



PROVIDER *News*



Important Change: **Service Facility Provider Number Required**

Effective January 1, 2008, all professional claims that are rendered at any of the place of service locations listed below will require the service facility provider number.

Paper submitters should place the service facility provider number in Block 32A/B of the CMS 1500. Electronic submitters should place the service facility provider number in loop 2310D. Claims submitted after January 1, 2008, will deny if the service facility location is not submitted on the claim. **This applies to both electronic and paper professional claims.**

Place of service locations include:

- 21 - Inpatient Hospital
- 22 - Outpatient Hospital
- 23 - Emergency Room - Hospital
- 31 - Skilled Nursing Facility
- 32 - Nursing Facility
- 51 - Inpatient Psychiatric Facility
- 61 - Comprehensive Inpatient Rehabilitation Facility.

If you currently have the service facility provider number, we encourage you to start submitting it on your claims. Submitting this information now will ensure your claims are processed without manual intervention.

Inside This Edition:

<i>Medicare Advantage PFFS</i>	2	<i>Important Reminders & Updates</i>	9
<i>2008 FreedomBlue Changes</i>	2	<i>New Specialty Drug Program</i>	10
<i>NaviNet Update</i>	3	<i>OPCR Updates</i>	12
<i>Credentialing Criteria</i>	4	<i>NPI Update</i>	13
<i>Super Blue Plus 2008</i>	6	<i>Submitting NPI on CMS 1500</i>	13
<i>Electronic Claims</i>	7	<i>2008 Changes for FEP</i>	14
<i>Patient Satisfaction Surveys</i>	8	<i>Flu Season</i>	15
<i>Revised Provider Manual</i>	8	<i>Blues On Call</i>	16
<i>FreedomBlue MS-DRGs</i>	9	<i>Updated Medical Policies</i>	17

Fall 2007



Medicare Advantage Private Fee For Service (MA PFFS) Terms and Conditions Available Online January 1, 2008

If you are a Medicare participating provider, you might be seeing members from around the country who are insured under a Blue Cross and/or Blue Shield Medicare Advantage Private Fee for Service (MA PFFS) plan. They will carry a Blue Cross and/or Blue Shield ID card with this logo:

MEDICARE | PFFS ADVANTAGE

Make a note of these important things about MA PFFS, as this product varies from the other Blue products you might currently participate in:

You can see and treat any Medicare Advantage PFFS members without having a contract with Highmark Health Insurance Company (HHIC).

If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.

Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.

Submit your MA PFFS claims to Mountain State Blue Cross Blue Shield.

MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan and we advise that you review them before servicing MA PFFS members.

For your convenience, effective January 1, 2008, you will find MA PFFS Terms and Conditions for all Blue Plans at: www.highmarkblueshield.com by providing the member's 3-letter alpha prefix. Watch for future updates regarding MA PFFS under "News and Bulletins" of the Provider Tab on our website, www.msbcbs.com.

Important FreedomBlue PPO Changes for 2008...

For 2008, all FreedomBlue PPO products will transition to more copayment-based cost sharing and less coinsurance. The move to copayments enables our members to more accurately predict their out-of-pocket costs. It also helps providers by allowing you to collect a set amount upfront.

Three new network products – FreedomBlue PPO Standard, FreedomBlue PPO Deluxe and FreedomBlue PPO Value – will replace former Options 1, 2 and 3, respectively. Routine dental benefits have been added to FreedomBlue PPO Deluxe for 2008. In-network deductibles have been eliminated and, in some instances, out-of-network coinsurance has been lowered.

Routine vision benefits have improved with the addition of the Davis Vision network. In addition to routine vision benefits, the FreedomBlue PPO

products also include routine hearing benefits as well as the SilverSneakers® fitness program, which offers members free fitness center memberships at participating sites.

The federal government pays FreedomBlue PPO a set amount by county for each member to offer PPO coverage. For 2008, HHIC grouped similar counties together to help ensure more competitive and consistent premiums. As a result of this change, some member's premiums increased. These premium increases are offset by additional benefits and reductions in member's out-of-pocket cost sharing.

Further details regarding the 2008 changes to FreedomBlue PPO and PFFS will be mailed out to providers and will also be posted on our website at www.msbsbc.com.

NAVINET UPDATE

NaviNet has now been available, free to our network facilities and providers, for 16 months. NaviNet allows you to get 'real-time' information about your patients' eligibility, benefits, claims, and authorizations along with many other transactions.

From May 15, 2006, through September 30, 2007, approximately 1.9 million transactions have occurred in NaviNet, averaging 118,000 transactions per month. We have 5,082 individual professional providers, 1,757 professional offices and 182 facility and ancillary providers utilizing NaviNet.

We are pleased with the number of providers and facilities currently using NaviNet and encourage all our other providers who have a computer and internet access to 'come-on-board' and enjoy the time, paper and cost saved by using NaviNet! You can enroll in NaviNet by calling NaviNet Customer Care at 1-888-482-8057 or accessing www.msbcbs.com/navinet and clicking on the 'Request NaviNet' link.

Following is a summary of our newest NaviNet Transactions. Watch for announcements for other transactions on Plan Central and the Customer Service/Customer Care file.

ALLOWANCE INQUIRY:

This professional provider transaction will return pricing amounts for the plan and procedure code selected. This saves the office time by not having to make a telephone call to verify pricing for specific CPT/HCPCS Codes.

EOB/REMITTANCE:

This inquiry transaction lets you download a copy of your weekly EOB and Remittance reports in PDF format so that you can view and print the reports. You need Adobe Reader on your computer to open these documents. NaviNet holds 121 days worth of remittances online.

CLAIMS DASHBOARD:

This feature allows the provider to track all pended and finalized claims by provider number instead of by individual member number. Pended claims are summarized by age. Graphs show historical dashboard data.

PROVIDER FILE MANAGEMENT:

Currently has 1 transaction available which is 'Provider Information'. The Provider Information transaction allows you to view your Mountain

State Provider File. This is a great way to make sure that all your office addresses, telephone numbers, networks, and practitioners are correct.

HOME CARE/HOSPICE

AUTHORIZATION SUBMISSIONS:

This feature lets you submit home care and hospice authorizations online to Mountain State instead of contacting us by fax or phone.

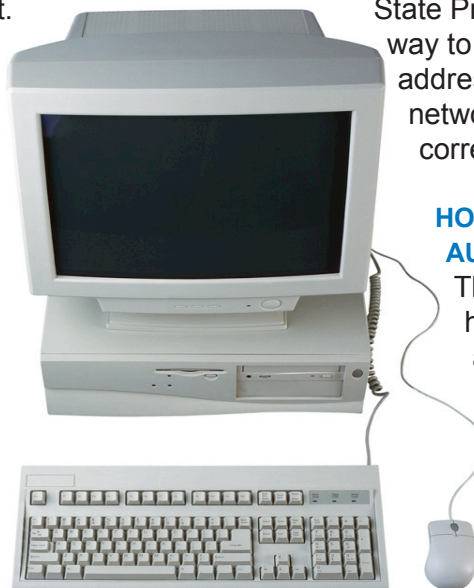
MEMBER RESPONSIBILITY CALCULATOR:

Professional providers can use the Estimated Member Responsibility Calculator to

determine what they can collect at point of care from Mountain State members who have not met their in-network deductible or in-network out-of-pocket. The Member Responsibility Calculator button appears on the bottom left corner of the Patient Benefit Accumulator Screen, if the member's Benefit Accumulator information is for the current year for our Medical/Surgical products. Up to 3 procedure codes can be entered and the estimated member liability will be returned.

UB CLAIM SUBMISSION:

UB Claim Submission allows facility claims to be submitted electronically. The addition of real-time claim submission will allow you to know the status of your claim at the time of entry. Claim errors are corrected online. This feature allows you to submit your Facility claims to Mountain State in the HIPAA 837I format via NaviNet.



