MOUNTAIN STATE Blue Cross Blue Shield
A HIGHMARK AFFILIATE

PROVIDER News

Updated Provider Manual

Recently Released!

Mountain State Blue Cross Blue Shield is pleased to announce the release of its new Provider Manual. This new manual has been extensively updated and expanded in an attempt to offer the most current and comprehensive information regarding Mountain State's business rules and guidelines affecting network providers. This expanded information also supports Mountain State's goal of making its administrative, clinical and reimbursement guidelines as accessible and transparent as possible.

Hard copies of this new manual are being distributed to all network providers. It can also be accessed on Mountain State's website, www.msbcbs.com. Future updates to the manual will be announced to the provider community via the *Provider News*, in addition to personal notification. Updates can be obtained through the website or by contacting the Provider Relations Department.

Mountain State welcomes any comments, suggestions, or clarifications from the provider community regarding this manual. On a periodic basis all comments and suggestions will be reviewed by the Mountain State Provider Advisory Committee. This committee, comprised of network physicians and other provider representatives, was created to offer comments and recommendations to Mountain State on provider billing, coding and administrative issues (see Chapter 1, Section 6 of the Provider Manual for more details).

The Provider Manual is applicable to all types of providers and supersedes and replaces all other previously issued provider manuals. If you have any questions on this matter, please contact our Provider Relations Department at (304) 424-7795 or (800) 798-7768, or you may contact your External Provider Relations Representative.

Inside This Edition:

Summer 2007

Introducing NaviNet Claims, the industry's most advanced and easy-to-use electronic claims processing platform.

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

What can NaviNet Claims do for you?

NaviNet Claims allows any physician or office administrator to easily manage everyday claim transactions with the click of a button, increasing efficiency and productivity and ultimately leading to significant cost reductions and more control over the reimbursement cycle. NaviNet Claims is available to integrate with your practice management system or as a stand-alone platform.

Providers can process and submit claims free of charge with health plans sponsoring NaviNet Claims, or choose to connect to 900+ payers nationwide for a monthly or yearly fee. To find out more about health plans that sponsor NaviNet Claims (including Mountain State), go to **www.navinetclaims.com** and click on Products & Services and then click on the product that is right for you.

NaviNet Claims is available 24/7 for claims submission.

Features of NaviNet Claims include:

Claim Pre-Processing – Passes claims through a stringent editing process before they are transmitted to Mountain State, resulting in improved first time pass and pay rates, reduced turnaround time and fewer denials.

Express Claim Correction – Corrects claims immediately using your own desktop, significantly reducing denial notices, speeding up the revenue cycle and increasing cash flow.

Claim Status Reporting – Tracks claim transactions and provides status reports right to your desktop, including acceptances and denials, submission and receipt confirmation, and payment status. It allows you to track claims through the entire reimbursement cycle – from your desktop, to the clearinghouse, to Mountain State.

Central Access to Multiple Health Plans – Offers a single access point for multi-payer transactions, which eliminates the need to manage multiple software solutions for your claim transactions.

Easy to Install, Learn and Use – Works with your existing Internet connection. NaviNet Claims takes care of installation, configuring and enrolling you with Mountain State.

Seamless Integration with Practice Management Systems – Integrates with virtually any practice management software system, ensuring seamless and fast implementation and reduction in duplicate data entry.

Security – Utilizes the power of the Internet with a highly secure transmission solution through HTTPS and SSL 128-bit encryption. No more busy numbers or broken connections, simply click with no worries.

Training and Support – Offers the most knowledgeable and responsive training and support team in the industry, at no cost. No more having to wait or read manuals. NaviNet Claims offers full hands on training catering to your schedule, 8am ET – 7pm ET.

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NaviNet Claims Continued...

NaviNet Claims offers a suite of products and services designed to meet the needs of any provider, regardless of size or workflow:

NaviNet Claims Integrated Claims Solution (ICS) enables claims submissions using your existing physician practice management system claim data. The ICS solution integrates with print image, NSF and 837 formats. Enter patient data and instead of printing claims to paper, simply print to file. ICS summarizes, applies payer-specific edits, allows you to correct errors and reformats the claim data into electronic transactions.

- Password- and user ID-protected
- Product updates offered at no charge
- Fully HIPAA compliant

NaviNet Claims Direct Claims Entry (DCE) is designed for electronic claims processing without a physician practice management system. It presents a HCFA 1500 form that includes all the appropriate fields in which to enter your claim data. Set up patient and provider demographic and identifier information only once and the system will populate data fields to create additional claims quickly and easily. The more you use it, the more it remembers and assists you.

- Lookup table for Place of Service, Type of Service, and Diagnosis and Procedure Code
- Error correction screen highlights errors in red
- Easy-to-understand directions are available to assist in correcting the claim

For more information about NaviNet Claims, please call 1-800-526-7276 or log on to: www.navinetclaims.com.

Age Eligibility for Insurance Coverage Increases

As of July 1, 2007, parents are now allowed to maintain insurance coverage for their unmarried, dependent children through the end of the month that the dependent turns 25. This change became effective as a result of the passage of House Bill 2940 during the 2007 Legislative Session.

A 19-25 year old child or stepchild qualifies for benefit coverage if he or she meets either the definition of a “qualifying child” or a “qualifying relative” under IRS rules. In general terms, individuals in this age category must meet the following criteria to qualify for this extended age eligibility: 1) Child or stepchild; 2) Unmarried: and 3) Does not provide more than one-half of his or her own support.

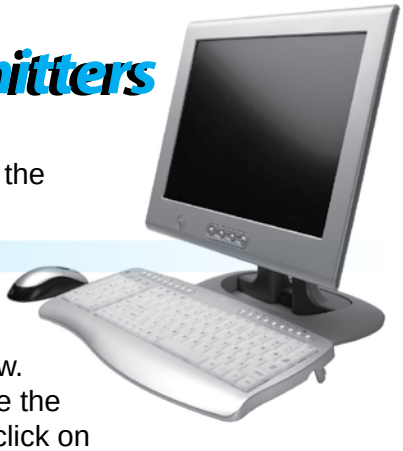
Children under the age of 19 have always been eligible for insurance coverage, and in most cases, adult dependent students are eligible up through the end of the calendar year in which they turn 25.

Mountain State Blue Cross Blue Shield implemented the new law on July 1, 2007, and where currently applicable, will continue to extend the student eligibility through the remainder of this calendar year. Upon approval of the Offices of the West Virginia Insurance Commissioner, Mountain State will implement the age eligibility rules of the new law to all students effective January 1, 2008.

Please Note: This change does not apply to FEP, Direct Pay and most Self-Funded accounts. Please contact Customer Service to check eligibility.

Attention All Electronic Claims Submitters

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



PWK Indicator on Electronic Claims

Electronic submitters—did you know that claims requiring attachments can be sent electronically? Attachments associated with a PWK (paperwork) segment should be sent (via fax or mail) at the same time the 837 HIPAA claims transaction is sent. Mountain State's business practice states that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication of the 837, thereby resulting in development or denial of your claim.

The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK.

A PWK Supplemental Claim Information Cover sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be printed from Mountain State's EDI website at: **http://www.msbcbs.com/PDFFILES/pwk-cover-sheet.pdf**

Mountain State's business practices and policy only support the following transmission types at this time:
- AA - Available on Request at Provider Site.
- BM - By Mail; mail to Mountain State Attachments, PO Box 7026, Wheeling WV 26003-0766.
- FX - By Fax; fax to (304) 234-7086

Please refer to our Provider EDI Reference Guide for further instructions. The Provider EDI Reference Guide can be found on our website at www.msbcbs.com. Choose the Provider drop down, click on MountainLink EDI option, and then choose Provider EDI Reference Guide.

ERA/EFT

Electronic submitters receiving Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT), please be aware you should receive your ERA on Wednesdays. The EFT process does not start until the following Friday around 5:00 pm and at the earliest, is not available until the following Monday.

