Mountain State Blue Cross Blue Shield Celebrates Opening of its New Headquarters

After much anticipation, planning and preparation, Mountain State Blue Cross Blue Shield (Mountain State) officially celebrated the opening of its new headquarters building in downtown Parkersburg with a ribbon cutting ceremony and open house on Thursday, September 17, 2009.

With approximately 200 people in attendance, including West Virginia Governor, Joe Manchin, many local, county and state dignitaries joined Mountain State executives in acknowledging the many partnerships and hard work dedicated to making this one time vision into a reality. In addition to Governor Manchin, other officials on hand to present their remarks included Jane Cline, West Virginia Insurance Commissioner; Robert Newell, Mayor, City of Parkersburg; Keith Burdette, Wood County Development Authority; Nan DeTurk, Executive Vice President, Highmark; Gregory K. Smith, Chairman of Mountain State’s Board of Directors and former company president; and Mountain State President, Fred Earley.

As the first non-government building to be built in downtown Parkersburg in many years, the new Mountain State headquarters was designed and

Governor Joe Manchin, Mountain State executives in addition to local, county and state officials prepare to cut the ribbon to officially open Mountain State’s new headquarters building.

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constructed using green building principles to promote water and energy efficiencies and waste reduction. The building provides ample natural lighting and a state of the art climate control system to help reduce electricity usage. Additionally, the building materials used were selected to provide the best indoor air quality possible.

“Efficiency was the driving force behind the decision to construct the new headquarters,” said Mountain State President, Fred Earley. “All in all the new building provides for a safe and efficient environment, which our workforce deserves. Also, we hope our new building will serve as a catalyst for other opportunities and development in the downtown area,” he added.

According to Parkersburg Mayor, Robert Newell, Mountain State’s new building is just the beginning in making the city’s downtown landscape change completely for the better by the year 2020. “Great things can happen when government takes an active role in economic development,” Mayor Newell said.

Wood County Development Authority Director, Keith Burdette thanked Parkersburg City Council and Mayor Newell for their work in keeping Mountain State’s headquarters based downtown. City officials, along with the West Virginia Economic Development Authority, put together a package to entice the company to remain downtown. The state development authority approved a $10 million loan to the company and the city put up an additional $300,000 over a two-year period to help make sure the company remained anchored downtown.

The new headquarters building consists of approximately 127,000 square feet, and has consolidated Mountain State’s 675 Parkersburg-based employees from four older buildings, into one state-of-the-art building, greatly enhancing operating efficiencies. When considering the possibility of constructing a new headquarters, Mountain State initiated an independent review with assistance from a development company. This review concluded that a new building would greatly improve operational efficiencies, and would result in lower facility operating costs. Based on initial estimates, annual costs associated with operating the new facility are projected to be 20 percent less per year over the next ten years.

In addition to operational efficiencies, fiscal efficiency was also an important consideration in erecting this new structure. Mountain State Board Chairman, Greg Smith noted that the actual cost of the proposed $27.3 million building was within one percent of budget. He also added that approximately 87 percent of the workforce used during construction was generated in the Mid-Ohio Valley.

As the official food vendor of the building’s Blue Café, AVI-Foodsystems Inc., gave officials a preview of its fare by offering hors d’oeuvres at a reception immediately following the ribbon cutting. Guided group tours of the new structure were also provided to those in attendance.
Administration of H1N1 Vaccine to be Covered for Most Mountain State Blue Cross Blue Shield Members

Mountain State Blue Cross Blue Shield (Mountain State) will cover physician services for the administration of the H1N1 vaccine for most members enrolled in its health insurance products and encourages physicians to immunize Mountain State patients who belong to high-risk groups identified by the Centers for Disease Control and Prevention (CDC).

Additionally, we will cover the number of vaccinations recommended by the CDC for the member's age group and/or condition.

Providers are reminded to use NaviNet® or the applicable HIPAA electronic transactions to verify patients' active/current Mountain State membership before providing immunization services, as non-Mountain State members may not be covered. (Real-Time functionality on NaviNet allows you to verify coverage at the point of service.)

Codes to Use When Submitting Claims to Mountain State

Mountain State will accept the following new procedure codes on claims submitted for H1N1 vaccine administration:

**CMS HCPCS:**
- G9141: Influenza A (H1N1) immunization administration (includes physician counseling the patient/family)
- G9142: Influenza A (H1N1) vaccine, any route of administration

**AMA CPT:**
- 90470: H1N1 immunization administration (intramuscular, intranasal), including counseling when performed
- 90663: Influenza virus vaccine, pandemic formulation, H1N1

**Please note:** Claims referencing codes G9142 and 90663 for the vaccine itself should be billed for $0, since the federal government is providing the vaccine free of charge. (Zero-dollar claims may aid in tracking utilization of the H1N1 vaccine.)

**Processing of the H1N1 Administration Fee**

Mountain State is currently processing claims for members who receive their seasonal flu shot at a pharmacy. If a pharmacy signs up to administer the H1N1 vaccine, Mountain State will process the service for members as indicated below:

**For Fully Insured/Direct Pay Business:**
- Eligible for Professional and Facility Billed Claims
- Paid at 100% for both In and Out-Of-Network Providers (No deductible, coinsurance or out-of-pocket costs for member)
- Price Out-Of-Network at Charge (No Member Liability)

**For Self-Funded Business:**
- Eligible for Professional and Facility Billed Claims
- Apply Deductible/Coinsurance/Out-of-Pocket Costs Based on Current Flu Vaccine Benefits
- Price Out-Of-Network at Product Allowance (Potential Member Liability)

**Please Note:** Various clients may decide to opt out of covering the H1N1 flu vaccine. To discuss this benefit further, please contact the appropriate customer service area identified on the member's identification card.

**For More Information**

For the latest information on the H1N1 virus, including details about high-risk groups, recommended immunization guidelines, information regarding antiviral therapy with Tamiflu® (oseltamivir phosphate) and vaccine availability, visit [www.cdc.gov/h1n1flu](http://www.cdc.gov/h1n1flu).

If you have questions regarding benefits eligibility please access this information via NaviNet®, or you may contact the appropriate customer service area located on the member’s identification card.

For questions regarding billing of these services you may contact Provider Services at 1-800-798-7768 or your assigned External Provider Relations Representative.
**NAVINET UPDATE**

**Claim/Estimation Submission**
The current ‘Claim/Estimate Submission’ transaction gives users a fly-out to select either the Claim Submission or Estimate Submission function. Users have stated that having both functions in the same fly-out can be confusing, resulting in the selection of the wrong transaction. Therefore, the transaction is being unbundled in November 2009, and will now be two separate transaction choices. The two new transactions will be ‘Claim Submission’ and ‘Estimate Submission’. Each of these will now have their own fly-out from Plan Central. The use of both the claim submission and estimate submission will not change. The claim log can be accessed from either of these fly-outs in addition to Office Central.

**Medicare Advantage**
Beginning with dates of service January 1, 2010 and after, any Medicare Advantage PPO claim submitted through NaviNet, from any Blue Cross Blue Shield plan, must be submitted with Highmark Health Insurance Company (HHIC) being the final payer on the ‘Payer’ page. In addition, the NAIC code of 71768 must be selected on the 'Header' page for the 1500 Claim Estimation, UB Claim Estimation and UB Claim Submission transactions. This change is necessary to accommodate network sharing of the Medicare Advantage networks that will occur through the Blue Cross Association. Until 1/1/2010 dates of service, please continue to use the 71768 NAIC code and HHIC payer codes only for the Mountain State Medicare Advantage members who have the HQM & HKP prefixes. Beginning with claim dates of service January 1, 2010 and after, Medicare Advantage members nationwide can be identified by a Blue Cross Blue Shield ID card with a suitcase logo with ‘MA’ inside the suitcase or simply noted as a Medicare Advantage PPO member. Be sure to ask for the member’s most recent Blue Cross Blue Shield identification card.

**Member Responsibility Calculator**
The Member Responsibility Calculator transaction that is currently available for professional providers under the Benefit Accumulator will be discontinued. Now that the 1500 Claim Estimation transaction is available to all professional providers you can get a more accurate estimation using this tool. The 1500 Claim Estimation tool works in concert with the Mountain State claims processing system, so you can be confident the patient responsibility and benefit limit information is accurate at the time you use this tool. This transaction considers coverage under the member’s benefit program, as well as the cost of the service to be provided and any deductible, coinsurance amount and/or copayment included in the member’s benefits program.

**Resource Center**
A new link has been added to our Resource Center in NaviNet. The ‘Real-Time Tools’ link includes a training material link to access a tutorial as well as the user guides. These links will help you maximize your use of the Real-Time claim estimation and claim submission functions. In addition, there is a link to order free support material for these Real-Time transactions.

**Provider Conferences**
It was great to see everyone who attended the Provider Conferences this year. Thank you for your input and support of NaviNet.
Hospital Claims To Be Submitted Electronically

During a recent review of claims submissions being received from hospitals contracted to provide services within the Mountain State Blue Cross Blue Shield (Mountain State) commercial and Highmark Health Insurance Company (HHIC) Freedom Blue networks, a large percentage of paper claims continue to be received. These paper claims are more costly to process and can ultimately result in payment delays. The submission of these claims electronically will further speed claims processing and payments.

The Administrative Simplification Compliance Act (ASCA) which became effective in 2003 requires claims be sent to Medicare electronically as a condition for payment; it is expected that most hospital providers are currently set up to submit claims electronically through a Clearinghouse.

Following the CMS action from 2003, Mountain State will also begin requiring all inpatient and outpatient hospital claims be submitted electronically as of January 1, 2010. This requirement is expected to benefit providers and Mountain State through the reduction of administrative costs, allowing claims to process uninterrupted through our system, reducing errors of compliance on PHI, and increasing our ability to pay all claims without manual intervention and speeding payment.

Consistent with CMS, Mountain State will grant a grace period through December 31, 2009, allowing hospitals and respective Trading Partners to make any system or process adjustments necessary. After January 1, 2010 however, claims will be returned when filed via paper media.

