Because every child deserves a healthy start, Mountain State Blue Cross Blue Shield (Mountain State) has committed to a $1.5 million contribution to further the health of West Virginia’s children through Governor Joe Manchin’s Kids First screening program. Announced during his State of the State address, Governor Joe Manchin defined this initiative as a public/private partnership designed to increase access to health screenings for children entering kindergarten starting in September 2008.

The Kids First program is being established through the use of administrative funds from the West Virginia Children’s Health Insurance Program (WV CHIP) to ensure every uninsured child entering kindergarten has a wellness screening prior to starting school. For those children who do not have access to health insurance, the Kids First program will provide them the opportunity to receive a health screen at their school. They will also receive an eligibility screening for health insurance through WV CHIP and Mountain Health Choices, the state’s new Medicaid program. For those children entering kindergarten who are insured, Kids First will encourage parents and guardians to take their children to an established medical provider for a health screening.

Providers from across the state who serve these children are asked to use the age-specific HealthCheck screening form (sample following on next page). This form meets the American Academy of Pediatrics standards outlined in the Bright
Futures protocol. Practitioners are requested to provide a copy of the completed screening form to the child’s parent/guardian. The completed HealthCheck form can be presented at kindergarten enrollment to facilitate school admittance. Provider support is requested to remind parents/guardians to take the completed HealthCheck form, immunization record and birth certificate with them to kindergarten enrollment.

As a result of the financial commitment from Mountain State, the Kids First Program can be expanded more quickly to include comprehensive screenings of children in additional grades within the school system. With the rise of critical health conditions affecting our state’s children, including obesity and diabetes, Mountain State considers its financial participation in this endeavor as part of the organization’s social mission to improve the overall health status of West Virginians through public and private partnerships.

Pediatric Program Specialists, from the Office of Maternal, Child and Family Health, are available to provide more detail and to respond to your questions. To learn more about the Kids First Initiative, go to www.wvkidsfirst.org or call 1-800-642-8522 or 304-558-2356.
Attention All Electronic Claims Submitters

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

277CA (Claims Acknowledgement) Reports
If you are an electronic submitter, please make sure you are working your 277CA report daily. This report will provide you with the claims that were not accepted into our system along with the reason why they were not accepted. You can correct the errors and resubmit the claims immediately. Below are some of the most common rejections and solutions to assist you in correcting the errors:

A3>33 error means the claim was submitted with an incorrect identification number. Please check the member’s Mountain State Blue Cross Blue Shield identification card for the correct identification number. (Note: Claims should be submitted with the 3-digit alpha prefix along with the 12-digit UMI. Claims submitted with the members’ social security number will not be accepted.)

A3>130>82 error, the rendering provider number is invalid. The individual number of the provider rendering the services needs to be in the NM1*82 field.

A3>130>85 error, the billing or pay to provider number is invalid. Make sure you are using the billing or pay to provider number, not the rendering or individual number in the NM1*85 field.

A3>130>77 means a professional claim was submitted with a place of service other than the physician’s office and the service facility location number is missing or invalid. This edit is effective January 1, 2008. The service facility provider number must be included on the claim if professional services are rendered at any of the following locations:

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

The Service Facility Provider Numbers can be located on our website at www.msbcbs.com under the provider tab, choose the News & Bulletin link. If you only provide the name and address of the service facility, your claims will deny. Please ensure you are using the XX qualifier for the NPI and the 1B qualifier for the legacy number. It is not required to use both numbers, but claims will process quicker if you include both NPI and legacy numbers.

New Recredentialing Non-Compliance Policy
Starting in 2008, providers will be contacted five times over a 60 day period regarding submission of complete recredentialing information. If the Plan does not receive the required documentation after that time period, the provider will be considered as voluntarily withdrawing from the networks. Providers will be issued a letter to that effect. The voluntary withdraw date will be 90 days from the date of the final recredentialing contact letter. If a provider decides to continue to participate with Mountain State and Highmark Health Insurance Company’s FreedomBlue networks, and submits the documentation following the notification period, he/she will processed as an initial applicant for credentialing and a new contract may need to be executed.
PROVIDER News

FreedomBlue EDI Change:

As of January 1, 2008, FreedomBlue Medicare Advantage electronic claims are no longer being serviced by Mountain State EDI. They will be serviced by Highmark EDI Operations. There is a link on the Mountain State website that will automatically direct you to the Highmark Health Insurance Company (HHIC) website. Paper claims submitters need to continue to mail claims to: MSBCBS, P.O. Box 7026, Wheeling, WV 26003. All customer service numbers will remain the same.

The change, which became effective January 1, 2008, is for submission date, not service date, so all electronic claims regardless of service date will now be serviced by Highmark EDI. All trading partners and clearinghouses have been made aware of this change and have been issued new trading partner numbers by Highmark.

Following are the steps to access the HHIC EDI website:

Go to the Mountain State website at www.msbcbs.com, choose provider drop down, then choose HHIC EDI.

Any questions regarding Freedom Blue electronic submissions should be directed to EDI Operations. Please see below for contact information and hours of operation. (Please note: These numbers are to be used for electronic submission issues only, such as 277CA issues and provider enrollment for electronic claims submissions. Any questions concerning claim status, patient eligibility, remittance rejections, benefits and any other customer service related issues will still be serviced by customer service.)

EDI Hours of Operation:
Monday thru Friday 8:00 am until 4:00 pm EST
Contact Information:
1-800-992-0246 (toll free number)
717-302-5170 (local number)
717-302-7182 (fax number)

NEW EDITS EFFECTIVE APRIL 11, 2008
Additional Steps Taken to Streamline Claims Processing

Strengthening Data Validation
As first reported last year, Mountain State Blue Cross Blue Shield launched a five-year program to enhance many core administrative functions within its information systems structure. Our goal is to offer state-of-the-art efficiency in servicing all of our customers, including providers.

The next phase, effective April 11, 2008, involves making additional edit checks for data completion and accuracy on claims prior to adjudication. With the additional upfront edits, our goal is to prevent incomplete and inaccurate electronic claims from entering the system, thus allowing for more efficient processing. For electronic claim submitters, these new edits will be reported on the X12 277 Claim Acknowledgement (277 CA) Transaction or 277 CA printable report.

In addition to the upfront edits, Mountain State will no longer attempt to correct or retrieve missing information for the situations listed on the next page. Instead, these situations will result in a rejection of the claim, and you will need to resubmit the claim with corrected data. For paper claim submitters, these new edits will result in claim denials reported on your Explanation of Benefits Notice. Trading Partners using the X12 835 Electronic Remittance Advice will receive the standardized Claim Adjustment Reason Codes and Remittance Advice Remark Codes.

Overall processing will be enhanced due to the reduction of claim suspensions and an increase in the timeliness of claims processing. You will be notified more quickly if a claim cannot be processed due to missing or inaccurate data and time-consuming status inquiries may be eliminated.

When a claim rejects, it’s important for your billing staff and/or vendor to understand exactly what was wrong and what’s needed to correct it.

Continued On Next Page
Details for Billing Staff, Clearinghouses and Vendors

The following chart provides the details necessary for billing staff, clearinghouses and vendors.

**New Edit Checks, Effective April 11, 2008**

For claims submitted using the HIPAA 837 electronic transaction, you may encounter the following error codes and descriptions on your X12 277 CA Transaction or 277 CA printable report.

