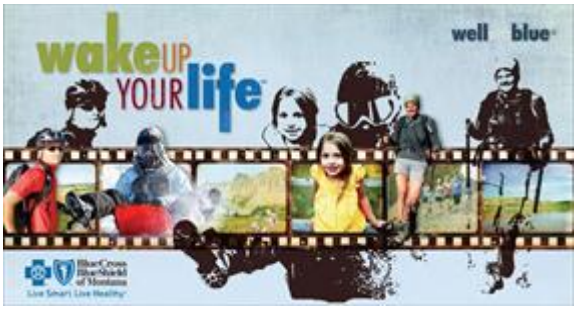
CapsuleNews℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS
First Quarter 2011

BCBSMT Initiates New Statewide Wellness Campaign



To help Montanans Live Smart Live Healthy℠, Blue Cross and BlueShield of Montana is proud to introduce Wake Up Your Life, our new wellness website dedicated to helping you get healthy, starting by injecting a little fun into your regular daily activities.

Wake Up Your Life showcases the WellwithBlue program (powered by Alere), and while you must meet certain requirements to use the full features of the site, all Montanans have access to information on nutrition, exercise, health, recipes, as well as exciting free programs like our 12-week Weight Loss Challenge, which kicked off right after the start of the new year. Over 4,700 Montanans registered for the challenge.

Wake Up Your Life also features information about our Wellness Team and the Integrated Healthcare Management (IHM) program. And to make sure the website remains fresh and engaging, it is filled with new articles every month.

Click here to find out how easy it is to start waking up your life today. Once on this page, you may register if you haven't used our website before, or log in if you have previously registered.

If you are new to WellwithBlue, use the left portion of the page labeled "First Time Here?" In this section, you will be able to create your own account using your Member ID from your Blue Cross and Blue Shield of Montana insurance card. To do so, enter only the number portion of your Member ID (without the alpha prefix) into the Member ID box. For example, if your Member ID reads YDH987654321, only enter 987654321 into the Member ID box. Next, select "Employee" in the relationship box. Then, click on the "Enter Site" button.

If you do not have BCBSMT insurance, you can still access our wellness website. Simply email IHM_Wellness@bcbsmt.com and request a Unique User ID to use in place of the Member ID. Type that ID into the Member ID box, and then select "Employee" in the relationship box. Then click on the "Enter Site" button.

On the following page, you will be asked to verify your gender, date of birth, and your Member ID or Unique User ID. Once this is completed, your final page will ask you to verify some additional information including your address. You will also be asked to enter an email address (optional) and create a username and password. After this step, you are ready to enjoy the many resources the WellwithBlue website has to offer!

Rationale for Benefit Administration

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

The purpose of medical policy is to guide coverage decisions and is not intended to influence treatment decisions. Providers are expected to make treatment decisions based on their medical judgment. Blue Cross and Blue Shield of Montana recognizes the rapidly changing nature of technological development and welcomes provider feedback on all medical policies. When using this policy to determine whether a service, supply, or device will be covered, please note that member contract language will take precedence over medical policy when there is a conflict.

Federal Mandate

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

Advanced Member Notice

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

Notice

Medical policies are published throughout the year, and all revised or new policies are available under New Policies. Any medical policy published with stricter criteria for coverage is available on the website for 90 days prior to implementation.

2010 Provider Satisfaction Survey Results

The results are in from the Blue Cross and Blue Shield of Montana (BCBSMT) 2010 provider satisfaction survey, administered by The Myers Group in Snellville, Georgia.

Of the 1,800 providers randomly selected from over 5,000 participating providers, 376 responded to the three-wave mail survey. We thank each of you who responded. Your feedback is very important to us. The survey measures 20 attributes to assist BCBSMT in developing a comprehensive plan for improving and maintaining your satisfaction with us.

The Top Box scores (excellent and very good response options) for overall health plan satisfaction were 86.6% compared with 84.1% in 2009, which indicates a 2.5 percent overall increase in satisfaction with BCBSMT. In addition, BCBSMT's ratings were significantly higher than the provider ratings for other health plans in all surveyed attributes.

