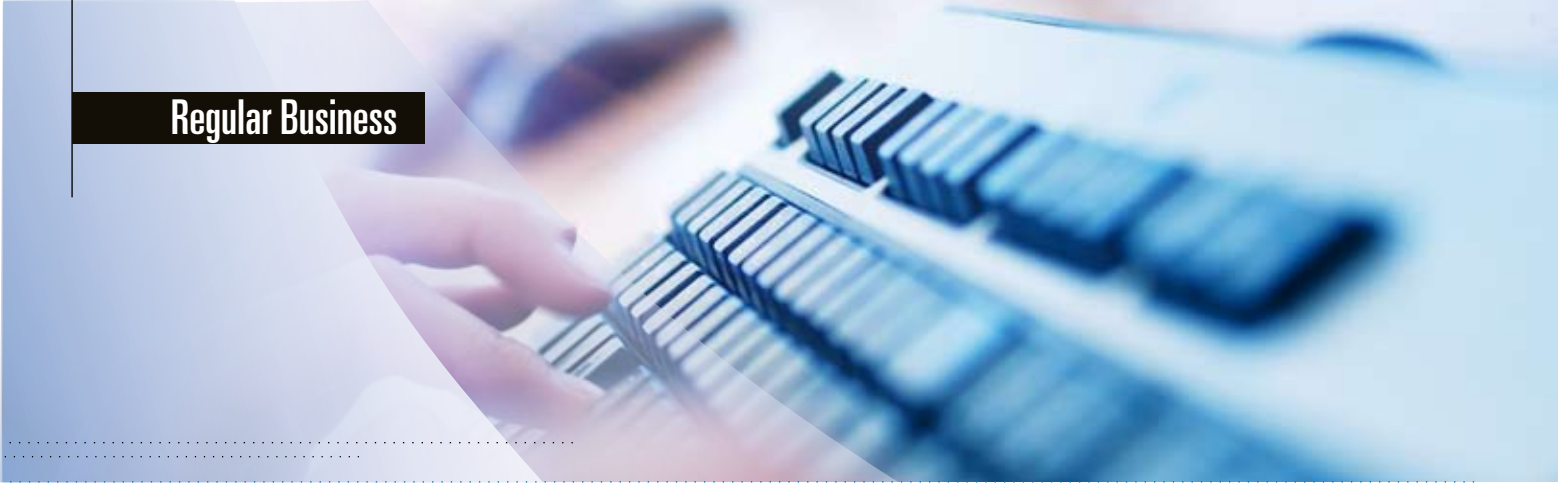
Your feedback is important to help us make improvements in our processes and make your interactions with BCBSMT a smooth and simple experience.

Starting this year, you will have an opportunity to tell us how we are doing through a phone and/or online satisfaction survey. At any point throughout the year, you may receive a call on behalf of BCBSMT seeking input on your experience with servicing out-of-area members. Our research vendor may invite you to participate in online surveys and collect your e-mail address. If your office is contacted, we encourage you to participate in these surveys. We take your feedback seriously and incorporate enhancements to our services.

If you need information about the BlueCard Program or have suggestions for improvements, there are three ways to contact us:

1. Contact Customer Service at 1-800-447-7828, Extension 8622.
2. Contact your Provider Network Service Representatives at 1-800-447-7828, Extension 3600, or by email at HCS-X3600@bcbsmt.com.
3. Visit us online at www.bcbsmt.com and click on Providers and then Provider manuals.

Thank you in advance for your participation. We appreciate your feedback.



TriCare/TriWest

Helpful Tips for Submitting TriCare Claims

The following suggestions will help ensure that TRICARE claims are accurately processed on the first submission:

The beneficiary's Social Security number (SSN) cannot be used when filing a TRICARE claim. TRICARE requires the use of the sponsor's (service member's) ID because all claims must conform to the information in the Defense Enrollment Eligibility Reporting System (DEERS). All TRICARE beneficiaries have a military identification card, which provides the sponsor number.

The exception is for a beneficiary who is divorced from the sponsor but was married to the sponsor for at least 20 years and remains eligible for TRICARE. In this instance, the individual should use his or her own SSN.