For any hospitals without a Trading Partner Agreement or other established electronic billing process, NaviNet has been made available by Mountain State at no cost to hospitals to allow access to an electronic portal to submit claims along with the availability of many other features.

It is understood that from time to time, there may be a circumstance that requires a claim(s) to be submitted via paper media. For these situations, contact should be made to your External Provider Relations Representative to discuss the issue and work towards a process which would allow for the hospital to submit claims electronically.

Two bulletins have been sent out as advance notice from Mountain State that beginning January 1, 2010, all commercial primary and secondary hospital inpatient and outpatient claim submissions are to occur electronically.

Questions regarding this information may be directed to the Office of Provider Relations, at 1-304-424-7795 or 1-800-798-7768, or your External Provider Relations Representative.

2009 Provider Conference Documents

If you were not able to attend one of our Statewide Provider Conferences, you can view the presentations on our website at www.msbcbs.com. If you have any questions, please contact your assigned Provider Relations Representative. The presentations covered include the following:

- 2009 BlueCard
- 2009 Credentialing 101
- HHIC 2010 Provider Workshop Presentation
- 2009 NaviNet Provider Workshop
HIPAA Mandated EDI Transactions Must be Updated to Version 005010

All electronic transactions mandated under HIPAA must be upgraded to Version 005010 due to federal regulations. Mountain State Blue Cross Blue Shield is committed to meeting the January 1, 2012, compliance date for this mandate. We are currently evaluating the impacts of Version 005010 to our systems and customers. We will continue to provide updates as our development progresses.

All providers who submit claims electronically will be impacted by this change and should contact their practice management software vendors to begin discussions about these electronic transaction changes. We encourage you to begin discussing these changes to ensure your claim submission software is ready and to send the following high level changes to your practice management software vendor:

**Electronic Claims and Remittance Advice (837 and 835)**
- Mountain State is working to be ready to accept Version 005010 837 claim transactions and create 835 remittance transactions by late Summer 2010.
- All providers sending electronic claims and receiving electronic remittance advices must use the Version 005010 transactions by January 1, 2012.
- Version 005010 requires the National Provider Identifier (NPI) be used for reporting and billing in the electronic claim (837) transaction. Mountain State legacy provider numbers will NOT be considered during the claim receipt and editing process of Version 005010.

**Claim Transaction Acknowledgements (999 and 277CA)**

The following will occur when a provider begins using Version 005010 837:
- Mountain State will be using Version 005010 standardized acknowledgment transactions within the claim submission and editing process.
- The 005010X231 999 Transaction (Implementation Acknowledgment for Health Care Insurance) will replace the current 997 (Functional Acknowledgement).
- Mountain State will discontinue creating a text based printable Claim Acknowledgment report. Trading Partners must be able to accept the 005010X214 277 Health Care Claim Acknowledgment (277CA) Transaction with implementation of the Version 005010 837 Claim.

Mountain State currently has the ability to perform real-time claim adjudication and claim estimation. Both of these processes will be converted to use the Version 005010 transactions. If you are interested in having this functionality integrated with your practice management system, now would be an excellent time to discuss that additional functionality with your practice management software vendor.

Mountain State plans to update our Inquiry Transactions (270/271 Eligibility, 276/277 Claim Status and 278 Authorization) to Version 005010 in the Second Quarter of 2011. This will align Mountain State with current BCBSA plans to update Blue Exchange and ITS to Version 005010. Watch for more information to follow in the near future.

**IMPORTANT NOTICE: Walmart Updates - New for 2010!**

Starting January 2010, all Walmart claims will be administered out of Arkansas. Walmart is currently administered by three different Blue Plans - Arkansas, Alabama and Health Care Service Corporation (HCSC), with 6,597 Walmart Associates working in West Virginia having their benefits administered in Alabama. This means that all covered Walmart Associates will be given a new Alpha prefix – WMW - and they will be issued new ID cards. Claims previous to 2010 must be filed within the one year run out period if they are to be considered for payment.
This year the Blue Cross Blue Shield Service Benefit Plan (FEP) is encouraging members to take a more active role in their health. Two new wellness initiatives have been created for this purpose.

The first program is called WalkingWorks®. WalkingWorks can help members walk their way to better health through online tools and resources that encourage them to incorporate walking into their daily routine and to set – and achieve – personal wellness goals. They can receive a free pedometer to count their daily steps and then record their progress with the online WalkingWorks tracking tool. Members log in at www.fepblue.org to sign up for this program. If they do not have access to the internet, they may call 1-888-706-2583. WalkingWorks was developed in cooperation with the President’s Council on Physical Fitness and Sports.

The second program is called Blue365®. This program offers FEP members access to savings from leading national companies on products and services for healthy lifestyles. Blue365 complements FEP member’ healthcare benefits by helping them live healthier everyday. This free program includes special offers and discounts from companies such as Curves®, Gold’s Gym®, Jenny Craig®, Nutrisystem®, eDiets®, LasikPlus®, QualSight®, Healthyroads®, and many more, as well as a wide range of helpful educational content and online resources – just for FEP members.

In addition to these programs, there are benefit changes for both Standard and Basic Options. Below is a list of the changes that will affect providers.

**Changes to Standard Option Only**
- The copayment for office visits to Preferred specialists is now $30 per visit. Previously, members paid $20 for visits to both specialists and primary care providers. The $20 copayment for office visits to Preferred primary care providers has not changed.
- At Preferred retail pharmacies, members may be eligible to receive their first 4 generic prescriptions filled (and/or refills ordered) per drug per calendar year at no charge when they change from certain brand-name drugs to a corresponding generic drug replacement.
- The coinsurance amount for certain Non-preferred professional and outpatient facility services are now 35% of the Plan allowance. Previously, the coinsurance amount was 30% of the Plan allowance for certain medical and surgical services, and 40% of the Plan allowance for certain mental health and substance abuse services.
- Members now pay 35% of the Plan allowance (plus any difference between our allowance and the billed amount) for anesthesia provided by a Non-participating anesthesiologist or certified registered nurse anesthetist (CRNA) (deductible applies). Previously, they paid 100% of the amount billed up to a maximum of $800.
- The copayment for inpatient care at Non-preferred hospitals is now $350 per admission. Previously, members paid $300 per admission for medical and surgical care, and $400 per day for mental health and substance abuse care.
- Benefits for outpatient mental health and substance abuse care are no longer limited to 25 visits per year. However, members must now obtain prior approval for outpatient mental health and substance abuse care in order to receive benefits. Previously, if they did not obtain prior approval, we provided benefits at Non-preferred benefit levels.
- Benefits for inpatient mental health care at Non-preferred facilities are no longer limited to 100 days per calendar year.
- Benefits for inpatient care at Non-preferred facilities to treat substance abuse are no longer limited to one 28-day stay per lifetime.
- We clarified that we waive the copayments for professional care provided in an emergency room by Non-participating providers when Medicare Part B is the primary payor.
- We clarified those situations in which the member’s responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

**Changes to Basic Option Only**
- The copayment for office visits to Preferred specialists is now $35 per visit. Previously, members paid $30 per visit. The $25 copayment for office visits to Preferred primary care providers has not changed.

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2010 Changes to the FEP Service Benefit Plan Continued...

- The copayment for inpatient care at Preferred hospitals is now $150 per day, up to $750 per admission. Previously, members paid $100 per day, up to $500 per admission.
- The member’s total responsibility for facility-billed maternity services provided at Preferred facilities is now limited to $150 per admission. Previously, they paid $100 for their inpatient facility care and $50 for each maternity-related visit to the outpatient department of a Preferred facility, plus 30% of the Plan allowance for drugs received in the outpatient department.
- The copayment for most outpatient facility care at Preferred hospitals is now $75 per day per facility. Previously, they paid $50 per day.
- The copayment for screening colonoscopies provided in the outpatient department of a Preferred hospital is now $25. Previously, they paid $50 for colonoscopy screening at Preferred facilities.
- We clarified that your coinsurance for non-preferred brand-name drugs does not accumulate toward your Catastrophic Protection Out-of-Pocket Maximum.
- We clarified that you pay 30% of our allowance for drugs and supplies administered or obtained in connection with your care.
- We clarified that we provide benefits in full for screening procedures billed by the outpatient department of a hospital or ambulatory surgical center (does not include screening colonoscopies).
- We have discontinued our Basic Consumer Option High Deductible Health Plan (HDHP).

Changes to both Standard and Basic Options

- Preferred and Member hospitals will not be able to bill members for any inpatient services related to specific types of medical errors and hospital-acquired conditions known as Never Events. In addition, we will no longer provide benefits to Preferred and Member hospitals for inpatient services related to Never Events.
- We now provide Preventive Care benefits for individual counseling on prevention and reducing health risks. In addition, we now provide Preventive Care benefits for the administration and interpretation of a Health Risk Assessment (HRA) questionnaire. Members must use a Preferred provider in order to receive these benefits.
- We clarified that members now have access to our online “Blue Health Assessment” tool which confidentially assesses overall health, identifies potential health risks, and provides members with a personal health action plan – at no charge.
- Members may be entitled to receive your annual physical examination or one visit for counseling on prevention and reducing health risks at no charge when they complete a Blue Health Assessment questionnaire and see a Preferred health care provider. Members will be able to print a certificate upon completion of the Blue Health Assessment questionnaire and bring it with them to the visit for verification.
- Children age 5 through 17 who meet certain Body Mass Index (BMI) criteria may be eligible to participate in our new Jump 4 Health Weight Management Program and receive up to 4 nutritional counseling visits at no cost when they use Preferred providers.
- We now provide benefits for the H1N1 Influenza (Swine) vaccine.
- We clarified the advantages of using generic drugs.
- Many of our Preferred retail pharmacies now participate in our vaccine network, allowing members the convenience of receiving certain vaccines at no charge at pharmacies in the vaccine network.
- We now provide benefits for Human Papillomavirus (HPV), Meningococcal, Pneumococcal, and Herpes Zoster (shingles) vaccines provided by Preferred retail pharmacies that participate in our vaccine network. Previously, these vaccines were not available through our vaccine network.
- We now provide benefits for speech-generating devices, limited to $1,000 per calendar year.
- We now provide benefits for oxygen billed for by skilled nursing facilities, nursing homes, and extended care facilities. Previously, benefits were not available for these types of expenses.
- We now provide benefits for up to 6 nutritional counseling visits per year. Previously, we provided benefits for up to 4 nutritional counseling visits per year.
- We now provide benefits for additional types of stem cell transplants.

