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A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

FOURTH QUARTER 2004

BCBSMT Recognized by HARVARD Medical School

BCBSMT was recognized recently by Harvard Medical School for increasing access to quality health care for members of the Helena-area Native American community, through a partnership formed earlier this year with the Helena Indian Alliance and the Leo Pocha Clinic.

“We appreciate the recognition of the Harvard Medical School and Blue Cross and Blue Shield Association for identifying the importance of our efforts to provide access to quality health care for all Montanans,” said Peter Babin, BCBSMT President and CEO. “For urban Indians, who move off reservations and become displaced or are forced to levels of employment that offer no insurance, access to quality health care is very limited, and we are working with the Helena Indian Alliance to identify the most pressing health care needs facing the Helena Native American community. We are very proud of our successful partnership with the HIA and of the significant accomplishments we have achieved together.”

Through the partnership, the Clinic has received financial support to increase the availability of the Clinic’s psychiatrist; some new instruments, and 12 computers with donated consultation time to resolve network problems and provide updated technology to improve claims management. A strategic partnership with Ridgeway Pharmacy provides the Clinic with vitamins, baby aspirin, and other drugs at little or no cost. According to Dr. Roy Arnold, BSBCMT’s Corporate Medical Director, “These additions allow the Leo Pocha Clinic to function with improved efficiency and service to its patients, and we are pleased to have the opportunity to work cooperatively with the HIA and the Native American community in our hometown.”

Harvard Medical School, in conjunction with the national Blue Cross and Blue Shield Association, is identifying programs from Blue Cross Blue Shield companies across the country that are effective in keeping quality health care affordable.

“The potential for reducing disparities in health care is one reason this partnership is worthy of recognition,” said researchers of the Harvard Medical School. “Through the efforts of BCBS of Montana, one local clinic has significantly increased access to care, offered medications to individuals who cannot afford them, and improved the clinic’s infrastructure. All of these changes could result in a healthier population requiring less care in the future.”

BlueWorks is a unique collaboration between BCBSA and the Harvard Medical School’s Department of Healthcare Policy to evaluate Blue Cross and Blue Shield company initiatives that address health care affordability, quality and access. Each quarter, a panel of experts from the Harvard Medical School selects a number of Blue Plan initiatives that have proven effective in improving the affordability and quality of care. Selected programs are published in *BlueWorks Quarterly*, which showcases innovative ideas and highlights programs at work today. Winning programs are also promoted throughout the BCBS System and the health care industry as examples of initiatives that can be replicated to help keep quality health care affordable in the United States.

The Helena Indian Alliance is a non-profit organization established to develop, implement, and maintain programs in the areas of health, education, mental health, employment, and housing. It is operated for the charitable purpose of promoting the cultural, social and economic welfare of the Native American community of Helena, Lewis & Clark County, Montana.

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MEDICAL
POLICY

NEW POLICIES

The Medical and Compensation Physician's Committee met during the third quarter of 2004 and approved the following New and Revised medical policies. Effective dates are listed on each policy. Note: Only the "Policy" section is included in revised policies and when the policy change is minor, just that portion of the policy is included. Medical policy is available online at www.bluecrossmontana.com.

VARICOSE VEINS,
TREATMENT OF

Chapter: Surgery - Procedures
New Policy

Effective Date: March 1, 2005

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DESCRIPTION

The venous system of the lower extremities consists of the superficial (greater and lesser saphenous veins) and deep system (popliteal and femoral veins) that are connected via perforator veins. Varicose veins of the superficial system are typically secondary to valve incompetence in the one-way valves present at the junctions between the bifurcation point of the deep and superficial systems. The venous pressure in the deep system is generally greater than the superficial system. Valve incompetence leads to pooling of blood and visible varicosities in the tributaries of the saphenous vein.

Many varicosities are asymptomatic. When present, symptoms may include itching, heaviness, tension, and pain. The term "varicose veins" does not apply to the telangiectatic dermal veins, described as "spider veins" or "broken blood vessels". While abnormal in appearance, these veins typically are not associated with symptoms, and their treatment is considered cosmetic.

Sclerotherapy alone is commonly used to treat this type of vein.

First, the treatment focuses on identifying the site of reflux and then on re-directing venous flow through veins with intact valves. Surgical treatment, commonly known as ligation and stripping, involves the following steps:

- Suture ligation and division of the saphenofemoral or saphenopopliteal junction.
- Stripping of the greater and/or lesser saphenous veins to remove the refluxing vein from circulation.
- Stab avulsion or injection sclerotherapy, at the time of the initial treatment or subsequently, used to remove varicose tributaries.

Various alternatives to ligation and stripping have been investigated, including endoluminal radiofrequency and laser ablation. Both therapies are designed to damage the intimal wall of the vessel resulting in fibrosis and ultimately obliteration of a long segment of the vein.

Radiofrequency ablation is performed by means of a specially designed catheter inserted through a small incision in the distal medial thigh to within 1-2 cm of the saphenofemoral junction. High frequency radiowaves are delivered through the catheter electrode causing direct heating of the vessel wall, resulting in vein collapse. Laser ablation is similarly performed except a bare-tipped laser fiber is introduced into the greater saphenous vein under ultrasound guidance.

POLICY

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

MEDICALLY NECESSARY

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

- Surgical treatment of the saphenous vein by ligation and stripping.
- Sclerotherapy as an adjunct to surgical treatment of venous reflux disease.
- Endoluminal radiofrequency ablation or endovascular laser ablation of the greater saphenous vein as an alternative to saphenous vein ligation and stripping.

PATIENT SELECTION
CRITERIA

BCBSMT applies the following patient selection criteria for patients undergoing surgical, endoluminal radiofrequency, or laser ablation:

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

COSMETIC

BCBSMT considers the treatment of superficial telangiectasias (spider veins) and asymptomatic varicosities to be cosmetic.

INVESTIGATIONAL

BCBSMT considers the following treatments investigational:

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

CODING

FOURTH QUARTER 2004

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Production
Fleming Graphics

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



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CPT CODES

36011 Selective catheter placement, venous system; first-order branch.

36470 Injection of sclerosing solution; single vein.

36471 Injection of sclerosing solution; multiple veins, same leg.

36475 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated.

36476 Second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure).

36478 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated.

36479 Second and subsequent veins treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure).

37204 Transcatheter occlusion or embolization, percutaneous, any method, non-central nervous system.

37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions.

37799 Unlisted procedure, vascular surgery.

75894 Transcatheter therapy, embolization, any method, radiologic supervision and interpretation.

HCPCS CODES

Note: Ultrasonic guidance (CPT 76937) may be billed in addition to S2131 but not in addition to S2130.

S2130 Endoluminal radiofrequency ablation of refluxing saphenous vein.

S2131 Endovascular laser ablation of long or short saphenous vein, with or without proximal ligation or division.

REVISED POLICIES

BREAST PUMPS, ELECTRICAL

Chapter: Durable Medical Equipment
Revised Policy

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Original Effective Date: March 26, 1996

Current Effective Date: March 1, 2005

POLICY

Prior authorization is recommended. A retrospective review will be performed if services are not medically necessary.

BCBSMT considers rental of an electric breast pump medically necessary when any of the following criteria are met:

- A preterm infant of less than 36 weeks gestation.
- An illness that requires the infant be detained in the hospital following discharge of the mother.
- An illness that requires readmission to the hospital for a breastfeeding infant in the first six months of life.
- An infant with a congenital anomaly such as cleft palate that interferes with breastfeeding.
- A "failure to thrive" infant if it is determined the mother's milk supply is inadequate.
- Any medical condition affecting the infant's ability to suck adequately, such as a congenital heart condition.
- Any illness, disease, or use of medication that requires the breastfeeding mother to "pump and dump" to maintain her milk supply for a limited period of time to resume breastfeeding when it is safe to do so.
- Any illness or disease of the breastfeeding mother that requires hospitalization and separation from her infant.

NONCOVERED SERVICES

An electric breast pump will not be allowed when it is solely for the convenience of the mother such as the mother returning to work.

EPIDURAL PAIN MANAGEMENT, POST-OPERATIVE

Chapter: Surgery - Procedures

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: December 1, 1990

Original Effective Date: December 1, 1990

Current Effective Date: March 1, 2005

POLICY

BCBSMT considers the use of epidural pain management medically necessary. Covered services include:

- Placement of the epidural catheter (CPT Code 62319).
- Monitoring by the anesthesiologist, including the day of the surgical procedure, and up to five days following the surgical procedure (CPT code 01996). Documentation of visits must be evident in the medical record and be available upon request.

ENHANCED EXTERNAL COUNTERPULSATION (EECP)

Chapter: Medicine: Treatments

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: April 10, 2002

Original Effective Date: May 17, 2002

Current Effective Date: March 1, 2005

POLICY

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

MEDICALLY NECESSARY

BCBSMT considers enhanced external counterpulsation (EECP) medically necessary for patients with angina pectoris who meet all three of the following criteria:

- Have a diagnosis of disabling angina (Class III or IV per the Canadian Cardiovascular Society Classification, or equivalent).
- Have failed medical management including all available classes of outpatient medications (nitrates, beta blocking agents, and calcium antagonists).
- Are not candidates for surgical revascularization such as coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) because:
 - The condition is inoperable or at high risk of operative complications or post-operative failure.

MEDICAL POLICY

- The coronary anatomy is not readily amenable to such procedures.
- There are co-morbid conditions which create excessive risk.

INVESTIGATIONAL

BCBSMT considers all other uses of EECIP investigational.

EXTRACORPOREAL SHOCK WAVE THERAPY (ESWT) FOR MUSCULOSKELETAL CONDITIONS

Chapter: Medicine: Treatments
Revised Policy

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Senior Staff Approval Date: May 8, 2002

Original Effective Date: May 17, 2002

Current Effective Date: March 1, 2005

POLICY

INVESTIGATIONAL

BCBSMT considers the use of ESWT investigational to treat the several conditions including, but not limited to, the following:

- Chronic plantar fasciitis.
- Chronic tendinitis of the shoulder.
- Tendinopathies including tendinitis of the shoulder and elbow (epicondylitis, tennis elbow).
- Stress fractures.
- Delayed union and non-union of fractures.
- Avascular necrosis of the femoral head.
- Peyronie's disease.

RATIONALE

BCBSMT does not believe there is compelling evidence from existing clinical studies that indicate a statistically significant improvement in pain reduction for patients treated with ESWT. For example, HealthTronics sponsored a double-blind, placebo-controlled trial of 260 patients with chronic plantar fasciitis. The outcome of this study indicated the majority of the positive treatment effect was observed in the evaluator's - not the patient's - assessment of heel pain.

Two other studies, rated as "fair", using criteria developed by the US Preventive Services Taskforce, indicated a greater degree of improvement in the ESWT group compared to placebo.

The Blue Cross and Blue Shield Technology Evaluation Center (TEC) states it is likely that ESWT is efficacious in reducing heel pain and improving activity for patients with chronic plantar fasciitis that is unresponsive to prior treatment. BCBSMT will review future published clinical studies for compelling evidence of ESWT's effectiveness with a clear link to clinically meaningful measurements.

POSITRON EMISSION TOMOGRAPHY (PET)

Chapter: Radiology

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: October 27, 2000

Original Effective Date: January 1, 2001

Current Effective Date: March 1, 2005

POLICY

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

MEDICALLY NECESSARY CARDIAC APPLICATIONS

BCBSMT considers PET scans for the following cardiac applications to be medically necessary:

- Myocardial perfusion to diagnose coronary artery disease when used instead of, but not in addition to, single photon emission computed tomography (SPECT) or following an inconclusive SPECT.
- Myocardial viability in patients with severe left ventricular dysfunction as a technique to determine candidacy for a revascularization procedure.

