Capsule News℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

Blue Cross Blue Shield of Montana
Live Smart. Live Healthy.℠

Second Quarter 2010

Inside This Issue

Making the New Health Care Laws Work for Montana

Blue Cross and Blue Shield of Montana (BCBSMT) is a strong supporter of health care reform and achieving coverage for all Montanans. Important advances toward achieving this are made more possible by the newly enacted health care reform laws entitled the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA). These laws present important new challenges for our country and for Montana. Mandates contained within these new laws will cause some disruption and some uncertainty, as one would expect with such a dramatic change in an important social policy.

To help improve understanding of the impact of health care reform in Montana, BCBSMT is providing this summary of many of the new laws and mandates associated with it. The intention of this publication is to help broaden understanding of the new laws from the perspective of Montana families, individuals, and employers.

Please note, the new health care reform laws are extensive, complex, and subject to regulatory guidance and interpretation that have yet to be released by the government. Therefore, this summary should not be considered a legal interpretation of the law. Please contact members of Montana's congressional delegation (202-224-3121), or contact appropriate legal counsel for legal interpretation of the new laws.

Making the New Health Care laws Work for Montana

This Publication Will Help You Understand:

- Timing and implementation of the new health care reform laws;
- New provisions that impact Montana employers: tax credits and health plan designs;
- Specific new mandates and services to which Montanans should pay attention; and
- Changes for children and youths upon which parents should focus.

This Publication Also Provides:

- Discussion points to improve understanding of important changes in the new health care law;
- Answers to questions frequently asked about the new health care reform laws.

For more information and updates regarding the effect of new health care reform laws on the state of Montana and its citizens, please contact the BCBSMT Health Care Transition Task Force at 406 437 6150 or email tim_warner@bcbsmt.com or frank_cote@bcbsmt.com.

Additional useful sources of information include:

- The U.S. Internal Revenue Service, which provides important information and updates for employers and individuals on a regular basis. The IRS website is www.irs.gov.
- The U.S. Department of Health and Human Resources, which provides useful updates and information about health care reform: Their website is: www.hhs.gov.

New Provisions That Impact Montana Employers: Tax Incentives and Health Plan Designs

Small Business Tax Credits (2010)

Beginning in 2010, qualified small businesses (those employing fewer than 25 employees and with average annual wages of less than $50,000), are eligible for tax credits. These credits are up to 35% of the employer's premium. Small employers with 10 or fewer workers with an average wage of $25,000 or less may receive the full value of the credit.

To qualify for a tax credit, an employer must contribute at least 50 percent of the total premium. Tax-exempt small businesses are eligible for a credit of up to 25 percent. In 2014, small employers who purchase coverage through an Exchange may receive a two-year tax credit of up to 50 percent. Tax-exempt businesses would be eligible for up to 35 percent.

Timing and Implementation of the New Health Care Reform Laws

The specific timing of the implementation of the new health care reform laws can be confusing. The starting points are the enactment dates of the laws, both of which were in late March 2010. The PPACA enactment date is March 23, 2010. The HCETCRA enactment date is March 30, 2010.

These are important dates because various provisions of the new laws are implemented over time using these dates as starting points. Some provisions of the new laws take effect immediately or within a few months. Other significant provisions will not be implemented for several years, including the implementation of the state-based Health Benefit Exchanges, which are not slated to go into effect until 2014.

Throughout this document, the dates of enactment and other aspects of the timing of the new laws are addressed.

Reinsurance for Retiree Health Benefit Plans (2010)

Beginning September 2010, the new laws establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees. This reinsurance program for early retirees is an incentive for employers to continue offering retiree coverage at least through the inception of the Exchange in 2014. The early retiree reinsurance program ends in 2014.

Employment-based plans (self- or fully insured) providing health benefits, including prescription drugs, to early retirees (retirees age 55 through 64) and their dependents can apply to receive reimbursement for a portion of the cost of coverage.

To participate in this program, reimbursements must be used to lower retiree health costs and may not simply be deposited into an employer's general assets. The reimbursements may be used to reduce premium costs, premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs for plan participants. The Secretary of the U.S. Health and Human Services (HHS) is required to develop a mechanism to monitor the appropriate use of such payments.

Eligibility for this program has some very specific requirements: An employment-based plan is a plan

maintained by a current or former employer (including a state or local government), employee organization, VEBA, or multiemployer plan. An employment-based plan that participates in the reinsurance program must implement programs and procedures to generate cost savings with respect to participants with chronic or high-cost conditions.

Reimbursement is 80 percent of a valid retiree claim between $15,000 and $90,000 (as adjusted each year based on the Medicare percentage increases). Reimbursements are not included in the employer's gross income.

The reinsurance program ends on January 1, 2014. Only $5 billion has been allocated to this program, and the HHS Secretary has authority to stop taking applications for the program based on the availability of funding.

Elimination of Lifetime Policy Limits (2010)
Beginning September 2010, six months after the enactment date, insured and self-funded plans will no longer be able to include lifetime limits on their policies. Insurers may still impose lifetime limits on "nonessential benefits." The government has yet to issue an exact definition of what benefits will fall within the "nonessential benefits" guidelines.

Elimination of Annual Limits on "Essential Benefits" (2010)
Beginning September 2010, plans will be limited in their ability to increase annual limits in their policies for "essential benefits" (this will be further clarified in HHS rules).

Simple Cafeteria Plans for Small Businesses (2010)
Effective for tax years after December 2010, the bill creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. A cafeteria plan is a written benefit plan maintained by an employer under which all participants are employees and each participant has the opportunity to select the particular benefits that he or she desires among a range of offered benefits. Under a cafeteria plan, employees may choose among two or more benefits consisting of cash (a taxable benefit) and qualified nontaxable benefits.

Medical Loss Ratios (2010)
For plan years starting six months after enactment, plans issuing individual or group health insurance are required to annually report the percentage of total premium revenue spent on reimbursement for clinical services; activities that improve health care quality; and all other "non-claims costs," excluding state taxes and licensing or regulatory fees. Health plans must provide rebates to consumers if their medical loss ratio (MLR) is less than 85% for large group coverage or 80% for individual and small group coverage. This MLR amount is on an aggregate, not a per policy basis.

Employer Mandates (2014)
Beginning in 2014, an annual penalty of $2,000 will be applied for firms with more than 50 employees that do not offer coverage. For employers with 50 or more workers, the new laws subtract the first 30 workers from the penalty calculation. The penalty for employees receiving a tax credit is the lesser of $3,000 for each employee receiving credit, or $2,000 per full-time worker. Part-time workers are included to determine whether an employer has 50 employees. An employee is considered full time if he or she works 30 or more hours per week.

New Mandates and Services to Which Montanans Should Pay Attention

Improving Consumer Information Through the Web (2010)
The new law requires the U.S. Department of Health and Human Services to establish an Internet website by July 2010 through which residents of a state can identify affordable health insurance options in that state. The website will also include information for small businesses, including coverage options, reinsurance for early retirees, and tax credits.

Improvements and Changes in Medicare and Medicare Advantage (2010)
Starting in 2011, if Medicare is a senior's primary form of health insurance, seniors will no longer have to pay for preventive care such as an annual physical, screenings for treatable conditions, or routine laboratory work. Certain Medicare Part D beneficiaries will get a $250 check from the federal government to help pay for prescription drugs currently not covered as a result of the Medicare Part D "doughnut hole." The doughnut hole refers to the gap in coverage that some Medicare Part D beneficiaries fall into when their drug costs are between $2,600 and $6,154 (these amounts are indexed for annual inflation). Depending on the coverage that Medicare Part D beneficiaries have, some beneficiaries may not have any prescription drug benefits when their drug costs reach this range. All Medicare Part D beneficiaries

have catastrophic coverage once their drug costs exceed $6,154.

As part of the new federal law, prescription drug assistance will be reduced starting in 2011 for high-income individuals and couples (making more than $85,000 as an individual or $170,000 combined income). More than 10 million people currently enrolled in a Medicare Advantage plan may be facing higher premiums because insurance company subsidies from the federal government will be reduced.

Access to a High-Risk Pool Option (2010)

The new federal health care laws establish a temporary national high-risk pool to provide health coverage to individuals with preexisting medical conditions who have not had coverage for six months or more. In Montana, there is already a high-risk pool alternative called the Montana Comprehensive Health Association (MCHA) to fulfill this role. Learn more at www.mthealth.org or 1-800-447-7828, Extension 2128. If a new high-risk pool supported by this new federal funding is created in Montana, it will likely be available in the second half of 2010 and will likely be administered by MCHA.

Flexible Spending Accounts (FSAs) Will Become Less Flexible (2013)

While there is no immediate impact on Montanans, starting in 2013 the new maximum annual contribution to flexible spending accounts will be $2,500. In addition, fewer services will qualify for FSA-qualified expenses. For example, people will no longer be able to use their FSA to help defray the cost of over-the-counter drugs unless the drug is prescribed by a physician or is insulin.

The "Montana Health Benefit Exchange" (2014)

The PPACA provides funding for the State of Montana (and all other states as well) to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014. The Exchange will be an Internet-based e-commerce website, allowing easy access to individuals who will be able to shop for a variety of health insurance products. Coverage and benefits of products featured on the Exchange will need to meet certain benefit standards as prescribed by the new health care laws. Individuals may continue to rely on insurance agents and consultants to help ensure that they are purchasing the most appropriate health care benefits for themselves and their family.