Finally, congratulations to Sherri Bell, LCSW, of Anaconda, the lucky raffle winner of an an IPod Touch held for all survey respondents!

Survey Item			Category Responses					Summary Rate Scores*				Mean Scores**	
	Plan	Valid n	Excellent	Very good	Good	Fair	Poor	2010	2009	2008	B.o.B.***	2010	B.o.B.***
Q1. Responsiveness and courtesy of the health plan's provider relations representative.	BCBS MT	347	21.6%	48.7%	24.5%	4.0%	1.2%	**70.3%**	68.2%	69.5%	55.9%	**3.86**	3.61
	All Others	329	4.3%	25.2%	46.5%	21.9%	2.1%	**29.5%**	25.4%	31.7%	33.2%	**3.08**	3.21
Q2. Timeliness to answer questions and/or resolve problems.	BCBS MT	349	18.1%	42.1%	27.5%	9.7%	2.6%	**60.2%**	59.9%	56.3%	47.9%	**3.63**	3.41
	All Others	332	3.0%	21.4%	43.4%	27.7%	4.5%	**24.4%**	20.3%	26.5%	30.2%	**2.91**	3.11
Q3. Frequency and effectiveness of provider representative visits.	BCBS MT	166	16.3%	25.3%	24.7%	18.1%	15.7%	**41.6%**	34.0%	33.3%	NA	**3.08**	NA
	All Others	153	3.3%	18.3%	29.4%	28.1%	20.9%	**21.6%**	15.3%	22.5%	NA	**2.55**	NA
Q4. Quality of provider orientation process.	BCBS MT	223	10.3%	22.4%	35.4%	22.9%	9.0%	**32.7%**	36.3%	35.2%	38.9%	**3.02**	3.19
	All Others	202	3.0%	11.9%	38.1%	28.7%	18.3%	**14.9%**	11.8%	19.8%	24.7%	**2.52**	2.93
Q5. Reasonableness of paperwork and documentation required by physicians.	BCBS MT	331	12.1%	30.2%	31.7%	18.4%	7.6%	**42.3%**	38.0%	40.8%	NA	**3.21**	NA
	All Others	326	3.7%	19.3%	36.8%	31.0%	9.2%	**23.0%**	16.4%	21.4%	NA	**2.77**	NA

** Summary Rate Scores are the sum of the most favorable response options (Excellent & Very good).*
*** Mean scores are the average of all responses.*
**** B.o.B. represents the 2009 TMG Commercial Book of Business Benchmark which consists of Primary Care Physicians, Specialists, and Behavioral Health Clinicians.*

Survey Item			Category Responses					Summary Rate Scores*				Mean Scores**	
	Plan	Valid n	Yes	No				2010	2009	2008	B.o.B.***	2010	B.o.B.***
Q6. Did you attend a Provider Roundtable meeting?	BCBS MT	338	2.1%	97.9%				**2.1%**	3.6%	NA	NA	NA	NA
			Excellent	Very good	Good	Fair	Poor						
Q6a. Usefulness of the BCBSMT Roundtable meeting.	BCBS MT	6	0.0%	50.0%	33.3%	16.7%	0.0%	**50.0%**	33.3%	NA	NA	3.33	NA
Q7a. Usefulness of the BCBSMT's Capsule News.	BCBS MT	300	11.3%	22.7%	40.7%	21.0%	4.3%	**34.0%**	34.4%	32.5%	NA	3.16	NA
Q7b. Usefulness of BCBSMT's Provider manuals.	BCBS MT	283	8.5%	21.9%	42.0%	21.6%	6.0%	**30.4%**	34.9%	33.3%	NA	3.05	NA
Q7c. Usefulness of BCBSMT's Provider contracts.	BCBS MT	294	7.5%	20.7%	43.5%	23.8%	4.4%	**28.2%**	29.7%	31.6%	NA	3.03	NA
Q7d. Usefulness of BCBSMT's Provider directories.	BCBS MT	284	8.8%	23.2%	44.4%	19.7%	3.9%	**32.0%**	36.3%	35.1%	NA	3.13	NA
Q8a. Usefulness of BCBSMT's Provider Services at www.bcbsmt.com/Providers.	BCBS MT	307	18.2%	37.5%	30.3%	8.5%	5.5%	**55.7%**	53.0%	41.6%	NA	3.54	NA
Q8b. Usefulness of BCBSMT's Secure Services (benefits, claims, eligibility) at www.bcbsmt.com.	BCBS MT	297	17.8%	39.1%	26.3%	9.1%	5.7%	**56.9%**	52.5%	40.6%	NA	3.54	NA
Q8c. Usefulness of BCBSMT's Customer Service at 1-800-447-7828.	BCBS MT	319	17.9%	40.1%	26.3%	10.3%	5.3%	**58.0%**	57.4%	54.0%	NA	3.55	NA