MEDICALLY NECESSARY ONCOLOGIC APPLICATIONS

BCBSMT considers PET scans for the evaluation of malignancy to be medically necessary when one or more of the following criteria are met:

- When PET scan results replace the need for an invasive diagnostic procedure. For most solid tumors, a biopsy diagnosis is made prior to the performance of PET scanning. The use of PET in the diagnosis of malignancies is expected to be rare.
- The stage of the cancer remains in doubt after completion of a standard diagnostic workup, including biopsy and conventional imaging such as computed tomography, magnetic resonance imaging, or ultrasound.
- For restaging after the completion of treatment to:
 - Detect residual disease.
 - Detect suspected recurrence.
 - Determine the extent of a known recurrence.

NOT MEDICALLY NECESSARY ONCOLOGIC APPLICATIONS

BCBSMT considers the use of PET scanning to monitor tumor response during the planned course of therapy as not medically necessary when the results of the PET scan will not alter the treatment plan.

OTHER MEDICALLY NECESSARY APPLICATIONS

BCBSMT considers PET scans to be medically necessary as follows:

1. For the diagnosis and treatment of Mild Cognitive Impairment (MCI) and early dementia in patient who meet all of the following criteria:
 - Documented cognitive decline of at least six months.
 - The diagnostic criteria for both Alzheimer's Disease (AD) and Fronto-Temporal Dementia (FTD) have been met.
 - The patient been evaluated for specific alternate neurodegenerative diseases or causative factors, and the cause of the clinical symptoms remains uncertain.
2. When used in the assessment of selected patients with refractory epileptic seizures who are candidates for surgery. Appropriate candidates for FDG PET scans for epileptic seizure patients are for those patients who meet the following criteria:

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- Complex partial seizures that have failed to respond to medical therapy.
- Advised to have a resection of a suspected epileptogenic focus located in the region of the brain accessible to surgery.
- Conventional techniques for seizure localization have been tried and provided data that suggested a seizure focus, but are were not sufficiently conclusive to permit surgery.
- The purpose of the PET examination should be to avoid subjecting the patient to extended preoperative electroencephalographic recording with implanted electrodes.

INVESTIGATIONAL

The progress of PET scan technology continues to change rapidly. BCBSMT will willingly update the medical policy when research demonstrates effectiveness. BCBSMT considers PET scans for the following conditions investigational:

1. Anorexia nervosa.
2. Cardiac diseases, other than those listed above.
3. Auto immune disorders with CNS manifestations including, but not limited to, the following:
 - Bahce's syndrome.
 - Lupus erythematosus.
4. Cerebrovascular diseases including, but not limited to, the following:
 - Arterial occlusive disease (arteriosclerosis, atherosclerosis).
 - Carotid artery disease.
 - Cerebral aneurysm.
 - Cerebrovascular malformations (AVM and Moya Moya disease).
 - Hemorrhage.
 - Infarct.
 - Ischemia.
5. Cerebral blood flow in newborns.
6. Degenerative motor neuron diseases including, but not limited to, the following:
 - Amyotrophic lateral sclerosis.
 - Friedreich's ataxia.
 - Olivopontocerebellar atrophy.

- Parkinson's disease.
 - Progressive supranuclear palsy.
 - Shy-Drager syndrome.
 - Spinocerebellar degeneration.
 - Steele-Richard-Olszewski disease.
 - Tourette's syndrome.
7. Demyelinating diseases, such as multiple sclerosis.
 8. Developmental, congenital, or inherited disorders including, but not limited to, the following:
 - Adrenoleukodystrophy.
 - Down's syndrome.
 - Huntington's chorea.
 - Kinky hair disease (Menkes' syndrome).
 - Sturge-Weber syndrome (encephalofacial angiomatosis) and the phakomatoses.
 9. Nutritional or metabolic diseases and disorders including, but not limited to, the following:
 - Acanthocytes.
 - Hepatic encephalopathy.
 - Hepatolenticular degeneration.
 - Metachromatic leukodystrophy.
 - Mitochondrial disease.
 - Subacute necrotizing encephalomyelopathy.
 10. Pyogenic infections including, but not limited to, the following:
 - Aspergillosis.
 - Encephalitis.
 11. Substance abuse, including the CNS effects of alcohol, cocaine, and heroin.
 12. Viral infections including, but not limited to, the following:
 - Acquired immuno deficiency syndrome (AIDS).
 - AIDS dementia complex.
 - Creutzfeldt-Jakob syndrome.
 - Progressive multifocal leukoencephalopathy.
 - Progressive rubella encephalopathy.
 - Subacute sclerosing panencephalitis.
 13. Vegetative versus "locked in state".

14. Migraine Headaches.
15. Psychiatric diseases and disorders including, but not limited to, the following:
 - Affective disorders, depression.
 - Obsessive-compulsive disorder.
 - Psychomotor disorders.
 - Schizophrenia.
16. Pulmonary diseases including, but not limited to, the following:
 - Adult respiratory distress syndrome.
 - Diffuse panbronchiolitis.
 - Emphysema.
 - Obstructive lung disease.
 - Pneumonia.

AUDIOLOGIST REIMBURSEMENT

Chapter: Administrative
Revised Policy

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Senior Staff Approval Date: September 24, 1996

Original Effective Date: November 1, 1996

Current Effective Date: March 1, 2005

POLICY

ROUTINE DIAGNOSES

BCBSMT will compensate services for routine hearing exams only when the member contract has a screening benefit.

MEDICALLY NECESSARY

BCBSMT considers audiometric studies medically necessary when hearing loss is the result of illness or injury including, but not limited to, the following:

- Otitis media.
- Acoustic neuroma.
- Meniere's disease.
- Labyrinthitis.
- Vertigo (dizziness).
- Tinnitus.
- Otosclerosis.
- Neoplasms of the auditory or central nervous system.
- Congenital anomalies.
- Surgery involving the auditory

MEDICAL POLICY

and/or central nervous system (e.g., skull-based tumors such as acoustic neuroma and meningioma).

- Facial nerve paralysis (Bell's palsy).
- Bacterial meningitis.
- Ototoxic drugs.
- Fractures of the temporal bone or trauma affecting the central auditory pathways.

Note: Diagnostic testing is covered under the medical section of the member contract.

INVESTIGATIONAL

BCBSMT considers the following audiometric studies to be investigational including, but not limited to, the following:

- Computerized dynamic posturography (CPT 92548).

NON-COVERED

BCBSMT considers the following audiometric studies non-covered including, but not limited to, the following:

- Sinusoidal vertical axis rotational testing (CPT 92546).
- Audiometric testing of groups (CPT 92559).

MEDICAL REVIEW

BCBSMT reviews the following codes to determine medical necessity including, but not limited to, the following:

- Spontaneous nystagmus, including gaze (CPT 92531).
- Positional nystagmus (CPT 92532).
- Caloric vestibular test, each irrigation (CPT 92533).
- Optokinetic nystagmus (CPT 92534).
- Visual reinforcement audiometry (CPT 92579).

PERCUTANEOUS VERTEBROPLASTY AND KYPHOPLASTY

Chapter: Surgery - Procedures

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: June 12, 2002

Original Effective Date: June 25, 2002

Current Effective Date: March 1, 2005

POLICY

Prior Authorization is recommended. A retrospective review will be performed if services are not prior authorized.

MEDICALLY NECESSARY

BCBSMT considers vertebroplasty and kyphoplasty to be medically necessary for patients who have failed standard nonsurgical treatment and who meet one of the following criteria:

- Osteolytic vertebral metastasis and myeloma with severe back pain where chemotherapy and radiation therapy have failed to relieve symptoms.
- Vertebral hemangiomas with severe pain or nerve compression where radiation therapy has failed to relieve symptoms.
- Osteoporotic vertebral collapse with persistent debilitating pain which has not responded to accepted standard medical treatment (e.g., initial bed-rest with progressive activity and bisphosphonates) for at least four weeks. The affected vertebra must be at least one third or more of its original height.

INVESTIGATIONAL

BCBSMT considers all other indications for use of vertebroplasty and kyphoplasty investigational.

CONTACTS FOR KERATOCONUS AND OTHER MEDICAL CONDITIONS OF THE EYE

Chapter: Vision

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Original Effective Date: November 1, 1996

Current Effective Date: March 1, 2005

POLICY

MEDICALLY NECESSARY

BCBSMT considers contacts to be medically necessary to treat conditions including, but not limited to, the following:

- Keratoconus.
- Congenital aphakia.

- Corneal abrasions.

Coverage for a maximum of three pair of contact lenses is allowed each benefit period. When medically necessary criteria are met, compensation is paid under medical benefits rather than under vision benefits.

CHEMICAL PEELS, DERMABRASION AND MICRODERMABRASION

Chapter: Medicine: Treatments

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: May 19, 1999

Original Effective Date: August 5, 1999

Current Effective Date: March 1, 2005

POLICY

BCBSMT considers the use of chemical peels, dermabrasion, and microdermabrasion primarily cosmetic in nature. Cosmetic services are an exclusion of most member contracts.

MEDICALLY NECESSARY

BCBSMT considers epidermal chemical peels or microdermabrasion (not dermabrasion) to be medically necessary to treat:

1. Patients under 40 years of age with active resistant comedomylic acne. *Prior authorization is recommended for patients over 40 years of age. A retrospective review will be performed if services are not prior authorized.* BCBSMT will allow up to four epidermal peels or microdermabrasion treatments per year for patients with active acne who are over 40 years of age when the following criteria are met:
 - Active acne that has persisted despite treatment with topical comedolytic agents. Office records will be requested and must include:
 - Documentation of all therapies.
 - Pre-treatment photographs.
 - Treatment beyond four sessions will require further documentation.
2. BCBSMT may consider epidermal

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chemical peels, microdermabrasion, or dermabrasion to be medically necessary to treat patients following surgical procedures (e.g., Mohs surgery) and traumatic scarring. If not prior authorized, these services will be reviewed to determine medical necessity.

NONCOVERED COSMETIC CONDITIONS

BCBSMT always considers the use of chemical peels, microdermabrasions, or dermabrasion noncovered when used to treat certain conditions including, but not limited to, the following:

- Photoaged skin.
- Wrinkles.
- Acne scarring.
- Sun damage (freckles).
- Rosacea.
- Self-limiting or self-correcting conditions such as pregnancy related melasma.

CONTINUOUS BLOOD GLUCOSE MONITORS (GLUCOMETERS)

Chapter: Durable Medical Equipment

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: October 27, 2000

Original Effective Date: January 1, 2001

Current Effective Date: March 1, 2005

POLICY

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

INVESTIGATIONAL

BCBSMT considers the GlucoWatch device investigational based on the lack of clinical data demonstrating that the use of this device is associated with an improvement in final health outcomes. In addition, there can be up to a 20% error rate in glucose readings when compared to conventional fingersticks.

MEDICALLY NECESSARY

BCBSMT acknowledges that information obtained from the more accurate,

physician interpreted 72-hour Continuous Glucose Monitoring System (CGMS) may identify patterns of glucose fluctuation not detected by frequent fingerstick monitoring of blood glucose levels. Pending publication of long-term results of clinical trials, BCBSMT will allow compensation for CGMS in patients who meet all of the following criteria:

- Are Type I insulin dependent diabetic.
- Monitor their glucose levels using conventional fingerstick glucose monitoring at least four times per day or are on insulin pump therapy.
- Are compliant with insulin administration and conventional fingerstick glucose monitoring regimens prescribed by their physician.