FreedomBlue Electronic Remittance Advice

Effective January 1, 2007, the Mountain State FreedomBlue Medicare Advantage Product was transferred to a new entity called Highmark Health Insurance Company (HHIC). This is an affiliate of Highmark Inc., with whom we have an affiliation. As a result of this transfer, any electronic claims for FreedomBlue members for service dates of January 1, 2007, and after must be submitted in a separate file with the NAIC code of 71768. We are no longer providing the Electronic Remittance Advice to the Trading Partners who are refusing to make the changes in their system to submit FreedomBlue claims separately.

Electronic Secondary Claim Submission - CAS Code Update

The value codes that were used to report deductible and coinsurance amounts of A1, A2, A3, B1, B2, B3, C1, C2 or C3 should no longer be used when submitting secondary claims electronically. The

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national standards group has confirmed that an oversight resulted in two places for reporting this amount in the 4010 Implementation Guide - the 2320 AMT and the 2320 CAS. The amount (previous payer paid to the patient) will be reported to the provider in the previous payer's 835 remittance in a CAS segment, and therefore can and should be reflected in the CAS segment (2320 loop) in an 837 claim to a secondary payer. The amount that the patient paid to the provider is not reported in this segment; rather, that amount is placed in the Patient Paid Amount AMT in the 2300 loop.

In order to provide Mountain State Blue Cross Blue Shield with the information it needs to process a secondary or tertiary claim, facilities are accustomed to reporting the corresponding prior payment information via Value Codes and Amounts. However, the HIPAA Implementation Guides require a different approach to communicating this information on electronic claims.

The Implementation Guides require **payers** to use CAS segments to explain to the **provider** any factors (called "adjustments") which caused the **claim and/or line amount paid** to differ from the **claim and/or line amount** originally charged. The explanation is communicated through the appropriate standard **Claim Adjustment Group Code** and **Claim Adjustment Reason Code**, along with the corresponding dollar amount.

Once the provider has received the remittance from the prior payer, they need to submit a claim for secondary or tertiary consideration to the next payer. In doing so, according to the Implementation Guides, **the provider needs to pass to the next payer the same information they received from the prior one about how their payment was calculated.** For example, if the primary payment had been impacted by a contractual obligation, a member deductible and a member coinsurance, all three of these would need to be reported electronically to the next payer using the appropriate Claim Adjustment Group and Reason codes.

In addition, the level at which the information is passed to the next payer must mirror the level at which it was provided in the prior payer's remittance:

- If the "adjustment" was applied at the **line level** on the prior payment, this is the way it would need to be reported on the secondary or tertiary claim.
- Likewise, if an adjustment was reported back to the provider at the **claim level**, the provider would need to report it to the next payer at the claim level.
- It is possible that **both** of these might occur on a given claim – as when a deductible is applied to an entire claim, but a copayment is also taken on one particular service reported on that claim.

Technical specifications for reporting this information via CAS segments can be found in the *837 Health Care Claim: Institutional implementation guides, version 004010A1*. Providers who do not already own a copy of this publication can purchase one from the supplier, WPC, at **www.wpc-edi.com**.

Value Codes and Amounts

On and after April 13, 2007, Value Codes and Amounts used to communicate patient responsibilities (such as – but not limited to – A1, A2, A7 and their equivalents for Payer B) can only be reported in the rare instances in which a facility would need to submit a paper claim. If Value Codes **of this type** are submitted on electronic claims on and after April 13, 2007, the claims will be rejected for the invalid information.

Other Value Codes and Amounts, such as those used to communicate the most common semi-private room rate, can still be considered valid on electronic claims submitted on and after April 13, 2007, depending upon the circumstances of the particular claim.

See the most current version of the national *UB-04 Data Specifications Manual* for complete information on the use of Value Codes and Amounts.

Balancing Requirement

Under these guidelines, in order for an electronically submitted secondary or tertiary claim to be considered valid, the amount paid by the prior payer plus the amount adjusted by the prior payer (i.e., deductible, coinsurance, co-payment and/or contractual obligation amounts, at the claim and/or line level, as appropriate) must equal the total amount charged for the services on the claim. This requirement was effective for claims submitted on and after April 13, 2007.

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Attention All Electronic Claims Submitters Continued

IMPACT/ACTION
Facilities are asked to work with their vendors and information systems departments to report payment information from the prior payer's 835 remittance on electronic claims submitted to Mountain State for secondary or tertiary consideration, according to the requirements defined in the *837 Health Care Institutional implementation guide version 004010A*. To avoid unnecessary claim rejections, please ensure that the updates comply with this requirement.

TIME FRAME
The requirements described in this bulletin were effective for electronic secondary or tertiary claims submitted to Mountain State on and after April 13, 2007. They were required by the Medicare Program effective September 29, 2006.

EXCEPTIONS
Please be aware that the requirements described in this article do not affect claims submitted via paper. It is to be noted, however, that barring exceptional circumstances, **all claims from Mountain State contracted facilities should be submitted electronically.**

Professional Claims and Service Facility Location

Effective January 1, 2008, all **professional** claims that are rendered at any of the following locations will require the service facility number if the place of service includes: 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 31 - Skilled Nursing Facility 32 - Nursing Facility 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility.

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

No Claim on File

If you have ever called Customer Service or checked NaviNet for the status of a claim and you are told that there is no claim on file, please make sure you are checking your **277CA (Claims Acknowledgement)** reports from your Trading Partner. Up-front edits that are done on claims can cause the claim to deny and not be entered into the system. You can find the denial reason on the **277CA** report, correct the claim and resubmit immediately. The **277CA** report is a valuable tool for you to use to ensure your claims are accepted into our system. If you are not receiving your **277CA** report, please contact your Trading Partner or Clearinghouse.

Admitting Diagnosis/Patient Reason for Visit

Reminder to Institutional Providers: The admitting diagnosis is required on all inpatient admission claims and encounters and the patient reason for visit is required for all unscheduled outpatient visits. For reporting in the Institutional 837 Health Care Claim Transaction, use admitting diagnosis qualifier **"BJ"** to indicate **"Admitting Diagnosis"** or **"ZZ"** to indicate **"Patient Reason for Visit"** in the **"HI"** segment. Please refer to your HIPAA Implementation Guide or your UB-04 manual for further instructions.

Subscriber ID Invalid

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

Please refer to our updated Provider EDI Reference Guide available on our website at: www.msbcbs.com. Choose the Provider drop down, click on MountainLink EDI option, and then choose Provider EDI Reference Guide.

Mountain State Blue Cross Blue Shield EDI Operations are available Monday through Friday from 8:00 am until 4:00 pm at 1(800) 344-5514, ext. 47728 or (304) 424-7728.

Medmark Specialty Drug Program Update

Medmark Specialty Pharmacy is the preferred provider for 71 specialty drugs on the mandatory Medmark Drug List including Myozyme, Lucentis, Soliris and Tysabri added July 1, 2007. This specialty drug program is required and applicable to Mountain State Blue Cross Blue Shield lines of business to include Traditional/Indemnity and PPO/POS, but it is not required for FreedomBlue and the FEP Service Benefit plan. For FreedomBlue and FEP, Medmark can be used for administrative convenience and is voluntary.

Tykerb and Sprycel were added July 1, 2007, to the voluntary oral oncology specialty drug program. This oral oncology medication program is within the member's prescription drug benefit, and is intended to reduce member and group prescription benefit costs. This program is not applicable to the FEP Program. Please use the oral oncology prescription form when ordering these drugs.

How the Program Works:

- Doctor's office faxes the Specialty Drug Request Form or the Oral Oncology Drug Request Form to Medmark, which serves as a prescription and authorization.
- Medmark obtains an authorization from Mountain State Blue Cross Blue Shield and verifies benefit eligibility with customer service.
- Medmark delivers the drug to the doctor's office or the member's home.
- Medmark bills for the drugs listed on the specialty drug request form. The doctor's office may still bill for the office visit and administration of the drugs in accordance with Mountain State Blue Cross Blue Shield's reimbursement and medical policy.
- Medmark has registered nurses and pharmacists available 24 hours a day, 7 days a week to answer questions.
- Medmark Inc.
  500 Noblestown Rd, Suite 200
  Carnegie, PA 15106
  Phone: 1-888-347-3416
  Fax # 1-877-231-8302

The Specialty Drug Request Form, Oral Oncology Drug Request Form and the Medmark Drug Lists are available under Provider-Specialty Drugs on the Mountain State Blue Cross Blue Shield Website at www.msbcbs.com.

