MOUNTAIN STATE Blue Cross Blue Shield
A HIGHMARK AFFILIATE

PROVIDER News

Highmark and Mountain State Blue Cross Blue Shield offer The SilverSneakers Fitness Program in West Virginia

Highmark Health Insurance Company and Mountain State Blue Cross Blue Shield are offering the award-winning SilverSneakers Fitness Program statewide in West Virginia. SilverSneakers is the nation's leading exercise program designed exclusively for older adults and is available at no cost to members of Highmark Health Insurance Company (HHIC) FreedomBlue Medicare Advantage and Mountain State Blue Cross Blue Shield Medicare Supplemental plans.

SilverSneakers is an innovative program specifically designed for Medicare beneficiaries' unique health and physical needs. Eligible members can receive a basic membership at participating fitness centers (for a current list of fitness centers, please see page 2), where they can enjoy specialized low-impact SilverSneakers fitness classes focusing on improving strength, flexibility, balance and coordination. Certified SilverSneakers fitness instructors teach the classes, and in addition to the classes, participants can also enjoy other fitness center membership amenities, including use of exercise equipment (e.g., treadmills, exercise bikes, etc.), weight training, circuit training and other fitness offerings (e.g., aerobics, social events).

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Meet Dr. Carl Tully- an inspirational West Virginia member of the SilverSneakers Fitness Program. His story on page 3.

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Summer 2008

The SilverSneakers Fitness Program

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Additionally, each fitness center has a specially trained Senior Advisor℠ to assist members in utilizing fitness center resources and classes. A unique reciprocity agreement also allows SilverSneakers members the opportunity to visit any participating fitness centers and class sites across the nation when they travel.

"The long-term health benefits of regular exercise for senior adults are compelling. In addition to helping seniors stay physically healthy, SilverSneakers also offers a great way for them to socialize, meet new friends and have fun," stated Mary Swanson, who founded the popular group exercise program nearly 15 years ago.

"We could not be more pleased that Medicare beneficiaries who are either members of HHIC's FreedomBlue Medicare Advantage plans or one of our Medicare Supplemental plans will now have the opportunity to participate in the SilverSneakers Program free of charge. We are committed to improving the overall health status of all West Virginians, and this program fits in very nicely with a number of other programs and tools we are using," said Gregory K. Smith, Mountain State Blue Cross Blue Shield President and CEO.

SilverSneakers Steps is also offered to Medicare Advantage FreedomBlue and Medicare Supplemental members residing more than fifteen miles away from a participating Fitness Center. "Steps" is a self-directed exercise program incorporating walking and other recreational activities with the goal of increasing members' physical activity levels. Because the program is not limited to one activity, members enjoy flexibility in reaching their fitness and wellness goals.

To enroll in SilverSneakers, members are asked to go to a participating fitness center and show their HHIC FreedomBlue or Mountain State Blue Cross Blue Shield Medicare Supplemental ID card. Fitness center staff will assist with enrollment and provide a tour of the location.

SilverSneakers Fitness Centers in West Virginia

Raleigh Co. YMCA
121 E. Main Street
Beckley, WV 25801
(304) 252-0715

Gold's Gym—Charles Town
64 Somerset Boulevard
Charles Town, WV 25414
(304) 728-4653

Huntington High YMCA
917 9th Street
Huntington, WV 25701
(304) 691-7113

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

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

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

YMCA of Kanawha Valley
300 Hillcrest Drive
Charleston, WV 25311
(304) 340-3527

Family Fitness Center
2804 Birch Street
Parkersburg, WV 26101
(304) 424-2348

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

J.B. Chambers YMCA
55 Lounez Avenue
Wheeling, WV 26003
(304) 242-8086

Nicholas Fitness Center
1104 Broad Street
Summersville, WV 26651
(304) 872-3023

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

Tyler Mountain YMCA
5113 Rocky Fork Road
Cross Lanes, WV 25313
(304) 776-3323

About The SilverSneakers® Fitness Program

The SilverSneakers® Fitness Program is offered by Healthways, an industry leader providing specialized, comprehensive Health and Care Support℠ solutions to help people maintain or improve their health. Founded in 1992, SilverSneakers is the nation's leading exercise program designed exclusively for older adults and offers an innovative blend of physical activity, healthy lifestyle and socially-oriented programming that allows older adults to take greater control of their health. The unique program is available at no additional cost to eligible Medicare members and is currently offered in 49 states at more than 2500 fitness centers and class sites. For more information regarding the SilverSneakers Fitness Program visit www.silversneakers.com or call 1-800-295-4993.

Participant of SilverSneakers Celebrates 95th Birthday!

On June 23, 2008, SilverSneakers participant, Dr. Carl Tully, celebrated his 95th Birthday. During a surprise party held at the Charleston Family YMCA, Mountain State Blue Cross Blue Shield presented Dr. Tully with a special SilverSneakers t-shirt in honor of his birthday and participation in the program.

Dr. Tully attributes his good health and longevity to being a member of the YMCA where he participates in the SilverSneakers Program five or six days a week. Because of his positive results, he recommends the program to everyone.

Born and raised in Charleston, Dr. Tully graduated with a degree in math from Morris Harvey College and was later accepted into the Army Specialized Training Program where he studied to become a doctor.

Early in his career, Dr. Tully practiced medicine at the U. S. Marine Hospital in Baltimore, MD, and served as a physician during the Korean War. He later returned to West Virginia and started his Family Medicine Practice in South Charleston, in which he maintained for forty years.

For ten years, Dr. Tully served as the Medical Director of St. Francis Hospital. He was also a tenured professor at WVU Medical School, where he taught family medicine until he retired from that position at the age of 65.

Dr. Tully has also held other positions within the community including: Chairman of the committee that created Little Creek Park, Chairman of the Recreation Committee, Member of Kanawha County School Board, Chairman of the WV Division of the American Cancer Society and Associate Medical Director for the WV State Compensation Department.

Dr. Tully's advise to those who would like to follow his good example of having a long, productive life is to "stay active". He adds that walking is a good thing to do if you are unable to participate in a more structured program.

Updates Recently Made to the Mountain State Blue Cross Blue Shield Provider Manual

As of July 2008, several updates were made to our Mountain State Blue Cross Blue Shield Provider Manual. To view a complete list of these changes, please access our website at www.msbcbs.com and click on "Provider Manual" under the "Provider" tab. Please reprint and replace any previously printed copies for your records. Below is a summary of the recent changes made in July:

Updates to Provider Manual
July 2008

Chapter 1: General Information

Page	Section	Change
4	1.1.4	Changed the name of provider agreement for consistency with the current agreement title.
20	1.8	Specified that planned material adverse changes affecting professional providers will be communicated 90 days in advance of the change. Also, clarified what changes does not constitute a material adverse change.

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Provider Manual Changes Continued...

Chapter 2: Participation with Mountain State

Page	Section	Change
3	2.1.1.a	Changed the name of provider agreement for consistency with the current agreement title.
4	2.1.1.a	Clarified how to request a copy of the provider agreement.
5	2.1.2	Changed to delineate between paper claim and electronic claim submission. Also, removed effective date of NPI number due to the date being in the past.
6	2.1.3	Changed the name of provider agreement for consistency with the current agreement title.
6-7	2.1.3.a	Updated language on how to correct provider information.

Chapter 3: Credentialing and Recredentialing

Page	Section	Change
7	3.3.4	Added Locum Tenens requirements.
12	3.4.7	Changed MD/DO credentialing to 90 days per Love Settlement; all others remain 120 days.

Chapter 4: Membership and Benefits Information

Page	Section	Change
		No changes.

Chapter 5: Reimbursement

Page	Section	Change
3	5.1.2	Referenced further information regarding vaccines and injectibles for MD/DO in Chapter 13.
11	5.1.5	Identified method in which to request fee schedule for professional providers.
11	5.1.6	Updated access to fee schedule conversion factors.

Chapter 6: Utilization Management

Page	Section	Change
17	6.5.2	Updated definition of Medical Necessity per Love Settlement.
17	6.5.2	Clarified MSBCBS' policy for Medical Necessity determinations.
22	6.6.6	Incorporated material adverse change as noted in Chapter 1, Section 8.
41	6.10.5	Confirmed Medical Necessity application to Behavioral Health services.
41	6.10.6	Confirmed Psychiatrists are included in the Provider Directory.
41	6.10.7	Confirmed mental health emergency services use prudent lay person laws.
42	6.10.8	Referenced means to obtain an authorization form

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Provider Manual Changes Continued...

Chapter 7: Billing and Claims Processing

Page	Section	Change
8	7.3.3	Incorporated material adverse change notification requirements.
9	7.3.4	Inserted new section from Love Settlement regarding required clinical information.
9	7.4	Updated language for NPI.
11	7.5.5	Added requirements for Locum Tenens physicians.
13	7.8	Updated Unclaimed Property Act and procedures.
15	7.11.2	Updated per Love Settlement provisions.
17	7.11.5	Updated per Love Settlement provisions.
18	7.11.7	Updated for Unclaimed Property Act and referenced Chapter 13 for Love Settlement revisions for MD/DO.

Chapter 8: Disease Management

Page	Section	Change
		No changes.

Chapter 9: Third Party Liability and Recoveries

Page	Section	Change
6	9.2	Corrected telephone number for Worker's Compensation cases.
7	9.4	Corrected spelling of "payor."
8	9.4	Corrected telephone number for Third Party Recoveries.

Chapter 10: Audits

Page	Section	Change
4	10.3	Updated E/M Coding audits to reflect current policy.
6	10.6	Updated Audit Appeal levels and referenced to BDERB process in Chapter 13.

Chapter 11: Quality Management

Page	Section	Change
		No changes.

To request a paper copy of these updates, please contact Provider Relations at 1-800-798-7768 or your External Provider Relations Representative.

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Provider Manual Changes Continued...

Chapter 12: Definitions

Page	Section	Change
3	Intro	Changed the name of provider agreement for consistency with the current agreement title.
3	12.1	Changed the name of provider agreement for consistency with the current agreement title.
5		Referenced "Medical Necessity" definition in Chapter 6.
6		Deleted duplicated definitions for "Pre-Admission Certification" and "Precertification," previously defined within the *Provider Manual* (Chapter 6).

Chapter 13: Policies & Procedures for MDs & DOs Only

Page	Section	Change
3	13.1	Overview of section.
3	13.2	Applicability.
3	13.3	Information on how to request reimbursement allowance on CPT codes.
4	13.4	Continuation of Care guidance.
5	13.5	New language for vaccines and injectibles for MD/DO from Love Settlement.
5	13.6	Love Settlement prompt pay language for MD/DO.
6	13.7	Love Settlement overpayment recovery procedures for MD/DO.
7	13.8	Description of Billing Dispute External Review Process (BDERP)
8	13.9	Significant Edit information.

PLEASE REMEMBER:

Service Facility Provider Number Is Required

Please remember that as of January 1, 2008, all professional claims rendered at any of the place of service locations listed below require the service facility provider number to be included on the claims submission.