Credentialing Criteria to Change in 2008

Mountain State Blue Cross Blue Shield (Mountain State) endeavors to keep network practitioners and providers informed about network credentialing policies and procedures. Starting January 1, 2008, Mountain State will be changing some of the required credentialing criteria. Read below for basic credentialing information. Credentialing details can be obtained by visiting the provider tab of Mountain State's website at www.msbcbs.com.

Network Contracting Process Changes!

All provider types will be required to be credentialed prior to contracting with Mountain State. Providers will not be reimbursed prior to credentialing as of January 1, 2008. The signed provider contract effective date will be determined by Mountain State upon completion of the credentialing process. This policy is already in place for the Medicare Advantage Network.

Credentialed Provider Types

Physicians-MDs, DOs, Chiropractors, Podiatrists, Oral/Maxillofacial Surgeons.

Allied Health Practitioners-Acupuncturists, Audiologists, Behavioral Health Counselors/Therapists, Certified Diabetic Educators, Certified Registered Nurse Practitioners, Certified Registered Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Certified Registered Nurse Midwives, Massage Therapists, Occupational Therapists, Physical Therapists, Physician Assistants, Psychologists, Registered Dieticians, Social Workers, Speech Language Pathologists/Therapists.

Facilities-Acute Care Hospitals, Ambulatory Surgical Centers, Behavioral Health Centers, Critical Access Hospitals, Federally Qualified Health Centers, Hospices, Psychiatric Hospitals, Rehabilitation Hospitals, Renal Dialysis Centers, Rural Health Clinics, Skilled Nursing Facilities, Specialty Hospitals.

Ancillary Organizations-

Ambulances, Durable Medical Equipment Providers, Hearing Aid Vendors, Home Health Agencies, Home Infusion Companies, Laboratories, Portable X-ray Suppliers.



Credentialing Criteria

As applicable, network practitioners must maintain:

- An active state license, in the state in which he/she practices
- An active DEA certificate, in the state in which he/she practices (new for 2008)
- Five years of work history for initial credentialing
- Professional Liability Insurance
- Board certification, which is preferred, but not required
- Hospital privileges at a Mountain State network or Blue Cross Blue Shield Association hospital
- 24/7 member coverage
- Availability 20 hours a week (PCPs)
- An onsite office review
- Collaborative agreement with a physician (Nurse Midwives, Nurse Practitioners, PAs)
- Medicare eligibility for the Medicare Advantage network
- Required amount of continuing education credits determined by the state licensing board

As applicable, network facilities and ancillary organizations must maintain:

- An active state license or business registration certificate
- Professional liability insurance
- Accreditation, which is preferred but not required
- Medicare eligibility/certification

Continued On Next Page

Practitioner Credentialing Applications

Mountain State will continue, in compliance with WV state law 64 CSR 89A, to utilize the West Virginia Uniform Credentialing and Recredentialing applications to obtain credentialing information for WV practitioners. Mountain State also accepts uniform credentialing applications mandated in other states such as Ohio and Maryland. The WV uniform applications are available online at www.wvinsurance.gov

Hospital Based Providers

Mountain State and Highmark have evaluated their respective credentialing processes for the Mountain State commercial PPO and Highmark Medicare Advantage networks. A change has been made that we believe will positively affect pathologists, radiologists, anesthesiologists, emergency room physicians, hospitalists and hospital based



allied health practitioners. Currently, these practitioners must successfully complete our full credentialing/recredentialing process to obtain and maintain status as a participating provider.

We recognize that these practitioner types employed in or contracted directly with an inpatient facility are held to many hospital board accreditations and credentialing standards. Therefore, we are making the following change that may impact you.

Starting in January of 2008, if you are a hospital based provider, other than allied health, and practice exclusively in an inpatient acute care facility, you will be exempt from the full credentialing process if you complete the required form that will be sent to you. However, if you also practice anywhere other than an inpatient acute care facility, you will be required to undergo full credentialing and recredentialing. Hospital based allied health practitioners will no longer undergo full credentialing and will not be required to complete the affirmation form.

Practitioners in Training

Mountain State will no longer credential or contract with practitioners who are still involved in a training program (i.e. residency, fellowship). Practitioners are welcome to apply for network participation when completion of training can be verified by the Plan.

24/7 Coverage

Practitioners must have the ability, directly or through on-call arrangements with another qualified plan-participating practitioner of the same or similar specialty, to provide coverage 24 hours a day, seven days a week. The 24/7 coverage can be accomplished through an answering service, pager or via direct telephone access whereby the practitioner (or his/her designee) can be directly accessed, if needed. A referral to a crisis line or the nearest ER is not acceptable coverage unless there is an arrangement made between the practitioner and the crisis line or ER whereby the practitioner (or his/her designee) can be contacted directly, if needed. It is not acceptable for any non-PCP practitioner to refer patients to their PCP after normal business hours.

Contact Information

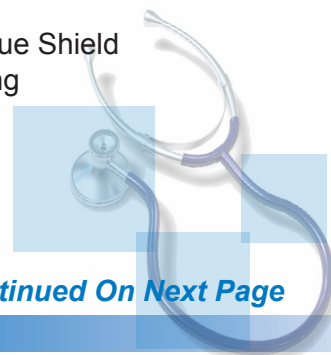
Starting in January of 2008, practitioner credentialing information will be primary source verified by Highmark's Credentialing Department.

All practitioner credentialing applications are to be forwarded to the following address:

Highmark Provider Data Services Department
P.O. Box 898842
Camp Hill, PA 17001
866-763-3224

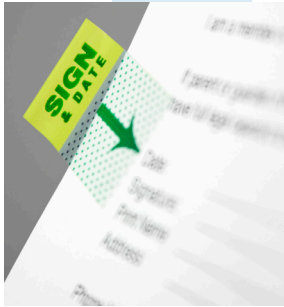
Facilities and ancillary organizations are to forward all requested credentialing documentation to:

Mountain State Blue Cross Blue Shield
Office of Network Credentialing
900 Pennsylvania Avenue
P.O. Box 1353
Charleston, WV 25325
888-475-2391



Continued On Next Page

Credentialing Criteria Continued...



Professional Provider Contracts are to be forwarded to Mountain State's Provider Relations Department:

Mountain State Blue Cross Blue Shield
Office of Provider Relations
700 Market Street
Parkersburg, WV 26101
800-533-3627

Mountain State/Highmark Medicare Advantage Network

Mountain State credentials providers who participate in the Medicare Advantage/Freedom Blue network that is managed by Highmark. Mountain State follows Highmark's credentialing policies and procedures for Freedom Blue credentialing. In order for practitioners to participate in the Freedom Blue network, Mountain State must obtain written documentation as proof of Medicare eligibility. Providers who currently do not appear to be Medicare eligible and/or new applicants will be asked to submit their written Medicare eligibility letter to the Plan. Medicare participation letters may be obtained from the carrier that originally issued the letter. A Medicare intermediary/carrier list may be obtained by visiting http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf.

Onsite Office Reviews

For the Medicare Advantage/Freedom Blue network, Mountain State and Highmark have developed standards and performance thresholds for office site and medical/treatment record keeping documentation. The Plans have procedures to ensure that the office of all primary care practitioners, obstetricians, gynecologists and high volume behavioral health practitioners are compliant with these standards. Mountain State and Highmark require the medical/treatment records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

Initial Denial, Corrective Action and Termination Reconsiderations and Appeals

Practitioners, facilities and ancillary organizational providers who have been initially denied, placed on a corrective action plan or have been recommended for termination and want to appeal the decision will appeal to two different entities, depending on network participation.

Providers will appeal to Mountain State's Office of Network Credentialing for commercial PPO/POS network participation issues and to Highmark for Medicare Advantage/Freedom Blue participation issues.

Introducing Super Blue Plus 2008...