If the beneficiary has other health insurance (OHI), use the name of the plan and not the employer. It is best to indicate "ABC Health Plan" rather than the name of the employer, "XYZ Company." If employer names or insurance supplements that are not actually primary carriers appear on the claim, TRICARE will deny the claim while review for OHI is performed.

Submit anesthesia claims with the time units. Use the industry standard of 15 minutes for each unit (60 minutes equals 4 units). If we see units on anesthesia claims, TriCare assumes they are time units of 60 minutes equals 4 units. The system adds the base units using standard anesthesia guidelines. All modifiers should be added using either the ASA PI-P6 series or the 99XXX series outlined in the CPT manuals.

Claims with only a V70.0 diagnosis will be denied. To establish medical necessity and process the claim according to TRICARE criteria, a clear, specific diagnosis should be used. However, a "rule out" diagnosis is also acceptable. Laboratories should bill for the "rule out" diagnosis if a specific diagnosis is not listed.

Bill the appropriate preventive diagnoses. TRICARE does not cover routine care, such as sports physicals, but does pay for certain preventive care, such as mammograms. The addition of accurate ICD-9 codes will assist in proper processing.

Submit all services on the same day by the same provider on one claim. Providers who separate services performed on the same day from the same rendering provider on separate claims are considered to be unbundling the services. All claims for the same date of service for the same beneficiary in the same place of service should be submitted together.

Frequent and inappropriate use of Modifier 25 or Modifier 59 could result in review by TriWest's Program Integrity department. Modifier 25 signifies separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service, and modifier 59 identifies distinct procedural services. Use of these modifiers may be appropriate when applied using current CPT manual guidelines.

For additional information, please visit the Provider Connection area of www.triwest.com or call 1-888-TRIWEST (888-874-9378). If you have questions, contact your Provider Network Service Representatives at hcs-x3600@bcbsmt.com or at 1-800-447-7828, Extension 3600.

[Continued on page 9]

[TriWest/TriCare continued from page 8]

TRICARE Offers New Autism Services Demonstration Project

A new Enhanced Access to Autism Services Demonstration Project from TRICARE will expand the TRICARE Extended Care Health Option (ECHO) benefit to a broader population of TRICARE beneficiaries with autism spectrum disorder, allowing the use of additional categories of Applied Behavior Analysis (ABA) providers, including tutors.

The demonstration project, effective for claims on or after March 15, 2008, is an enhancement to the TRICARE ECHO program for those TRICARE beneficiaries diagnosed with an autism spectrum disorder. This demonstration project allows reimbursement for behavioral-based tutoring services from providers, including non-certified educational intervention service providers and tutors (and tutors-in-training), who provide applied behavior analysis (ABA) services.

Authorized supervisors will be required to direct and oversee these tutors, who will provide hands-on services to children with autism. Tutors must be credentialed and specially trained to work with children with special needs.

All care submitted for reimbursement under the autism demonstration will require prior authorization. Applicable beneficiary cost-shares will apply. After the TRICARE beneficiary pays his or her monthly cost share, TRICARE will pay up to $2,500 per calendar month for each ECHO-registered beneficiary for authorized ECHO benefits (the limit on ECHO Home Health Care benefits is separate). If an ECHO beneficiary's costs exceed $2,500 in a calendar month, the beneficiary is responsible for paying the additional costs.

We also have created a special area for the Autism Demonstration Project in the Popular Links area of www.triwest.com/provider. There you can find frequently asked questions and definitions, autism spectrum disorder (ASD) provider roles and responsibilities, PCM and specialized ASD provider roles and responsibilities, supervision requirements of tutors and tutors-in-training, tutors and tutors-in-training participation requirements and letters to ASDs and PCMs.

If you have questions, contact your Provider Network Service Representatives at hcs-x3600@bcbsmt.com or at 1-800-447-7828, Extension 3600.

TriWest HEALTHCARE ALLIANCE®

16010 N. 28th Avenue
Phoenix, AZ 85053
Main: 602-564-2000
Fax: 602-564-0000

www.triwest.com

May 2, 2008

On behalf of TriWest Healthcare Alliance I'd like to thank you for your extraordinary commitment to the military community in serving as a TRICARE network provider.

We feel that it is an absolute honor and privilege to serve the men, women and families of our U.S. Armed Forces in the West Region communities and we fully realize that we would not be able to accomplish that without your partnership and continued dedication and exceptional care.