The Individual Mandate (2014)

Starting in 2014, individuals will have to purchase health insurance or risk being fined. The fines for not purchasing insurance will be levied based upon the greater of a flat dollar amount or a percentage of income. Starting in 2014, the lowest fine would be $95 per individual per year, or 1% of a person's income, and then increase to a high of $695, or 2.5% of an individual's taxable income by 2016.

Premium Subsidies/Tax Credits (2014)

If your income is under 400% of the federal poverty level, you may get assistance from the federal government in the form of tax credits to help you pay for the insurance.

Additionally, the health care reform laws mandate a reduction in the maximum out-of-pocket amounts that those under 400% of the poverty level have to pay. A cost-sharing subsidy for out-of-pocket health care costs will be available as well.

Increased Access to Medicaid (2014)

Beginning in 2014, Medicaid will be expanded to 133 percent of the poverty level ($14,404 for individuals and $29,326 for a family of four). It is expected that up to 100,000 people will be added to Medicaid in Montana at 133 percent of the poverty level.

High-Cost Health Plan Tax, Often Referred to as the "Cadillac Tax" (2018)

Beginning in 2018, a 40% excise tax will apply to premium amounts of over $10,200 for a single policy and $27,500 for a family policy.

Changes for Children and Youths Upon Which Parents Should Focus

"Healthy Montana Kids" Remains an Important Option (Current)

Healthy Montana Kids remains a good option for children who qualify. Learn more at www.hmk.gov. BCBSMT is a proud partner of the HMK program, which is Montana's version of the national Child Health Insurance Program (CHIP). Through the BCBSMT Caring Foundation, the HMK dental program was recently expanded significantly to allow for a much-improved dental benefit and greater access to dental care for HMK-enrolled children.

Medicaid Remains (Current)

Montanans who rely on Medicaid for health care

coverage of their children should not experience any significant disruption. In 2014, the new law does increase the number of people who qualify for Medicaid by expanding eligibility up to 133% of the poverty level. At 133% of the poverty level, it is estimated that up to 100,000 additional Montanans will be eligible for Medicaid. Interested Montanans can learn more at http://hmk.mt.gov/familyresources.shtml.

Children Allowed to Stay on their Parents' Health Care Plan Until Age 26 (2010)

Starting in September 2010, the new health care reform laws establish a national standard for allowing children to stay on their parents' health care plan. Going forward, if you have an adult child (married or unmarried), your child can stay on your insurance policy until he or she turns 26 years old. An exception applies until 2014 for those currently covered by a plan issued in the small group (less than 50 employees) market. Currently Montana law requires coverage for an unmarried dependent until age 25, so an additional year of coverage is afforded by the new federal law as long as the dependent child qualifies under the law.

No Preexisting Condition Exclusion for Children Under Age 19 (2010)

Starting in 2010, insurers cannot impose a preexisting condition exclusion on coverage of children under 19 years of age.

Discussion: There are Important Changes to Understand in the New Health Care Laws

You Cannot Be "Dropped"

This is a common statement made by advocates of the new law. This refers to a provision that makes it unlawful for a health insurance company to "drop" you (cancel your policy) if you get sick. As a not-for-profit, mutual benefit corporation dedicated to providing the most affordable, highest quality health care to Montanans, BCBSMT has no history of "dropping" members when they get sick. A small handful of members over the years have lost their coverage when false information was provided on their applications for coverage with BCBSMT. Fraud remains illegal in the new health care reform law, and insurers remain able to terminate the coverage of members who provide false information on their applications for coverage or otherwise attempt to defraud their insurers.

You Cannot Be Denied Insurance

This is another benefit of the new law. Starting in 2010, insurers cannot impose a preexisting condition exclusion on coverage of children under 19 years of age. Starting in 2014, an insurer has to accept anyone who applies for coverage.

Your Medical Care Dictates Your Coverage Limits

This refers to a provision in the new law that states that insurance companies can no longer institute lifetime caps on health care coverage. The reason for caps on coverage is to help keep the costs of members' premiums as low as possible. The few people who do exceed their coverage caps, which can be as low as $1 million or as high as $5 million, are currently able to convert their coverage to the Montana Comprehensive Health Association coverage, a high-risk health plan coverage alternative with which BCBSMT partners; those people also may have special opportunities to enroll in group coverage, if available, e.g., a spouse's group coverage. Insurers may still impose lifetime limits on "nonessential benefits." The government has yet to issue an exact definition of what benefits will fall within the "nonessential benefits" guidelines.

Answers to Questions Frequently Asked About the New Health Care Reform Laws

1. How will health care reform affect the cost of my premiums?

Short-term, BCBSMT members' premiums are not directly impacted by the new health care reform law. BCBSMT is doing everything possible to keep premiums low, including lowering our administrative costs, helping members get the right care at the right time from the right provider, and promoting the use of generic drug alternatives when appropriate.

It remains to be seen what impact on premiums will occur. People who are sick might face lower premiums because plans will not be permitted to charge sick people more than healthy people. However, healthier people might pay more. Older people could still be charged more than younger people, but the gap may not be as large.

The bigger question is what happens to rising medical costs, which drive up premiums. Even proponents of the new law acknowledge that efforts in the legislation to control health costs, such as a new board to oversee Medicare spending, won't have much of an effect, if any, for several years.

2. Will my insurance coverage be as good as it is today? How will it affect my policy?

If you are with BCBSMT, your coverage will continue to be high quality and provide you with easy access to in-network care providers. The BCBSMT network remains the best in the state, including more than 95 percent of Montana's doctors and medical providers and 100 percent of Montana hospitals.

3. How will the legislation affect young adults?

If you're an adult, but younger than age 26, you can generally stay on your parent's insurance coverage. This change will begin later this year but will require regulations that clearly spell out eligibility criteria.

In addition, starting in 2014 people in their 20s will be given the option of buying a "catastrophic" plan that will have lower premiums. The coverage will largely only kick in after the individual has $6,000 in out-of-pocket expenses. This provision takes effect in 2014. As more information is available about how this program is implemented, updates will be provided by BCBSMT.

4. Will age 26 dependent coverage be retroactive to January 1, 2010?

No, this provision will apply to plan years that are new or renew beginning in September 2010.

5. If there are no longer exclusions that deny access to insurance for people with preexisting medical conditions, will there be a waiting period for preexisting conditions?

This provision does not apply to all policies until 2014. In 2014 there may be open enrollment periods for people to purchase insurance. If a person does not purchase his or her insurance during the open enrollment period, it is possible that waiting periods could apply.

6. Will there be a cap on increases to insurance premiums?

No. However, plans will be required to meet medical loss ratios, and "excessive" rate increases will be reviewed by HHS in cooperation with state regulatory authorities.

7. I don't have health insurance. Will I have to get it, and what happens if I don't?

Under the new law, most Americans must have insurance by 2014 or pay a penalty. The penalty would start at $95, or up to 1 percent of income, whichever is greater, and rise to $695, or 2.5 percent of income, by 2016. This is an individual limit; families have a limit of $2,085, also starting in 2014. Some people can be exempted from the insurance requirement, called an individual mandate, because of financial hardship or religious beliefs or if they are American Indians, for example.

8. I want health insurance, but I can't afford it. What do I do?

Depending on your income, you might be eligible for Medicaid, the state-federal program for the poor and disabled, which will be expanded sharply beginning in 2014. Low-income adults, including those without children, will be eligible, as long as their incomes don't exceed 133 percent of the federal poverty level, or $14,404 for individuals and $29,326 for a family of four according to current poverty guidelines.

If you have children, Healthy Montana Kids remains a good option for children who qualify. Learn more at www.hmk.gov. BCBSMT is a proud partner of the HMK program, which is Montana's version of the national Child Health Insurance Program (CHIP).

9. What if I make too much for Medicaid but still can't afford coverage?

You might be eligible for government subsidies (premium credits) to help you pay for private insurance that would be sold in the new state-based insurance marketplaces called Exchanges, slated to begin operation in 2014. Premium subsidies will be available for individuals and families with incomes between 133 percent and 400 percent of the poverty level ($14,404 to $43,320 for individuals and $29,326 to $88,200 for a family of four).

10. How will the legislation affect the kind of insurance I can buy? Will it make it easier for me to get coverage, even if I have health problems?

If you have a medical condition, the new law will make it easier for you to get coverage; plans will be barred from rejecting applicants based on health status once the Exchanges are operating in 2014. In the meantime, the

law will create a temporary high-risk insurance pool for people with medical problems who have been rejected by plans and have been uninsured at least six months. This will occur this year. In Montana, the Montana Comprehensive Health Association fulfills this role. Learn more at www.mthealth.org or call 1-800-447-7828, Extension 2128.

Starting in 2010, insurers cannot impose a preexisting condition exclusion on coverage of children under 19 years of age. As well, they can no longer set lifetime coverage limits for adults and kids. In 2014, annual limits on coverage will be banned. Insurers may still impose lifetime limits on "nonessential benefits." The government has yet to issue an exact definition of what benefits will fall within the "nonessential benefits" guidelines.

New policies sold on the Exchanges will be required to cover a range of benefits, including hospitalizations, doctor visits, prescription drugs, maternity care, and certain preventive tests.

11. I own a small business. Will I have to buy insurance for my workers? If so, what help can I get?

It depends on the size of your firm. Companies with fewer than 50 workers will not face any penalties if they don't offer insurance.