WELCOME To Our New Groups:

Pleasant Valley Hospital
Effective Date: 6/1/07
Number of employees: 576
Group location: Point Pleasant
Product Type: PHO/PPO
Claims processing location: Wheeling
Account Representative: Stacey Hart
Alpha Prefix: ZPO

St. Joseph's Hospital
Effective Date: 5/1/07
Number of employees: 787
Group location: Parkersburg
Product Type: PHO/PPO
Claims processing location: Parkersburg
Account Representative: Karen Crouser Hunt
Alpha Prefix: ZPN

NPI UPDATE:

*Mountain State Blue Cross Blue Shield Recommends NPI Dual Submission Prior to Submitting NPI Only**

Mountain State Blue Cross Blue Shield would like to congratulate those providers who have attained their National Provider Identification (NPI) compliance. For providers who are not yet compliant, the following article includes important reference material to assist you with your efforts. The Mountain State NPI Contingency Plan can be found on our website at **www.msbcbs.com**.

Mountain State's information systems are now ready to accept your NPI, but will continue to accept the following on transactions until at least November, 2007:

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

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

The The Centers for Medicare and Medicaid Services (CMS) contingency is limited and requires demonstration of good-faith efforts to achieve HIPAA NPI compliance. HIPAA covered entities not showing good-faith efforts to become compliant could face civil monetary penalties.

Mountain State has worked to be HIPAA NPI compliant by the federally mandated May 23, 2007, deadline, and therefore, will continue to accept NPIs on electronic transactions. Mountain State encourages HIPAA covered entities to forge ahead with their own efforts to be HIPAA NPI compliant as soon as possible.

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

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

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

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

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

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NPI UPDATE Continued:

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

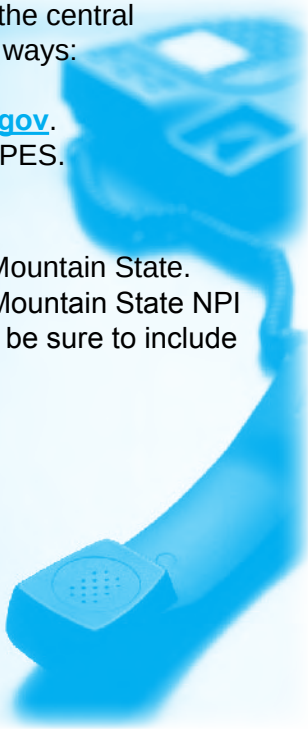
1) Complete the Web-based application process online at **https://nppes.cms.hhs.gov**.
2) Download and complete a paper application from the Web site, and mail it to NPPES.
3) Call NPPES at 1-800-465-3203 (TTY: 1-800-692-2326) for a paper application.

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

Fax: 304-424-7713

E-mail: msnpiupdate@msbcbs.com

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



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

Additional Reimbursement for the Surgical Tray to be Discontinued

Since 2002, the Centers for Medicare and Medicaid Services (CMS) has recognized the surgical tray expense in the Practice Expense component of the RVU. Although CMS discontinued independent reimbursement for surgical trays, Mountain State continues to reimburse for the surgical tray (HCPCS code A4550) when billed with a surgical procedure performed in the physician's office.

Since Mountain State uses the RBRVS methodology, the surgical tray is included in the Practice Expense component of the RVU. Beginning January 1, 2008, Mountain State will discontinue providing additional reimbursement for the surgical tray, A4550.

Mountain State reimburses professional services via the RBRVS reimbursement methodology. The Mountain State conversion factors were increased in July 2007.

For additional information, please visit our website, **www.msbcbs.com** to view the medical policy for Provider Overhead Expense, Z-39, which will be updated to reflect this change effective January 1, 2008.

Introducing Mountain Health Choices:

West Virginia's New Medicaid Program

Editor's Note: With providers playing an important role in the success of West Virginia's new Medicaid Program, Mountain Health Choices, the following article is being provided by the West Virginia Department of Health and Human Resources (WVDHHR). Mountain State Blue Cross Blue Shield is committed to assisting the WVDHHR in its communication efforts of this program.

West Virginia's new Medicaid Program, Mountain Health Choices, promotes patient responsibility and wellness. It is currently operating in three pilot counties (Lincoln, Upshur and Clay), with plans to expand the number of counties in the upcoming months.

In West Virginia, Medicaid's annual budget is approximately $2.5 billion. The program pays for the healthcare of approximately 22 percent of the state's total population. 85 percent of the state's Medicaid population suffer from or are at risk for chronic conditions, 70 percent are obese and sedentary. Mountain Health Choices seeks to partner with providers and members to reduce the incidence of costly, chronic conditions that prove to be devastating upon the lives of West Virginians.

Mountain Health Choices contains two benefit plans which are now available to those members linked to the program through DHHR's Aid to Families with Dependent Children and Temporary Assistance for Needy Families. The basic plan covers all mandatory services as well as some optional ones. Pharmacy is limited to four prescriptions a month and non-emergent transportation is limited to five round-trip visits a year. The enhanced plan covers additional services as well as services the state has never offered to Medicaid members before, such as cardiac rehabilitation and weight management.

In order to enroll in the enhanced plan, a member must schedule a well-visit with his or her physician. At that visit, the member will discuss the member agreement with the healthcare provider. Only by signing the member agreement in consultation with the healthcare provider may the member enroll in the enhanced plan. Once the member agrees to enroll in the enhanced plan, the member develops a health improvement plan in conjunction with his or her healthcare provider. The health improvement plan reflects the tests, screenings, healthcare classes and number of well visits needed in the coming year in order for the member to achieve optimal health goals.

Additional information regarding Mountain Health Choices can be found at the Bureau for Medical Services website (http://www.wvdhhr.org/bms) or by calling Shannon Riley at (304) 558-1700.

IMPORTANT UPDATE:

Kidney Disease Screening and Laboratory Testing - Effective June 1, 2007

Reimbursement for annual kidney disease screening and laboratory testing for any person when reimbursement for laboratory or x-ray services are covered under the policy and are performed for kidney disease screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery by the board of medicine. Tests are as follows: Any combination of blood pressure testing, urine albumin or urine protein testing and serum creatinine testing.

Important Reminders & Updates

- ***Anesthesia Providers*** – The revised billing guidelines for anesthesia services can be found on our website - **www.msbcbs.com**.
- ***Member ID Cards*** – Providers please make sure to request current member ID cards to copy and place in their patient chart. Occasionally, you may be required to submit a copy of the members ID card for verification. Snapshots of both front and back will be needed and we ask that the card is legible.
- ***Current Medical Policies*** – All Mountain State Blue Cross Blue Shield Medical Policies, and a complete list of codes/services requiring prior authorization, can easily be referenced under the provider tab of our website - **www.msbcbs.com**.
- ***Appeal Rights*** – Mountain State's appeal rights recently changed and can be accessed on our website.
- ***Provider Workshops*** – Information has been mailed to your office regarding the schedule for our upcoming Provider Workshops. You may also visit our website for online registration.
- ***Routine Preventive Services*** – Secondary routine preventive services must be billed to Mountain State using the appropriate HCPC code. This means if you filed the claim to a primary payor using the preventive CPT code you must refile the claim to Mountain State using the appropriate routine HCPC code to prevent denial.

With Sincere Thanks to the Provider Community:

You will never know how meaningful it has been to me and my family for the many cards, flowers, calls, visits and prayers from the provider community during the death of my mother Mildred White. The show of support has been so overwhelming and appreciated more than you will ever know.

During my career at MSBCBS I have always felt blessed with the reward of the relationships I have made and it is evident to me through these past few weeks that those relationships are genuine.

Again thank you I appreciate you,
Joyce Landers and Family

Preventive Guidelines Available on Website!

Mountain State Blue Cross Blue Shield is committed to promoting and providing quality care for all members. That is why we have developed the following preventive guidelines to be used in the care of all our members with the understanding that additional services should be rendered based upon the special needs of the individual patient. 2007 guidelines have been established for:

- Prenatal/Perinatal Care
- Pediatric Care
- Adult Care
- Adult (Over 65) Care

These guidelines can be accessed under the "Health Watch" section of our website at www.msbcbs.com

Medicare Claims – New Crossover Consolidation Process

More Claims Will Be Automatically Submitted to the Secondary Payer

How do I submit Medicare primary/Blue Plan secondary claims?