** Summary Rate Scores are the sum of the most favorable response options (Yes, and Excellent & Very good).*
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***Note:** Q6a is gated by Q6 (i.e., only those responding "Yes" to Q6 answered Q6a) and therefore, has a low valid n. Caution should be used when interpreting data.*

Survey Item			Category Responses					Summary Rate Scores*				Mean Scores**	
	Plan	Valid n	Excellent	Very good	Good	Fair	Poor	2010	2009	2008	B.o.B.***	2010	B.o.B.***
Q9. The health plan's administration of the PCP's referrals to a specialist.	BCBS MT	220	10.9%	32.3%	41.8%	11.8%	3.2%	**43.2%**	42.7%	35.4%	47.5%	**3.36**	3.44
	All Others	208	1.4%	23.1%	46.2%	20.2%	9.1%	**24.5%**	20.6%	24.8%	32.0%	**2.88**	3.15
Q10. The health plan's facilitation of clinical care for patients.	BCBS MT	250	9.2%	30.4%	44.0%	13.6%	2.8%	**39.6%**	37.3%	38.8%	37.9%	**3.30**	3.28
	All Others	235	1.7%	22.6%	48.5%	22.1%	5.1%	**24.3%**	15.5%	23.1%	24.3%	**2.94**	3.06
Q11. The health plan's support of physician relationship with patients.	BCBS MT	248	10.9%	29.0%	38.7%	15.7%	5.6%	**39.9%**	35.6%	40.8%	NA	**3.24**	NA
	All Others	232	1.7%	20.3%	45.3%	22.4%	10.3%	**22.0%**	12.8%	25.4%	NA	**2.81**	NA
Q12. Degree to which the plan covers and encourages preventive care and health wellness.	BCBS MT	287	12.5%	29.6%	28.2%	19.2%	10.5%	**42.2%**	37.1%	34.0%	46.7%	**3.15**	3.43
	All Others	272	2.9%	18.0%	36.8%	27.2%	15.1%	**21.0%**	13.2%	16.1%	28.8%	**2.67**	3.05
Q13. Degree to which the plan provides information on coverage and what the plan would pay for needed healthcare services.	BCBS MT	327	11.9%	30.3%	35.8%	15.6%	6.4%	**42.2%**	NA	NA	NA	**3.26**	NA
	All Others	306	2.6%	17.6%	41.8%	26.5%	11.4%	**20.3%**	NA	NA	NA	**2.74**	NA
Q14. Degree to which the plan provides information and services to your patient to make informed decisions about needed medical care.	BCBS MT	267	7.5%	22.8%	43.8%	20.2%	5.6%	**30.3%**	NA	NA	NA	**3.06**	NA
	All Others	256	2.0%	11.7%	43.0%	33.6%	9.8%	**13.7%**	NA	NA	NA	**2.63**	NA
Q15. The health plan's support of appropriate clinical care for patients.	BCBS MT	292	8.9%	27.4%	40.8%	17.5%	5.5%	**36.3%**	41.0%	39.1%	37.9%	**3.17**	3.28
	All Others	274	1.8%	14.2%	46.7%	29.2%	8.0%	**16.1%**	14.7%	18.8%	24.3%	**2.73**	3.06
Q16. The health plan's support provided concerning medical management of patients.	BCBS MT	246	10.2%	26.4%	43.1%	15.4%	4.9%	**36.6%**	35.8%	32.5%	NA	**3.22**	NA
	All Others	232	3.0%	14.7%	50.0%	25.9%	6.5%	**17.7%**	11.4%	18.7%	NA	**2.82**	NA

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*** Mean scores are the average of all responses.*

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Note: The same benchmark ("The health plan's facilitation/support of appropriate clinical care for patients") is used for Q10 and Q15. Please use caution when interpreting data.