Companies can get tax credits to help buy insurance if they have 25 or fewer employees and a workforce with an average annual employee wage of up to $50,000. Tax credits of up to 35 percent of the cost of premiums will be available this year and will reach 50 percent in 2014. The full credits are for the smallest firms with low-wage workers; the subsidies shrink as companies' workforce numbers and average wages increase.

Firms with more than 50 employees that do not offer coverage will have to pay an annual fee of up to $2,000 per full-time employee if any of their workers get government-subsidized insurance coverage in the Exchanges. The first 30 workers will be excluded from the assessment.

12. What's a cafeteria plan?

A cafeteria plan is a written benefit plan maintained by an employer under which all participants are employees and each participant has the opportunity to select the particular benefit that he or she desires among a range of offered benefits. Under a cafeteria plan, employees may choose among two or more benefits consisting of cash (a taxable benefit) and qualified nontaxable benefits. A common qualified nontaxable benefit is coverage under an accident or health plan.

A cafeteria plan can be funded by employer or employee contributions or a combination of both. Employee contributions for qualified benefits under a cafeteria plan generally are made on a pre-tax basis through salary reduction.

Cafeteria plans are subject to various rules, including what are called "nondiscrimination rules." Generally, this means that a plan may not discriminate in favor of highly compensated individuals as to eligibility for the plan or as to contributions and benefits.

The new laws provide for a "safe harbor" from the nondiscrimination requirements for cafeteria plans for small employers. The safe harbor would require that the cafeteria plan satisfy minimum eligibility and participation requirements and minimum contribution requirements.

The new health care reform laws establish a new simple cafeteria plan. Eligible employers for the cafeteria plan are those that employed an average of 100 or fewer employees on business days during either of the two preceding years.

Participation requirements for a simple cafeteria plan are met if:

(1) All employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and
(2) Each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

The contribution requirements are met if the employer is required to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to, without regard to whether a qualified employee makes any salary reduction contribution:

A uniform percentage (not less than 2 percent) of the employee's compensation for the plan year, or an amount that is not less than the lesser of:

(1) Six percent of the employee's compensation for the plan year; or,
(2) Twice the amount of the salary reduction contributions of each qualified employee.

13. I'm over 65. How will the legislation affect seniors?

The Medicare prescription-drug benefit will be improved substantially. This year, seniors who enter the Part D coverage gap, known as the "doughnut hole," will receive $250 a year from the federal government to help pay for their medications.

Drug company discounts on brand-name drugs and federal subsidies and discounts for all drugs will gradually reduce the gap, eliminating it by 2020. That means that seniors, who now pay 100 percent of their drug costs once they hit the doughnut hole, will eventually pay 25 percent of their drug costs out of pocket.

And, as under current law, once seniors spend a certain amount on medications, they will get "catastrophic" coverage and pay only 5 percent of the cost of their medications.

Meanwhile, government payments to Medicare Advantage, the private-plan part of Medicare, will be frozen starting in 2011, and cut in the following years. If you're one of the 10 million enrollees, you could lose extra benefits that many of the plans offer, such as free eyeglasses, hearing aids, and gym memberships. To cushion the blow to beneficiaries, the cuts to health plans in high-cost areas of the country such as New York City and South Florida — where seniors have enjoyed the richest benefits — will be phased in over as many as seven years.

Beginning this year, the law will make all Medicare preventive services, such as screenings for colon, prostate, and breast cancer, free to beneficiaries.

14. How much is all this going to cost? Will it increase my taxes?

The package of benefits and mandates incorporated into the new health care reform laws is estimated to cost $938 billion over a decade. But because of higher taxes and fees and billions of dollars in Medicare payment cuts to providers, the package is estimated to lower the federal budget deficit by $143 billion over 10 years, according to the Congressional Budget Office.

If you have a high income, you may face higher taxes. Starting in 2013, individuals will pay a higher Medicare payroll tax of 2.35 percent for individuals earning more than $200,000 a year and couples earning more than $250,000, up from the current 1.45 percent. Also, you will face an additional 3.8 percent tax on unearned income such as dividends and interest over the $200,000/$250,000 annual income threshold.

Starting in 2018, the law will also impose a 40 percent excise tax on the portion of most employer sponsored health coverage (excluding dental and vision) that exceeds $10,200 a year for individuals and $27,500 for families. The tax is often referred to as a "Cadillac" tax.

The law also will raise the threshold for deducting unreimbursed medical expenses from 7.5 percent of adjusted gross income to 10 percent for those people who itemize their deductions when determining their income taxes.

The law also will limit the amount of money you can put in a flexible spending account to pay medical expenses to $2,500 starting in 2013. The law also disallows paying for over-the-counter medication with flexible spending account dollars.

Starting in 2010, commercial tanning salons will pay a 10 percent tax, a cost that may be passed on to the consumer.

Rationale for Benefit Administration

Medical policy is developed through consideration of peer-reviewed medical literature, FDA approval status, accepted standards of medical practice in Montana, Technology Evaluation Center evaluations, and the concept of medical necessity. BCBSMT reserves the right to make exceptions to medical policy that benefits the member when advances in technology or new medical information become available.

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. Blue Cross and Blue Shield of Montana recognizes the rapidly changing nature of technological development and welcomes provider feedback on all medical policies.

When using this policy to determine whether a service, supply, or device will be covered, please note that member contract language will take precedence over medical policy when there is a conflict.

Federal Mandate

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

Advanced Member Notice

Participating providers can have a member complete and sign an Advanced Member Notification form stating that BCBSMT will not cover this service, supply, device, or drug. Refer to the Advanced Member Notification medical policy for more information.

The following new and revised medical policies were approved in April 2010 with the effective date listed in the policy. You may call BCBSMT at 1-800-447-7828 to request a copy.

Medical Policy: New

Medicine

- Allogeneic Hematopoietic Stem-Cell Transplantation for Genetic Diseases and Acquired Anemias
- Automated Point-of-Care Nerve Conduction Tests
- Chronic Intermittent Intravenous Insulin Therapy (CIIIT)
- Monitored Anesthesia Care (MAC) during Gastrointestinal Endoscopy
- Extracorporeal Photopheresis as a Treatment of Graft-versus-Host Disease, Autoimmune Disease, and Cutaneous T-Cell Lymphoma
- Gastric Electrical Stimulation
- Insulin Potentiation Therapy
- Low-Level Laser Therapy
- Noninvasive Measurements of Cardiac Hemodynamics in the Ambulatory Care-Outpatient Setting

Surgery: Procedures

- Cryoablation of Prostate Cancer
- Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors
- Cryosurgical Ablation of Primary or Metastatic Liver Tumors
- Percutaneous Transluminal Angioplasty of Intracranial Atherosclerotic Stenoses With or Without Stenting

Therapies

- Prolotherapy

BCBSMT

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.

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 (click on Providers, then Provider Manuals). If you have suggestions for improvement or content, email your Provider Network Service Representatives at HCS-X6100@bcbsmt.com or call 1-800-447-7828, Extension 6100.

Claims Processing Reminder

Blue Cross and Blue Shield of Montana does not follow Medicare's policy and compensation methodology associated with provider-based billing. Our system will deny Revenue Codes 510 and 519 on a UB04 claim. We recognize the professional services and compensate based on an RVU method.

Reprocessing of claims to change the place of service on the professional claim from 11 (office) to 22 (outpatient hospital) is not allowed. We will not allow the Revenue Code 510 to be changed to 761. Exceptions to this are Medicare secondary policies, BlueCard, VA claims, and RHC claims.

Provider Online Services Quick Reference Guide Updated

The Provider Online Services Quick Reference Guide has been updated with the latest information to help you use our online services. The Guide will help you navigate through our post-login features. It outlines step-by-step instructions for completing all the functionality to you as a Provider.

Register today to view claims, eligibility, benefits, and a host of useful information. Log on to www.bcbsmt.com and click on Providers to learn more.

If you experience problems registering, call the BCBSMT Online Services Hotline by calling 1-800-447-7828, Extension 2124 or email webdesk@bcbsmt.com.

Radiopharmaceutical Billing for Outpatient Laboratory, X-Ray, and Diagnostic Services

BCBSMT has implemented a change to its drug pricing methodology as outlined in the *Business Process Change Amendment for Participating Provider* letter mailed in November of 2009 and in the Drug Compensation Policy available at www.bcbsmt.com.

The following information clarifies how units of service are billed for certain radiopharmaceutical materials. These billing guidelines are consistent with those established by the Centers for Medicare and Medicaid (CMS).