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

Place of service locations include:
21 - Inpatient Hospital
22 - Outpatient Hospital
23 - Emergency Room - Hospital
31 - Skilled Nursing Facility
32 - Nursing Facility
51 - Inpatient Psychiatric Facility
61 – Comprehensive Inpatient Rehabilitation Facility.

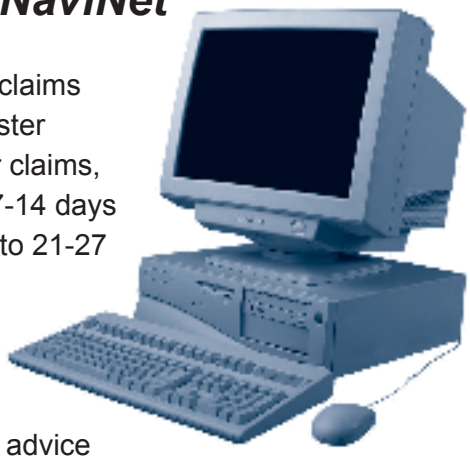
NAVINET UPDATE

1500 Claim Submission Now Available With NaviNet

Mountain State is pleased to announce a new transaction via NaviNet. NaviNet now has a 1500 Claim Submission transaction that will allow professional provider claims to be submitted real-time electronically. The entry screens are easy to use, with helpful search and select options. The 1500 Claim Submission will allow you to know the acceptance of your claim at the time of entry. If errors are identified, you correct them on-line. This feature allows you to submit professional claims to Mountain State Blue Cross Blue Shield in the HIPAA 837P format via NaviNet.

Some of the major benefits of electronic claims submission are:

- You save money on forms and postage.
- You save time. Paper claims can take 2-3 days to reach us through the postal system; once the claim is received, it must be scanned into our system and then hand keyed. Keypunch errors can occur.
- Electronic claims process faster than paper claims, generally 7-14 days compared to 21-27 days.
- You can receive your remittance advice electronically.
- You can have your check electronically deposited into your bank account.



This added transaction will also be a topic of dissusion at our Provider Workshops. If you are interested in getting this 1500 Claim Submission through NaviNet, please contact your external Provider Relations Representative.

ATTENTION PROVIDERS:

When billing FreedomBlue® Medicare Advantage claims electronically, you are required to use the appropriate NAIC codes or your claims will deny.

NAIC Code 71768

West Virginia providers billing for HHIC FreedomBlue members with alpha prefixes HKP, HQM and ZPM are required to use NAIC code 71768. The ZPM alpha prefix should no longer be used for service dates after December 31, 2007. The enrollment source Plan Code on the member's identification card for HHIC FreedomBlue members is 377.

NAIC Code 54828

West Virginia providers billing for Highmark FreedomBlue PFFS members with alpha prefix HKS or FEM should use 54828, since their enrollment source Plan Code is 363 (Highmark). Providers should treat these as any other claim by submitting to Mountain State. West Virginia providers billing for Highmark FreedomBlue PFFS members with alpha prefix HKR or FER should also use 54828, since the enrollment source Plan Code is 378 (Highmark). The enrollment source Plan Code 377 is not applicable for alpha prefix HKS, FER, HKR or FEM and claims will not be accepted if billed under the NAIC code of 71768.

If the enrollment source Plan Code on the member's identification card is 377, the member is an HHIC FreedomBlue member. The West Virginia provider

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ATTENTION PROVIDERS CONTINUED:

should bill Highmark Health Insurance Company (HHIC) with the NAIC code 71768. The alpha prefix for HHIC members are HKP, HQM and ZPM.

If the enrollment source Plan Code on the member's identification card is 363 or 378, the member is a Highmark member. The West Virginia provider should bill Mountain State under NAIC code 54828. The alpha prefix for Highmark FreedomBlue members is HKS or FEM for enrollment source Plan Code 363 and HKR or FER for enrollment source Plan Code 378.

Please refer to the chart below for West Virginia providers to use when billing electronic FreedomBlue claims:

Plan	Alpha Prefix	Plan Code	NAIC Code
Highmark Blue Cross Blue Shield	HKS, FEM	363	54828
Highmark Blue Shield	HKR, FER	378	54828
Highmark Health Insurance Company (HHIC)	HKP, HQM, ZPM	377	71768

Mountain State providers will still continue to send their paper claims to:
Mountain State Blue Cross Blue Shield
P.O. Box 7026
Wheeling, WV 26003-7026.

A new edit to reject electronic claims back to the provider when submitted to the incorrect NAIC code will become effective November 7, 2008, with a claim status code of "116", "CLAIM SUBMITTED TO THE INCORRECT PAYOR". When this denial is received on the 277CA report, please check the member's three digit alpha prefix and submit the claim to the correct NAIC code detailed above.

If you have questions regarding this notice you may contact the EDI Operations of Mountain State Blue Cross Blue Shield at 1-888-222-5950 or 304-424-7728.

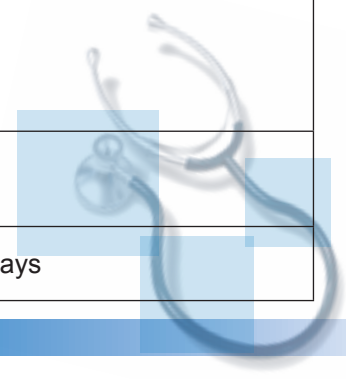
WELCOME To Our New Group:

West Virginia Pipe Trades Health and Welfare Fund
Effective Date: 09-01-08
Number of Employees: 460
Group Location: Wellsburg, WV 26070
Product Type: PPO
Claims Processing Location: Wheeling
Account Representative:
Thomas Alderson

Standards for Accessibility

To stay healthy, members must be able to see their physicians when needed. To support this goal, we are sharing with you Mountain State's Standards for Accessibility for our Commercial and Medicare Advantage products for PCPs, medical specialists and behavioral health specialists. The standards set forth specific timeframes in which practitioners should respond to member needs, based on symptoms.

PCP AND MEDICAL SPECIALIST STANDARDS	
Patient's Need:	Performance Standard:
Emergency/life threatening care (acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in: • serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; • serious impairment to bodily functions; or • serious dysfunction of any bodily organ or part)	Immediate response upon notice or knowledge of the condition. Response could include referring patient to the Emergency Room.
Urgent care appointments (medical condition that requires rapid clinical intervention, • high fever, persistent vomiting/diarrhea)	Office visit within 24 hours
Regular and routine care appointments • Routine care (symptomatic): non-urgent care for symptomatic conditions (e.g. headache, cold, cough, rash, joint/muscle pain, etc.)	Office visit within 7 days
Regular and routine care appointments • Routine wellness appointments (e.g. asymptomatic/preventive well child exams, physical exams, etc.)	Office visit within 30 days
After-hours access • Access to practitioner after the practice's regular business hours.	24 hours a day/seven days a week. Practitioners are encouraged to return calls within 30 minutes, barring extenuating circumstances. This includes covering physicians.
In-office waiting time	Physicians are encouraged to see patients with scheduled appointments within 60 minutes of their scheduled appointment time.
BEHAVIORAL HEALTH SPECIALIST STANDARDS	
Patient's Need:	Performance Standard:
Care for a life-threatening emergency (immediate intervention is required to prevent death or serious harm to patient or others)	Immediate response upon notice or knowledge of the condition. Response could include referring patient to the Emergency Room.
Care for a non-life-threatening emergency (rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety)	Care within 6 hours
Urgent care (timely evaluation is needed to prevent deterioration of the patient's condition)	Office visit within 48 hours
Routine office visit (patient's condition is considered to be stable)	Office visit within 10 business days



Credentialing Criteria
Changes for 2008

Mountain State Blue Cross Blue Shield (Mountain State) endeavors to keep network practitioners and providers informed about network credentialing polices and procedures. Below are some of the changes that have been or will be taking place in 2008. A complete list of credentialing requirements may be obtained by visiting the "Provider Tab" of Mountain State's website, **www.msbcbs.com**.

WV Uniform Credentialing Applications-Mandatory Use

In compliance with WV law, Mountain State requires the submission of the WV state mandated Uniform Credentialing and Recredentialing applications for WV practitioners. The most current versions of the applications are required to be submitted for processing. The most current version of the application can be obtained at www.wvinsurance.gov. Providers who practice in Ohio, Maryland, Virginia, Pennsylvania and Kentucky may now submit the CAQH application.

Initial Credentialing Time Frames for Practitioners-New Requirements

Mountain State's credentialing procedures are designed to facilitate prompt review and decision making regarding a provider's credentialing application. The following mandates listed below will be followed by Mountain State as required.

Beginning in September 2008, in accordance with Love Settlement Agreement, MDs and DOs are required to be initially credentialed and notified of their credentialing status within 90 days of the Plan receiving a complete credentialing application.

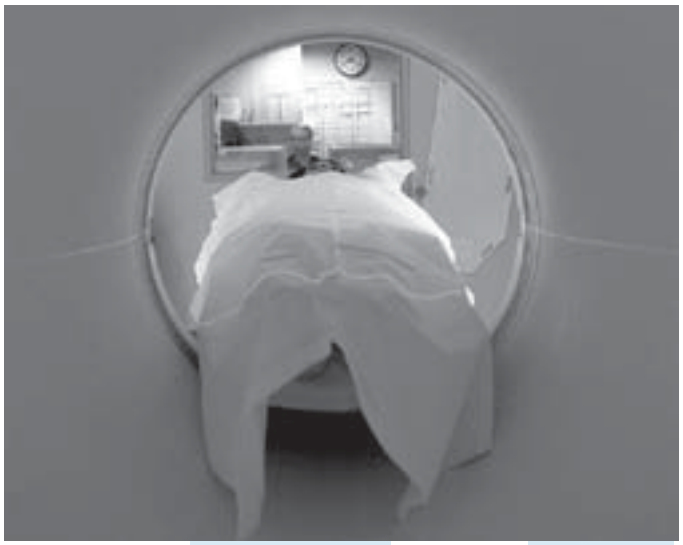
In accordance with the Ohio Healthcare Simplification Act, all practitioners who participate with Mountain State and whose primary site of service is located in Ohio are required to be initially credentialed and notified of their credentialing status within 90 days of the Plan receiving a complete or incomplete credentialing application.

As usual, all other practitioner types will be initially credentialed within 120 days of the submission of a credentialing application, in compliance with West Virginia State Code §30-45-2 (Section 11).

Revision to CT Scan Credentialing Requirements

Mountain State has revised a credentialing element for CT scan providers. Onsite reviews will no longer be required for initial credentialing. State survey and accreditation survey results will now be accepted, in lieu of a Mountain State onsite review.

CT scan providers who are currently contracted with Mountain State have until December 31, 2008, to submit all required credentialing elements to the Office of Network Credentialing. Please call 888-475-2391 (Option 7) with any questions.