Survey Item			Category Responses					Summary Rate Scores*				Mean Scores**	
	Plan	Valid n	Excellent	Very good	Good	Fair	Poor	2010	2009	2008	B.o.B.***	2010	B.o.B.***
Q17. Accuracy of claims processing.	BCBS MT	346	21.4%	40.2%	25.1%	11.3%	2.0%	**61.6%**	61.7%	58.1%	41.0%	**3.68**	3.28
	All Others	331	5.4%	23.3%	43.5%	23.0%	4.8%	**28.7%**	24.9%	24.8%	28.8%	**3.02**	3.11
Q18. Timeliness of claims processing.	BCBS MT	348	34.2%	32.2%	23.6%	7.5%	2.6%	**66.4%**	62.7%	64.5%	42.0%	**3.88**	3.28
	All Others	333	1.5%	21.6%	42.9%	24.9%	9.0%	**23.1%**	14.6%	19.4%	29.7%	**2.82**	3.09
Q19. Ease of using health plan's provider claims payment register.	BCBS MT	259	27.4%	32.4%	25.9%	10.4%	3.9%	**59.8%**	59.2%	59.9%	NA	**3.69**	NA
	All Others	237	3.0%	24.9%	44.7%	22.8%	4.6%	**27.8%**	22.2%	30.0%	NA	**2.99**	NA

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Survey Item	Plan	Valid n	Category Responses					Summary Rate Scores*				Mean Scores**	
								2010	2009	2008	B.o.B.***	2010	B.o.B.***
Q20. Would you recommend BCBSMT to other patients?	BCBSMT	353	Definitely yes	Probably yes	Probably not	Definitely not		94.9%	91.8%	90.6%	89.2%	3.41	3.30
			47.9%	47.0%	3.7%	1.4%							
Q21. Would you recommend BCBSMT to other physicians?	BCBSMT	356	Definitely yes	Probably yes	Probably not	Definitely not		95.2%	91.0%	90.7%	89.7%	3.43	3.30
			49.2%	46.1%	3.4%	1.4%							
Q22. Overall satisfaction with BCBSMT?	BCBSMT	365	Very satisfied	Somewhat satisfied	Neither	Somewhat dissatisfied	Very dissatisfied	86.6%	84.1%	82.7%	81.8%	4.29	4.15
			48.8%	37.8%	9.0%	2.7%	1.6%						
Q23. Overall satisfaction with other health plans?	All Others	363	Very satisfied	Somewhat satisfied	Neither	Somewhat dissatisfied	Very dissatisfied	63.6%	65.6%	63.6%	78.1%	3.57	3.89
			7.7%	55.9%	24.2%	9.9%	2.2%						

** Summary Rate Scores are the sum of the most favorable response options (those response options shaded gray).*
*** Mean scores are the average of all responses.*
**** B.o.B. represents the 2009 TMG Commercial Book of Business Benchmark which consists of Primary Care Physicians, Specialists, and Behavioral Health Clinicians.*

BCBSMT Access and Availability Standards

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

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

Urgent Care

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

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

Non-Urgent Care with Symptoms

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

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

Routine Care

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

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

Preventive Care and Immunizations

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

Preventive care and Immunizations are health care services designed for the prevention and early detection of illness in asymptomatic people. More information is available in the BCBSMT provider manual. If you have suggestions for improvement or content, email your Provider Account Consultant atHCS-X6100@bcbsmt.com or

call 1-800-447-7828, Extension 6100.