A9500—Technetium tc-99m sestamibi, diagnostic, per study dose

- One unit of service equals one prepackaged syringe A9508---Iodine I-131 iobenguane sulfate, diagnostic, per 0.5 millicurie
- One unit of service equals one single dose vial (2 ml vial with total volume of 0.5 ml with total activity of, at calibration time, 1.15 mCi of Iobenguane Sulfate I 131 Injection)

A9536—Technetium Tc-99m depreotide, diagnostic, per study dose, up to 35 millicuries

- One unit of service equals 15 mCi A9542—Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries
- One unit of service equals 3.2 mg /2 ml A9548—Indium IN-111 pentetate, diagnostic, per 0.5 millicurie
- One unit of service equals one single dose vial (1 mCi/ml, 1.5 ml)

A9553—Chromium Cr-51, sodium chromate, diagnostic, per study dose, up to 250 microcuries

- One unit of service equals a 1.25 ml vial
- A9556—Gallium Ga-67 citrate, diagnostic, per millicurie
- One unit of service equals one single dose vial
- A9558—Xenon Xe-133 gas, diagnostic, per 10 millicuries
- One unit of service equals one single dose vial (10 mCi vial)

A9559—Cobalt Co-57 cyancobalamin, oral, diagnostic, per study dose up to 1 microcurie

- One unit of service equals one capsule

A9563—Sodium phosphate P-32, therapeutic, per millicurie

- One unit of service equals one single dose vial (0.67 mCi/ml, 7.5 ml

A9568—Technetium Tc-99m arcitumomab, diagnostic, per study dose, up to 45 millicuries

- One unit of service equals one single dose vial (1.25 mg/vial)

A9582—Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries

- One unit of service equals 10 mCi

If you have questions, email Health Care Services at HCS-X6100@bcbsmt.com.

Revised Fees for Specific Codes and Modifiers Effective July 1, 2010

In May 2010, the Centers for Medicare and Medicaid Services (CMS) revised the relative value units (RVUs) for approximately 6,744 codes and modifiers. BCBSMT uses CMS RVUs to calculate provider compensation, and the BCBSMT fee schedule will be updated with an effective date of July 1, 2010. The website will be updated no later than July 8, 2010.

Please note that the July 1 updates are not in conjunction with the sustainable growth rate discussions that are currently happening in Washington, D.C.

More information is available in our provider compensation policies published at www.bcbsmt.com. You must have a User ID and Password to review the compensation policies and fee schedules. If you have questions, call your provider representatives at 1-800-447-7828, Extension 6100, or email them to HCS-X6100@bcbsmt.com.

BlueCard®

Easier Access to Precertification/Preauthorization Information for Out-of-Area Blue Members

We are pleased to announce enhancements to the BlueCard Eligibility Line. These changes will improve your experience in verifying eligibility and obtaining precertification/preauthorization information for your out-of-area Blue patients. Please note the changes as follows.

If calling 1-800-676-BLUE (2583) to obtain precertification/preauthorization only:

Effective April 1, 2010, when precertifications/preauthorizations for a specific member are handled separately from eligibility verifications, your call will be routed directly to the area that handles precertifications/preauthorizations. You will choose from four options regarding the type of service for which you are calling:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Durable medical equipment (DME)

Upon making your selection, you will be transferred to the appropriate area of the member's Plan to handle your specific request.

If calling 1-800-676-BLUE (2583) to obtain eligibility only or if you need both eligibility and precertification/preauthorization:

Your call will be handled like it is today. You will select the option to obtain eligibility and precertification/preauthorization information. First, your eligibility inquiry will be addressed. Then you will be transferred, as appropriate, to the precertification/preauthorization area.

If you have any questions about the BlueCard Eligibility Line (1-800-676-BLUE), please email your Provider Network Service Representatives at HCS-X6100@bcbsmt.com or call 1-800-447-7828, Extension 6100.

Federal Employee Program

Never Events

Never Events are considered adverse events or errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients. Recently, Never Events have become an issue that requires attention by health insurance companies. In 2008, the Centers for Medicare and Medicaid Services (CMS) eliminated additional payments to hospitals for certain preventable conditions acquired during the hospital stay, as well as issued a National Coverage Determination that it would not cover wrong surgeries (e.g., wrong patient, wrong body part, or wrong procedure).

Additionally, national competitors and several states implemented similar Never Events policies, while Blue National Accounts have requested consistency in how the Blue Cross and Blue Shield Plans manage Never Events. Policy requirements were passed in March 2009 to create a consistent approach to address Never Events. The requirements became effective January 1, 2010, and apply to the Federal Employee Program (FEP) and Medicare Advantage Programs.

The FEP Never Events policy stipulates that Plans:

- Require all Preferred hospital providers to populate the Present on Admission (POA) field indicator on all inpatient hospital claims for all Never Events, as applicable.
- Not reimburse Preferred or Member hospitals for inpatient services related to Never Events from FEP Program funds.
- Require all Preferred and Member hospitals to hold members and the FEHB Program harmless for any inpatient services related to Never Events.

Note: The FEP Never Events policy applies to all inpatient acute hospital claims. Medicare A prime inpatient acute facility claims are exempt from FEP Never Events processing.

Implementation Policy

Effective for services performed on and after January 1, 2010, FEP Express will not provide benefits to Preferred facilities for the inpatient treatment of the hospital-acquired conditions listed in Table 1, nor for the E-Code medical diagnoses listed in Table 2.

Table 1 – List of Conditions or Events Defined as Hospital-Acquired Conditions with Diagnosis and Procedure Codes

Condition or Event	Diagnosis (DX) Codes	ICD-9 Procedure Codes (if required)
Foreign object retained after surgery	998.4, 998.7	
Air embolism	999.1	
Blood incompatibility	999.6	
Pressure ulcer stages III & IV	707.23, 707.24	
Falls and trauma (and DX codes' ranges)		
Fracture	800–829	
Dislocation	830–839	
Intracranial Injury	850–854	
Crushing Injury	925–929	
Burn	940–949	
Electric Shock	991–994	
Catheter-associated urinary tract infection	996.64	
Vascular catheter associated infection	999.31	
Manifestations of poor glycemic control	250.10–250.13, 250.2–250.23, 251.0; 249.10–249.11, 249.20–249.21	
Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)	519.2 with procedure codes	36.10 – 36.19
Surgical site infection following certain orthopedic surgeries	996.67, 998.59 with procedure codes	81.01–81.08, 81.23–81.24, 81.31–81.83, or 81.85
Surgical site infection following bariatric surgery for obesity	Principal diagnosis is 278.01, 998.59 with procedure codes	44.38, 44.39 or 44.95
Deep vein thrombosis or pulmonary embolism following total knee	415.11, 415.19; 453.40– 453.42 with procedure codes	00.85-00.87, 81.51–81.52, or 81.54

Table 2 – List of Procedures Defined as Preventable Medical Errors (PMEs), by Diagnosis Code

Condition or Event	Diagnosis (DX) Codes	ICD-9 Procedure Codes (if required)
Performance of inappropriate operation on correct patient (wrong surgery)	E876.5	NA
Performance of operation (procedure) intended for another patient (wrong patient)	E876.6	NA
Performance of correct operation (procedure) on wrong body part/side/site (wrong body part).	E876.7	NA

Pharmacy

Improving Health Outcomes with E-Prescribing

Effective July 1, 2010, BCBSMT is partnering with Prime Therapeutics, LLC (Prime) to offer providers electronic prescribing (e-prescribing) capabilities for our members that have Prime as their third-party drug vendor. Participation is voluntary, whether you are already connected to a point-of-care (POC) technology vendor, or your office decides to join this rapidly growing trend.

BCBSMT will incur all transactional charges related to our providers' use of this service; the only cost to providers is the initial investment in a POC vendor. Mark Meredith, PharmD, Pharmacy Program Director states: "Blue Cross and Blue Shield of Montana is proud to offer electronic prescribing functionality for our members and providers. E-prescribing is a proven means of reducing health care costs, administrative burden, and adverse medication events."

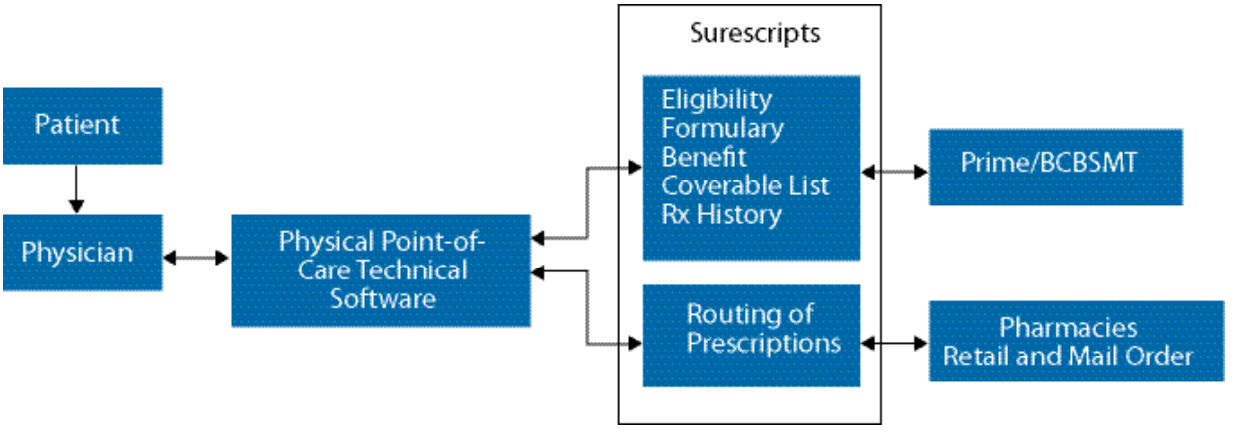
Prior to performing any e-prescribing function, patient consent must be given. You will then have access to certain information regarding member benefits.

Programs are in place to promote cost-effective, clinically appropriate, and safe medication therapy. Confirming a patient's formulary information and coverage lists conveys a cost savings to the patient that may have an impact on their adherence to therapy.