Recredentialing Noncompliance-Reminder

Providers who do not return their recredentialing applications/documentation in a timely manner will be issued a voluntary withdraw letter. Providers who submit the necessary information within thirty days of receiving the withdraw letter will be processed as an initial applicant.

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New Abbreviated Credentialing Procedure for Hospital Based Physicians

Hospital based practitioners will no longer be required to undergo full credentialing with Mountain State. Physicians who work full time in an inpatient setting will be given the opportunity to be reviewed under an abbreviated process. Please contact the Office of Provider Relations at 800-798-7768 with any questions. (Refer to article on page 22.)

Emergency Medicine Certification Requirements-Reminder

Medical Doctors and Doctors of Osteopathy who work in an Emergency Room setting **part time** and are not board certified in Emergency Medicine, must submit proof of the following required certifications: (1) Advanced Cardiac Life Support (ACLS) (2) Advanced Trauma Life Support (ATLS) and (3) Pediatric Advanced Life Support (PALS).

Practitioners who are currently contracted with Mountain State have until the end of 2008 to obtain the required certifications. New applicants must have already obtained the required certifications to pass initial credentialing.

Onsite Office Reviews for Network Practitioners-New Procedure

For the HHIC Medicare Advantage network, Mountain State will now conduct abbreviated onsite office reviews for network practitioners. Onsite reviews will now be conducted based on random samples, member complaints and any other issues identified during diagnosis validation reviews. Providers who do not pass the onsite review will be given six months to correct any identified deficiencies. Contact Mountain State's Office of Network Credentialing at 888-475-2391 with any questions.

Sleep Lab/Center Credentialing-New Mountain State Initiative

Mountain State has developed credentialing criteria for providers who offer sleep management services. The criteria applies to those who perform the studies, not to the practitioners who interpret them. The standards will go into effect on September 1, 2008. For sleep management providers who are already participating in Mountain State's commercial network, you will have until August 31, 2009 to meet the credentialing requirements. Providers who apply to participate after September 1, 2008 will be required to meet the credentialing criteria, prior to being contracted.

Credentialing Criteria	WV	OH	KY	VA	PA	MD
State License/ Registration/Certificate of Need (CON)	State CON/ Business Registration	N/A	State Business License	State Business License	State Business License	State Business License
The American Academy of Sleep Medicine (AASM)	Required	Required	Required	Required	Required	Required
Professional Liability Insurance $1/$3 million	Required	Required	Required	Required	Required	Required
Medicare Eligible	Required	Required	Required	Required	Required	Required
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) **FOR HOSPITALS ONLY**	Required	Required	Required	Required	Required	Required

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Credentialing Criteria Continued

Credentialing and Recredentialing of Orthodontists-New Initiative

Mountain State's Office of Network Credentialing has developed credentialing criteria for Orthodontist who provide services related to cleft palate repair.

The requirements are:

1. Active state license in the state in which he/she practices;
2. Completion of a Cleft Craniofacial Orthodontic Fellowship accredited by the Commission on Dental Accreditation(CODA);
3. Professional liability insurance in the amounts of $1.0 million per occurrence and $3.0 aggregate;
4. Ability to provide 24/7 coverage to members;
5. Individually eligible to participate with Medicare for the Medicare Advantage network;
6. Five years of work history for initial credentialing.

Locum Tenen Physicians-Reminder

Mountain State and Highmark credential locum tenen physicians based on the length of time the physician will be providing care in the Plan's network service area. Locum Tenen physicians who will be providing services for at least six months or longer will be required to undergo initial recredentialing and, if applicable, recredentialing, at least every three years. (Please refer to Chapter 3, page 7, Section 3.3.4 of our Provider Manual)

Credentialing and Recredentialing of General Dentists-New Initiative

In conjunction with Highmark, Mountain State's Office of Network Credentialing will soon be credentialing general dentists who create oral appliances for patients with sleep management issues. The requirements will be posted in an upcoming issue of the Provider News and on msbcbs.com under the credentialing section of the provider tab.

Important Reminders & Updates

Change In Fax Number:

Effective August 11, 2008, all providers can fax requests for medical records to our new toll free number: 1-866-251-0740.

Room Rate Updates:

Facility Providers please submit all room rate changes/ updates to the Department of Provider Relations, 700 Market Square, Parkersburg, WV 26101, or fax to 304-424-7713. This information is important in processing your claims timely and accurately.

From BLUES ON CALL℠

Adherence and Persistence Not the Same

Thanks to recent advances in the SMART® Registry, physicians are now getting all sorts of information about their patients that they never got before. Among the new data points are persistence reports, which—though useful—often get misinterpreted.

Persistence measures the continued use of medication over time. It is reported as a percentage of days supplied of a medication divided by the total number of calendar days elapsed. In other words, it tells you how regularly your patient filled his or her prescription.

Patients with prescription fill rates of 80% or more are labeled as persistent. Patients with lower prescription fill rates are labeled as nonpersistent and may be flagged for follow-up. Unfortunately, the measure is not perfect. It may flag patients who turn out to be taking their medication exactly as directed, and it may miss patients who are not. Here's why.

Persistence values tell you only about a patient's tendency to fill prescriptions through traditional channels. They do not tell you whether patients are: receiving free samples of their medication from sources such as the Veteran's Administration; using pill-splitting as a cost-cutting measure; or taking the right dose of medication, at the right time, and while following any special instructions (such as, "take with food," or "take on an empty stomach").

Indeed persistence is not synonymous with adherence (also called compliance). The latter term speaks not only to how much medication a patient takes, but also to how the patient follows the medication's administration guidelines. As a result, patients labeled as persistent may nevertheless be nonadherent and still need medication follow-up. In fact, the converse may also be true.

Persistence reports lay the groundwork for a conversation about overall medication adherence, especially if the numbers indicate that a patient is facing barriers to taking medications as prescribed. Studies show that regular monitoring of medication use improves patient adherence[1]. Plus, improving adherence is one of the most effective and least expensive ways to lower risk factors and reduce adverse outcomes, hospitalizations, and death.

Adherence Support Available to Your Patients

Mountain State Blue Cross Blue Shield Blues on Call℠ offers your patients access to Health Coaches trained in improving medication adherence. To learn more about the role Health Coaches can play in supporting your patients, call a Blues On Call Provider Service Specialist at 1-888-777-9522.

[1] http://archinte.ama-assn.org/cgi/content/abstract/167/6/540?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=adherence&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT

MDMED-ART-HMMTNST-rev2

Mountain State Blue Cross Blue Shield

Contracting & Reimbursement Update...

The following information is a continuation of our communication and update to providers on changes that have or will occur - along with reminders to assist providers with developing and maintaining billing practices to achieve fast and accurate reimbursement.

CPT and HCPCS Codes Required for Hospital Reimbursement

Mountain State Blue Cross Blue Shield now requires the inclusion of CPT and HCPCS procedure codes for all inpatient and outpatient claims effective as of July 15, 2008.

Only HCPCS procedure code(s) that are valid on the date(s) of service are to be reported in the Principal and/or Other Procedure code Fields on outpatient claims. If a HCPCS procedure code is not valid on the date(s) the service(s) was performed, or any ICD-9 procedure code is reported on an outpatient claim in the Principal and/or Other Procedure code Fields, the provider will receive a rejection.

If a rejection is received indicating an incorrect code was reported for the date(s) the procedure(s) was performed, please resubmit the claim using the HCPCS procedure code(s) that was valid on the date(s) of service.

Outpatient Prospective Payment System (OPPS) Claims should be submitted on a UB form and follow Original Medicare guidelines for billing. Accurate and complete coding of CPT and HCPCS procedure codes, procedure modifiers, revenue codes, and units (especially surgery units) will maximize your reimbursement and speed the processing of claims. The *Hospital OPPS Billing and Reimbursement Guide*, which provides more detailed information, is available on the Mountain State website at **www.msbcbs.com** under the "Provider" dropdown menu, "News & Bulletins".

Present on Admission Requirement

Mountain State has implemented Present on Admission (POA) requirements for acute-care hospitals providing services to Commercial members and HHIC Medicare Advantage members with FreedomBlue PPO and FreedomBlue PFFS coverage on inpatient claims.

POA information must be submitted on both Commercial and Medicare Advantage claims effective July 19, 2008. On and after that date, claims submitted without POA information will be rejected.

POA information is not required for all facility types; however, for those requiring POA information, an indicator must be reported for every diagnosis code on the claim.

Exempted Facility Types

Mountain State and HHIC exempt the same facility types from the POA requirement as CMS. Those facility types are as follows:

- Critical Access Hospitals
- Long-Term Care Hospitals
- Cancer Hospitals
- Children's Inpatient Facilities
- Inpatient Rehabilitation Facilities
- Psychiatric Hospitals

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Mountain State Blue Cross Blue Shield
Contracting & Reimbursement Update Continued...

2008 RBRVS Reimbursement Updates
In the Winter and Spring editions of this newsletter, Providers were advised of Mountain State's review of the RVUs and budget neutrality factor implemented by the Centers for Medicare and Medicaid Services (CMS) for 2008. Mountain State is happy to announce that the annual update effective 7-1-2008 has been completed. A new conversion factor has been created for all Evaluation and Management services, CPT codes 99201 through 99499. In addition the conversion factor for OB/GYN Medical services (59000-59051, 59200-59622) has increased. All other conversion factors remain unchanged. To obtain a copy of the Summary of Reimbursement Methods and Fees effective July 1, 2008, please visit our website at **www.msbcbs.com**.

Laboratory and Pathology Update
Mountain State will be updating the laboratory and pathology services that do not have RVUs developed by CMS by using the Ingenix 2008 RVUs. The effective date is September 1, 2008.

Immunoglobulin Update
Mountain State will be reimbursing some of the Immunoglobulin services at 85% beginning January 1, 2009. The codes affected are 90281, 90371, 90375, 90376, 90379, 90386, 90396, J1571 and J1573.

Coding Reminders
Mountain State would like to take this opportunity to provide some coding reminders.

- Specific guidelines are presented at the beginning of each section in the CPT codebook. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section. In addition, the Introductory section provides helpful information.
- Add-On Codes describe a service that can only be reported in addition to a primary procedure. An add-on code is identified by the used of a '+' symbol beside the code and listed in Appendix D of the CPT codebook. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. Add-on codes are also exempt from the multiple procedure modifier 51 which is defined in Appendix A.

Medmark Update
Mountain State will be adding some of the intravenous immune globulin services to the mandatory Medmark Drug List effective September 1, 2008. Following is a list of HCPCS and CPT codes:

CPT/ HCPCS code	Description
90283	Immune globulin (IgIV), human, for intravenous use
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
J1561	Injection, immune globulin, (Gamenex), intravenous, nonlyophilized (e.g. liquid), 500 mg
J1562	Injection, immune globulin (Vivaglobin), 100 mg
J1566	Injection, immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized, (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), intravenous, nonlyophilized (e.g. liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma), intravenous, nonlyophilized (e.g. liquid), 500 mg
J2791	Injection, Rho (D) immune globulin (human), (Rhophylac), intramuscular of intravenous, 10 IU

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Mountain State Blue Cross Blue Shield
Contracting & Reimbursement Update Continued...

