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THE CAPSULE NEWS℠

℠Service Marks of Blue Cross and Blue Shield of Montana

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS — THIRD QUARTER 2005

SAVE FOR FUTURE REFERENCE

SAVE FOR FUTURE REFERENCE

from the CEO

It is an honor and privilege for me to have recently been selected by the Board of Directors to serve as the President and CEO of Blue Cross and Blue Shield of Montana (BCBSMT), and I am looking forward to meeting and working with you over the coming months and years.

Our vision at BCBSMT is to be the health plan of choice for Montanans. To make that vision a reality, we will focus on our core business, that is, providing coverage and peace of mind for thousands of Montanans; we must earn the respect of Montanans by setting high ethical standards as a company; and we must excel as an innovative leader in offering access to affordable, quality health-care coverage for Montanans. But having grown up in Montana and devoting the past 31 years to BCBSMT, I know your help is absolutely essential to make our vision a reality!

Over the years, your willingness to partner with us has provided our 230,000 members with an extensive network of physicians, professionals, and hospitals. We thank you for all you have done in the past. But we all have more to do, and only by working together as partners can we find solutions to the health care crisis facing Montanans; only by working together can we reduce the high number of uninsured Montanans.

Through our ongoing partnerships with you and other Montana health care providers, we have made great strides over the years in providing access to health care to thousands of Montanans. It is through these partnerships that we can provide products like Blue Care, which offers low-income, uninsured Montanans lower premiums for basic health care coverage. Together with you and the Montana Department of Health and Human Services, we launched the Children's Health Insurance Program (CHIP) and have been able to provide health insurance to more than 10,000 low-income Montana children. Through the Caring Foundation of Montana, you have helped over 5,000 uninsured children receive basic preventive health care services. Thank you!

Working together with you for more than six decades, we have accomplished many good things in Montana, and I look forward to working with all of you to accomplish even more.

We have a great team of professionals at BCBSMT, each with a deep spirit to serve Montanans, and I am very proud to be their leader and have the opportunity and challenge to see that our fellow citizens have access to the best health insurance available in Montana.

I want to hear from you and get your thoughts. Please call me at (406) 444-8267 or on our toll-free line at 800-447-7828, or send me an email at Sherry@bcbsmt.com. If I am not immediately available, leave me a message, and I will get back to you as soon as possible.

Sincerely,

Sherry L. Cladouhos

2005 HEALTH CARE TEAM SERVICES PROVIDER WORKSHOPS
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Blue Cross and Blue Shield of Montana is working

UNDERSTANDING THE BCBSMT DRIVERS OF HEALTH CARE COSTS

Blue Cross and Blue Shield of Montana (BCBSMT) is working hard to keep health care affordable and accessible. Since its creation in the early 1940s, BCBSMT has provided protection and peace of mind for its members when they needed it most when their health is at stake. Today, BCBSMT continues this tradition by working to ensure its members, and in fact, all Montanans have access to affordable health care.

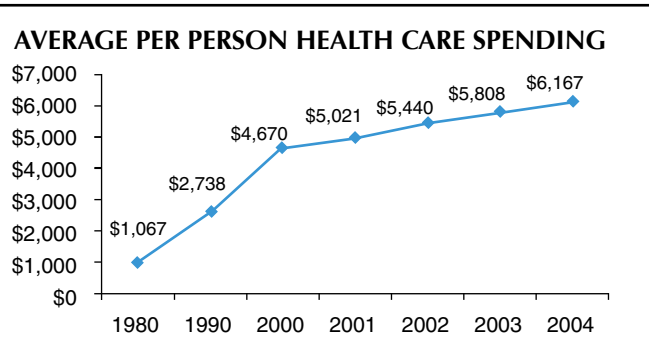
Accessible and affordable health care is a top concern not only for businesses and individuals, but also for our state's leadership. As health care costs continue to increase, so does the cost of health insurance. The result is more people go without this important protection.

Today, 19% of Montana's population does not have health insurance placing us among the ten states with the highest percentage of uninsured. In this article, we address three cost issues that affects all Montanans:

- Some reasons health care costs are increasing.
- How these costs impact health insurance premiums.
- What BCBSMT is doing to help contain these costs.

HOW MUCH DO WE SPEND ON HEALTH CARE?

In 2000, the average amount each person in the United States spent on health care was $4,670. By 2004, that amount increased 32% to $6,167. The following graph illustrates spending per person since 1980. According the Center for Medicare and Medicaid Services (CMS) this upward trend is expected to continue and by 2014, per person spending is estimated to rise to $11,045. In Montana in 2004, the average amount each person spent on health care was $4,963.



WHAT CAUSES HEALTH CARE COSTS TO INCREASE?

A variety of factors are contributing to the higher cost of health care. Let's take a closer look at the nine major contributing factors to increased health care costs.

1. **Demographics**

   The population in the United States is aging, and people use more health care services as they get older, which in turn leads to higher health care costs. The problem will become more acute as the first wave of Baby Boomers hits Medicare age in 2013. By 2020, 16.5% of the country's total population will be over 65 compared to 12.7% in 2000. Currently in Montana, 13.4% of our population is over the age of 65.

2. **Health Status**

   Overall, the health status of the population in the United States is not good. While heredity plays a big role in overall health, lifestyle, diet, and physical activity are equally important. Studies show that obesity–defined as at least 20% over ideal body weight–is dramatically increasing. In 2002, 31%, or about 51 million Americans, were classified as obese. Significant health care cost increases, both for health services (diabetes, heart disease, and joint and back problems) and for medications, are tied directly to obesity. In Montana, about 18% of the population is considered obese.

WHAT BCBSMT IS DOING?

At BCBSMT, we have a full-time Wellness and Innovative Product Coordinator who assists employer groups in the delivery of wellness and health promotion services which are de-

THIRD QUARTER 2005

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Production
Fleming Graphics

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BlueCross BlueShield of Montana

hard to keep health care affordable and accessible"

signed to strategically impact worker health and productivity. Recently, we introduced Well With Blue℠ , a health promotion and wellness program for our employer groups.

3. **Chronic Disease**

   Chronic disease, such as cancer, heart disease, diabetes, allergies, asthma, and arthritis, require long-term medical care. New treatments are lengthening the life span of the chronically ill and improving their quality of life, but these benefits come at a cost.

WHAT BCBSMT IS DOING?

At BCBSMT, we have implemented a disease management program for our members who suffer from chronic diseases. Our goal is to help them better understand their condition and what they can do to manage their disease and minimize complications and long-term effects.

4. **Technology Advances**

   Improvements in existing technology and the rapid implementation of new technologies have improved our ability to treat illness and injury. These advances come at a cost. For example, in Montana, an MRI/CT scan of the neck and head costs approximately $1,250 per procedure compared to about $50 for a standard X-ray. Over the next five years, the annual compound growth rate in the use of MRIs alone is expected to be more than 12%.

WHAT BCBSMT IS DOING?

Reviews indicate that some of these scans are performed unnecessarily, so BCBSMT partnered with several Montana radiology groups to launch a program to reduce unnecessary diagnostic scans. These radiologists work directly with physicians to review whether various procedures proposed for a patient are medically necessary and/or appropriate for the symptoms. In one month alone, 907 proposed MRI and CT scans were reviews. The radiologists disallowed 19, thereby saving costs on unnecessary procedures.

5. **Demand for, and Variability of, Hospital and Physician Services**

   Americans are heavy consumers of medical services, as evidenced by the dramatic increases in per capita health care spending. Hospital and physician services represent the largest share of our health care dollars. As usages increases, so does the cost of providing the services; physicians and hospitals need more staff, office space, and equipment. A national shortage of nurses and other medical professional also means higher wages to recruit and retain personnel. Those increased costs of doing business are passed on to the consumer.

   Physician costs for BCBSMT members increased 27% from $79 per service in 1999 to $100 per service in 2003. From 1999 to 2003, charges for hospital outpatient services for BCBSMT members rose from $455 to $621 per case or 36%. Inpatient charges from1999 to 2003 rose from $2,011 to $2,815 per day or 40%. The cost per service increased at the same time the total number of services or utilization also increased.

WHAT BCBSMT IS DOING?

At BCBSMT, we are developing educational materials to help our member be wiser health care consumers. In 2005, we are partnering with physicians and a hospital in the state to develop a "pay for performance" pilot program through which delivery of services becomes more standardized.

6. **Prescription Drug Costs and Usage**

   In 1992, the average American had just over seven prescriptions per year; by 2001, the number had jumped to ten prescriptions with the top 50 best-selling drugs accounting for 45% of the sales. Drug sales increased to $184 billion in 2003, and direct-to-consumer advertising plays an important role in this increase. Consumers are more aware of new drugs for specific ailments, and they often request the name-brand drug from their physician. Pharmaceutical companies pass the costs of advertising to consumers through the sale of the name-brand drug.

WHAT BCBSMT IS DOING?

Because of the impact drug spending has on insurance premium costs, BCBSMT has been educating members and encouraging the use of generic drugs when available. The use of generic drugs can reduce health care costs while still preserving health care quality. In 2005, the average price difference between the brand-name drug and its generic equivalent was about $54.

As a result of our education efforts, the use of generic drugs increased to 52.7% in the third quarter of 2004, compared to 47.8% in the same quarter of 2003.

BCBSMT also developed and distributed a drug handbook listing all drugs now available, both brand-name and generic, for specific conditions or problems and the associated costs of each. Armed with this handbook, our members can take a more active role in working with their medical professionals to ensure they are getting the best value for their money.

7. **Regulations**

   Federal and State legislators and agencies develop new laws and regulations that apply to insurers annually. Such rules and regulations may require business enhancements that must be implemented and followed. For example, the Health Insurance Portability and Accountability Act–Privacy Provision (HIPAA), which went into effect in April 2003, requires health care providers, including insurance companies, to follow certain guidelines to maintain the privacy of their customers or patients. Another portion of HIPAA standardizes how insurance companies must process claims electronically. BCBSMT estimates that its cost

continued next page

UNDERSTANDING THE DRIVERS OF HEALTH CARE COSTS

BCBSMT

continued

of complying with HIPAA's privacy provisions exceeded $5,000,000.

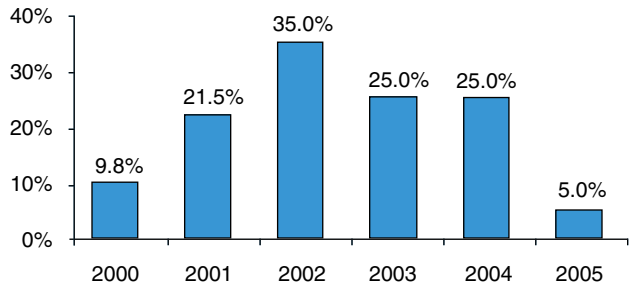
Some laws and regulations apply to benefit requirements. Such mandated benefits cause health care and insurance costs to increase because demand for the benefit increases. Additionally, everyone must pay higher insurance premiums to cover the cost of providing the mandated benefit. For example, the addition of mandated contraceptives would increase the cost per person by $1.30 to $5.00 for a family of four. Mandated benefits through 2003 increased the cost of insurance premiums $15.50 per member per month or $62.00 for a family of four.

Currently, BCBSMT is licensed under Title 33 of the Montana Code Annotated as a Health Service Corporation. A Health Service Corporation is defined as a non-profit corporation which is organized or operated for the purposes of establishing and operating a non-profit plan or plans under which prepaid hospital care, medical-surgical care, and other health care and services, or reimbursement therefore, may be furnished to a member or beneficiary. BCBSMT is regulated by the State of Montana and the Federal Government.

8. Litigation

Litigation, or protecting against it, also increases costs. As the number of medical lawsuits increases, so does the cost of medical malpractice insurance. In Montana, premiums for medical malpractice insurance have nearly triples since January 2000, according to Utah Medical Insurance, a malpractice insurance carrier for the Montana Medical Association. This cost is passed on to the consumer in the form of higher fees for medical services.

MONTANA MEDICAL MALPRACTICE INSURANCE RATE INCREASES 2000-2005



To guard against lawsuits, medical professionals may practice defensive medicine, i.e., performing unnecessary tests and procedures merely to prevent potential lawsuits.

9. Consequences of a Large Uninsured Population

Approximately 41 million Americans are uninsured–almost 15% of the nation's population, according to the Kaiser Foundation, a non-profit private operating foundation focusing on the major health care issues facing the nation.

Montana's uninsured rate of 18.9% ranks among the top ten states. This is not surprising because Montana ranks 44th in per capita income, and 85% of the Montana jobs are in small businesses where group health coverage is less likely to be offered.

Uninsured Montanans can be found in all walks of life–they are not simply low-income individuals or the unemployed. As insurance premiums continue to rise to address increasing health care costs, healthy individuals may choose to get along without coverage, so they simply drop their insurance to save money. That impacts everyone else's health insurance premiums because as the number of healthy people in the insurance pool decreases, premiums to the remainder must go up to cover the associated costs.

Additionally, when the uninsured get sick, they may delay treatment, resulting in worsening health and the need for more costly treatment. Many uninsured may be unable to pay for services they receive. These costs are then passed on to those who have insurance. This is known as cost shifting. Health care professionals who provide services to the uninsured end up increasing the fees for their insured patients to covert the cost of charity and bad debt. Cost shifting also results from low reimbursement rates for government programs that may fall below the actual cost of delivery of care.

WHAT BCBSMT IS DOING?

To help address Montana's large uninsured population, BCBSMT, along with a group of Montana physicians and hospitals, created Blue Care, a lower-cost basic benefit plan for low-income, uninsured Montanans. The participating physicians and hospitals accept significantly reduced payments from BCBSMT for their services to hold the cost of premiums at a level that more Montana workers can afford.

BCBSMT also supports the Caring Foundation of Montana, a nonprofit 501(c)(3) corporation that provides primary and preventive health care services at no cost to low-income, uninsured Montana children and mammograms and prostate cancer screenings to low-income, uninsured adults. The Foundation operates exclusively on donations, and every dollar donated is used for health care services because BCBSMT provides all the administrative support for the program, including medical payment and contracting. Medical professionals and providers across the state partner with the Foundation under agreements to receive significantly lower payments for their services.

SO WHO PAYS FOR HEALTH CARE?

Federal, state, employer, and private health insurance plans pay more than 80% of all health care costs. However, from 1993 to 2000, the share of Federal revenues devoted to health care declined, so the share paid by state and private employers has increased. At the same time, the insured consumers share of health care costs has remained fairly steady. Therefore, a significant component in combating these spiraling costs is consumer education.

THE IMPACT OF INCREASED COSTS ON INSURANCE PREMIUMS

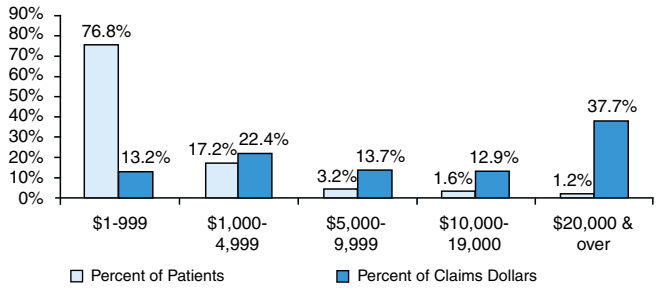
Premium costs for group health insurance rose over 50% between 2000 and 2004, with employers absorbing most of the increase. Premiums for individual insurance coverage have also increased significantly. As health care costs increase, so does the amount the health insurer must pay to the medical professionals and providers. As more advanced and expensive treatments become available, those costs are reflected in the cost of the premiums.