Effective January 1, 2008, Mountain State will be offering a new line of products called Super Blue Plus 2008. These products follow the core benefits of the Super Blue Plus 2000 products with changes to co-payments, out of pocket maximums, prescription drug coverage choices, and added preventive benefits. These products were developed in an effort to reduce costs, emphasize prevention and align our products with our competitors'. They will be offered to our current and potential new customers. A brief explanation of each plan, along with the preventive benefit schedule, can be referenced on our website at www.msbcbs.com.

Attention Electronic Claims Submitters

The following information is intended for providers who submit their claims electronically. This information includes updates, reminders, changes, etc. to the processes involved in conducting these transactions.

NaviNet Claims

Mountain State Blue Cross Blue Shield is proud to introduce the addition of NaviNet Claims to its NaviNet online system. This new program offers the industry's best platform for sending, confirming and checking the status of claims electronically. NaviNet Claims provides claims submission products, services and an electronic claims clearinghouse, as well as comprehensive training and support that reduce administrative costs and improve claim workflow for providers.

If you are a small volume provider and are currently not electronically enabled, please call NaviNet Claims at 1-800-526-7276 or log on to www.navinetclaims.com for more information.

Subscriber ID Invalid

Mountain State Blue Cross Blue Shield members have all been issued new identification numbers. These numbers are referred to as UMI's (Unique Member Identification), which are a three digit alpha prefix followed by twelve digits. Claims submitted with the members social security number will not be accepted into our system. Please ensure you are asking the member for their most recent identification card. It is also suggested that you take a copy of the front and back of the member's identification card for your records.

Rendering/Pay to Numbers for Professional Claims

Whether you are billing electronically via the 837P or paper on a CMS 1500, there seems to be much confusion regarding the placement of Rendering and Pay to numbers on claim submissions.

On paper claims billed to Mountain State, in the shaded area of the field, block 24I should be the qualifier of 1B, which indicates Blue Shield provider number. The shaded area of block 24J should be the rendering number assigned to the provider by Mountain State. The rendering provider's NPI is placed in the unshaded area of block 24J.

The pay to NPI is reported in block 33A and the pay to number (including the 1B qualifier) assigned to the provider by Blue Shield is reported in block 33B.

For further instructions, please refer to the National Uniform Claim Committee website at www.nucc.org.

For electronic submissions, the pay to and rendering numbers are identified in the REF segment. Below is an example of how a provider in a group practice should submit their pay to and rendering information electronically:

Pay To:
Loop: 2010AA Billing/Pay To Provider

NM1*85*1*NAME OF GROUP PRACTICE****XX*9
876543210 (XX designates NPI)
N3*852 ANY STREET
N4*PARKERSBURG*WV*26101
REF*1B*009876543 (1B designates Blue Shield assigned pay to number)
REF*EI*147258369 (EI designates tax id number)

Rendering:
Loop: 2310B Rendering/Provider of Service
Provider

NM1*82*1*IMA*EXAMPLE MD****XX*1234567890
(XX designates NPI)
REF*1B*001234567 (1B designates Blue Shield assigned pay to number)
REF*EI*147258369 (EI designates tax id number)

In most instances, the provider, whether they are in a solo practice or a group practice will be assigned two different Blue Shield numbers by Mountain State. One number designates the Pay to number and the other number designates the rendering (or servicing) number. If the claims are billed with the incorrect placement of these numbers, they will reject. If you have any questions regarding which number is your rendering and which number is your pay to, please contact Mountain State Blue Cross Blue Shield Provider Relations at 1-800-798-7768.



Patient Satisfaction Surveys

On an annual basis, we gather data on member satisfaction in several ways. A survey is conducted to assess FreedomBlue members'

satisfaction with the care and service they receive from their physicians and the health plan. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey tool is utilized. This tool is used by all Medicare Advantage plans, and we are able to benchmark our results to other plans across the nation. The CAHPS survey assesses member satisfaction in the following areas:

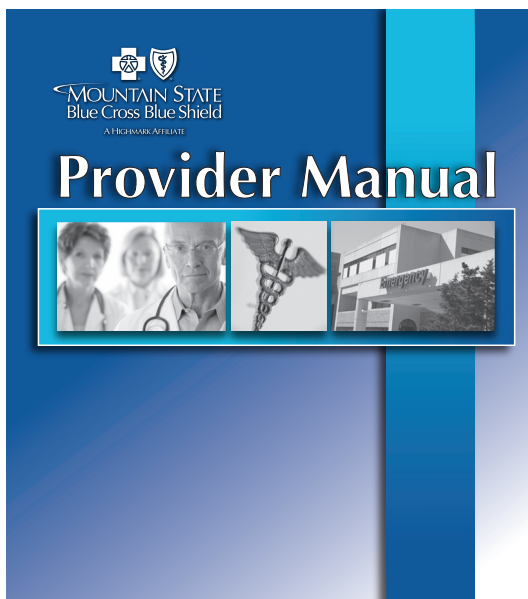
- Getting needed care
- Getting care quickly
- How well doctors communicate
- Customer service
- Plan information on costs
- Shared decision making
- Health promotion and education
- Coordination of care
- Ratings of personal doctor, specialist, health care and health plan

A separate survey is conducted to gather member feedback on satisfaction with behavioral health care practitioners, facilities and plan service.

Coordination and Continuity of Care Surveys

You may have already responded to or will soon be receiving a request to respond to a survey which is currently being distributed to network physicians and home health agencies. These surveys are part of the annual monitoring that we do as a health plan to ensure ongoing improvement in the coordination and continuity of our member's care during their various transitions in care. The surveys will be asking for information on the method of, the timeliness of and the usefulness of the communications between home health agencies and prescribing physicians. We plan to use the compiled data from these surveys to identify areas in which the communications between these two providers of care can be enhanced in an effort to avoid unnecessary readmissions to the acute care setting.

We work hard to ensure that our members receive quality care and that the health plan provides high quality and timely service. We appreciate the ongoing support and service you provide to our members. Together, we can make a difference in the quality of care members receive!



Revised Mountain State Blue Cross Blue Shield Provider Manual Now Available!

- **Hard copies have been mailed to all network providers.**
- **For additional copies you may access our website at www.msbcbs.com.**
- **Future updates will be announced via the *Provider News* and through our website.**

FreedomBlue MA PPO MS-DRGs Implementation

Beginning January 1, 2008, Highmark Health Insurance Company (HHIC) will begin reimbursing acute care inpatient claims using the newly created CMS Medical Severity (MS)-DRGs for the FreedomBlue Medicare Advantage (MA) PPO product in West Virginia. Consistent with your MA Hospital Agreement, transitioning to the new MS-DRGs will allow HHIC to emulate traditional Medicare reimbursement. Please remember that although traditional Medicare will implement these changes on October 1, 2007 - and in order for HHIC to update the claims processing system - the MS-DRGs will not be implemented until January 1, 2008, for FreedomBlue claims.

Important Reminders & Updates

2008 DRG Update for Commercial Products

Mountain State will not be adopting the Medical Severity-DRG (MS-DRG) reimbursement methodology for commercial products in January 2008. Mountain State will continue using DRG grouper version 24 with system capability of cross walking the MS-DRGs back to version 24. Mountain State's review and evaluation of the MS-DRG will take place during the 2008 calendar year for possible implementation later in 2008 or 2009.



Changes to Claims Billing Guidelines for Nurse Practitioners (NP) and Physicians' Assistants (PA)

With the exception of Medicare Advantage claims, NPs and PAs, when employed, can now submit their claims for rendered services under the supervising physician's name and ID number. Providers should continue to bill for Medicare Advantage FreedomBlue claims as currently being submitted to CMS. For further details regarding supervisory guidelines, please refer to Medical Policy Z-27. Both the Mountain State and Medicare Advantage Medical Policy link can be found on our website at www.msbcbs.com.