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2010 Changes to the FEP Service Benefit Plan Continued...

- We now provide benefits for up to 7 days of inpatient hospice care for members not previously enrolled in a home hospice care program, in addition to 7 days of inpatient care every 21 days for members enrolled in a home hospice care program. Previously, we provided benefits for up to 5 days of inpatient hospice care only for those members already enrolled in a home hospice program.
- We now also provide benefits for up to 7 days of continuous home hospice care. Previously, benefits were not available for this type of hospice care. Case management accreditation for this Plan is now provided either through URAC or through Health Plan accreditation from NCQA.
- Chiropractors/Doctors of Chiropractic (D.C.) are now listed as “physicians.” Previously, these types of providers were listed as “other covered health care professionals.” We also clarified reimbursable chiropractic services.
- We added licensed mental health and substance abuse professionals who provide mental health and/or substance abuse services within the scope of their license, to the list of covered health care professionals.
- Members must now obtain prior approval for outpatient intensity-modulated radiation therapy (IMRT). Previously, these types of services did not require prior approval.
- We clarified that you may request prior approval and receive specific benefit information in advance for surgical procedures (including maternity care) to be provided by a Non-participating physician when the charge for that care will be $5,000 or more.
- We clarified the benefit payment levels that apply to routine physical examinations and screening procedures performed in the outpatient department of a hospital.
- We clarified the benefit payment levels that apply to colonoscopies.
- We clarified U.S. Food and Drug Administration (FDA) limitations on the use of immunizations and vaccines.
- We clarified that benefits are not available for telephone consultations related to your medical care.
- We clarified that benefits are not available for genetic screening.
- We clarified that Maternity Care benefits are not provided for oral tocolytic agents.
- We clarified that benefits are not available for deluxe lens features for eyeglasses.
- We clarified that benefits are not available for private duty nursing in any setting.
- We clarified that benefits are not available for wheelchair van services or gurney van services.
- We clarified that benefits are not available for professional charges for shift differentials.

Please Read: Important Provider Information on New Wellness Initiatives for Federal Employees under the Service Benefit Plan

What are the programs?

Beginning 1/1/2010, the BlueCross and BlueShield Service Benefit Plan for FEP employees will reward members when they complete either the adult Blue Health Assessment or a child’s BMI assessment. The intent of these programs is to encourage wellness and prevention and aim to remove barriers to care.

The member reward will be enhanced benefits:

- If an adult member completes the Blue Health Assessment, our Health Risk Assessment, the copayment for his/her subsequent annual physical examination or an individual preventive counseling visit will be waived. The member will receive a certificate that entitles them to a preventive visit at no charge and the member will be directed to present the certificate to the...
The second incentive targets children who complete a BMI assessment. Once the BMI assessment is complete, the member will receive a certificate to present at the time of care. The copayments for up to four (4) nutritional counseling visits will be waived. This incentive is limited to children ages five through seventeen, whose Body Mass Index (BMI) falls in the 85th percentile or higher, according to standards established by the Centers for Disease Control and Prevention (CDC). Only those children who meet these requirements will be presented a certificate. The member must complete the child BMI Assessment and present a certificate of completion in order for the provider to waive the copayment for the visit. (Following this article is a copy of the certificate for your reference.)

The certificates for both programs will include the member’s name, Contract ID #, effective date and expiration date.

**How does it affect my office?**

1. The directions for providers can be found on the certificates; we are also providing them here for your convenience:
2. If a Service Benefit Plan member presents a certificate, please do NOT collect the copayment amount from the member at the time of visit. The reimbursement from the local BlueCross BlueShield Plan for these visits will include the payment of the copayment.
3. If a member presents a certificate and an office visit copayment is collected in error for these types of visits, providers will be required to refund this amount to the member upon receiving payment from the local BlueCross BlueShield Plan.
4. To ensure correct reimbursement the claim must be filed with the appropriate evaluation/management procedure code and diagnosis to reflect that the visit was primarily a routine/annual examination for adults or the appropriate medical nutrition therapy/nutritional counseling codes and diagnosis to reflect the visit was primarily a nutritional counseling visit for children.
5. Providers may retain the certificate for their records; it is not required to be submitted with the claim.
6. The child certificate encompasses four visits, so providers are asked to sign and date the certificate when presented by the member in order for the member to track usage of visits.
7. For questions about the certificate or the process, please contact the local BlueCross BlueShield plan.

Members will be told they do not have to pay copayments for these visits, so we want to ensure our members do not get charged copayment amounts for these visits. Please follow these important directions and do not charge a copayment when a member brings in a certificate. Reimbursement for this visit will be 100 percent of the Plan Allowance, including payment of the copayment amount.

**What action do you need to take?**

1. Please ensure that the entire office staff is aware of these programs and the process, especially those that normally collect member copayments and arrange appointments. If the patient is a Service Benefit Plan member, you may want to ask if they have a certificate to waive the copayment amount.
2. Beginning on 1/1/2010, follow the directions on the certificate that are listed above when a certificate is presented by a Service Benefit Plan member to ensure a positive member experience with your office and the patient’s health coverage.

We hope that these programs will encourage wellness and prevention. We appreciate your support of these programs that encourage good health practices for our Service Benefit Plan members.
About The BlueCross and BlueShield Service Benefit Plan

The local BlueCross and BlueShield Plans underwrite and administer the BlueCross and BlueShield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) Program. Sixty percent of all federal employees and retirees who receive their health care benefits through the government’s FEHB Program are members of the Service Benefit Plan. Any questions regarding benefit changes for 2010 and these new programs should be directed to Customer Service at 1-800-535-5266.

MyBlue Wellness Certificate

This certificate entitles the above Service Benefit Plan member to:

One (1) Free Annual Physical Examination or Individual Preventive Counseling Office Visit at a BlueCross BlueShield Plan Preferred Provider. Valid from XXXX/XXXX to XX/XX/XXXX.

Provider Information and Instructions:

- Please do not collect reimbursement amount from the member at the time of visit. You may report the service and the payment of the copayment.
- If you collect an office visit copayment and you report the service for reimbursement, you must report the appropriate evaluation and management procedure code and diagnosis related to the visit. The BlueCross BlueShield Plan will not reimburse this claim.

You may retain this certificate for your records; it is not required to be submitted with the claim.

If you have a question about this certificate or the process, please contact the local BlueCross BlueShield Plan.

MyBlue Wellness Certificate

This certificate entitles the above Service Benefit Plan member to:

Four (4) Nutritional Counseling Visits with no member cost-share at a BlueCross BlueShield Plan Preferred Provider upon presentation of this certificate. Valid from XXXX/XXXX to XX/XX/XXXX.

Provider Information and Instructions:

- Please sign and date the certificate when presented by the member to verify the member's visit count. Do not charge the member to track usage of visits.
- Please do not collect reimbursement or copayment amount from the member at time of visit. Your reimbursement for these visits will include the payment of the member copayment or coinsurance.

If you have a question about this certificate or the process, please contact the local BlueCross BlueShield Plan.
Beginning Jan. 1, 2010, Highmark Health Insurance Company (HHIC) and 13 other Blue Medicare Advantage PPO (MA PPO) Plans will participate in reciprocal network sharing. This network sharing will allow all Blue MA PPO members – including FreedomBlueSM PPO – to obtain in-network benefits when traveling or living in the service area of any other participating Blue MA PPO Plan as long as the member sees a contracted MA PPO provider.

Impact to FreedomBlue PPO Providers
If you are a contracted HHIC FreedomBlue PPO provider and you see MA PPO members from other participating Blue Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your FreedomBlue PPO contract. These members will receive in-network benefits in accordance with their member contract.

Impact to non FreedomBlue PPO Providers
If you are not a contracted HHIC FreedomBlue PPO provider and you provide services for any Blue Medicare Advantage PPO members, you will receive the Medicare allowed amount for covered services and the member will receive out of network benefits according to their member contract.

For Urgent or Emergency care, you will be reimbursed at the member’s in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How to recognize an out-of-area member from a Plan participating in the BCBS MA PPO network sharing
You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo.

Note: Use of this logo is not mandated until 2012. HHIC and some other Blue plans will be using the logo on ID cards in 2010. However, ID cards from several other Blue plans may not include the logo until 2012.

Providing Services to Medicare Advantage PPO members from other participating Blue Plans
If you are a contracted HHIC FreedomBlue PPO provider, beginning Jan. 1, 2010, you should provide the same access to care for members of other participating Blue Medicare Advantage PPO Plans as you do for FreedomBlue PPO members. You can expect to receive the same contracted rates for such services.

If you are not a contracted HHIC FreedomBlue PPO provider you may see Blue Medicare Advantage PPO members but you are not required to do so. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

Note: If your practice is closed to new HHIC FreedomBlue PPO members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your HHIC FreedomBlue PPO members.

Verifying Benefits and Eligibility for Out-of-Area Blue MA PPO Members
Call BlueCard Eligibility Line at 1.800.676.BLUE (2583) and provide the member’s three-digit alpha prefix located on the ID card to obtain eligibility information.

Claims Submission Process
You should submit claims for services provided to Blue MA PPO out-of-area members to HHIC FreedomBlue PPO under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Continued On Next Page
FreedomBlue℠ PPO to Participate in MA PPO Network Sharing Program with Other Blue Plans

For Electronic Claims Submission use NAIC number 71768 as you currently do today for HHIC Freedom Blue PPO.