For example, in 1993, BCBSMT handled 457 cases costing more than $50,000 each. A decade later in 2003, BCBSMT handled 247 cases over $100,000 averaging $178,368 per case. In the first half of 2004, cases over $100,000 surpassed the 2003 total with 279 cases averaging $168,000, totaling $47,004,940.

As the following chart indicates, high-cost cases ($10,000 and above) comprised 50.6% of all dollars paid out by BCBSMT in 2003. The chart also illustrates some of the basic principles of how insurance "risk" works and why rates increase even for those members who have far fewer claims or claims that are significantly less than $10,000.

All plan participants become part of the risk pool but approximately 77% of members receive only 13% of the total claims payments. However, these members help bear the cost of about 1.2% of members who have claims reimbursements in excess of $20,000.

2003 COMMUNITY GROUP CLAIMS VS. DISTRIBUTION BY CLAIM SIZE*

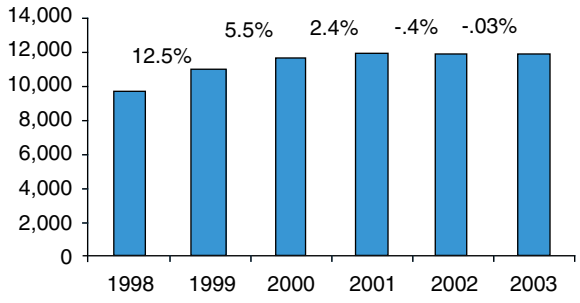


* Source: Based on services and charges for Blue Cross and Blue Shield of Montana Members

New and more expensive treatment is only part of the continuing increase in costs. Even for routine hospitalization, the charge per case has increased 61% since 1996, from $6,208 to more than $10,000 in 2003.

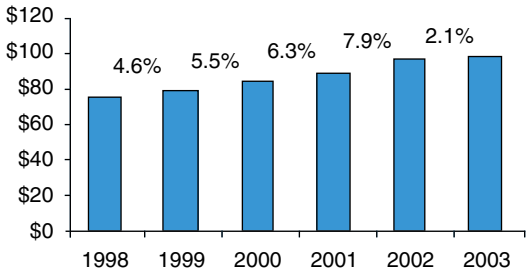
Not only are the charges per service increasing, but also each covered member is receiving more services. The following graphs reflect the steady increases experienced since 1998 by BCBSMT in professional provider services and their costs.

PROFESSIONAL PROVIDER SERVICES/1,000 MEMBERS



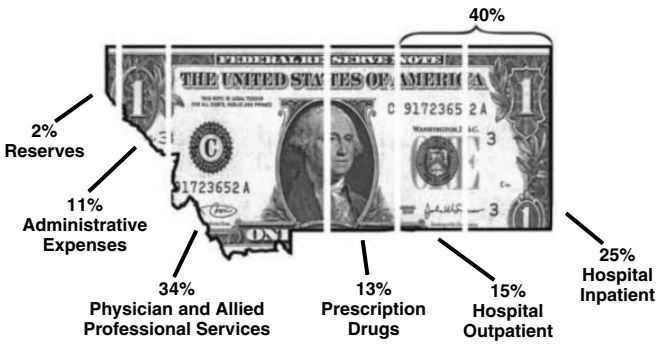
* Source: Based on services and charges for BCBSMT Members

PROFESSIONAL PROVIDER CHARGE/SERVICE*



* Source: Based on services and charges for BCBSMT Members

HOW MEMBER DOLLARS ARE SPENT



Blue Cross and Blue Shield of Montana Member Experience January through June 2004

Rising health care costs directly drive premium increases, while administrative costs and net revenues remain small components of premiums. 11% for administrative expenses pays for BCBSMT operational costs. The fastest growing components of administrative costs are customer service changes and information technology, both of which are required to meet new HIPAA regulations.

More information about the factors driving up the cost of health care is available at www.bcbs.com/mcrg/index.html and www.bcbs.com/coststudies.

MEDICAL POLICY

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

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

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

NEW POLICIES

ARTIFICAL INTERVERTEBRAL DISC

Chapter: Surgery - Procedures
Upcoming/Revised Policy
Effective Date:
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DESCRIPTION

Artificial intervertebral disc replacement surgery, also referred to as total disc replacement or spinal arthroplasty, has been used internationally for over 15 years. On October 26, 2004, the FDA approved the CHARITE™ Artificial Disc for use in the United States. As part of the FDA approval, the manufacturer of the CHARITE™ disc, DePuy Spine, agreed to conduct a postapproval study using a maximum of 366 subjects to evaluate the long-term safety and effectiveness of the device. Study subjects will be evaluated for a total of five years post-implantation.

An alternative to artificial disc replacement is spinal fusion that is controversial partly because of the difficulty in determining whether a patient's back pain is related to degenerative disc or facet disease and partly because of the modest rate of success with the procedure itself. In addition, spinal fusion alters the biomechanics of the back, potentially leading to premature disc degeneration at adjacent levels.

In contrast, artificial discs are designed to restore disc height and to seek to preserve normal physiologic motion at the operative level and normal biomechanics of the adjacent vertebrae. The first FDA-approved artificial disc uses two metal endplates that are press-fit into adjacent vertebrae and a central-free polyethylene core. This central component is held into place by the surrounding normal soft tissues (such as ligaments and the disc annulus) and shifts dynamically with the disc space during spinal motion.

POLICY

Prior authorization is recommended.

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

MEDICALLY NECESSARY

BCBSMT considers the use of the CHARITE™ artificial intervertebral disc medically necessary for patients who meet all of the following criteria:

- Are at least 18 years old and skeletally mature.
- Have a diagnosis of degenerative disc disease located at L4/L5 or L5/S1 that causes chronic pain and disability confirmed by patient history and radiographic studies.

  Note: Chronic pain and disability must be demonstrated by a minimum pain score of 40 mm using a 100 mm visual analog scale (VAS) and a disability score of 40 or greater using the Oswestry Disability Index (ODI), and the patient also should have a normal psychometric profile (by pain diagram and consideration of Waddel signs).
- Have only one level of disease involvement when considering the operative site and its adjacent discs.

  Note: Adjacent discs must have normal appearance on a CT or MRI, and if the adjacent disc is mildly abnormal in appearance, the patient must have discography studies that confirm the adjacent disc is not a source of pain.
- Have failed an adequate trial of conservative, non-surgical treatment for at least six months.

INVESTIGATIONAL

BCBSMT considers the use of artificial intervertebral disc surgery investigational for patients with any of the following contraindications:

- Replacement of more than one disc.
- Replacement of a disc located outside of L4/S1.
- The presence of any of the following conditions at the planned operative site (which includes adjacent levels):
  - Isolated radicular compression syndromes due to disc herniation determined by a MRI or CT scan showing lateral recess stenosis; however, consideration for compensation will be given in cases where previously present radicular compression has largely resolved as demonstrated by a pain map (at least 80% of the pain in the back and less than or equal to 20% radicular compression) and radiologic studies.
  - Moderate or severe degenerative facet disease.
  - Greater than 3 mm of spondylolisthesis.
  - Unilateral or bilateral spondylolysis.

- Prior spinal fusion.
- Previous spinal surgery at the same level, except for: discectomy, laminotomy, or nucleolysis.
- Discectomy or decompression with remaining posterior lesion.

- The presence of any of the following spinal conditions:
  - Scoliosis greater than 10 degrees.
  - Bony lumbar stenosis.
  - Spinal tumor.

  Note that Degenerative disc disease at a non-continguous segment should be carefully evaluated.
- The presence of any of the following extraspinal or systemic conditions:
  - Obesity with a body mass index of 35 or greater.
  - Metal allergy or sensitivity to implant materials.
  - Pregnancy.
  - Autoimmune disorder.
  - Active systemic infection or infection localized to the site of implantation.
  - Patients at risk for osteoporosis such as postmenopausal women, or individuals with a past history of steroid use. Such patients should have pre-operative bone density studies. The presence of osteopenia is a relative contraindication, and the presence of osteoporosis with T scores of >2.5 is an absolute contraindication.
  - A chronic condition which might require use of steroids in the future.

CODING

CPT CODES

0091T (July 2005).

22899 Unlisted procedure, spine.

49999 Unlisted procedure, abdomen, peritoneum or omentum.

NEW DRUG POLICIES

HMG CoA REDUCTASE INHIBITORS (ALTOPREV, CRESTOR, LESCOL/XL, PRAVACHOL)

Chapter: Drugs
Effective Date: July 1, 2005
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DESCRIPTION

HMG CoA reductase inhibitors (HMGs) are the agents of choice for the management of elevated low-density lipoprotein cholesterol. All of these agents have relatively similar effectiveness and tolerability; however, recent studies suggest that Crestor may have a more potent lipid lowering effect and higher toxicity.

Drug	Average Decrease In Cholesterol	Average Increase In HDL Cholesterol	Average Decrease In Triglycerides	Familial Hypercholesterolemia	Tolerability
lovastatin	16 - 34%	2 - 9.5%	None	Hetero only	<3% stop
Lipitor	24 - 45%	5 - 9%	17 - 37%	Yes	<2% stop
Zocor	19 - 36%	11 - 16%	12 - 34%	Yes	<1% stop
ALTOPREV See Generic Lovastatin					
Crestor	33 - 46%	8 - 22%	10 - 35%	Yes	<4% stop
Lescol/Xl	8 - 27%	6 - 11%	12 - 23%	Hetero only	<1% stop
Pravachol	16 - 33%	2 - 12%	11 - 24%	Hetero only	<2%
From Mosby's Drug Consult, Copyright © 2005 Mosby, Inc					

POLICY

The purpose of this policy is to promote the use of evidence-based, cost-effective HMG CoA reductase inhibitors. Prescriptions for generic and/or formulary drugs, i.e., lovastatin, Lipitor, and Zocor, do not require prior authorization.

Effective July 1, 2005, BCBSMT requires members try one of the drugs listed in the table above and meet one of the criteria for exceptions below before it will approve a prescription for the non-formulary drugs, Altoprev, Crestor, Lescol/XL, or Pravachol.

Prior authorization is recommended.

Member pharmacy benefits are contract-specific, and most, but not all, contracts recommend prior authorization.

BCBSMT will approve Altoprev, Crestor, Lescol/XL, or Pravachol if the member has tried one of the formulary drugs and meets any one of the following criteria:

1. The patient has tried lovastatin, Lipitor, or Zocor and experienced myopathy. The patient must try one other generic and/or formulary drug before BCBSMT will approve Altoprev, Crestor, Lescol/XL or Pravachol.
2. The patient has tried lovastatin at a dose of 40 mg/day but has not achieved LDL-C goals.
3. A patient has tried lovastatin at doses lower than 40 mg/day (e.g., 10 mg/day, 20 mg/day) but cannot tolerate further dose escalation up to 40 mg/day.
4. At baseline, the patient requires more than a 30% reduction in LDL-C to meet NCEP ATP III LDL-C goals.
5. The patient has a diagnosis of homozygous familial hyperlipidemia, hypertriglyceridemia, or primary dysbetalipoproteinemia. Authorization for Zocor or Lipitor may be given without a prior trial of lovastatin.
6. The patient is using an HMG for secondary prevention of CV or other clinical events (e.g., thrombotic stroke, coronary bypass surgery, acute coronary syndromes, MI, coronary revascularization, acute coronary syndromes, or vascular claudication). BCBSMT will approve Zocor.

MEDICAL POLICY

7. If the patient requires use of agents that have a noted drug/drug interaction with lovastatin, then a trial of lovastatin is not required, and Lipitor or Zocor may be authorized. Some specific examples of drug interactions with lovastatin include concomitant use of potent inhibitors of cytochrome P450 (CYP) 3A4 (e.g., itraconazole, ketoconazole, erythromycin, clarithromycin, HIV protease inhibitors, and nefazodone). Also, a patient receiving cyclosporine, gemfibrozil, other fibrates, or lipid-lowering doses of niacin (greater than or equal to one g/day), should not use doses of lovastatin greater than 20 mg/day. A patient receiving amiodarone or verapamil should not exceed 40 mg/day of lovastatin. Other drug/drug interactions not noted in this policy may also be clinically significant.
8. Exceptions are not recommended without first trying lovastatin in the following circumstances:
   - Patient with a diagnosis of low HDL-C. Other HMGs are FDA-approved for this indication, and lovastatin is not; however, other lipid-lowering agents or lovastatin can be used.
   - Use for the primary prevention of CHD. Lovastatin has an FDA-approved indication for this use based on the positive clinical results noted in the Air Force/ Texas Coronary Atherosclerosis Prevention Study.
   - Adolescent patients and children. Lovastatin is indicated as an adjunct to diet to reduce total-C, LDL-C and apolipoprotein B levels in adolescent boys and girls, 10-17 years old, with heterozygous familial hypercholesterolemia.

LEUKOTRIENE PATHWAY INHIBITORS (ACCOLATE, SINGULAIR)

Chapter: Drugs
Effective Date: July 1, 2005
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DESCRIPTION

This policy addresses the use of the following leukotrine inhibitors:

- Accolate (zafirlukast) (non-formlary).
- Singulair (montelukast) (formulary).

Accolate is FDA approved for the prophylaxis and chronic treatment of asthma in adults and children ages five and older. Singulair is FDA approved for the prophylaxis and chronic treatment of asthma in adults and children ages 12 months and older. It is also FDA approved for the relief of symptoms of seasonal allergic rhinitis in adults and children ages two and older.

The National Asthma Education and Prevention Program (NAEPP) and the National Heart, Lung, and Blood Institute (NHLBI) expert panel concluded that low-dose inhaled corticosteroids are the preferred treatment over leukotriene pathway inhibitors for mild persistent asthma in adults and children. The leukotriene pathway inhibitors are an alternative treatment (not preferred) to be considered when "patient circumstances regarding administration of inhaled corticosteroids warrants selection of oral treatment." These guidelines recommend that leukotriene pathway inhibitors may be used in combination with inhaled corticosteroids for adults and children with moderate persistent asthma.

Leukotriene inhibitors have also been used for the treatment of seasonal nasal allergies. Nationally established guidelines indicate that intranasal steroids are the appropriate first-line treatment for seasonal nasal allergies.

POLICY

The purpose of this policy is to promote the use of evidence-based, cost-effective medications.

Effective July 1, 2005, *prior authorization is recommended.*

Member pharmacy benefits are contract-specific, and most, but not all, contracts recommend prior authorization.

Singulair or Accolate may be approved under the following circumstances:

1. Patients with asthma or reactive airway disease.
   - For patients agefive and older -- Accolate (zafirlukast) (non-formlary).
   - For patients under five years old -- Singulair (montelukast) (formulary).
2. For patients with allergic rhinitis, BCBSMT allows the use of Singulair only after members have tried at least one product in two of the following three groups. Exceptions are not recommended for Accolate. Accolate is not FDA approved for this indication and was no better than a placebo for seasonal allergic rhinitis (SAR) in one small study.

Group 1

- Astelin Nasal Spray (formulary).

Group 2

- A nasal corticosteroid.
- Formulary options such as Flonase, Nasonex, Vancenase.
- Non-formulary options such as Beconase, Beconase AQ, Nasalide, Nasarel, Nasacort, Nascort AQ, Rhinocort AQ.

Group 3

- Non-sedating antihistamines such as Alavert, Alavert D, Allegra, Allegra-D, Clarinex, Clarinex D, Claritin (over-the-counter), Claritin D (over-the-counter), and Zyrtec.