Conversion Factors Increase May 1, 2011
Effective May 1, 2011, Blue Cross and Blue Shield of Montana (BCBSMT) is increasing the resourced-based relative value system (RBRVS) conversion factor to $60.10 and the anesthesia conversion factors to $54.15.

In the RBRVS system, services are assigned units of value, known as Relative Value Units (RVU), based on the resources (physician's work, the practice expense, and professional liability insurance) required to provide the services. BCBSMT uses the Transitioned Non-Facility RVU and Transitioned Facility RVU totals. The applicable total RVU is multiplied by the BCBSMT conversion factor to calculate the BCBSMT allowable fee for participating providers.

Payment for the administration of anesthesia is based on the American Society of Anesthesiology ethodology. The compensation method for physicians and certified registered nurse anesthetists is a base and time unit calculation (base units plus time units multiplied by the conversion factor). Anesthesia time is reported in minutes, and each 15-minute increment equals one unit. More information is available in the Relative Value Unit and Anesthesia Compensation policies published at bcbsmt.com (click on Providers and then Provider Policies).

If you have questions, email your Provider Account Consultant at HCSX6100@bcbsmt.com or call 1-800-447-7828, Extension 6100.

Healthy Montana Kids Initiates New Temporary Coverage

Effective January 1, 2011, the Healthy Montana Kids (HMK) Program launched a new Presumptive (i.e.,temporary) Eligibility Program. Presumptive Eligibility will permit qualifying Montana children to access health care while they are evaluated for regular HMK coverage. Presumptive Eligibility currently is offered through Montana hospitals, including critical access and Indian Health Service facilities, when uninsured children present for services.

To qualify for the Presumptive Eligibility Program, the family completes a brief application at the hospital; then an HMK-trained hospital staff member reviews the information on the application and determines whether the family's income is within HMK or HMK Plus guidelines. Generally all children under age 19 in a family are enrolled as presumptively eligible at the same time. A family may qualify for presumptive eligibility only once every 12 consecutive calendar months. Coverage under the Presumptive Eligibility Program ends no later than the last day of the month following submission of the application but may end earlier. For example, temporary coverage for a Presumptive Eligibility Application received July 20 cannot extend beyond August 31. However, the temporary coverage may end earlier if the family is determined ineligible prior to August 31. The family is encouraged to complete and submit an HMK application along with required documentation as soon as possible, but no later than the end of the next month, so there will be no lapse in an eligible child's HMK coverage.

To obtain health care services during the presumptive eligibility period, families will receive a copy of their Presumptive Eligibility Application and a Proof of Temporary Coverage Letter as proof of their temporary eligibility status. These documents will verify their status until the family receives a letter from the HMK Program providing additional coverage and identification information.

Children determined presumptively eligible receive the same benefits as children enrolled in either HMK or HMK Plus. Providers must verify the child's ID number, using the web portal at www.mtmedicaid.org and clicking on the "Montana Access to Health" link, prior to submitting claims for services.

"We want to reach Montana's uninsured children every way we can," said Katherine Buckley-Patton, Program Director for Healthy Montana Kids. "Presumptive Eligibility supports families as they seek services and offers another option for enrollment in the Healthy Montana Kids Program."

For additional information about presumptive eligibility, contact Trinda Smith at 1-877-543-7669, Extension 3098, or email tsmith@mt.gov.

HHS Releases Final Rules for HIPAA 5010 and ICD-10

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) released the following two final rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding updated standards for electronic health care transactions:

1. X12 Version of 5010 HIPAA Transactions Standards and Code Sets
   This rule introduced modifications because the current 4010A1 electronic transaction standards are outdated and include rules that no longer align with business practices in the health care industry. HHS adopted the corrections to the approved X12 versions on October 13, 2010. The changes were published in the Federal Register on January 16, 2009.