Medmark Update Continued...

Mountain State Blue Cross Blue Shield will be adding the following drug to the Medmark Injectable Drug Program effective January 1, 2009.

J7323 Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose.

September 2008 payment reduction for certain diagnostic imaging procedures

Mountain State Blue Cross Blue Shield is reducing its payment for certain diagnostic imaging services when more than one service is performed for the same patient, during the same session, on the same service date. This payment reduction will be similar to the policy implemented by the Centers for Medicare & Medicaid Services in January 2006. This policy was put into practice for HHIC's Medicare Advantage product, FreedomBlue℠ PPO, in April 2007.

The payment reduction will become effective Sept. 1, 2008, and will affect only the technical component of the diagnostic imaging services.

Please refer to the April 2008 **Special Bulletin (available on line at Provider drop down)** for a complete listing of the procedure codes included in this program.

Moderate Sedation Add On Codes

Mountain State Blue Cross Blue Shield will be changing the pricing methodology for Moderate Sedation add-on codes from an anesthesia unit to a service unit effective January 1, 2009. The coding database selects anesthesia base units when the pricing methodology is designated as an anesthesia unit. The nomenclature for these add-on codes is specific to time, therefore base units will no longer be applied. When you perform moderate sedation, please report the actual units in Box 24G (Days or Units) of the CMS 1500 Claim Form. One unit equals each additional 15 minutes. This guideline is an exception and applies to the following add-on codes:

+ 99145 - moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes

+ 99150 - moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time

If you have any questions please contact your assigned External Provider Relations Representative.

Implementation of bundling certain services provided during critical care effective January 2009

Mountain State Blue Cross Blue Shield (MSBCBS) will begin to include certain services in its payment for critical care codes 99291 and 99292 effective January 1, 2009.

According to the 2008 AMA CPT guidelines the following services are considered part of critical care codes 99291 and 99292 when they're performed during the critical care period by the physician providing critical care:

- interpretation of cardiac output measurements (93561, 93562)
- chest X-rays (71010, 71015, 71020)
- pulse oximetry (94760, 94761, 94762)
- blood gases, and information data stored in computers, for example, ECGs, blood pressures, hematologic data (99090)
- gastric intubation (43752, 91105)
- temporary transcutaneous pacing (92953)
- ventilatory management (94002-94004, 94660, 94662)
- vascular access procedures (36000, 36410, 36415, 36591, 36600)

As of Jan. 1, 2009, if you report these services in addition to code 99291 or 99292, MSBCBS will include payment for those services in its payment for critical care.

If you perform any other services (that are not listed above) during the critical period, please report those services separately.

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Mountain State Blue Cross Blue Shield
Contracting & Reimbursement Update Continued...

January 2009 endoscopic services payment reduction planned for Medicare Advantage

Highmark Health Insurance Company (HHIC) intends to implement a payment reduction for endoscopic services when one or more services having the same endoscopic base code are performed on the same day for the same patient.

HHIC plans to implement the endoscopic payment reduction in January 2009 for its Medicare Advantage products, FreedomBlue℠ PFFS (Private-Fee-for-Service) and FreedomBlue℠ PPO.

HHIC's payment reduction will be the same as the Centers for Medicare & Medicaid Services' reduction by paying the full allowance of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy.

The base endoscopy codes, listed below, can also be found on the Medicare Physician Fee Schedule in the endoscopic base code field.

HCPCS	Description	Endoscopic Base Code
29806	Shoulder arthroscopy/surgery	29805
29807	Shoulder arthroscopy/surgery	29805
29819	Shoulder arthroscopy/surgery	29805
29820	Shoulder arthroscopy/surgery	29805
29821	Shoulder arthroscopy/surgery	29805
29822	Shoulder arthroscopy/surgery	29805
29823	Shoulder arthroscopy/surgery	29805
29824	Shoulder arthroscopy/surgery	29805
29825	Shoulder arthroscopy/surgery	29805
29826	Shoulder arthroscopy/surgery	29805
29827	Arthroscop rotator cuff repr	29805
29828	Arthroscopy biceps tenodesis	29805
29834	Elbow arthroscopy/surgery	29830
29835	Elbow arthroscopy/surgery	29830
29836	Elbow arthroscopy/surgery	29830
29837	Elbow arthroscopy/surgery	29830
29838	Elbow arthroscopy/surgery	29830
29843	Wrist arthroscopy/surgery	29840
29844	Wrist arthroscopy/surgery	29840
29845	Wrist arthroscopy/surgery	29840
29846	Wrist arthroscopy/surgery	29840
29847	Wrist arthroscopy/surgery	29840
29861	Hip arthroscopy/surgery	29860
29862	Hip arthroscopy/surgery	29860
29863	Hip arthroscopy/surgery	29860
29871	Knee arthroscopy/drainage	29870
29873	Knee arthroscopy/surgery	29870
29874	Knee arthroscopy/surgery	29870
29875	Knee arthroscopy/surgery	29870
29876	Knee arthroscopy/surgery	29870
29877	Knee arthroscopy/surgery	29870
29879	Knee arthroscopy/surgery	29870
29880	Knee arthroscopy/surgery	29870
29881	Knee arthroscopy/surgery	29870
29882	Knee arthroscopy/surgery	29870
29883	Knee arthroscopy/surgery	29870
29884	Knee arthroscopy/surgery	29870
29885	Knee arthroscopy/surgery	29870
29886	Knee arthroscopy/surgery	29870
29887	Knee arthroscopy/surgery	29870
31510	Laryngoscopy with biopsy	31505
31511	Remove foreign body, larynx	31505
31512	Removal of larynx lesion	31505
31513	Injection into vocal cord	31505
31527	Laryngoscopy for treatment	31525
31528	Laryngoscopy and dilation	31525
31529	Laryngoscopy and dilation	31525
31530	Laryngoscopy w/fb removal	31525
31535	Laryngoscopy w/biopsy	31525
31540	Laryngoscopy w/exc of tumor	31525
31560	Laryngoscop w/arytenoidectom	31525
31570	Laryngoscope w/vc inj	31525
31531	Laryngoscopy w/fb & op scope	31526
31536	Laryngoscopy w/bx & op scope	31526
31541	Larynscop w/tumr exc + scope	31526
31545	Remove vc lesion w/scope	31526
31546	Remove vc lesion scope/graft	31526
31561	Larynscop, remve cart + scop	31526
31571	Laryngoscop w/vc inj + scope	31526
31576	Laryngoscopy with biopsy	31575
31577	Remove foreign body, larynx	31575
31578	Removal of larynx lesion	31575
31579	Diagnostic laryngoscopy	31575
31623	Dx bronchoscope/brush	31622
31624	Dx bronchoscope/lavage	31622
31625	Bronchoscopy w/biopsy(s)	31622
31628	Bronchoscopy/lung bx, each	31622
31629	Bronchoscopy/needle bx, each	31622
31630	Bronchoscopy dilate/fx repr	31622

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Mountain State Blue Cross Blue Shield
Contracting & Reimbursement Update Continued...

Base Endoscopy Codes Continued...

31631	Bronchoscopy, dilate w/stent	31622
31635	Bronchoscopy w/fb removal	31622
31636	Bronchoscopy, bronch stents	31622
31638	Bronchoscopy, revise stent	31622
31640	Bronchoscopy w/tumor excise	31622
31641	Bronchoscopy, treat blockage	31622
31645	Bronchoscopy, clear airways	31622
43201	Esoph scope w/submucous inj	43200
43202	Esophagus endoscopy, biopsy	43200
43204	Esoph scope w/sclerosis inj	43200
43205	Esophagus endoscopy/ligation	43200
43215	Esophagus endoscopy	43200
43216	Esophagus endoscopy/lesion	43200
43217	Esophagus endoscopy	43200
43219	Esophagus endoscopy	43200
43220	Esoph endoscopy, dilation	43200
43226	Esoph endoscopy, dilation	43200
43227	Esoph endoscopy, repair	43200
43228	Esoph endoscopy, ablation	43200
43231	Esoph endoscopy w/us exam	43235
43232	Esoph endoscopy w/us fn bx	43235
43236	Uppr gi scope w/submuc inj	43235
43237	Endoscopic us exam, esoph	43235
43238	Uppr gi endoscopy w/us fn bx	43235
43239	Upper GI endoscopy, biopsy	43235
43240	Esoph endoscope w/drain cyst	43235
43241	Upper GI endoscopy with tube	43235
43242	Uppr gi endoscopy w/us fn bx	43235
43243	Upper gi endoscopy & inject	43235
43244	Upper GI endoscopy/ligation	43235
43245	Uppr gi scope dilate strictr	43235
43246	Place gastrostomy tube	43235
43247	Operative upper GI endoscopy	43235
43248	Uppr gi endoscopy/guide wire	43235
43249	Esoph endoscopy, dilation	43235
43250	Upper GI endoscopy/tumor	43235
43251	Operative upper GI endoscopy	43235
43255	Operative upper GI endoscopy	43235
43256	Uppr gi endoscopy w/stent	43235
43257	Uppr gi scope w/thrml txmnt	43235
43258	Operative upper GI endoscopy	43235
43259	Endoscopic ultrasound exam	43235
43261	Endo cholangiopancreatograph	43260
43262	Endo cholangiopancreatograph	43260
43263	Endo cholangiopancreatograph	43260
43264	Endo cholangiopancreatograph	43260
43265	Endo cholangiopancreatograph	43260
43267	Endo cholangiopancreatograph	43260
43268	Endo cholangiopancreatograph	43260
43269	Endo cholangiopancreatograph	43260
43271	Endo cholangiopancreatograph	43260
43272	Endo cholangiopancreatograph	43260
44361	Small bowel endoscopy/biopsy	44360
44363	Small bowel endoscopy	44360
44364	Small bowel endoscopy	44360
44365	Small bowel endoscopy	44360
44366	Small bowel endoscopy	44360
44369	Small bowel endoscopy	44360
44370	Small bowel endoscopy/stent	44360
44372	Small bowel endoscopy	44360
44373	Small bowel endoscopy	44360
44377	Small bowel endoscopy/biopsy	44376
44378	Small bowel endoscopy	44376
44379	S bowel endoscope w/stent	44376
44389	Colonoscopy with biopsy	44388
44390	Colonoscopy for foreign body	44388
44391	Colonoscopy for bleeding	44388
44392	Colonoscopy & polypectomy	44388
44393	Colonoscopy, lesion removal	44388
44394	Colonoscopy w/snare	44388
44397	Colonoscopy w/stent	44388
45303	Proctosigmoidoscopy dilate	45300
45305	Proctosigmoidoscopy w/bx	45300
45307	Proctosigmoidoscopy fb	45300
45308	Proctosigmoidoscopy removal	45300
45309	Proctosigmoidoscopy removal	45300
45315	Proctosigmoidoscopy removal	45300
45317	Proctosigmoidoscopy bleed	45300
45320	Proctosigmoidoscopy ablate	45300
45321	Proctosigmoidoscopy volvul	45300
45327	Proctosigmoidoscopy w/stent	45300
45331	Sigmoidoscopy and biopsy	45330
45332	Sigmoidoscopy w/fb removal	45330
45333	Sigmoidoscopy & polypectomy	45330
45334	Sigmoidoscopy for bleeding	45330
45335	Sigmoidoscopy w/submuc inj	45330
45337	Sigmoidoscopy & decompress	45330
45338	Sigmoidoscopy w/tumr remove	45330
45339	Sigmoidoscopy w/ablate tumr	45330
45340	Sig w/balloon dilation	45330
45345	Sigmoidoscopy w/stent	45330
45379	Colonoscopy w/fb removal	45378
45380	Colonoscopy and biopsy	45378
45381	Colonoscopy, submucous inj	45378
45382	Colonoscopy/control bleeding	45378

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Mountain State Blue Cross Blue Shield
Contracting & Reimbursement Update Continued...