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier. When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to Mountain State Blue Cross Blue Shield.

If the remittance indicates that the claim was not crossed over, submit the claim to Mountain State Blue Cross Blue Shield with the Medicare remittance advice.

For claim status inquiries, contact Mountain State Blue Cross Blue Shield.

What is Medicare crossover consolidation and how does it affect my claim processing?

To simplify and streamline claim submission, the Centers for Medicare and Medicaid Services (CMS) has now consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA). Under this program, the COBC will automatically forward most Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Blue Plans have now implemented the Medicare crossover consolidation process system-wide. You should be experiencing an increased level of "one-stop" billing for your Medicare primary claims.

This change may affect the timing of the secondary payment from the Blue Plan.

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14-30 business days for you to receive payment from the Blue Plan.

What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to your initial claim submission, don't automatically submit another claim. Rather, you should:

- Review the automated resubmission cycle on your claim system.
- Wait 30 days.
- Check claims status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Who do I contact if I have questions?

If you have questions, please call Mountain State Blue Cross Blue Shield at 1-888-809-9121. For FEP Medicare claims, please call 1-800-535-5266.

Ease Into Medicare Advantage With FreedomBlue

Today, your patients with Medicare desire greater flexibility and value-added services in their healthcare coverage. That's why Highmark Health Insurance Company, in association with Mountain State Blue Cross Blue Shield, is pleased to offer FreedomBlue, a Medicare Advantage PPO.

FreedomBlue Makes It Easy For Your Patients

FreedomBlue offers members exceptional freedom of choice, value and comprehensive benefits with an emphasis on preventive care. With FreedomBlue, members:

- Are covered for all of the benefits of Original Medicare, plus a wide range of additional benefits, such as preventive care, routine vision and hearing care and Part D prescription drug coverage
- Can receive benefits in or out of network (out of network benefits are paid at a lower level)
- Have access to a wide range of health and wellness programs, including Blues On Call care decision support, the nationally acclaimed SilverSneakers Fitness Program and the Dr. Dean Ornish Program for Reversing Heart Disease

FreedomBlue Makes It Easy For You

FreedomBlue providers benefit from:

- A dependable revenue stream with timely and accurate fee-for-service payments
- Administrative ease as FreedomBlue does not require referrals
- Exceptional provider support with online medical policy and medical management through NaviNet, as well as other online provider resources

For more information contact your Mountain State Blue Cross Blue Shield Provider Relations Representative at 1-800-798-7768.

IMPORTANT NOTICE:

Mountain State Blue Cross Blue Shield Blues On Call Satisfaction Survey

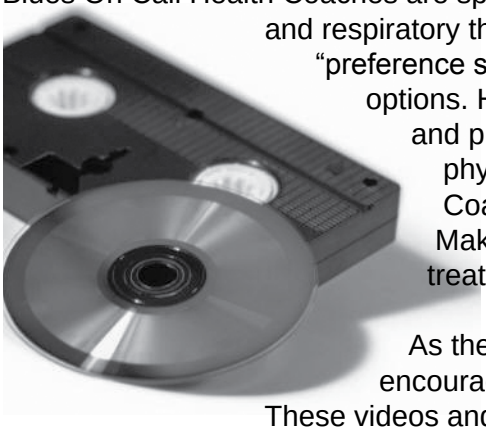
Coming soon, the Mountain State Blue Cross Blue Shield's Blues On Call Provider Satisfation Survey!
Let your voice be heard.
Your opinion of the program is important to us!
Look for the Blues On Call Provider Satisfaction Survey in the mail in mid-September.
We appreciate your feedback!

BLUES ON CALL℠

Shared Decision-Making® Videos Prime Patients for Informed Discussions

As medicine evolves and becomes more nuanced, physicians are increasingly faced with patients whose conditions can be reasonably treated in more than one way. This phenomenon has the advantage of offering patients choices, but it also means that physicians have to spend more time explaining treatment options and outlining their potential risks and benefits. Blues On Call℠ is working to make that process easier by offering patients Shared Decision-Making® videos and round-the-clock telephonic access to Health Coaches.

Blues On Call Health Coaches are specially trained healthcare professionals such as nurses, dietitians and respiratory therapists. They provide your patients with information about their "preference sensitive" conditions and present unbiased views of treatment options. Health Coaches help patients identify and consider personal values and preferences and encourage patients to work closely with their physicians in making treatment choices. When appropriate, Health Coaches can also send patients printed materials and Shared Decision-Making® videos that provide engaging, unbiased information about treatment and screening options.



As the name implies, Shared Decision-Making® videos are designed to encourage patient participation in the medical decision-making process. These videos and accompanying booklets provide patients with the knowledge they need to begin a productive discussion with their physicians. The information presented is evidence-based and independently vetted by the Foundation for Informed Medical Decision Making, a non-profit organization dedicated to improving the quality of medical decisions.

A good example is the Shared Decision-Making® video *Treatment Choices for Uterine Fibroids*. This video and the booklet that comes with it describe the various treatment options for fibroids, including:

- "Watchful waiting;"
- Medical management of fibroid symptoms with NSAIDs, oral contraceptives, and medicated IUDs;
- Nonsurgical interventions, such as uterine artery embolization and focused ultrasound ablation;
- Myomectomy; and
- Hysterectomy.

After explaining each treatment option, the program lists the probabilities of different potential treatment outcomes. The section on myomectomy, for instance, tells women that the procedure relieves symptoms in about 80% of cases and usually preserves fertility, but that fibroids reappear in 1 in 4 women.

With this information in hand and the support of a Health Coach, it is easier for women to discuss with their doctors how they feel about the alternative treatments based on their values and lifestyles. Ultimately, this approach often results in a more informed decision and greater patient satisfaction.

The library of more than 20 Shared Decision-Making® videos tackles topics ranging from herniated discs to depression. The information presented in those videos is also available in web modules. To find out more about how you can refer patients to Health Coaching, contact the Blues On Call Provider Hotline at 1-888-777-9522.

Mountain State Partners with WholeHealth Networks, Inc. to Offer Affinity Program to Members

Beginning August 10, 2007, Mountain State will launch a new discount program for all members. To help our members "Have a Greater Hand in Their Health," Mountain State Blue Cross Blue Shield has partnered with Healthways WholeHealth Networks, Inc. to offer a new, nationwide Complementary Wellness Discount Program. One of the first components of Mountain State's new "MemberPerks Program," the Complementary Wellness Discount Program now gives our members access to discounted complementary and alternative medicine services through more than 35,000 practitioners and facilities nationwide, with discounts of up to 30% on products and services, including:

- Chiropractic care
- Acupuncture
- Yoga, Pilates and tai chi classes
- Massage therapy
- Nutrition counseling
- Personal trainers
- Herbal consultations
- Vitamins
- Health magazines
- Fitness centers*

WholeHealth Networks is the leading national network of over 35,000 Complementary and Alternative Medicine (CAM) practitioners. WholeHealth works with employers, health plans and associations covering 90 million lives nationwide. Their mission is to help practitioners and clients prosper in the healthcare marketplace by making alternative health and wellness practitioners available to members.

Providers interested in participating in the discount-case CAM program should call WholeHealth at 1-800-274-7526 to request an application. Providers will need to extend a discount of at least 10%.

Benefits of Participation:

- As a participating practitioner you will have the unique opportunity to reach over 90 million patients through WholeHealth's client relationships with health plans, employers, universities, associations and government agencies, who direct their cash patients to our practitioner network.
- Your practice is marketed as part of an exclusive practitioner network through member practitioner directories, websites, call centers and consumer education materials.
- WholeHealth educates health care consumers and conventional physicians about the use and benefits of complementary medicine, increasing the base of potential new patients.
- Participating CAM practitioners consult with and refer to each other, thereby bringing new opportunities to strengthen partnerships with other practitioners.