3. Patients with chronic urticaria should have tried one of the oral antihistamines listed in Group 3 or hydroxyzine. If these drugs have been tried, BCBSMT will approve Singulair or Accolate, whichever is a formulary drug.
4. Patients with atopic dermatitis should have tried a prescription topical corticosteroid or a topical immunomodulator (Elidel, Protopic). If one of these drugs has been tried, BCBSMT will approve Singulair. Exceptions are not recommended for Accolate. Controlled trials are needed to establish the efficacy of Accolate for atopic dermatitis.
5. In infants with acute respiratory syncytial virus bronchiolitis, BCBSMT

will approve Singulair (montelukast) (formulary). Exceptions are not recommended for Accolate because it has not been studied for this indication.

6. Interstitial cystitis. Singular can be prescribed only if the patient has tried two alternative therapies for this condition (e.g., tricyclic antidepressants (amitriptyline, doxepin, imipramine), antihistamines (hydroxyzine, cimetidine), pentosan polysulfate (Elmiron®), aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), phenazopyridine (Pyridium), oxybutynin (Ditropan), nifedipine (Procardia), gabapentin (Neurontin), intravesicular therapy (dimethyl sulfoxide, hyaluronic acid, heparin, Bacillus Calmette-Guerin)).

Exceptions are not recommended for the following:

- Bronchitis. These agents have not been studied for this indication.
- A sole diagnosis of COPD. Singulair and Accolate have not been adequately studied for this indication. Long-term studies are needed to determine efficacy in COPD; however, if a patient has COPD with an asthmatic component (e.g., secretions), refer to Criteria 1 – Patients with Asthma or Reactive Airway Disease.
- The prevention or treatment of capsular contracture post-breast implantation. Additional trials are needed to determine the efficacy of these agents.
- The management of dysmenorrhea. One study found no difference between Singulair and a placebo in the management of menstrual symptoms.
- The treatment of cystic fibrosis. Additional trials are needed to determine the efficacy of these agents; however, if a patient has cystic fibrosis with an asthmatic component, refer to Criteria 1 – Patients with Asthma or Reactive Airway Disease.
- The treatment of chronic pancreatitis. One study found no difference between montelukast and a placebo in any of the efficacy parameters measured.
- The treatment or prophylaxis of vulvovaginal candidiasis. Additional trials are needed to determine the efficacy of these agents.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (CELEXA, LEXAPRO, PAXIL CR, PEXEVA, PROZAC WEEKLY, SARAFEM, ZOLOFT)

Chapter: Drugs
Upcoming/Revised Policy
Effective Date: July 1, 2005
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DESCRIPTION

Selective serotonin reuptake inhibitors (SSRIs) are a class of oral drugs used to treat a wide range of mood and anxiety disorders including, but not limited to, the following:

- Obsessive compulsive disorder (OCD).
- Panic disorder.
- Social anxiety disorder (social phobia).
- Post-traumatic stress disorder (PTSD).
- Bulimia-nervosa.
- Generalized anxiety disorder (GAD).

A number of SSRIs are available in both brand name and generic form. Each may be highly effective for some patients and not for others. Finding the right medication for each patient is often a process of trial and error, and no well-established guidelines exist to aid in determining which drug to try first. See next page for a table of FDA-approved indications.

POLICY

The purpose of this policy is to promote the use of evidence-based, cost-effective generic SSRIs. Effective July 1, 2005, BCBSMT requires that members try one of the generic SSRIs before it will approve the following brand-name SSRI's:

- Citalopram.
- Fluoxetine.
- Fluvoxamine.
- Paroxetine.

Prior authorization is recommended.

Member pharmacy benefits are contract-specific, and most, but not all, contracts recommend prior authorization.

- Celexa.
- Lexapro.
- Paxil CR.
- Pexeva.
- Prozac Weekly.
- Sarafem.
- Zoloft.

EXCEPTIONS

Prior authorization exceptions are as follows:

1. The patient was started on Lexapro, Paxil CR, Paxil suspension, Pexeva, Zoloft, or Prozac Weekly for at least four weeks prior to July 1, 2005.
2. Patients who have taken brand name Lexapro, Paxil CR, Pexeva, Zoloft, or Prozac Weekly at any time in the past and discontinued their use may receive authorization to restart the SSRI used in the past, regardless of the formulary status. For example, a patient who has used Zoloft in the past for depression and discontinued its use may receive authorization for coverage of Zoloft.
3. The drug was prescribed by a psychiatrist.
4. The patient is a child or adolescent 18 years old or younger.
5. The patient exhibits suicidal ideation.

SARAFEM

Exceptions for Sarafem can be made based on the following:

- The patient has a diagnosis of PMDD and has tried generic fluoxetine. PMDD is the mood disorder, depression, or dysphoria associated with premenstrual syndrome (PMS). Coverage is not recommended for physical symptoms (e.g., bloating, breast tenderness, dysmenorrhea) associated with PMS.
- The patients with PMDD has suicidal ideation.

MEDICAL POLICY

FDA-APPROVED INDICATIONS

Brand (generic)	MDD	OCD †	Panic Disorder	Bulimia Nervosa	PTSD	Social Anxiety Disorder	GAD	Premenstrual Dysphoric Disorder
Celexa (citalopram)	X							
Lexapro (escitalopram)	X						X	
Prozac, generics (fluoxetine)	X**	X	X	X				
Prozac Weekly (fluoxetine)	X*							
Sarafem (fluoxetine)								X
Generics (fluvoxamine)		X						
Paxil, generics (paroxetine HCl)	X	X	X		X	X	X	
Paxil CR (paroxetine HCl)	X		X			X		X
Pexeva (paroxetine mesylate)	X	X	X					
Zoloft (sertraline)	X	X	X		X	X		X

*MDD = Major depressive disorder; †Fluoxetine, fluvoxamine, and sertraline are FDA-approved for OCD in children and adolescents; *Approved for the prevention of relapse during the continuation treatment phase of depression. ** Fluoxetine is FDA-approved for MDD in children and adolescents; HCl = Hydrochloride.*

Exceptions are not recommended for patients who have taken Sarafem and discontinued its use. These patients should try generic fluoxetine.

TOPAMAX (TOPIRAMATE)

Chapter: Drugs
Effective Date: July 1, 2005
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DESCRIPTION

Topamax is a FDA-approved oral medication for adjunctive therapy for partial seizures. There are other off-label uses for which considerable research evidence exists to support efficacy, including bipolar and other affective disorders, migraine, and eating disorders. Common side effects of this drug include loss of appetite and weight loss; consequently, off-label use for weight control presents a large potential for abuse.

POLICY

Prior authorization is recommended.

BCBSMT will cover Topamax only for the treatment of covered conditions.

COVERED

Topamax coverage includes, but is not limited to, the following diagnoses:

- Migraine.
- Epilepsy.
- Bipolar disorder.
- Binge-eating disorder.
- Bulimia Nervosa.

NON-COVERED

BCBSMT will not cover the use of Topamax for the following conditions:

- Weight loss (including weight loss caused by other medications).
- To prevent weight gain.

AVASTIN (BEVACIZUMAB)

Chapter: Drugs
Upcoming/Revised Policy
Effective Date: July 1, 2005
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DESCRIPTION

Avastin (Bevacizumab) was FDA approved on February 26, 2004, for use in combination with intravenous 5-fluorouracil-based chemotherapy for first-line treatment of patients with metastatic carcinoma of the colon or rectum. The efficacy of Avastin as a single agent treatment has not been established.

Avastin is a recombinant humanized monoclonal IgG1 antibody. It works by binding to and inhibiting the biologic activity of human vascular endothelial growth factor (VEGF) in *in vitro* and *in vivo* assay systems. In binding to VEGF, it prevents interaction with receptors on the surface of endothelial cells preventing cell proliferation and new blood vessel formation in *in vitro* models of angiogenesis. It is produced in a Chinese hamster ovary mammmalian cell expression system.

The recommended dose is five mg/kg once every 14 days as an IV infusion until disease progression is detected. In clinical trials, gastrointestinal perforation and wound dehiscence (complicated by intra-abdominal abscesses) occurred at an increased incidence in patients receiving Avastin compared to controls; therefore, it is recommended that therapy be delayed at least 28 days following major

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surgery or until the surgical incision is fully healed.

POLICY

Prior authorization is recommended.

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

MEDICALLY NECESSARY

BCBSMT considers the use of Avastin medically necessary when the following criteria are met:

- Diagnosis of metastatic carcinoma of the colon or rectum.
- Given in conjunction with oral or intravenous 5-fluorouracil-based chemotherapy.

NOTE: Use for longer than six months requires a re-evaluation by BCBSMT to establish continued response to therapy.

INVESTIGATIONAL

BCBSMT considers the use of Avastin investigational for treatments,including, but not limited to, the following:

- Diagnoses other than metastatic carcinoma of the colon or rectum.
- For use as a single-agent therapy without the concurrent use of oral or intravenous 5-fluorouracil-based chemotherapy.
- For use after the progression of disease has been documented.

CODING

CPT CODES

96410 Chemotherapy administration, intravenous; infusion technique, up to one hour.

96412 Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour (list separately in addition to the code for primary procedure).

HCPCS CODES

J3590 Unclassified biologics.

J9035 Injection, bevacizumab, 10 mg.

NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAID)

Chapter: Drugs
Effective Date: July 1, 2005
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DESCRIPTION

Drugs affected include the following:

- Arthrotec - Diclofenac sodium and misoprostol tablets.
- Prevacid® and NapraPAC™ - Lansoprazole delayed-release capsules and naproxen tablets.
- Ponstel - Mefenamic acid capsules.
- Mobic - Meloxicam tablets.

Diclofenac sodium, mefenamic acid, and meloxicam are all non-steroidal anti-inflammatory drugs (NSAIDs) that exhibit anti-inflammatory, analgesic, and antipyretic activities. The mechanism of these agents, like other NSAIDs, is related to prostaglandin synthetase inhibition. These agents appear to inhibit both cyclooxygenase (COX)-1 and COX-2 isoenzymes at therapeutic doses.

Although individual differences may exist which cannot be well explained, NSAIDs are generally thought to possess similar efficacy for the management of acute and chronic pain and other conditions associated with pain when administered in equipotent doses.

NSAIDs have been associated with the risk of GI toxicity, which range from mild-to-moderate effects (e.g., dyspepsia and nausea) to serious, life-threatening events (e.g., bleeding, perforation, obstruction of the stomach). All NSAIDs carry a warning stating it has been demonstrated that upper GI ulcers, gross bleeding, or perforation caused by NSAIDs appear to occur in approximately 1% of the patients treated for 3-6 months and in about 2-4% of the patients treated for one year (Table 1, page 12).

POLICY

The purpose of this policy is to promote the use of evidence-based, cost-effective generic NSAIDs. Also refer to the medical policy, Drugs: Cyclooxygenase-2 (COX-2) Inhibitors (Celebrex).

Effective July 1, 2005, BCBSMT requires members try at least two of the generic NSAIDs (Table 2, page 12) or to meet one of the criteria for exceptions below before it will approve a prescription for the non-formulary NSAIDs, Arthrotec, Prevacid, NapraPAC, Ponstel, or Mobic.

Prior authorization is recommended.

Member pharmacy benefits are contract-specific, and most, but not all, contracts recommend prior authorization.

BCBSMT will approve Arthrotec, Prevacid, NapraPAC, Ponstel, or Mobic if any one of the following criteria are met:

- The patient has tried two unique generic prescription strength NSAIDs for the current condition.
- Mobic may be given for patients with reduced platelet counts.
- Patients on warfarin (Coumadin) or Dicumarol who have been started and stabilized on non-formulary Arthrotec, Mobic, Ponstel, or Prevacid NapraPAC.
- Prevacid NapraPac will be recommended for coverage if the patient has taken both omeprazole and naproxen (Naprosyn®) 250 mg, 375 mg, or 500 mg twice daily or enteric-coated naproxen (Naprelan®), 375 mg, or 500 mg twice daily).

Exceptions are not recommended for:

- Prevacid NapraPac if the patient has only tried over-the-counter naproxen, other NSAIDs besides naproxen, a cyclooxygenase-2 (COX-2) inhibitor (Bextra®, Celebrex®, Vioxx®), or other PPIs besides omeprazole.
- Use during the pre-operative period; and
- Patients taking Plavix or other anti-platelet drugs.

CYCLOOXYGENASE-2 (COX-2) INHIBITORS (CELEBREX)

Chapter: Drugs
Effective Date: July 1, 2005
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MEDICAL POLICY

TABLE 1. FDA-APPROVED INDICATIONS

Indications	Diclofenac Sodium Plus Misoprostol	Mefenamic Acid	Meloxicam	Naproxen Plus Lansoprazole
Osteoarthritis	*		x	**
Adult rheumatoid arthritis	*			**
Ankylosing spondylitis				**
Mild to moderate pain in patients aged ≥ 14 years (when therapy will not exceed 7 days)		x		
Primary dysmenorrhea		x		

**In patients at high risk of developing NSAID-induced gastric and duodenal ulcers and their complications.*

***In patients with a history of documented gastric ulcer who require the use of an NSAID to reduce the risk of NSAID associated gastric ulcers.*

TABLE 2. Generic NSAIDs (IR = immediate release and ER = extended elease)

Diclofenac Sodium (IR and ER)	Indomethacin	Naproxen Sodium (IR and ER)
Diclofenac Potassium	Ketoprofen (IR and ER)	Oxaprozin
Etodolac (IR and ER)	Ketoralac	Piroxicam
Fenoprofen	Meclofenamate	Sulindac
Flurbiprofen	Nabumetone	Tolmetin Sodium
Ibuprofen	Naproxen	

DESCRIPTION

Celecoxib (Celebrex) is a NSAID that works primarily by inhibiting prostaglandin synthesis by way of cyclooxygenase-2 (COX-2). Celebrex does not inhibit cyclooxygenase-1 (COX-1). Other NSAIDs do inhibit COX-1 which is believed to lead to adverse effects on the gastrointestinal tract. The product labeling for all NSAIDs and COX-2 inhibitors states that patients with a prior history of peptic ulcer disease and/or GI bleeding who use NSAIDs have a 10-fold higher risk for developing a GI bleed. "Advanced age" defined as 65 or older has been cited as a risk factor for GI toxicity.

Celebrex is also being investigated for use in cancer treatment when combined with other chemotherapy agents. Several clinical trials are underway to explore its effectiveness in a variety of cancer types.

The FDA-approved indications for Celebrex include:

- Osteroarthritis.
- Adult rheumatoid arthritis.
- Management of acute pain in adults.
- Treatment of primary dysmenorrhea.
- To reduce the number of adenomatous colorectal polyps in familial adenomatous polyposis.
- As an adjunct to usual care (e.g., endoscopic surveillance, surgery).

POLICY

The purpose of this policy is to promote the use of evidence-based, cost-effective COX-2 inhibitors. Also refer to the Non-steroidal Anti-Inflammatory Drug (NSAID) policy.

Effective July 1, 2005, BCBSMT requires that members try two prescriptions or over-the counter NSAIDs before it will approve a prescription for Celebrex (Table 3, page 13).

Prior authorization is recommended.

Member pharmacy benefits are contract-specific, and most, but not all, contracts recommend prior authorization.

EXCEPTIONS

BCBSMT covers Celebrex for patients who meet any one of the following criteria:

- Is age 65 or older.
- Has past history of peptic ulcer disease and/or a GI bleed, perforation, or obstruction.
- Requires use of long-term (greater than 1 month) oral corticosteroid therapy.
- Currently taking warfarin (Coumadin) or dicumarol.
- Has been diagnosed with rheumatoid arthritis.
- Has reduced platelet counts.
- Has familial adenomatous polyposis or jas attentuated adenomatous polyposis coli with adenomatous colorectal polyps.