In addition, patients must have one or more of the following:

- Elevated hemoglobin A1C levels above eight.
- Inadequate glycemic control as manifested by widely fluctuating blood glucose levels (e.g., nocturnal or severe hypoglycemic episodes [< 50 mg/dl] and hyperglycemic episodes [> 150 mg/dl]).

CORNEAL TOPOGRAPHY

Chapter: Vision

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: May 19, 1999

Original Effective Date: August 5, 1999

Current Effective Date: March 1, 2005

POLICY

MEDICALLY NECESSARY

BCBSMT considers computerized corneal topography (in addition to an evaluation and management service) to be medically necessary for the accurate diagnosis and management of corneal curvature abnormalities including, but not limited to, the following:

- Post-operative corneal transplantation (V42.5).
- Lamellar keratoplasty (V45.6).
- Post-operative high astigmatism after cataract or glaucoma surgery (V45.6,

367.20, 367.22).

- Corneal ulcer (370.00-370.07).
- Corneal deformity (371.70-371.73).
- Mechanical complication of corneal graft (996.51).
- Nodular degeneration of the cornea (371.46).
- Corneal degenerations (371.40-371.49).
- Keratoconus (371.60-371.62).
- Hereditary corneal dystrophies (371.50-371.58).
- Pterygium (372.40-372.45).

NONCOVERED

BCBSMT considers corneal topography non-covered if performed with a non-covered service including, but not limited to, the following:

- Radial keratotomy.
- LASIK.

VACUUM-ASSISTED CLOSURE OF CHRONIC WOUNDS (NEGATIVE WOUND PRESSURE THERAPY)

Chapter: Durable Medical Equipment

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: February 13, 2002

Original Effective Date: March 27, 2002

Current Effective Date: March 1, 2005

POLICY

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

MEDICALLY NECESSARY

Vacuum-Assisted Closure (VAC) of wounds may be considered medically necessary for patients with a chronic nonhealing wound (being present for at least 30 days) including, but not limited to, the following:

- Stage III or IV pressure ulcer.
- Neuropathic ulcer (e.g., diabetic).
- Venous or arterial insufficiency ulcer.
- A chronic ulcer of mixed etiology.

MEDICAL POLICY

DURATION OF THERAPY

The majority of patients achieve sufficient wound closure within six weeks of vacuum-assisted therapy although some may take longer. Records must be submitted at initiation of therapy and every four weeks thereafter to establish treatment efficacy. Documentation must include wound characteristics and measurements including wound length, width, and depth that demonstrate progressive wound healing. Coverage beyond four months is generally considered not medically necessary.

For all wounds, the following components of a wound therapy program must be documented prior to approval of negative wound pressure therapy:

- Evaluation, care, and wound treatment measurements.
- Application of wound dressings to keep the wound moist.
- Debridement of necrotic tissue, if present.
- Evaluation of, and provision for, adequate nutritional status.
- Evaluation and provision of adequate arterial status when treating an extremity.

For Stage III or IV pressure ulcers, additional documentation must support that:

- The patient has been appropriately turned and positioned.
- The patient has used a support surface for pressure ulcers on the posterior trunk or pelvis.
- The patient's moisture and incontinence have been appropriately managed.

For neuropathic ulcers, additional documentation must support that:

- The patient has been on a comprehensive diabetic management program.
- The patient must not smoke.
- Measures to reduce pressure on a foot ulcer have been accomplished with appropriate modalities.

For venous insufficiency ulcers, additional documentation must support that:

- Compression bandages and/or garments have been consistently applied.

- Leg elevation and ambulation have been documented.

CRITERIA FOR NON-COVERAGE

Negative pressure wound therapy will be denied if one or more of the following are present:

- The presence of necrotic tissue with eschar.
- Untreated osteomyelitis within the vicinity of the wound.
- Cancer present in the wound.
- The presence of a fistula to an organ or body cavity within the vicinity of the wound.
- The wound has been present for less than 30 days.

END OF COVERAGE

Wound measurements must be consistently and regularly documented in the medical record and must demonstrate progressive wound healing from month to month. Coverage for VAC will end when any measurable degree of wound healing has failed to occur over the prior month. Coverage also may end when:

- Four months of treatment have elapsed including the time VAC was used in the inpatient setting.
- In the judgment of the treating physician, adequate wound healing has occurred.

MULTIPLE MEDICAL SERVICES

Chapter: Administrative

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: August 3, 1987

Original Effective Date: October 22, 1987

Current Effective Date: March 1, 2005

POLICY

COVERED SERVICES

On January 1, 2002, BCBSMT began allowing the billing of both a preventive medicine evaluation and management (E&M) service on the same day as an established or new patient E&M service when both of the E&M services are part of the same encounter. The reporting of the E&M service should be significant

enough to require additional work to perform the key components of the problem-focused E&M service. An insignificant or trivial problem or abnormality encountered in the process of performing the preventive medicine evaluation and management should not be reported separately.

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

NON-COVERED SERVICES

Benefits are not available for multiple medical services including, but not limited to, the following:

- Admits and office calls billed on the same day by the same physician.
- Miscellaneous medical services billed on the same day by the same physician.
- Ancillary medical services billed on the same day as an office call by the same physician.
- Office calls billed on the same day as an emergency room visit by the same provider.
- Two office calls billed on the same day by the same physician, except when billing for a preventive medicine E&M and a problem-focused E&M on the same visit (see policy above).

MOUTH INCISION AND DRAINAGE

Chapter: Surgery - Procedures

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Original Effective Date: December 8, 1987

Current Effective Date: March 1, 2005

POLICY

Oral surgeons, dentists, or physicians generally provide this service. Medi-

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

cal benefits are available for incision and drainage of conditions found in the mouth including, but not limited to, the following:

- Abscesses.
- Cysts.
- Hematomas.

RETIRED POLICIES

EFFECTIVE DECEMBER 8, 2004

The following policies will be retired and are no longer considered active policies.

1. Out-of-State Charges.
2. Assistant for Arthroscopic and Laproscopic Scoping Procedures.

Retired policies address services that fall into one or more of the following categories:

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

PAIN CLINICS

Chapter: Therapies

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: November 14, 2001

Original Effective Date: January 1, 2002

Current Effective Date: March 1, 2005

POLICY

PRIOR AUTHORIZATION OF PAIN CLINIC SERVICES

Prior authorization for inpatient services is recommended. Call customer service at 1-800-447-7828 or fax information to 1-406-444-8451. Referrals will be made to case management as needed. The following criteria apply:

- Inpatient services are pre-certified through case management and must meet inpatient criteria.
- Outpatient services are allowed through case management on an individual consideration basis only.
- A retrospective review will be

performed if services are not prior authorized.

- Chemical dependency issues and treatment, including ongoing use or abuse of prescription or non-prescription drugs, must be successfully addressed before prior authorization review.

Physical therapy, occupational therapy, pool therapy, cognitive therapy, and bio-feedback are addressed under separate medical policies.

COVERED SERVICES

BCBSMT considers *medical* pain management services provided by chronic pain clinics eligible for coverage subject to the terms and limitations of the member contract as long as the services meet individual medical policy criteria. The following criteria apply:

- Individual or group psychiatric services may be considered for coverage when provided one-on-one and billed separately by a covered provider for a patient with a mental nervous diagnosis.
- An initial, individual, face-to-face evaluation is an eligible covered service when billed by a covered provider.
- Education services are subject to the terms and limitations of the member contract.

NON-COVERED SERVICES

BCBSMT considers the following services non-covered including, but not limited to, the following:

- Coordination of non-covered benefits.
- Evaluations for non-covered services.
- An evaluation that is not an individual face-to-face session.
- Self-help therapy.
- Stress management services.
- Lectures.
- Video presentations.
- General strengthening exercise programs.
- Ergonomics.
- Cognitive therapy.
- Work hardening.

INVESTIGATIONAL

BCBSMT considers *behavioral* health pain management services provided by chronic pain clinics "investigational" because of the lack of scientific studies supporting the long-term benefits of such programs.

BONE MINERAL DENSITY STUDIES-BONE DENSITOMETRY

Chapter: Radiology

Revised Policy

©2004 Blue Cross and Blue Shield of Montana

Senior Staff Approval Date: February 15, 1995

Original Effective Date: April 26, 1995

Current Effective Date: March 1, 2005

POLICY

Prior authorization is recommended for:

- Women under 50 years of age.
- Men whose contract does not have a screening or preventive benefit.
- Members who have had a bone density test less than two years ago.

MEDICALLY NECESSARY

For members whose contract does not have a screening or preventive benefit, BCBSMT:

- Considers heel ultrasonography (CPT 76977) non-covered because it is used only for screening purposes. This is a covered service for members who have a contract that covers preventive services.
- Allows re-evaluation densitometries every two years.
- Considers the use of bone density studies medically necessary for members who meet one or more of the following criteria:
 - Women who are menopausal (256.2, 256.31, 627.1-627.9, 627.4, V498.1).
 - Have a diagnosis of osteoporosis (733.00 - 733.19).
 - Taking FDA approved medication for the treatment of osteoporosis including, but not limited to, the following:
 - Bisphosphonates.

MEDICAL
POLICY

- Calcitonin.
- Selective estrogen receptor modulators (SERMS).
- Taking medication that increases the risk of osteoporosis such as Dilantin, Depakote (Divalproex sodium), Depakene syrup (Valproate sodium), Depakene (Valproic acid), or Gonadotropin Releasing Hormone (GnRH).
- Glucocorticoid therapy such as Prednisone, Prednisolone, Betamethasone, Dexamethasone, and Decadron.
- A disease/condition where estrogen is contraindicated (e.g., a patient who has a history of blood clots or breast cancer).
- A history of pathologic fracture or vertebral fracture not associated with trauma.
- An abnormal heel densitometry screen based on the WHO criteria listed above. If treatment is initiated, a follow-up central BMD must be done to determine the need for pharmacologic treatment and ongoing monitoring of treatment response.
- A medical condition that puts them at greater risk for osteoporosis, for example:
 - Long-term oral glucocorticoid therapy for various conditions including, but not limited to, the following:
 - Rheumatoid arthritis (714.0).
 - Chronic active hepatitis (571.49).
 - Inflammatory bowel disease (555.0-556.9).
 - Asthma (493.10-493.91) Does not include inhaled steroid use.
 - Chronic obstructive pulmonary disease (491.20-491.21).
 - Lupus, scleroderma (710.0-710.1).
 - Sarcoidosis (135).
 - Multiple sclerosis (340).
 - Hyperparathyroidism (252.0).
 - Hyperthyroidism or thyrotoxicosis (242.0-242.9).
 - Endocrinopathies associated with osteoporosis including, but not limited to, the following:
 - Acromegaly and gigantism

(253.0).

- Prolactinoma (258.9).
- Male hypogonadism or testicular dysfunction (257.2).
- Cushing's syndrome (255.0).
- Renal failure patients (584-586).
- Organ transplant patients.
- Anorexia nervosa (307.1).
- Paget's disease (731.0).
- Algoneurodystrophy (733.7).

NOT MEDICALLY NECESSARY

For members whose contract does not have a screening or preventive benefit, BCBSMT considers bone density studies not medically necessary in some situations including, but not limited to, the following:

- Routine screening for osteoporosis (V82.81).
- Routine follow-up screening for patients with a previous DEXA-T score above -2.0 (e.g., -1.9, -1.8).

GOING
SOMEWHERE?**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 *Services for Providers*,
then *Service Team*.