<table>
<thead>
<tr>
<th>Claim Status Code</th>
<th>Claim Status Category Code</th>
<th>Claim Status Code Description</th>
<th>Claim Status Category Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>455 and 145 with Entity code 85</td>
<td>A8</td>
<td>Revenue code for services rendered Entity’s specialty/taxonomy code (Entity code 85 = Billing Provider)</td>
<td>Acknowledgment/Rejected for relational field in error</td>
</tr>
<tr>
<td>475</td>
<td>A3</td>
<td>Procedure code not valid for patient’s age</td>
<td>Acknowledgment/Returned as unprocessable claim</td>
</tr>
</tbody>
</table>

If you submit your claims on paper, you may encounter the following denial codes and descriptions on your Explanation of Benefits notices. Trading Partners using the X12 835 Electronic Remittance Advice will receive the standardized Claim Adjustment Reason Codes and Remittance Advice Remark Codes to explain the error denial.

<table>
<thead>
<tr>
<th>Rejection Code</th>
<th>Rejection Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B5606</td>
<td>In order to process the claim, additional information is required. Please resubmit the claim with a prescription for this service. Electronically enabled providers should resubmit electronically.</td>
</tr>
<tr>
<td>P5039</td>
<td>In order to process this claim, additional information is required. The claim should be resubmitted with a valid modifier and associated number of services rendered. Electronically enabled providers should resubmit electronically.</td>
</tr>
<tr>
<td>P5040 *</td>
<td>The patient’s coverage does not provide for this service in the place of treatment reported. Therefore, no payment can be made.</td>
</tr>
<tr>
<td>P5010 *</td>
<td>The procedure code reported is not appropriate for the patient’s age. Please resubmit claim with verification of the patient’s age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.</td>
</tr>
<tr>
<td>P5011 *</td>
<td>The procedure code reported is not appropriate for the patient’s age. Please resubmit claim with verification of the patient’s age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.</td>
</tr>
<tr>
<td>P5012</td>
<td>The patient’s sex is invalid for the reported procedure. Please resubmit the claim with verification of the patient’s sex and/or a corrected procedure code or a complete description of service. Electronically enabled providers should resubmit electronically.</td>
</tr>
</tbody>
</table>

* These paper claim rejections correspond to the upfront 277 CA edits listed above.
Getting Started – Electronic Claims Submissions

Electronically Enabled Providers
Note: The following questions are applicable if you directly submit electronic claims using your own Trading Partner ID (i.e., you do not submit through a billing service or clearinghouse).

Are there any types of claims that cannot be electronically submitted?
- All medical and surgical claims, including secondary claims, can be submitted electronically to Mountain State.

What are the advantages to submitting claims electronically?
- Claims should be received and processed faster than going through the U.S. Postal System.
- There is an immediate acknowledgment of file receipt and acceptance or rejection of claims into the adjudication system.
- There are no postage fees, or other costs associated with printing and mailing the paper claims.
- There is less time spent by office staff on claim submissions.
- Practice should receive payment more quickly.

Are we required to submit our claims electronically?
- Mountain State is not requiring providers to submit their claims electronically.
- Current efforts are strongly focused on increasing the rate and percentage of electronic submissions from all of our providers and trading partners.

What Practice Management System (PMS) software packages does Mountain State recommend, and what companies offer these packages?
- Mountain State does not recommend a particular PMS software package or software vendor.
- Mountain State does maintain a list of software vendors who have successfully tested their software for electronic claim submission to Mountain State.

Becoming Electronically Enabled

How do I get started?
- This Web site will help you get started applying for and requesting a Trading Partner ID.
- EDI Operations is a department within Mountain State dedicated to assisting you with any questions.

How do I contact EDI Operations?
- You can contact EDI Operations at 1-888-222-5950 or 304-424-7728, Monday through Friday from 8 a.m. to 4 p.m.
- You can also contact them via email at the following email address: msemc@msbcbs.com

Is the EDI Transaction Application available on the website?
- Yes, this application is located on the website. Click on the MountainLink EDI link under the provider tab choose the appropriate agreement.

I am electronically enabled. When I have attachments that I send to Mountain State, should I submit the claim via paper or electronically?
- You should transmit the claim electronically to Mountain State, using transmission codes in the PWK segment, loop 2300-claim information to provide detail related to the supplemental information that you are sending for the claim.

Continued On Next Page
• You should review the specifications in the EDI Reference Guide or work with your Practice Management Software vendor to ensure that the PWK segment is available and properly configured to work with Mountain State processing guidelines.

How do I indicate that I am sending attachments when electronically submitting the claim?
• There are multiple transmission codes within the PWK segment to provide details related to the supplemental information that you are sending for the claim. Specifications for the PWK Segment can be found in the EDI Reference Guide.

I submitted electronically, but my claims are being rejected. Why?
• There are numerous reasons for claim rejections.
• Trading Partners should work with their PMS software vendor and/or EDI Operations to determine the cause for rejection.
• EDI Operations can assist you with the analysis of the acknowledgment transactions provided by Mountain State throughout the electronic claim submission process.

If my electronic claim submission is being rejected, should I drop to a paper submission?
• You should NOT drop rejected electronic claims to paper. Effective Jan. 8, 2007, Mountain State aligned its electronic and paper submission processing guidelines. Dropping rejected electronically submitted claims to paper will only result in the same rejection, unless a correction to the claim (based on the corresponding rejection code) is made.

EDI Reports for Electronically Enabled Providers

How can I review the status of my electronically submitted claims?
• Mountain State provides a 997 Functional Acknowledgment transaction, which advises whether the file was accepted or rejected.
• Mountain State provides a 277 Claim Acknowledgment (277 CA) transaction or a printable version that is used to acknowledge receipt of claim submissions, including the acceptance or rejection of each claim.
• Mountain State provides the 276/277 Claim Status Request and Response transaction for verifying status on claims accepted into the adjudication system.

How can I receive the 277 CA transaction?
• Mountain State produces the 277 CA transaction for all electronic submitters for use by those PMS software vendors who have programmed their system to retrieve the file.
• You should refer to the EDI Trading Partner Web site and talk to your PMS software vendor to determine the necessary data requirements to electronically receive the 277 claim acknowledgment transactions.

How do I obtain a printable version of the 277CA transaction?
• The printable version is an electronic report that utilizes all the data from the 277CA transaction, which has been formatted for ease of viewing by the office staff.
• This report is available for Trading Partners whose PMS software does not accommodate retrieving the 277 CA transaction.
• This report can be obtained by contacting EDI Operations at 1-888-222-5950 or 304-424-7728.
CT Scan Credentialing Criteria

Mountain State Blue Cross Blue Shield (Mountain State) endeavors to keep network practitioners and providers informed about network credentialing policies and procedures. Starting in November of 2007, Mountain State will initiate credentialing criteria that pertains to outpatient general computed tomography (CT) services and cardiac computed tomography angiography (CCT-A) services. Credentialing details may also be obtained by visiting the provider tab of Mountain State’s website at www.msbcbs.com.

Outpatient CT Provider Types and Credentialing Criteria

1. Hospitals that provide outpatient CT and/or CCT-A services;
2. Free standing imaging facilities that provide outpatient CT and/or CCT-A services;
3. Physician offices that provide outpatient CT and/or CCT-A services.

Accreditation:
A copy of a current letter or certificate of accreditation, both of which will be inclusive of the accreditation expiration date. Accepted accreditations are:

1. The American College of Radiology (ACR) for free standing and physician office based outpatient CT scanners;
2. The Intersocietal Commission Accreditation of CT Labs (ICACTL) for free standing and physician office based outpatient CT scanners;
3. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for hospital based outpatient CT scanners.

- Image Interpretation: Mountain State requires that physicians interpreting CT images be participating providers with the Plan.