Base Endoscopy Codes Continued...

45383	Lesion removal colonoscopy	45378
45384	Lesion remove colonoscopy	45378
45385	Lesion removal colonoscopy	45378
45386	Colonoscopy dilate stricture	45378
45387	Colonoscopy w/stent	45378
45391	Colonoscopy w/endoscope us	45378
45392	Colonoscopy w/endoscopic fnb	45378
46604	Anoscopy and dilation	46600
46606	Anoscopy and biopsy	46600
46608	Anoscopy, remove for body	46600
46610	Anoscopy, remove lesion	46600
46611	Anoscopy	46600
46612	Anoscopy, remove lesions	46600
46614	Anoscopy, control bleeding	46600
46615	Anoscopy	46600
47553	Biliary endoscopy thru skin	47552
47554	Biliary endoscopy thru skin	47552
47555	Biliary endoscopy thru skin	47552
47556	Biliary endoscopy thru skin	47552
38570	Laparoscopy, lymph node biop	49320
49321	Laparoscopy, biopsy	49320
49322	Laparoscopy, aspiration	49320
49323	Laparo drain lymphocele	49320
49324	Lap insertion perm ip cath	49320
49325	Lap revision perm ip cath	49320
58541	Lsh, uterus 250 g or less	49320
58550	Laparo-asst vag hysterectomy	49320
58660	Laparoscopy, lysis	49320
58661	Laparoscopy, remove adnexa	49320
58662	Laparoscopy, excise lesions	49320
58670	Laparoscopy, tubal cautery	49320
58671	Laparoscopy, tubal block	49320
58672	Laparoscopy, fimbrioplasty	49320
58673	Laparoscopy, salpingostomy	49320
50555	Kidney endoscopy & biopsy	50551
50557	Kidney endoscopy & treatment	50551
50561	Kidney endoscopy & treatment	50551
50572	Kidney endoscopy	50570
50574	Kidney endoscopy & biopsy	50570
50575	Kidney endoscopy	50570
50576	Kidney endoscopy & treatment	50570
50580	Kidney endoscopy & treatment	50570
50953	Endoscopy of ureter	50951
50955	Ureter endoscopy & biopsy	50951
50957	Ureter endoscopy & treatment	50951
50961	Ureter endoscopy & treatment	50951
50974	Ureter endoscopy & biopsy	50970
50976	Ureter endoscopy & treatment	50970
52001	Cystoscopy, removal of clots	52000
52005	Cystoscopy & ureter catheter	52000
52007	Cystoscopy and biopsy	52000
52010	Cystoscopy & duct catheter	52000
52204	Cystoscopy w/biopsy(s)	52000
52214	Cystoscopy and treatment	52000
52224	Cystoscopy and treatment	52000
52234	Cystoscopy and treatment	52000
52235	Cystoscopy and treatment	52000
52240	Cystoscopy and treatment	52000
52250	Cystoscopy and radiotracer	52000
52260	Cystoscopy and treatment	52000
52265	Cystoscopy and treatment	52000
52270	Cystoscopy & revise urethra	52000
52275	Cystoscopy & revise urethra	52000
52276	Cystoscopy and treatment	52000
52277	Cystoscopy and treatment	52000
52281	Cystoscopy and treatment	52000
52282	Cystoscopy, implant stent	52000
52283	Cystoscopy and treatment	52000
52285	Cystoscopy and treatment	52000
52290	Cystoscopy and treatment	52000
52300	Cystoscopy and treatment	52000
52301	Cystoscopy and treatment	52000
52305	Cystoscopy and treatment	52000
52310	Cystoscopy and treatment	52000
52315	Cystoscopy and treatment	52000
52317	Remove bladder stone	52000
52318	Remove bladder stone	52000
52320	Cystoscopy and treatment	52000
52325	Cystoscopy, stone removal	52000
52327	Cystoscopy, inject material	52000
52330	Cystoscopy and treatment	52000
52332	Cystoscopy and treatment	52000
52334	Create passage to kidney	52000
52341	Cysto w/ureter stricture tx	52000
52342	Cysto w/up stricture tx	52000
52343	Cysto w/renal stricture tx	52000
52344	Cysto/uretero, stricture tx	52000
52400	Cystouretero w/congen repr	52000
52402	Cystourethro cut ejacul duct	52000
52345	Cysto/uretero w/up stricture	52351
52346	Cystouretero w/renal strict	52351
52352	Cystouretero w/stone remove	52351
52353	Cystouretero w/lithotripsy	52351
52354	Cystouretero w/biopsy	52351

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Simple Precautions Can Help Prevent MEDICAL ID THEFT

Medical Identity Theft – the incidence of someone fraudulently posing as another person to receive health care services, controlled substances or other benefits – is on the rise and is increasing the cost of health care for everyone. The consequences for individual victims, from monetary and benefit losses to lengthy delays in resolving identity theft related issues and restoring benefits, are significantly damaging.

Mountain State is asking network providers to assist in preventing Medical ID Theft by taking these simple precautions:

- Request all patients to provide a current Photo ID (i.e. driver's license, passport, etc.) in addition to a current Mountain State member ID card prior to each visit.
- Verbally alert patients about Medical ID Theft and advise them to closely guard their member ID cards.
- Post fliers or signs at your reception window and throughout your office alerting patients to be aware of Medical ID Theft and its consequences.
- Take note of any suspicious activity involving persistent or frequent patient requests for services or controlled substances that are not clinically appropriate.

If you or anyone in your office suspects Medical ID Theft, please call Mountain State's Fraud Hotline, toll-free at 1-800-788-5661. You will be connected to a voice mailbox and asked to leave a message. Messages are checked daily and a staff member of Mountain State's Special Investigations Unit will contact you to discuss your concerns.

Mountain State Blue Cross Blue Shield

Contracting & Reimbursement Update Continued...

Base Endoscopy Codes Continued...

52355	Cystouretero w/excise tumor	52351
57454	Bx/curett of cervix w/scope	57452
57455	Biopsy of cervix w/scope	57452
57456	Endocerv curettage w/scope	57452
57460	Bx of cervix w/scope, leep	57452
57461	Conz of cervix w/scope, leep	57452
58558	Hysteroscopy, biopsy	58555
58559	Hysteroscopy, lysis	58555
58560	Hysteroscopy, resect septum	58555
58561	Hysteroscopy, remove myoma	58555
58562	Hysteroscopy, remove fb	58555
58563	Hysteroscopy, ablation	58555
58565	Hysteroscopy, sterilization	58555
66711	Ciliary endoscopic ablation	66710

NPI UPDATE:

Provider Tax ID Numbers Not Matching the ID Numbers Linked to the Provider's NPI On File

Electronic claims submitters are reminded that, effective May 23, 2008 — the date on which the CMS contingency guidelines for HIPAA-covered entities expired — Mountain State began rejecting electronic claim submissions that do not contain an NPI in the billing, rendering provider and service facility field (when applicable) and began returning the claims to the provider. Additionally, Mountain State is rejecting electronic inquiry transactions — such as eligibility, authorization and claims status inquiries — that do not contain NPIs. For more information, reference the "Provider EDI Reference Guide" on Mountain State's Web site at **www.msbcbs.com/msbc_trading.htm**.

In the process of maintaining Mountain State Blue Cross Blue Shield's information systems for compliance with the Centers for Medicare & Medicaid Services' (CMS) HIPAA mandate and enforcement of the NPI Final Rule, Mountain State has found that some network providers' tax identification (ID) numbers submitted on electronic claims do not match the tax IDs that are linked to the NPI on file with us.

In an effort to avoid paying claims to the wrong provider, effective September 12, 2008, Mountain State will reject electronic claims that include tax ID numbers that do not match the providers' tax ID-NPI combination that we have on file in our information systems. Additionally, when such a rejection is issued, the following rejection codes will be included on the 277 claim acknowledgment (277 CA) report:

Claim Status Category Code:
A8 — Rejected for relational field in error

Claim Status Codes:
128 — Entity's Tax ID
562 — Entity's National Provider Identifier (NPI)

Entity ID:
85 — Billing Provider

In recent months, Mountain State has been proactively contacting practices when this issue has arisen regarding electronic claim submissions to assist providers in resolving the matter. Effective September 12, 2008, Mountain State will simply reject such electronic claims and return them to the submitter. 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 **www.msbcbs.com/msbc_trading.htm**. Or you may contact your Mountain State Provider Relations Representative. To check your tax ID number or numbers on file with Mountain State, please call 1-800-798-7768 or 304-424-7795.

HHIC (Highmark Health Insurance Company) FreedomBlue PPO and PFFS Benefits Updates for 2009

HHIC has filed for the 2009 benefits and premiums with the Centers for Medicare & Medicaid Services (CMS). CMS is expected to approve plan changes in September 2008. Our goal continues to be providing a wide range of coverage choices with stable out of pocket costs to the member.

Current members will receive a combined Annual Notice of Change and Evidence of Coverage document by October 31, 2008. Medicare beneficiaries can change their coverage during the Annual Election period which runs from November 15 to December 31, 2008.

Update on Credentialing and Contracting Requirements for Hospital Based Providers

We previously announced in our Winter 2008 Provider News that Hospital Based Providers must complete Mountain State's full credentialing and recredentialing process to obtain and maintain their status as a participating provider. The following guidelines have been implemented to allow hospital based providers to exempt from the full credential process providing the following criteria is met by the provider:

Mountain State Blue Cross Blue Shied (Mountain State) and Highmark have evaluated their respective credentialing processes for Mountain State networks and Highmark Health Insurance Company (HHIC) Medicare Advantage PPO networks. A change has been made that we believe will positively affect pathologists, radiologists, anesthesiologists, emergency room providers, hospitalists and hospital based allied health providers.

Currently, these providers must successfully complete our full credentialing and recredentialing process to obtain and maintain status as a participating provider. We recognize that these practitioner specialties/types employed in or contracted directly with an inpatient facility are held to many hospital board accreditations and credentialing standards.