If you bill MA PPO claims with NAIC 54828 your claims will reject.

If it is necessary to submit Paper Claims there is a new P.O.Box for Medicare Advantage PPO claims:
P.O. Box 7004
Wheeling WV, 26003

To appeal a claim or for servicing related matters please contact Mountain State Customer Service at 1-800-543-7822.

Reimbursement for Services Provided to Out-of-Area MA PPO Members from Participating Blue Plans
If you are a HHIC FreedomBlue PPO contracted provider, benefits will be based on your contracted HHIC FreedomBlue PPO rate for providing covered services to MA PPO members from any participating MA PPO Plan. Once you submit the MA claim, HHIC FreedomBlue PPO will work with the other participating Blue Plan to determine benefits and send you the payment.

Reimbursement for Service Provided to Out-of-Area MA PPO Members from Blue Plans Not Participating in the MA PPO Network Sharing
When you provide covered services to other Medicare Advantage PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the MA claim, HHIC FreedomBlue PPO will send you the payment. However, these services will be paid under the member’s out-of-network benefits unless the services are for urgent or emergency care.

Determining Member Cost Sharing Levels and Copayments
A MA PPO member cost sharing level and copayment is based on their health plan, but are the same for any MA PPO contracted providers in the HHIC FreedomBlue PPO service area. You may collect the copayment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1.800.676.BLUE (2583).

No Balance Billing for Difference between Charge and Allowance
You may not balance bill the member for the difference between your charge and the HHIC FreedomBlue PPO allowance for a particular service. However, members may be balance billed for any deductibles, co-insurance and/or copayments.

If you have any questions regarding the reciprocal MA PPO network sharing program or products, or reimbursement for services provided to out-of-area MA PPO members, contact Provider Services at 1-800-798-7768 or your Provider Relations Representative.

Blue is Going Green

In an effort to support our environmental and corporate initiatives, Mountain State Blue Cross Blue Shield will begin distributing the Provider News newsletter electronically effective January 2010. The reduction of our paper usage is an important step in our Going Green Project. Once this transaction occurs, you will be able to view this publication via our website at www.msbCBS.com, and will no longer be receiving a printed copy. If you have any questions or comments regarding this initiative, please contact the Office of Provider Relations, at 1-304-424-7795 or 1-800-798-7768, or your External Provider Relations Representative.
Important FreedomBlue℠ and BlueRx℠ Changes for 2010

Highmark Health Insurance Company (HHIC) remains committed to offering its members a variety of products to help meet their health insurance needs. For 2010, HHIC will continue to offer a comprehensive selection of Medicare Advantage options. Due to significant decreases in federal funding for Medicare Advantage, FreedomBlue PPO and FreedomBlue PFFS – our Private Fee for Service plan – each will experience significant premium increases. Premiums for BlueRx, Highmark Senior Resources’ Medicare Part D prescription drug program, will decrease for BlueRx Complete, but will increase for BlueRx Value and BlueRx Plus.

FreedomBlue PPO Changes
For all FreedomBlue PPO plans in 2010, the out-of-network deductible has increased to $500. Annual physical exams are covered at 100 percent, both in-network and out-of-network. Skilled nursing facility (SNF) copayments will apply for days 16-55 per admission. A total out-of-pocket (OOP) maximum of $3,400 is being applied to all FreedomBlue PPO plans. Once members reach this OOP spending level, all benefits will be covered at 100 percent. Most member cost sharing will contribute to the total OOP calculation. Member cost sharing for Part B drugs will now be applied as a 20 percent coinsurance. Some Part B drugs continue to be exempt from member cost sharing. (Please watch your mail for a Special Bulletin that will provide specific details on Part B drug cost sharing for 2010.) A denture benefit will be added for plans that include a dental benefit. Other plan-specific changes are outlined below.

FreedomBlue PPO Value
Copayments for specialist, mental health and substance abuse, outpatient rehabilitation services, Medicare-covered chiropractic and podiatry services, and comprehensive dental services each will increase to $35.

- Copayments for vision and hearing exams each will increase to $35.
- The SNF copayment is increasing to $50 and the SNF OOP maximum is increasing to $2,000.
- The long-term acute care (LTAC) copayment is increasing to $75 and the LTAC OOP maximum is increasing to $750.
- Ambulance copayments are increasing to $100 per one-way trip.
- The copayment for non-hospital urgent care will increase to $35.
- The DME/prosthetics/orthotics and diabetic monitoring testing devices and supplies OOP maximums are increasing to $750.

FreedomBlue PPO Standard

- The copayment for outpatient surgery is increasing to $100.
- The SNF copayment is increasing to $50 and the SNF OOP maximum is increasing to $2,000.
- The LTAC copayment is increasing to $75 and the LTAC OOP maximum is increasing to $750.
- Ambulance copayments are increasing to $75 per one-way trip.
- The DME/prosthetics/orthotics and diabetic monitoring testing devices and supplies OOP maximums are increasing to $750.

Continued On Next Page
FreedomBlue PPO Changes (continued)

<table>
<thead>
<tr>
<th>FreedomBlue PPO Deluxe</th>
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<tbody>
<tr>
<td>Copayments for specialist, mental health and substance abuse, outpatient rehabilitation services, routine and Medicare-covered chiropractic and podiatry services, and comprehensive dental services each will increase to $25.</td>
</tr>
<tr>
<td>Copayments for vision and hearing exams each will increase to $25.</td>
</tr>
<tr>
<td>The copayment for outpatient surgery is increasing to $75.</td>
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<tr>
<td>The copayment for inpatient hospital admissions will increase to $200 and the annual OOP maximum for inpatient hospital admissions will increase to $600.</td>
</tr>
<tr>
<td>A $35 copayment for SNF is being added with a $1,400 SNF OOP maximum.</td>
</tr>
<tr>
<td>A $75 copayment for LTAC is being added with a $750 LTAC OOP maximum.</td>
</tr>
<tr>
<td>Ambulance copayments are increasing to $75 per one-way trip.</td>
</tr>
<tr>
<td>The copayment for non-hospital urgent care will increase to $25.</td>
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<td>The DME/prosthetics/orthotics and diabetic monitoring testing devices and supplies OOP maximums are increasing to $750</td>
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</table>

FreedomBlue PPO to Participate in MA PPO Network Sharing Program with Other Blue Plans

Beginning Jan. 1, 2010, FreedomBlue PPO and 13 other Blue Medicare Advantage PPO (MA PPO) Plans will participate in reciprocal network sharing. This network sharing will allow all Blue MA PPO members – including FreedomBlue PPO – to obtain in-network benefits when traveling or living in the service area of any other participating Blue MA PPO Plan as long as the member sees participating MA PPO providers. For additional information, see the August 2009 issue of Provider News. You can access the issue online at www.msbcbs.com. Select the Provider tab, then News & Bulletins. Then click on Provider Newsletter in the upper right corner of the Web page. More details will also be available on the Plan Central page of NaviNet®.

FreedomBlue PPO Premium Rates

In Berkeley, Boone, Braxton, Cabell, Calhoun, Clay, Doddridge, Gilmer, Grant, Hardy, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Mason, Mingo, Nicholas, Ohio, Pendleton, Putnam, Ritchie, Roane, Tucker, Upshur, Wayne and Wirt counties, the monthly premium rates are $30 for FreedomBlue PPO Value, $70 for FreedomBlue PPO Standard, and $123 for FreedomBlue PPO Deluxe.

In Barbour, Brooke, Fayette, Greenbrier, Hampshire, Hancock, Harrison, Marion, Marshall, McDowell, Mercer, Mineral, Monongalia, Monroe, Morgan, Pleasants, Pocahontas, Preston, Raleigh, Randolph, Summers, Taylor, Tyler, Webster, Wetzel, Wood and Wyoming counties, the monthly premium rates are $70 for FreedomBlue PPO Value, $99 for FreedomBlue PPO Standard, and $186 for FreedomBlue PPO Deluxe.

FreedomBlue PFFS Changes

For 2010, the FreedomBlue PFFS Enhanced plan will be eliminated; only FreedomBlue PFFS Choice and FreedomBlue PFFS Choice Plus will be offered. Annual physical exams are covered at 100 percent. The out-of-pocket (OOP) maximum will decrease to $3,400 for all FreedomBlue PFFS plans. Member cost sharing for Part B drugs will now be applied as a 20 percent coinsurance. Some Part B drugs continue to be exempt from member cost sharing. ([Please watch your mail for a Special Bulletin that will provide additional details on Part B drug cost sharing for 2010.]) Ambulance copayments are increasing to $100 per one-way trip. Other plan-specific changes are outlined on the next page.
**FreedomBlue PFFS Changes** (continued)

### FreedomBlue PFFS Choice

<table>
<thead>
<tr>
<th>Copayments for PCP, specialist, mental health and substance abuse, outpatient rehabilitation services, Medicare-covered chiropractic and podiatry services, and comprehensive dental services each will increase to $35.</th>
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<tbody>
<tr>
<td>Copayments for vision and hearing exams each will increase to $35.</td>
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<tr>
<td>The copayment for outpatient surgery will increase to $200.</td>
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<tr>
<td>The copayment for LTAC will increase to $100.</td>
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<tr>
<td>The copayment for non-hospital urgent care will increase to $35.</td>
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### FreedomBlue PFFS Choice Plus

<table>
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<tr>
<th>Copayments for PCP, specialist, mental health and substance abuse, outpatient rehabilitation services, Medicare-covered chiropractic and podiatry services, and comprehensive dental services each will increase to $30.</th>
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</thead>
<tbody>
<tr>
<td>Copayments for vision and hearing exams each will increase to $30.</td>
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<tr>
<td>The copayment for LTAC will increase to $75.</td>
</tr>
<tr>
<td>The copayment for non-hospital urgent care will increase to $30.</td>
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*Important note: Although this PFFS product shares the FreedomBlue name, it is different from the FreedomBlue PPO product, as it is a non-network plan with no contracted providers that allows a member to see any licensed Medicare-eligible professional provider and be treated at any facility that is eligible to receive Medicare payment, as long as the provider and/or facility has not opted out of the Original Medicare program and accepts HHIC’s Terms and Conditions of Participation. The plan is also available nationwide to retirees of employer groups who opt to offer FreedomBlue PFFS.*

### FreedomBlue PFFS Premium Rates

The monthly premium rates are $85 for FreedomBlue PFFS Choice and $82 for FreedomBlue PFFS Choice Plus.