- Medicare Eligibility for Highmark’s Medicare Advantage Network

- Professional Liability Insurance: $1.0 million per occurrence and $3.0 million aggregate.

- Lack of Medicare or Medicaid sanctions or Medicare Opt Out

- Equipment: Owned or leased by a MSBCBS credentialed provider.

- Hours of Operation: At least 40 hours a week.

- Onsite Reviews: Conducted by Mountain State to ensure compliance.

Network CT Approval Process

1. Providers who are currently participating with Mountain State, as of the effective date of the policy, and are presently being reimbursed for CT services, will be given one year to become credentialed.
2. Providers who are currently participating with Mountain State and are applying to perform CT services, as of the effective date of the policy, will be required to become credentialed, prior to being authorized to perform CT services for Mountain State members.
3. Providers who are not currently participating with Mountain State, as of the effective date of the policy, and are applying to perform CT services will be required to become credentialed, prior to being authorized to perform CT services for Mountain State members.

Contact Information

Provider Relations (Professional Providers): 800-798-7768

Provider Contracting and Reimbursement (Facilities): (304) 357-7562

Network Credentialing: 888-475-2391 (Option 6)
**NPI UPDATE:**

Effective May 23, 2008, Mountain State Blue Cross Blue Shield Will Reject Electronic Claims That Don’t Contain NPIs In Billing, Rendering Provider and Service Facility Field

Electronic claims submitted without a billing, rendering provider, and service facility NPI will be returned to the provider beginning May 23, 2008. Please begin using the billing, rendering provider, and service facility NPI by this date.

Mountain State’s information systems will continue to accept the following on transactions until May 23, 2008, when the Contingency Plan ends:

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

Mountain State recommends providers use the dual strategy option until claims have been processed with correct payment and it has been confirmed the NPI is translating to the legacy number that was submitted on the transactions. Providers should carefully migrate to the use of only the NPI in transactions after payments have been confirmed to process correctly using the NPI before the May 23, 2008 deadline.

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

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

- Be active in efforts to be HIPAA NPI compliant.
- Obtain an NPI and report it to MSBCBS.

- Work with software vendors, clearinghouses and trading partners to send and receive compliant transactions.
- Document the good-faith efforts that they have employed or are employing toward NPI compliance.

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

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

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

Instructions on how to get the NPI, share the NPI and use the NPI can be found on [www.msbcbss.com](http://www.msbcbss.com).
Effective January 1, 2008, all Blue Plans started crossing over Medicare claims for services covered under Medigap and Medicare Supplemental products. This resulted in automatic claims submission of Medicare claims to the Blue secondary payer, and reduced or eliminated the need for the provider’s office or billing service to submit an additional claim to the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide.

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

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member’s ID card for additional verification.
- Be certain to include the alpha prefix as part of the member identification number. The member’s ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.
- When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:
  - If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to Mountain State.
  - If the remittance indicates that the claim was not crossed over, submit the claim to Mountain State with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, contact Mountain State at 1-800-543-7822.

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

What should I do in the meantime?
If you submitted the claim to the Medicare intermediary/carrier, and haven’t received a response to your initial claim submission, don’t automatically submit another claim. Rather, you should:

- Review the automated resubmission cycle on your claim system.
- Wait 30 days.
- Contact Mountain State to check claims status before resubmitting.

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

Who do I contact if I have questions?
If you have questions, please call Mountain State at 1-800-543-7822.
**NAVINET UPDATE**

**Submitting Authorizations Via NaviNet**

All NaviNet enabled providers (professional and facility/ancillary) are requested to submit their authorizations for Mountain State members via NaviNet. You will save time submitting the authorizations online, instead of contacting us by fax or phone.

This transaction has various dropdown boxes and search features to streamline the keying process. Clinical information is typed online to eliminate the faxing of information. Once authorizations are submitted to Mountain State, you immediately receive the tracking number/authorization number and can track the status from pended to complete.

Status updates are returned to you as Action Items. Remember that ‘Incomplete’ Action Items are responses from Mountain State that you have not read, while “Complete” Action Items are responses that were read. If additional information is needed to process your request the Action Item will give you a place to type your response and then submit it to us electronically.

You also have an electronic filing cabinet that stores all of the authorizations you create in NaviNet. This file is located under the Office Central tab and is listed as the Referral/Auth Log. The file will sort by various means, including member name, member ID# or you can sort by “Plan Name Contains”, then select “Mountain” and you will receive ALL Mountain Sate authorizations created in NaviNet.

For more information on this transaction, log into NaviNet and review the User Guides under the Customer Service tab/NaviNet Customer Care, or contact Michelle Beihl at 304-234-7069. For NaviNet questions or to schedule training, please contact your assigned External Provider Relations Representative. A training demo is also available on the NaviNet Customer Care page to assist you with all NaviNet transactions.

---

**New Process For Charge Audit Adjustments**

Mountain State Blue Cross Blue Shield has implemented a new process for adjustments performed as a result of Charge Audit for Inpatient and Outpatient claims.

The previous process was as follows:
Upon completion of the audit, the unsupported charges are adjusted (recovered) and the unbilled and/or underbilled charges are adjusted. The facility was not required to submit a corrected bill.

As of January 1, 2008, the new process has been changed to:
Upon completion of the audit the unsupported and underbilled charges will be adjusted accordingly. However, the facility will be required to submit a corrected bill for the unbilled or underbilled charges.

If you have any questions regarding these changes please contact the Charge Audit Department at (304) 347-7799 or (304) 347-7713.
West Virginia Medication Alternatives for the Elderly

In conjunction with West Virginia’s Quality Improvement Organization - the West Virginia Medical Institute - Highmark Health Insurance Company (HHIC) is currently working to decrease the number of older members who are prescribed medications that are on the list of “Drugs to be Avoided in the Elderly” (DAE).

During a review of 2007 drug claims for FreedomBlue members, it was concluded that 32% of members were prescribed at least one DAE medication. Information regarding this subject was recently mailed to all primary care providers. We are asking for assistance from all providers in helping to reduce this rate.

The following table details the drugs to avoid and the recommended agents to be considered as alternatives. To receive a laminated copy of this table to display in your office, please contact your assigned External Provider Relations Representative.

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Drugs to Avoid</th>
<th>Concerns</th>
<th>Formulary Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety</td>
<td>meprobamate (Equagesic, Equanil, Miltown)</td>
<td>Highly addictive and sedating anxiolytic</td>
<td>Buspar, Buspirone HCl (buspirone)</td>
</tr>
<tr>
<td>Antiemetic</td>
<td>Trimethobenzamide (Tigan)</td>
<td>Can cause extrapyramidal side effects. Low effectiveness as an antiemetic</td>
<td>Antivert (meclizine), Compazine (prochlorperazine), Zofran (ondansetron)</td>
</tr>
<tr>
<td>Antidepressant</td>
<td>amitriptyline (Elavil) doxepin (Sinequan, zonalon)</td>
<td>Long half-life of drug and risk of producing excessive CNS stimulation, sleep disturbances, and increasing agitation</td>
<td>Celexa (citalopram), Remeron (mirtazapine), Zoloft (sertraline)</td>
</tr>
<tr>
<td>Analgesic/Non-narcotic/NSAIDs</td>
<td>Indomethacin (Indocin) ketorolac (Toradol) naproxen (naproxy)</td>
<td>Avoid all use in older patients since many have asymptomatic GI pathology</td>
<td>Short-term use: Short acting NSAID, Cox II</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>cyproheptadine (Periactin) dexchlorpheniramine (Polaramine) diphenhydramine (Benadryl) ephedrine hydroxyzine (Vistaril, Atarax) promethazine (Phenergan) tripelemamine</td>
<td>May have potent anticholinergic properties. Can cause sedation, weakness, blood pressure changes, dry mouth, problems with urination and can lead to falls</td>
<td>Allegra (fexofenadine), Astelin (azelastine)</td>
</tr>
</tbody>
</table>
### Drug Class