With e-prescribing you will be able to check and confirm information about the following:

- Eligibility
- Formulary
- Benefits
- Coverage List - Indicates those drugs that have specific coverage rules:
  - Step Therapy
  - Quantity Limits
  - Prior Authorization Requirements
  - Copayment list-indicates drug price level of member
- Prescription History

Surescripts is the switching company for our e-prescribing platform. The diagram below shows the process of e-prescribing. The entire process is real time and takes seconds to complete.



Prime defines Electronic Prescribing, or e-prescribing, as the process of creating, storing, and transmitting prescription information electronically, either by computer or hand-held device. E-prescribing allows prescribers to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point-of-care. The term "e-prescribing" does not apply to prescriptions either by fax or over the phone.

Surescripts website, www.surescripts.com, will provide certification status of your current POC vendor and also provide information on how to obtain certification status. If your office is already using an Electronic Health Record (EHR) system, this website will identify whether your system can be enabled for e-prescribing through the Surescripts network. If you would like to acquire software for e-prescription capabilities, you may also visit this website to review the e-prescribers buyer's guide to provide tips on choosing a POC vendor, and a list of vendors certified to connect to the Surescripts network. POC vendors and pharmacies in the Surescripts network will be notified by Surescripts that another payer (BCBSMT) has been added to their network.

The website also identifies pharmacies that integrate "e-prescriptions" into their order fulfillment. PrimeMail and Ridgeway Mail Order Pharmacy are both equipped to receive electronic prescriptions from physicians as well as send and receive refill request/response transactions. If you are unable to send an electronic prescription to either of these pharmacies, contact your POC vendor for assistance.

E-prescribing has been described as the solution to improved patient safety and reducing sky-rocketing medication costs. It is estimated that approximately 7,000 deaths occur each year in the United States due to medication errors. These errors are predominately due to hand-writing illegibility, wrong dosing, missed drug-drug or drug-allergy reactions. With approximately 3 billion prescriptions written annually, which constitutes one of the largest paper-based processes in the United States, the writing of prescriptions can be streamlined and efficient by using an e-prescribing system.

Current market trends show e-prescribing growing rapidly within the industry as it is being introduced at a steady pace to physicians, pharmacies, and payers. Provider acceptance is the key to e-prescribing success in the future. The POC technology vendor that provides support to prescribers is an important factor; knowing the way around your software is integral to the momentum of your e-prescribing practices. Integrating e-prescribing into your daily process can save time and promote positive outcomes in efficiency and patient safety.

Prime's e-prescribing technology and processes are compliant with Centers for Medicare and Medicaid Services (CMS) requirements.

For further information regarding our e-prescribing offerings, please call Melanie Bostrom, CPhT, Pharmacy Program Analyst, at 1-800-447-7828, Extension 6456.

Please contact your POC vendor for questions or training on the software you are utilizing.

Epocrates.com No Longer Supported

As a result of the new e-prescribing functionality, BCBSMT will no longer use epocrates.com to publish our formulary online.

TriCare/TriWest

Got a Claim? TriWest Improves Claims Search Capabilities

Based on user feedback and a usability study, TriWest Healthcare Alliance and its claims processor Wisconsin Physicians Services (WPS) have enhanced the claims search functionality on the secure website at www.triwest.com/provider.

Registered users now have several new search options to easily search and find claims associated with their office(s). Examples of the new search criteria are as follows:

- Search by process date
- Search by claim number
- Search by patient account number
- Search by check number
- Search by individual provider

In addition, the following improvements were also made:

- Added expandable help links
- Modified the search screen to make some fields optional
- Redesigned the claim search and result screens to make them more intuitive
- Added claim paid date information to the search results screen

Providers need to be registered to take advantage of these new changes and the many other benefits of the secure provider portal that include:

- Verify patient eligibility
- Research covered benefits and check referral/authorization and medical review requirements for specific codes
- Submit referrals/authorizations online and check their status regardless of how the request was submitted
- Submit claims online and check claim status regardless of how the claim was submitted
- Download remittance advices
- Claims correspondence/Webmail

For secure access to the TriWest website, simply click on the "Register Now" button to get started.

For more information, refer to the TRICARE Operations Manual at http://manuals.tricare.osd.mil/

Electronic Remittance Advice (ERA) Can Reduce Your Paperwork

The Electronic Remittance Advice (ERA) can help improve your business office workflow and productivity. ERA can be automatically loaded into your accounts receivable system, depending on your software.

Also known as the 835 transaction, your ERA can be a secure and reliable alternative to manually posting claim adjudication information to an accounts receivable software program and allow you more time to focus on caring for your patients.

How Does It Work?
Containing the same information on claim payment, deductible, and coinsurance, ERA is the electronic equivalent of the paper remittance advice (also known as Explanation of Benefits or EOB) and provides details on how your claims were processed.

As soon as your TRICARE claims are finalized, your ERA is generated.

What are the benefits of ERA?
Depending on your practice management system and internal workflow, ERA can improve your business office workflow and productivity by:

- Eliminating the need to manually enter and process paper EOBs
- Eliminating errors associated with manual posting of paper EOBs
- Eliminating the need to store and file paper EOBs
- Decreasing the time spent reconciling accounts receivable

How can I start receiving ERA?
To enroll, please download and complete the Electronic Remittance Advice (PDF) document or the fill-and-print version located at www.triwest.com, Find a Form tab, and return it to:

WPS Electronic Data Services
P.O. Box 8128
Madison, WI 53708-8128

When you choose to receive ERAs, your files will be sent to you in the ANSI (American National Standards Institute) X12 835 format, version 4010A1, and can be downloaded from the WPS Bulletin Board System (BBS) or through the secure website at www.triwest.com/provider.

For further information about ERA, refer to the *835 Electronic Remittance Advice Transaction guide* located in the EDI/Secure Web area of www.triwest.com/provider.

TriCare/TriWest Provider Roundtable July 13

TriWest Healthcare Alliance is hosting a provider education roundtable discussion in Billings on July 13, 2010. The roundtable runs from 9 to 11:30 a.m. at the Mansfield Education Center at Saint Vincent Healthcare. You must preregister, and there is no charge to attend the roundtable.

Each attendee will receive a new Provider Handbook and Quick Reference Guides. New information about the enhanced functionality of the secure provider portal will be presented along with review of current TriWest Healthcare policies and procedures.

You may register for this conference by emailing your provider relations representatives at HCS-X6100@bcbsmt.com. You will receive email confirmation and receive a reminder email about the date, time, and location. The seminar should last about 2.5 hours and includes time to ask questions.

If you have questions about the agenda, email HCS-X6100@bcbsmt.com or call 1-800-447-7828, Extension 6100.

Health Care Services

Provider Relations Updates

Health Care Services (HCS), commonly known as provider relations, is the department responsible for issues beyond the scope of the BCBSMT Customer Service Department, such as:

- Provider network development, maintenance, and credentialing
- Provider compensation analysis, methodologies, and implementation
- Provider database maintenance

Email Health Care Services at HCS-X6100@bcbsmt.com or call 1-800-447-7828, Extension 6100, for new provider contracts and provider contract questions, NPI questions, credentialing and re-credentialing status, provider workshops, and complex claims issues beyond the scope of Customer Service. If they are unavailable at the time of your call, your message will be returned within 24 hours.

Continue to contact Customer Service at 1-800-447-7828 for routine benefits, eligibility, and claims questions. You may also register with us at www.bcbsmt.com to view benefits, claims, and eligibility information online.

The provider service team has updated its website, provider fee schedules, and is preparing for this year's provider roundtable meetings.

Provider Roundtables

It's that time of year again!

Our Provider Account Consultants are beginning to schedule Provider Roundtable discussions for 2010. This is an informal, one-on-one group meeting for us to update you on new things within our organization and the insurance industry and also for you to bring your feedback and issues to discuss. Listed below are the popular topics of discussion from the past.

- Online Services Overview
- BlueCard
- Claims (billing and payment)
- TriCare/TriWest (military provider network)
- New BCBSMT updates
- Contracting

To schedule a roundtable discussion, please call your Provider Account Consultants at 1-800-447-7828, Extension 6100 or email HCS-X6100@bcbsmt.com.

TriCare/TriWest Provider Roundtable July 13

TriWest Healthcare Alliance is hosting a provider education roundtable discussion in Billings on July 13, 2010. The roundtable runs from 9 to 11:30 a.m. at the Mansfield Education Center at Saint Vincent Healthcare. You must preregister, and there is no charge to attend the roundtable.

Each attendee will receive a new Provider Handbook and Quick Reference Guides. New information about the enhanced functionality of the secure provider portal will be presented along with review of current TriWest Healthcare policies and procedures.

You may register for this conference by emailing your provider relations representatives at HCS-X6100@bcbsmt.com. You will receive email confirmation and receive a reminder email about the date, time, and location. The seminar should last about 2.5 hours and includes time to ask questions.