Types of Providers included in the CAM program:

- Acupuncturist
- Chiropractic Physician
- Ayurvedic
- Chinese Herbal Medicine
- Dietician, Registered (RD)
- Herbal Consultant
- Homeopath
- Nutritional Counselor
- Occupational Therapist
- Personal Trainer/Exercise Specialist
- Physical Therapist
- Pilates Instructor
- Qi Gong Instructor
- Tai Chi Instructor
- Yoga Instructor
- Holistic Nurse
- Holistic or Integrative
- Naturopathic Physician
- Pain Practitioner
- Alexander Technique
- Energy Healing Practitioner
- Feldenkrais
- Hellerwork
- Massage Therapist
- Clinical Massage Therapist
- Naprapathy, DN
- Oriental Bodywork
- Reflexologist
- Rolfing & Structural Integration
- Tragerwork
- Behavioral Health
- Guided Imagery/Hynotherapy
- Hypnotist (non-clinical)
- Music Therapy
- Mindfullness-Based Stress Reduction Teacher
- Mind-Body Skills Instructor
- Fitness Centers & Athletic Clubs
- Doula Practitioner
- Childbirth Educator

MEDICAL POLICY UPDATES

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

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

Recent updates or changes are as follows:

Medical Policy Bulletin L-82 (Cytochrome p450 Genotyping)
Genotyping for cytochrome p450 polymorphism considered experimental
Effective: May 14, 2007

Mountain State Blue Cross Blue Shield considers genotyping to determine cytochrome p450 (CYP450) genetic polymorphisms, for example, the AmpliChip microarray test, for aiding in the choice of drug or dose to increase effectiveness and/or avoid toxicity experimental or investigational. A participating, preferred, or network provider may bill the member for the denied test.

The clinical value of this type of genetic testing has not been established. Prospective studies are needed to assess the benefits and potential risks of this technology in guiding drug selection and dose adjustment.

Use procedure codes 88384-88386—array-based evaluation of multiple molecular probes, 11 through 500 probes, or codes 83890-83914 when less than 11 probes are evaluated—to report this testing.

Recent advances in molecular biology have improved the understanding of genetic factors underlying many adverse drug reactions that are responsible for many debilitating side effects and are a major cause of death following drug therapy. A significant proportion of adverse drug reactions are caused by genetic polymorphism and genetically based inter-individual differences in drug absorption, disposition, excretion or metabolism.

MA Also applicable to FreedomBlue.

Medical Policy Bulletin Z-27 (Eligible Providers and Supervision Guidelines)
Supervision guidelines explained
Effective: June 4, 2007

Mountain State Blue Cross Blue Shield pays for covered services only when they are personally performed by an eligible professional provider or under that provider's direct personal supervision in accordance with the following licensure and employment criteria:

Eligible professional providers are those providers defined as duly licensed, and acting within their scope of license. They include:

- Audiologists
- Certified registered nurses
  - Certified registered nurse anesthetists
  - Certified registered nurse practitioners
  - Certified enterostomal therapy nurses
  - Certified community health nurses
  - Certified psychiatric mental health nurses
  - Certified clinical nurse specialists
  - Clinical laboratories
- Dentists
- Doctors of chiropractic
- Doctors of medicine
- Doctors of osteopathy
- Nurse midwives
- Optometrists
- Physical therapists
- Podiatrists
- Psychologists
- Speech pathologists
- Teachers of the hearing impaired

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Mountain State Blue Cross Blue Shield will also reimburse covered services performed by licensed health care practitioners, who are employed and personally supervised by eligible professional providers.

For purposes of this guideline, Mountain State Blue Cross Blue Shield defines "health care practitioner" as a person who is licensed to perform health-related services, but is not eligible for direct reimbursement from Blue Shield. Examples of health care practitioners include a registered nurses (RN), licensed practical nurses (LPN), and physician assistant (PA).

The eligible professional providers listed above are not subject to these employment and/or direct personal supervision requirements. Rather, they are governed by the state licensure regulations applicable to their profession.

"Personal supervision" means that the professional provider must be present in the immediate vicinity, in the event his or her personal assistance is required for the procedure or to assume care of the patient.

For its supervision guidelines, Mountain State Blue Cross Blue Shield defines "immediate vicinity" as within the same office or suite of offices, so that the professional provider can respond promptly to a request for assistance. Availability of the supervising professional provider by telephone does not constitute direct personal supervision.

There may be exceptions to these guidelines depending on the individual member's contract, and provider network rules.

MA Does not apply to FreedomBlue.

Medical Policy Bulletin M-47 (Automated Visual Field Examinations)
How to report automated visual field examinations
Effective: April 9, 2007

Report automated visual field examinations with the appropriate code:

92081—visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, autoplot, arc perimeter, or single stimulus level automated test, such as octopus 3 or 7 equivalent)

92082—visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on goldmann perimeter, or semiquantitative, automated suprathreshold screening program, humphrey suprathreshold automatic diagnostic test, octopus program 33)

92083—visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, octopus program g-1, 32 or 42, humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2

Mountain State Blue Cross Blue Shield considers all services for automated visual field examinations (92081–92083) bilateral. Mountain State Blue Cross Blue Shield will not make separate payment for each eye.

Select the appropriate code, 92081–92083, to report "untaped" automated visual field examinations.

Use procedure code 92499—unlisted ophthalmological service or procedure—to report a "taped" automated visual field examination. When you report code 92499, please include a complete description of the service performed in the narrative section of the electronic or paper claim.

MA Also applicable to FreedomBlue.

Medical Policy Bulletin S-93 (Percutaneious {Transluminal} Balloon Valvuloplasty)
Percutaneous aortic balloon valvuloplasty eligible for specific indications
Effective: July 23, 2007

Mountain State Blue Cross Blue Shield recognizes percutaneous balloon valvuloplasty of the aortic

Continued On Next Page

valve (92986) as an eligible surgical procedure for:

- congenital aortic stenosis (746.3) (most commonly performed on neonates, infants, children, and young adults)
- patients with calcified valves (424.1)
- adults who are poor candidates for aortic valve replacement surgery

If percutaneous balloon valvuloplasty is performed for any other condition, Mountain State Blue Cross Blue Shield considers it not medically necessary. A participating, preferred, or, network provider may not bill the member for the denied procedure.

MA Also applicable to FreedomBlue. FreedomBlue also considers percutaneous aortic balloon valvuloplasty eligible for patients with severe aortic stenosis with cardiogenic shock, for whom the procedure acts as a "bridge" to surgery.

Medical Policy Bulletin S-192 (Ultrafiltration in Decompensated Heart Failure {Aquapheresis})
Blue Shield determines ultrafiltration to treat decompensated heart failure to be investigational
Effective: February 26, 2007

Mountain State Blue Cross Blue Shield considers the use of ultrafiltration, also known as aquapheresis therapy, to treat patients with heart failure experimental or investigational. A participating, preferred, or network provider can bill the member for the denied service.

To report ultrafiltration in decompensated heart failure, use procedure code 37799—unlisted procedure, vascular surgery—and enter the words "ultrafiltration in decompensated heart failure" in the narrative field of the electronic or paper claim.

Fluid overload is a common medical problem that can occur from a variety of causes, including renal failure, post-surgical fluid overload, metabolic disease, and congestive heart failure. Patients with heart failure represent the largest group of fluid-overloaded patients. Heart failure is the progressive inability of the heart to pump enough blood to support the vital organs and often leads to a buildup of fluid, causing swollen legs and arms, fatigue, and eventually excess fluid in the lungs and severe life-threatening shortness of breath. To date, intravenous diuretics have been the standard treatment for fluid overload.

Ultrafiltration is a process to remove fluid (excess salt and water) from the blood by using pressure differentials during treatment with a dialysis machine or smaller filtration device.

Ultrafiltration is generally used for those with decompensated heart failure whose fluid overload is unresponsive to medical management.

MA Also applicable to FreedomBlue.

Medical Policy Bulletin X-24 (Bone Mineral Density Studies)
Mountain State Blue Cross Blue Shield allows more indications for bone mineral density studies
Effective: April 9, 2007

Mountain State Blue Cross Blue Shield will now pay for bone mineral density studies when they're performed for post ablative ovarian failure (256.2) and for breast cancer patients who are on aromatase inhibitors. There is no specific diagnosis code for breast cancer patients who are on aromatase inhibitors.