   Some of the changes to the X12 standard electronic transactions include:
   - Claim/Encounter – Institutional, Professional, and Dental (837I,P,D)
   - Enrollment (834)
   - Authorization/Referral Request and Response (278)
   - Payment/Remittance Advice (835)
   - Premium Payment (820)
   - Eligibility Request and Response (270/271)
   - Claims Status Inquiry and Response (276/277)
2. International Classification of Diseases (ICD-10) This final rule overhauls the diagnosis coding and inpatient procedure coding standards for health care claims by requiring field size expansion and complete redefinition of code values and their interpretation.Significant changes include, but are not limited to:
   - Classification logic for ICD-10 differs significantly from ICD-9. ICD-10 uses up to seven alphanumeric characters (ICD-9 uses up to five).
   - ICD-10 introduces a one-digit version indicator to identify ICD-9 from ICD-10 and increases the number of diagnosis codes supported on a claim.
   - The diagnostic classification set (ICD-10-CM) includes about 120,000 codes (almost 10 times the number used under ICD-9), and the procedure usage set (ICD-10-PCS) includes more than 200,000 codes (roughly 50 times as many as ICD-9).

For both rule changes the compliance deadline forcovered entities is January 1, 2012, except for small health plans, which will have until January 1, 2013, to be compliant.

The HIPAA 5010 and ICD-10 final rules apply to all HIPAAcovered entities, including health plans, health care clearinghouses, and health care providers. These rules are designed to bring greater consistency and accuracy in electronic health care transactions.

HIPAA 5010 brings more consistency to health care transactions, ultimately making it easier for health care providers to submit the same information to all insurance carriers. The HIPAA 5010 transactions are a prerequisite for the successful implementation and use of the ICD-10 code sets. Because the field size for ICD codes increases from 5 to 7 bytes, the earlier compliancedate for HIPAA 5010 transactions will allow for the new ICD-10 code parameters.

ICD-10 will provide increased clinical granularity to diagnosis and procedure coding and will ultimately support advances in the quality of care, the effectiveness of clinical processes, and the accuracy of analytics.

Three Recommendations for Making Sure You are Compliant

1. Be proactive and learn about the HIPAA 5010 and ICD-10 compliance requirements by visiting the CMS website at http://www.cms.gov/ and the HHS website at http://www.hhs.gov/ocr/privacy/.
2. Contact your claims clearinghouse and begin planning for the requirements, changes, and impacts from HIPAA 5010 and ICD-10.
3. Ask your vendors for their plan on conversion, testing, and costs to meet the HIPAA 5010 and ICD 10 dates.

BCBSMT Readiness

BCBSMT is committed to providing excellent service and to compliance and support of HIPAA 5010 and ICD-10. Our implementation strategy for HIPAA 5010 is under way, and we are working with our clearinghouse (Healthe-Web, Inc.) to make sure that all incoming and outgoing transactions will meet the required deadlines.

BCBSMT is developing a multi-year strategy for adopting ICD-10 diagnosis coding requirements. We have established a cross-functional steering team that is researching issues, assessing systems, reviewing business processes, and educating our staff and its affiliates about implementation procedures.

BCBSMT is testing the HIPAA 5010 transactions with selected 4010A1 trading partners. If you would like to begin testing with us, contact Jeremy Crouse at 437-5415 to make arrangements. Some critical dates to keep in mind are:

- December 31, 2011: Healthy-e-Web will accept and transmit both standards (4010A1 and 5010) as permitted by the final rule until that date.
- January 1, 2012: BCBSMT will only use X12 Version 5010 for HIPAA transactions after that date.
- October 1, 2013: BCBSMT will comply with the ICD-10 mandate by that date.

Please visit www.bcbsmt.com for updates to our readiness status. You may also visit Health-e-Web at http://www.hewedi.com/ for more information.

If you have questions, send an email to HCS-X6100@bcbsmt.com or call 1.800.447.7828, Extension 6100.

New Vaccine Administration Codes

The CPT Editorial Panel of the American Medical Association recently released the following new component-based vaccine administration codes, effective January 1, 2011:

- 90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component.
- 90461 – each additional vaccine/toxoid component (list separately in addition to code for primary procedure)
  The component-based vaccine administration codes will replace CPT 90465 – 90468.

The new codes allow a provider to report each vaccine component separately. CPT defines a component as all antigens in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components. The new codes are structured in a way that will account for each component administered, regardless of whether it is single-component or a multiple component/combination vaccine.