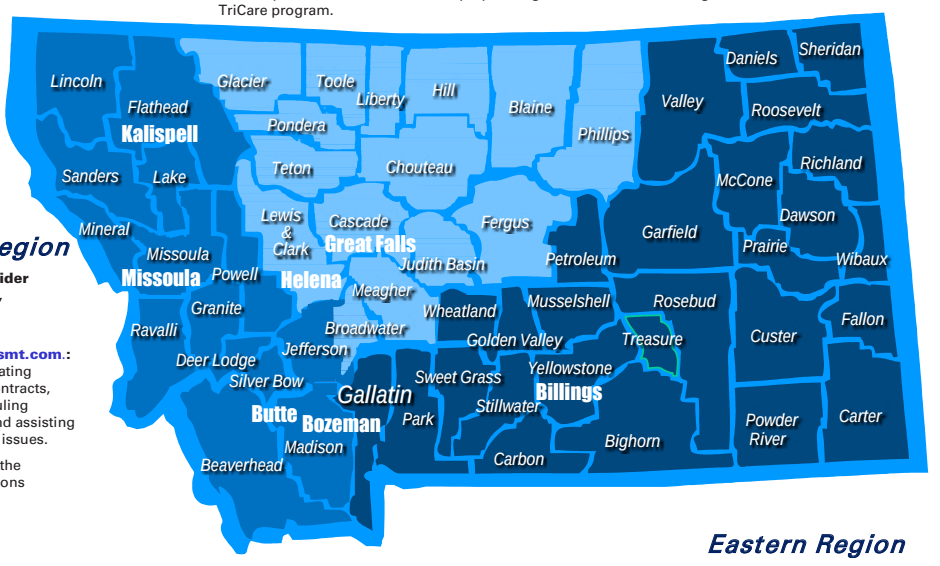
If you have questions about the agenda, email HCS-X6100@bcbsmt.com or call 1-800-447-7828, Extension 6100.

External Team

Central Region

Ronda DeMars, Provider Account Consultant, 1-800-447-7828, Extension 6067 Ronda_DeMars@bcbsmt.com: Responsible for negotiating provider and facility contracts, developing and scheduling education sessions, and assisting with complex provider issues .

Ronda specializes in the Federal Employee Program, Medicare Advantage, and TriCare program.



Western Region

Michelle Wirth, Provider Account Consultant,

1-800-447-7828 , Extension 6068 Michelle_Wirth@bcbsmt.com.: Responsible for negotiating provider and facility contracts, developing and scheduling education sessions, and assisting with complex provider issues.

Michelle specializes in the Department of Corrections program .

Internal Resource

Jenifer Sampson, Provider Account Consultant, 1-800-447-7828, Extension 6121 Jenifer_Sampson@bcbsmt.com

Jenifer is a designated internal resource responsible for assisting provider offices with resolving recurring problems, providing continuing education, and updating contracts, and is assigned to special projects.

Eastern Region

Julie Sakaguchi, Provider Account Consultant, 1-800-447-7828 , Extension 6122 Julie_Sakaguchi@bcbsmt.com: Responsible for negotiating provider and facility contracts, developing and scheduling education sessions, and assisting with complex provider issues .

Julie specializes in the BlueCard Program and Blue Distinctions and Care Sourcing.

Health Care Reform's Impact on the Fight Against Health Care Fraud

Health care fraud was a common subject in discussions leading up to the recently passed health care reform legislation. Now that health care reform is a reality, how does this legislation impact the fight against health care fraud? The following discussion focuses on provisions included in the original legislation (H.R. 3590), signed into law by President Obama on March 23, 2010. It also includes provisions in the "reconciliation" bill, which is identified as H.R. 4872.

The primary anti-fraud provisions of H.R. 3590 are contained in Title VI, beginning with Section 6401. These provisions include:

- Additional screening of providers (Section 6401)
- Requirement that providers and suppliers adopt compliance programs (Section 6401)
- Expanded data matching (Section 6402(a))
- Beneficiary involvement in fraud schemes (Section 6402)
- Return of overpayments (Section 6402)
- Kickbacks as false claims (Section 6402)
- Suspension of payments (Section 6402)
- Increased funding for anti-fraud effort (Section 6402(i))
- Specific changes related to the provision of DME supplies and home health care services (Sections 6405, 6406, and 6407)
- Enhanced penalties
- Additional criminal sentencing provisions

The reconciliation legislation (H.R. 4872) includes a smaller number of anti-fraud provisions, with the inclusion of the following:

- Additional funding for anti-fraud activities, which appears to be in addition to the funding from the original legislation
- Additional oversight of DME suppliers

You can research the details of these provisions on your own, but in summary, providers will be held more accountable through additional screening and mandatory compliance programs, additional activities will be added under the definition of false claims, funding of anti-fraud activities will be increased by as much as $105 million per year between 2011 and 2020, and penalties for the commission of a fraud will be increased. More details will be available as these programs are put into place.

If you have questions or concerns about fraud or questionable practices, call our fraud hotline at 1-800-621-0992, or you may email us at fraud@bcbsmt.com. More information is also available on our website at 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 21 years, and he has received the DPHHS Inspector General's Integrity Award for his work in health care fraud. Karl has also 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 5214, or by email at kkrieger@bcbsmt.com.

Participating Providers: March 1 to April 30, 2010

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, they received a new effective date and are listed below.

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

Marc E. Adams, MD	Shelby	Family Medicine
Steven J. Ayres, MD	Great Falls	Gastroenterology
Carissa A. Benjamin, DPT	Missoula	Physical Therapy
Bradford A. Bergman, MD	Great Falls	Internal Medicine
Barbara J. Burke, PA-C	Hamilton	Physician Assistant
Scott L. Burnett, DDS	Cut Bank	Dentist
Sally Ann R. Chisholm, SLP	Missoula	Speech Therapy
Steven M. Chrzanowski, MD	Great Falls	Internal Medicine
Christopher M. Corsi, MD	Kalispell	Endocrinology, Diabetes, & Metabolism
Eula M. Crippen, LCPC	Butte	Licensed Clinical Professional Counselor
Marcy L. Daly, DPT	Victor	Physical Therapy
Richard Lee Gallager, MD	Billings	Pathology
Sonya M. Gilson, FNP	Great Falls	Nurse Practitioner
Mitchell J. Goff, MD	Billings	Ophthalmology
Thomas R. Hoffman, MD	Butte	Child Psychiatry
Gregory S. Houlihan, DO	Superior	Family Medicine
Mackay J. Hull, DDS	Billings	Oral Surgery
Arlynn D. Irish, PA	Miles City	Physician Assistant
Tory B. Katz, MD	Bozeman	Internal Medicine
Leonard W. Keppler, DDS	Livingston	Dentist
Kids Behavioral Health of Montana	Butte	Residential Treatment Facility
Sean E. Knighton, MSN	Chester	Nurse Practitioner
Justin L. Knowles, MD	Helena	Emergency Medicine
Martin A. Koyle, MD	Missoula	Urology
Deborah M. Lewis, FNP	Great Falls	Nurse Practitioner
Robert D. Marks, MD	Ennis	Family Medicine
Neal M. Maxfield, CRNA	Great Falls	Certified Registered Nurse Anesthetist
Kevin A. McCafferty, MD	Great Falls	Emergency Medicine
Elizabeth E. McCarthy, FNP	Great Falls	Nurse Practitioner
Joan Marie McMahon, MD	Lewistown	Internal Medicine
John J. Meehan, MD	Missoula	Pediatric Surgery
Georgia A. Milan, MD	Missoula	Family Medicine
Orthopedic Center of Montana	Great Falls	Surgery Center
Gina M. Painter, DPM	Great Falls	Podiatry
Kristen L. Park, MD	Billings	Neurology w Special Qualifications in Child Neurology
Judy A. Rigby, MD	Kalispell	Pediatrics
Camille M. Ristroph, MD	Dillon	Family Medicine

Joel C. Rutherford, DPM	Billings	Podiatry
Ruth L. Sampson, MD	Billings	Endocrinology, Diabetes, & Metabolism
Darci L. Sgrignoli, OT	Bozeman	Occupational Therapy
Alan H. Shaw, DPM	Bozeman	Podiatry
Brock M. Smith, CRNA	Great Falls	Certified Registered Nurse Anesthetist
Virginia H. Spradlin, LCSW	Whitefish	Licensed Clinical Social Worker
James M. Summers, DO	Missoula	Obstetrics and Gynecology
Lori E. Swenson, OT	Bozeman	Occupational Therapy
The Birth Center	Missoula	Birthing Center
Bridget T. Troy, LCSW	Great Falls	Licensed Clinical Social Worker
Robert P. Wagner, DMD	Billings	Dentist
Brett M. Williams, FNP	White Sulphur Springs	Nurse Practitioner
Glenn A. Winslow, MD	Great Falls	Surgery
Bert W. Winterholler, DDS	Billings	Oral Surgery

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

Daniel F. Alderman, MD	Bozeman	Radiology
David E. Anderson, MD	Great Falls	Internal Medicine
Sandra S. Appleby, FNP	Bozeman	Nurse Practitioner
Andrew A. Barber, DO	Great Falls	Emergency Medicine
Cindy Bartling, MSW	Missoula	Licensed Clinical Social Worker
Julia A. Bell, MD	Hamilton	Psychiatry
Bradford A. Bergman, MD	Great Falls	Internal Medicine
Derek A. Biby, PT	Whitefish	Physical Therapy
Leroy N. Biesheuvel, PA-C	Broadus	Physician Assistant
Barbara L. Boik, LCPC	Bozeman	Licensed Clinical Professional Counselor
Peter L. Burleigh, MD	Great Falls	Obstetrics and Gynecology
Gregory P. Burton, MD	Helena	Ophthalmology
Patrick J. Cahill, MD	Billings	Neurology
Margaret L. Carnegie, MD	Missoula	Family Medicine
Marcel C. Chappuis, PHD	Thompson Falls	Psychology
Steven M. Chrzanowski, MD	Great Falls	Internal Medicine
Lianna M. Danielson, FNP	Bigfork	Nurse Practitioner
Lianna M. Danielson, FNP	Whitefish	Nurse Practitioner
Rich T. Danielson, PT	Missoula	Physical Therapy
Kirsten K. Daugherty, SLP	Butte	Speech Therapy
Stuart A. Davis, MD	Billings	Orthopaedics
Jose C. DeSouza, MD	Bozeman	Endocrinology, Diabetes, & Metabolism
Jose C. DeSouza, MD	Butte	Endocrinology, Diabetes, & Metabolism
Jose C. DeSouza, MD	Great Falls	Endocrinology, Diabetes, & Metabolism