Change to Length of Stay

Mountain State Blue Cross Blue Shield Health Services Department has initiated a change in the length of stay designation for initial certification for DRG facilities. The previous initial length of stay was an automatic seven (7) day certification for admissions meeting criteria. This has been revised to an initial five (5) day length of stay. The change was made in an effort to more efficiently capture the subscribers' discharge needs. We appreciate your assistance to help ensure optimal and quality health outcomes for our members.

Alpha Prefix Change

During the fourth quarter of 2007, all Mountain State Point of Service groups will be receiving a new Alpha Prefix of ZPA. New ID cards will be issued to these members reflecting the change.

Coordination of Benefits

All Mountain State Coordination of Benefits (COB) are verified annually, however, at times members do not return the information needed to process their claims. As a reminder, the COB questionnaire is available on our website at www.msbcbs.com. If a member does not return the questionnaire you will see a denial appear on your explanation of benefits or remittance advice. Providers may print the COB questionnaire from our website allowing a request to be made to the member to complete and return to Mountain State. Once the information is received, the denied claims will be reprocessed.

New Specialty Drug Program Being Offered for HHIC FreedomBlue MA PPO

Effective January 1, 2008, Medmark will be the preferred provider of 72 specialty drugs for FreedomBlue MA PPO. This specialty drug program is **required/mandatory** and applicable to Highmark Health Insurance Company Inc. (HHIC) FreedomBlue MA PPO product. A listing of the drugs is supplied below and on the following page.

How The Program Works

- Doctor's office faxes the Specialty Drug Request Form, which serves as a prescription and authorization, to Medmark.
- Medmark obtains an authorization from HHIC and verifies benefit eligibility with customer service.
- Medmark delivers the drug to the doctor's office or the member's home.
- Effective January 1, 2008, Medmark will bill for the drugs listed on the specialty drug request form. This form can be accessed through the Mountain State website at www.msbcbs.com. The doctor's office may still bill for the office visit and administration of the drug in accordance with HHIC's reimbursement and medical policy.
- Medmark has registered nurses and pharmacists available 24 hours a day, 7 days a week to answer questions. Their contact information is as follows: Medmark Inc., 500 Noblestown Rd, Suite 200, Carnegie, PA 15106. Phone: 1-888-347-3416; Fax # 1-877-231-8302.

Brand Name	Generic Name (billing code description)	HCPCS Code	Prior Authorization Required
Actimmune	interferon gamma-1b	J9216	N
Aldurazyme	laronidase	J1931	Y
Amevive	alefacept	J0215	Y
Avonex	interferon beta-1a	J1825 & Q3025	N
Betaseron	interferon beta-1b	J1830	N
Botox	botulinum toxin type A	J0585	Y
Bravelle	urofollitropin for injection (purified)	J3355	N
Cerezyme	imiglucerase	J1785	N
Cetrotide	cetorelix acetate	J3490	N
Copaxone	glatiramer acetate	J1595	N
Eligard	leuprolide acetate (implant)	J9217	N
Enbrel	etanercept	J1438	N
Fabrazyme	agalsidase beta	J0180	Y
FACTOR PRODUCTS			N
· Factor VIIa-NovoSeven	(coagulation factor, recombinant)	J7189	N
· Factor VIII	(antihemophilic factor, human)	J7190	N
· Factor VIII	(antihemophilic factor (porcine))	J7191	N
· Factor VIII	(antihemophilic factor, recombinant)	J7192	N
· Factor IX	(antihemophilic factor, purified, non-recombinant)	J7193	N
· Factor IX	complex	J7194	N
· Factor IX	(antihemophilic factor, recombinant)	J7195	N
· Autoplex T, Feiba VH	(anti-inhibitor coagulant complex)	J7198	N

Brand Name	Generic Name	HCPDS Code	Authorization
Follistim	follitropin beta	S0128	N
Ganirelix (Antagon)	ganirelix acetate	S0132	N
Gonal-F	follitropin alpha	S0126	N
Growth Hormones	(Genotropin, Humatrope, Norditropin, Nutropin, Protropin, Saizen, Serostim, Tev-Tropin)	J2940 J2941	N
Hyalgan	sodium hyaluronate	Q4083	N
IVIG [immune globulin] (lyophilized and non-lyophilized)	(Carimune, Gammar-P, Gamimune)	J1566 J1567	Y
IVIG [immune globulin]	Flebogamma only	Q4091	Y
IVIG [immune globulin]	Gamunex only	Q4092	Y
IVIG [immune globulin]	Octagam only	Q4087	Y
IVIG [immune globulin]	Gammagard only	Q4088	Y
Lioresal Inj for Intrathecal	baclofen	J0476	N
Lioresal Injection	baclofen	J0475	N
Lucentis	ranibizumab injection	J3490	N
Lupron Depot (3.75mg)	leuprolide acetate	J1950	N
Lupron Depot (7.5mg)	leuprolide acetate	J9217	N
Macugen	pegaptanib sodium	J2503	N
Myobloc	botulinum toxin type B	J0587	Y
Myozyme	alglucosidase alfa	S0147	N
Orencia	abatacept	J0129	Y
Orthovisc	high molecular weight hyaluronan	Q4086	N
Pergonal	menotropins	S0122	N
Plenaxis	abarelix	J0128	N
Prialt	ziconotide intrathecal	J2278	Y
Raptiva	efalizumab	S0162	N
Rebif	interferon beta-1a	Q3026	N
Remicade	infliximab	J1745	Y
Repronex	menotropins	S0122	N
Risperdal Consta	risperidone	J2794	N
Supartz	sodium hyaluronate	Q4083	N
Synagis	palivizumab	90378	Y
Synvisc	hylan GF 20	Q4084	N
TheraCys	BCG (intravesical)	J9031	N
Thyrogen	thyrotropin alfa	J3240	N
TICE BCG	BCG (intravesical)	J9031	N
Trelstar	triptorelin pamoate	J3315	N
Tysabri	natalizumab	Q4079	Y
Vantas	histrelin implant	J9225	N
Viadur	leuprolide acetate implant	J9219	N
Visudyne	verteporfin	J3396	N
Vivaglobin	immune globulin subcutaneous	J1562	Y
Xolair	omalizumab	J2357	Y
Zoladex	goserelin acetate implant	J9202	N



Mountain State Blue Cross Blue Shield Reimbursement Update...

Lab Update

Mountain State uses Ingenix RVUs (when CMS RVUs are not available) to establish the allowance for laboratory services. Laboratory services allowances using the 2007 Ingenix RVUs were updated with an effective date of September 1, 2007.

WVSBP Update

Using PEIA pricing for the West Virginia Small Business Plan, Mountain State updated the Durable Medical Equipment (DME) services with an effective date of August 1, 2007. The drug and biological schedules and laboratory schedules were updated with an effective date of September 1, 2007.

2008 RBRVS Reimbursement Updates

The CMS 2008 Annual Update will be reviewed by Mountain State during the winter of 2007, and spring of 2008, with an effective date of July 2008. During this review period, Mountain State will review and analyze the CMS changes. As Mountain State finalizes plans for the annual update we will provide an update to our provider community. New codes for 2008 will be added effective January 1, 2008. Like CMS, Mountain State will continue the implementation of the transitional RVU and budget neutrality (BN) factor for 2008. For Highmark Health Insurance Company's (HHIC's) FreedomBlue PPO professional reimbursement will follow the CMS RBRVS schedule effective January 1, 2008. The Mountain State WVSBP product will follow the same RBRVS allowances and implementation dates as PEIA. Mountain State would like to provide an example for providers regarding the RBRVS calculation for our commercial business using the BN factor related to the RVU Work component.

This calculation applies only to services that have a value assigned to the Work component. Mountain State does not utilize the GPCI component in the RVU calculation.