It has to be blue

Services
for
Providers



➔ **Compensation Policies**

- Place of Service
- Vaccine and Drug
- Compensation Updates

➔ **Provider Manuals**

- Prior Authorization Drugs
- Department of Corrections Claims
- HCFA 1500 Instructions (box 23)
- Contact and Administration Information
- FEP Credentialing

www.bluecrossmontana.com

Regular Business

2004 PROVIDER SATISFACTION SURVEY RESULTS

BCBSMT completed its annual provider satisfaction survey during October and November 2004. The Myers Group in Snellville, GA administrated the survey. 1,400 providers were randomly selected from over 4,000 participating providers, and 314 responded to the 3-wave mail survey. The survey measures 19 attributes to assist BCBSMT in developing

a comprehensive plan for improving and maintaining provider satisfaction.

The Top Box (excellent and very good response options) scores for overall health plan satisfaction is 67.0% compared to 72.8% in 2003, 79.6% in 2002, and 64.8% in 2001. However, the ratings for BCBSMT are significantly higher

than the provider ratings for other plans in all surveyed attributes. Compared to last year's BCBSMT Top Box scores, the overall satisfaction with BCBSMT decreased by 5.8%.

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

	Survey Item	BCBSMT Others	2004 Top Box Score	2003 Top Box Score	2002 Top Box Score	2001 Top Box Score
1	Responsiveness and courtesy of Provider relation's representatives.	BCBSMT Others	50.9% 20.2%	61.0% 21.0%	64.9% 25.9%	57.1% 27.3%
2	Timeliness to answer questions and/or resolve problems.	BCBSMT Others	46.5% 18.0%	52.9% 15.6%	58.0% 17.7%	49.7 25.5%
3	Frequency and effectiveness of provider representative visits.	BCBSMT Others	17.7% 53%	25.8% 9.1%	31.2% 9.0%	25.4% 15.4%
4	Quality of provider orientation process.	BCBSMT Others	22.3% 6.7%	29.7% 7.9%	35.1% 9.4%	26.6% 13.9%
5	Reasonableness of paperwork and documentation.	BCBSMT Others	24.5% 10.0%	34.5% 16.6%	35.7% 13.0%	29.5% 18.5%
6	Usefulness of BCBSMT's New Provider Workshop Format.	BCBSMT Others	35.8% na	39.1% na	34.9% na	40.3% na
7A	Usefulness of Capsule News.	BCBSMT Others	30.4% na	39.3% na	37.2% na	40.5% na
7B	Usefulness of Provider Manuals.	BCBSMT Others	27.6% na	39.8% na	32.4% na	35.5% na
7C	Usefulness of Provider Contracts.	BCBSMT Others	27.1% na	34.7% na	29.6% na	25.4% na
7D	Usefulness of Provider Directories.	BCBSMT Others	30.0% na	43.0% na	37.8% na	38.8% na
8	The health plan's administration of the PCP's specialist referrals.	BCBSMT Others	21.0% 13.5%	26.6% 16.7%	29.5% 16.0%	30.5% 21.7%
9	The health plan's facilitation of clinical care for patients.	BCBSMT Others	23.7% 12.2%	30.1% 13.7%	35.1% 14.9%	30.2% 19.8%
10	The health plan's support of physician relationship with patients.	BCBSMT Others	22.2% 14.3%	29.3% 14.8%	32.3% 14.9%	29.4% 18.5%
11	Degree to which prevention and wellness are covered/encouraged.	BCBSMT Others	23.1% 14.3%	27.3% 11.9%	27.2% 11.4%	26.9% 16.6%
12	The health plan's support of appropriate clinical care for patients.	BCBSMT Others	22.0% 13.9%	33.5% 15.4%	34.1% 12.4%	29.8% 18.8%
13	The health plan's support concerning medical management.	BCBSMT Others	21.5% 10.7%	26.9% 12.1%	33.2% 11.2%	28.2% 15.1%
14	Accuracy of claims processing.	BCBSMT Others	49.4% 21.4%	50.0% 22.7%	58.4% 23.1%	45.5% 24.1%
15	Timeliness of claims processing.	BCBSMT Others	52.6% 15.9%	57.0% 18.1%	63.8% 10.0%	51.2% 18.4%
16	Ease of using health plan's provider claims payment register.	BCBSMT Others	47.3% 15.9%	60.0% 29.2%	55.9% 21.4%	50.6% 21.8%
17	Would you recommend BCBSMT to other patients?	BCBSMT	77.5%	35.9%	37.9%	26.0%
18	Would you recommend BCBSMT to other physicians?	BCBSMT	75.5%	34.5%	36.1%	26.1%
19	Overall satisfaction with BCBSMT.	BCBSMT Others	67.0% 57.8%	72.8% 58.4%	79.6% 55.5%	64.8% 59.4%

Regular Business

ASTHMA AWARD ENTRY DEADLINE

Are you a health care provider who has demonstrated leadership in managing environmental triggers as part of your comprehensive asthma management program? Would you like to receive some recognition for your important work? If so, the U.S. Environmental Protection Agency invites you to apply online at www.asthmaawards.info for the National Environmental Leadership Award in Asthma Management.

Applications will be accepted until February 15, 2005. Join your peers in demonstrating that managing environmental triggers as part of a comprehensive asthma management program can improve the lives of the more than 20 million asthmatics in America.

DOC DEPARTMENT OF CORRECTIONS MEDICAL PROGRAM

BCBSMT administers claims processing for the medical program run by the State of Montana Department of Corrections (DOC). This program is not an insurance plan, there are no deductibles or co-payments, and dependents (including newborns) are not covered. The State of Montana covers only adult inmates and juvenile offenders sentenced to the DOC.

ADULT AND JUVENILE INMATES

Each individual covered by the DOC is assigned an identification number that includes the alpha prefix AO (Adult Offender) or JO (Juvenile Offender). Adult identification numbers are formatted with three or five preceding zeros, AO, and then a five- or seven-digit number (000AO1234567, 00000AO12345). Juvenile identification numbers are formatted with five preceding zeros, JO, and then a five-digit number (00000JO12345). Do not submit claims with the individual's social security number.

All inpatient hospital admissions must receive prior authorization by calling APS Healthcare at 1-800-635-5271, extension 8797. Should you have any questions concerning adult and juvenile inmates' claims submitted to BCBSMT, contact Customer Service at 1-800-447-7828, extension 3603.

PRE-RELEASE AND COUNTY JAIL INMATES

Claims for pre-release inmates and inmates held in county jails must have approval by DOC. Contact Laura Janes at 1-406-846-3363 or Sherri Townsend at 1-406-444-7843. Claims for pre-release inmates and inmates held in county jails are to be mailed directly to the DOC at:

Department of Corrections
Attention: Sherri Townsend
P.O. Box 201301
Helena, MT 59620

CODING CODING CLARIFICATION: CIRCUMCISIONS

BCBSMT is receiving claims for circumcisions of infants over 31 days old being billed with newborn circumcision codes, 54150 and/or 54160. An infant is considered a newborn up to 31 days old. When an infant is over 31 days old, CPT codes 54152 or 54162 should be reported on the claim.

For any questions, contact the provider network service representative for your area (see inside back cover).

DELETED CODES

DELETED CODE GRACE PERIOD ENDING IN 2005

Effective January 1, 2005, BCBSMT will no longer have a 90-day grace period for deleted CPT, HCPCS, and ASA procedure codes. The HIPAA transaction and code set regulations require usage of the medical code set valid at the time the

service is provided. Therefore, deleted codes submitted with dates of service after January 1, 2005, will no longer be accepted.

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

DME

DME PRIOR AUTHORIZATION

Prior authorization is recommended for some services including some durable medical equipment (DME), to help providers and members avoid unexpected expenses, benefit reductions, or claim denials. The prior authorization process determines coverage for medically necessary services, supplies, or treatment. If prior authorization is not obtained, a retrospective review is performed after the claim(s) is submitted to determine whether the services, supplies, or treatment were medically necessary and/or were a benefit of the member's contract. DME for which prior authorization is recommended includes, but is not limited to, the following:

- Large dollar items over \$1000 or contract specific items.
- DME or prosthesis repair or replacement over \$500.
- Air fluidized beds.
- Bone growth stimulator.
- Breast Pumps.
- Electric hospital beds.
- Electric wheel chairs and power accessories.
- Neuromuscular stimulators.
- Osteogenesis.
- Power operated vehicles.
- TENS unit/interferential unit.

More prior authorization information is available in the BCBSMT Provider Manual at www.bluecrossmontana.com. Click on *Services for Providers, Provider Manuals*, and then *Chapter 3: Benefit Management*. If you have any questions, call customer service at 1-800-447-7828.



BLUECARD MEDICARE SUPPLEMENTAL AND MEDICARE ADVANTAGE COVERAGE

If you are a provider who accepts Medicare assignment or who provides services to members from other Blue Plans, the following questions and answers clarify common issues about out-of-state Medicare claims and supplemental coverage.

WHAT ARE BLUE CROSS AND/OR BLUE SHIELD MEDICARE-RELATED (MEDICARE PRIMARY) CLAIMS?

These are claims for members whose primary coverage is Medicare and secondary (supplemental) coverage is provided by a Blue Cross and/or Blue Shield Plan. Examples include:

- Medigap (also called Medicare Supplemental, Medicare Complementary, and Medicare Extended).
- Medicare carve-out.

HOW DO I IDENTIFY A MEMBER WITH A MEDICARE-RELATED POLICY?

Often, members will carry more than one identification (ID) card. A member's current ID card, if Medicare is the primary payer, should be a standard Medicare card without a Blue Cross and/or Blue Shield logo. Members may also present a separate ID card with a Blue Cross and/or Blue Shield logo for secondary coverage.

WHERE DO I SUBMIT BLUE CROSS AND/OR BLUE SHIELD MEDICARE-RELATED CLAIMS?

When Medicare is primary, submit claims to your Medicare intermediary.

If the member has secondary coverage, it is essential that you enter the correct Blue Plan name as the secondary carrier. Do not enter BCBSMT if the secondary coverage is with another Blue Plan. Verify the Blue Plan name by contacting 1-800-676-Blue (2583).

After receipt of the Medicare Remittance Notice (MRN) from Medicare, review the indicators. If the indicator on the remittance signifies the claim crossed-over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan, and you can make claim status inquiries through BCBSMT. If there is no cross-over indicator on the remittance, submit the claim to BCBSMT with the MRN.

Do not submit Medicare-related claims to BCBSMT before receiving a MRN from Medicare. Duplicate claims delay claim processing and create administrative inefficiencies for you and the insurance plan.

WHAT ARE BLUE CROSS AND/OR BLUE SHIELD MEDICARE ADVANTAGE CLAIMS?

Medicare+Choice and Medicare Risk claims are now referred to as Medicare Advantage. Several Blue Plans have been authorized by the Centers for Medicare and Medicaid Services (CMS) to offer these products in the form of HMOs and PPOs. The Blue Plan is the primary payer for Medicare Advantage claims.

HOW DO I IDENTIFY A MEMBER WITH A MEDICARE-ADVANTAGE POLICY?

Ask for the member ID card. Medicare Advantage members will not have a standard Medicare card, but rather a Blue Cross and/or Blue Shield logo will be visible on the ID card. Members enrolled in a Medicare Advantage product agree to obtain most services through network providers but may seek services in another state.

Verify eligibility by contacting 1-800-676-Blue (2583) and provide the alpha prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the alpha prefix, and report it to BCBSMT.

WHERE DO I SUBMIT OUT-OF-STATE MEDICARE ADVANTAGE CLAIMS?

Submit claims to BCBSMT. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment is made directly by a Blue Plan. Based upon CMS regulations, if you are a provider who accepts Medicare assignment and renders service to Medicare Advantage members from other Blue Plans, you will be compensated the equivalent of the current Medicare allowable amount for all covered services. CMS regulations state the Medicare allowable amount is considered payment in full. Compensation is made directly by the Blue Plan, and you may collect only the co-payment amounts from the member at the time of service and may not charge or balance bill the member.