BCBSMT does not allow exceptions for the following:

- Prevention of colon cancer.
- During the pre-operative/peri-operative/post-operative period. No

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TABLE 3. Generic NSAIDs (IR = immediate release and ER = extended release)

Diclofenac Sodium (IR and ER)	Indomethacin	Naproxen Sodium (IR and ER)
Diclofenac Potassium	Ketoprofen (IR and ER)	Oxaprozin
Etodolac (IR and ER)	Ketoralac	Piroxicam
Fenoprofen	Meclofenamate	Sulindac
Flurbiprofen	Nabumetone	Tolmetin Sodium
Ibuprofen	Naproxen	

evidence has been published showing a decrease in hemorrhagic complications after surgery when receiving a COX-2 inhibitor versus an NSAID.

- For patients taking clopidogrel, low-molecular weight haparins (e.g., fondaparinux, tinzaparin, enoxaparin, dalteparin) or other similar drugs.
- When used for the treatment of cancer as part of a cancer-chemotherapy regimen.

EPOETIN ALFA (EPO) AND DARBEPOETIN ALFA (NON-ESRD PATIENT USE)

Chapter: Drugs
Upcoming/Revised Policy
Effective Date: July 1, 2005
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DESCRIPTION

Epoetin alfa (EPO), also known as erythropoietin, is a biologically engineered protein used to treat anemia by stimulating bone marrow to make new red blood cells. Epogen is marketed to treat anemia caused by end-stage renal disease (ESRD). Procrit is marketed to treat anemia not caused by ESRD.

Darbepoetin alfa is also a recombinant human erythropoietin with the addition of two n-linked oligosaccharide chains resulting in a three-fold increase in half-life compared to epoetin alfa. Aranesp is the trade name for this drug, and it is marketed to treat anemia caused by chronic renal failure and chemotherapy-induced anemia in patients with non-myeloid malignancies.

POLICY

This policy addresses the use of epoetin alfa and darbepoetin alfa to treat patients with anemia secondary to conditions other than ESRD. The use of these drugs in ESRD patients is not addressed by this policy. The following causes for anemia must be ruled out prior to starting either epoetin alfa or darbepoetin alfa:

- Iron deficiency.
- Underlying infection or inflammatory process.
- Underlying hematologic disease (e.g., hemolysis).
- Vitamin deficiencies (folic acid or B-12).
- Aluminum intoxication.
- Osteitis fibrosa cystica.
- Blood loss (e.g., hemolysis, GI bleeding).

BCBSMT will cover epoetin alfa or darbepoetin alfa when the following medical necessity criteria are met:

MEDICALLY NECESSARY - EPOETIN ALFA

BCBSMT considers the use of epoetin alfa medically necessary to treat anemia when:

- The patient's pre-treatment hemoglobin is less than or equal to 11 gm/dl, and hematocrit is less than or equal to 33%. Coverage is provided to a maximum hemoglobin of 13 gm/dl and hematocrit of 39%. Epoetin alfa may be used to prepare patients with hemoglobin values in the 10-13 gm/dl range for elective, non-cardiac, non-vascular surgery in the pre-operative period when there is a high risk of peri-operative allogenic blood transfusion due to anticipated blood loss.
- The patient is being treated for anemia secondary to one of the following:
  - Induced by the chemotherapeutic drug, Zidovudine.
  - Associated with chemotherapy for a malignancy.
  - For a life-threatening nonmalignant condition.
  - Associated with the following malignancies even if the patient is not currently receiving chemotherapy (anemia of malignancy):
    - Nodular lymphoma.
    - Multiple myeloma.
    - Chronic lymphoid leukemia.
    - Myelodysplastic syndromes.
  - Allogenic stem cell transplantation.
  - Preparation for surgery.
  - Chronic renal failure.

DOSAGE LIMITATIONS - EPOETIN ALFA

BCBSMT will not cover administration of dosages higher than recommended by the FDA and the United States Pharmacopeia Drug Information (USP DI) guidelines of 300 units/kg/three times per week.

Anemia of non-ESRD:

- Initial dose: Recommended starting does of epoetin is 50-100 units/kg/three times per week (FDA/USP DI). Dose adjustments can be made after two to six weeks (depending on response).
- Maintenance dose: Dosage adjustments should be made to maintain the target hemoglobin level. Dose intervals of up to one week may be used for maintenance therapy (USP DI). Dosages higher than 300 units/kg/three times per week (or 900 units/kg/week) are not recommended by the manufacturer and will not be covered.

Anemia in patients preparing for elective surgery:

- 300 units/kg/day for 10 days prior to

MEDICAL POLICY

surgery, on the day or surgery, and for four days after surgery.

- 600 units /kg/once a week, 21, 14, and seven days prior to surgery and on the day of surgery.

Anemia associated with all other indications:

- Initial dose: The recommended starting dose is 100-150 units/kg/three times per week (FDA/USP DI; see guidelines for any individual variation in recommendations).
- Failure to respond to initial dose: Dose increases are recommended if a satisfactory response is not noted after eight weeks of treatment.
- Maintenance dose: Dosage adjustments should be made to maintain the target hemoglobin level. Dosages higher than 300 units/kg/three times per week (or 900 units/kg/week) are not recommended by the manufacturer and will not be compensated.

  NOTE: Patients who have not responded within 12 weeks to the maximal epoetin alfa dose of 900 units/kg/week with a hemoglobin increase of two gm/dl or a decrease in red blood cell transfusion requirement of at least 50%, should have the drug discontinued because continued treatment is unlikely to produce any benefit. Concurrent use of epoetin alfa and darbepoetin alfa is not allowed.

MEDICALLY NECESSARY - DARBEPOETIN ALFA

BCBSMT considers the use of darbepoetin alfa medically necessary to treat anemia when the patient's pre-treatment hemoglobin is less than or equal to 11 gm/dl, and hematocrit is less than or equal to 33%. Coverage is provided up to a maximum hemoglobin of 13 gm/dl and hematocrit of 39%. Darbepoetin alfa may be used to prepare patients with hemoglobin values in the 10-13 gm/dl range for elective, non-cardiac, non-vascular surgery in the preoperative period when there is a high-risk of perioperative allogenic blood transfusion due to anticipated blood loss.

Darbepoetin alfa is medically necessary when one or more the following criteria are met:

- The patient is receiving chemotherapy for a malignancy.
- The patient has one of the following malignancies even if the patient is not currently receiving chemotherapy (anemia of malignancy):
  - Nodular lymphoma.
  - Multiple myeloma.
  - Chronic lymphoid leukemia.
  - Myelodysplastic syndromes.
- The patient has chronic renal failure but is not on dialysis (non-ESRD patients).

DOSAGE LIMITATIONS

Darbepoetin alfa may be administered at the following dosages per FDA/USP DI guidelines. BCBSMT will not compensate for administration of higher dosages.

Anemia of non-ESRD:

- Initial dose: Recommended starting dose of darbepoetin is 0.45 ug/kg/week (FDA/USP DI) or 0.75 ug/kg/2 weeks (USP DI; extended dosing). If an increase in hemoglobin concentration of less than 1 gram/dL over 4 weeks is noted and iron stores are adequate, the dose of darbepoetin may be increased approximately 25% of the previous dose (USP DI). Further increases may be made at four-week intervals until the specified hemoglobin is obtained.
- Maintenance dose: Dosage adjustment should be made to maintain the target hemoglobin level. Dose intervals of between one to four weeks are recommended (FDA and USP DI).

Anemia associated with chemotherapy of malignant and non-malignant disease:

- Initial dose: The recommended starting dose is 2.25 ug/kg/week (FDA) or 1.5-2.25 ug/kg/week (USP DI). An extended initial dosing regimen using three to five ug/kg/2 weeks may also be used (USP DI). BCBSMT will not compensate for higher doses.
- Maintenance dose: Dosage adjustment should be made to maintain the target hemoglobin level.

Anemia of malignancy:

- Initial and maintenance dose: Because the FDA has not specifically addressed anemia treatment in patients with anemia of malignancy, BCBSMT follows the same treatment guidelines provided above for anemia associated with chemotherapy of malignant and non-malignant disease (initial dose of 1.5-2.25 ug/kg/week or 3-5 ug/kg/2 weeks).

  NOTE: Patients who have not responded within 12 weeks to maximal darbepoetin doses with a hemoglobin increase of 2 gm/dl or a decrease in red blood cell transfusion requirement of at least 50%, should have the drug discontinued because continued treatment is unlikely to produce any benefit. Concurrent use of epoetin alfa and darbepoetin alfa is not allowed.

CODING

FOR NON-ESRD PATIENTS

Q0136 Injection, epoetin alpha, (for non ESRD use), per 1,000 units.

Q0137 Injection, darbepoetin alfa, 1 mcg (non-ESRD use).

J0880 Injection, darbepoetin alfa, 5 mcg.

REVISED POLICIES

CARDIAC REHABILITATION

Chapter: Therapies
Upcoming/Revised Policy
Effective Date:
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Senior Staff Approval Date: October 1, 1990
Original Effective Date: March 1, 1990
Current Effective Date: January 7, 2004

POLICY

Benefits for cardiac rehabilitation are generally contract specific. Call Customer Service at 1-800-447-7828 for specific member information. If the member contract does not limit cardiac rehabilitation benefits, 36 visits will be allowed per cardiac event. A retrospective review will be performed if services are not prior authorized.

Cardiac events and/or diagnoses eligible for cardiac rehabilitation benefits

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

include, but are not limited to, the following:

- Myocardial infarction.
- Coronary angioplasty.
- Heart transplant.
- Valvular surgery.
- Congestive heart failure.
- Heart-lung transplant.
- Arrhythmias.
- Coronary Artery Bypass Graft Surgery.
- Cardiac stent placement.

PHASE I

Benefits are available without review for inpatient services.

PHASE II

Benefits are member-contract specific. If not limited in the member contract, benefits are available for 36 consecutive sessions/visits (up to 3 times per week for 12 weeks) without review.

Prior authorization for further sessions is recommended and will be allowed based on medical necessity. A break in the sessions will negate further session allowances unless documentation is provided supporting the medical necessity for the interruption of therapy. Call Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451.

PHASE III

Benefits are not available. This phase is not monitored and is considered maintenance.

For contracts without a limited cardiac rehabilitation benefit, if a new documented cardiac event occurs during Phase I or II, the 36 session/visits can begin again. For contracts with a benefit limitation, the outpatient rehabilitation maximum (dollar and/or visit) per benefit period still applies.

HYPERBARIC OXYGEN THERAPY

Chapter: Medicine: Treatments
Upcoming/Revised Policy
Effective Date:
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Original Effective Date: October 22, 1987
Current Effective Date: May 10, 2003

POLICY

Localized hyperbaric oxygen therapy is considered investigational.

Prior authorization is recommended.

Call Customer Service at 1-800-447-7828 or fax your request to the Medical Review Department at 406-444-8451.

A retrospective review will be performed if services are not prior authorized.

The Undersea and Hyperbaric Medical Society recommends review for continued treatments after a specified number of treatments for several conditions. BCBSMT follows these recommendations and will prior authorize the recommended number of treatments only for the conditions listed below. Further treatment will be reviewed for medical necessity based on medical records. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day treatment period.

BCBSMT considers systemic hyperbaric oxygen pressurization medically necessary for the treatment of the following conditions:

- Acute traumatic ischemia, six days of treatment (up to three treatments daily).
- Anemia, profound with exceptional blood loss (only when a blood transfusion is impossible or must be delayed).
- Carbon monoxide poisoning, acute (five treatments).
- Cerebral edema, acute.
- Chronic non-healing wounds of the lower extremity in diabetic patients that are Wagner* grade III or higher that have not responded to 30-days of conventional therapy (one or two treatments daily).
- Cyanide poisoning (acute).
- Decompression sickness (the bends) (ten treatments).
- Gas embolism (acute) – (ten treatments).
- Gas gangrene (ten treatments).
- Mycoses, refractory - mucomycosis, actinomycosis, canibolus coronato.
- Necrotizing soft tissue infections (thirty treatments).
- Osteomyelitis, acute (refractory to standard medical management) – (forty treatments).
- Prophylactic pre- and post-treatment for patients undergoing dental surgery of a radiated jaw.
- Radiation necrosis (osteoradionecrosis and soft tissue radiation necrosis) (sixty treatments).
- Skin grafts or flaps, compromised (twenty treatments following placement of flap or graft).

*The Wagner classification system of wounds is defined as follows: grade 0 = no open lesion; grade 1 = superficial ulcer without penetration to deeper layers; grade 2 = ulcer penetrates to tendon, bone, or joint; grade 3 = lesion has penetrated deeper than grade 2 and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths; grade 4 = wet or dry gangrene in the toes or forefoot; grade 5 = gangrene involves the whole foot or such a percentage that no local procedures are possible and amputation (at least at the below the knee level) is indicated.

BCBSMT considers localized hyperbaric oxygen pressurization investigational regardless of diagnosis, and considers systemic hyperbaric oxygen pressurization investigational for treatment, including, but not limited to, the following:

- Bone grafts.
- Brain injury.
- Brown recluse spider bites.
- Acute carbon tetrachloride poisoning.
- Cerebal palsy.
- Acute cerebrovascular accident (thrombotic or embolic).
- Chronic refractory osteomyelitis.
- Crohn's disease.
- Cutaneous, decubitus, and stasis ulcers.
- Fracture healing.
- Hydrogen sulfide poisoning.
- Intra-abdominal and intracranial

MEDICAL POLICY

abscesses.
- Lepromatous leprosy.
- Meningitis.
- Multiple sclerosis.
- Pseudomembranous colitis (antimicrobial agent-induced colitis).
- Pyoderma gangrenosum.
- Radiation myelitis.
- Retinal artery insufficiency, acute.
- Retinopathy, adjunct to scleral buckling procedures in patients with sickle cell peripheral retinopathy and retinal detachment.
- Sickle cell crisis and/or hematuria.
- Head and spinal cord injury.
- Thermal burns (acute).

AFTER HOURS, STAT, CALL BACK AND/OR TECHNICAL SUPPORT CHARGES

Chapter: Administrative
Upcoming/Revised Policy
Effective Date:
©2005 Blue Cross and Blue Shield of Montana
Senior Staff Approval Date: December 8, 1987
Original Effective Date: December 8, 1987
Current Effective Date: January 1, 2003

POLICY

After Hours

BCBSMT considers the following after-hours charges to be inclusive of other services rendered:

- 99050 Services requested after office hours in addition to basic services.
- 99052 Services requested between 10:00 PM and 8:00 AM in addition to basic service.
- 99054 Services requested on Sundays and holidays in addition to basic service.

BCBSMT will allow CPT code 99058 (office services provided on an emergency basis) when all of the following criteria are met:

- The service is rendered in an office setting.
- The member requires emergency treatment.
- The service is provided in lieu of the member traveling to a different facility.
- The service is provided on a weekday between 8 p.m. and 7 a.m., on a weekend, or holidays.
- The service is provided by physician or non-physician providers who do not normally work evenings, weekends, or holidays as part of their regular schedule.

Stat Charges, Call Back Charges, On Call Charges, And/Or Tech Support Charges

BCBSMT does not cover hospital stat charges and/or technical support charges. Staff providing service(s) are employees of the hospital, and these charges are considered inclusive of the billed service(s) (i.e., laboratory, x-ray, respiratory, and surgery).

AMBULATORY BLOOD PRESSURE MONITORING

Chapter: Durable Medical Equipment
Upcoming/Revised Policy
Effective Date:
©2005 Blue Cross and Blue Shield of Montana
Original Effective Date: September 21,1994
Current Effective Date: January 1, 1997

POLICY

MEDICALLY NECESSARY

BCBSMT considers ambulatory blood pressure monitoring medically necessary when all of the following criteria are met:

- Blood pressure measurements taken in the office setting on at least three separate visits with two measurements taken at each visit are greater than 140/90.
- At least two documented blood pressure measurements taken outside the office are less than 140/90.
- There is no evidence of end-organ damage.