2007 Non-Facility Pricing Amount =
[(Work RVU * Budget Neutrality Adjustor (0.8994)) +
(Transitioned Non-Facility PE RVU) +
(MP RVU)] * Conversion Factor
2007 Facility Pricing Amount =
[(Work RVU * Budget Neutrality Adjustor (0.8994)) +
(Transitioned Facility PE RVU) +
(MP RVU)] * Conversion Factor

Following is an example using 99213:

2007 Non-Facility Pricing Amount =
(0.92 * 0.8994) + 0.71 + 0.03 = 1.57 (Total NF RVU)
* 47.69 = 74.87

2007 Facility Pricing Amount=
(0.92 * 0.8994) + 0.25 + 0.03 = 1.11 (Total Fac
RVU) * 47.69 = 52.93

AWP Change

Average Wholesale Price (AWP) is used to determine the allowances for drugs, biologicals, injectables, chemotherapy, and immunizations. Mountain State is implementing a change in the allowance for these services effective January 1, 2008. The new allowance will be 85% of AWP for the PPO, POS, and Steel products. This change will not affect immunizations (remain at 100% of AWP) or the Medmark Specialty Drug Program.

NPI UPDATE:

Mountain State Blue Cross Blue Shield

Recommends NPI Dual Submission Prior to Submitting NPI Only*

The Mountain State Blue Cross Blue Shield NPI Contingency Plan will be reviewed in November 2007. Please check our website at www.msbcbs.com for any updates.

Mountain State's information systems will continue to accept the following on transactions until at least November 2007, when the Contingency Plan is updated:

- Legacy number only; no NPI on transactions
- Dual strategy; both NPI and Legacy numbers on transactions that support dual submission
- NPI only; no legacy number on transactions

Mountain State recommends providers use the dual strategy option until claims have been processed with correct payment and it has been confirmed the NPI is translating to the legacy number that was submitted on the transactions. Mountain State will reassess our customer's readiness to be compliant during the fall of 2007. In November 2007, a decision will be made regarding our enforcement of the NPI Final Rule.

The Centers for Medicare and Medicaid Services (CMS) contingency is limited and requires demonstration of good-faith efforts to achieve HIPAA NPI compliance. HIPAA covered entities not showing good-faith efforts to become compliant could face civil monetary penalties. MSBCBS encourages HIPAA covered entities to forge ahead with their own efforts to be HIPAA NPI compliant as soon as possible.

In order to demonstrate good-faith efforts, providers who are HIPAA covered entities should:

- Be active in efforts to be HIPAA NPI compliant.
- Obtain an NPI and report it to MSBCBS.
- Work with software vendors, clearinghouses and trading partners to send and receive compliant transactions.
- Document the good-faith efforts that they have employed or are employing toward NPI compliance.

* Providers should do the following before submitting NPI only on transactions:

- Submit in dual mode (both NPI and legacy number).
- Contact your software vendor, clearinghouse and/or trading partner to ensure that organization can send and receive transactions with NPI only, along with additional data required for "cross-walking" to legacy IDs. Please note: You may have already obtained an NPI and reported it to MSBCBS; however, if your software vendor, clearinghouse and/or trading partner cannot accommodate or use the NPI in its system and in electronic transactions, processing and/or payment of your claims may be delayed.
- Submit a small number of claims with the NPI only and confirm they are processed and paid correctly prior to submitting additional claims with the NPI only.

Visit www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf to read the CMS contingency requirements in detail via a document titled "Guidance on Compliance with the HIPAA NPI Rule." Note there is a " " symbol between NPI" and "Contingency" in the web address.

Continued On Next Page

Tips for submitting NPI and Blue Shield Provider Number on CMS 1500

Correct placement of the NPI and Blue Shield Provider numbers is critical for claim submission and processing. Incorrect placement of the NPI and Blue Shield Provider numbers will delay the processing of your claims. The NPI and appropriate qualifier must be placed in the correct field on the CMS 1500. See the field requirements to the right.

I. ID. QUAL	J. RENDERING PROVIDER ID. #
NPI#	

NPI UPDATE Continued:

Get it! Act now! The National Plan and Provider Enumeration System (NPPES) is the central electronic enumerating system in place for obtaining your NPI. You can apply in several ways:

- 1) Complete the Web-based application process online at <https://nppes.cms.hhs.gov>.
- 2) Download and complete a paper application from the Web site, and mail it to NPPES.
- 3) Call NPPES at 1-800-465-3203 (TTY: 1-800-692-2326) for a paper application.

Share it! Act now! Once you receive your NPI, please report this new number to Mountain State. You may do so by simply forwarding a copy of your NPPES confirmation e-mail, or the Mountain State NPI Submission Form to the fax number, e-mail address or U.S. Mail address below. Please be sure to include your name, Mountain State nine-digit provider number and NPI on any submission.



Fax: 304-424-7713

E-mail: msnpiupdate@msbcbs.com

U.S. Mail: Office of Provider Relations
PO Box 1948
Parkersburg, WV 26102

Use it! Act now! For detailed instructions on including your NPI on your electronic claim submission, please consult the "Provider EDI Reference Guide," which is available via Mountain State's web site at http://www.msbcbs.com/msbc_trading.htm.

FEP Benefit Changes for 2008

The Service Benefit Plan offered by Blue Cross Blue Shield to Federal Employees has announced benefit changes for 2008.

Changes to both Options:

For 2008 West Virginia will not be considered a "Medically Underserved" state, therefore, services must be provided by a covered provider under the FEP Benefit Plan. As an example, members will not be able to see a massage therapist for covered benefits.

FEP will add the following benefits for 2008:

- Hearing aids for children up to age 22 limited to \$1,000 per ear per calendar year.
- Bone anchored hearing aids for adults when medically necessary due to traumatic injury or malformation of the external or middle ear, limited to \$1,000 per ear per calendar year.
- Inpatient and outpatient care related to the treatment of children up to age 22 with severe dental caries.
- Pre-enrollment visits for home hospice care when provided by a physician employed by the hospice agency.
- Benefits for ambulance transport services subject to a member co-payment of \$50 per day. In

Continued On Next Page

FLU SEASON 2007-2008

According to the Immunization Action Coalition, the strongest motivating factor for a patient to seek vaccination against influenza and other illnesses is a recommendation from his or her physician, nurse or other healthcare provider.

Mountain State Blue Cross Blue Shield recognizes that patients rely on their primary care physician for expert care and guidance in matters relating to their health. We appreciate the vital role that providers and clinical staff members play in helping patients understand the importance of getting an annual flu shot. That's why we are committed to working with providers to ensure that our members who are at high risk for flu and its complications receive a flu shot.

We truly need the help of providers to encourage flu immunization, particularly among adults ages 50 to 64, people of all ages with certain chronic conditions and other patients who belong to one of the priority groups identified by the Centers for Disease Control and Prevention (CDC) as being especially at risk.

(Visit www.cdc.gov/flu for more information about priority groups.) People who didn't receive the flu shot last year may need extra encouragement to get immunized this year.

We also encourage providers to promote flu immunization among the healthcare professionals in each office. Healthcare professionals with direct patient contact are classified by the CDC as individuals who should be vaccinated annually. By receiving a flu shot, patient care staff members are not only protecting themselves and their patients, but they are also safeguarding their loved ones and the community at large from the spread of influenza.

For complete details on the recommended immunization guidelines for the 2007-2008 influenza season, visit www.cdc.gov/flu/professionals/acip/index.htm.

We thank all providers for their support and continued dedication to improving the health of the people in our community.

FEP Benefit Changes for 2008 Continued...

In addition, benefits will also be provided for medically necessary emergency care provided at the scene when transport services are not required.

- Benefits for office visits and diagnostic tests related to the treatment of morbid obesity.