Codes 90460 and 90461 must be reported in addition to the vaccine and toxoid code(s) 90476-90749. Report Codes 90460 and 90461 only when the physician or qualified health care professional provides faceto-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccine to patients over 18 years of age, report Codes 90471-90474.

Example: A four-month-old patient receives diphtheria, tetanus, acellular pertussis, Haemophilus influenza type b, inactivated polio combination from his physician. The physician counsels the parents on the risks of each component and the disease for which each component provides protection. The services are billed as follows:

CPT Code	Code Description	Units Billed
90698	DIPTHERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIN VACCINE, HAEMOPHILUS INFLUENZA TYPE B, AND POLIOVIRUS VACCINE, INACTIVATED (DTAP-HIB-IPV), FOR INTRAMUSCULAR USE *this vaccine contains 5 components	1 unit
90460	IMMUNIZATION ADMINISTRATION THROUGH 18 YEARS OF AGE VIA ANY ROUTE OF ADMINISTRATION, WITH COUNSELING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; FIRST VACCINE/TOXOID COMPONENT	1 unit
90461	IMMUNIZATION ADMINISTRATION THROUGH 18 YEARS OF AGE VIA ANY ROUTE OF ADMINISTRATION, WITH COUNSELING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; EACH ADDITIONAL VACCINE/TOXOID	4 units

If you have questions, please contact your Health Care Services Representative at 1-800-447-7828, Extension 6100, or by email at HCS-X6100@bcbsmt.com.

TriCare/TriWest

Electronic Funds Transfer = Quicker Payments, Less Paperwork

To receive your TRICARE payments quicker while reducing the amount of paper used in your daily transactions, TriWest Healthcare Alliance and its claims processor, Wisconsin Physicians Service Insurance Corporation (WPS), are now offering Electronic Funds Transfer (EFT) to network providers that use Electronic Remittance Advice (ERA).

EFT
EFT is a process that allows your payment to be deposited directly into your checking or savings account and eliminates any delays you may encounter with mail procedures. EFT replaces the paper checks you currently receive for TRICARE West Region claim payments.

To be eligible to receive an EFT from TriWest, you need to be a network provider that receives ERAs. An ERA is the electronic equivalent of the paper remittance advice (also known as Explanation of Benefits or EOB) and provides details on how your claims were processed.

In addition, it will be necessary to complete an EFT application form and send it to WPS to begin using EFT. Once the completed agreement form is received, WPS will complete a pre-note process with your bank and work directly with your office on a smooth conversion to EFT.

ERA
An ERA provides information on claims payments, deductibles, cost-shares and copayments. ERA can help decrease the time spent reconciling accounts receivable, eliminate manual data entry and paper processing, eliminate errors associated with manual posting of paper remittance advices and eliminate the need to store and file paper copies.

When you choose to receive ERAs, your files will be sent to you in the ANSI (American National Standards Institute) X12 835 format, version 4010A1, and can be downloaded from the WPS Bulletin Board System (BBS) or through WPS's secure FTP process. To make sure you have an opportunity to become accustomed to reconciling reimbursements via ERA, we will also provide paper copies of the EOBs for 45 days before we "Go Green" and stop sending paper copies.

To learn more about TRICARE West Region EFT or ERA, TriWest and WPS have created frequently asked questions documents with basic questions on both EFT and ERA. You may also contact one of the WPS EDI Marketing Consultants at 1-800-782-2680, option 4; visit the TriWest website atwww.triwest.com/provider or visit the WPS website at http://www.wpsic.com/edi/tricare_sub.shtml.