BCBSMT considers ambulatory blood pressure medically necessary in the following instances:

- For severely hypertensive patients who are refractory to intensive hypertensive drug therapy (the use of three drugs simultaneously in maximum doses).
- For patients who are receiving antihypertensive therapy but are reporting hypotensive symptoms.
- For patients thought to be having autonomic dysfunctions.

SLEEP STUDIES - POLYSOMNOGRAPHY

Chapter: Medicine, Tests
Upcoming/Revised Policy
Effective Date:
©2005 Blue Cross and Blue Shield of Montana

POLICY

Prior authorization is not recommended for attended sleep studies.

MEDICALLY NECESSARY

BCBSMT considers an attended polysomnography (sleep study) performed in a sleep laboratory medically necessary as a diagnostic test of OSA/UARS and as a technique to initiate and titrate CPAP in patients with clinically significant OSA/UARS when patients are suspected of having obstructive sleep apnea. Symptoms include, but are not limited to, the following:

- Excessive daytime sleepiness which may be documented on the Epworth Sleepiness Scale.
- Auto accidents related to sleepiness.
- Observed apneic episodes.
- Hypertension/pulmonary hypertension or CVA (stroke).

REPEAT TESTING

Previous testing performed by the attending physician, to the extent the results are still pertinent, should not be duplicated; however, more than one polysomnography may be needed per the following guidelines:

- One polysomnography is needed to confirm a diagnosis of obstructive sleep apnea syndrome.
- A second polysomnography may be required to adjust the CPAP device.
- An additional polysomnograph may be necessary for evaluating treatment

response and making subsequent treatment management decisions.

NON-COVERED

BCBSMT considers the following services non-covered:

- Multiple sleep latency testing (MSLT) in the diagnosis of obstructive sleep apnea except to exclude or confirm narcolepsy in the diagnostic work-up.
  - The test involves four or five sleep opportunities occurring at two-hour intervals. The time to sleep and the occurrence of REM sleep are documented. The MSLT assesses excessive daytime sleepiness. The presence of REM sleep on two out of four or five naps is supportive evidence of narcolepsy.
- Unattended (unsupervised) sleep studies. The American Sleep Disorders Association guidelines state unattended portable sleep studies may be acceptable under some circumstances, and exceptions will be made on an individual basis.
- Polysomnography for the following conditions which can be diagnosed through more appropriate means:
  - Bruxism.
  - Drug dependency.
  - Enuresis.
  - Nocturnal myoclonus.
  - Shift work and schedule disturbances.
  - Somnambulism (sleep walking).
  - Migraine headaches.
  - Snoring.

OBSTRUCTIVE SLEEP APNEA – MEDICAL, SURGICAL AND NON-SURGICAL TREATMENT

Chapter: Medicine, Treatments
Upcoming/Revised Policy
Effective Date:
©2005 Blue Cross and Blue Shield of Montana

POLICY

BCBSMT considers treatment medically necessary only when diagnostic studies document clinically significant obstructive sleep apnea/upper airway resistance syndrome (OSA/UARS). For respiratory insufficiency in patients with diagnoses other than sleep apnea (e.g., progressive muscular degeneration diseases) or for cardiovascular disease (CVD), high blood pressure, and coronary artery disease (CAD), treatment should be reviewed on an individual basis.

Non-surgical Treatment: CPAP (continuous positive airway pressure), NCPAP (nasal continuous positive airway pressure), DPAP (demand positive airway pressure)

BCBSMT considers CPAP, NCPAP, and DPAP medically necessary for the treatment of clinically significant OSA/UARS and does not recommend prior authorization. These devices maintain positive air pressure in the upper airway to keep it open during sleep. While compliance can be a problem, careful follow-up can significantly improve compliance.

Bi-level positive airway pressure (BiPAP) or auto-adjusting CPAP (APAP) may be considered medically necessary in patients who have a failed a trial of CPAP. The following rules apply:

- BCBSMT will compensate for the rental of CPAP, NCPAP, BiPAP, or DPAP for 12 months. After 12 months of rental, the device is considered purchased. Further compensation for rentals will not be made.
- The purchase of CPAP, NCPAP, or DPAP equipment will be allowed only after 3 months of rental.

Removable Dental/Oral Appliances (e.g., bionator, tongue-retaining devices, or mandibular advancing/positioning devices).

Prior authorization is recommended.

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

The following rules apply:

- These appliances will be covered under the DME benefit of the contract.
- HCPCS code S8260 should be used to bill for the appliances.
- Maximum allowance will be $500 including all related charges.
- Benefits are not covered for oral appliances for the purpose of reduction of snoring.

SURGICAL TREATMENT

Prior authorization is recommended for the following surgical treatments.

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

- Uvulopalatopharyngoplasty (UPPP) with or without inferior sagittal osteotomy (ISO) with hyoid suspension.
- Septoplasty (nasal obstruction must be documented).
- Mandibular and maxillary advancement (MMA).
- Glossectomy (tongue reduction).
- Hyoid suspension.

Documentation of hypopharyngeal obstruction by either fiberoptic endoscopy or cephalometric radiographs is required.

When applicable, BCBSMT requires the following services to be tried prior to surgical treatment:

- Conservative measures, including a trial of CPAP for at least one month.
- Standard medical treatments.
- Standard non-surgical treatments.

NON-COVERED TREATMENT

BCBSMT considers the following services non-covered:

- Over-the-counter bite guards.
- Somnoplasty.
- Treatment of simple snoring in the absence of documented OSA because it is not considered a medical condition.

INVESTIGATIONAL TREATMENT

BCBSMT considers the following services investigational:

- Laser-assisted uvulopalatoplasty - an outpatient alternative proposed as a treatment of snoring with or without associated OSA.

MEDICAL POLICY

- Electrosleep therapy - the passage of weak electric currents to the brain to induce sleep.
- Topographic electroencephalogram mapping in the diagnosis and/or medical management of obstructive sleep apnea syndrome.
- Somnoplasty for the treatment of obstructive sleep apnea. There is inconclusive evidence the service has a beneficial effect on health outcomes.
- Radiofrequency ablation of the soft palate with or without radio-frequency reduction of the palatal tissues.
- Palatal stiffening procedures including a cautery-assisted palatal stiffening operation and insertion of palatal implants.

CLAIMS STATUS

ELIGIBILITY

BENEFITS

QUICK TIP

To quickly check claim status on Secure Services, just enter the patient's member/health plan identification number or search by name and date of birth.

www.bluecrossmontana.com

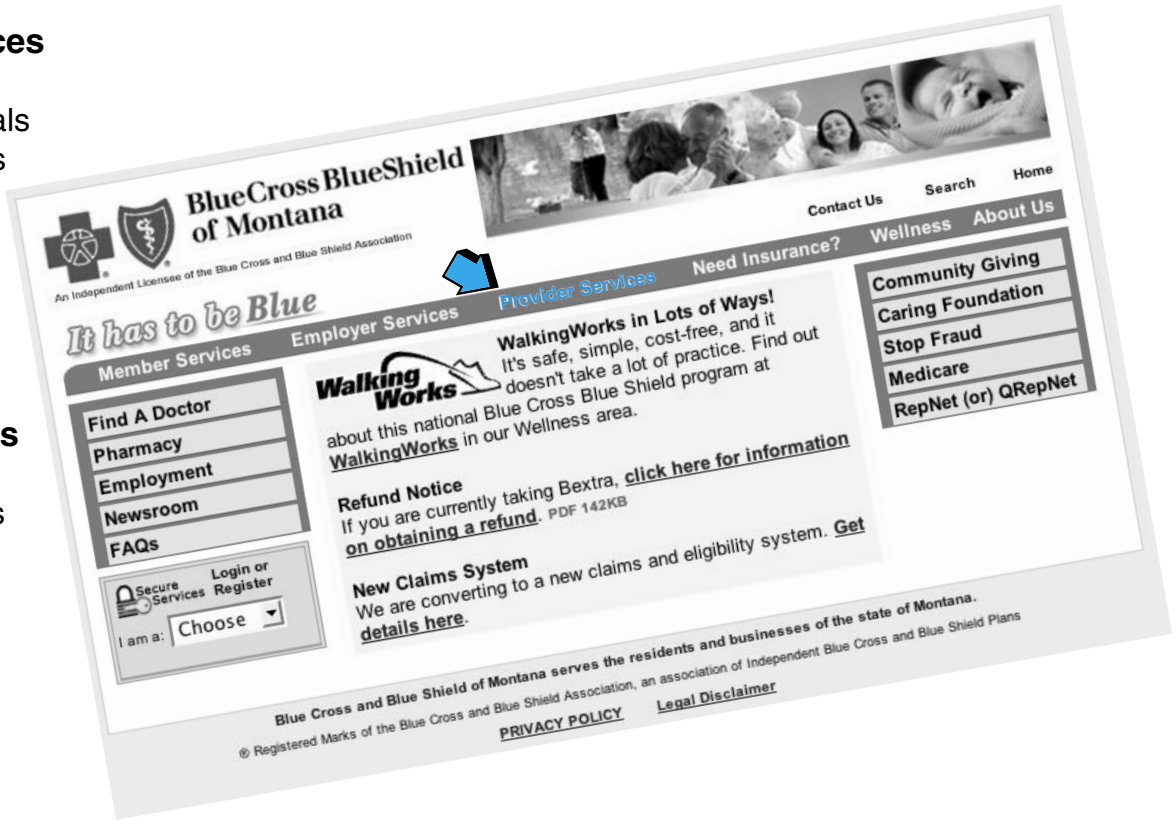
It has to be Blue. . .

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

News & Reports
- Capsule News
- HEDIS Reports

Forms
- Prior Authorize
- Claim Forms
- Credentialing

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



Regular Business

YOU'RE INVITED

2005 PROVIDER WORKSHOPS

HEALTH CARE TEAM SERVICES

On behalf of BCBSMT, Health Care Services would like to invite you and your staff to attend the BCBSMT 2005 Provider Workshops. Participant feedback from the well-attended 2004 workshops was incorporated into this year's agenda and includes the latest information concluding with an open panel discussion.

Date	City	Location	Time
November 1	Great Falls	Heritage Inn	8:30-12:00
November 3	Helena	Great Northern Hotel	8:30-12:00
November 8	Havre	Northern Montana Hospital	8:30-12:00
November 8	Glendive	Glendive Medical Center	8:30-12:00
November 9	Glasgow	Frances Mahon Deaconess Hospital	8:30-12:00
November 10	Lewistown	Central Montana Medical Center	8:30-12:00
November 15	Miles City	Holy Rosary Healthcare	1:30-5:00
November 16	Billings	Holiday Inn Grand Montana	1:30-5:00
November 22	Bozeman	Bozeman Deaconess Hospital	8:30-12:00
November 29	Kalispell	West Coast Kalispell Center Hotel	1:30-5:00
November 30	Missoula	Grant Creek Inn	8:30-12:00

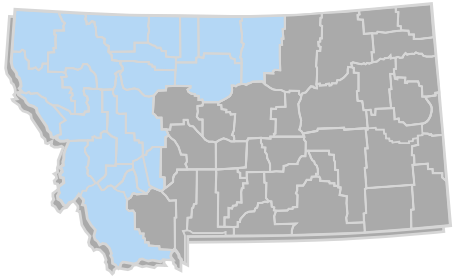
Contact one of the following provider network representatives at 1-800-447-7828 with any questions, and RSVP at least two days before the workshop you plan to attend.

WESTERN REGION

Linda Orth, Ext. 8273
lorth@bcbsmt.com

Dan Polette, Ext. 8715
dpolette@bcbsmt.com

Jenifer Sampson, Ext. 8468
jsampson@bcbsmt.com



EASTERN REGION

Christine Burbank, Ext. 8260
cburbank@bcbsmt.com

Kathy Polette, Ext. 8511
kpolette@bcbsmt.com

Terry Manska, Ext. 8870
tmanska@bcbsmt.com

The Health Care Services Department is looking forward to seeing you again and appreciates your participation.

Regular Business

CLAIMS ACCURACY INITIATIVE

CAI UPDATE

CPT CODE

90780-90781 IV Infusion

CLAIMS ACCURACY INITIATIVE

BCBSMT compensates for IV infusion therapy pre-medication for the following drugs when billed with chemotherapy infusion:

- Rituximab.
- Paclitaxel alone (effective July 1, 2004 and after).
- Paclitaxel with Carboplatin.
- 5FU with Leucovorin.
- Doxorubicin with Cyclophosphamide.
- Etoposide with Cisplatin.

CPT codes 90780 and 90781 and HCPCS codes G0347 and G0348 are inclusive to procedures 96410-96414 when provided with any other chemotherapeutic agent. However, when IV therapy is provided by a physician (or under direct physician supervision) and the IV therapy was used to deliver medication such as an antiemetic (and not simply hydration), separate compensation may be allowed upon review of documentation.

To ensure accurate claims processing, append modifier 99 to IV infusion therapy codes 90780, 90781, G0347, and G0348. If not billing for the specified drugs on the same claim, list the chemotherapy drugs in box 19 on the HCFA 1500 claim form. However, if the claim includes J-codes for the cited chemotherapy drugs, do not list the drugs in box 19.

RATIONALE

Reporting both intravenous therapies represent a duplication of services.

CPT CODE

76000-76005 Fluoroscopy

CLAIMS ACCURACY INITIATIVE

BCBSMT allows separate compensation for CPT codes 76000-76005 when submitted with the following CPT codes:

10022	27648	63650	64622
20525	32002	64421	64623
20610	33967	64470	64626
20670	36597	64472	64627
20680	62270	64475	64680
23350	62272	64476	64681
24220	62273	64479	73222
25246	62282	64480	73722
25565	62287	64483	77778
25605	62310	64484	
26650	62311	64517	
27093	62318	64520	
27095	62350	64530	
27096			

continued next column

RATIONALE

Fluoroscopic guidance is considered an integral component for most procedures; however, BCBSMT has determined that separate compensation is allowable for the listed procedures because of the increased risk associated with these procedures. BCBSMT considers fluoroscopic guidance with all other procedures as a common fundamental component.

MODIFIER 25

Modifier 25 is defined as a significant and separately identifiable evaluation and management services by the same physician on the same day of the procedure or other service.

CLAIMS ACCURACY INITIATIVE

Effective August 1, 2005, BCBSMT revised its modifier 25 policy to clarify all significant and separately identifiable evaluation and management (E&M) services performed by the same physician on the same day that are eligible for compensation. The coding guidelines are similar to those used by CMS.

The E&M services in Table 1 do not require modifier 25 to be eligible for additional compensation when billed with a procedure with the same date of service.

TABLE 1

CPT Code	Service
92002-92004	New Patient Ophthalmology Services
99201-99205	New Patient
99281-99288	Emergency Department Services
99321-99323	Domiciliary, Rest Home
99341-99345	Home Services

The E&M services in Table 2 require modifier 25 to be eligible for additional compensation when billed with a procedure with the same date of service.

TABLE 2

CPT Code	Service
92012-92014	Established Patient Ophthalmology E&M Codes
99211-99215	Established Patient E&M Codes
99217-99220	Hospital Observation Services
99221-99239	Hospital Inpatient Services

continued next page

TABLE 2 *continued*

99241-99275	Office or Other Outpatient Consultations
99289-99296	Critical Care
99298-99299	Intensive (non-critical) Low Birth Weight Service
99301-99316	Nursing Facility Services
99331-99333	Domiciliary, Rest Home (established)
99347-99350	Home Services (established)
99354-99360	Prolonged Services
99361-99373	Case Management Services
99374-99380	Care Plan Oversight
99381-99387	New Patient Preventive
99391-99397	Established Patient Preventive Medicine Codes
99401-99429	Counseling/Risk Reduction
99431-99440	Newborn Care
99450-99456	Special E&M Services
99499	Other E&M

BCBSMT may request medical records to verify that the billed E&M services represent a significant and separately identifiable E&M service.