#### Antipsychotics, typical

<table>
<thead>
<tr>
<th>Drugs to Avoid</th>
<th>Concerns</th>
<th>Formulary Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mesoridazine Besylate (Serentil)</td>
<td>Greater potential for CNS and extrapyramidal side effects</td>
<td>Abilify (aripiprazole), Geodon (ziprasidone), Orap (pimozide), trifluoperazine, Zyprexa (olanzapine non-injection)</td>
</tr>
<tr>
<td>thioridazine (Mellaril)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Amphetamines

<table>
<thead>
<tr>
<th>Drugs to Avoid</th>
<th>Concerns</th>
<th>Formulary Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>amphetamine mixtures (Adderall)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzphetamine (Didrex)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dextroamphetamine (Dexedrine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dexamfetamin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diethylpropion (Tenuate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>methamphetamine (Desoxyn)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>methylphenidate (Ritalin, Methylin, Concerta)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pemoline (Cylert)</td>
<td>Potential for dependence, angina, hypertension and myocardial infarction</td>
<td>No preferred agents exist within the drug class</td>
</tr>
<tr>
<td>phendimetrazine (Prelu-2, Bontril)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>phentermine (Isonam, Adipex)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Barbiturates (except for phenobarbital when used to control seizure activity)

<table>
<thead>
<tr>
<th>Drugs to Avoid</th>
<th>Concerns</th>
<th>Formulary Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>amobarbital / Secobarbital (Tuinal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amytal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>butabarbital (Butisol)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>butalbital combinations, fiornal, fiorcet, esgic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mephobarbital (Meboral)</td>
<td>Highly addictive and causes more adverse effects than most sedatives or hypnotic drugs in the elderly</td>
<td>Barbiturates are not a covered benefit under Medicare Part D. Evaluate indication for use and potential for patient ability to self-pay for medication if benefits outweigh risks.</td>
</tr>
<tr>
<td>Pentobarbital (Nembutal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenobarbital secobarbital (Seconal)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Long-acting

<table>
<thead>
<tr>
<th>Drugs to Avoid</th>
<th>Concerns</th>
<th>Formulary Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>chlordiazepoxide (Librium)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chlordiazepoxide/amitriptyline (Limbitrol)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diazepam (Valium, Diastat)</td>
<td>Long half-life in elderly patients (often several days), producing prolonged sedation and increasing the risk of falls and fractures</td>
<td>Benzodiazepines are not a covered benefit under Medicare Part D. Evaluate indication for use and potential for patient ability to self-pay for medication. Potential alternative of buspirone (Buspar, buspirone HCl) for anxiety indications.</td>
</tr>
<tr>
<td>flurazepam (Dalmam)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Calcium channel blockers

<table>
<thead>
<tr>
<th>Drugs to Avoid</th>
<th>Concerns</th>
<th>Formulary Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>nifedipine (Procardia, Adalat) – short-acting only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Class</td>
<td>Drugs to Avoid</td>
<td>Concerns</td>
</tr>
<tr>
<td>------------</td>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>Gastrointestinal antispasmodics</td>
<td>dicyclomine (Bentyl)</td>
<td>GI antispasmodic drugs are highly anticholinergic and have uncertain effectiveness</td>
</tr>
<tr>
<td>H2 antagonist</td>
<td>cimetidine (Tagamet)</td>
<td>CNS adverse effects including confusion</td>
</tr>
<tr>
<td>Belladonna alkaloids (including combination drugs)</td>
<td>atropine sulfate</td>
<td>All have uncertain effectiveness and are strongly anticholinergic. Avoid all use - particularly long-term use</td>
</tr>
<tr>
<td></td>
<td>belladonna</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hyoscyamine (Anasap, Cystospaz, Levsin, Levsonex)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In combination (Barbipenn, Bellergal-S, Butibel, Donnatai)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>scopolamine (Scopace, Transderm-Scope)</td>
<td></td>
</tr>
<tr>
<td>Skeletal muscle relaxants</td>
<td>carisoprodol (Soma)</td>
<td>Most muscle relaxants and antispasmodic drugs are poorly tolerated by elderly patients. They cause anticholinergic adverse effects, sedation, and weakness</td>
</tr>
<tr>
<td></td>
<td>chlorzoxazone (Paraflex)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>cyclobenzaprine (Flexeril)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>metaxalone (Skelaxin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>methocarbamol (Robaxin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>orphenadrine (Norflex)</td>
<td></td>
</tr>
<tr>
<td>Oral estrogen</td>
<td>Oral estrogen (Premarin, Ogen, Menest)</td>
<td>No cardioprotective effect. Significant risk of carcinogenic effects (breast and endometrial cancer)</td>
</tr>
<tr>
<td>Oral hypoglycemics</td>
<td>chlorpropamide (Diabinese)</td>
<td>Has a prolonged half-life in elderly patients and could cause prolonged hypoglycemia. It is the only oral hypoglycemic that can cause syndrome of inappropriate antidiuretic hormone secretion</td>
</tr>
<tr>
<td>Narcotics</td>
<td>meperidine (Demerol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pentazocine (Talacen, Talwin, Talwin compound, Talwin NX)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>propoxyphene combinations (Darvon compound, Darvon N, Darvocet-N)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>propoxyphene (Darvon)</td>
<td>CNS adverse effects, may cause confusion</td>
</tr>
<tr>
<td>Drug Class</td>
<td>Drugs to Avoid</td>
<td>Concerns</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Vasodilators</td>
<td>dipyridamole (Persantine)</td>
<td>Short acting only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May cause orthostatic hypotension</td>
</tr>
<tr>
<td></td>
<td>cyclandelate (Cyclospasmol)</td>
<td>Lack of efficacy</td>
</tr>
<tr>
<td></td>
<td>isoxsuprine (Vasodilan)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>desiccated thyroid</td>
<td>Concerns about cardiac effect</td>
</tr>
<tr>
<td></td>
<td>nitrofurantoin (Macrodantin)</td>
<td>May cause renal impairment</td>
</tr>
<tr>
<td></td>
<td>methyltestosterone (Android, Virilon, Testred)</td>
<td>Potential for prostatic hypertrophy and cardiac problems</td>
</tr>
<tr>
<td>Other - injectables</td>
<td>atropine injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>diazepam injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dicyclomine injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>diphenhydramine injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dipyridamole injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hydroxyzine injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ketorolac injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>meperidine injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mesoridizine injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(serentil)</td>
<td></td>
</tr>
<tr>
<td>Other - injectables</td>
<td>methocarbamol injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>orphenadrine injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pentazocine (Talwin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pentobarbital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>promethazine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Premarin injectable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>scopolamine injectable, patches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>trimethobenzamide (Tigan)</td>
<td></td>
</tr>
<tr>
<td>Other -</td>
<td>Nandrolone</td>
<td></td>
</tr>
<tr>
<td>Other -</td>
<td>Oxandrolone</td>
<td></td>
</tr>
<tr>
<td>Other -</td>
<td>Stanozolol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Testosterone</td>
<td></td>
</tr>
</tbody>
</table>
WVSBP Update – Using PEIA pricing for the West Virginia Small Business Plan, MSBCBS updated the RBRVS, drugs and biologicals, cast and splint supplies and Durable Medical Equipment (DME) services with an effective date of 01-01-08 based upon the availability of the information from the PEIA.