Participating Providers

Mary C. DeSouza, NP	Great Falls	Nurse Practitioner
Tami R. Dieruf, NP	Great Falls	Nurse Practitioner
Scott M. Dreblow, PA-C	Boulder	Physician Assistant
Barbara J. Eckstein, FNP	Bozeman	Nurse Practitioner
Dana Eisenberg, LCSW	Missoula	Licensed Clinical Social Worker
Stacie B. Erfle, OT	Belgrade	Occupational Therapy
Stacie B. Erfle, OT	Bozeman	Occupational Therapy
Laura M. Ferries, MD	Billings	Internal Medicine
Tricia M. Flohr, PT	Belgrade	Physical Therapy
Tricia M. Flohr, PT	Bozeman	Physical Therapy
David M. Fortenberry, MD	Cut Bank	Surgery
David M. Fortenberry, MD	Kalispell	Surgery
Cindy H. Gallea, NP	Frenchtown	Nurse Practitioner
Cindy H. Gallea, NP	Lolo	Nurse Practitioner
Cindy H. Gallea, NP	Missoula	Nurse Practitioner
Cindy H. Gallea, NP	Seeley Lake	Nurse Practitioner
Arthur W. Giebel, MD	Great Falls	Ophthalmology
Jennifer L. Gilliard, LCPC	Butte	Licensed Clinical Professional Counselor
Daniel A. Gold, MD	Big Sandy	Family Medicine
Barry N. Haicken, MD	Whitefish	Surgery
Kathryn L. Hall, PA-C	Billings	Physician Assistant
Cathie S. Henneberry, FNP	Miles City	Nurse Practitioner
Michael J. Hennessy, MD	Great Falls	Orthopaedics
Forest D. Henning, LCSW	Missoula	Licensed Clinical Social Worker
William B. Howard, MD	Hot Springs	Radiology
William B. Howard, MD	Plains	Radiology
William B. Howard, MD	Ronan	Radiology
William B. Howard, MD	Superior	Radiology
Thomas R. James, MD	Billings	Family Medicine
Harlen H. Johnson, DC	Bigfork	Chiropractic
Steven P. Johnson, MD	Butte	Anesthesiology
Steven P. Johnson, MD	Kalispell	Anesthesiology
Donna D. Johnson-Jensen, LCPC	Glasgow	Licensed Clinical Professional Counselor
Kevin T. Kelly, MD	Great Falls	Anesthesiology
Judith A. Kurien, LCSW	Alberton	Licensed Clinical Social Worker
John F. Lee, MD	Polson	Surgery, Vascular
John G. MacCart, MD	Harlowton	Family Medicine
Christopher Martinez, PT	Billings	Physical Therapy
Christopher Martinez, PT	Bozeman	Physical Therapy
Rachel M. Mattern, PA-C	Helena	Physician Assistant
Alisha J. McGinnis, OD	Great Falls	Optometry
Michael J. McLaughlin, PHD	Great Falls	Psychology
Alexia S. Mehrle, MD	Bozeman	Emergency Medicine

Participating Providers

Georgia A. Milan, MD	Florence	Family Medicine
Frank L. Miller, MD	Havre	Obstetrics and Gynecology
Patricia A. Moran, MD	Belgrade	Family Medicine
Patricia A. Moran, MD	Manhattan	Family Medicine
Thomas M. Morris, SP	Butte	Speech Therapy
Nicholas J. Okon, DO	Billings	Neurology
Gina M. Painter, DPM	Great Falls	Podiatry
Lindy K. Paradise, MD	Bozeman	Radiology
Fred W. Pickering, DC	Red Lodge	Chiropractic
Sarah E. Pocker, PT	Kalispell	Physical Therapy
Sarah E. Pocker, PT	Whitefish	Physical Therapy
Michael G. Rhode, MD	Bozeman	Pathology
Charles F. Rinker, MD	Bozeman	Surgery
Kari S. Ritter, MD	Bozeman	Internal Medicine
Brian M. Rost, PT	Missoula	Physical Therapy
Cynthia F. Rubio, MD	Bozeman	Rheumatology
Amy E. Rue, LCPC	Belgrade	Licensed Clinical Professional Counselor
Michael Alex Sirr, MD	Helena	Emergency Medicine
Katherine M. Sluder, FNP	Helena	Nurse Practitioner
Pamela S. Smith, MD	Miles City	Pediatrics
Shelby N. Smith, DC	Missoula	Chiropractic
Myra H. Sommers, LCSW	Dillon	Licensed Clinical Social Worker
Seth A. Spanos, MD	Cut Bank	Family Medicine
Candace K. Stearns, APRN	Billings	Nurse Practitioner
Lance L. Stewart, MD	Great Falls	Family Medicine
Michael J. Susich, DDS	Billings	Dentist
Duane M. Swanz, OD	Billings	Optometry
Anna R. Taft, LCSW	Missoula	Licensed Clinical Social Worker
Charles C. Talton, MD	Anaconda	Family Medicine
Janet A. Thomas, MD	Great Falls	Pediatrics
Mary A. Thompson, OT	Bozeman	Occupational Therapy
Jonnelle D. Tucker, PA	Big Sandy	Physician Assistant
Kim W. Waterfall, MD	Hamilton	Family Medicine
Nina E. Wendt, PHD	Great Falls	Psychology
Nina E. Wendt, PHD	Helena	Psychology
Nina E. Wendt, PHD	Wolf Creek	Psychology
Nina E. Wendt, PHD	Wolf Point	Psychology
Stacy L. Whitaker, DO	Great Falls	Obstetrics and Gynecology
Jamey D. Williams, PT	Great Falls	Physical Therapy
Glenn A. Winslow, MD	Great Falls	Surgery
Patrick M. Wolberd, LCSW	Livingston	Licensed Clinical Social Worker
Mary M. Wolf, MD	Harlowton	Family Medicine
Mary M. Wolf, MD	Lewistown	Family Medicine

Reed L. Yeater, MD	Polson	Emergency Medicine
Robert Zelman, DO	Great Falls	Interventional Cardiology
Robert Zelman, DO	Missoula	Interventional Cardiology

Blue Cross and Blue Shield of Montana welcomes these new managed care providers.

Marc E. Adams, MD	Shelby	Family Medicine
Elizabeth M. Allen, LAC	Helena	Licensed Addiction Counselor
Steven J. Ayres, MD	Great Falls	Gastroenterology
Amy C. Berghold, FNP	Belgrade	Nurse Practitioner
Bradford A. Bergman, MD	Great Falls	Internal Medicine
Joseph E. Bilau, PT	Kalispell	Physical Therapy
Kate L. Blakeslee, PA	Billings	Physician Assistant
Carol S. Blum, PHD	Hamilton	Psychology
David C. Boharski, CRNA	Butte	Certified Registered Nurse Anesthetist
Joseph D. Boland, LCSW	Great Falls	Licensed Clinical Social Worker
Robin L. Boland, MSN	Great Falls	Nurse Practitioner
Broadwater Health Center	Townsend	Hospital
Ammie M. Chapman, DC	Lewistown	Chiropractic
Sally Ann R. Chisholm, SLP	Missoula	Speech Therapy
Steven M. Chrzanowski, MD	Great Falls	Internal Medicine
Joseph R. Colella, OD	Bozeman	Optometry
Christopher M. Corsi, MD	Kalispell	Endocrinology, Diabetes, & Metabolism
Melissa A. Dacumos-Pizarro, OD	Great Falls	Optometry
Marcy L. Daly, DPT	Victor	Physical Therapy
Patrick M. Donahoe, EDD	Bozeman	Licensed Clinical Professional Counselor
Jane E. Fineberg, MSW	Bozeman	Licensed Clinical Social Worker
Jody L. Fink, OD	Bozeman	Optometry
Gretchen L. Fowell, FNP	Great Falls	Nurse Practitioner
Richard Lee Gallager, MD	Billings	Pathology
Lynette F. Gordy, NP	Billings	Nurse Practitioner
Marcella E. Grayson, LCSW	Butte	Licensed Clinical Social Worker
Marcella E. Grayson, LCSW	Anaconda	Licensed Clinical Social Worker
William A. Hahnstadt, PHD	Missoula	Psychology
Kim N. Hawkins, PT	Kalispell	Physical Therapy
Alyson E. Hinderager, FNP	Great Falls	Nurse Practitioner
Pauline A. Hohenberger, OT	Billings	Occupational Therapy
Gregory S. Houlihan, DO	Superior	Family Medicine
Jamey L. Ivey, LCPC	Great Falls	Licensed Clinical Professional Counselor
Cynthia K. Johnson, OD	Bozeman	Optometry
Janice B. Johnson, LCSW	Kalispell	Licensed Clinical Social Worker
Michael G. Johnson, DC	Hamilton	Chiropractic
Tory B. Katz, MD	Bozeman	Internal Medicine