Currently, there is a small volume of Medicare Advantage members. Be sure to review the remittance to note references to CMS requirements for Medicare allowable amount, member payment responsibility, and balance billing limitations. If you have any questions, contact BlueCard customer service at 1-800-447-7828, extension 8622.

More information about BlueCard Claims processing is available in the BCBSMT Provider Manual at www.bluecrossmontana.com. Click on *Services for Providers, Provider Manuals*, and then *BlueCard Out-of-State Claims*.

BCBS ILLINOIS TO PROCESS CLAIMS FOR STATE FARM GROUP MEDICAL PLAN

Effective January 1, 2005, BCBS Illinois will administer the State Farm Insurance Companies' Group Medical PPO Plan. The Group Medical Plan is only offered to State Farm associates (employees, agents and employees of agents, and retirees) and not the general public. The administration of the State Farm Group Medical Plan does not include medical policies that are sold as a line of business by State Farm agents. As with any Blue Cross and Blue Shield policy, the ID card is key.

Regular Business

All State Farm Group Medical Plan members will be issued a BCBSIL card with the standard BlueCard PPO suitcase logo. Please note that the identification number will not be the subscriber's social security number, but an alternate identification number assigned by BCBSIL with the alpha prefix is SFZ.



State Farm®

MILLER, AMY

Identification No. SFZ11122333
Group No. 021171

 PPO

To the Member: Your benefit plan requires that you contact the Medical Services Advisor (MSA) one business day prior to hospital admission, Private Duty Nursing, Home Health Care, and Skilled Nursing Facility or within two business days of an admission for emergency, maternity care, mental health or chemical dependency. Failure to contact the MSA may reduce your available benefits. For questions regarding benefits, membership, and claims for medical care, please call the Group Medical Customer Service number and select the appropriate group. GROUP MEDICAL CUSTOMER SERVICE UNIT: 1-888-652-4013

Medical Provider Locator: To find a PPO Provider in your service area or when traveling, please call customer service. For claims information via the Internet: www.bcbsil.com/staffform

To Medical Providers: Please file all medical claims with your local Blue Cross and Blue Shield Plan.

To The Member: If a provider does not file a claim on your behalf, please contact the customer service unit.

BlueCross BlueShield of Illinois, an Independent licensee of the BlueCross BlueShield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

SFZ-PPO

coach, who provides information, support, and guidance. Health coaches work with physicians, the member and the member's family, and various community resources to provide assistance with management of the individual's chronic condition. Special programs may be available through the Internet or include customized educational materials, and program participants also may receive newsletters or other educational materials.

This program is not intended to replace physician care. It is a complementary program to the services you are providing to your BCBSMT enrolled patients and is intended only as a source for information and guidance.

Healthy Together services are provided by APS Healthcare, a global leader in health education and support, behavioral health, case management, and disability services. APS Healthcare has provided services for chronic illnesses for more than ten years and has been a leader in behavioral health services for more than 15 years. Supporting the professional staff are on-site physicians who provide medical guidance. APS Healthcare NW holds URAC Health Utilization Management accreditations for its Behavioral Health and Medical Services Utilization Management and its Behavioral Health and Medical Case Management Departments.

BCBSMT welcomes your referrals of our members to the Healthy Together Program, especially those newly diagnosed with the above health conditions. We also encourage you to notify BCBSMT any time a patient's risk level or condition changes to ensure our health coaches are extending the appropriate and most effective resources to members.

Information submitted to this program regarding your patient is maintained with the utmost security and confidentiality in accordance with HIPAA. The information is used to identify patients appropriate for case management as well as to analyze community standards of care to establish best practices.

BCBSMT is excited to partner with you and APS Healthcare to provide its members with these additional health care resources. For more information on the

Healthy Together Program or to refer your patient, please call APS Healthcare toll-free at 1-800-635-5271 beginning December 1, 2004.

CLAIMS

HCFA 1500 AND UB92 PRIOR AUTHORIZATION FIELDS

BCBSMT is receiving claims with information not required, or incomplete, that is delaying claims payment. HCFA box 23 and UB92 box 63 refer to prior authorization numbers generated by health plans when providers request prior authorization for services or an inpatient stay.

Incomplete or incorrect information entered will suspend claims for manual review. To ensure claims process on the first pass, leave these fields blank, or, if applicable, enter the prior authorization number in its entirety in the HCFA box 23 or UB92 box 63. BCBSMT or APS Healthcare will give your office a prior authorization prior to filing the claim.

More information about submitting claims is available in the BCBSMT Provider Manual at www.bluecrossmontana.com. Click on *Services for Providers*, then *Provider Manuals*. Should you have any questions or concerns, contact Customer Service at 1-800-447-7828.

NPI

NATIONAL PROVIDER IDENTIFIER

As part of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, the Secretary of Health and Human Services adopted the National Provider Identifier (NPI) as the standard enumerator for covered health care providers. The final rules adopting the NPI as the standard were published on January 23, 2004. The rules indicate the NPI will be a ten-digit numeric identifier that will contain no intelligence about the provider or provider group to which it is

HEALTHY TOGETHER

BCBSMT AND APS HEALTHCARE LAUNCH HEALTHY TOGETHER PROGRAM

BCBSMT wants to keep its members healthy, active, and productive. Feeling their best can be difficult if the member is living with a chronic health condition. That's why BCBSMT is offering a free program, Healthy Together, to members enrolled in BCBSMT health plans beginning December 1, 2004. Healthy Together is for those who are living with cardiac diseases (CAD, CHF, risk factor management of hypertension and hyperlipidemia), diabetes, or co-morbid diabetes with depression.

Selected individuals have an opportunity to work one-on-one with a specially trained licensed clinician, or health

assigned. The number is intended to be permanent and will remain constant even if the provider changes locations, specialties, or affiliations. Covered health care providers will be required to use the NPI in all standard electronic transactions effective May 23, 2007.

The NPI will be managed by a federal computerized database known as the NPPES (National Plan and Provider Enumeration System). Health care providers (covered or not) may obtain a NPI on or after May 23, 2005. Health plans are required to accept the NPI beginning May 23, 2007, unless the health plan is "small" in which case it has until May 23, 2008.

Once the NPI is fully implemented, it will simplify claims processing because providers will not be required to use each payers' assigned number for billing purposes. Instead, providers will use the NPI to identify themselves on all claims, regardless of the payer.



- **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.

PARADIGM COLLABORATIVE CARE FOR NICU INFANTS

Each year in the U.S., nearly 400,000 low birth weight and other medically complex infants are admitted to neonatal intensive care units (NICUs). For health care plans, this complex population has proved problematic. Case volume is relatively low, yet length of stay and costs are high. Care regimens are complicated, and practice patterns vary. Oversight of this population requires internal expertise that few health plans possess.

Precisely because of these factors, BCBSMT looked to ParadigmHealth Management (Paradigm) to provide specialty management for all NICU babies born to BCBSMT members. Paradigm managers visit all the network hospital NICUs and are a resource for families and clinicians. Their objective is to ensure continuity of care, which includes proactive discharge planning and home care planning. To optimize results of this relationship for BCBSMT members and their babies, BCBSMT encourages neonatologists to notify BCBSMT as soon as a member's baby is admitted to a NICU.

Paradigm was formed in 1996 with the goal of helping health plans and health care providers more effectively manage the process of care for NICU babies—not only in the hospital but through the transition to home. Paradigm accomplishes this through collaboration with community physicians and has provided comprehensive care management for more than 40,000 babies in 40 states, and Paradigm is currently working with neonatologists in more than 500 hospitals.

Paradigm uses clinical management guidelines, developed by a national board of neonatologists and validated by regional practitioners. Paradigm's neonatal DRGs and clinical information system allow Paradigm to track NICU patients by birth weight, diagnosis, severity of illness, utilization, and outcomes.

Hallmarks of the Paradigm NICU care management system are:

- On-site care management (by NICU-trained RNs).
- Oversight by regional medical directors (all neonatologists).
- Promotion of attending physician's authority over clinical decisions.
- Use of community physicians (on regional practitioner committees) to confirm (or identify exceptions to) guidelines.
- Monitoring of the continuum of care.
- Documentation of patient management in relation to expectations.
- Measurement/validation of quality outcomes.

A key component of the Paradigm program is information. Paradigm measures and reports excellent results (98% of infants ranked as excellent or good in health status at follow-up) and high family satisfaction rating (94% ranked the overall experience as excellent or good). Paradigm also documents a number of treatment norms and outcome variables and benchmarks the "best" practice and most effective use of resources. This comparative data is helpful for hospitals, neonatologists, nurses, and health care plans.

Hospitals and Neonatology, Pediatric, OB-GYN physicians and Home Health Agencies will receive more information about the program scheduled to begin in January 2005. If you have any questions, contact Sharon Robinson at 1-800-447-7828, extension 8430, or by e-mail at srobinson@bcbsmt.com.



 **CLAIMS STATUS**

 **ELIGIBILITY**

 **BENEFITS**

www.bluecrossmontana.com

Regular Business



2005 MEDICARE DEDUCTIBLES AND CO-PAYMENTS

PART A INPATIENT

Day 1-60: \$912.00 Deductible
Day 61-91: \$228.00 Co-Payment
Per Day
Day 91-159: \$456.00 Lifetime
Reserve Days

PART A SKILLED NURSING

Day 1-20: Paid in Full by Medicare
Day 21-100: \$114.00 Co-Payment
Per Day

PART B

\$110.00 Deductible

DIABETES MICROALBUMINURIA PROJECT

The National Committee for Quality Assurance (NCQA) and American Diabetes Association recommend monitoring patients on an annual basis with diabetes for the development of nephropathy. The standard of care is to test for microalbuminuria in all patients with diabetes who have not already been diagnosed with renal disease.

BCBSMT monitors primary care providers (PCPs) in managed care networks for compliance with nephropathy monitoring recommendations. In 2004, the number of managed care physicians who met the guideline increased to 48.9% from a 2003 level of 45.6%.

BCBSMT would like to help managed care providers do even better in 2005. To that end, BCBSMT has partnered with Roche Diagnostics to provide free Micral® semi-quantitative microalbuminuria test strips to all managed care PCPs. If you are a PCP in a BCBSMT managed care network, you will receive

a packet in the mail from SGI. This packet will contain product information and a vial of 30 free Micral test strips. If your office is CLIA certified, you may charge the usual fee for performing these tests (CPT 82044). These test strips are 94% as sensitive and 94% as specific as a 24-hour urine albumin to creatinine ratio, without the cumbersome and unpleasant features of the latter. Also, because the test is performed in the office, it is easier for you, as a provider, to ensure annual compliance for appropriate patients.

The spot albumin-to-creatinine ratio is also a recommended screening test for nephropathy. This test is favored by some PCPs as being comparable to the 24-hour test in sensitivity and specificity but simpler to perform. However, its higher accuracy is accompanied by a somewhat higher cost. Either test is approved by NCQA for nephropathy monitoring by itself, or the spot albumin to creatinine ratio can be used to follow up on positive Micral test results to reduce the chance of false positives. At any rate, 24-hour urine collection for nephropathy screening should rarely be necessary.

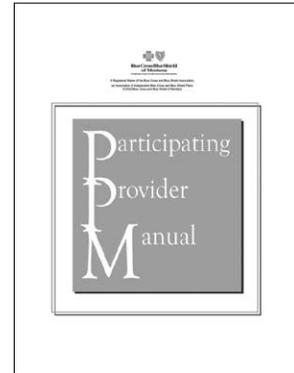
If you have any questions about this project, call Mary Sims, M.D. at 1-800-447-7828, extension 8784, or by e-mail at msims@bcbsmt.com.