AWP (Average Wholesale Price) Change – Effective February 1, 2008, MSBCBS is implementing a change in the allowance for those services (drugs, biologicals, injectibles, chemotherapy agents and home infusion drugs) which use AWP as the basis for the allowance. The new allowance will be 85% of AWP for the PPO, POS, and Steel products. This change will not affect Traditional business, immunizations or the Medmark Specialty Drug Program.

CT Scans, MRI and Linear Accelerator – MSBCBS has updated the reimbursement for the global and technical components for these services. Effective January 1, 2008 the conversion factor will be $70.63 for the technical component and technical component of the global (20% reduction) for PPO and Traditional, and $53.47 for POS. The conversion factor for the professional component (modifier 26) remains unchanged. A related change was effective November 26, 2007 for the Cardiac CT Angiography services. A separate bulletin was mailed in December 2007.

2008 RBRVS Reimbursement Updates – In 2007, MSBCBS implemented the RBRVS annual update with an effective date of July 1, 2007 for our commercial products. This provided MSBCBS the time to effectively review and analysis the comprehensive changes made by CMS. The RBRVS 2008 annual update for will be effective July 1, 2008. During the winter and spring MSBCBS will review and analyze the CMS changes. As MSBCBS finalizes plans for the annual update we will provide an update to our provider community. The new codes were added effective 1-1-2008 utilizing the CMS Work RVU Budget Neutral Factor of 0.8806. Like CMS, MSBCBS will continue the implementation of the transitional RVU for 2008. For Highmark Health Insurance Company’s (HHIC’s) FreedomBlue PPO professional reimbursement will follow the CMS RBRVS schedule effective January 1, 2008

Preventive Guidelines Available on Website!

Mountain State Blue Cross Blue Shield is committed to promoting and providing quality care for all members. That is why we have developed the following preventive guidelines to be used in the care of all our members with the understanding that additional services should be rendered based upon the special needs of the individual patient. 2008 guidelines have been established for:

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

These guidelines can be accessed under the “Provider News and Bulletins” section of our website at www.msbcbs.com
Important Reminders & Updates

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

Claims Being Submitted With Incorrect Member Information
Claims should be submitted with the full name of the patient who appears on the ID card. Please do not submit the initial of the patient’s first name or any nicknames. Approximately 7,329 claims have stopped within our system for patient verification because of these errors. This causes a delay in processing and getting disbursements back to the provider in a timely manner. Verification and/or correction within your system or your vendor’s system may result in a better turnaround of your payments and allow us to service you in a more efficient manner. Thank you for your cooperation and assistance.

Imaging Authorization Changes Coming Soon
Highmark Health Insurance Company (HHIC) FreedomBlue PPO will require authorizations for the same imaging procedures as Highmark FreedomBlue PPO. Authorizations will be required for different levels of diagnostic imaging including CAT, MRI and PET scans. Making authorization requirements consistent will help ensure that FreedomBlue members receive the same care across Pennsylvania and West Virginia. More detailed information will be provided in the coming months.

WELCOME To Our New Groups:

Building Trades Welfare Fund of the Ohio Valley
Effective Date: 1/1/08
Number of employees: 377
Group location: WV
Product Type: PPO
Claims processing location: Wheeling
Account Representative: Thomas Alderson
Alpha Prefix: ZPO

Global Contact Services (GCS)
Effective Date: 1/1/08
Number of employees: 1500
Group location: WV, NC, VA, TX, FL, OH, AZ
Product Type: PPO
Claims processing location: Parkersburg
Account Representative: Cathy Cain
Alpha Prefix: ZPN
Basic Consumer Option
What You Should Know!

The Blue Cross and Blue Shield Service Benefit Plan is offering a new benefit option in 2008 called the Basic Consumer Option (a sub-option of Basic Option). This sub-option is a high-deductible health plan that encourages Blue Cross and Blue Shield Service Benefit Plan members to act as consumers when spending their benefits dollars, much as they do when making any other purchasing decision. For 2008, Basic Consumer Option is offered to federal employees who live in the following four pilot areas: Ohio, Minnesota, Tennessee and Missouri – Kansas City.

Success with Basic Consumer Option requires that all partners in the healthcare experience be well-informed. Ultimately, our goal is not only to empower Blue Cross and Blue Shield Service Benefit Plan members with the tools needed to be smart healthcare “shoppers” but to help our providers better understand the common features of Basic Consumer Option. Although the Blue Cross and Blue Shield Service Benefit Plan in your area is not part of the pilot, a member with this option may seek services outside their local plan. If this should occur, you will find some helpful information below about the distinct features of this plan as well as tips that will guide you when submitting claims for these Blue Cross and Blue Shield Service Benefit Plan members.

Basic Consumer Option Key Features

Network of Providers – Similar to Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option, Basic Consumer Option offers members great access to our network of Preferred (PPO) providers. Basic Consumer Option members must see preferred providers in order to receive benefits, except in certain circumstances, such as emergencies.

New ID card - A valid Blue Cross and Blue Shield Service Benefit Plan Basic Consumer Option ID card is needed with the debit card.

Medical services - Basic Consumer Option pays 100% of covered preventive care services not subject to the deductible. Once the deductible is met, Basic Consumer Option pays 100% of the Plan allowance for all other traditional covered services.

Deductible – Basic Consumer Option has a $2,900 calendar year deductible for self only enrollments, and a $5,800 calendar year deductible for self and family enrollments. This deductible must be met before Traditional medical coverage begins. This deductible includes both medical and pharmacy services.

Financial Components - This high deductible health plan is combined with a tax-favored Health Savings Accounts (HSA) or Health Reimbursement Arrangement (HRA) to help members better manage their healthcare costs.

Debit Card - The card allows members to pay for and track out-of-pocket costs using funds from their HSA. Not all members will have a Blue Cross Blue Shield debit card. Members may use any form of payment that is accepted by the provider for services.
Provider Data and Decision Support Tools – The Blue Cross and Blue Shield Service Benefit Plan provides information about healthcare providers (such as demographic, provider types/specialties, hospital affiliations, etc.) to members through the Blue Cross and Blue Shield Service Benefit Plan Online Provider Directory, available through www.fepblue.org. In addition to searching for a provider, decision support tools on cost and hospital profile information (i.e., cost ranges by episode treatment or groupings by conditions, profile data on length of stay, and hospital volumes and complications by procedure) are available through www.fepblue.org. This information is provided to help members make healthcare decisions.

Provider Tips

Carefully determine the member’s financial responsibility before processing payment. You can access the member’s *accumulated deductible by contacting the customer service department listed on the back of the member’s ID card or by using the local plan’s online services.

Ask members for their Basic Consumer Option ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information and avoid unnecessary claims payment delays.

Check eligibility and benefits by calling us at 800-535-5266.

Quick Tip: for faster processing, use electronic capabilities.

If the member presents a debit card be sure to verify the out-of-pocket amounts before processing payment. Providers may forego using the debit card and submit the claims to the local plan for processing. The provider remit will advise the provider of member responsibilities.

Providers may use the debit card or any other accepted form as payment for all medical services provided in their office. These services should be billed to the local Plan and should not be applied to the debit card. If you have any questions about the member’s benefits or to request *accumulated deductible information, please contact us at 800-535-5266.