MA Does not apply to FreedomBlue.

Medical Policy Bulletin V-44 (Medical Nutrition Management Services {MNT})
Medical nutrition therapy coverage guidelines explained
Effective: September 10, 2007

Mountain State Blue Cross Blue Shield covers medical nutrition therapy (MNT) for patients with the conditions listed in the following chart. (The chart includes those diagnoses or conditions that most commonly benefit from MNT in improving desired health outcomes. This is not an all-inclusive list.)

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042
Human immunodeficiency virus (HIV) disease

250.00-250.93
Diabetes mellitus

260, 261, 262, 263.0-263.9, 264.0-264.9, 265.0-265.2, 266.0-266.9, 267, 268.0-268.9, 269.0-269.9
Nutritional deficiencies

270.0-270.9
Disorders of amino-acid transport and metabolism

272.0-272.9
Disorders of lipid metabolism

275.0-275.3, 275.40-275.49, 275.8, 275.9
Disorders of mineral and calcium metabolism

276.1
Hyponatremia

276.7
Hyperpotassemia

276.8
Hypopotassemia

277.00-277.09
Cystic fibrosis

277.81-277.89, 277.9
Other specified disorders of metabolism

278.01
Morbid obesity

307.1, 307.50-307.59
Anorexia nervosa and eating disorders

345.00-345.91, 780.39
Epilepsy and other convulsive disorder

401.0-401.9, 402.00-402.91, 403.00-403.91, 404.00-404.93, 405.00-405.99
Hypertensive disease

410.00-410.92, 411.0-411.1, 411.81-411.89, 412, 413.0-413.9, 414.00-414.07, 414.10-414.19, 414.8, 414.9
Ischemic heart disease

416.0-416.9
Chronic pulmonary heart disease

425.0-425.9
Cardiomyopathy

428.0-428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9
Heart failure

429.0
Myocarditis

429.1
Myocardial degeneration

429.2
Cardiovascular disease

429.3
Cardiomegaly

531.00-531.91, 532.00-532.91, 533.00-533.91, 534.00-534.91, 535.00-535.61
Gastric ulcer, duodenal ulcer, peptic ulcer, gastrojejunal ulcer, gastritis, and duodenitis

536.0-536.3, 536.40-536.49, 536.8, 536.9, 537.0-537.6, 537.81-537.89, 537.9
Disorders of function of stomach and gastrostomy complications, and other disorders of stomach and duodenum

555.0-560.2, 560.30-560.39, 560.81-560.89, 560.9, 562.00-562.03, 562.10-562.13, 564.00-564.09, 564.1-564.7, 564.81-564.89. 564.9
Regional enteritis, ulcerative colitis, vascular insufficiency of intestine, other and unspecified noninfectious gastroenteritis and colitis, intestinal obstruction, diverticula of intestine, and functional digestive disorders

569.60-569.69, 569.81-569.89, 569.9
Colostomy and enterostomy complications, and other specified disorders of the intestines

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570, 571.0-571.3, 571.40-571.49, 571.5-571.9, 572.0-572.8, 573.0-573.9, 574.00-574.91, 575.10-575.12, 575.2-575.9, 576.0, 576.9, 577.0-577.9, 578.0-578.9, 579.0-579.9
Liver diseases, cirrhosis, and other diseases of the digestive system

580.0-580.4, 580.81-580.89, 580.9, 581.0-580.3, 581.81-581.89, 581.9, 582.0-582.4, 582.81-582.89, 582.9, 583.0-583.7, 583.81-583.89, 583.9, 584.5-585.9, 586, 587, 588.0, 588.1, 588.81-588.89, 589.0-589.9, 590.00-590.01, 590.10-590.11, 590.2-590.3, 590.80-590.81, 590.9, 591, 592.0-593.6, 593.70-593.89, 593.9, 594.0-594.9, 595.0-595.4, 595.81-595.89, 595.9, 596.0-596.4, 596.51-596.59, 596.6-597.0, 597.80-597.89, 598.00-598.01, 598.1-599.5, 599.60-599.69, 599.7, 599.81-599.84, 599.9
Glomerulonephritis, nephrotic syndrome, nephritis, renal failure, infections of kidney, calculus of kidney and ureter, and disorder of bladder

642.00-642.94
Hypertension complicating pregnancy, childbirth, and the puerperium

648.80-648.84
Gestational diabetes

733.00-733.09
Osteoporosis

751.0-751.5, 751.60-751.69, 751.7-751.9
Congenital anomalies of the digestive system

753.0, 753.10-753.29, 753.3
Congenital anomalies of kidney

783.0-783.1, 783.21-783.22, 783.3, 783.40-783.43
Symptoms concerning nutrition, metabolism, and development

Mountain State Blue Cross Blue Shield may deny claims for MNT for other diagnoses or conditions as not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied service. If denied MNT claims are appealed, Mountain State Blue Cross Blue Shield will give them individual consideration.

When reported separately, Mountain State Blue Cross Blue Shield will combine charges for medical nutrition therapy and process the services under the appropriate medical visit procedure codes. If MNT is the only service performed, Mountain State Blue Cross Blue Shield will pay for it in accordance with the member's medical care benefits.

Here are the procedure codes you can use 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

MNT is an important part of the prevention and treatment of many diseases and conditions. MNT is the assessment of the patient's nutritional status followed by therapy. The overall goal of MNT is to assist the patient in making changes in his or her nutrition and exercise habits leading to improved health through optimal nutrition. MNT may be performed as an outpatient service in a professional provider's office, in an outpatient facility, or in the patient's home.

MA Does not apply to FreedomBlue.

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Medical Policy Bulletin Z-1 (Ultraviolet Light Therapies)
PUVA Eligible for Severe Urticaria Pigmentosa
Effective: June 11, 2007

Mountain State Blue Cross Blue Shield will now pay for psoralens and ultraviolet light therapy (PUVA) when it is used to treat patients with severe urticaria pigmentosa (cutaneous mastocytosis) when all other forms of treatment have failed.

Report ICD-9-CM diagnosis code 757.33 for urticaria pigmentosa.

Mountain State Blue Cross Blue Shield determines coverage for PUVA according to the individual or group customer benefits.

MA Does not apply to FreedomBlue.

Screening Services
Report appropriate procedure and diagnosis codes when providing screening services .

When you provide screening services, please remember to report the appropriate screening procedure code, as well as a screening ICD-9-CM diagnosis code on the claim.

If you do not report screening procedures with the appropriate procedure and diagnosis codes, Mountain State Blue Cross Blue Shield may deny these claims.

Mountain State Blue Cross Blue Shield's coverage for certain procedures depends on whether the service performed is a screening procedure or a medically necessary diagnostic procedure. Often, a screening test is ordered and performed, but the claim is submitted with a procedure code that is indicative of a medically necessary procedure.

Common screening procedure codes include, 99381-99387 (initial comprehensive preventive medicine evaluation and management), 99391-99397 (periodic comprehensive preventive medicine re-evaluation and management), and 99401-994120 (preventive medicine counseling and/or risk factor reduction interventions). Here are more examples of frequent screening procedure codes and their corresponding terminology:

G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination

G0102 Prostate cancer screening; digital rectal examination

G0103 Prostate cancer screening; prostate specific antigen test (PSA)

G0104 Colorectal cancer screening; flexible sigmoidoscopy

G0105 Colorectal cancer screening; colonoscopy on individual at high risk

G0106 Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema

G0120 Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema

G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

G0122 Colorectal cancer screening; barium enema

G0123 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision

G0124 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician

G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician

G0143 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision

Continued On Next Page

G0144 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision

G0145 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision

G0147 Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision

G0148 Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening

G0202 Screening mammography, producing direct digital image, bilateral, all views

G0328 Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations

G0366 Electrocardiogram, routine ECG with 12 leads, performed as a component of the initial preventive examination with interpretation and report

G0389 Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening

P3000 Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under the physician supervision

P3001 Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by the physician

S0601 Screening proctoscopy

S0605 Digital rectal examination, annual

S0610 Annual gynecological examination, new patient

S0612 Annual gynecological examination, established patient

S0613 Annual gynecological examination; clinical breast examination without pelvic examination

S3645 HIV-1 antibody testing of oral mucosal transudate

0066T Computed tomographic (CT) colonography (ie, virtual colonoscopy); screening

77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)

77057 Screening mammography, bilateral (2-view film study of each breast)

82270 Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)

MA Does not apply to FreedomBlue.