RATIONALE

BCBSMT adopts coding guidelines similar to CMS.

MODIFIER 57

Effective July 1, 2005, BCBSMT revised the modifier 57 policy allowing an E&M service in conjunction with specific procedures. All E&M services appended with modifier 57 are compensated according to the global days assigned to the procedure:

- E&M services will not be eligible for compensation with procedures assigned 0-10 global days.
- E&M services provided on the date of, or one day prior to, the procedure will be compensated for procedures assigned 90 global days.

BCBSMT follows CMS guidelines for modifier 57 compensation. This rationale can be found in the CPT Assistant Article, December 2004©.

Modifier 57 is used to identify an E&M service provided on the day before or day of surgery in which the initial decision is made to perform major surgery. Medicare designates as major surgery all surgical procedures assigned a 90-day global surgery period. Medicare's global surgery policy includes the E&M service provided on the day before, or the day of, a major surgical procedure unless the E&M service was the occasion where the initial decision to perform surgery was made. Appending modifier 57 to the appropriate E&M code indicates that fact; and if covered, modifier 57 allows payment for the E&M service.

Exceptions to the policy include E&M services listed in Table 3 that do not require a modifier to be eligible for compensation when billed with a procedure on the same date of service.

TABLE 3

CPT Code	Service
92002-92004	New Patient Ophthalmology Services
99201-99205	New Patient
99281-99288	Emergency Department Services
99321-99323	Domiciliary, Rest Home
99341-99345	Home Services

RATIONALE

BCBSMT adopts CMS coding guidelines.

SERVICE

Assistant At Surgery (Modifiers 80, 81, 82, AS).

CLAIMS ACCURACY INITIATIVE

Effective August 1, 2005, BCBSMT updated the list of surgical codes allowing an assist at surgery.

RATIONALE

BCBSMT follows CMS guidelines for CPT codes designated *always* and *never* allowing an assistant at surgery. CMS also has a designation of *sometimes*. BCBSMT does not have a category for the designation of sometimes, and the majority of codes in this category are designated as *never*.

If a surgical assistant service is denied, providers may submit an appeal for individual consideration. The appeal should include medical records documenting the unusual circumstances to support medical necessity.

A complete listing of codes allowing an assist at surgery is available at www.bluecrossmontana.com. Click on *Provider Services* and then *Provider Manuals*.

Regular Business

MEDICARE MINUTE

MEDICARE B ONLINE SERVICES

Medicare Part B has established a new list serve at www.medicare.bcbsmt.com. Select *Provider* then *Subscribe to the Medicare List Serve*. Advantages include:

- Immediate Medicare B updates.
- Immediate fee schedule updates not published in bulletins.
- Immediate MedLearn Matters articles.
- Monthly Medicare B bulletin.

NPI

NATIONAL PROVIDER IDENTIFICATION, UB-04, AND CMS-1500

BCBSMT is working diligently to comply with the National Provider Identification (NPI) regulations and is currently analyzing the impact to BCBSMT business and technical systems. Critical to the success of the NPI project is maintaining communication and coordinating efforts with the provider community.

BCBSMT will share information through the Capsule News, provider workshops, the BCBSMT website, and direct mail.

BCBSMT has adopted a transition plan to discontinue use of the BCBSMT provider number to the new Federally mandated NPI number. Beginning January 1, 2006, BCBSMT will accept the NPI on electronic claims (837 transactions) in addition to BCBSMT provider identification numbers. Electronic claims that contain only an NPI will be returned.

Beginning January 1, 2007, BCBSMT will accept claims (paper and electronic) that contain only an NPI. This is the current target date; however, this timeframe could change as BCBSMT works though the technical aspects. More information regarding NPI and claims submission will be made available next year.

UB-92 CLAIM FORM

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

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

CMS-1500 CLAIM FORM

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

The current HCFA-1500 form will be discontinued February 1, 2007, and only the proposed CMS-1500 form should be used. Any claims resubmitted must use the proposed CMS-1500 form from this date forward even though earlier submissions may have been on the current HCFA-1500 form. More information is available at http://www.nucc.org.

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

TRIWEST HEALTHCARE ALLIANCE®

TRIWEST PROVIDER EDUCATION AND TAX IDS

BCBSMT is the network subcontractor for the TriWest Healthcare Alliance and is responsible for developing the provider network that provides medical services to the men and women in the nations armed forces. To become a network provider, contact your BCBSMT Network Development Representative (see inside back cover).

PROVIDER EDUCATION

When you become a network provider, you are required to attend a TriWest seminar or take an e-seminar at www.triwest.com within 120 days. Additionally, existing network providers are required attend one TriCare seminar or online education annually. If you have any questions concerning educational seminars, contact your Provider Network Service Representative (see inside back cover).

TAX ID NUMBERS FOR NETWORK AND NON-NETWORK PROVIDERS

Wisconsin Physician Services (WPS) processes TriWest claims, and one of the most critical elements for accurate processing is your tax ID number. If you are changing your tax ID number, it is very important to contact BCBSMT with your new tax ID number as soon as possible. If you are not a TriWest network provider, you will need to contact WPS at 1-888-TRIWEST (874-9378) and give them your tax ID number to process claims. BCBSMT delivers TriWest updated provider network information each week, but tax ID changes take at least two weeks to be updated in the WPS system.

If you have any questions, contact your Provider Network Service Representative (see inside back cover).

MEDICARE PART D

MEDICARE PRESCRIPTION DRUG COVERAGE

Medicare will soon offer prescription drug coverage known as Medicare Part D. Medicare Part D is welcomed relief for rising drug costs for Medicare eligible members.

WHO CAN JOIN AND WHEN?

If a beneficiary currently has Medicare Part A and/or Part B, they can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. If they join by December 31, 2005, the Medicare prescription drug plan coverage will begin on January 1, 2006. If enrolling after December 31, 2005, coverage will be effective the first day of the month after the enrollment month.

After May 15, 2006, there is a likelihood of paying a higher monthly premium unless the member is currently covered by a drug plan that offers at least as much benefit as a Medicare Part D. This higher premium will be paid for the life of the members' Part D plan.

HOW MUCH DOES IT COST?

As with other insurance, members will pay a monthly premium with an estimated $250 annual deductible. Members will also pay a co-payment or co-insurance for their prescriptions. Cost sharing, including the premium, will vary depending on which drug plan is chosen. Some plans may offer more coverage and additional drugs for a higher monthly premium. Furthermore, if a member has limited income and qualifies for the low-income subsidy, they may not have to pay a premium or deductible.

WHEN WILL MORE INFORMATION BECOME AVAILABLE?

Detailed information about Medicare prescription drug plans will be available after October 1, 2005. Throughout 2005, Medicare has provided general information through traditional media and their website (www.medicare.gov). This fall, members will:

- Receive the *Medicare & You 2006* handbook in the mail listing the Medicare prescription drug plan available in their area.
- Be able to obtain free personalized information at www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to help them choose the plan that meets their needs.
- Have availability of free counseling from the State Health Insurance Assistance Program (SHIP) and other local and community-based organizations. Call 1-800-MEDICARE to get the telephone number of the nearest SHIP.

QNXT UPDATE: ROLL 2 FREEZE DATES

Conversion to the new claims payment system; QNXT, continues, and Roll 2 already is well underway. Providers have received two letters explaining the freeze dates for membership and claims payment. Important dates to remember are highlighted in the following.

The claims payment freeze dates are **October 9 through October 21, 2005**. Roll 2 of the QNXT system conversion will affect about 50% of BCBSMT members, and claims payments for these members cannot be made during the freeze. Providers should ensure that BCBSMT receives as many claims as possible by **October 7, 2005**. A special pay cycle will run on **October 8** for all the claims received.

Note that the claims payment freeze affects only the members in Roll 2. Normal pay cycles on the *old* system for all our other members will continue to run.

BCBSMT has a Prospective Interim Payment process that would allow receipt of emergency cash payments during the **October 9 through October 21** freeze period.

Note also that the membership freeze is now in effect from **August 13 to October 17**. Claims for new members enrolled during this period, including newborns, will start processing on October 21, 2005. Also, on **October 21**, BCBSMT will run another special pay cycle on validated claims processed on the new system between **October 9 and October 21**.

The important dates to remember are:

- **August 13 to October 17** – Membership freeze.
- **October 7** – BCBSMT must receive all your claims.
- **October 8** – Special pay cycle to pay claims received on or by October 7.
- **October 9 through October 21** – Claims payment freeze.
- **October 21** – Special pay cycle to pay claims processed between October 9 and October 21.

We appreciate your patience and assistance during this conversion. If you have questions, contact your provider network representative (see inside back cover).

FAX:

1-406-447-3570

MAIL:

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

E-MAIL:

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

Regular Business

RVU

SEPTEMBER RVU CHANGES

The Centers for Medicare and Medicaid Services updated Relative Value Units (RVU) for CPT codes 97810, 97811, 97813, and 97814 effective September 1, 2005. The tables below show the previous and new RVUs and the BCBSMT facility and non-facility compensation.

RVU CHANGES

CPT	March 1, 2005 RVU		September 1, 2005 RVU	
	Non-Facility	Facility	Non-Facility	Facility
97810	0.63	0.63	1.01	0.86
97811	0.53	0.53	0.78	0.72
97813	0.68	0.68	1.08	0.93
97814	0.58	0.58	0.88	0.79

COMPENSATION CHANGES

CPT	March 1, 2005 Allowance		September 1, 2005 Allowance	
	Non-Facility	Facility	Non-Facility	Facility
97810	$35.29	$35.29	$56.57	$48.17
97811	$29.69	$29.69	$43.69	$40.33
97813	$38.09	$38.09	$60.49	$52.09
97814	$32.49	$32.49	$49.29	$44.25

POLICIES

COMPENSATION POLICIES UPDATED

Some BCBSMT provider compensation policies are updated and published at www.bluecrossmontana.com (click on Provider Services and Provider Policies). Anesthesia, clinical laboratory, non-physician, and physician compensation policies added language clarifications, but these changes do not affect claims processing.

The Vaccine and Drug Compensation Policy was updated to reflect chemotherapy drug compensation changing from 112.5% of Average Wholesale Price (AWP) to 100% AWP effective for claims with dates of service from January 1, 2006 and after. A list of high-cost injectable medications was also added to the policy.

The Out-of-state Provider Compensation Policy was retired.

If you have any questions, contact your provider network representatives (see inside back cover).

It has to be Blue

www.bluecrossmontana.com

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

News & Reports
- Capsule News
- HEDIS Reports

Forms
- Prior Authorize
- Claim Forms
- Credentialing

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

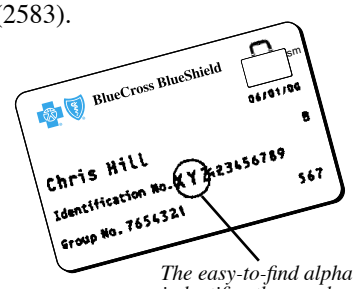
ALPHA PREFIX

USE CURRENT ALPHA PREFIX AND MEMBER ID NUMBERS

Blue Cross and Blue Shield (BCBS) Plans across the country and in Montana are in the process of removing Social Security numbers from ID cards, and by January 1, 2006, more than 93 million Blue Plan members will have new ID cards. Now more than ever, it is important for providers to use the most current alpha prefix and member ID number. Remember the following when submitting claims for all BCBS members:

- Make copies of both sides of the member's ID card. To ensure that the member gives you the most current ID card, you may want to request the card at every visit.
- Enter the identification number **exactly** as it appears on the member's card, including the three-character alpha prefix. Do not assume that you know alpha prefixes or member identification numbers.
- Following the three-character alpha prefix, the ID number may include any combination of alpha/numeric characters for a maximum length of 17 characters.

If you have questions about a member's ID number, call Customer Service at 1-800-447-7828 or log onto Secure Services at www.bluecrossmontana.com. Out-of-state member eligibility can be obtained by calling 1-800-676-BLUE (2583).



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

BlueCHIP®

BLUECHIP – SIMPLIFIED ENROLLMENT FORM AND INCOME GUIDELINES

Over 19% of Montana's population is uninsured, and that includes a large number of children under age 19. The Children's Health Insurance Program (CHIP), a program administered by the Montana Department of Health and Human Services (DPHHS) provides insurance coverage to low-income, uninsured Montana children up to the age of 19. Funding for the program comes from the Federal Government and the State of Montana. BCBSMT is the only payer currently providing insurance coverage for qualified CHIP children (BlueCHIP), but any insurance company in the state can participate in the program.

Today, 10,900 children are covered by CHIP. To hold down the costs of the program, many providers around the state participate in the BlueCHIP provider network and offer services to BlueCHIP children at a significant discount. DPHHS, the State of Montana, and BCBSMT truly appreciate this partnership.

Effective July 1, 2005, CHIP will receive additional state funding and increase the number of children enrolled in the program. If you have patients that may qualify, refer them to the CHIP office at 1-877-543-7669. A new simplified insurance form together with instructions is available on the CHIP website at http://chip.mt.gov. Click on *How to Apply*. You may also call the CHIP office if you would like to receive applications and informational brochures. The current income guidelines are listed below:

Family Size children and adults	**Family Annual Income** approximately
2	$19,245
3	$24,135
4	$29,025
5	$33,915
6	$38,505

Children may be eligible for CHIP even if the family annual income is higher than listed (depending on the number of family members working and dependent care paid).

More information about filing BlueCHIP claims can be found in the BCBSMT provider manual at www.bluecrossmontana.com. Click on *Provider Services* and then *Provider Manuals*.

PROMPT PAY LEGISLATIVE CHANGES

Montana's prompt pay legislation governing interest payments was changed during the recent 2005 legislative session. Prompt pay legislation requires insurers to pay interest on "clean" claims that are not paid within 30 days. The previous law required payment even if the interest was considerably less than the cost to prepare and mail the payment. The 2005 legislature amended the law to require payment of interest when the interest due exceeds $5.00. The amendment will apply to interest payments due on and after October 1, 2005.

Regular Business

Health HeW eb

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

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

SURVEY

BCBS PROVIDER SATISFACTION SURVEYS

The Blue Cross and Blue Shield Association's BlueCard Program is conducting an annual satisfaction survey. The Response Center, an independent research company, will conduct telephone interviews on behalf of BCBSMT using a randomly selected sample of providers who have served BlueCard members within the past year. The Response Center will ask to speak with the person who is most knowledgeable about filing Blue Cross and Blue Shield claims and/or the billing department. This year's survey will be administered from September through early November.

BCBSMT is also conducting its annual provider satisfaction survey. The Myers Group will be administering a three-wave mail survey beginning in late September and/or early October. Randomly selected participating providers will receive a questionnaire surveying 19 different attributes about BCBSMT.

Both surveys help BCBSMT and the Blue Cross and Blue Shield Association identify ways to better serve the medical community and members.

As a reminder, both surveys will not ask for any personal or confidential information such as provider or tax identification or social security numbers. BCBSMT received questions last year from providers inquiring about "companies" asking for this information on our behalf. These entities do not represent BCBSMT or the BCBS Association. Do not provide anyone with personal or sensitive business information.

If you have any questions about either survey, contact Mike McGuire at 1-800-447-7828, extension 8412.