For that reason, we would like to update you on the process, timeline and impact of the next TRICARE contract, which is currently open for bid to competitors.

The current TRICARE contract is expected to be extended until March 31, 2010. The new contract, on which we intend to bid, will likely be awarded by the end of 2008, with a contract effective date of April 1, 2010. There is no action required on your part to continue as a TRICARE provider during this time.

Other companies planning to bid for this contract may contact you during this time. However, keep in mind that TriWest offers stability and a proven track record, including an established network, established claims administration and proven processes. In fact, we have every confidence that the next West Region contract will be again awarded to TriWest.

TriWest's unwavering commitment to being a provider-friendly health plan administrator and its unique ability to administer this program is clearly demonstrated in results such as these:

- More than 99% of all referral requests are processed within 2 days
- More than 96% of all authorization requests are processed within 2 days
- Approximately 97% of clean claims submitted online are processed in 15 days or less
- Approximately 99.7% of all clean claims are processed in 30 days or less
- Approximately 98% of all calls to 1-888-TRIWEST are answered within 30 seconds.

TriWest is committed to doing *Whatever It Takes* to retain exceptional providers such as yourself so that our military community has convenient access to quality healthcare services. As we work toward the successful award of a third TRICARE contract, you will still have local TRICARE representatives and the superb, uninterrupted service that you deserve. TriWest will continue to strive to enhance your experience as a TRICARE provider.

Please feel free to contact your local TRICARE representative should you have any questions about this process or suggestions for ways that TriWest may serve you better. You'll also find updates on the Provider Connection pages of www.triwest.com throughout the bid process.

We value your partnership and deeply appreciate your ongoing commitment and support of our U.S. military and their families as they continue to make sacrifices for our country. We look forward to many, many years of partnering with you to provide them with the exceptional health care which they so richly deserve.

Sincerely,

David J. McIntyre,
President and CEO

BlueCross BlueShield of Montana

Live Smart. Live Healthy.℠

Other Business

Change in Processing of CPT Codes 78890 and 78891

BCBSMT currently has a medical policy titled *Generation of Automated Data* that states BCBSMT considers the generation of automated data as a noncovered service. The CPT codes included in this medical policy are 78890 and 78891.

Effective September 9, 2008, BCBSMT will deny claims for the generation of automated data as inclusive of other services billed on the same date of service. As a result of this change in our policy, members will not be responsible for these charges if billed by a participating provider.

If you have questions, call your Provider Network Service Representatives at 1-800-447-7828, Extension 3600. The *Generation of Automated Data* medical policy is available online at www.bcbsmt.com. Click on Providers and then Medical Policy.

BCBSMT Access and Availability Standards

Participating providers treat BCBSMT members as they would any other patient and have agreed to cooperate in monitoring accessibility of care for members, including scheduling of appointments and waiting times. Participating providers must meet the following appointment standards:

1. Emergency services must be made available and accessible at all times.
2. Urgent care appointments must be available within 24 hours.
3. Appointments for non-urgent care with symptoms must be made available within 10 calendar days.
4. Appointments for immunizations must be available within 21 calendar days.
5. Appointments for routine or preventive care must be available within 45 calendar days.

Emergency Services And Emergency Medical Condition

Participating providers are required to have 24-hour availability of emergency services and qualified on-call coverage available to BCBSMT members.

Emergency Services means health care items and services furnished or required to evaluate and treat an emergency medical condition.

Emergency Medical Condition is a condition manifesting itself with symptoms of sufficient severity, including severe pain, in which the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. The covered person's health would be in serious jeopardy.
2. The covered person's bodily functions would be seriously impaired.
3. A body organ or part would be seriously damaged.

Urgent Care

Participating providers must see BCBSMT members within 24 hours of their request for an appointment.

Urgent Care is health care that is not an emergency service but is necessary to treat a condition or illness that could reasonably be expected to present a serious risk of harm if not treated within 24 hours.

Non-Urgent Care With Symptoms

Participating providers must see BCBSMT members within 10 calendar days of their request for an appointment.

Non-Urgent Care is health care required for an illness, injury, or condition with symptoms that do not require care within 24 hours to prevent a serious risk of harm but do require care that is neither routine nor preventive in nature.