Changes to Standard Option only:

- Medco is now the administrator of the Mail Service Prescription Drug Program effective January 1, 2008.
- The calendar year deductible is now \$300 for Self Only coverage and \$600 for Self and Family coverage.
- The catastrophic out-of-pocket maximum for deductibles, coinsurance, and co-payments is now \$4,500 per year when you use Preferred providers and \$6,500 per year when you use Non-preferred providers.
- Benefits will now be provided for facility care (other than accident and maternity care) provided in the outpatient department of a Preferred hospital at 85% of our Plan allowance. In addition, we now provide benefits for facility care (other than maternity care) provided in the outpatient department of a Non-preferred hospital at 70% of our Plan allowance.

There are no benefit changes affecting only the Basic Option for 2008.

Heart Failure Video Program Promotes Self-Care

Heart failure patients can have a tremendous impact on their functional and symptomatic status and on their overall well being if they know how to properly manage their condition. Many patients, for example, could avoid the need for emergency services to treat pulmonary edema if they knew how to detect the signs of imminent decompensation and practiced appropriate self-care. Indeed, worsening heart failure symptoms are often linked to diuretic nonadherence, excessive sodium consumption, or both. Additionally, patients often overlook clues such as sudden weight gain or peripheral edema that could help them pre-empt medical emergencies.

Unfortunately, most patients do not fully grasp the potential impact of missing a diuretic, overindulging in salt, or of gaining a few pounds of fluid weight. That's why we now offer members the Shared Decision-Making® video and booklet program *Living with Heart Failure: Helping Your Heart Day-to-Day*.

The program uses lay language and interviews with real heart failure patients to teach patients the most important steps they can take to preserve their health. In particular, the program underscores the importance of uninterrupted diuretic use, consistent sodium restriction, and daily weighing.

Using animation and other visuals, the program explains the relationship between heart failure symptoms, kidney function, and fluid retention. As a result, viewers learn to make the connection between breathlessness and salty indiscretions—a connection that is conceptually difficult for many.

Because people are often under the mistaken impression that sodium restriction means merely avoiding the saltshaker, the program lists the specific steps involved in following a sodium restricted diet. Viewers learn, for example, that the sodium people consume comes mostly from processed and prepackaged foods rather than from salt added in food preparation. In so doing, viewers learn which foods to avoid and which foods make good choices. They also learn that sodium lurks in unexpected

places, such as antacids, laxatives, and sleep-aids.

Like the section on sodium, the program's section on daily weighing provides detailed practical information. It teaches viewers that they must weigh themselves at the same time each day, in the same state of dress, and that they must keep a record of each weight. The program teaches people that weight monitoring has nothing to do with "fat" weight. In fact, viewers learn that significant weight changes, like symptomatic changes, should prompt a call to their doctor or the use of an action or symptom response plan.

Although many people with heart failure do not have an action or symptom response plan, the program encourages viewers to develop one with their doctors. These plans, which can be tailored to each patient's individual needs, can help patients determine when they need to call their provider and when some other action is appropriate.

The video and booklet provide patients with comprehensive, evidence-based, unbiased information vetted by the Foundation for Informed Medical Decision Making, a non-profit organization dedicated to improving the quality of medical decisions. Most importantly, it encourages patients to work with their doctors to find the best way to cope with their limitations and improve their health.

To find out more about the *Living with Heart Failure: Helping Your Heart Day-to-Day* video and other Shared Decision-Making® services, contact the Blues On CallSM Physician Hotline, 1-888-777-9522. A Blues On Call Provider Service Specialist will return your call within two business days.

Shared Decision-Making® is a registered trademark of the Foundation for Information Medical Decision Making. Used with permission.

Blues On CallSM is a service mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

© Health Dialog 2007



MEDICAL POLICY **UPDATES**

As an added enhancement to our Provider News, Mountain State Blue Cross Blue Shield will now be communicating Medical Policy updates in each of our upcoming issues.

Our medical policies are also available online through NaviNet® or at www.msbcbs.com. An alphabetical, as well as a sectional index, is available on the Medical Policy page. You can search for a medical policy by entering a key word, policy number, or procedure code.

Recent updates or changes are as follows:

Medical Policy Bulletin I-8 (Immunizations)

FluMist now eligible for payment.

Effective: October 15, 2007

Mountain State Blue Cross Blue Shield now provides coverage for the vaccine FluMist®.

Mountain State will determine coverage for FluMist according to the member's contract for dependent children as well as applicants or members and their spouses. For individuals outside this population, Mountain State will base coverage on the member's contract.

Report FluMist with procedure code 90660— influenza virus vaccine, live, for intranasal use.

FluMist is an intranasal live virus influenza vaccine for healthy children and adolescents, ages 5 years to 17 years, and healthy adults, ages 18 to 49.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin M-18 (Diagnostic Endocardial Electrical Stimulation {EES} vs. Ablation Procedures)

Catheter ablation eligible for specific indications.

Effective: November 12, 2007

Mountain State Blue Cross Blue Shield recognizes catheter ablation as an eligible surgical procedure when it's performed for any of these indications:

427.0:

Paroxysmal supraventricular tachycardia

426.81, 426.82:

"Normal" supraventricular tachycardia

426.7:

Accessory bypass tract arrhythmia (Wolff-Parkinson-White Syndrome)

427.89:

Radiofrequency catheter ablation or modification of the atrioventricular junction for ventricular rate control of symptomatic atrial tachyarrhythmias

426.89:

Symptomatic sustained atrioventricular nodal reentrant tachycardia

427.32:

Atrial tachycardia or atrial flutter

427.1:

Patients without structural heart disease (i.e., ischemic or idiopathic cardiomyopathy) with symptomatic sustained monomorphic ventricular tachycardia; or bundle branch reentrant ventricular tachycardia

414.8, 425.4:

Ischemic or idiopathic cardiomyopathy with ventricular tachycardia

427.31:

Atrial ablation for elimination of atrial fibrillation

Mountain State considers any other uses of catheter ablation not medically necessary; therefore, they are not covered. A participating, preferred, or network provider may not bill the member for the denied surgery.

Use procedure code 93650, 93651, or 93652 to report catheter ablation.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin M-50 (Implantable Cardiac Loop Recorder) **Cardiac event recorders coverage guidelines explained.**

Effective: January 14, 2008

Continued On Next Page

Mountain State Blue Cross Blue Shield will pay for the implantation of a cardiac loop recorder when it's used to determine the cause of recurrent, but infrequent dizziness. This includes:

- palpitations (785.1)
- dizziness (780.4)
- syncope and collapse (780.2)
- other transient symptoms that could be due to arrhythmia (426.82, 426.9, 427.60, 427.89, 427.9)

Mountain State will deny all other uses of cardiac loop recorders as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service.

Use code 33282 to report the insertion of the device. This includes the initial programming. Use code 33284 to report the removal of the device.

When the above conditions are met, Mountain State will cover the electronic analysis of the implantable loop recorder system. Report this service with code 93727. This service includes the retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data, and reprogramming.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin O-13 (Cranial Orthosis for Plagiocephaly)

Cranial orthosis as sole treatment of synostotic plagiocephaly will be denied as not medically necessary.

Effective: January 14, 2008

Mountain State Blue Cross Blue Shield is changing its denial position on cranial orthosis (S1040) used as the sole treatment of synostotic plagiocephaly (ICD-9-CM diagnosis code 756.0) from experimental or investigational to not medically necessary. A participating, preferred, or network provider may not bill the member for the denied device.

This change will take effect on Jan. 14, 2008.

Mountain State continues to cover cranial orthotic devices used in the postoperative treatment of

synostotic plagiocephaly for infants with moderate to severe residual plagiocephaly after surgical correction. A two-month trial of conservative therapy following surgery must have failed to improve the deformity.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-183 (Partial and Total Hip Resurfacing by Arthroplasty)

Partial and total hip resurfacing arthroplasty now eligible.