Participating Providers

Kids Behavioral Health of Montana	Butte	Residential Treatment Facility
Neil E. Kidwell, LCSW	Billings	Licensed Clinical Social Worker
Douglas J. Kimball, OD	Bozeman	Optometry
William D. Kirsh, DO	Billings	Family Medicine
Martin A. Koyle, MD	Missoula	Urology
Jennifer A. Krueger, PA-C	Butte	Physician Assistant
Donna J. Langston, LCPC	Red Lodge	Licensed Clinical Professional Counselor
Shannon K. Lee, PA-C	Kalispell	Physician Assistant
Deborah M. Lewis, FNP	Great Falls	Nurse Practitioner
Sandra M. Lippy, LCSW	Billings	Licensed Clinical Social Worker
James B. MacMillan, MD	Miles City	Obstetrics and Gynecology
Lynnda L. MacMillan, NP	Miles City	Nurse Practitioner
Robert D. Marks, MD	Ennis	Family Medicine
Neal M. Maxfield, CRNA	Great Falls	Certified Registered Nurse Anesthetist
Kevin A. McCafferty, MD	Great Falls	Emergency Medicine
Elizabeth E. McCarthy, FNP	Great Falls	Nurse Practitioner
Joan Marie McMahon, MD	Lewistown	Internal Medicine
Kyle D. McMurray, OD	Bozeman	Optometry
Lisa A. McNamee, LCPC	Livingston	Licensed Clinical Professional Counselor
John J. Meehan, MD	Missoula	Pediatric Surgery
Timothy J. Messer, PT	Missoula	Physical Therapy
Georgia A. Milan, MD	Missoula	Family Medicine
Tamara A. Nava, LCPC	Hamilton	Licensed Clinical Professional Counselor
Orthopedic Center of Montana	Great Falls	Surgery Center
Gina M. Painter, DPM	Great Falls	Podiatry
Kristen L. Park, MD	Billings	Neurology w Special Qualifications in Child Neurology
David B. Powell, LCSW	Livingston	Licensed Clinical Social Worker
Jill C. Powell, PA-C	Billings	Physician Assistant
Coda E. Reynolds, FNP	Butte	Nurse Practitioner
Judy A. Rigby, MD	Kalispell	Pediatrics
Camille M. Ristroph, MD	Dillon	Family Medicine
Ruth L. Sampson, MD	Billings	Endocrinology, Diabetes, & Metabolism
Darci L. Sgrignoli, OT	Bozeman	Occupational Therapy
Renee K. Sharpsten, PA-C	Great Falls	Physician Assistant
Alan H. Shaw, DPM	Bozeman	Podiatry
Walter F. Shore, LAC	Billings	Licensed Addiction Counselor
Charyl C. Skates, LCPC	Bozeman	Licensed Clinical Professional Counselor
Patricia L. Skergan, DC	Missoula	Chiropractic
Brock M. Smith, CRNA	Great Falls	Certified Registered Nurse Anesthetist
James M. Summers, DO	Missoula	Obstetrics and Gynecology
Ann C. Szalda-Petree, LCSW	Missoula	Licensed Clinical Social Worker
Rainya D. Taylor, LCPC	Billings	Licensed Clinical Professional Counselor

The Birth Center	Missoula	Birthing Center
Michael M. Ulrich, LCSW	Billings	Licensed Clinical Social Worker
Brett M. Williams, FNP	White Sulphur Springs	Nurse Practitioner
Glenn A. Winslow, MD	Great Falls	Surgery
Carol L. Winters, LCPC	Kalispell	Licensed Clinical Professional Counselor

The following providers are no longer participating with the managed care provider network.

Daniel F. Alderman, MD	Bozeman	Radiology
David E. Anderson, MD	Great Falls	Internal Medicine
Sandra S. Appleby, FNP	Bozeman	Nurse Practitioner
Andrew A. Barber, DO	Great Falls	Emergency Medicine
Tondy M. Baumgartner, LCSW	Missoula	Licensed Clinical Social Worker
Julia A. Bell, MD	Hamilton	Psychiatry
Bradford A. Bergman, MD	Great Falls	Internal Medicine
Derek A. Biby, PT	Whitefish	Physical Therapy
David C. Boharski, CRNA	Great Falls	Certified Registered Nurse Anesthetist
Peter L. Burleigh, MD	Great Falls	Obstetrics and Gynecology
Gregory P. Burton, MD	Helena	Ophthalmology
Patrick J. Cahill, MD	Billings	Neurology
Heather M. Cashell, MSW	Hamilton	Licensed Clinical Social Worker
Marcel C. Chappuis, PHD	Thompson Falls	Psychology
Steven M. Chrzanowski, MD	Great Falls	Internal Medicine
Paul B. Coats, FNP	Kalispell	Nurse Practitioner
Paul B. Coats, FNP	Columbia Falls	Nurse Practitioner
Lianna M. Danielson, FNP	Bigfork	Nurse Practitioner
Rich T. Danielson, PT	Missoula	Physical Therapy
Stuart A. Davis, MD	Billings	Orthopaedics
Jose C. DeSouza, MD	Great Falls	Endocrinology, Diabetes, & Metabolism
Mary C. DeSouza, NP	Great Falls	Nurse Practitioner
Tami R. Dieruf, NP	Great Falls	Nurse Practitioner
Scott M. Dreblow, PA-C	Bozeman	Physician Assistant
Laura M. Ferries, MD	Billings	Internal Medicine
Tricia M. Flohr, PT	Bozeman	Physical Therapy
David M. Fortenberry, MD	Kalispell	Surgery
Cindy H. Gallea, NP	Seeley Lake	Nurse Practitioner
Cindy H. Gallea, NP	Frenchtown	Nurse Practitioner
Cindy H. Gallea, NP	Missoula	Nurse Practitioner
Cindy H. Gallea, NP	Lolo	Nurse Practitioner
Arthur W. Giebel, MD	Great Falls	Ophthalmology
Jennifer L. Gilliard, LCPC	Butte	Licensed Clinical Professional Counselor
Barry N. Haicken, MD	Whitefish	Surgery

Participating Providers

Kathryn L. Hall, PA-C	Billings	Physician Assistant
Michael J. Hennessy, MD	Great Falls	Orthopaedics
Forest D. Henning, LCSW	Missoula	Licensed Clinical Social Worker
William B. Howard, MD	Ronan	Radiology
William B. Howard, MD	Superior	Radiology
William B. Howard, MD	Plains	Radiology
William B. Howard, MD	Hot Springs	Radiology
Thomas R. James, MD	Billings	Family Medicine
Harlen H. Johnson, DC	Bigfork	Chiropractic
Steven P. Johnson, MD	Kalispell	Anesthesiology
Kevin T. Kelly, MD	Great Falls	Anesthesiology
Jennifer A. Krueger, PA-C	White Sulphur Springs	Physician Assistant
Judith A. Kurien, LCSW	Alberton	Licensed Clinical Social Worker
John F. Lee, MD	Polson	Surgery, Vascular
John G. MacCart, MD	Harlowton	Family Medicine
Rachel M. Mattern, PA-C	Helena	Physician Assistant
Alisha J. McGinnis, OD	Great Falls	Optometry
Georgia A. Milan, MD	Stevensville	Family Medicine
Georgia A. Milan, MD	Florence	Family Medicine
Frank L. Miller, MD	Havre	Obstetrics and Gynecology
Patricia A. Moran, MD	Belgrade	Family Medicine
Gina M. Painter, DPM	Great Falls	Podiatry
Lindy K. Paradise, MD	Bozeman	Radiology
Sarah E. Pocker, PT	Whitefish	Physical Therapy
Sarah E. Pocker, PT	Kalispell	Physical Therapy
Charles F. Rinker, MD	Bozeman	Surgery
Kari S. Ritter, MD	Bozeman	Internal Medicine
Cynthia F. Rubio, MD	Bozeman	Rheumatology
Amy E. Rue, LCPC	Belgrade	Licensed Clinical Professional Counselor
Renee M. Schoening, LCPC	Deer Lodge	Licensed Clinical Professional Counselor
Pamela S. Smith, MD	Miles City	Pediatrics
Shelby N. Smith, DC	Missoula	Chiropractic
Myra H. Sommers, LCSW	Dillon	Licensed Clinical Social Worker
Seth A. Spanos, MD	Cut Bank	Family Medicine
Candace K. Stearns, APRN	Billings	Nurse Practitioner
Holly C. Strong, MD	Great Falls	Internal Medicine
Charles C. Talton, MD	Anaconda	Family Medicine
Janet A. Thomas, MD	Great Falls	Pediatrics
Michael M. Ulrich, LCSW	Billings	Licensed Clinical Social Worker
Kim W. Waterfall, MD	Hamilton	Family Medicine
Stacy L. Whitaker, DO	Great Falls	Obstetrics and Gynecology
Johnny L. Willcut, FNP	Kalispell	Nurse Practitioner

Jamey D. Williams, PT	Great Falls	Physical Therapy
Glenn A. Winslow, MD	Great Falls	Surgery
Mary M. Wolf, MD	Harlowton	Family Medicine
Robert Zelman, DO	Missoula	Interventional Cardiology