MANAGED CARE

FAXED REFERRALS REQUIRE NO ADDITIONAL COPY

When faxing referrals to BCBSMT, there is no need to mail BCBSMT the original. This slows down claims processing since duplicate referrals must be investigated.

More information is available in the BCBSMT Provider Manual at www.bluecrossmontana.com. Click on *Services for Providers*, then *Provider Manuals*. Should you have any questions or concerns, contact Customer Service at 1-800-447-7828.



PROVIDER MANUAL NOT ONLY FOR PARTICIPATING PROVIDERS

The provider manual published at www.bluecrossmontana.com is available for any medical service provider submitting a claim to BCBSMT. The manual contains information to help your office with the day-to-day business operations with BCBSMT and claims for BCBSMT, BlueCHIP, Caring Program for Children, Federal Employee Program, managed care, and out-of-state patients. While some information is only applicable to participating providers, the medical claims chapter lists the required fields on a HCFA 1500 claim form, and the payment and appeals chapter explains the payment process and common reasons claims payment is delayed.

BCBSMT has received claims without the required information such as procedure and diagnosis codes from ineligible providers (e.g., massage therapists and acupuncturists). Although an ineligible provider may not be able to contract with BCBSMT, some plans may have payable benefits for those types of services, and claims will not process if certain information is not available.

To download the provider manual, log onto www.bluecrossmontana.com, click on *Services for Providers* and the *Provider Manuals*. The manual is updated quarterly and is published by chapter in a printer friendly format. E-mail Mike McGuire at mmcguire@bcbsmt.com or call 1-800-447-7828, extension 8412, for questions concerning updates, functionality, content, and formatting.

PROVIDER NUMBERS, CREDENTIALING, AND PARTICIPATION STATUS

Recently, BCBSMT received inquiries about the difference between having a BCBSMT provider identification (ID) number and being a participating provider. All providers submitting claims are assigned a BCBSMT provider ID number regardless of whether they are participating, non-participating, or not eligible to contract with BCBSMT. To participate in the BCBSMT traditional network, two processes must take place above and beyond obtaining a provider ID number.

First, physicians (MD, DO, DPM) and chiropractors must be credentialed. Physician and non-physician providers must be credentialed to participate in the managed care, Federal Employee Program (FEP), and TriWest (formerly CHAMPUS) provider networks. Credentialing criteria and applications are available at www.bluecrossmontana.com or you may contact the Credentialing Analyst for your area (see inside back cover).

Second, separate contracts must be signed for each provider network (BCBSMT traditional, FEP, joint venture/managed care, Montana HealthLink, TriWest, BlueCHIP, Blue Care, and Caring Program for Children). If signed contracts are received but the credentialing process is not complete, providers are assigned a provider ID number and compensated as a non-participating provider (payment is sent to the member). When the credentialing process is complete, the provider is compensated as a participating provider (payment is sent to the provider).

The credentialing process may take several weeks to complete. Providers who know they will be practicing in Montana are encouraged to start credentialing as soon as possible. Providers who are in the process of being credentialed will not be retroactively compensated at participating provider allowable fees. Providers credentialed or re-credentialed before December 1, 2003, will need to re-credential two years from their last credentialing date. Providers credentialed or re-credentialed after December 1, 2003, will need to re-credential every three years from their last credentialing date.

Providers who are not re-credentialed within the required timeframe will receive a Notice of Contract Deficiency. Once credentialing lapses, participation in all applicable networks ends. To participate again, the provider must go through credentialing as a new applicant, and a 90-day waiting period is imposed before participating status is re-instated. If you receive such a notice, complete and immediately return your

re-credentialing application or contact the BCBSMT Credentialing Department to obtain a new re-credentialing application.

More information is available in the Provider Manuals, Provider Policies, and Credentialing sections at www.bluecrossmontana.com or you can contact your Provider Network Development or Service Representative for your area (see inside back cover).

Download the BCBSMT formulary to your PDA @ epocrates.com



PHARMACY AND THERAPEUTICS COMMITTEE

BCBSMT held its quarterly Pharmacy and Therapeutic (P&T) Committee meeting on October 7, 2004. Participating BCBSMT physicians from various specialties were either present or teleconferenced for the meeting. The P&T committee's purpose is to review, discuss, and make decisions regarding pharmaceutical drugs and their formulary status with the goal of high-quality, low-cost drugs on the formulary. If you have any questions, please call Tina Wong at 1-800-447-7828 ext. 8843.

FOURTH QUARTER 2004 CHANGES TO THE FORMULARY

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

Drug	Therapeutic Class	Formulary Status
Amerge	Triptan Headache Drugs	Non-Formulary
Apoken	Antiparkinsonian Dopaminergic	Non-Formulary
Avita	Acne Vulgaris	Non-Formulary
Cefzil	Beta Lactam Antibiotics	Non-Formulary
Cipro XR	Quinolones	Non-Formulary
Crestor	HMG CoA Reductase Inhibitors	Non-Formulary
Ertaczo	Antifungals Topical	Non-Formulary
Estrasorb	Estrogens	Non-Formulary
Estrogel	Estrogens	Non-Formulary
Ketek	Ketolides	Non-Formulary
Pentasa	Inflammatory Bowel	Non-Formulary
Pexeva	SSRI	Non-Formulary
Pravachol	HMG CoA Reductase Inhibitors	Non-Formulary
Vytorin	HMG Combinations	Formulary
Zocor	HMG CoA Reductase Inhibitors	Formulary



**BlueCross
BlueShield**

Federal Employee Program
www.fepblue.org

2005 Standard Option Benefits At-A-Glance

WHAT YOU PAY		
SERVICES	2005 STANDARD OPTION PPO BENEFIT	2005 STANDARD OPTION NON-PPO BENEFIT
PREVENTIVE SERVICES		
Preventive screenings: Pap smears, mammograms, stool tests for blood, prostate specific antigen tests, cholesterol tests, sigmoidoscopies and related office visit charge	<ul style="list-style-type: none"> ▪ \$15 for each related office visit ▪ Nothing for preventive screening tests 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% Plan Allowance for covered tests ▪ The preventive screening office visit is not covered
Routine physical exams, including a history and risk assessment, chest X-ray, EKG, urinalysis, CBC and metabolic and general health panel tests annually	<ul style="list-style-type: none"> ▪ \$15 for the office visit ▪ Nothing for related preventive screening tests 	<ul style="list-style-type: none"> ▪ Not a benefit
Influenza & Pneumonia Immunizations — once every calendar year	<ul style="list-style-type: none"> ▪ \$15 office visit copayment ▪ Nothing for immunizations 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% Plan Allowance
Well Child Care up to age 22	<ul style="list-style-type: none"> ▪ Nothing for covered charges 	<ul style="list-style-type: none"> ▪ Nothing for covered charges
Dental Care for services listed in the 2005 Service Benefit Plan brochure fee schedule	<ul style="list-style-type: none"> ▪ Your out-of-pocket costs are limited to a Maximum Allowable Charge (MAC) ▪ Benefits paid according to the fee schedule in the 2005 Service Benefit Plan brochure 	<ul style="list-style-type: none"> ▪ Benefits paid according to the fee schedule in the 2005 Service Benefit Plan brochure ▪ You are responsible for balance up to Billed charges
PHYSICIAN'S CARE		
Inpatient services, including surgical and medical care	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 10% Preferred Provider Allowance (PPA) 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% Plan Allowance
Outpatient surgery and related diagnostic tests such as X-rays, laboratory tests, and machine diagnostic tests **	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 10% PPA 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% Plan Allowance
Home and office visits, second surgical opinions, outpatient consultations, and medical emergency care	<ul style="list-style-type: none"> ▪ \$15 for the visit charge, with no deductible 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% Plan Allowance
Outpatient physical, occupational and speech therapy, Physical, occupational and speech therapy - combined maximum of 75 visits per year	<ul style="list-style-type: none"> ▪ \$15 for each visit 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% Plan Allowance
MATERNITY CARE		
Inpatient Hospital Care - Precertification is not required	<ul style="list-style-type: none"> ▪ Nothing for covered charges 	<ul style="list-style-type: none"> ▪ \$300 per admission copayment ▪ 30% Plan Allowance at Non-member hospitals
Physician care including delivery and pre-and post-natal care	<ul style="list-style-type: none"> ▪ Nothing for covered charges 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% Plan Allowance
PRESCRIPTION DRUGS		
Prescription Drugs Mail Service Pharmacy Up to a 90-day supply per prescription or refill	<ul style="list-style-type: none"> ▪ \$10 copayment for generic drugs ▪ \$35 copayment for brand name drugs 	<ul style="list-style-type: none"> ▪ \$10 copayment for generic drugs ▪ \$35 copayment for brand name drugs
Prescription Drugs Retail Pharmacy Up to a 90-day supply per prescription or refill	<ul style="list-style-type: none"> ▪ 25% PPA at the time of purchase 	<ul style="list-style-type: none"> ▪ 100% of Billed charges at the time of purchase, file a claim, then receive 55% of Average Wholesale Price (AWP) as reimbursement
HOSPITAL / FACILITY CARE		
Hospital inpatient room and board and other inpatient hospital services - Precertification required	<ul style="list-style-type: none"> ▪ Unlimited Days ▪ \$100 per admission copayment 	<ul style="list-style-type: none"> ▪ Unlimited days ▪ \$300 per admission copayment ▪ 30% Plan Allowance at Non-member hospitals ***
Outpatient surgery	<ul style="list-style-type: none"> ▪ 10% PPA 	<ul style="list-style-type: none"> ▪ 25% of Plan Allowance at Member Facilities and Non-member facilities
Outpatient services including medical emergency care, diagnostic tests, renal dialysis, radiation therapy, chemotherapy, and physical, occupational and speech therapy ** Physical therapy, occupational and speech therapy - combined maximum of 75 visits per year	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 10% PPA 	<ul style="list-style-type: none"> ▪ Subject to \$250 calendar year deductible ▪ 25% of Plan Allowance at Member facilities and Non-member facilities
ACCIDENTAL INJURY		
Covered charges in connection with and within 72 hours after an accidental injury at a facility or in a physician's office (See the definition of accidental injury in the 2005 Service Benefit Plan brochure .) Includes outpatient medical care, diagnostic tests, and ambulance transportation	<ul style="list-style-type: none"> ▪ Nothing for covered charges 	<ul style="list-style-type: none"> ▪ Any difference between the Plan Allowance and the billed amount

** Certain diagnostic cancer tests are paid differently.

*** Emergency admissions to Non-member hospitals are paid at 100% of Plan Allowance after the \$300 per admission copayment.