Download the BCBSMT formulary to your PDA @ epocrates.com

Pharmacy

More pharmacy information available at www.bluecrossmontana.com

PHARMACY AND THERAPEUTICS COMMITTEE

BCBSMT held its quarterly Pharmacy and Therapeutic (P&T) Committee meeting on September 7, 2005. Participating physicians from various specialties were either present or teleconferenced for the meeting. The P&T committee's purpose is to review, discuss, and make decisions regarding pharmaceutical drugs and their formulary status with the goal of high-quality, low-cost drugs on the formulary. If you have any questions, contact Tina Wong at 1-800-447-7828, extension 8843.

THIRD QUARTER 2005 CHANGES TO THE FORMULARY

During the September 7, 2005, P&T Committee meetings, two new drugs were reviewed for formulary placement. Effective immediately, the following changes were made to the BCBSMT drug formulary that is used for the majority of its business. We encourage physicians to reference the formulary when prescribing medications for BCBSMT members.

Drug	Therapeutic Class	Formulary Status
Lantus Cartridges	Diabetes	Formulary
Ventavis	Other Vasodilating Drugs	Non-Formulary
Zylet	Ophthalmic Steroids	Non-Formulary

Participating Providers

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

The following pages list new and terminated providers for the Traditional Participating Provider Network and the Joint Venture Managed Care Provider Network. Also included are providers who are no longer participating with these networks.

May 18, 2005 to September 1, 2005

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

Deborah A. Angersbach, DC	Billings	Chiropractic
Andrew A. Barber, DO	Great Falls	Emergency Medicine
Elaine A. Barbieri, MD	Great Falls	Allergy & Immunology
Maureen L. Berumen, LCPC	Helena	Lic. Clin. Prof. Counselor
Timothy L. Bewley, PA-C	Choteau	Physician Assistant
Julia M. Bolding, MD	Great Falls	Rheumatology
Hallie A. Bornstein Banziger, PhD	Missoula	Psychology
Jennifer L. Brunsdon, MD	Helena	Family Practice
Ronald M. Buss, MD	Helena	Emergency Medicine
Deborah H. Cades, PA	Livingston	Physician Assistant
Deborah H. Cades, PA	Bozeman	Physician Assistant
Dawn M. Christian, PT	Missoula	Physical Therapy
Tyler B. Coleman, LCPC	Stevensville	Lic. Clin. Prof. Counselor
Monte L. Cooper, DDS	Great Falls	Dentist
Colleen E. Crane, MSW	Bozeman	Lic. Clin. Social Worker
Jeffrey S. Cummins, LCSW	Billings	Lic. Clin. Social Worker
Bryan L. Curry, LCPC	Butte	Lic. Clin. Prof. Counselor
Michelle L. Danielson, MD	Helena	Pediatrics
Clifford W. Davis, PA-C	Three Forks	Physician Assistant
Jon Tor K. Dewitt, DC	Havre	Chiropractic
Bradley K. Draper, MD	Billings	Dermatology
Alexandra L. Flerchinger, NP	Polson	Nurse Practitioner
Henry H. Gary, MD	Missoula	Surgery, Neurological
Daniel J. Gebhardt, MD	Harlowton	General Practice
Brett E. Gilleo, LCPC	Missoula	Lic. Clin. Prof. Counselor
Milton S. Glatterer Jr, MD	Kalispell	Surgery, Thoracic
Douglas L. Griffith, MD	Kalispell	Surgery, Neurological
Kathryn F. Hatch, MD	Billings	Surgery
Jeanne M. Hebl, CNM	Missoula	Certified Nurse Midwife
Robin S. Horrell, MD	Billings	Ear, Nose, and Throat
Gregory Thomas Jacobs, DO	Billings	Emergency Medicine
Steven P. Johnson, MD	Kalispell	Anesthesiology
Jaqueline Jones, PT	Lewistown	Physical Therapy
Kevin T. Kelly, MD	Great Falls	Anesthesiology
Alan B. Langburd, MD	Billings	Cardiovascular Disease
Jeffrey B. LaPlume, PT	Kalispell	Physical Therapy
Joyce E. Lee, PA	Bigfork	Physician Assistant
Christopher R. Lieb, MD	Miles City	Internal Medicine
Janice M. Linn, MD	Billings	Family Practice
Catherine S. Love, NP	Kalispell	Nurse Practitioner
Richard S. Mauseth, MD	Great Falls	Pediatrics
Georgianna S. Mayer, NP	Fort Benton	Nurse Practitioner
Joseph M. McClain, MD	Great Falls	Surgery, Cardiovascular
Heather L. McGuire, MD	Billings	Nephrology
Samuel J. Mitchell, MD	Missoula	Family Practice
Stephen S. Nagy, MD	Helena	Psychiatry
Lyle John Onstad, MD	Great Falls	Family Practice
Sylvia A. Owen, MD	Kalispell	Dermatology
Kevin R. Pancich, PT	Bozeman	Physical Therapy
Lynn M. Preston, DO	Billings	Cardiovascular Disease
Matthew J. Prill, DDS	Billings	Dentist
Dennis S. Probst, DO	Polson	Family Practice
Andrew R. Randak, MD	Billings	Anesthesiology
Steven G. Roberts, DO	Bozeman	Family Practice
John M. Schallenkamp, MD	Billings	Radiation Oncology
Constantine G. Scordalakes, MD	Sidney	Obstetrics and Gynecology
Michael Settevendemie, LCPC	Missoula	Psychology
Mathew B. Smolkin, MD	Helena	Pathology
Snyders Drug Stores Inc	Laurel	Pharmacy
Snyders Drug Stores Inc	Helena	Pharmacy
Snyders Drug Stores Inc	Billings	Pharmacy
Teresa M. Spanogle, LCPC	Hamilton	Lic. Clin. Prof. Counselor
Kari L. Steffen, MD	Billings	Neonatal-Perinatal Medicine
Lili A. Stiff, LCPC	Bozeman	Lic. Clin. Prof. Counselor
Cynthia P. Stoddard, MD	Butte	Psychiatry
Chad M. Swanson, OD	Helena	Optometry
Cade J. Taylor, DC	Belgrade	Chiropractic
Kristen J. Townley, MD	Missoula	Dermatology
Remington M. Townsend, DDS	Billings	Dentist
Patrick W. Tufts, MD	Superior	Family Practice
Robert S. Wagenaar, MD	Helena	Family Practice
Kelly S. Wait, PT	Bozeman	Physical Therapy

Kyle Wassmer, DDS	Billings	Dentist
Andrew C. Waters, PT	Bozeman	Physical Therapy
Joyce Ann Williams, DO	Billings	Rheumatology
Misty D. Williams, PT	Corvallis	Physical Therapy
Robert F. Yacavone, MD	Kalispell	Gastroenterology
Tye B. Young, DO	Billings	Internal Medicine
Troy R. Ypma, OD	Columbia Falls	Optometry

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

Megan W. Adkins, FNP	Hamilton	Nurse Practitioner
Jake J. Allen, MD	Great Falls	Surgery
Anthony V. Anderson, MD	Glasgow	Family Practice
Loy L. Anderson, MD	Great Falls	Family Practice
Gina M. Ardiana, NP	Moiese	Nurse Practitioner
Gina M. Ardiana, NP	Ronan	Nurse Practitioner
Gina M. Ardiana, NP	Saint Ignatius	Nurse Practitioner
Gina M. Ardiana, NP	Polson	Nurse Practitioner
Michael E. Banwart, OD	Great Falls	Optometry
Elaine M. Becker, CNM	Great Falls	Certified Nurse Midwife
Charles L. Blackburn, DDS	Billings	Dentist
Ryan T. Bower, MD	Helena	Family Practice
Daniel C. Brooke, MD	Miles City	Orthopaedics
Mary L. Cato, NP	Ronan	Nurse Practitioner
Stephen Wayne Coon, PT	Butte	Physical Therapy
Lea G. Cornell, MD	Bigfork	Family Practice
Michael A. Covlin, MD	Billings	Obstetrics and Gynecology
Mark Coward, MD	Missoula	Family Practice
Dale O. Lines	Kalispell	Medical Equipment
John P. Daniels, MD	Arlee	Family Practice
Michael F. Doubek, MD	Great Falls	Internal Medicine
James R. Drynan, MD	Butte	Internal Medicine
Virginia L. Forbes, NP	Hamilton	Nurse Practitioner
Raymond O. Giles, DC	Missoula	Chiropractic
Paul Gorsuch, MD	Great Falls	Surgery, Neurological
Charles E. Green, MD	Kalispell	Anesthesiology
Cynthia M. Hermes, CNM	Billings	Certified Nurse Midwife
Ronald F. Hughes, MD	Great Falls	Psychiatry
Bernadette M. Hunter, LPC	Missoula	Lic. Clin. Prof. Counselor
Kristine A. Hunter, MD	Helena	Internal Medicine
Mark Irion, MD	Miles City	Radiology
Mark Irion, MD	Forsyth	Radiology
Kathleen Olivia Janis, LCPC	Helena	Lic. Clin. Prof. Counselor
Carl L. Keener, MD	Dillon	Psychiatry
Carl L. Keener, MD	Butte	Psychiatry
Carl L. Keener, MD	Helena	Psychiatry
Clyde Knecht, MD	Libby	Surgery
Curt G. Kurtz, MD	Bozeman	Family Practice
Curt G. Kurtz, MD	Belgrade	Family Practice
Ladonna K. Ladd, NP	Conrad	Nurse Practitioner
Ladonna K. Ladd, NP	Great Falls	Nurse Practitioner
Katherine M. Laible, PA-C	Helena	Physician Assistant
Kirk T. Laughbaum, DC	Wolf Point	Chiropractic
Alan Loendorf, DPM	Miles City	Podiatry
Kristine M. Logan, MPT	Colstrip	Physical Therapy
Ronald E. Losee, MD	Ennis	Orthopaedics
Niall Patrick Madigan, MD	Billings	Cardiovascular Disease
Joseph C. Maheras, MD	Billings	Internal Medicine
Dennis P. Malinak, MD	Kalispell	Psychiatry
Dennis P. Malinak, MD	Butte	Psychiatry
Mary C. Mallon, OT	Missoula	Occupational Therapy
Anne Manktelow, MD	Missoula	Pediatric Surgery
Irene R. Martin, MD	Eureka	Family Practice
Irene R. Martin, MD	Kalispell	Family Practice
William R. McGregor, MD	Great Falls	Surgery
Mission Valley Medical Oxygen	Polson	Oxygen Supplier
Mission Valley Medical Oxygen	Polson	Medical Equipment
Elizabeth D. Moore, PA-C	Three Forks	Physician Assistant
Elizabeth D. Moore, PA-C	Manhattan	Physician Assistant
Barry A. Morguelan, MD	Missoula	Internal Medicine
Eric N. Mosqueda, MD	Butte	Pediatrics
Richard A. Nelson, MD	Billings	Neurology
Robert W. Nelson, MD	Billings	Family Practice
Teresea Olson, PA	Baker	Physician Assistant
Gerald E. Peters Jr., MD	Billings	Dermatology
John A. Peters, MD	Bozeman	Psychiatry
Robert D. Pfeffer, MD	Great Falls	Radiation Oncology
Sheri L. Rolf, MD	Billings	Ear, Nose, and Throat
Laine C. Russell, DO	Miles City	Family Practice
Ladd D. Rutherford, MD	Bozeman	Orthopaedics
David S. Schaefer, MD	Helena	Psychiatry
Eric W. Schmidt, MD	Great Falls	Hematology and Oncology
Tristan A. Seitz, MD	Helena	Internal Medicine
Julie L. Shulman, LCPC	Bozeman	Lic. Clin. Prof. Counselor
Peggie A. Smith, PA-C	Billings	Physician Assistant
Wayne L. Smithberg, MSW	Billings	Lic. Clin. Social Worker
William H. Smoot, MD	Billings	Dermatology
Thomas R. Stephenson, MD	Scobey	General Practice
William W. Stewart, MD	Kalispell	Urology
William J. Taylor, PHD	Fort Benton	Psychology
William J. Taylor, PHD	Great Falls	Psychology
Tommathew T. Thomas, MD	Glendive	Internal Medicine
Beth E. Thompson, MD	Missoula	Internal Medicine
Stacy L. Upton, PT	Kalispell	Physical Therapy
Kristin R. Veneman, DO	Whitefish	Pediatrics
Dulcinea A. Voermans, PT	Helena	Physical Therapy
Dulcinea A. Voermans, PT	Butte	Physical Therapy
Robyn F. Wahl, PT	Butte	Physical Therapy

Frank L. Walker, MD	Missoula	Emergency Medicine
Frank L. Walker, MD	Bozeman	Emergency Medicine
Stewart R. Ward, OD	Missoula	Optometry
Dick Warner, DDS	Montana City	Dentist
Eric D. Weiner, MD	Kalispell	Internal Medicine
James B. Wendt, MD	Billings	Geriatric Medicine
Jason J. Wheeler, DDS	Billings	Dentist
Jessica Anne Wheeler, DDS	Billings	Dentist
Elizabeth M. White, MD	Kalispell	Internal Medicine
Robert Wu, MD	Great Falls	Anesthesiology
John W. Zakrzewski, PT	Billings	Physical Therapy
John W. Zakrzewski, PT	Laurel	Physical Therapy

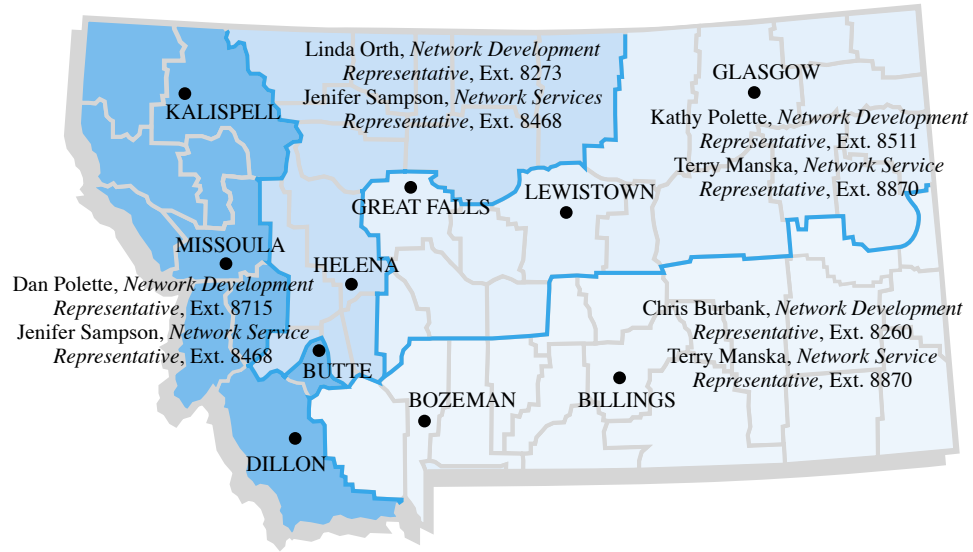
Blue Cross and Blue Shield of Montana welcomes these new Joint Venture Providers.