Routine Care

Participating providers must see BCBSMT members within 45 calendar days of their request for an appointment.

[Continued on page 12]

[Other Business continued from page 11]

Routine Care is health care for a condition that is not likely to substantially worsen in the absence of immediate medical intervention and is not an urgent condition or an emergency. Routine care can be provided through regularly scheduled appointments without risk of permanent damage to the person's health status.

Preventive Care And Immunizations

Participating providers must see BCBSMT members within 45 calendar days of their request for an appointment for preventive care and within 21 calendar days of their request for an appointment for immunizations.

Preventive Care and Immunizations are health care services designed for the prevention and early detection of illness in asymptomatic people.

More information is available in the BCBSMT provider manual published at www.bcbsmt.com. If you have suggestions for improvement or content, contact your Provider Network Service Representatives at hcs-x3600@bcbsmt.com or at 1-800-447-7828, Extension 3600.

BCBSMT Provider Manual Updated

The BCBSMT Provider Manual has been updated and published at www.bcbsmt.com. The manual is continually reviewed for clarity and style with the goal of providing simple and direct instructions. A summary of material changes made in the second quarter of 2008 include:

1. Updated the Credentialing introduction with "Credentialing will be complete within 90 days of receipt of all of the required documentation, including verification of all of the data supplied in the application. The Credentialing Committee meets twice monthly." (1-5).
2. Moved electronic claims information from Chapter 4: BCBSMT Medical Claims to Chapter 2: Online Services. Updated the Health-e-Web Internet address to www.hewedi.com (2-1).
3. Added prior authorization step-by-step guidelines (3-3).
4. Updated CMS-1500 claim form box 24j instructions (4-11).
5. Updated Products and Accounts Excluded from the BlueCard® Program (6-1).
6. Included the new physician incorrect payment adjustment process (10-12).

If you have suggestions for improvement or content, contact your Provider Network Service Representatives at hcs-x3600@bcbsmt.com or at 1-800-447-7828, Extension 3600.

Asymptomatic Postmenopausal Status – V4981

BCBSMT previously classified Diagnosis Code V4981 (Asymptomatic Postmenopausal Status [age-related/natural]) as medical, and claims were processed according to the member's medical benefits. Effective October 1, 2008, Diagnosis Code V4981 will be classified as a routine diagnosis instead of a medical diagnosis. Services that had previously been processed under the medical benefit will be denied if a member does not have a routine benefit. This change will primarily affect claims for DEXA scans.

If you have questions, call Customer Service at 1-800-447-7828 or your Provider Network Service representatives at Extension 3600.

Overpayment Recovery Business Process Change

For Physicians (MD, DO, DPM)

Blue Cross and Blue Shield of Montana (BCBSMT) is changing the current process of overpayment recovery or "reversals" for physicians (M.D., D.O., and D.P.M.) This business process change will not impact Medicare Supplement plans, the Federal Employee Program, or BlueCard (out-of-state) claims.

Currently when a claim has been paid in error or overpaid, BCBSMT initiates an adjustment to the claim and automatically recovers the overpayment amount from the total dollar amount on the next Provider Claims Remittance (PCR). The current process occurs without your involvement and includes a notation of "Reversal of Claim XXXX" and/or "Adjustment of Claim XXXX."

With our new process, when a claim has been paid in error or overpaid, BCBSMT will provide you written notice that will include the patient's name, the date of service, the original payment amount, the overpayment amount, and a specific explanation for the adjustment. You will have 30 days to submit the overpayment to BCBSMT or to submit an appeal regarding the overpayment. If you do not submit the overpayment to BCBSMT or file an appeal in writing within 30 days, BCBSMT will recover the overpayment consistent with its current business practice.

Please understand that you have a choice in the implementation of this business process change. All physicians should have received a letter the first week of July with notification of the option to continue the current process of overpayment recovery or reversals. If you choose to receive 30 days written notice and write a check to BCBSMT for an overpayment amount, then no action or response is required.

If you have questions or need more information, call our Health Care Services team at 1-800-447-7828, Extension 3600, or email them at HCS-X3600@bcbsmt.com. More information about reversals for nonphysicians is available in the BCBSMT Provider Manual published at www.bcbsmt.com. Click on Providers and then Provider Manuals (Chapter 10, page 12).