File claims for Blue Cross and Blue Shield Service Benefit Plan Basic Consumer Option members to Mountain State Blue Cross Blue Shield.

Services are covered just as they are under Basic Option. Contact your local Plan for a complete description of covered benefits, exclusions and limits.

For questions please contact FEP Customer Service at 800-535-5266.

* Accumulated deductible information is based on claims received to date; the information is not real-time.
Credentialing and Contracting Requirements

Effective January 1, 2008, Mountain State changed some of the required credentialing and contract criteria. Credentialing details can be obtained by visiting the provider tab of Mountain State’s website at www.msbcbcs.com. This information was also published in the Fall 2007 Provider News.

Network Contracting Process Changes!
All provider types will be required to be credentialed prior to contracting with Mountain State. Effective January 1, 2008, providers will not be reimbursed prior to completion of the credentialing process and the contract effective date will be determined by Mountain State. This policy is already in place for the Medicare Advantage Network.

Credentialed Provider Types

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


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

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

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

**UPDATE:**

**Hospital Based Providers**
Mountain State and Highmark have evaluated their respective credentialing processes for the Mountain State commercial PPO and Highmark Medicare Advantage networks. Pathologists, radiologists, anesthesiologists, emergency room physicians, hospitalists and hospital based allied health practitioners must successfully complete our full credentialing/recredentialing process to obtain and maintain status as a participating provider.

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

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

**All practitioner credentialing applications are to be forwarded to the following address:**
Highmark Provider Data Services Department
P.O. Box 898842
Camp Hill, PA 17001
866-763-3224

Continued On Next Page
CREDENTIALING AND CONTRACTING REQUIREMENTS

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

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

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

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

MEDICAL POLICY UPDATES

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

Our medical policies are also available online through NaviNet® or at www.msbcbs.com. An alphabetical, as well as a sectional index, is available on the Medical Policy page. You can search for a medical policy by entering a key word, policy number, or procedure code. Please note: A separate link exists for researching Medicare Advantage Medical Policies.

Recent updates or changes are as follows:

Medical Policy Bulletin S-60 (Artificial Hearts and Ventricular Assists Devices)
Mountain State Blue Cross Blue Shield covers Thoratec HeartMate for certain patients.
Effective: October 29, 2007

Mountain State Blue Cross Blue Shield pays for the implantation (33975, 33976) and removal (33977, 33980) of these devices as destination therapy in accordance with FDA-approved use:

- Thoratec HeartMate® XVE LVAS
- Thoratec HeartMate Left Ventricular Assist System (SNAP VE LVAS)

Mountain State defines destination therapy as implanting the XVE LVAS or the SNAP VE LVAS device as permanent support for end-stage heart failure patients not eligible for heart transplants.

Both of these criteria must be met:

- The patient has end-stage heart failure (ICD-9-CM codes 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.9), and,

The following enrollment criteria, which is required for the REMATCH trial, must also be met:

- The patient must be at least 18 years of age.
- The patient must have chronic heart failure (NYHA Class III or IV on inotropes/IABAP).
- The patient is not eligible for heart transplant due to age, diabetes, kidney failure, or other co-morbidity.
- The patient is receiving reasonable doses of digoxin, diuretics, and ACE inhibitors (unless intolerant).
- The patient has a left Ventricular Ejection Fraction less than or equal to 25 percent.
- The patient has a VO2 max less than or equal to 14 ml/kg/min, unless failed inotrope wean.

The exclusion criteria includes:

- any medical condition that, if corrected, would improve heart function

Continued On Next Page
any condition that could result in a poor surgical risk
prior heart transplant, left ventricular reduction, or cardiomyoplasty
stroke, impaired cognitive function, history of severe cerebral vascular disease
severe end-organ damage

MA For Medicare Advantage coverage guidelines, see Medicare Advantage Medical Policy Bulletin S-60.

Medical Policy Bulletin Z-27  (Eligible Providers and Supervision Guidelines)
Supervision of service guidelines explained.

Mountain State Blue Cross Blue Shield pays for covered services only when they are personally performed by an eligible professional provider or under that provider’s personal supervision, in accordance with certain licensure and employment criteria.

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

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

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

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

“Personal supervision” means that the professional provider must be present in the immediate vicinity or must be immediately available by electronic means, for example, telephone, radio, and telecommunications, in the event his or her personal assistance is required for care of the patient. All supervision must be in accordance with the state licensure requirements of the performing licensed health care practitioner.

When providing care to his or her patient, the professional provider has medical and legal responsibility for the services provided, whether performed personally or by a licensed employee. This includes the ability to take over the procedure or to care for the patient in the event it becomes necessary. For example, patients may experience an acute medical problem, for example, syncopal episode, cardiac arrest, even during non-invasive diagnostic procedures. It is also possible for equipment failure to result in circumstances that require patient management by a physician.

For reimbursement purposes, Mountain State Blue Cross Blue Shield requires that services reported for its members are either personally performed by the eligible professional provider or under that provider’s personal supervision. Mountain State Blue Cross Blue Shield cannot pay some health care practitioners directly. Rather Mountain State will pay either the supervising participating, preferred, or network physician, or the patient. In most cases, the amount

Continued On Next Page
paid will be the same as that which would be paid if the services were personally performed by the reporting physician. When reporting supervised services, the supervising provider should report the service on the claim as if he or she performed it personally and document the details in the patient's medical record.

Certain diagnostic tests have been identified that have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include Holter monitoring (93224, 93230, and 93235), cardiac event monitoring (93268), and sleep studies (95807-95811). These procedures are performed under the physician's overall management and control, but the physician is not present for the duration of the test.

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

MA Does not apply to Medicare Advantage.

Otoplasty to improve hearing impairment considered reconstructive surgery.
Effective: March 17, 2008

Beginning March 17, 2008, Mountain State Blue Cross Blue Shield will consider otoplasty as reconstructive surgery when it's performed to improve hearing impairment, whether the ears are absent or deformed from trauma, surgery, disease, or congenital defect.

Mountain State Blue Cross Blue Shield defines hearing impairment as a loss of at least 15 decibels outside the normal hearing range in the affected ear(s) documented by audiogram. The degree of hearing loss refers to the severity of the loss. Normal range or no hearing loss = 0dB to 20dB. If an otoplasty is performed for any other indications, Mountain State Blue Cross Blue Shield will consider it as cosmetic surgery rather than reconstructive.

Report otoplasty with procedure code 69300—otoplasty, protruding ear, with or without size reduction.

Mountain State Blue Cross Blue Shield defines cosmetic and reconstructive surgery
Mountain State Blue Cross Blue Shield defines cosmetic surgery as surgery performed exclusively to improve an individual's appearance. Cosmetic surgery is generally not eligible for payment. A participating, preferred, or network provider may bill the member for denied cosmetic surgery. However, Mountain State Blue Cross Blue Shield will cover cosmetic surgery when it's performed to correct a condition resulting from an accident.

Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Mountain State Blue Cross Blue Shield generally covers reconstructive surgery.

MA Does not apply to Medicare Advantage.

New coverage guidelines for treating port wine stains and rosacea.
Effective: March 17, 2008

Mountain State Blue Cross Blue Shield has established new coverage criteria for the treatment of port wine stains and the non-pharmacological treatments of rosacea. Mountain State Blue Cross Blue Shield will apply these criteria beginning March 17, 2008.

Mountain State Blue Cross Blue Shield will cover the treatment of port wine stain lesions on the face and neck as reconstructive surgery. Mountain State Blue Cross Blue Shield considers the treatment of port wine stain lesions on the trunk or extremities as cosmetic.