Effective: November 5, 2007

Mountain State Blue Cross Blue Shield considers hip resurfacing an eligible alternative to total hip arthroplasty when the patient is likely to outlive a traditional total hip arthroplasty prosthesis.

Mountain State will pay for partial hip resurfacing when it's performed using an FDA-approved device in patients with osteonecrosis of the femoral head and healthy acetabular cartilage.

Mountain State will pay for total hip arthroplasty when it's performed using an FDA-approved metal-on-metal device in patients with chronic pain and/or disability secondary to significant disease, for example, osteoarthritis, traumatic arthritis, rheumatoid arthritis, osteonecrosis, or dysplasia.

Mountain State considers partial and total hip resurfacing experimental or investigational for all other indications. A participating, preferred, or network provider may bill the patient for the denied service.

How to report partial or total hip resurfacing

When you report partial or total hip resurfacing, use procedure code 27299. When you report code 27299, please include the description "partial hip resurfacing arthroplasty" or "total hip resurfacing arthroplasty" in the narrative field of the electronic or paper claim.

Partial hip resurfacing involves the removal of diseased or damaged bone and reshaping of only the head of the femur. An artificial shell is then placed over the area, protecting the underlying bone

Continued On Next Page

from further damage. Total hip resurfacing is used for bone surface damage due to a broader range of conditions resulting in damage to both the femoral head and the acetabulum, or hip socket. This is a more extensive procedure, in that the diseased or damaged bone is removed from both the femoral head and the acetabulum. A protective metal shell is then placed both over the femoral head, and in the acetabulum, into which the femoral head fits.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin S-16 (Assistant Surgery Eligibility Criteria)

Mountain State Blue Cross Blue Shield covers assistant surgery performed by a certified registered nurse practitioner.

Effective: August 6, 2007

On Aug. 6, 2007, Mountain State Blue Cross Blue Shield began to cover assistant surgery performed by a certified registered nurse practitioner (CRNP). Mountain State will pay the surgeon or group that employs the CRNP.

Report both of these modifiers when you submit claims for assistant surgery performed by an employed CRNP:

- 80—assistant surgery
- AS—physician assistant, nurse practitioner services for assistant-at-surgery (non-team member)

Since Mountain State reimburses the surgeon for supervising the CRNP assistant-at-surgery, please report the name and provider number or NPI of the surgeon on the claim as the performing or rendering provider.

Mountain State will also pay for assistant surgery services by independently practicing CRNPs. Independently practicing CRNPs should report assistant surgery with modifier 80.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-34 (Surgical Injections and Drugs)

Mountain State allows separate payment for surgical injections and medications.

Effective: November 5, 2007

Frequently, when a physician performs a surgical injection procedure, he or she precedes the injection with local anesthesia and also administers medication into the site.

Beginning Nov. 5, 2007, Mountain State Blue Cross Blue Shield will pay for the surgical injection procedure and the medication administered.

Mountain State will not pay for the local anesthesia (A9270). A participating, preferred, or network provider may bill the member for the anesthesia.

Mountain State defines local anesthesia as direct infiltration of the incision, wound, or lesion.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin S-67 (Cochlear Implantation)

Bilateral cochlear implantation covered in some cases.

Effective: July 9, 2007

Mountain State Blue Cross Blue Shield considers bilateral cochlear implantation medically necessary when the alternative of unilateral cochlear implant plus a hearing aid in the contralateral ear will not result in a binaural benefit, that is, in those patients with hearing loss of a magnitude where a hearing aid will not produce the required amplification.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-115 (Intravascular Ultrasound {IVUS})

Mountain State Blue Cross Blue Shield covers intravascular ultrasound for non-coronary vessels.

Effective: August 6, 2007



Continued On Next Page

Mountain State Blue Cross Blue Shield now covers intravascular ultrasound (IVUS) for non-coronary vessels (code 37250, 37251, 75945, and 75946) when performed as an adjunct to vascular interventional procedures.

IVUS is an imaging technique in which a miniaturized ultrasound transducer and rotational mirror are mounted on the tip of a catheter and inserted directly into an artery or vein to produce two-dimensional tomographic images or three-dimensional computer-enhanced reconstruction of planar IVUS images. It is intended to image the arterial wall in addition to the internal lining of coronary and non-coronary vessels before, during, and after procedures, including, but not limited to, angioplasty, atherectomy, or placement of a stent. The images allow physicians to plainly see tears, precisely determine the size and shape of a plaque buildup or blood clot, or evaluate the effectiveness of an angioplasty.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin S-133 (Endovascular Aneurysm Repair)

Treatment of ruptured aortic aneurysms with endoprosthesis not covered.

Effective: November 12, 2007

Mountain State Blue Cross Blue Shield does not cover endoprostheses as a treatment of ruptured abdominal aortic aneurysms (ICD-9-CM code 441.3) because it's considered experimental or investigational. A participating, preferred, or network provider can bill the member for the denied service.

Mountain State does cover an endovascular stent-graft for non-ruptured abdominal aortic aneurysms (AAA) as a treatment for these indications:

- aneurysms measuring 5.0 centimeters or greater; or,
- aneurysms measuring 4.5–5.0 that are rapidly expanding or are symptomatic.

If the endovascular stent grafting performed for non-ruptured AAA does not meet the previous indication guidelines, Mountain State will deny it as not medically necessary. A participating, preferred,

or network provider may not bill the member for the denied service.

Select the appropriate code within this range to report endoprostheses: 34800–34834.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-159 (Nucleoplasty and Biacuplasty)

Biacuplasty considered investigational.

Effective: August 6, 2007

Mountain State Blue Cross Blue Shield considers biacuplasty an experimental or investigational procedure. Mountain State does not pay for biacuplasty because there are no long-term studies to support or prove its safety and effectiveness. A participating, preferred, or network provider may bill the member for the denied procedure.

Use procedure code 64999 to report biacuplasty. When you report code 64999, please include the description "biacuplasty" in the narrative section of the electronic or paper claim.

Biacuplasty is a minimally invasive percutaneous procedure for the treatment of chronic discogenic pain originating from annular fissures or contained disc herniations. Radiofrequency energy is used to heat and decompress disc material, thereby reducing pressure on surrounding nerve roots.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin X-17 (Obstetrical Ultrasound)

Policy guideline change when reporting both obstetrical echography and fetal biophysical profiling on the same date of service.

Effective: October 29, 2007

The following paragraph is being removed from the policy:

Obstetrical ultrasound with fetal biophysical profile

Biophysical profiling (BPP)(codes 76818 or 76819) is used in the evaluation of high-risk pregnancies

Continued On Next Page

and is generally performed during the time of gestation when the fetus could be delivered at once if necessary (typically, the 34th week). When an obstetrical ultrasound is performed on the same day as a BPP, the charges are combined under the code for the BPP (76818 or 76819, as appropriate).

Also, the fetal BPP codes are being removed from this policy because the policy applies to obstetrical ultrasound procedures, not fetal biophysical profiling. All mergers driven by this policy guideline will be discontinued.

Medical Policy Bulletin Y-1 (Physical Medicine) Infrared light therapy coverage indications outlines.

Effective: October 29, 2007

Effective October 29, 2007, Mountain State Blue Cross Blue Shield will not cover infrared and/or near-infrared light and/or heat, including monochromatic infrared energy, when it's used as a physical medicine modality for the treatment, including the symptoms, such as pain, arising from these conditions:

- diabetic and/or non-diabetic peripheral sensory neuropathy
- wounds and/or ulcers of the skin and/or subcutaneous tissues

A participating, preferred, or network provider may not bill the member for the denied service.

Use code 97026—application of a modality to one or more areas; infrared—to report this service.

Mountain State continues to cover infrared therapy when it's used to treat other musculoskeletal conditions.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin Y-7 (Neuromuscular Electrical Stimulation {NMES}) Horizontal Stimulation considered investigational.