Medical Policy Bulletin I-7 (Erythropoietin {EPO, Epoetin, Epoetin Alfa, Darbepoetin Alfa [Aranesp]})
Mountain State Blue Cross Blue Shield changes coverage guidelines for Erythropoiesis stimulating agents
Effective: July 9, 2007

Mountain State Blue Cross Blue Shield is changing its coverage guidelines for the erythropoiesis-stimulating agents (ESA) Epoetin Alfa [Epogen®, Procrit®] and Darbepoetin Alfa [Aranesp®] on July 9, 2007. Mountain State Blue Cross Blue Shield is making these changes because of the U.S. Food and Drug Administration's (FDA) warnings about certain dangerous side effects of ESAs.

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In March 2007, the FDA issued a public health advisory outlining new safety information, including revised product labeling about ESAs.

In response to the FDA ESA alerts and labeling changes, Mountain State Blue Cross Blue Shield has updated its Medical Policy Bulletin I-7, Erythropoiesis stimulating agents (Epoetin Alfa [Epogen®, Procrit®], Darbepoetin Alfa [Aranesp®], to comply with the changes.

New ESA coverage guidelines

Mountain State Blue Cross Blue Shield will determine coverage for ESAs according to the individual or group customer benefits.
Mountain State Blue Cross Blue Shield may consider ESAs reasonable and necessary for the treatment of anemia when reversible causes of anemia are identified and managed. ESAs may be initiated when the patient's hematocrit (HCT) is less than 36 percent or when their hemoglobin (Hgb) is less than 12g/dL, and when their anemia is associated with any of these conditions:

- End stage renal disease (ESRD) (585.6) on dialysis, or chronic kidney disease (CKD) Stage V on dialysis.

  If an ESA is administered on the same day as dialysis, Mountain State Blue Cross Blue Shield considers it an integral part of the dialysis. The ESA is not eligible as a separate service.

  If the ESA is reported on the same day as dialysis and the charges are itemized, Mountain State Blue Cross Blue Shield will combine the charges and will pay for only the dialysis. In this instance, Mountain State Blue Cross Blue Shield's payment for dialysis performed on the same date of service includes the allowance for the ESA. A participating, preferred, or network provider may not bill the member separately for the ESA.

  If the erythropoiesis stimulating agent is given independently, report it with code J0882, J0886, or Q4081(see "How to report an ESA" on Page 24 for each code's terminology).

  When the ESA is not a benefit, that is, when it is contractually excluded, it is not covered. A participating, preferred, or network provider can bill the member for the denied ESA.

- Chronic renal failure not on dialysis, or CKD Stage II-V not on dialysis (585.1, 585.2, 585.3, 585.4, 585.5, 585.9)

- Renal tubular damage secondary to cisplatin chemotherapy

- Treatment of anemia associated with documented multiple myeloma. (The patient may or may not be receiving chemotherapy.)

- Antineoplastic therapy. (The patient should be receiving a course of antineoplastic therapy or should have received antineoplastic therapy within the last three months.)

- Acquired Immunodeficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) receiving Zidovudine (AZT) therapy. ***(All of these patient indications should apply):***
  - AZT doses of 4200 mg or less per week
  - Endogenous levels of erythropoietin of 500 MU/ml or less
  - Treatment lasting no longer than three months following the discontinuation of AZT

- Myelodysplastic syndrome (Endogenous erythropoietin level should be less than 500 MU/ml.)

- Anemia of prematurity

- Anemia associated with chronic illness. (Anemia of chronic illness is a secondary manifestation of an underlying disorder. Because anemia of chronic disease is typically not severe, Epoetin alfa administration may not be the appropriate treatment of choice.)

- Preoperative use ***(All of these patient indications must apply):***
  - Patient is undergoing noncardiac or nonvascular surgery.
  - Patient is not a candidate for autologous blood transfusion.
  - Patient is expected to lose more than two units of blood during surgery.
  - Preoperative workup has revealed that anemia is related to chronic disease.
  - Antithrombotic prophylaxis should be strongly considered for concurrent use.

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If an ESA is used for any other indication, Mountain State Blue Cross Blue Shield considers it not medically necessary; therefore, it is not covered. A participating, preferred, or network provider may not bill the member for the denied ESA.

How to report an ESA

Here are the ESA procedure codes and their corresponding terminology for your reporting purposes:

- J0881—Darbepoetin alfa, 1 microgram (non-ESRD use)
- J0882— Darbepoetin alfa, 1 microgram (for ESRD on dialysis)
- J0885— Epoetin alfa, (for non-ESRD use), 1000 units
- J0886— Epoetin alfa, 1000 units (for ESRD on dialysis)
- Q4081—Epoetin alfa, 100 units (for ESRD on dialysis)

MA Does not apply to FreedomBlue

Medical Policy Bulletin I-42 (Zoledronic Acid {Zometa})
Zoledronic acid covered for Paget's Disease
Effective: July 1, 2007

Mountain State Blue Cross Blue Shield covers zoledronic acid (Reclast®), a bisphosphonic acid and inhibitor of osteoclastic bone resorption, for the treatment of Paget's disease.

If Reclast is used for any other diagnosis, Mountain State Blue Cross Blue Shield will consider it experimental or investigational. In this instance, Mountain State Blue Cross Blue Shield will deny the drug as not covered. A participating, preferred, or network provider can bill the member for the denied injection.

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.

Use code Q4095 to report zoledronic acid (Reclast).

Reclast is FDA-approved for the treatment of Paget's disease of bone (731.0) in men and women. Treatment is indicated in patients with Paget's disease of bone with elevations in serum alkaline phosphatase of two times or higher than the upper limit of the age-specific normal reference range, or those who are symptomatic, or those at risk for complications from their disease, to induce remission (normalization of serum alkaline phosphatase).
A single dose of Reclast injection should not exceed 5 mg. The duration of infusion should be no less than 15 minutes.

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.

The safety and effectiveness of the use of Reclast in pediatric patients have not been established.

MA Does not apply to FreedomBlue.

Medical Policy Bulletin L-28 (Tumor Markers)
ImmunoCyst test covered for monitoring bladder cancer recurrence
Effective: September 10, 2007

Mountain State Blue Cross Blue Shield covers the ImmuoCyt test when it's reported as an adjunct to cytology and cystoscopy to monitor bladder cancer recurrence.

Use procedure code 88346—immunoflourescent study, each antibody, direct method—to report the ImmunoCyt test.

The ImmunoCyt test uses fluorescence immunohistochemistry using antibodies to mucin glycoprotein and a carcinoembryonic antigen. These antigens are found on bladder tumor cells. This test is intended to increase the sensitivity of cytology for the detection of tumor cells in the urine of individuals previously diagnosed with bladder cancer. It is indicated for use in conjunction with cytoscopy as an aid in the management of bladder cancer.

MA Also applicable to FreedomBlue.

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Medical Policy Bulletin M-51 (Nerve Conduction Velocity {NCV} Studies)
Non-invasive electrodiagnostic testing considered investigational
Effective: July 1, 2007

Mountain State Blue Cross Blue Shield considers non-invasive electrodiagnostic testing with an automated computerized hand-held device, for example, NC-Stat, experimental or investigational. It is not eligible for coverage. A participating, preferred, or network provider can bill the member for the service.

To report this type of testing, use procedure code S3905.

Automated non-invasive nerve conduction testing has been developed to stimulate and measure neuromuscular signals that are useful in diagnosing and evaluating conditions involving nerve entrapment.

MA Does not apply to FreedomBlue.

Medical Policy Bulletin M-13 (Neurophysiological Studies)
Magnetoencephalography and magnetic source imaging now eligible
Effective: July 1, 2007

Mountain State Blue Cross Blue Shield will pay for magnetoencephalography (MEG) or magnetic source imaging (MSI) when they're used in the presurgical evaluation of certain patients with medically refractory epilepsy. This includes:

- non-lesional superficial cortical epilepsy
- lesional epilepsy within or adjacent to the eloquent cortex
- epilepsy associated with large structural lesions
- ongoing or recurrent seizure activity following previous resections for epilepsy
- cases where the seizure focus has not been detected or well localized by traditional methods.