Health Insurance Fraud News Briefs

Industry analysts estimate that fraud affects anywhere from 3-10% of all health care claims. Nationally, that means as much as $500 million dollars could be lost to fraud EVERY DAY! Here are some recent healthcare fraud cases we found interesting.

Identity Theft and Prescription Fraud

A 46-year old woman used her identity, her ex-husband, her young children, her former lawyer, and a stranger to fill more than 100 fraudulent prescriptions between 2004 and 2007. She was sentenced to jail after pleading guilty to identity fraud, insurance fraud, false health care claims, larceny over $250, and fraudulently obtaining a controlled substance (second offense).

Expensive Counseling

A 49-year old mental health provider was indicted on 10 counts of health care fraud after allegedly being paid more than $578,000 by insurers for bogus claims. These claims allegedly include face-to-face psychotherapy sessions with patients while she was on vacation in different states or countries and billing for more complex procedures than were actually performed.

How Many Patients Can You See in a Day?

A 62-year old physician agreed to a plea agreement on charges that he up-coded thousands of evaluation and management codes over a five-year period. During this time, the doctor would have had to spend more than 24 hours a day treating patients on at least 32 occasions. On six of those days, he claims to have seen more than 100 patients.

Medical Supplies For Sale

A former medical supply company executive was found guilty of stealing from both sides. The 44-year old COO fraudulently billed more than $600,000 to insurance carriers by assigning incorrect procedure codes to wrist braces and walking boots – resulting in higher payments than normally allowed. It wasn't enough to con insurers, though, as the executive also used company checks to pay more than $360,000 on personal bills.

Dentists Do It Too

A 40-year old dentist has been charged with fraudulently billing four different insurance carriers more than $29,000 for services that were never rendered or for more extensive procedures than were actually performed. For example, one scheme involved billing for costly procedures such as periodontal scaling and root planing when he had only performed routine cleanings.

These cases illustrate only a small sample of the thousands of health care fraud cases across the nation every year. In addition to affecting the insurance premiums paid by members, this activity also casts a shadow across the majority of providers who are honest and ethical in their activities. BCBSMT asks you to help us to stop fraud in Montana by notifying us about any questionable activity you might identify in your daily business. Identifying and eliminating fraud is good for everyone.

If you have questions or concerns about fraud or questionable practices, call our fraud hotline at 1-800-621-0992, or you may e-mail us at fraud@bcbsmt.com. Additional information is also available on our website at http://www.stopfraud.bcbsmt.com.

Karl Krieger currently serves as a BCBSMT Special Investigator and is a Certified Fraud Examiner and an Accredited Health Care Fraud Investigator. Karl has been employed by BCBSMT for over 19 years, has received the DPHHS Inspector General's Integrity Award for his work in health care fraud, and has served 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.

New Provider Development Representative Joins HCS

Kim Morrison has recently joined Health Care Services (HCS) as a Provider Development Representative in the Helena office along with Ronda DeMars and Debbie Dahl. Kim is a native Montanan born in Glendive who has spent the last 20 years working on the provider side of health care. She has been a business manager and/or practice manager for medium to large provider groups and has extensive experience in provider office finances and contracting, and operational, clinical, and medical billing management in the Seattle, Washington, area.

Kim can answer questions about your professional and facility BCBSMT contracts and is excited to be working closely with Montana's health care community. Her focus is on professional and facility providers in eastern Montana.

If you would like to schedule an on-site educational session or have questions about your provider contract with BCBSMT, Montana HealthLink PPO, Medicare Advantage (MedicareBlue PPO), Federal Employee Program, TriWest/TriCare, Children's Health Insurance Plan, Caring Program for Children, or the managed care contract, call Kim at 1-800-447-7828, Extension 8754.