### BlueRx Changes

The premium for BlueRx Complete will decrease for 2010. Premiums for BlueRx Value and Blue Rx Plus will increase. Retail and mail order pharmacy copayments for the initial coverage period will change for all plans. The initial coverage limit will increase to $2,830 for all plans. The catastrophic coverage limit will increase to $4,550 for all plans. For all plans, during the catastrophic coverage period, cost sharing will be copayments of $2.50 for generic and multi-source brand medications and $6.30 for single-source brand medications or a 5 percent coinsurance, whichever is greater. Other plan-specific changes are outlined below.

#### BlueRx Value

| The deductible will increase to $310 to match Medicare. |
| The preferred brand copayment will increase to $33. |
| The non-preferred brand copayment will increase to $63. |
| The monthly premium will increase to $56.20. |

#### BlueRx Plus

| The generic copayment will increase to $7. |
| The preferred brand copayment will increase to $40. |
| The non-preferred brand copayment will increase to $90. |
| The monthly premium will increase to $51.30. |

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BlueRx Changes (continued)

BlueRx Complete

<table>
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<tr>
<th>Description</th>
<th>Amount</th>
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<tr>
<td>The generic copayment will increase to $7.</td>
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<tr>
<td>The preferred brand copayment will increase to $35.</td>
<td></td>
</tr>
<tr>
<td>The non-preferred brand copayment will increase to $70.</td>
<td></td>
</tr>
<tr>
<td>The monthly premium will decrease to $93.90.</td>
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</table>

We recognize that member communication and education are a priority, as well. In addition to this Special Bulletin to our participating providers, all FreedomBlue PPO, FreedomBlue PFFS and BlueRx members will receive their “Annual Notification Letter” and Evidence of Coverage in October with complete details about the changes for 2010. We will also host member meetings throughout the region to provide further opportunities for member education and communication.

We appreciate your ongoing efforts to support FreedomBlue PPO, FreedomBlue PFFS and BlueRx for the Medicare beneficiaries in our region.

Highmark is a registered mark of Highmark Inc. Blue Cross, Blue Shield, the cross and shield symbols and FreedomBlue and BlueRx are service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. NaviNet is a registered trademark of NaviNet, Inc. NaviNet, Inc. is an independent company that provides a secure, Web-based portal between providers and health care insurance plans.

Preventive Health Guidelines and Clinical Practice Guidelines for Your HHIC FreedomBlue PPO and PFFS Patients

Available Online
The HHIC Quality Management Department and participating network physicians annually review and update the Preventive Health Guidelines and Clinical Practice Guidelines, which are distributed to the practitioner community as a reference tool to encourage and assist you in planning your patients’ care. To help make the information more accessible and convenient for you, we post the Key Points and links to the complete set of guidelines online. Just visit www.highmarkbcbs.com and click on the Providers tab at top right. You’ll find the guidelines under Clinical Reference Materials. (NaviNet® users, simply click on Resource Center from the Plan Central page.)

The Preventive Guidelines include:
- Adult (under and over 65)
- Pediatrics
- Prenatal/perinatal

There are Clinical Practice Guidelines for the following conditions/patient needs:
- ADHD
- asthma
- chest pain
- COPD
- cholesterol management
- heart failure
- depression
- diabetes
- hypertension
- smoking cessation
- substance abuse

Please ask your clinical support staff to bookmark this Web page as a handy reference tool to help plan your patients’ care. To obtain a paper copy of the guidelines or Key Points, write to:

Quality Management Department
Highmark Blue Cross Blue Shield
Fifth Avenue Place
120 Fifth Avenue, Suite P1601
Pittsburgh, PA 15222
SilverSneakers® Fitness Program Proven to Reduce Health Care Costs

Older adults who participate in the Healthways SilverSneakers Fitness Program visit their primary and specialty physicians more, are admitted to the hospital less and have lower overall healthcare costs, according to a new study funded by the Centers for Disease Control and Prevention.

The study, “Managed-Medicare Health Club Benefit and Reduced Health Care Costs Among Older Adults,” was conducted by Group Health and the University of Washington and published by the National Center for Chronic Disease Prevention and Health Promotion. Researchers studied nearly 5,000 SilverSneakers participants over a two-year period. Participants’ healthcare costs were compared to those of a control group of more than 9,000 people of the same age and gender who were not taking part in this physical activity program.

Key conclusions from the study include:
- Reduced healthcare costs - SilverSneakers participants had significantly lower total adjusted healthcare costs, saving an average of $500 compared with a control group that did not participate in the SilverSneakers program.
- Cost savings increase with increased usage - SilverSneakers participants who averaged at least two fitness center visits per week over two years incurred at least $1,252 less in healthcare costs in year 2 than those who visited less than once per week on average. The savings were even more pronounced among those who visited more than twice a week.
- Increased preventive care - Preventive care is highly correlated to the SilverSneakers program. Participants had higher outpatient primary and specialty care visits, but fewer inpatient admissions than the control group.
- Effective retention for long-term benefits - SilverSneakers has a high retention rate, with approximately 61 percent of participants extending participating location membership into the second year.

SilverSneakers is the nation’s leading exercise program designed exclusively for older adults and is available to Mountain State Blue Cross Blue Shield’s Medifil members at no additional cost beyond their monthly premium.

The program focuses on improving muscular strength, endurance, range of movement and flexibility through a variety of fitness classes tailored to the needs of older adults and taught by certified instructors. Many members utilize the program at 19 participating locations throughout West Virginia.

To learn more about the SilverSneakers Fitness Program, please contact your local SilverSneakers Account Manager at 304-610-8203 or visit www.silversneakers.com.

1Nguyen, Huong Q. “Managed Medicare Health Club Benefit and Reduced Health Care Costs Among Older Adults” Preventing Chronic Disease, Volume 5 No. 1 January 2008.
The next release of the SMART Registry will be mailed to Mountain State Blue Cross Blue Shield providers in March 2010. The SMART Registry provides information to doctors on their patients with one or more of the chronic conditions managed by the Blues On CallSM Program.

New in 2010!
To protect PHI, all doctors with more than 11 patients in the Blues On Call Program will now receive the SMART Registry on encrypted CD rather than in binder format. In the past, you may have received a hard copy version of the SMART Registry. This new electronic version includes all of the information found in the print Registry with the added benefit of the filter and sort capabilities of the reports.

One week prior to SMART Registry delivery, you will receive a letter from BOC including your unique encryption password. Outside encryption, the CD includes instructions for entering your password, enabling you access to the reports.

The CD includes a read-only PDF file of the entire SMART Registry as well as all supplemental materials; an Excel file of the Group Registry Reports with information that can be sorted and patient address file. The CD also includes reminder template letters directed toward patients with diabetes, asthma, CHD, HF, COPD and hypertension to alert members of a missing test or treatment or the need for an office visit.

If you have any questions about using the SMART Registry CD, please don’t hesitate to call the toll-free Blues On Call Physician Hotline at 1-888-777-9522. A Provider Service Specialist (PSS) will be happy to address any questions you may have to make sure you can get the most out of this valuable resource.

A PSS can work with you and your clinical office staff to sort the CD to provide the most important information for you. PSSs can also meet with you and your staff to review the SMART Registry reports and to help with making referrals to the Blues On Call Program. If you would like to request a PSS meet with you, call the Physician Hotline at 1-888-777-9522.

You may obtain an optional hard-copy version of the SMART Registry by requesting in advance. To request a hard-copy version of your Registry, please call the toll-free Blues On Call Physician Hotline at 1-888-777-9522. The deadline to make this request is 12/31/09.

SMART® is a registered trademark of Health Dialog Services Corporation. Used with permission.

SilverSneakers Participating Locations - September 28, 2009

Huntington High YMCA
917 9th Street
Huntington, WV  25701
304-697-7113

Tri-County YMCA
200 Carls Lane
Scott Depot, WV  25560
304-757-0016

Tyler Mountain YMCA
5113 Rocky Fork Rd
Cross Lanes, WV  25313
304-776-3323

YMCA of Kanawha Valley
300 Hilcrest Dr.
Charleston, WV  25311
304-340-3527

Princeton Health and Fitness Center
321 12th St. Ext
Princeton, WV  24740
304-487-7876

Nicholas Fitness Center
1104 Broad St
Summersville, WV  26651
304-872-3023

The Fitness Complex of Roane General Hospital
200 Hospital Drive
Spencer, WV  25276
304-927-6810

Family Fitness Center
2804 Birch St
Parkersburg, WV  26101
304-424-2348

Marietta Family YMCA
300 N. 7th Street
Marietta, OH  45750
740-373-2250

The Fitness Complex of Roane General Hospital
200 Hospital Drive
Spencer, WV  25276
304-927-6810

Family Fitness Center
2804 Birch St
Parkersburg, WV  26101
304-424-2348

Harrison County YMCA
Lowndes Hill Park
Clarksburg, WV  26302
304-623-3303

Berkeley 2000 Recreation Center
273 Woodbury Ave.
Martinsburg, WV 25404
304-264-4842

Gold’s Gym – Charles Town
64 Somerset Blvd
Charles Town, WV  25414
304-728-4653

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WVSBP Update
Throughout calendar year 2010, using PEIA pricing for the West Virginia Small Business Plan (WVSBP), Mountain State Blue Cross Blue Shield will update all fee schedules within two months of receipt of the appropriate information from the PEIA. These fee schedules include RBRVS, DMEPOS, Clinical Lab, Drugs and Biologicals among others.