Mountain State Blue Cross Blue Shield will consider the non-pharmacological treatments of rosacea, including but not limited to, laser and light therapy, dermabrasion, chemical peels, surgical debulking, and electrosurgery, as cosmetic.

These guidelines are appropriate for the majority of individuals. Each person’s unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Report procedure codes 17106-17108 for the treatment of port wine stains.

You may report the following procedure codes for the non-pharmacological treatment of rosacea. This is not an all-inclusive list.

15780-15783 for dermabrasion
15788-15793 for chemical peels
17000-17004 for electrosurgery

Continued On Next Page
Mountain State Blue Cross Blue Shield defines cosmetic surgery as surgery performed solely to improve an individual’s appearance. Cosmetic surgery is generally not eligible for payment. A participating, preferred, or network provider may bill the member for the denied service. However, cosmetic surgery is eligible when performed to correct a condition resulting from an accident in accordance with the member’s benefit.

Reconstructive surgery is performed to improve or restore functional impairment or to alleviate pain and physical discomfort resulting from a condition, disease, illness, or congenital birth defect. Mountain State Blue Cross Blue Shield generally covers reconstructive surgery.

**Medical Policy Bulletin Y-9 (Manipulation Services)**

**How to report time-based physical medicine services with an E/M service.**

**Effective: March 17, 2008**

Time-based physical medicine services include the time required to perform all aspects of the service including pre-, intra-, and post-service work, for example, an assessment of the patient. Therefore, a separate evaluation and management (E/M) service must be medically necessary. The separate E/M service should not routinely be reported with physical medicine services. Report separate E/M services only in these circumstances:

- initial examination of a new patient or condition,
- acute exacerbation of symptoms or a significant change in the patient’s conditions, or
- distinctly different indications, which are separately identifiable and unrelated to the physical medicine service.

If medical care is reported for any of the above circumstances, report modifier 25 with the E/M service to identify it as a separately identifiable service.

Please include documentation in the patient’s medical record that a separate E/M service was performed in addition to the therapeutic procedure or modality.

**Medical Policy Bulletin Y-9 (Manipulation Services)**

**Manipulation services require specific medical record documentation.**

**Effective: March 17, 2008**

Mountain State Blue Cross Blue Shield requires that manipulation services (98925-98929, 98940-98943) be appropriate for the diagnosis you report. Also, you must include certain documentation in the patient’s medical record for each service performed for each date of service.

Documentation must include the following to validate the appropriateness of the manipulation:

- A record of the patient’s subjective complaint,
- An objective assessment or physical findings to support the manipulation,
- A clear description of the type of adjustment provided, including the body region to which the adjustment was performed, and,

The five spinal regions referred to in the descriptions for codes 98940-98942 are: cervical (includes atlanto-occipital joint), thoracic (includes costovertebral and costotransverse joints), lumbar, sacral, and pelvic (sacro-iliac joint).

Report services based on the number of regions manipulated, for example, if two regions are manipulated, report code 98940. If more than one segment is manipulated in a single region, it is still considered one region for reporting purposes.

The five extraspinal regions identified for code 98943 are: the head (including temporomandibular joint, excluding the atlanto-occipital), lower extremities, upper extremities, rib cage (excluding costotransverse and costovertebral joints), and abdomen.

Procedure code 98943 describes treatment to one or more extraspinal regions; therefore, report the service once regardless of how many individual extraspinal manipulations are performed.

Eleven regions are identified for codes 98925-98929. These include: head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdomen, and visceral.

**Continued On Next Page**
A region includes all muscles or ligaments attached to the region being treated. For example, the trapezius muscle is in the same region as the cervical and thoracic spine.

In your documentation you may include these phrases: spinal manipulation, spinal adjustment, manual adjustment, manual manipulation, chiropractic adjustment, chiropractic manipulation, osteopathic manipulation, or abbreviations such as CMT or OMT. It is also appropriate to record the actual chiropractic or osteopathic technique being employed.

**Additional instructions for related modalities**

Mountain State considers physical medicine procedures and modalities that are performed solely to relax and prepare the patient for a manipulation procedure (application of hot or cold packs [97010] and massage [97124]) an inherent part of the manipulation. These services are not eligible for separate payment when reported on the same day as manipulation. A participating, preferred, or network provider may not bill the member for the denied services.

Joint mobilization (97140) can be used to treat spinal or extraspinal conditions. Mountain State Blue Cross Blue Shield considers code 97140 an inherent part of a manipulation procedure. It is not eligible for separate payment when reported on the same day as manipulation. A participating, preferred, or network provider may not bill the member for the denied service.

When codes 97010, 97124, or 97140 are performed on a separate body region, unrelated to the manipulation procedure, Mountain State Blue Cross Blue Shield will consider them for separate payment. For example, patients may experience referred symptoms, such as sciatica to an extremity caused by spinal misalignment. In such cases, treatment of the causative diagnosis, for example, spinal misalignment, is medically necessary. However, Mountain State Blue Cross Blue Shield will consider separate treatment of the extremity medically necessary only if objective findings demonstrate a distinct, unrelated physical problem with the extremity. Otherwise, Mountain State Blue Cross Blue Shield will consider treatment to the extremity in this example to be related to the primary service (treatment of spinal misalignment).

When codes 97010, 97124, and/or 97140 are performed on separate body regions and are unrelated to the manipulation procedure, report modifier -59 along with them. In these instances, include documentation in the patient’s medical record that identifies the distinct body regions and diagnoses for which these services were provided.

**Medical Policy Bulletin Y-1 (Physical Medicine) Constant and supervised attendance modalities reporting guidelines clarified.**

Effective: March 17, 2008

Physical medicine modalities vary according to whether direct (one-on-one) or supervised contact is required for the treatment.

Direct one-on-one contact requires that the provider is physically present and maintains visual, verbal, and/or manual contact with the patient throughout the procedure.

Constant attendance modalities (codes 97032-97039) are those modalities that require direct (one on one) patient contact by the provider. These are time-based codes that include the time required to perform all aspects of the service, including pre-, intra- and post-service work. Documentation must include the amount of time spent in providing all aspects of this service.

Supervised modalities (codes 97010-97028) do not require direct one-on-one patient contact. These are not time-based codes. Report these codes only once during a patient encounter (visit), regardless of the amount of time spent supervising the modality or the number of body areas treated.

Documentation for all physical medicine modalities and therapeutic procedures must include:

- the patient’s subjective complaint,
- an objective assessment,
- the region being treated, and
- the specific modality or therapeutic procedure performed.

When you report electrical stimulation, remember to include documentation in the patient’s medical records that indicates whether the modality was attended (electrical stimulation with constant attendance, code 97032) or unattended (supervised electrical stimulation, code 97014).

**MA** Does not apply to Medicare Advantage.
Medical Policy Bulletin Y-1 (Physical Medicine)

Report code 97799 for electromagnetic therapy performed for treating musculoskeletal conditions.

Effective: March 17, 2008

Do not use code G0295 to report electromagnetic therapy performed to treat musculoskeletal conditions, since G0295 is defined for the treatment of wounds. Instead, use code 97799 to report this therapy for treatment of musculoskeletal conditions. When you report code 97799, please include the term “electromagnetic therapy” in the narrative section of the electronic or paper claim.

Mountain State Blue Cross Blue Shield considers electromagnetic therapy experimental or investigational when it’s used to treat musculoskeletal conditions. A participating, preferred, or network provider may bill the member for the denied therapy.