Kim Morrison
Provider Development Representative
Health Care Services

[First Quarter 2008] CapsuleNews 14

Participating Providers: March 17 to May 31, 2008

The following pages list new and terminated providers for the Traditional Participating Provider Network and the Joint Venture Managed Care Provider Network. *Note: If a participating provider has changed locations, the provider received a new effective date and is listed below.*

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

Brian J. Albiero, DC	Bigfork	Chiropractic
Adam J. Benson, MD	Missoula	Radiology
Anthony A. Bouldin, MD	Billings	Neurology w Special Qualifications in Child Neurology
Christopher T. Caldwell, DO	Missoula	Neuromusculoskeletal Medicine
Adam Deutchman, MD	Missoula	Surgery
John A. Duncan, MD	Billings	Surgery, Neurological
Cynthia S. Edstrom, MD	Kalispell	Pediatrics
Shawnee Lynn Farnham, DO	Helena	Psychiatry
Pamela S. Foss, DC	Bigfork	Chiropractic
Gallatin Rest Home	Bozeman	Skilled Nursing / Extended Care
Lisa L. Grossman, PT	Great Falls	Physical Therapy
Tony L. Ham, MD	Roundup	Family Medicine
Dana S. Harvey, PA-C	Butte	Physician Assistant
Robert A. Headley, MD	Missoula	Emergency Medicine
William V. Huval, MD	Helena	Surgery
Jay M. Levy, MD	Billings	Surgery, Neurological
Katherine L. Markette, MD	Missoula	Radiation Oncology
Kimberley A. Marquis, MD	Bozeman	Pulmonary Disease
Thomas Blair Matheson, MD	Baker	Surgery
Margaret M. Menendez, MD	Missoula	Radiation Oncology
Miranda Meunier, NP	Billings	Nurse Practitioner
Amber A. Milburn, DC	Stanford	Chiropractic
Eric C. Roberts, MD	Great Falls	Physical Medicine & Rehabilitation
Jessica M. Stone, MD	Bozeman	Psychiatry
Ryan J. Strecker, PT	Billings	Physical Therapy
James M. Sweet, MD	Billings	Allergy & Immunology
Tommy D. Warden, DC	Kalispell	Chiropractic

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

James H. Armstrong, MD	Kalispell	Family Medicine
Diedra Bethune, NP	Missoula	Nurse Practitioner
Christopher A. Boor, PT	Bozeman	Physical Therapy
Christopher A. Boor, PT	Belgrade	Physical Therapy
Dennis A. Chenovick, DDS	Helena	Dentist
Kenneth R. Conger, MD	Bozeman	Urgent Care
Linda S. Cornetet, PT	Colstrip	Physical Therapy
Mark J. Dell'Aglio, MD	Billings	Gastroenterology
Shawnee Lynn Farnham, DO	Helena	Psychiatry
Brad D. Fischer, PT	Colstrip	Physical Therapy
Brad D. Fischer, PT	Billings	Physical Therapy
Robert M. Fry, LCSW	Great Falls	Licensed Clinical Social Worker
Deborah L. Hapcic, PT	Bozeman	Physical Therapy
Kathleen M. Ingalls, PT	Bigfork	Physical Therapy
John R Larson, MD	Great Falls	Anesthesiology

Dale C. Lee, LCPC	Billings	Licensed Clinical Professional Counselor
Janice M. Linn, MD	Billings	Family Medicine
Laura J. McBain, OT	Belgrade	Occupational Therapy
Glenn W. Mclaughlin, MD	Helena	Obstetrics and Gynecology
Aaron R. Moos, DC	Bozeman	Chiropractic
Craig J. Panos, MD	Polson	Family Medicine
Shannon K Penland, MD	Great Falls	Internal Medicine
Mariah Peterson, PT	Missoula	Physical Therapy
Thomas S. Reich, MD	Great Falls	Otolaryngology
Pamela R. Roberts, MD	Kalispell	Family Medicine
Carol C. Sims, LCPC	Livingston	Licensed Clinical Professional Counselor
Stephen D. Smith, MD	Missoula	Obstetrics and Gynecology
Michael Stemborski, LCPC	Helena	Licensed Clinical Professional Counselor
Michael Stemborski, LCPC	Kalispell	Licensed Clinical Professional Counselor
Kae M. Sukut, PA-C	Glasgow	Physician Assistant
Leah J. Treadwell, MD	Kalispell	Family Medicine
Laura L. Wetherelt, NP	Miles City	Nurse Practitioner