New Major Depression Condition (Disease) Management ProgramTriWest Healthcare Alliance Corp. (TriWest) has expanded its array of Condition (Disease) Management programs to now include support for eligible TRICARE beneficiaries suffering from major depression. It joins the current Condition Management programs offered by TriWest for asthma, diabetes, COPD (lung disease), and heart failure. This program is a no-cost entitlement available to eligible beneficiaries. To be eligible to participate in TriWest's Major Depression program, beneficiaries must be referred to TriWest by the Department of Defense (DoD). Eligibility is determined by patient health, which is based on claims history.Beneficiaries may not self-refer to Condition Management programs, nor may they be referred by providers or military clinics. TriWest receives a bimonthly computer file from the DoD, with a list of eligible candidates for various Condition Management programs. TriWest's Condition Management personnel contact each candidate by phone, conduct an initial phone assessment, explain how the program works, and invite them to participate.Visit www.triwest.com/depression for more information and resources."

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Visit www.triwest.com/depression for more information and resources.

Share Your E-mail Address with TriWest

To communicate with you more effectively and expeditiously about its programs and processes, TriWest Healthcare Alliance needs your e-mail address.

Our goal is to communicate the right information to the right person at the right time to ensure that you have the information you need to receive reimbursement quickly and efficiently. We want to provide resources to help you care for TRICARE beneficiaries, including those active duty service members in your community with recent combat experience. We also want to notify you about educational opportunities in your community.

We will not sell or distribute your e-mail address with other companies nor will we send spam emails or overload your e-mail account. We generally send an eNewsletter every two to three weeks.

You can share your e-mail address with us using one of the following methods:

- Register for the secure website at www.triwest.com/provider
- Sign up for the TRICARE eNews at www.triwest.com/ provider
- Give your e-mail address to your local TRICARE representative
- Share your e-mail address with the TriWest representative when calling 1-888-TRIWEST

Also, if you receive an e-mail request to complete your online "profile" for purposes of e-mail communications, please respond.

Submitting Duplicate and Corrected Claims

Two types of claim submission that often result in confusion or delay are duplicate and corrected claims. This article will discuss some of the issues associated with both types of claims and to ensure the claims you submit are appropriate.

Duplicate Claims

A duplicate claim is defined as a claim submitted to an insurer (BCBSMT) from the same provider, for the same beneficiary, for the same item or service, for the same date of service. Some providers repeatedly bill the same claim until payment is received – delaying processing on other claims and contributing to the cost of health care through the repeated processing of a claim by the insurer.

Submitting more than one claim for the same item or service could cause a provider to be identified as an abusive biller. Also, if a pattern of duplicate billing presents itself or minor changes are constantly made to duplicate claims, an investigation of potential fraud may be initiated.

To avoid problems with duplicate bills, make sure your billing software isn't set to automatically refile claims until they are paid, do not resubmit a claim that originally received zero payment (due to a denial or application of the patient's deductible), make sure a contracted biller isn't automatically refiling your claims to increase their reimbursement (if they are paid per claim submission), and never submit multiple claims for the same service with different information on the claim (different diagnosis, charge, provider, etc.).

Corrected Claims

Corrected claims are different than duplicate claims because they are generally submitted by a provider in an attempt to correct incorrect information that was submitted on the original claim. Corrected claims are generally submitted after the original claim has already been processed.

The BCBSMT Provider Manual discusses the proper procedure for the submission of corrected claims. Corrected claims are sent to Customer Service to adjust the original claim. Sending them to the Claims Department will result in denial of the claim as a duplicate claim. Do not send a corrected claim electronically because it will also be denied as a duplicate. Clearly indicate on the claim "Corrected Claim," "Corrected Diagnosis," or some other indicator identifying the claim as corrected and what is being corrected (i.e., procedure code, date of birth, etc.).

Send all corrected claims, except Federal Employee Program, to:

Customer Service
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604

Submit corrected Federal Employee Program claims to:

Customer Service
Blue Cross and Blue Shield of Montana
P.O. Box 5029
Great Falls, MT 59403

Records must be included to document why the claim should be corrected for the change to be made. NEVER submit a corrected claim with incorrect information for the sole reason of obtaining or increasing the insurance reimbursement. This type of activity could be considered insurance fraud under Montana Code Annotated 33-1-1202.

More information about submitting claims can be found in the BCBSMT Provider Manual.

If you have questions or concerns about fraud or questionable practices, call our fraud hotline at 1-800-621-0992 or visit www.stopfraud.bcbsmt.com.

 Participating Providers