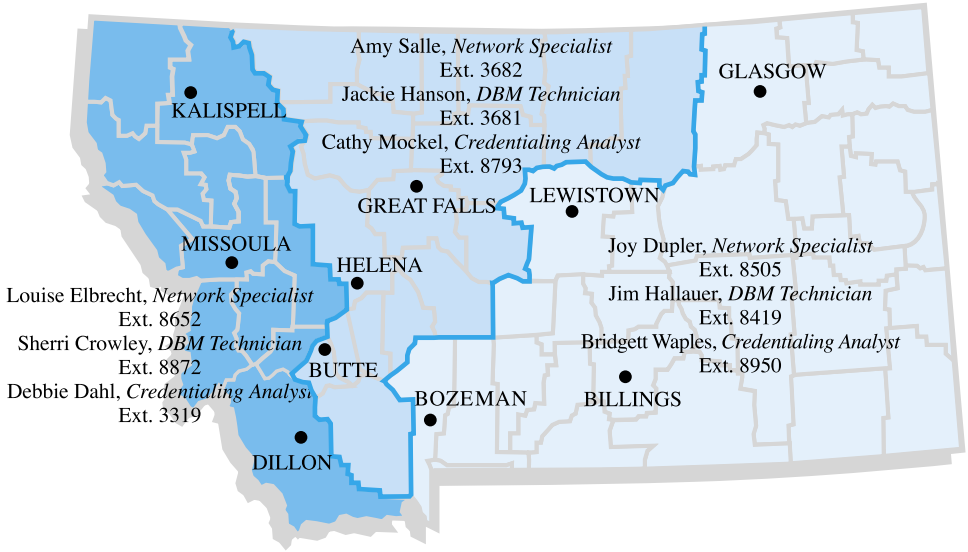
Steven J. Anderson, PT	Bozeman	Physical Therapy
Elizabeth M. Asserson, PhD	Bozeman	Psychology
Aimee E. Avison, PA-C	Polson	Physician Assistant
Andrew A. Barber, DO	Great Falls	Emergency Medicine
Elaine A. Barbieri, MD	Great Falls	Allergy & Immunology
Regina T. Basolo, LCPC	Belgrade	Lic. Clin. Prof. Counselor
Gabor Benda, MD	Bozeman	Family Practice
Maureen L. Berumen, LCPC	Helena	Lic. Clin. Prof. Counselor
Timothy L. Bewley, PA-C	Choteau	Physician Assistant
Robert B. Blake, MD	Bozeman	Orthopaedics
Cheryl R. Blank, PHD	Bozeman	Psychology
Julia M. Bolding, MD	Great Falls	Rheumatology
Kathryn Borgenicht, MD	Bozeman	Internal Medicine
Scot J. Bowen, DC	Billings	Chiropractic
Bozeman Deaconess Hospital	Bozeman	Hospital
Bozeman Deaconess Hospital	Bozeman	Speech Therapy
Bozeman Deaconess Hospital	Bozeman	Occupational Therapy
Bozeman Deaconess Hospital	Bozeman	Physical Therapy
Bozeman Deaconess Hospital	Bozeman	Lab / Xray / Machine Tests (outpatient)
Neil S. Bricco, LCPC	Belgrade	Lic. Clin. Prof. Counselor
Sarah E. Bronsky, MD	Bozeman	Family Practice
Jennifer L. Brunsdon, MD	Helena	Family Practice
Shawn Burwell, MD	Livingston	Obstetrics and Gynecology
Andrea K. Cady, MD	Bozeman	Family Practice
John D. Campbell, MD	Bozeman	Orthopaedics
Rebecca E. Canner, MD	Livingston	Family Practice
Rebecca E. Canner, MD	Bozeman	Family Practice
Patricia E. Cantrell, PA-C	Bozeman	Physician Assistant
Annie L. Castillo, MD	Bozeman	Oncology
James F. Cleary, MD	Livingston	Family Practice
James F. Cleary, MD	Bozeman	Family Practice
Cosmetic Surgical Arts	Missoula	Surgery Center
Gary P. Crawford, MD	Bozeman	Orthopaedics
David B. Culp, NP	Hamilton	Nurse Practitioner
Michelle L. Danielson, MD	Helena	Pediatrics
Mark C. Deibert, MD	Bozeman	Orthopaedics
Timothy J. DeVries, PA-C	Bozeman	Physician Assistant
Christine E. Drivdahl-Smith, MD	Miles City	Family Practice
Martha (Lass) F. Dudley, LCPC	Belgrade	Lic. Clin. Prof. Counselor
Blair D. Erb, MD	Bozeman	Cardiovascular Disease
Kristi J. Fischer, PT	Billings	Physical Therapy
Robert J. Flaherty, MD	Bozeman	Family Practice
Joshua J. Flohr, DC	Belgrade	Chiropractic
Benjamin N. Flook, MD	Livingston	Family Practice
Brian J. Frykman, PA-C	Bozeman	Physician Assistant
Daniel M. Gannon, MD	Bozeman	Orthopaedics
Henry H. Gary, MD	Missoula	Surgery, Neurological
Robert R. Gaskill, OD	Billings	Optometry
Shaun J. Gillis, MD	Bozeman	Obstetrics and Gynecology
Milton S. Glatterer Jr, MD	Kalispell	Surgery, Thoracic
Douglas L. Griffith, MD	Kalispell	Surgery, Neurological
Tim B. Grossman, MD	Helena	Urology
Lexi L. Gulbranson, MD	Bozeman	Family Practice
Carl R. Hansen, PT	Kalispell	Physical Therapy
Heather H. Hart, PA-C	Bozeman	Physician Assistant
Kathryn F. Hatch, MD	Billings	Surgery
Robert A. Hathaway, MD	Bozeman	Internal Medicine
Jeanne M. Hebl, CNM	Missoula	Certified Nurse Midwife
Ronald N. Hecht, DC	Bozeman	Chiropractic
Denise A. Helin, MD	Livingston	Obstetrics and Gynecology
Jack O. Hensold, MD	Bozeman	Hematology
Jack O. Hensold, MD	Bozeman	Oncology
Michael T. Herring, MD	Bozeman	Internal Medicine
Pamela J. Hiebert, MD	Bozeman	Internal Medicine
Gregory P. Hoell, DC	Bozeman	Chiropractic
David J. Hoffman, MD	Bozeman	Family Practice
Karen J. Izbicki, PA-C	Bozeman	Physician Assistant
Gregory Thomas Jacobs, DO	Billings	Emergency Medicine
Jerrold E. Johnson, MD	Bozeman	Family Practice
Michael C. Jones, DC	Bozeman	Chiropractic
Rebecca J. Kane, FNP	Bozeman	Nurse Practitioner
Kevin T. Kelly, MD	Great Falls	Anesthesiology
David B. King, MD	Belgrade	Family Practice
Marsha L. Kirchner, LCPC	Missoula	Lic. Clin. Prof. Counselor
Heather D. Kjerstad, MD	Belgrade	Family Practice
Heather D. Kjerstad, MD	Bozeman	Family Practice
Alan B. Langburd, MD	Billings	Cardiovascular Disease
Joyce E. Lee, PA	Bigfork	Physician Assistant
Gary J. Litle, DC	Bozeman	Chiropractic
James E. Loeffelholz, MD	Bozeman	Internal Medicine
Richard S. Mauseth, MD	Great Falls	Pediatrics
Kimberly A. Maxwell, DC	Stevensville	Chiropractic

Jacqueline J. McAdam, MPT	Butte	Physical Therapy
Bryan S. McDaniel, PA-C	Bozeman	Physician Assistant
David I. McLaughlin, MD	Bozeman	Family Practice
Ralph Adron Medley, MD	Helena	Surgery
Samuel J. Mitchell, MD	Missoula	Family Practice
Patricia A. Moran, MD	Belgrade	Family Practice
Anna K. Nash, PT	Helena	Physical Therapy
Patricia A. Nichols, LCPC	Billings	Lic. Clin. Prof. Counselor
Stephen A. Nickisch, MD	Bozeman	Obstetrics and Gynecology
Dennis L. Noteboom, MD	Livingston	General Practice
Debora A. O'Brien, LCPC	Cut Bank	Lic. Clin. Prof. Counselor
Timothy O'Brien, MD	Bozeman	Orthopaedics
Peggy E. O'Hara, MD	Livingston	Pediatrics
Sylvia A. Owen, MD	Kalispell	Dermatology
Anders V. Persson, MD	Bozeman	Internal Medicine
Erich Pessl, MD	Bozeman	Family Practice
Erich Pessl, MD	Livingston	Family Practice
Erica L. Peterson, MD	Bozeman	Family Practice
Michael H. Power, MD	Billings	Ophthalmology
James Thomas Priddy, MD	Billings	Ophthalmology
Dennis S. Probst, DO	Polson	Family Practice
Ellen Jones Purser, DC	Bozeman	Chiropractic
Royce G. Pyette, MD	Bozeman	Orthopaedics
Christine M. Quinn, NP	Bozeman	Nurse Practitioner
Leonard R. Ramsey, MD	Bozeman	Family Practice
Wes W. Rashid, DPM	Kalispell	Podiatry
Daniel P. Rausch, MD	Polson	Family Practice
Genevieve Kara Reid, MD	Livingston	Family Practice
John B. Robbins, MD	Bozeman	Internal Medicine
Jon F. Robinson, MD	Bozeman	Orthopaedics
Robert R. Roeper, DO	Hamilton	Emergency Medicine
Christopher S. Rost, PA-C	Bozeman	Physician Assistant
George J. Saari, MD	Bozeman	Internal Medicine
Dan D. Satchell, DC	Belgrade	Chiropractic
Gregory W. Schneider, MD	Livingston	Family Practice
Gregory W. Schneider, MD	Bozeman	Family Practice
Mark Schulein, MD	Livingston	Family Practice
Michael Settevendemie, LCPC	Missoula	Lic. Clin. Prof. Counselor
Barry N. Smith, MD	Billings	Orthopaedics
Mathew B. Smolkin, MD	Helena	Pathology
Larry W. Sonnenberg, MD	Bozeman	Family Practice
Joan M. Spannring, NP	Bozeman	Nurse Practitioner
Teresa M. Spanogle, LCPC	Hamilton	Lic. Clin. Prof. Counselor
Steven R. Speth, MD	Bozeman	Orthopaedics
Kari L. Steffen, MD	Billings	Neonatal-Perinatal Medicine
Cade J. Taylor, DC	Belgrade	Chiropractic
Vicki L. Thuesen, NP	Butte	Nurse Practitioner
Kristen J. Townley, MD	Missoula	Dermatology
John A. Vallin, MD	Bozeman	Physical Medicine & Rehabilitation
Timothy S. Visscher, MD	Livingston	Psychiatry
Timothy S. Visscher, MD	Bozeman	Psychiatry
Michael J. Vlases, MD	Bozeman	Internal Medicine
Robert S. Wagenaar, MD	Helena	Family Practice
Gordon Steven Wallace, LCPC	Billings	Lic. Clin. Prof. Counselor
Alan A. Wanderer, MD	Bozeman	Allergy & Immunology
Andrew C. Waters, PT	Bozeman	Physical Therapy
Virginia Watts, LCPC	Belgrade	Lic. Clin. Prof. Counselor
Heather J. Wheeler, MD	Bozeman	Family Practice
Joyce Ann Williams, DO	Billings	Rheumatology
Nichole M. Wiltshire-Scala, SLP	Bozeman	Speech Therapy
Robert F. Yacavone, MD	Kalispell	Gastroenterology
Stacey L. Young, NP	Hamilton	Nurse Practitioner
Troy R. Ypma, OD	Columbia Falls	Optometry

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

Megan W. Adkins, FNP	Hamilton	Nurse Practitioner
Gina M. Ardiana, NP	Moiese	Nurse Practitioner
Elaine M. Becker, CNM	Great Falls	Certified Nurse Midwife
Ryan T. Bower, MD	Helena	Family Practice
Karla Rae Carr, OT	Billings	Occupational Therapy
Mary L. Cato, NP	Ronan	Nurse Practitioner
Stephen Wayne Coon, PT	Butte	Physical Therapy
Lea G. Cornell, MD	Bigfork	Family Practice
Alyne E. Eickert, PT	Billings	Physical Therapy
Alyne E. Eickert, PT	Laurel	Physical Therapy
Virginia L. Forbes, NP	Hamilton	Nurse Practitioner
Cynthia M. Hermes, CNM	Billings	Certified Nurse Midwife
Kristine A. Hunter, MD	Helena	Internal Medicine
Joseph C. Maheras, MD	Billings	Internal Medicine
Jacqueline J. McAdam, MPT	Helena	Physical Therapy
William R. McGregor, MD	Great Falls	Surgery
Barry A. Morguelan, MD	Missoula	Internal Medicine
Eric N. Mosqueda, MD	Butte	Pediatrics
Robert D. Pfeffer, MD	Great Falls	Radiation Oncology
Eric W. Schmidt, MD	Great Falls	Hematology and Oncology
Tristan A. Seitz, MD	Helena	Internal Medicine
Peggie A. Smith, PA-C	Billings	Physician Assistant
Wayne L. Smithberg, MSW	Billings	Lic. Clin. Social Worker
William H. Smoot, MD	Billings	Dermatology
Stacy L. Upton, PT	Kalispell	Physical Therapy
Kristin R. Veneman, DO	Whitefish	Pediatrics
Dulcinea A. Voermans, PT	Butte	Physical Therapy
Robyn F. Wahl, PT	Butte	Physical Therapy
Eric D. Weiner, MD	Kalispell	Internal Medicine
Elizabeth M. White, MD	Kalispell	Internal Medicine
John W. Zakrzewski, PT	Laurel	Physical Therapy
John W. Zakrzewski, PT	Billings	Physical Therapy





HEALTH CARE TEAM SERVICES

1-800-447-7828

PROVIDER SERVICE TEAMS

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

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

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

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

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

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

FRAUD

ANTI-FRAUD EFFORTS SAVE BLUE CROSS BLUE SHIELD PLANS NEARLY $228 MILLION IN 2004

Karl Krieger, CFE, AHFI

Blue Cross and Blue Shield Plans' anti-fraud efforts resulted in the recovery of nearly $228 million in 2004, according to recent anti-fraud data released by the Blue Cross and Blue Shield Association (BCBSA). Blue Plans' Special Investigative Units (SIU) recovered approximately $120 million and prevented the additional loss of almost $108 million, demonstrating how Blue Plans – in partnership with law enforcement – aggressively identify and pursue fraud and take corrective action.

Other anti-fraud data released by BCBSA includes:

- 663 cases referred to law enforcement authorities—14.7% increase.
- 189 warrants and indictments issued—17% increase.
- Hotline calls received by Plans increased by more than 15% for a total of more than 80,000 calls.

According to the National Healthcare Anti-Fraud Association, fraudulent health transactions constitute a small fraction of the four billion annual health care transactions a year but carry a high price tag. Estimates by government and law enforcement agencies place the loss to fraud as high as $90 billion, or about five percent of the total $1.8 trillion spent on health care in 2004.

BCBSMT is an active participant in the fight against health care fraud with a fully staffed SIU that works with local, state, and federal law enforcement agencies to identify, investigate, and prosecute fraudulent activity. In 2004, the BCBSMT SIU received more than 400 referrals and reported more than 25 cases to law enforcement. These numbers are up significantly in 2005, with more than 600 referrals projected by year-end and more than 40 cases already reported to law enforcement this year.

If you are aware of fraudulent activity or have questions about healthcare fraud, please call me at 1-800-447-7828, extension 8211. You can also access our website at www.stopfraud.bcbsmt.com.

Karl Krieger currently serves as a BCBSMT Special Investigator, is a Certified Fraud Examiner, and an Accredited Health Care Fraud Investigator. Karl has been employed by BCBSMT for over 15 years, has received the DPHHS Inspector General's Integrity Award for his work in health care fraud, and currently serves as Vice-President on the Board of Directors for the Big Sky Chapter of the Association of Certified Fraud Examiners. Karl can be reached at 1-800-447-7828, extension 8211, or by email at kkrieger@bcbsmt.com. For more information, refer to the BCBSMT anti-fraud website at www.stopfraud.bcbsmt.com.

1-800-621-0992

stopfraud.bcbsmt.com

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