If you are a hospital based provider, and practice exclusively in an acute care setting (inpatient facility), you will be exempt from the full credentialing process. However, if you also practice anywhere other than an inpatient setting, you will be required to undergo full credentialing and recredentialing.

To be exempt from the full credentialing process, we must obtain a signed Affirmation of Medical Practice Statement Form (Affirmation) for our records indicating, among other things, that you practice exclusively in an acute care setting. The Affirmation is maintained at the practice level.

Therefore, should you join another practice we will require that you complete another Affirmation. Mountain State also requires a copy of your current medical license with each Affirmation.

Please send all Affirmations to:
Mountain State Blue Cross Blue Shield
Office of Provider Relations
P.O. Box 1948
Parkersburg, WV 26102

If you have any questions concerning this process, please contact Provider Relations at 1-800-798-7768 or you may access this information via Mountain State' website at www.msbcbs.com under the "Provider" dropdown menu then select News & Bulletins.

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Affirmation of Medical Practice Statement

By signing this affirmation, I declare my desire to join or remain a provider of Mountain State Blue Cross Blue Shield's (MSBCBS) commercial PPO/POS network and/or Highmark Health Insurance Company (HHIC) Medicare Advantage PPO Network.

I understand that the information herein will be used by MSBCBS and/or HHIC in making decisions about my participation in the networks.

I understand that credentialing will not be required as a condition of my becoming a party to the Network Provider Agreements, provided that (1) the services I provide to members serviced by the networks are delivered exclusively in the acute care hospital setting; (2) I provide medical care for such members only when they receive services in a Blue Cross Blue Shield Network Participating hospital; (3) I possess a current license in good standing in the state in which services are provided; (4) I have current active malpractice insurance that meets or exceeds the MSBCBS and/or HHIC requirements; (5) I actively participate with Medicare/Medicaid and have never been debarred from, or excluded from participation in, any Medicare/Medicaid government program; and (6) I am a member of the practice listed below.

By signing below, I am confirming that conditions (1) through (6) in the above paragraph are true and accurate statements.

I will be providing services to members serviced by the Networks in the following acute care hospitals:

_____

_____

Please indicate your specialty (required) _____

I understand that if I begin to provide service to members outside of a Network Participating acute care hospital, I will have to be credentialed by MSBCBS and/or HHIC as a condition of administrative and regulatory compliance with MSBCBS Network Provider Agreements and participation in the applicable Networks.

Group Practice Name: _____ _____

Type2/Group National Provider Identifier (NPI) _____

MSBCBS Group Provider Number: _____

Group Practice Name: _____ _____

Type2/Group National Provider Identifier (NPI) _____

MSBCBS Group Provider Number: _____

Group Practice Name: _____ _____

Type2/Group National Provider Identifier (NPI) _____

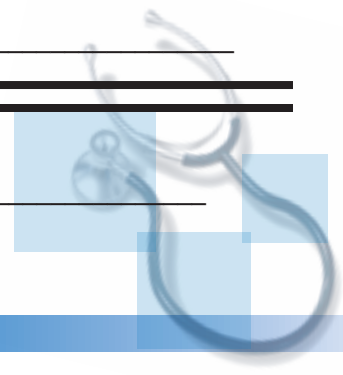
MSBCBS Group Provider Number: _____

Individual Practice Name: _____ _____

Type1/Individual National Provider Identifier (NPI) _____

MSBCBS Group Provider Number: _____

Physician Signature: _____ Date: _____



Provider Notification of Adoption of Average Wholesale Price (AWP) for Additional Drugs, Biologicals, Immunizations and Radiopharmaceuticals

Mountain State Blue Cross Blue Shield (Mountain State) has performed a recent review of CPT and HCPCS codes that are considered to be drugs, biologicals, immunizations or radiopharmaceuticals. Mountain State has identified a few services that are currently reimbursing under a different method than AWP. Effective January 1, 2009, the codes below will be reimbursed at 85% of AWP allowance for Mountain State PPO, POS and Steel business.

Code	Description
90389	Tetanus immune globulin (TIg), for intramuscular use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
A4642	Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries
A9502	Technetium Tc-99m tetrofosmin, diagnostic, per study dose, up to 40 millicuries
A9503	Technetium Tc-99 medronate, diagnostic, per study dose, up to 30 millicuries
A9505	Thallium TI-201 thallous chloride, diagnostic, per millicurie
J0152	Injection, adenosine for diagnostic use, 30 mg (not be used to report any adenosine phosphate compounds; instead use A9270)
J0275	Alprostadil urethral suppository (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)
P9043	Infusion, plasma protein fraction (human), 5%, 50 ml
P9045	Infusion, albumin (human), 5% 250ml
Q0163	Diphenhydramine HCl, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48-hour dosage regimen.
Q0164	Prochlorperazine maleate, 5mg oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

If you have questions or need more information about this change, please contact your Provider Relations Representative.

Billing Dispute External Review Process "BDERP"

As of September 5, 2008, the Billing Dispute External Review Process ("BDERP") is available to physicians who are class members of the Love Settlement Agreement (limited to MDs and DOs who have not otherwise opted out of the Love Settlement Agreement) and the physician groups comprised of such physicians. The BDERP process is intended to resolve disputes arising from covered services provided to Mountain State members regarding Mountain State's application of its coding and payment rules and methodologies for fee for service claims to patient specific factual circumstances.

Please be advised, physicians and physician groups must exhaust Mountain State's internal appeal process for billing disputes before submitting a BDERP request. This requirement will be deemed to have been satisfied if Mountain State has responded to the physician or physician group appeal, and Mountain State's response indicates internal review has been exhausted **or** if there has been no response from Mountain State's of its decision within thirty (30) calendar days after you have supplied all documentation reasonably needed to complete the internal appeal/review.

For more information, instructions and forms, please visit www.msbcbs.com and click on the Provider dropdown, News & Bulletins.

Medicare Advantage FreedomBlue Record Retention Requirement Change – From 6 Years to 10 Years

Providers should be aware that the Centers for Medicare and Medicaid Services (CMS) revised the record retention period requirements from 6 years to 10 years. CMS requires that records be maintained for a minimum of 10 years, or such longer period as required by Law, and contracted providers agree to audits and inspection of all records required by Law.

Providers are now required to maintain records involving Medicare Advantage FreedomBlue Members through 10 years from the final date of the contract period or completion of any CMS audit.

MEDICAL POLICY UPDATES

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 M-33 (Tilt Table Testing)
Mountain State Blue Cross Blue Shield expands coverage of tilt table testing to non-hospital settings.
Effective: June 9, 2008

Mountain State Blue Cross Blue Shield now covers tilt table testing when it's performed in a non-hospital setting as well as a hospital setting. Since patients can become quite ill and sometimes require resuscitation, the place of service must be adequately staffed and equipped to provide advanced cardiopulmonary resuscitation when tilt table testing is performed outside of the hospital setting. The expanded coverage became effective June 9, 2008.

Please report tilt table testing with procedure code 93660—evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention.

The tilt table is used to evaluate the autonomic nervous system control of cardiovascular function in patients who have syncope, pre-syncope, or vasovagal syncope.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-200 (Percutaneous Intracranial Balloon Angioplasty With or Without Stenting)
Percutaneous intracranial balloon angioplasty or stenting considered investigational.
Effective: June 16, 2008

Mountain State Blue Cross Blue Shield considers percutaneous intracranial balloon angioplasty or stenting of intracranial arteries experimental or investigational in the treatment of intracranial atherosclerosis and subarachnoid hemorrhage-induced vasospasm.

Mountain State Blue Cross Blue Shield does not cover intracranial balloon angioplasty or stenting because the clinical safety and effectiveness of the procedures has not been established. A participating, preferred, or network provider may bill the member for the denied service.

Use procedure code 61630, 61635, 61640, 61641, or 61642, as appropriate, to report percutaneous intracranial balloon angioplasty or stenting.

Percutaneous intracranial balloon angioplasty involves the insertion of a balloon-tipped catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The balloon is then deflated and the catheter is withdrawn, leaving the vessel with increased patency. Stents may be placed within narrowed vessel areas to prevent future occlusion and maximize bloodflow.

MA Does not apply to Medicare Advantage

Medical Policy Bulletin E-1 (Durable Medical Equipment)
Positioning pillows coverage guidelines clarified.
Effective: June 9, 2008

Mountain State Blue Cross Blue Shield does not pay for positioning cushions, pillows, or wedges. This includes, but is not limited to backrest cushions, cervical pillows, lumbar pillows, massage pillows, positioning pillows, sleeping pillows, standard pillows made of allergy-free materials, and traction pillows.

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Because most positioning cushions, pillows, and wedges do not primarily and customarily serve a medical purpose, they do not meet Mountain State Blue Cross Blue Shield's definition of durable medical equipment (DME). Therefore, they are not covered. A participating, preferred or network provider may bill the member for the denied cushions, pillows, or wedges.

Report code E0190 for positioning cushions, pillows, or wedges, any shape or size.

Cushions and pillows covered when part of or an accessory to covered DME

Mountain State Blue Cross Blue Shield may cover cushions or pillows if they are an integral part of, or a medically necessary accessory to covered DME, for example, wheelchair seat cushions, cushions and/or pillows for nasal masks or cannula interface, specialized support surfaces used to prevent or treat decubiti. Report these types of cushions and pillows with the code that is specific to the cushion or pillow provided.

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

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin Z-67 (Experimental/ Investigational)
Insertion of optical drainage device not covered.
Effective: July 14, 2008

Mountain State Blue Cross Blue Shield considers the insertion of an optical drainage device, specifically, the iStent trabecular micro-bypass stent, as experimental or investigational. Mountain State Blue Cross Blue Shield will deny claims reporting this service. A participating, preferred, or network provider may bill the member for the denied service. Select one of these codes to report this procedure:

0191T—insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach

0192T—insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin Z-67 (Experimental/ Investigational Services)
Placement of intraocular radiation source applicator classified as "experimental".
Effective: July 14, 2008

Mountain State Blue Cross Blue Shield considers the placement of an intraocular radiation source applicator, such as the Epi-Rad system, experimental or investigational. Mountain State Blue Cross Blue Shield will deny claims reporting this service. A participating, preferred, or network provider may bill the member for the denied service.

Use code 0190T-placement of intraocular radiation source applicator (list separately in addition to primary procedure)- to report this procedure.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-93 (Percutaneous {Transluminal} Balloon Valvuloplasty)
Percutaneous transluminal balloon mitral valvuloplasty eligibile for mitral valve stenosis.
Effective: January 12, 2009

Mountain State Blue Cross Blue Shield covers percutaneous balloon valvuloplasty of the mitral valve when it's performed for patients with severe uncomplicated mitral valve stenosis (ICD-9-CM diagnosis codes 394.0, 394.2, 396.0, 396.1) in whom the anatomical features of the valve are favorable. Mountain State Blue Cross Blue Shield considers treatment for any other conditions not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service.
Report percutaneous transluminal balloon mitral valvuloplasty with code 92987.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-16 (Assistant Surgery Eligibility Criteria)Assistant surgery not eligible for code 59510. Effective: January 12, 2009

Beginning Jan. 12, 2009, Mountain State Blue Cross Blue Shield will no longer pay for assistant surgery for procedure code 59510—routine

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obstetric care including antepartum care, cesarean delivery, and postpartum care.