WHAT YOU PAY		
SERVICES	2005 STANDARD OPTION PPO BENEFIT	2005 STANDARD OPTION NON-PPO BENEFIT
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospital - precertification required	<ul style="list-style-type: none"> In full after \$100 per admission deductible Unlimited days 	<ul style="list-style-type: none"> \$400 daily copayment at member hospitals and Non-member hospitals 100 days per calendar year for mental conditions 28 days per lifetime for substance abuse
Outpatient Facility Care	<ul style="list-style-type: none"> Subject to \$250 calendar year deductible 10% PPA 	<ul style="list-style-type: none"> Subject to the \$250 per day calendar year deductible 25% Plan Allowance at member facilities and Non-member facilities Combined total of 25 visits per calendar year
Inpatient Professional Care	<ul style="list-style-type: none"> Subject to \$250 calendar year deductible 10% PPA 	<ul style="list-style-type: none"> Subject to the \$250 calendar year deductible 40% of Plan Allowance
Outpatient Professional Care	<ul style="list-style-type: none"> \$15 copayment per visit Up to 2 hours per visit Treatment plan needed prior to 9th visit 	<ul style="list-style-type: none"> Subject to the \$250 calendar year deductible 40% of Plan Allowance Combined total of 25 visits per calendar year per patient
OTHER SERVICES		
Catastrophic Protection (Please refer to the 2005 Service Benefit Plan brochure for charges applied to the benefit.)	<ul style="list-style-type: none"> 100% payment level begins after you pay \$4000 out-of-pocket in coinsurance, copayment and deductible expenses 	<ul style="list-style-type: none"> 100% payment level begins after you pay \$6000 out-of-pocket in coinsurance, copayment and deductible expenses

2005 Basic Option Benefits At-A-Glance

WHAT YOU PAY	
SERVICES	2005 BASIC OPTION NETWORK BENEFIT
PREVENTIVE CARE	
Preventive screenings and related office visit charge. Routine physical exams	<ul style="list-style-type: none"> \$20 office visit copayment for primary care provider \$30 office visit copayment for specialists Nothing for covered preventive screenings billed by your doctor
Well Child Care Up To Age 22	<ul style="list-style-type: none"> Nothing for covered charges
Routine Dental Care	<ul style="list-style-type: none"> \$20 office visit charge 2 exams and cleanings per year Annual X-rays Sealants for children up to age 16
PHYSICIAN CARE	
Surgical Care	<ul style="list-style-type: none"> \$100 copayment per surgeon
Home and office visits, second surgical opinions and consultations	<ul style="list-style-type: none"> \$20 office visit charge for primary care provider \$30 office visit copayment for specialists
MATERNITY CARE	
Inpatient Hospital and Physician Care - Precertification is not required	<ul style="list-style-type: none"> Nothing for Pre-natal and Post-natal care and delivery Hospital charges subject to facility copayments
PRESCRIPTION DRUGS	
Mail Service Pharmacy	<ul style="list-style-type: none"> Not a benefit
Retail Pharmacy	<ul style="list-style-type: none"> Up to an initial 34-day supply \$10 copayment for generic drugs \$25 copayment for formulary brand name drugs 50% coinsurance (\$35 minimum) for non-formulary brand name drugs
HOSPITAL / FACILITY CARE	
Hospital Inpatient - Precertification Required	<ul style="list-style-type: none"> \$100 per day up to \$500
Outpatient Facility Care	<ul style="list-style-type: none"> \$40 per day per facility copayment
Outpatient Surgery	<ul style="list-style-type: none"> \$40 copayment
ACCIDENTAL INJURY / EMERGENCY CARE	
Accidental Injury Care - emergency room	<ul style="list-style-type: none"> \$50 copayment
Medical Emergency - emergency room	<ul style="list-style-type: none"> \$50 copayment
Accidental Injury and Medical Emergency - Physician care	<ul style="list-style-type: none"> \$50 copayment
CHIROPRACTIC CARE	
Spinal manipulations	<ul style="list-style-type: none"> Up to 20 spinal manipulations per year \$20 copayment Chiropractic Care
OTHER SERVICES	
Catastrophic Benefits	<ul style="list-style-type: none"> 100% Payment level begins after you pay \$5000 out-of-pocket in coinsurance and copayment expenses



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 providers for its traditional participating provider network and the Joint Venture managed care provider network. Also included are providers who are no longer participating with these networks.
September 1 to November 30, 2004

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

Anderson Family Pharmacy.....Great Falls.....Medical Equipment
 Jason L. Blaser, MD.....Billings..... Pathology
 Mark Edward Blossom, MD..... Chinook..... Internal Medicine
 Barbara A. Bottomly, LCPCGreat Falls..... Lic. Clin. Prof. Counselor
 Eric M. Brandeberry, MDKalispell..... Family Practice
 Marlin R. Braun, DC.....Livingston.....Chiropractic
 Donald E. Burtch, LCPCKalispell..... Lic. Clin. Prof. Counselor
 Michael R. Butz, PhDBillings.....Psychology
 Douglas W. Chase, PTBillings.....Physical Therapy
 Christine J. Childers, PhD.....Lakeside.....Psychology
 Gretchen H. Coble, PT.....Helena.....Physical Therapy
 Gordon L. Cox, MD.....Billings..... Pathology
 Melissa Smythe Crawford, LCSWHelena..... Lic. Clin. Social Worker
 Andrew C. Cromwell, DDSAnaconda..... Dentist
 Aaron J. Derry, PAMissoula..... Physician Assistant
 Roger J. Diegel, MDKalispell.....Rheumatology
 Eastern Montana Cancer Center Miles City..... Radiation Oncology
 Tamara M. Easton, LCPCBillings.....Lic. Clin. Prof. Counselor
 Terry Scott Edwards, MDBozeman..... Family Practice
 James V. English, PsyD.....Great Falls.....Psychology
 Jill M. Follett, PTBillings.....Physical Therapy
 Susan F. Galbreath, LCSWBrowning..... Lic. Clin. Social Worker
 Gary Gales, PTMissoula.....Physical Therapy
 Steven W. Galyon, MDSidney.....Ear, Nose, and Throat
 Megan E. Gordley, DC.....Whitefish.....Chiropractic
 Daniel K. Gordon, MDGreat Falls..... Family Practice
 Patricia J. Grena, DOCut Bank..... Family Practice
 Lexi L. Gulbranson, MD.....Bozeman..... Family Practice
 Lexi L. Gulbranson, MD.....Missoula..... Family Practice
 Virginia Lee Harrison, MDHelena..... Internal Medicine
 Donovan K. Hayes, DCHelena.....Chiropractic
 Tari K. Heppel, LCSWPlains..... Lic. Clin. Social Worker
 Frances B. Herbert, MD.....Great Falls..... Urology
 Rolf H. Holle, MDMissoula.....Pulmonary Disease

Marcus A. Johnson, MDGreat Falls..... Family Practice
 Mary Jozwiak, MDBillings..... Internal Medicine
 Alaina L. Knight, LCPCBozeman..... Lic. Clin. Prof. Counselor
 Elisabeth A. Lincoln, NP.....Great Falls..... Nurse Practitioner
 Joseph E. Loos, MSW.....Missoula..... Lic. Clin. Social Worker
 Janey E. Maki, MDMiles City...Obstetrics and Gynecology
 Marilyn J. Manco-Johnson, MDBillings..... Pediatric
 Hematology-Oncology
 Heather L. McRee, DOHelena..... Family Practice
 Jeannie M. Muir-Padilla, MDBillings..... Pathology
 Thomas D. Mulgrew, MD.....Helena.....Psychiatry and Neurology
 George Chris Nadasi, PhDKalispell.....Psychology
 Robert W. Nelson, MDBillings..... Family Practice
 Mark H. Nicholson, MDBillings.....Psychiatry
 Varghese Parambi, MDGreat Falls..... Nephrology
 Jim Paulsen, LCSWBillings..... Lic. Clin. Social Worker
 Gregg D. Pike, MDGreat Falls..... Orthopaedics
 Plaza United PharmacyGreat Falls..... Medical Equipment
 Julie C. Ponti, PAKalispell..... Physician Assistant
 Frank A. Raiser, MDButte.....Surgery, General
 Michael J. Rossi, PAMissoula..... Physician Assistant
 Hazel F. Samilowitz, MD.....Kalispell.....Psychiatry
 Carly J. Sather-Heyne, PT.....Whitefish.....Physical Therapy
 Karrin W. Sax, NP.....Kalispell..... Nurse Practitioner
 James J. Schellenger, MDRoundup..... Family Practice
 Gregory W. Schneider, MD.....Bozeman..... Family Practice
 Gregory W. Schneider, MD.....Livingston..... Family Practice
 Sherwood Medical SupplyEureka..... Medical Equipment
 Sidney Health Center
 dba Clinic PharmacySidney.....Medical Equipment
 David E. Siewert, MD.....Manhattan..... Internal Medicine
 John A. Sisson, PHDHamilton.....Psychology
 Amy C. Skaggs, LCSWGreat Falls..... Lic. Clin. Social Worker
 Kurt R. Solari, DCMissoula.....Chiropractic

Kevin M. Stenson, PTButte.....Physical Therapy
 Donald Q. Thai, MDBillings.....Neurology
 Thrifty White StoresSidney.....Medical Equipment
 Shannon G. Tipton, MD.....Butte.....Surgery, General
 Michael J. Vlases, MD.....Bozeman.....Internal Medicine
 Kraig Allan Ward, MD.....Great Falls.....Physical Medicine
 & Rehabilitation
 Tamara M. Welsh, MD.....Great Falls.....Family Practice
 Jonathon M. Wilhelm, DCBelgrade.....Chiropractic
 Steven E. Williamson, MDBillings.....Family Practice
 Malcolm D. Winter Jr., MDMiles City.....Internal Medicine

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

A R Belknap MD PA.....Butte.....Radiology
 Kathy J. Adams, SP.....Billings.....Speech Therapy
 Carter E. Beck, MDMissoula.....Surgery, Neurological
 Sherry Birch, SLPLivingston.....Speech Therapy
 Kenneth C. Brewington, MDMissoula.....Surgery, Neurological
 Sarah E. Bronsky, MDBozeman.....Family Practice
 Roger G. Brown, MD.....Kalispell.....Plastic Surgery
 Arturo Camacho, MDBillings.....Surgery, Neurological
 Howard Christy Chandler, MDMissoula.....Surgery, Neurological
 Dawn Christian, PT.....Missoula.....Physical Therapy
 Paula S. Colledge, PAMissoula.....Physician Assistant
 Wayne Cure, PAMiles City.....Physician Assistant
 John Michael Dempsey, MD.....Ronan.....Family Practice
 Debbie Doyle, OTLivingston.....Occupational Therapy
 Jennifer H. Dull, OD.....Billings.....Optometry
 Carlos M. Duran, MDMissoula.....Surgery, Cardiovascular
 Carlos M. Duran, MDMissoula.....Surgery, Thoracic
 Howard Lee Finney, MDGreat Falls.....Surgery, Neurological
 Joseph Garcia, MD.....Billings.....Cardiovascular Disease
 Henry H. Gary, MDMissoula.....Surgery, Neurological
 Fred L. Griffin, MDMissoula.....Psychiatry
 Cynthia J. Ibes, OTLivingston.....Occupational Therapy
 Charles L. Johnson, MDKalispell.....Urgent Care
 Mark A. Johnston, MDKalispell.....Psychiatry
 Bonita Juroe, LCPCKalispell.....Lic. Clin. Prof. Counselor
 Kimberley A. Kaftan, SLP.....Havre.....Speech Therapy
 Mary Ann Kozel, PTKalispell.....Physical Therapy
 Mary Ann Kozel, PTPolson.....Physical Therapy
 Stephen Lee, LCPC.....Miles City.....Lic. Clin. Prof. Counselor
 Chriss Anthony Mack, MDMissoula.....Surgery, Neurological
 Julie B. Maggiolo, MDAnaconda.....Psychiatry

Milana M. Marsenich, LCPC.....Polson.....Lic. Clin. Prof. Counselor
 Caroline M. Rehder, PTLivingston.....Physical Therapy
 F. Clifford Roberson, MDMissoula.....Surgery, Neurological
 John E. Russo, MDScobey.....General Practice
 Camilla R. Saberhagen, MDBillings.....Infectious Disease
 Russell G. Sarver, MDBillings.....Urology
 Jacqueline B. Sherman, PhD.....Lewistown.....Psychology
 Pennie Strong Tague, LCPCKalispell.....Lic. Clin. Prof. Counselor
 Daniel S. Tarnowski, DCBozeman.....Chiropractic
 Roger E. Terry, PTMissoula.....Physical Therapy
 Monica Trimble, LCSW.....Missoula.....Lic. Clin. Social Worker
 Ronald H. Ullman, MD.....Billings.....Ophthalmology
 Mitch Vap, PTDeer Lodge.....Physical Therapy
 James R. Williams, OD.....Bozeman.....Optometry
 Gary Yee, LCPC.....Kalispell.....Lic. Clin. Prof. Counselor
 Bob G. Zadow, LCPCMiles City.....Lic. Clin. Prof. Counselor