If MEG or MSI are used for any other indications, Mountain State Blue Cross Blue Shield considers them experimental or investigational. They are not covered. A participating, preferred, or network provider can bill the member for the denied service.

You may report MEG with code 95965, 95966, or 95967. Use code S8035 to report MSI.

MEG measures neurological activity of the brain using magnetic fields. This information can be superimposed on an anatomic image of the brain, typically an MRI, to produce a functional or anatomic image of the brain, referred to as magnetic source imaging. MEG and MSI have been found to be useful in anatomical localization of areas of seizure focus and epileptogenic lesions in the brain.

MA Does not apply to FreedomBlue.

Medical Policy Bulletin S-54 (Implantation of Subcutaneous Intravascular Catheter)
Clarification addressing when to report code 96523

Use code 96523 to report irrigation of implanted venous access devices for drug delivery systems when the irrigation is provided on a different day from the injection or infusion service.

Mountain State Blue Cross Blue Shield pays for subcutaneous catheter maintenance as a distinct and separate service on a day in which drug delivery through the implanted access device is not provided. Do not report procedure code 96523 if an injection or infusion through the port is provided on the same day.

MA Also applicable to FreedomBlue.

Medical Policy Bulletin Z-8 (Sleep Disorder Services)
Polysomnograms performed on portable equipment not covered
Effective: September 10, 2007

Mountain State Blue Cross Blue Shield considers polysomnograms performed on portable equipment in any place of service experimental or investigational. This includes polysomnograms attended by a technologist, as well as unattended

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studies. A participating, preferred, or network provider may bill the member for the denied study.

Mountain State Blue Cross Blue Shield does not cover portable polysomnograms because there is no evidence that the portable equipment has advanced to the point where the accuracy and quality of data equal a polysomnogram performed on standard equipment.

Use procedure code 94799—unlisted pulmonary service or procedure—to report portable polysomnograms. When you report code 94799, please include this description in the narrative section of the electronic or paper claim: "portable polysomnography."

MA Does not apply to FreedomBlue.

Medical Policy Bulletin R-8 (Non-Malignant Applications of Positron Emission Tomography {PET}) and R-9 (Oncologic Applications of PET Scanning)
Mountain State Blue Cross Blue Shield to stop covering PET and PET/CT scans performed on coincidence detection systems
Effective: September July 10, 2007

Beginning Sept. 10, 2007, Mountain State Blue Cross Blue Shield will no longer cover PET scans or PET/CT fusion studies when they're performed on coincidence detection systems (procedure code S8085). This equipment does not provide images that meet the accepted standard of quality that is achieved when these tests are performed on a dedicated PET or PET/CT scanner.

Mountain State will deny claims for PET or PET/CT scans performed on coincidence detection systems. A participating, preferred, or network provider may not bill the member for the denied service.

A coincidence detection imaging system uses a modified SPECT gamma camera that has been adapted to produce PET-like images. PET scans performed using a modified gamma camera or coincidence detection imaging system should be reported using procedure code S8085—FDG imaging using dual-head coincidence detection system (non-dedicated PET scan).

MA Does not apply to FreedomBlue.

New Code Announcements
These new procedure codes and modifiers became available for your reporting purposes on July 1, 2007.

Code	Terminology
S9152	Speech therapy, re-evaluation
Q4087	Injection, immune globulin, (Octogam), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4088	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4089	Injection, RHO (d) immune globulin (human), (RHOphylac), intravenous, 100 iu
Q4090	Injection, Hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 ml
Q4091	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4092	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4093	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)
Q4094	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)
Q4095	Injection, Zoledronic acid (Reclast), 1 mg

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Modifier	Terminology
KG	DMEPOS item subject to DMEPOS Competitive Bidding Program Number 1
KK	DMEPOS item subject to DMEPOS Competitive Bidding Program Number 2
KL	DMEPOS item delivered via mail
KT	Beneficiary resides in a competitive bidding area and travels to a non-competitive area and receives item from a non-contract supplier
KU	DMEPOS item subject to DMEPOS Competitive Bidding Program Number 3

Mountain State Blue Cross Blue Shield does not cover high dose rate electronic brachytherapy. This brachytherapy service is considered experimental or investigational.

Effective July 1, 2007 the code is 0182T (high dose rate electronic brachytherapy, per fraction). A participating, preferred, or network provider may bill the member for the denied service.

Mountain State Blue Cross Blue Shield considers corneal hysteresis determination experimental or investigational. Mountain State will deny claims reporting this service. A participating, preferred, or network provider can bill the member for the denied service. Use code 0181T—corneal hysteresis determination, by air impulse, bilateral, with interpretation and report—to report this procedure.

Mountain State Blue Cross Blue Shield considers the 64 lead or greater electrocardiogram experimental or investigational. Mountain State will deny claims reporting this service. A participating, preferred, or network provider can bill the member for the denied service. Use these procedure codes to report this service:

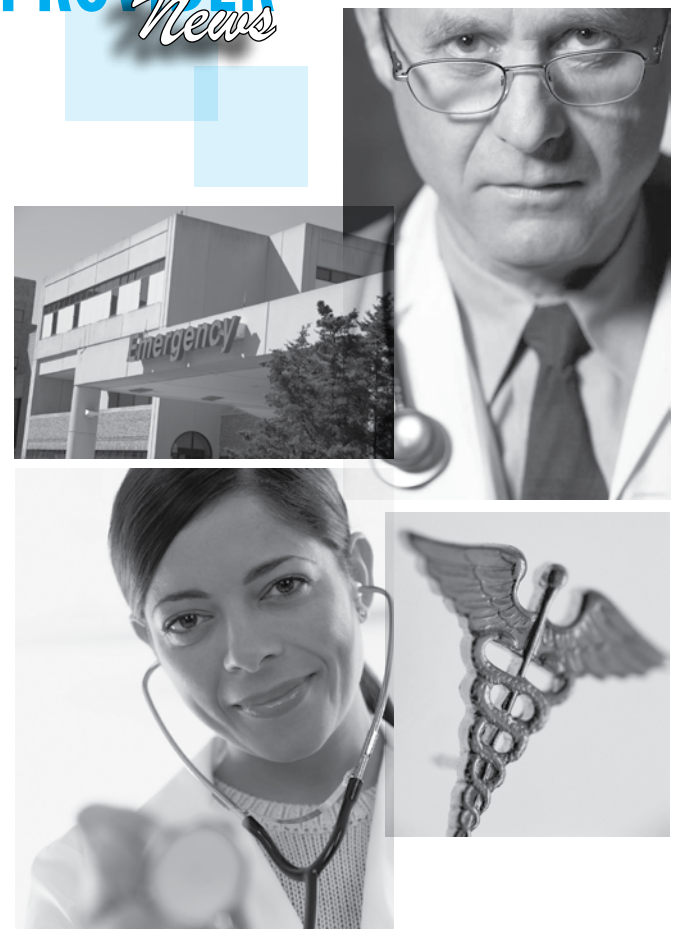
0178T—electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report
0179T—electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report
0180T—electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only

MA Also applicable to FreedomBlue.

Deleted Code Announcements
Mountain State Blue Cross Blue Shield has deleted code G8300—clinician documented that patient was not an eligible candidate for optic nerve head evaluation during the reporting year—on July 1, 2007. There is no replacement code for G8300.

Here are two codes that will be deleted on July 1, 2007. A replacement code is included for code 0024T.

Code	Terminology	Replacement code
0024T	Non-surgical septal reduction therapy (eg, alcohol ablation), for hypertrophic obstructive cardiomyopathy, with coronary arteriograms, with or without temporary pacemaker	93799
0133T	Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with injection of implant material into and along the muscle of the lower esophageal sphincter (eg, for treatment of gastroesophageal reflux disease)	No replacement code
S2078	Laparoscopic supracervical hysterectomy (subtotal hysterectomy), with or without removal of tubes(s), with or without removal of ovary(s)	58541, 58542, 58543, 58544



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