When a physician, physician assistant, or certified registered nurse practitioner assists at a cesarean delivery but does not provide antepartum and/or postpartum care, report the assistant-at-surgery services with a procedure code that represents only the cesarean delivery. In these instances, please report code 59514—cesarean delivery only.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin M-11 (Diagnostic Services – Technical and Professional Components)
Diagnostic services: Professional and technical components reporting guidelines explained.
Effective: May 12, 2008

When both components of a diagnostic procedure are performed by the same eligible professional provider in a setting other than inpatient hospital, outpatient hospital, skilled nursing facility, or ambulatory surgical center, a single charge should be reported for the total procedure.

If a "total charge" procedure is reported in an inpatient hospital setting, outpatient hospital setting, skilled nursing facility, or an ambulatory surgical center, Mountain State Blue Cross Blue Shield will limit its payment to the eligible professional provider for only the interpretation or professional component. Any technical costs of a diagnostic procedure performed in a facility setting are reimbursed to the facility.

Mountain State Blue Cross Blue Shield can pay separately for the two components of a diagnostic procedure when each is performed by different eligible professional providers, for example, the provider who owns the equipment reports only the technical component; the interpreting provider reports only the professional component. Each provider should report the procedure code with the appropriate modifier to reflect the actual services performed, for example, modifier 26 for professional component; modifier TC for technical component.

Most diagnostic services, such as radiology studies and diagnostic medical procedures, include a distinct technical component, consisting of equipment and technical personnel costs. There is also a professional component, which represents the interpretation of diagnostic test results by the eligible professional provider.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin I-85 (Natalizumab (Tysabri®)
Natalizumab now covered for treating Crohn's disease.
Effective: January 14, 2008
Issued: May 19, 2008

Mountain State Blue Cross Blue Shield will provide coverage for natalizumab (Tysabri®) for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn's disease with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional Crohn's disease therapies and inhibitors of TNF-α.

Natalizumab should not be used in combination with immunosuppressants, for example, 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate, or inhibitors of TNF-α. Aminosalicylates may be continued during treatment with natalizumab.

The recommended dose of natalizumab for Crohn's disease is 300 mg intravenous infusion over one hour every four weeks. If the patient with Crohn's disease has not experienced a therapeutic benefit by 12 weeks of induction therapy, discontinue natalizumab. For patients with Crohn's disease that start natalizumab while on chronic oral corticosteroids, taper steroid use as soon as a therapeutic benefit of natalizumab has occurred. If the patient with Crohn's disease cannot be tapered off of oral corticosteroids within six months of starting natalizumab, discontinue natalizumab. Other than the initial six-month taper, providers should consider discontinuing natalizumab for patients who require additional steroid use that exceeds three months in a calendar year to control their Crohn's disease.

Tysabri is not approved for use in patients under age 18.

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Only providers registered in the Crohn's disease TOUCH™ Prescribing Program may prescribe natalizumab for Crohn's disease.

Mountain State Blue Cross Blue Shield considers the use of natalizumab for any indication other than Crohn's disease or multiple sclerosis experimental or investigational. Therefore, it is not eligible for payment. A participating, preferred, or network provider may bill the member for the denied medication.

Use code J2323 to report natalizumab.

Mountain State Blue Cross Blue Shield determines coverage for natalizumab according to individual or group customer benefits. Natalizumab is not reimbursable under the prescription drug benefit.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin Y-21 (Cognitive Rehabilitation)
Cognitive rehabilitation now eligible for payment.
Effective: July 7, 2008

Mountain State Blue Cross Blue Shield now pays for cognitive rehabilitation for a brain injury related to these conditions:

- anoxia (ICD-9-CM 348.1, 994.1)
- brain hemorrhage and cerebral thrombosis (ICD-9-CM 430, 431, 432.0-432.9, 433.00-433.91, 434.00-434.91, 438.0, 438.10-438.19, 997.01-997.02)
- concussion (ICD-9-CM 850.0, 850.11-850.12, 850.2-850.9, 852.00-852.59, 853.00-853.19, 854.00-854.19, 907.0, 959.01)
- encephalopathy (ICD-9-CM 348.30-348.31, 349.82)
- fractured skull (ICD-9-CM 800.00-800.99, 801.00-801.99, 803.00-803.99, 804.00-804.99, 905.0)
- post-concussion syndrome (ICD-9-CM 310.1, 310.2, 310.8, 310.9)

Conditions designated by a range of ICD-9-CM diagnosis codes include all valid codes within that range. When choosing a diagnosis code, select one that best represents the member's condition. And, please remember to report diagnosis codes to the highest level of specificity.

When cognitive rehabilitation is reported for a condition that is not listed, Mountain State Blue Cross Blue Shield will consider it experimental or investigational. A participating, preferred or network provider may bill the member for the denied service.

Use code 97532—development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes—to report cognitive rehabilitation.

Procedure code 97532 is listed as part of the occupational therapy benefits. Mountain State Blue Cross Blue Shield determines coverage for occupational therapy according to individual or group customer benefits.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin V-20 (Prolonged Detention or Critical Care)
Implementation of bundling certain services provided during critical care.
Effective: January 1, 2009

Effective January 1, 2009, Mountain State Blue Cross Blue Shield will consider these services as part of critical care codes 99291 and 99292 when they're performed during the critical care period by the physician providing critical care:

- interpretation of cardiac output measurements (93561, 93562)
- chest X-rays (71010, 71015, 71020)
- pulse oximetry (94760, 94761, 94762)
- blood gases, and information data stored in computers, for example, ECGs, blood pressures, hematologic data (99090)

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• gastric intubation (43752, 91105)

• temporary transcutaneous pacing (92953)

• ventilatory management (94002-94004, 94660, 94662)

• vascular access procedures (36000, 36410, 36415, 36591, 36600)

If you report these services in addition to code 99291 or 99292, Mountain State Blue Cross Blue Shield will include those services in its payment for critical care. If you perform any services that are not listed during the critical period, please report those services separately.

MA For Medicare Advantage, see Medicare Advantage medical policy bulletin V-20.

Medical Policy Bulletin I-90 (Abatacept {Orencia}®)
Abatacept Covered for Juvenile Idiopathic Arthritis
Effective: August 18, 2008

Mountain State Blue Cross Blue Shield covers Abatacept (Orencia®) for the treatment of pediatric patients 6 years of age and older with moderately to severely active polyarticular juvenile idiopathic arthritis.

The use of Orencia® for any indication other than adult rheumatoid arthritis or juvenile idiopathic arthritis is considered experimental/investigational. Therefore, it is not eligible for payment. A participating, preferred or network provider may bill the member for the denied medication.

Orencia® may be used as monotherapy or in combination with DMARDs, for example, methotrexate, but should not be used with TNF antagonists.

The recommended dose of Orencia® for patients 6 to 17 years of age with juvenile idiopathic arthritis who weigh less than 75 kg is 10 mg/kg calculated based on the patient's body weight at each administration. Pediatric patients weighing 75 kg or more should be administered Abatacept following the adult dosing regimen, not to exceed a maximum dose of 1000mg. Orencia® should be administered as a 30-minute intravenous infusion. Following the initial administration, Abatacept should be given at 2 and 4 weeks after the first infusion and every 4 weeks thereafter.

Report Orencia® with procedure code J0129.

Mountain State Cross Blue Shield determines coverage for Orencia® according to the individual or group customer medical benefits. Mountain State Cross Blue Shield does not provide reimbursement for Orencia® under the member's prescription drug benefit.

MA Also applicable to Medicare Advantage effective February 16, 2009

Medical Policy Bulletin I-8 (Immunizations)
Per the Center for Disease Control's Advisory Committee on Immunization Practices, the following three new vaccines are being added to this policy.
Effective: June 26, 2008

Kinrix™ Vaccine Now Covered

On June 26, 2008 the Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) voted to include the new vaccine Kinrix™ [Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed and Inactivated Poliovirus Vaccine] in the childhood immunization program.

Mountain State Blue Cross Blue Shield began to provide coverage for the FDA-approved vaccine Kinrix™ as of June 26, 2008. Mountain State Blue Cross Blue Shield will determine coverage for Kinrix™ according to the member's contract.

Report the Kinrix™ vaccine with procedure code 90696.

A single dose of Kinrix™ is indicated for active immunization against diphtheria, tetanus, pertussis, and poliomyelitis as the fifth dose in the diphtheria, tetanus, and acellular pertussis (DTaP) vaccine series and the fourth dose in the inactivated poliovirus vaccine (IPV) series in children 4 through 6 years of age whose previous DTaP vaccine doses

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have been with Infanrix® (Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed) and/or Pediarix® [Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined] for the first three doses and Infanrix® for the fourth dose.

MA Not applicable to Medicare Advantage

Pentacel® Vaccine Now Covered

On June 26, 2008, the Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP) voted to include Pentacel® (Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus and Haemophilus b Conjugate [Tetanus Toxoid Conjugate] Vaccine) in the childhood immunization program.

Pentacel® vaccine is indicated for active immunization against diphtheria, tetanus, pertussis, poliomyelitis and invasive disease due to Haemophilus influenzae type b. Pentacel® vaccine is approved for use in children 6 weeks through 4 years of age (prior to fifth birthday). Pentacel® vaccine is optimally administered using a 4-dose schedule at 2, 4, 6, and 15-18 months of age.

Mountain State Blue Cross Blue Shield will provide coverage for the FDA-approved vaccine Pentacel® as of June 26, 2008. Mountain State Blue Cross Blue Shield will determine coverage for Pentacel® according to the member's contract.

Report Pentacel® vaccine with procedure code 90698.

MA Not applicable to Medicare Advantage

Rotarix® Vaccine Now Covered

On June 26, 2008, the Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) voted to include the new vaccine Rotarix® [Rotavirus Vaccine, Live, Oral] in the childhood immunization program.

Rotarix® is indicated for the prevention of rotavirus gastroenteritis caused by G1 and non-G1 types (G3, G4, and G9) when administered as a 2-dose series in infants and children.

Mountain State Blue Cross Blue Shield will provide coverage for the FDA-approved vaccine Rotarix® as of June 26, 2008. Mountain State Blue Cross Blue Shield will determine coverage for Rotarix® according to the member's contract.

Report Rotarix® with procedure code 90681.

MA Not applicable to Medicare Advantage

Medical Policy Bulletin S-112 (Co-Surgery) Additional Procedures Eligible for Co-Surgery Effective: August 4, 2008

Mountain State Blue Cross Blue Shield considers these additional procedure codes eligible for payment for co-surgery.