Medmark Program Update
The following drugs will be added to the mandatory Medmark Injectable Drug program effective February 1, 2010:
- Orencia  J0129
- H. P. Acthar  J0800
- Remicade  J1745
- Lupron  J1950, J9217
- Omnitrope  J2941
- TEV-Tropin  J2941
- Zorbite  J2941
- Trelstar Depot  J3315
- Cimzia  J3590
- Simponi  J3590
- Theracys  J9031
- Tice BCG  J9031
- Zoladex  J9202
- Supprelin  J9226

2010 New Code Updates
The new codes for 2010 will be adopted by Mountain State Blue Cross Blue Shield effective January 1, 2010, utilizing the Centers of Medicare and Medicaid Services (CMS) fully implemented RVU and WV GPCI’s for 2010. The complete annual update of the CMS RBRVS will be effective July 1, 2010. This allows Mountain State the opportunity to review and analyze the changes made by CMS. As Mountain State finalizes plans for the annual update we will provide information to our provider community.

Mountain State will be updating RBRVS reimbursable provider services that do not have Medicare RVUs using Ingenix RVUs and WV GPCIs effective February 1, 2010. Lab services are excluded from this update.

For Highmark Health Insurance Company’s (HHIC’s) FreedomBlue PPO, the professional reimbursement will follow the CMS RBRVS schedule effective January 1, 2010.

ATTENTION ONCOLOGISTS:
Effective February 1, 2010, Allowable Rental Period for Ambulatory Infusion Pump to Change from Monthly to Daily Rate/Unit Under Procedure Code E0781

Effective with dates of service of February 1, 2010, and beyond, Mountain State will change the allowable rental period for ambulatory infusion pumps (i.e., portable external infusion pumps) from a monthly rate/unit to a daily rate/unit when billed under procedure code E0781 (ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient).
BlueExchange® Enhances the BlueCard® Business Process

BlueExchange, developed by the Blue Cross and Blue Shield Association, an association of independent Blue Cross® and Blue Shield® Plans, enhances the efficiency of the BlueCard business process. BlueExchange is an electronic solution that provides HIPAA compliance for Inter-Plan transactions and allows for electronic communication between the provider and a member’s Home Plan.

BlueExchange is accessible through the NaviNet® web portal or through trading partners that support eligibility and benefit requests. Providers can obtain member eligibility and benefits information (including remaining amounts) and claim status (including claim adjustment status). Through the NaviNet web portal, providers may also submit a referral/authorization for an out-of-area member. Responses to these inquiries will come from the members’ Home Plan for the majority of the BlueCard requests.

When submitting a referral/authorization through BlueExchange, the Home Plan of the member will generally respond by contacting the originator of the request by fax, telephone, or written confirmation. Please note that the response transmitted is based on the member’s coverage, eligibility, and account information on file at the Home Plan for either the date that the request is initiated or the date of service on the request.

In order for this process to work, a member’s alpha prefix must be included as part of the ID number when the inquiry is submitted. The alpha prefix is a critical component, as it is used to route the inquiry to the appropriate Home Plan. Without the alpha prefix, an inquiry will not be generated because the process will not be able to identify the correct Home Plan to respond to the inquiry.

For more information regarding the topic, please contact your External Provider Relations Representative.

REMINDER: CREDENTIALING CRITERIA FOR OUTPATIENT CT AND SLEEP SERVICES PROVIDERS

Mountain State Blue Cross Blue Shield implemented new credentialing criteria for outpatient CT providers effective January 1, 2009, and for Sleep Service providers effective September 1, 2009. Existing providers were notified a year in advance of the new criteria.

As a reminder, the criteria for both CT and Sleep Services pertain to hospital based, physician office, and freestanding providers. In addition, all existing providers are required to notify Mountain State of the addition of either type of service, and comply with all credentialing standards prior to reimbursement for the services. New providers are required to notify Mountain State at the time of their initial credentialing/contracting process if they provide either of these services to members and must also comply with credentialing for these services prior to reimbursement.

If you have any questions related to the credentialing criteria or need to notify Mountain State of the addition of services please contact the Office of Network Credentialing at 1-888-475-2391.

UPDATED CREDENTIALING POLICIES AND CRITERIA

As a resource to professional and facility/organizational providers, we have posted our updated Credentialing Policies and Criteria grids to our website. Please visit www.msbcbs.com and click on the Provider drop down menu, selecting Credentialing.
As an added enhancement to our Provider News, Mountain State Blue Cross Blue Shield communicates Medical Policy updates in each issue.

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 O-28 (Knee Orthoses)
Revision to June 2009 Provider Newsletter article.
Effective: October 12, 2009

In the June 2009 Provider Newsletter, it was noted that on October 12, 2009, Mountain State medical policy O-28 (Knee Orthoses) would become effective and Mountain State medical policy B-54 (Orthotics) would be archived. The portion of the statement involving Mountain State medical policy B-54 (Orthotics) was incorrect. The correct information is as follows. On October 12, 2009, Mountain State medical policy O-28 (Knee Orthoses) will become effective and published on the Mountain State website as scheduled. At that time, Mountain State medical policy B-51 (Knee Braces) will be archived and become ineffective. The services documented in medical policy B-51 (Knee Braces) will be addressed in medical policy O-28 (Knee Orthoses). Medical Policy B-54 (Orthotics) will remain active on the Mountain State website. We do apologize for any inconvenience. If you have any questions or concerns regarding this, please contact Paula Yonker by phone at 304-347-7794 or via email at paula.yonker@msbcbs.com.

MA For Freedom Blue, see Medicare Advantage medical policy O-28 (Knee Orthoses).

Medical Policy Bulletin X-24 (Bone Mineral Density Studies)
Mountain State Blue Cross Blue Shield expands bone density testing frequency limitation.
Effective: August 24, 2009

Mountain State Blue Cross Blue Shield generally limits coverage for eligible bone density studies to one test every 365 days from the date of the previous bone density study, regardless of the anatomic area tested or the imaging modality used to perform the study. Mountain State Blue Cross Blue Shield has expanded this limitation to allow for more frequent bone mass measurements under these circumstances:

- To allow simultaneous axial (spine, hips, pelvis) and peripheral (forearm, radius, wrist) bone density testing for hyperparathyroidism (ICD-9-CM diagnosis codes 252.00, 252.01, 252.02, 252.08)
- To allow peripheral (forearm, radius, wrist) bone density testing in the very obese patient (defined as a patient with a BMI of 35 or greater [ICD-9-CM diagnosis codes V85.35-V85.39, V85.4]) when the patient’s weight exceeds the weight limit for the DXA table
- To allow peripheral (forearm, radius, wrist) bone density testing when the hips or spine cannot be measured or interpreted because of severe arthritis and/or previous surgery

If a bone density study is performed for a condition that is covered under the “general coverage” criteria and the date of service falls within the 365 day frequency limitation, but does not meet one of the expanded criteria listed above, Mountain State Blue Cross Blue Shield will deny the service as not medically necessary.

Mountain State Blue Cross Blue Shield will deny services that do not meet its medical necessity criteria as not medically necessary. A participating, preferred,
or network provider may not bill the member for the
denied service unless the provider has given advance
written notice, informing the member that the service
may be deemed not medically necessary and providing
a cost estimate. The member must agree in writing to
assume financial responsibility before receiving the
service. The signed agreement should be maintained in
the provider’s records.

Mountain State Blue Cross Blue Shield also updated
the dosage threshold for patients on long-term steroid
therapy (such as prednisone) from 7.5 mg per day to 5
mg per day.

You can read the complete up-to-date version of
Mountain State Blue Cross Blue Shield’s bone density
studies medical policy, X-24, online.

MA Does not apply to Medicare Advantage. See

Medical Policy Bulletin O-8  (Braces and
Supports)
Custom Fabricated ankle-foot and knee-ankle-
foot orthoses covered according to specific
criteria.
Effective:  February 15, 2010

Mountain State Blue Cross Blue Shield covers ankle-
foot orthoses and knee-ankle-foot orthoses that are
molded-to-patient-model, or custom-fabricated for
ambulatory patients when the basic coverage criteria
and one of the following criteria are met:

● the patient could not be fitted with a prefabricated
ankle-foot orthosis

● the condition necessitating the orthosis is expected
to be permanent or of longstanding duration (more
than six months)

● there is a need to control the knee, ankle, or foot in
more than one plane

● the patient has a documented neurological,
circulatory, or orthopedic status that requires
custom fabricating over a model to prevent tissue
injury

● the patient has a healing fracture that lacks normal
anatomical integrity or anthropometric proportions

These guidelines apply to these procedure codes:
L1900, L1904, L1907, L1920, L1940, L1945, L1950,
L2020, L2030, L2034, L2036, L2037, L2038, L2106,
L2108, L2126, L2128, L2232, L2320, L2330, L2387,
L2520, L2526, L2755, L2800, L4030, L4040, L4045,
L4050, and L4055.

MA  Also applicable to Medicare Advantage.

Medical Policy Bulletin R-4  (Radiation Therapy)
High dose rate electronic brachytherapy
considered investigational.
Effective:  September 7, 2009

Mountain State Blue Cross Blue Shield considers high
dose rate electronic brachytherapy experimental or
investigational for all conditions and uses.

Mountain State Blue Cross Blue Shield does not
cover high dose rate electronic brachytherapy
because there is insufficient scientific peer-reviewed
published literature comparing the results obtained
through the use of electronic brachytherapy versus
standard radioisotope-based brachytherapy. Also,
prospective clinical studies are needed to determine
the procedure’s effectiveness in short and long term
patient outcomes, rates of recurrence, patient toxicity,
patient selection criteria, standardized performance
protocols, and patient safety. The Axxent® Electronic
Brachytherapy System by Xoft®, Inc. of Fremont,
California is an example of this technology.

Mountain State Blue Cross Blue Shield will deny claims
for this service as experimental or investigational. In
this case, a participating, preferred, or network provider
may bill the member for the denied service.