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

Michelle C. Arnold-McMahon, PTBillings.....Physical Therapy
 Robert A. Babbitt, PAC.....Kalispell.....Physician Assistant
 Dirk M. Beyer, ODHamilton.....Optometry
 Jason L. Blaser, MD.....Billings.....Pathology
 Mark Edward Blossom, MDChinook.....Internal Medicine
 Eric M. Brandeberry, MDKalispell.....Family Practice
 Kristin A. Brueck, PT.....Missoula.....Physical Therapy
 Michael R. Butz, PhDBillings.....Psychology
 Dessye-Dee M. Clark, CNSMissoula.....Clinical Nurse Specialist
 Gretchen H. Coble, PTHelena.....Physical Therapy
 Roger J. Diegel, MDKalispell.....Rheumatology
 Pady J. Dusing, CNMKalispell.....Certified Nurse Midwife
 Jeanne M. Dussault, LCPCGreat Falls.....Lic. Clin. Prof. Counselor
 Tamara M. Easton, LCPCBillings.....Lic. Clin. Prof. Counselor
 Megan E. Gordley, DC.....Whitefish.....Chiropractic
 Daniel K. Gordon, MDGreat Falls.....Family Practice
 Laura M. Harper-Hall, LACBillings.....Cert. Chem. Dep. Counselor
 Virginia Lee Harrison, MDHelena.....Internal Medicine
 Rita A. Haskins, OTKalispell.....Occupational Therapy
 Leslie Hayden, PT.....Whitefish.....Physical Therapy
 Mark S. Heppe, MD.....Ronan.....Family Practice
 Rolf H. Holle, MDMissoula.....Pulmonary Disease
 Chu Shei Hong, MDGreat Falls.....Internal Medicine
 Marcus A. Johnson, MDGreat Falls.....Family Practice
 Mary Jozwiak, MDBillings.....Internal Medicine
 Jennifer K. Koffler, PA-C.....Billings.....Physician Assistant
 Lisa B. Lovejoy, MDMissoula.....Family Practice

Lisa A. Lysne, LCSWGreat Falls..... Lic. Clin. Social Worker
 Marilyn J. Manco-Johnson, MDBillings..... Pediatric
 Hematology-Oncology
 Heather L. McRee, DOHelena..... Family Practice
 Paula J. Mills, LCPC.....Anaconda..... Lic. Clin. Prof. Counselor
 Jeannie M. Muir-Padilla, MDBillings..... Pathology
 Thomas D. Mulgrew, MDHelena.....Psychiatry and Neurology
 George Chris Nadasi, PhD.....Kalispell.....Psychology
 G. Gregg Neibauer, DPMMissoula.....Podiatry
 Mark H. Nicholson, MDBillings.....Psychiatry
 Varghese Parambi, MDGreat Falls..... Nephrology
 Gregg D. Pike, MDGreat Falls..... Orthopaedics
 Shelley R. Poss, NP.....Great Falls..... Nurse Practitioner
 Barbara E. Prescott, NP.....Polson..... Nurse Practitioner
 Frank A. Raiser, MDButte.....Surgery, General
 Jennifer J. Rose, ODBillings..... Optometry
 Sherilyn D. Rossiter, LCPCMissoula..... Lic. Clin. Prof. Counselor
 Krista K. Scott, PTPolson.....Physical Therapy
 Pamela L. Skonord, PTKalispell.....Physical Therapy
 Kurt R. Solari, DCMissoula.....Chiropractic
 Shannon G. Tipton, MD.....Butte.....Surgery, General
 Tamara M. Welsh, MD.....Great Falls..... Family Practice
 Bryce A. Yasenak, PTHamilton.....Physical Therapy

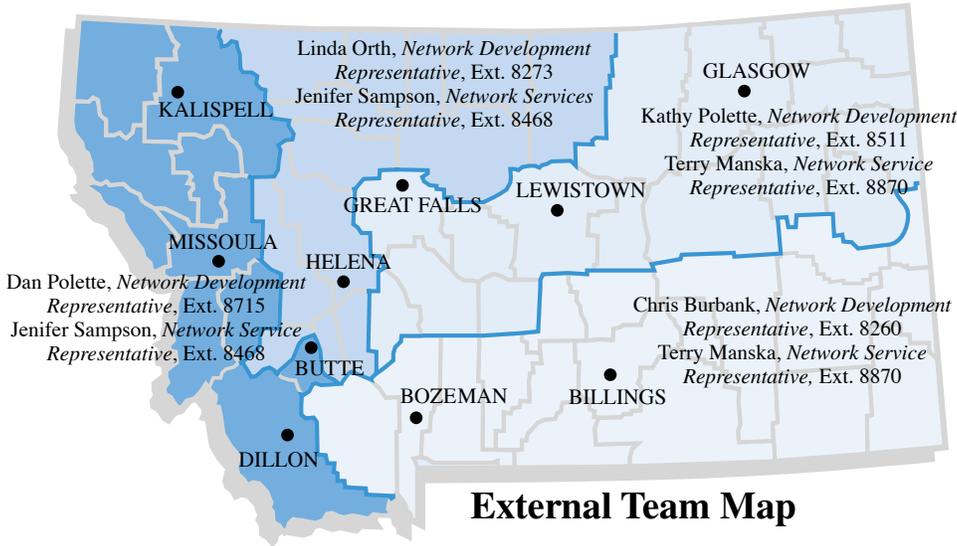
The following providers are no longer participating with the Joint Venture Provider Network.

A. R. Belknap, MD, PA.....Butte.....Radiology
 Arturo Camacho, MDBillings..... Surgery, Neurological
 John Michael Dempsey, MD.....Ronan..... Family Practice
 Carlos M. Duran, MDMissoula..... Surgery, Cardiovascular
 Fred L. Griffin, MDMissoula.....Psychiatry
 Gordon E. Harrison, DCHardin.....Chiropractic
 Charles L. Johnson, MDKalispell..... Urgent Care
 Patrick D. Jones, LCPCBillings..... Lic. Clin. Prof. Counselor
 Mary Ann Kozel, PTKalispell.....Physical Therapy
 Mary Ann Kozel, PTPolson.....Physical Therapy
 Julie B. Maggiolo, MDAnaconda.....Psychiatry
 Milana M. Marsenich, LCPC.....Polson..... Lic. Clin. Prof. Counselor
 Thomas M. Morris, SP.....Butte.....Speech Therapy
 Patricia J. Pezzarossi, MDMiles City.....Pediatrics
 Jacqueline B. Sherman, PhD.....Lewistown.....Psychology
 Ronald H. Ullman, MD.....Billings..... Ophthalmology
 Gary Yee, LCPC.....Kalispell..... Lic. Clin. Prof. Counselor

Season's Greetings

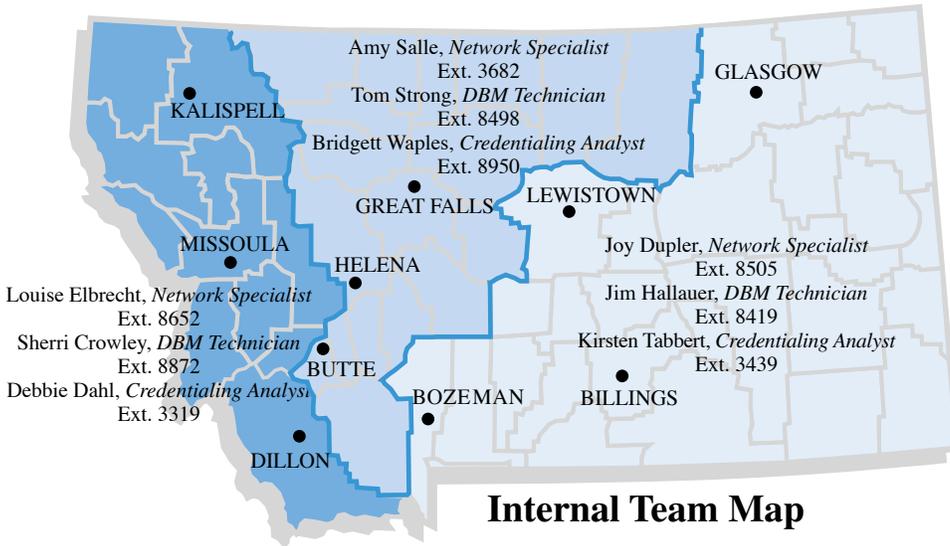


*Maahlt Bengtson Linda Oatt
 Paul Peller Christy Byrland
 Greg Schneider Daniel Pollett
 William M. Duke T. Manska
~~Shirley Brown~~ Sherri Cleavelly
 Jeanne B. Skaynor Tom Strong
 Mary H. Oker Amy Sallee
 Jeanne Tomaska Jennifer Sampson
 Juanita Brewer Kathy Pollette
 Gary Depler Sara Wong
 Sherry Murphy Mark
 Bridget Waples M. Sims
 Deb Stewart Richard Doran
 Jacqueline Hanson Barbara Gilbreath*



EXTERNAL TEAM

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



INTERNAL TEAM

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, 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 credentialing database maintenance. If you change your address, tax ID or Social Security Number or your on-call list, or if you have any questions about your listing in provider directories, contact the appropriate Internal Team member listed on the map.



BCBSMT HEALTH CARE SERVICES
1-800-447-7828

FRAUD

HEALTH CARE FRAUD A TOP CONCERN FOR AMERICAN CONSUMERS

A post-election poll conducted by the Blue Cross Blue Shield Association (BCBSA) identified health care and prescription drug costs as two domestic issues that should be priorities for the incoming Congressional members. Surveyed consumers ranked health care (40%) slightly behind the number one domestic priority, the economy and jobs (41%), and ahead of Social Security and Medicare (29%).

When asked to identify the leading factors behind the rise in health care costs, consumers identified:

- Prescription drug costs (60 percent).
- Cost of hospital care (51 percent).
- Medical malpractice insurance and lawsuits (48 percent).
- *Waste, fraud, and abuse* (44 percent).

When asked to select the top health care issues the new Congress should address beginning in January 2005, consumers identified:

- Assuring access to health coverage for every American (68 percent).
- Access to affordable prescription drugs (67 percent).
- Slowing the steep rise in health care

costs (63 percent).

- *Reducing costly fraud and abuse in the health care system* (56 percent).

With fraud and abuse costing American consumers as much as \$1 out of every \$7 spent on health care, the public has finally recognized fraud as a primary contributor to increasing premiums, declining benefits, and increasing numbers of uninsured who can no longer afford coverage.

BCBSMT challenges the Montana health care community to help identify the few who steal from all of us. As fraudulent providers profit (sometimes very handsomely) from their illegal activity, insurers are forced to increase premiums to your patients, reduce benefits, and try to maintain adequate compensation for ethical providers. By working together, BCBSMT hopes to reduce fraudulent activity and the resulting negative effect it has on everyone involved in the health care system.

If you suspect a provider or patient may be involved in fraudulent claim activity, please call the BCBSMT Fraud Hotline at 1-800-447-7828, extension 3468. Referrals may be made anonymously. More information on health care fraud is online at www.stopfraud.bcbsmt.com. The full report issued by the BCBSA is online at <http://onlinepressroom.net/bcbsa>.

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.



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