33875 - DESCENDING THORACIC AORTA GRAFT, WITH OR WITHOUT BYPASS

39561 - RESECTION, DIAPHRAGM; WITH COMPLEX REPAIR (EG, PROSTHETIC MATERIAL, LOCAL MUSCLE FLAP)

44160 - COLECTOMY, PARTIAL, WITH REMOVAL OF TERMINAL ILEUM WITH ILEOCOLOSTOMY

47120 - HEPATECTOMY, RESECTION OF LIVER; PARTIAL LOBECTOMY

51596 - CYSTECTOMY, COMPLETE, WITH CONTINENT DIVERSION, ANY OPEN TECHNIQUE, USING ANY SEGMENT OF SMALL AND/OR LARGE INTESTINE TO CONSTRUCT NEOBLADDER

62258 - REMOVAL OF COMPLETE CEREBROSPINAL FLUID SHUNT SYSTEM; WITH REPLACEMENT BY SIMILAR OR OTHER SHUNT AT SAME OPERATION

Please be aware that other Mountain State medical policies may effect the eligibility of these codes.

MA Not applicable to Medicare Advantage

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Medical Policy Bulletin L-83 (RedPath-PathFinder TG)
RedPath's *PathFinderTG*® eligible for certain conditions
Effective: July 28, 2008

Mountain State Blue Cross Blue Shield considers RedPath Integrated Pathology's *PathFinderTG*® eligible when performed in:

- pancreatic cyst samplings/fluid to definitively discriminate reactive from neoplastic conditions of the pancreas, identify which premalignant diseases will progress to cancer and those that will not, and to distinguish nonmucinous from mucinous cysts.
- stereotactic brain biopsies or fine-needle aspirations to provide glioma diagnosis and classification, assess tumor aggressiveness, discriminate glioma from reactive gliosis, and predict tumor response to certain chemotherapeutic regimens through analysis of the chromosomal 1p/19q deletion and identified LOH mutations.

Note: Individual consideration may be given for unique clinical circumstances based on a review of applicable medical records.

When requesting or billing for the *PathFinderTG*®, clinical documentation should include (but not be limited to):

- The test requisition form
- Specific reasons for the additional testing to include how results will change patient management;
- Verification of patient notification that additional testing through RedPath's *PathFinderTG*® process and assays has been requested; and
- Evidence that the service was provided in keeping with published peer-reviewed literature and utilization criteria which includes:

  PathFinderTG® is not intended for "first-line" pathology analysis;

  PathFinderTG® is to be used only when an indeterminate diagnosis of malignancy remains after traditional pathologic and microscopic staining and analysis; and

  PathFinderTG® should be used only when its use will result in targeted, patient specific treatment and effective utilization of healthcare resources.

There is a lack of independent clinically-validated testing of this technology involving correlation of the *PathFinderTG*® results to patient outcome data for all other indications or conditions. Therefore, Mountain State considers RedPath's *PathFinder TG*® experimental/investigational for all other indications. In these cases, it is not covered and not eligible for payment. A participating, preferred, or network provider can bill the member for the denied test in these cases.

Use procedure code 84999 – Unlisted chemistry procedure - appended with modifier 90 – reference (outside) laboratory - to report RedPath's *PathFinderTG*®. When you report code 84999 with modifier 90, please include the description "PathFinder TG" in the narrative section of the electronic or paper claim.

MA For Medicare Advantage, see Medicare Advantage medical policy L-83 for guidelines.

Medical Policy Bulletins G-24 (Obesity) and S-145 (Endoscopic Gastroplasty or Gastroplication with Suturing of the Esophagogastric Junction)
StomaphyX™ device not covered, considered experimental/investigational
Effective: September 1, 2008

Mountain State Blue Cross Blue Shield considers endoscopic procedures, for example, insertion of the StomaphyX™ device to treat weight gain after bariatric surgery to remedy a large gastric stoma or large gastric pouch experimental/investigational. Mountain State also considers the StomaphyX™ device experimental/investigational when it is used for other indications, for example, treatment of gastroesophageal reflux disease.

Mountain State Blue Cross Blue Shield does not cover this procedure because well-designed large population, multicenter, controlled clinical trials with long-term follow-up are needed. A participating,

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preferred or network provider can bill the member for the denied service.

Report the endoscopic insertion of the StomaphyX™ device with code 43999, as appropriate. When you report unlisted code 43999, please include the words "endoscopic insertion of the StomaphyX device" in the narrative field of the electronic or paper claim.

The StomaphyX™ device, a new endoluminal delivery system, is used for endoluminal transoral tissue approximation and ligation in the gastrointestinal tract. Currently, the StomaphyX™ device is being used in the treatment of weight gain after bariatric surgery to remedy a large gastric stoma or large gastric pouch. It is also being used in the treatment of gastroesophageal reflux disease.

MA Not applicable to Medicare Advantage

Medical Policy Bulletin Y-19 (Vertebral Axial Decompression {VAX-D})
Decompression Therapy Not Eligible for Reimbursement
Effective: February 16, 2009

Mountain State Blue Cross Blue Shield considers decompression therapy, for example, VAX-D, DRX9000™, SpineMED®, Tru-Trac™ Traction Table, experimental/investigational. It is not eligible for payment for any condition, including both acute and chronic back pain. A participating, preferred or network provider may bill the member for the denied therapy.

Mountain State does not cover decompression therapy because there is not enough data to permit scientific conclusions about its role and effectiveness when compared to conservative therapy, including traditional mechanical traction.

Use procedure code S9090 – vertebral axial decompression, per session - to report this service.

Decompression therapy, a non-surgical treatment for back pain, is primarily used for chronic low back pain caused by herniated discs and degenerative disc disease. The treatment is performed through the application of distractive tension along the spinal axis. Treatment protocol varies based on the system being used to provide the therapy.

MA Not applicable to Medicare Advantage

Medical Policy Bulletin M-18 (Diagnostic Endocardial Electrical Stimulation {EES} vs. Ablation Procedures
Catheter Ablation Coverage Guidelines Change

On **Aug. 4, 2008**, Mountain State Blue Cross Blue Shield began to cover catheter ablation for supraventricular tachycardia and symptomatic sustained atrioventricular nodal reentrant tachycardia when reported with ICD-9-CM diagnosis code 427.89. Mountain State Blue Cross Blue Shield will also pay for catheter ablation when it's performed for paroxysmal supraventricular tachycardia—ICD-9-CM diagnosis code 427.2.

Effective **Feb. 16, 2009**, Mountain State Blue Cross Blue Shield will no longer cover catheter ablation for:

- supraventricular tachycardia—ICD-9-CM diagnosis code 426.81 or 426.82
- symptomatic sustained atrioventricular nodal reentrant tachycardia—ICD-9-CM diagnosis code 426.89.

MA Also applicable to Medicare Advantage on February 16, 2009.

Medical Policy Bulletin Y-9 (Manipulation Services)
Massage or Hot or Cold Packs Performed with Manipulations Not Covered
Effective: February 16, 2009

Mountain State Blue Cross Blue Shield does not pay for the application of hot or cold packs (97010) or massage (97124) when performed as part of a manipulation service. A participating, preferred or network provider may not bill the member for the denied service.

Mountain State will pay for the application of hot or cold packs or massage if they are performed on a separate body region, unrelated to the manipulation service.

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These guidelines apply to hot or cold packs regardless of whether they are applied before or after the manipulation service.

A therapeutic massage can be done either manually or with a hand-held device. Mountain State Blue Cross Blue Shield considers both methods part of a manipulation when performed in the same area as a manipulation.

Unattended massages, that is, those performed by a chair, mattress, or table, do not require the services of a professional provider. Mountain State Blue Cross Blue Shield does not cover unattended massages.

MA Not applicable to Medicare Advantage

Medical Policy Bulletin S-151 (Transmyocardial {Laser} Revascularization {TMR})
Transmyocardial Revascularization Eligibility Explained
Effective: February 16, 2009

Effective February 16, 2009, Mountain State Blue Cross Blue Shield considers transmyocardial (laser) revascularization (TMR) eligible for the following conditions:

- intermediate coronary syndrome (411.1)
- angina decubitus (413.0)
- prinzmetal angina (413.1)
- other and unspecified angina pectoris (413.9)

If TMR is reported for any other indications, Mountain State Blue Cross Blue Shield considers it experimental/investigational. It is not covered. A participating, preferred, or network provider may bill the member for the denied service.

TMR can be performed as a stand-alone procedure in patients with ischemic myocardium who are not candidates for other types of revascularization procedures, such as coronary artery bypass grafting (CABG) or percutaneous transluminal coronary angioplasty (PTCA) due to anatomical features within their coronary circulation. TMR as a stand-alone therapy is eligible as a last resort for patients with severe (Canadian Cardiovascular Society classification classes III or IV) angina (stable or unstable), which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. The angina must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectory, or coronary bypass.

In addition, patients must have:

- an ejection fraction of 25 percent or greater;
- areas of viable ischemic myocardium (as demonstrated by diagnostic study) which are not capable of being revascularized by direct coronary intervention; and
- been stabilized or have had maximal efforts to stabilize acute conditions such as severe ventricular arrhythmias, decompensated congestive heart failure or acute myocardial infarction.

TMR can also be performed in conjunction with CABG in patients with areas of ischemic myocardium that cannot be treated with bypass grafting. TMR performed as an adjunct to CABG is an eligible service.

Use procedure 33140 to report TMR as a stand-alone procedure. If TMR is performed in conjunction with CABG, use procedure code 33141 to report it.

MA Not applicable to Medicare Advantage

Medical Policy Bulletin S-82 (Intra-Atrial/ Intravenous Therapeutic Procedures)
Venous Percutaneous Transluminal Angioplasty
Effective: February 16, 2009

Mountain State Blue Cross Blue Shield will recognize venous percutaneous transluminal angioplasty as an eligible surgical procedure when performed for superior vena cava obstruction from benign and malignant diseases. Use codes 35476 — Transluminal balloon angioplasty, percutaneous; venous, and 75978 — Transluminal balloon angioplasty, venous, radiological supervision and

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interpretation - to report venous percutaneous transluminal angioplasty.

Mountain State Blue Cross Blue Shield will also pay for venous percutaneous transluminal angioplasty when performed:

- on renal patients who have peripheral arterial/venous fistulas for dialysis and on renal patients who have a centrally placed catheter (403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 584.5-584.9, 585.1-585.9, 586, 996.73,

- as part of the transjugular intrahepatic portosystemic shunt (TIPS) procedure.

Individual consideration will be given for venous percutaneous transluminal angioplasty performed for the treatment of congenital heart disease (746.00-746.09, 746.1-746.7, 746.81-746.89, 746.9).

Mountain State Blue Cross Blue Shield considers venous percutaneous transluminal angioplasty not medically necessary when used in the treatment of any other conditions.

MA Not applicable to Medicare Advantage

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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