Use procedure code 0182T—high dose rate electronic
brachytherapy, per fraction—to report this service.

Standard or conventional brachytherapy uses
a radioactive isotope to deliver high dose rate
brachytherapy to a tumor site. Electronic brachytherapy

Continued On Next Page
uses electricity and miniature X-ray tubes instead of radioactive materials as the energy source of radiation for treatment. A balloon-type device with very small cylinders is connected to equipment that supplies power to the miniature X-ray tubes. The cylinders carry the energy from the miniature X-ray tubes to the tumor. The device is removed after treatment is completed. High dose rate electronic brachytherapy was developed as an alternative method for delivering intracavitary or interstitial brachytherapy treatment.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin X-50 (Magnetic Resonance Spectroscopy (MRS))
Magnetic resonance spectroscopy now covered for certain conditions.
Effective: August 17, 2009

Mountain State Blue Cross Blue Shield now covers magnetic resonance spectroscopy (MRS) (code 76390) for these indications:

● to assess the evidence or suspicion of a primary or secondary brain neoplasm that cannot be completely characterized on conventional imaging, or to differentiate between radiation necrosis and residual or recurrent brain tumor, or to assess for residual or recurrent brain tumor following treatment or therapy (ICD-9-CM diagnosis codes 191.0-191.9, 198.3, 225.0, 237.5, 239.6)

● to assess evidence or suspicion of inborn errors of metabolism, including, but not limited to leukoencephalopathies of childhood

If MRS is performed and it does not meet Mountain State Blue Cross Blue Shield’s medical necessity criteria, it will be denied as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service unless the provider has given advance written notice, informing the member that the service may be considered not medically necessary and providing a cost estimate. The member must agree in writing to assume financial responsibility before receiving the service. The signed agreement should be maintained in the provider’s records.

MA Does not apply to Medicare Advantage. See Medicare Advantage Medical Policy N-43.

Medical Policy Bulletin E-34 (Respiratory Assist Devices)
Number of respiratory assist device accessories to be restricted.
Effective: February 15, 2010

Beginning Feb. 15, 2010, Mountain State Blue Cross Blue Shield will consider the following maximum number of accessories medically necessary for use with a respiratory assist device (E0470, E0471), for example, BiPAP:

<table>
<thead>
<tr>
<th>Procedure code and number allowed</th>
<th>Terminology</th>
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<tbody>
<tr>
<td>A4604 1 per 3 months</td>
<td>Tubing with integrated heating element for use with positive airway pressure device</td>
</tr>
<tr>
<td>A7027 1 per 3 months</td>
<td>Combination oral/nasal mask, used with continuous positive airway pressure device, each</td>
</tr>
<tr>
<td>A7028 2 per 1 month</td>
<td>Oral cushion for combination oral/nasal mask, replacement only, each</td>
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<tr>
<td>A7029 2 per 1 month</td>
<td>Nasal pillows for combination oral/nasal mask, replacement only, pair</td>
</tr>
<tr>
<td>A7030 1 per 3 months</td>
<td>Full face mask used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7031 1 per 1 month</td>
<td>Face mask interface, replacement for full face mask, each</td>
</tr>
<tr>
<td>A7032 2 per 1 month</td>
<td>Cushion for use on nasal mask interface, replacement only, each</td>
</tr>
<tr>
<td>A7033 2 per 1 month</td>
<td>Pillow for use on nasal cannula type interface, replacement only, pair</td>
</tr>
<tr>
<td>A7034 1 per 3 months</td>
<td>Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap</td>
</tr>
<tr>
<td>A7035 1 per 6 months</td>
<td>Headgear used with positive airway pressure device</td>
</tr>
</tbody>
</table>
These frequency limitations are consistent with the frequency limitations Mountain State Blue Cross Blue Shield established for CPAP accessories.

Mountain State Blue Cross Blue Shield will deny quantities of supplies greater than those listed as not medically necessary if documentation does not clearly explain the medical necessity of the excess quantities. A participating, preferred, or network provider may not bill the member for the denied supplies.

Mountain State Blue Cross Blue Shield covers accessories used with a respiratory assist device when the coverage criteria for the respiratory assist device are met. If the coverage criteria are not met, Mountain State Blue Cross Blue Shield will deny the accessories as not medically necessary. A participating, preferred, or network provider may not bill the member for the denied accessories.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

MA  Does not apply to Medicare Advantage.

Medical Policy Bulletin E-36  (Speech Generating Devices)
Speech generating devices (SGD) eye gaze access device coverage guidelines outlined.
Effective: July 13, 2009

Mountain State Blue Cross Blue Shield considers eye gaze or eye glance technology, for example, DynaVox EyeMax System, medically necessary for a member who meets the requirements for a speech generating device (SGD), but has limited use of his or her extremities. These extremity limitations would make the member unable to control or sustain fine or gross body movements that would enable him or her to access an SGD using more conventional access methods such as switches or direct touch. An eye gaze or eye glance access device enables the SGD user to access their communication device using their eyes.

The member must have direct vision in one or both eyes. For full control over the system, they should be able to look up, down, left and right. The member must also have adequate vision to view the screen, and must have the ability to focus on one spot for a brief period of time. You must submit medical records and/or additional documentation for Mountain Blue Cross Blue Shield to determine coverage for eye gaze access devices.

Eligible medical diagnoses for an eye gaze access device may include, but are not limited to:

- brain and spinal cord injuries
- CVA
- multiple sclerosis
- ALS
- cerebral palsy
- other degenerative and genetic conditions

Use procedure code E2599 to report an eye gaze or eye glance access device for an SGD. When you report code E2599, please include the term “eye gaze/eye glance access device” along with the manufacturer and model number of the device in the narrative section of the electronic or paper claim.

For more information on SGDs and related
accessories, please review Mountain State Blue Cross Blue Shield Medical Policy E-36, Speech Generating Devices.

Mountain State Blue Cross Blue Shield determines coverage for durable medical equipment according to individual or group customer benefits.

**MA** Does not apply to Medicare Advantage.

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**Medical Policy Bulletin Z-8 (Sleep Disorder Services)**
**Coverage expanded for the use of laser to vaporize tonsils’ surface.**
**Effective: September 28, 2009**

Mountain State Blue Cross Blue Shield now covers the use of the laser to vaporize the surface of the tonsils. This procedure is also known as cryptolysis or subtotal tonsillectomy.

Mountain State Blue Cross Blue Shield also covers the use of the laser as a surgical tool in an otherwise standard tonsillectomy procedure and to sequentially vaporize the tonsils in a series of outpatient visits.

Laser ablation of the tonsils or laser-assisted tonsillectomy is also eligible for coverage when it’s performed in conjunction with LAUP (laser-assisted uvulopalatoplasty) for the treatment of obstructive sleep apnea. Either a hand held carbon dioxide laser, a potassium-titanyl-phosphate (DTP/532), or an ND:YAG laser may be used to perform this procedure.

Use procedure code 42999—unlisted procedure, pharynx, adenoids, or tonsils—to report these procedures. When you report code 42999, please provide a complete description of the procedure you performed in the narrative section of the electronic or paper claim.

**MA** Does not apply to Medicare Advantage.

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**Medical Policy Bulletin L-43 (KRAS Mutation Analysis in Metastatic Colorectal Cancer)**
**KRAS mutation analysis covered for predicting nonresponse to cetuximab and panitumumab in the treatment of metastatic colorectal cancer. Effective: October 1, 2009**

Mountain State Blue Cross Blue Shield covers KRAS mutation analysis for predicting nonresponse to anti-epidermal growth factor receptor monoclonal antibodies cetuximab (Erbitux®, ImClone Systems) and panitumumab (Vectibix™, Amgen) in the treatment of metastatic colorectal cancer.

If KRAS mutation analysis is used for any other applications, Mountain State Blue Cross Blue Shield considers it experimental or investigational. A participating, preferred, or network provider may bill the member for the denied test.

Use procedure code S3713—KRAS mutation analysis testing—to report this test.

Cetuximab and panitumumab are US Food and Drug Administration (FDA)-labeled for use in the treatment of refractory metastatic colorectal cancer. The FDA updated the “indication and usage” section of the labels of Amgen’s Vectibix and ImClone/BMS’ Erbitux to note that “retrospective analyses of metastatic colorectal cancer trials have not shown a treatment benefit for the EGFR inhibitors in patients whose tumors had KRAS mutations in codon 12 or 13,” and that the use of the drugs is not recommended for the treatment of colorectal cancer patients with these mutations. Ongoing studies are investigating the use of these EGFR inhibitors as monotherapy and as part of combination therapy in first, second, and subsequent lines of therapy. A proportion of patients with colorectal cancer have tumors that harbor a somatic KRAS mutation that may affect tumor response to EGFR inhibitors. KRAS mutations lead to EGFR-independent activation of intracellular signaling pathways, resulting in tumor cell proliferation, protection against apoptosis, increased invasion and metastasis, and activation of tumor-induced angiogenesis.
KRAS mutation analysis is typically performed using polymerase chain reaction methodology followed by sequencing of variants. KRAS oncogene testing is commercially available as an in-house laboratory-developed test. Such tests are regulated under the Clinical Laboratory Improvement Amendments. MA Does not apply to Medicare Advantage.

Medical Policy Bulletin I-42 (Zoledronic Acid {Reclast®, Zometa®})
Two additional indications covered for Reclast. Effective: March 16, 2009
Issued: October 5, 2009

Mountain State Blue Cross Blue Shield now provides coverage for zoledronic acid (Reclast®), a bisphosphonic acid and inhibitor of osteoclastic bone resorption, for the treatment of two additional indications:

● The prevention of osteoporosis in postmenopausal women (733.90) who have documented failure of oral bisphosphonate therapy.

● The prevention of glucocorticoid induced osteoporosis in men and women who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and who are expected to remain on glucocorticoids for at least 12 months (ICD-9-CM diagnosis code V58.65). Documented failure of oral bisphosphonate therapy is required.