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

Daniel F. Alderman, MD	Bozeman	Radiology
Adam J. Benson, MD	Missoula	Radiology
Big Sky IV Care	Kalispell	I. V. Therapy
Christopher T. Caldwell, DO	Missoula	Neuromusculoskeletal Medicine
John H. Craft, CRNA	Butte	Certified Registered Nurse Anesthetist
Trevor H. Crane, DC	Great Falls	Chiropractic
Brenda M. DeGrazio, CNM	Missoula	Certified Nurse Midwife
Justine M. DeRousse, PA	Kalispell	Physician Assistant
Cynthia S. Edstrom, MD	Kalispell	Pediatrics
Edith H. Ellsworth, CNS	Great Falls	Clinical Nurse Specialist
Shawnee Lynn Farnham, DO	Helena	Psychiatry
Jamie B. Glenn, CNM	Butte	Certified Nurse Midwife
Lisa L. Grossman, PT	Great Falls	Physical Therapy
Tony L. Ham, MD	Roundup	Family Medicine
Dana S. Harvey, PA-C	Butte	Physician Assistant
Clint O. Hoxie, OD	Hamilton	Optometry
William V. Huval, MD	Helena	Surgery
Jon J. Johnson, MD	Kalispell	Internal Medicine
James Jutzy, MD	Bozeman	Radiology
Nancy J. Knaff, NP	Kalispell	Nurse Practitioner
Monique L. Krebsbach, PT	Missoula	Physical Therapy
Kelli K. Lala, PA	Billings	Physician Assistant
Katherine L. Markette, MD	Missoula	Radiation Oncology
Kimberley A. Marquis, MD	Bozeman	Pulmonary Disease
Ruth A. McDonald, MD	Billings	Pediatric Nephrology
Margaret M. Menendez, MD	Missoula	Radiation Oncology
Benjamin J. Miller, FNP	Missoula	Nurse Practitioner
Jolene D. Monheim, PT	Great Falls	Physical Therapy
Timothy F. Obermiller, MD	Kalispell	Pulmonary Disease
Matthew L. Parliament, DC	Helena	Chiropractic
Brent P. Pistorese, MD	Kalispell	Pulmonary Disease
Carolyn J. Porter, NP	Kalispell	Nurse Practitioner
Frank M. Rembert, MD	Bozeman	Radiology
Melody C. Rice, LCPC	Butte	Licensed Clinical Professional Counselor
Dennis L. Rich, MD	Bozeman	Radiology

Eric C. Roberts, MD	Great Falls	Physical Medicine & Rehabilitation
Darci L. Sgrignoli, OT	Ennis	Occupational Therapy
Rex P. Spear, MD	Bozeman	Radiology
Ronald W. Tharp, MD	Bozeman	Radiology
Kevin M. Vogelzang, PT	Missoula	Physical Therapy
Richard M. Wallace, MD	Bozeman	Radiology
Tommy D. Warden, DC	Kalispell	Chiropractic
Cynde A. Watkins, NP	Helena	Nurse Practitioner
Rebecca L. Webber-Dereszynski, LCPC	Billings	Licensed Clinical Professional Counselor

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

James H. Armstrong, MD	Kalispell	Family Medicine
Diedra Bethune, NP	Missoula	Nurse Practitioner
Shawnee Lynn Farnham, DO	Helena	Psychiatry
Brad D. Fischer, PT	Billings	Physical Therapy
Brad D. Fischer, PT	Billings	Physical Therapy
Deborah L. Hapcic, PT	Bozeman	Physical Therapy
Kathleen M. Ingalls, PT	Bigfork	Physical Therapy
Monique L. Krebsbach, PT	Missoula	Physical Therapy
John R Larson, MD	Great Falls	Anesthesiology
Glenn W. Mclaughlin, MD	Helena	Obstetrics and Gynecology
Paul R. Ouradnik, DPM	Billings	Podiatry
Craig J. Panos, MD	Polson	Family Medicine
Shannon K. Penland, MD	Great Falls	Internal Medicine
Thomas S. Reich, MD	Great Falls	Otolaryngology
Pamela R. Roberts, MD	Kalispell	Family Medicine
Carol C. Sims, LCPC	Livingston	Licensed Clinical Professional Counselor
Stephen D. Smith, MD	Missoula	Obstetrics and Gynecology
Michael Stemborski, LCPC	Kalispell	Licensed Clinical Professional Counselor
Leah J. Treadwell, MD	Kalispell	Family Medicine