Effective: October 29, 2007

Mountain State Blue Cross Blue Shield does not pay for horizontal stimulation because its effectiveness compared to traditional electrical stimulation or interferential stimulation has not been established. Mountain State considers horizontal stimulation an experimental or investigational therapy. A participating, preferred, or network provider can bill the member for the denied therapy.

Use code 97799—unlisted physical medicine/rehabilitation service or procedure—to report horizontal stimulation. When you report code 97799, please include the words “horizontal therapy” in the narrative section of the electronic or paper claim.

Horizontal stimulation is an alternative technique for providing electrical stimulation in which the direction of the electrical current moves through the tissues in a horizontal direction rather than vertically.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin Z-3 (Hyperbaric Oxygen {HBO} Therapy)

How to report total body HBO for failed skin graft.

Effective: January 14, 2008

Mountain State Blue Cross Blue Shield reimburses total body hyperbaric oxygen (HBO) therapy for the preservation of compromised skin grafts when it's reported with ICD-9-CM diagnosis code V42.3.

Beginning Jan. 14, 2008, please report ICD-9-CM diagnosis code 996.52 instead of V42.3 to represent the preservation of a compromised skin graft.

Mountain State limits its payment for HBO therapy to therapy administered in a chamber to the entire body.

MA Also applicable to Medicare Advantage.

Continued On Next Page

Archived Policies

Medical Policy Bulletin I-1 (Rabies Injections) Archived

Reporting guidelines for rabies injections.

Effective: July 30, 2007

When rabies injections are given as a treatment after exposure to a possibly rabid animal or as an immunization (as a preventive measure when there hasn't been any exposure) please report the appropriate code:

- 90375—rabies immune globulin (Rlg), human, for intramuscular and/or subcutaneous use
- 90376—rabies immune globulin, heat-treated (Rlg-HT), human, for intramuscular and/or subcutaneous use
- 90675—rabies vaccine, for intramuscular use
- 90676—rabies vaccine, for intradermal use

If a rabies injection is given as an immunization as a preventive measure, Mountain State will determine coverage according to the member's contract for dependent children as well as applicants or members and their spouses who are up to and including 20 years of age. For individuals outside this population, Mountain State will base coverage on the member's contract.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-7 (Surgical Injections)

This policy is being archived.

Effective: October 29, 2007

Medical Policy Bulletin R-1 (Stereotactic Radiosurgery)

Coverage for stereotactic radiosurgery expanded.

Effective November, 12, 2007

Mountain State Blue Cross Blue Shield now covers stereotactic radiosurgery for:

- pancreatic tumors (157.0-157.9, 197.8, 230.9), and
- non-resectable early stage non-small cell lung cancer (162.0-162.9, 197.0, 231.2)

- Mountain State Blue Cross Blue Shield also covers stereotactic radiosurgery for these indications:
- arteriovenous malformations (747.81)
- acoustic neuromas (225.1)
- pituitary adenomas (227.3)
- non-resectable, residual, or recurrent meningiomas (225.2, 225.4)
- solitary or multiple brain metastases in patients having good performance status and no active systemic disease (defined as extracranial disease that is stable or in remission) (191.0-191.9, 198.3)
- primary malignancies of the central nervous system, such as high-grade gliomas (initial treatment or treatment of recurrence), vestibular schwannomas, chordomas, chondrosarcomas, oligodendrogliomas (170.9, 171.0, 192.0-192.9)
- craniopharyngiomas (194.3, 227.3)
- neoplasms of the pineal gland (194.4, 227.4)
- nasopharyngeal or paranasal sinus malignancies (147.0-147.9, 160.0-160.9)
- hemangiomas (228.00, 228.02)
- trigeminal neuralgia refractory to medical management (350.1)

Mountain State Blue Cross Blue Shield considers stereotactic radiosurgery experimental or investigational when it's used to treat any other conditions or disorders. A participating, preferred, or network provider may bill the member for the denied service.

Mountain State Blue Cross Blue Shield does not cover stereotactic radiosurgery for other conditions or disorders because of insufficient scientific evidence that proves that it improves patient health outcomes for other conditions. Blue Shield will continue to review the results of clinical trials and research studies when they are published.

MA Does not apply to Medicare Advantage.

Providers Can Now Inquire Directly Regarding Mountain State Medical Policies

Effective November 1, 2007, providers will be able to send inquiries to Mountain State regarding specific medical policy issues. The inquiries may be sent via email or mail. This initiative will enable the provider to inquire directly to Mountain State's Medical Policy Department with questions or concerns regarding existing policies or the potential need for future medical policies.

When a provider submits an inquiry, there are specific criteria that should be documented. Mountain State will need individual provider information, medical policy number and name, detailed description of the reason for inquiry, copies of references or current peer reviewed articles, etc. Mountain State has created an inquiry form that can be accessed on the website at www.msbcbs.com. If a provider is sending an inquiry by mail, please send the completed form to the following address:

Medical Policy Inquiry

Provider Name: _____

Contact Name: _____

Provider Address: _____

Provider Email Address: _____

Provider Phone Number: _____

Provider Specialty: _____

Blue Shield Billing Number: _____

Blue Shield Performing Number: _____

NPI Number: _____

Medical Policy Number: _____

Medical Policy Name: (Please be specific as to whether this is related to Mountain State Blue Cross Blue Shield Medical Policy or Medicare Advantage Medical Policy) _____

Reason for Inquiry (please document specific questions/concerns to be reviewed):

Sources/References/Current Peer Review Articles: _____

To assist in conducting your review, please include any applicable Mountain State Claim numbers: _____

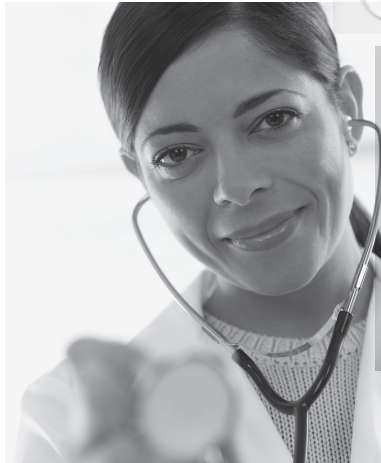
Please email this form to MSmedicalpolicy@msbcbs.com or mail to:

Mountain State Blue Cross Blue Shield
 Medical Policy Department
 P.O. Box 1353
 Charleston, WV 25325
 Attention: Paula Yonker, RN, CPC

Mountain State Blue
 Cross Blue Shield
 Medical Policy
 Department
 P.O. Box 1353
 Charleston, WV 25325
 Attn: Paula Yonker,
 RN, CPC

If a provider is sending an inquiry via email, please attach the completed form and email to msmedicalpolicy@msbcbs.com. Please review this sample form for your records and information.





Mountain State's *Provider News* is designed to serve providers by offering information that will make submitting claims and treating our subscribers easier. We want to know what you would like to see in upcoming issues of this newsletter. Do you have a question that needs to be answered that you think other providers would be interested in? Are there issues or problems not addressed in this publication? If so, let us know. Send your questions and concerns to:

Mountain State Provider News
Post Office Box 1353
Charleston, WV 25325
or call
Provider Relations
Toll-Free 1-800-798-7768
or email
leah.worley@msbcbs.com

Mountain State Blue Cross Blue Shield's policy of equal employment opportunity is to recruit, hire, promote, reassign, compensate and train for all job classifications without regard to race, color, religion, sex, age national origin, disability or veteran status.

Mountain State Blue Cross Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

® Registered Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.



MOUNTAIN STATE
Blue Cross Blue Shield

A HIGHMARK AFFILIATE

Post Office Box 1948
Parkersburg, WV 26102

PRESORTED
STANDARD
U.S. POSTAGE
PAID
PERMIT #80
PARKERSBURG
WV 26101