Mountain State Blue Cross Blue Shield has covered the use of Reclast® for these indications:

● Paget’s disease of bone (731.0) in men and women.

● Osteoporosis to increase bone mass (ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.09, 733.14) in patients who have documented failure of oral bisphosphonate therapy.

Osteoporosis may be confirmed by the presence or history of osteoporotic fracture or by a finding of low bone mass (BMD more than 2.5 standard deviations below the normal adult reference population, that is, T-score).

Mountain State Blue Cross Blue Shield considers a 6-12 month trial of oral bisphosphonates adequate to determine treatment failure. Mountain State Blue Cross Blue Shield defines treatment failure as:

● new fracture despite bisphosphonate therapy of six months or more, or

● a T-score less than or equal to -3.0 despite bisphosphonate therapy of 12 months or more.

Mountain State Blue Cross Blue Shield may give individual consideration to claims for Reclast® in documented cases for patients who have difficulty with oral bisphosphonate dosing requirements, which include an inability to sit upright for 30 to 60 minutes and/or swallow a pill. Individual consideration may also be given for patients who have esophagitis, gastritis, or esophageal or gastric ulcers that prohibit the use of oral bisphosphonates.

Reclast injection contains the same active ingredient found in Zometa®, used for oncology indications. A patient already being treated with Zometa® should not be treated with Reclast®.

If the patient can tolerate oral bisphosphonates, then Mountain State Blue Cross Blue Shield considers the injectable form not medically necessary. It is not covered. A participating, preferred, or network provider may not bill the member for the denied service unless the provider has given advance written notice, informing the member that the service may be deemed not medically necessary and providing a cost estimate. The member must agree in writing to assume financial responsibility before receiving the service. The signed agreement should be kept in the provider’s records.

Mountain State Blue Cross Blue Shield considers the use of Reclast® for any other indication as experimental or investigational; therefore, it is not covered. A participating, preferred, or network provider may bill the member for the denied service.

Use code J3488 to report zoledronic acid (Reclast®).
Mountain State Blue Cross Blue Shield determines coverage for Reclast according to individual or group customer benefits. Reclast is not reimbursable under the prescription drug benefit.

**MA** Does not apply to Medicare Advantage.

**New eligibility criteria for immune prophylaxis with palivizumab (Synagis) for respiratory syncytial virus (RSV) effective November 1, 2009.**

**Medical Policy Bulletin I-20 (Immune Prophylaxis for Respiratory Syncytial Virus {RSV})**

**Effective: November 1, 2009**

In the August 2009 Provider Newsletter, one of the values for the month of May was published incorrectly. Please see the corrected table on the following page.

### Maximum number of palivizumab doses for season beginning November 1

The maximum number of palivizumab doses for RSV prophylaxis of preterm infants without chronic lung disease, on the basis of birth date, gestational age, and presence of risk factors (shown for geographic areas beginning prophylaxis on November 1).△

<table>
<thead>
<tr>
<th>Month of birth</th>
<th>May 1-3 of previous RSV season</th>
<th>May 4-31 of previous RSV season</th>
<th>June 1-30</th>
<th>July 1-31</th>
<th>August 1-31</th>
<th>September 1-30</th>
<th>October 1-31</th>
<th>November 1-30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month of birth</td>
<td>Less than 28 weeks, 6 days of gestation and less than 12 months of age at start of season</td>
<td>29 weeks, 0 days through 31 weeks, 6 days of gestation and less than 6 months of age at start of season</td>
<td>32 weeks, 0 days through 34 weeks, 6 days of gestation and with risk factor △</td>
<td>5</td>
<td>0△</td>
<td>0△</td>
<td>5</td>
<td>5</td>
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</tbody>
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△If infant is discharged from the hospital during RSV season, fewer doses may be required.

△For risk factors, see pages 565-566 of the American Academy of Pediatrics 2009 *Red Book*.

△Some of these infants may have received one or more doses of palivizumab in the previous RSV season if discharged from the hospital during that season. If so, they still qualify for up to five doses during their second RSV season.

△Zero doses because infant will be older than 6 months of age at start of RSV season.

△Zero doses because infant will be older than 90 days of age at start of RSV season.

△On the basis of the age of patients at the time of discharge from the hospital, fewer doses may be required, because these infants will receive one dose every 30 days until the infant is 90 days of age.

Source: American Academy of Pediatrics 2009 *Red Book*, Table 3.61

### Attention Highmark Health Insurance Company (HHIC) network providers: Medicare Advantage icon indication to change.

HHIC’s Medicare Advantage products follow the national Medicare decisions and the local coverage decisions of Palmetto GBA.

When national or local Medicare coverage decisions are not available, Highmark Blue Cross Blue Shield’s medical policy guidelines—referred to as “gap-fill” policies in these instances—apply to HHIC products.

In the Provider Newsletter, the Medicare Advantage

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*Continued On Next Page*
MA icon indicates when Highmark Blue Cross Blue Shield’s medical policy guidelines apply to HHIC products.

As of Dec. 31, 2009, HHIC will no longer use the Highmark Blue Cross Blue Shield medical policy guidelines as gap-fill medical policies for its products. You will see the Medicare Advantage icon [MA] included in the indemnity medical policy articles in the October 2009 Provider Newsletter. However, beginning with the December 2009 Provider Newsletter, the Medicare Advantage icon will no longer be used as an identifier on indemnity medical policy articles.

MA icon to identify HHIC Medicare Advantage policies
You will continue to see the Medicare Advantage icon [MA] in the Provider Newsletter, but it will point out HHIC’s Medicare Advantage medical policies. The Provider Newsletter will include announcements about new, or revisions to, Medicare Advantage policies. If you are a HHIC provider, look for the Medicare Advantage icon [MA] for Medicare Advantage policy-related information that’s specific to you.

The following medical policy updates apply to Highmark Health Insurance Company (HHIC) medical policies only.

**HHIC Medical Policy Bulletin N-4 (Medical Nutrition Therapy (MNT))**

Medical Nutrition therapy services coverage guidelines explained.  
**Effective: February 15, 2010**

Effective Feb. 15, 2010, HHIC’s Medicare Advantage products will cover medical nutrition therapy (MNT) services provided by a registered dietitian or nutritionist for members who have diabetes or renal disease and after a transplant when referred by their physician. The Centers for Medicare & Medicaid Services’ National Coverage Determination 180.1 defines these guidelines.

For purposes of disease management, this includes:

- an initial assessment of nutrition and lifestyle assessment
- nutrition counseling
- information regarding managing lifestyle factors that affect diet
- follow-up visits to monitor progress managing diet

**General conditions of coverage**

- The treating physician must prescribe these services and renew their referral yearly if continuing treatment is needed into another calendar year.
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician.
- Services may be provided either on an individual or group basis.
- For a member with a diagnosis of diabetes, Diabetic Self-Management Training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit may be covered. The only exception is that DSMT and MNT may not be provided on the same day to the same member.

MNT services are covered according to these parameters:

- Three hours of one-on-one counseling services are covered during the first year of therapy.
- Two hours of one-on-one counseling services are covered each year after the initial year of therapy.

HHIC considers additional hours of service medically necessary and eligible if the treating physician determines that there is a change in the member’s condition, diagnosis, or, treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

HHIC will pay for MNT when one of these ICD-9-CM diagnosis codes is reported:

**Continued On Next Page**
Noncovered MNT services
A member may not receive MNT and DSMT on the same day.

If MNT is provided for conditions other than those listed above, HHIC considers it not medically necessary. A provider may not bill the member for the denied MNT unless he or she has given advance written notice, informing the member that the service may be deemed not medically necessary and providing a cost estimate. The member must agree in writing to assume financial responsibility before receiving the service. The signed agreement, in the form of a Pre-Service Denial Notice, should be maintained in the provider’s records.

How to report MNT services
Use the following procedure codes, as appropriate, to report MNT:

97802—medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803—medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804—medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

G0270—medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes

G0271—medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes

Use code 97802 only once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be reported under code 97803 or G0270. Report all subsequent group visits under code 97804 or G0271.

Payment for dietitian and nutritionist services
HHIC pays for a registered dietitian or nutrition professional services at the lesser of the actual charge or 85 percent of the physician fee schedule.

MNT services, including individual medical nutrition therapy delivered through an interactive telecommunications system, may be covered when the above guidelines are met.
HHIC Medical Policy Bulletin N-89 (Physician Laboratory and Pathology Services)
How to report physician component of laboratory and pathology services.
Effective: November 9, 2009

HHIC provides reimbursement for the physician (professional) component of these laboratory and pathology services:

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<td>83020</td>
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<td>G0418</td>
<td>G0419</td>
<td>P3001</td>
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</tbody>
</table>

Please do not report modifier 26 with procedure codes 85060, 85097, 86077, 86078, 86079, 86141, 88141, 88321, 88325, or 88329. These procedure codes represent professional services; therefore, the professional component or technical component concept does not apply.

If you report only the professional component for laboratory and pathology services that are not included on the above list, HHIC will deny the service as not covered. A provider may not bill the member for the denied service.

For more information about physician laboratory and pathology services, see Medicare Advantage Medical Policy N-89.

SilverSneakers Participating Locations - Continued from page 19

Lakeview Fitness Center
1 Lakeview Drive
Morgantown, WV 26508
304-594-9561

J.B. Chambers YMCA
55 Lounez Ave
Wheeling, WV 26003
304-242-8086

Total Training Center
550 Glenmore Loop Rd
Elkins, WV 26241
304-636-0322

Fairmont Fitness
1509 Fairmont Avenue
Fairmont, WV 26554
304-366-1962

Greenbrier Valley YMCA
540 Jefferson Street
Lewisburg, WV 24901
304-645-4000

Weirton Millsop Community Center
3420 Main St.
Weirton, WV 26062
304-797-8520

Absolute Fitness
6005 U.S. Rte.60 E. # 211
Barboursville, WV 25504
304-733-1600

Barboursville, WV 25504
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:

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