Mountain State Blue Cross Blue Shield pays for electromagnetic therapy only when it’s used to treat chronic ulcers.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin I-5 (Chelation Therapy/Chemical Endarterectomy)

Chelation therapy with edentate calcium disodium to be denied as not medically necessary.

Effective: March 17, 2008

Mountain State Blue Cross Blue Shield currently allows coverage for chelation therapy (J0600) for these conditions:

- control of ventricular arrhythmias or heart block associated with digitalis toxicity
- emergency treatment of hypercalcemia
- heavy metal poisoning
- thalassemia intermedia with hemochromatosis
- Wilson’s disease

Mountain State Blue Cross Blue Shield is changing its coverage position for edetate calcium disodium when it’s reported for any other conditions. In these cases, Mountain State Blue Cross Blue Shield will deny the edetate calcium disodium as not medically necessary instead of not covered. A participating, preferred, or network provider may not bill the member for the denied service.

If edetate disodium (EDTA) is reported with procedure code J3520 in the treatment of atherosclerosis, arteriosclerosis, or any other condition, Mountain State Blue Cross Blue Shield considers it experimental or investigational. It is not covered. A participating, preferred, or network provider may bill the member for the denied service.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin X-17 (Obstetrical Ultrasound)

Mountain State Blue Cross Blue Shield changes obstetrical ultrasound and fetal biophysical profiling reimbursement policy.

Effective: October 29, 2007

Mountain State Blue Cross Blue Shield now pays separately for obstetrical ultrasound studies in addition to fetal biophysical profiling (codes 76818, 76819) when performed during the same session on the same day.

Each study must have a separate interpretation and report signed by the interpreting physician. Both studies are performed using ultrasound imaging; however, the data acquired in each test differs.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin G-21 (Procedures of Questionable Current Usefulness)

Coverage changes for retrobulbar injection.

Effective: October 29, 2007

Mountain State Blue Cross Blue Shield no longer considers retrobulbar injection a Procedure of Questionable Current Usefulness (POQCU). Mountain State Blue Cross Blue Shield pays for POQCU procedures only if documentation satisfactorily establishes the procedure’s medical necessity in the case at hand.

As of Oct. 29, 2007, retrobulbar injection processes in accordance with Mountain State Blue Cross Blue Shield’s routine payment mechanism for surgical services.

Continued On Next Page
Mountain State Blue Cross Blue Shield has extended coverage of coronary computed tomography (CCT) for the evaluation of the heart and coronary arteries. This service is also known as computed tomography angiography or CTA. Mountain State Blue Cross Blue Shield will pay for this procedure for these clinical indications:

- Evaluation of chest pain
  - intermediate pre-test probability of coronary artery disease
  - uninterpretable ECG or unable to exercise
  - no ECG changes and serial enzymes negative
  - uninterpretable or equivocal stress test
- Evaluation of suspected coronary anomalies
- Assessment of complex congenital heart disease, including anomalies or coronary circulation, great vessels, cardiac chambers, and valves
- Evaluation of coronary arteries in patients with new onset heart failure to assess etiology
- Evaluation of cardiac mass (suspected tumor or thrombus)
- Patients with technically limited images from echocardiogram, MRI or TEE
- Evaluation of pericardial conditions (pericardial mass, constrictive pericarditis, or complications of cardiac surgery)
- Evaluation of pulmonary vein anatomy prior to invasive radiofrequency ablation for atrial fibrillation
- Noninvasive coronary vein mapping before placement of biventricular pacemaker
- Noninvasive coronary arterial mapping, including internal mammary artery before repeat cardiac surgical revascularization
- Evaluation of suspected aortic dissection or thoracic aortic aneurysm
- Evaluation of suspected pulmonary embolism

Mountain State Blue Cross Blue Shield continues to cover CCT for the assessment of suspected congenital anomalies of coronary circulation.

Mountain State Blue Cross Blue Shield considers CCT performed for all other clinical indications and applications experimental or investigational. A participating, preferred, or network provider may bill the member for the denied service.

At this time, there is insufficient scientific evidence to determine whether CCT improves patient health outcomes for other conditions. Mountain State Blue Cross Blue Shield will continue to review the results of clinical trials and research studies when they’re published.

MA Does not apply to Medicare Advantage.

Mountain State Blue Cross Blue Shield considers computerized dynamic posturography experimental/investigational.

There is insufficient evidence to determine whether computerized dynamic posturography detects vestibular dysfunction or whether computerized dynamic posturography distinguishes between peripheral and central vestibular dysfunction. Computerized dynamic posturography is considered experimental/investigational.

MA Does not apply to Medicare Advantage.

**New brachytherapy code**

Code 0182T—high dose rate electronic brachytherapy, per fraction—is a new code that became available on July 1, 2007 for your reporting purposes.

Continued On Next Page
Medical Policy Bulletin M-54 (Thoracic Electrical Bioimpedance)
Thoracic electrical bioimpedance eligible for specific indications.
Effective: June 16, 2008

Beginning June 16, 2008, Mountain State Blue Cross Blue Shield considers thoracic electrical bioimpedance (TEB) medically necessary for these conditions:

- Differentiation of cardiogenic from pulmonary causes of acute dyspnea when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Optimization of atrioventricular (A/V) interval for patients with A/V sequential cardiac pacemakers when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Monitoring of continuous inotropic therapy for patients with terminal congestive heart failure, when those patients have chosen to die with comfort at home, or for patients waiting at home for a heart transplant.
- Evaluation for rejection in patients with a heart transplant as a predetermined alternative to a myocardial biopsy. If a biopsy is performed after TEB, please document the medical necessity of the biopsy in the patient’s records.
- Optimization of fluid management in patients with congestive heart failure when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

Mountain State Blue Cross Blue Shield considers TEB not medically necessary for all other indications including when used for patients:

- with proven or suspected disease involving severe regurgitation of the aorta,
- with minute ventilation sensor function pacemakers, since the device may adversely affect the functioning of that type of pacemaker,
- during cardiac bypass surgery, or,
- in the management of all forms of hypertension (with the exception of drug-resistant hypertension).

Mountain State Blue Cross Blue Shield defines drug resistant hypertension as failure to achieve goal blood pressure in patients who are adhering to full doses of an appropriate 3-drug regimen that includes a diuretic.

A participating, preferred, or network provider may not bill the member for TEB when it’s denied as not medically necessary.

TEB devices, a form of plethysmography, monitor cardiac output by non-invasively measuring hemodynamic parameters, including stroke volume, systemic vascular resistance, and thoracic fluid status.

MA For Medicare Advantage, see Medicare Advantage medical policy bulletin M-54.

Medical Policy Bulletin S-11 (Pheresis Therapy/ECI)
Low density lipid apheresis: reporting guidelines change.
Effective: December 3, 2007

Here are the procedure codes you should use to report low density lipid (LDL) apheresis treatment:

- 36516—therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion
- S2120—LDL apheresis using heparin-induced extracorporeal LDL precipitation

Mountain State Blue Cross Blue Shield covers LDL apheresis for patients with:

- homozygous familial hypercholesterolemia (272.0) as an alternative to plasmapheresis
- heterozygous familial hypercholesterolemia who have failed a 6 month trial of diet therapy, and maximum tolerated combination drug therapy (Mountain State defines maximum tolerated drug therapy as a trial of drugs from at least two separate classes of hypolipidemic agents such as bile acid sequestrants, HMG-CoA reductase...
inhibitors, fibric acid derivatives, or Niacin/Nicotinic acids) and who meet these FDA-approved indications:

- functional hypercholesterolemic heterozygotes with LDL greater than 300 mg/dl
- functional hypercholesterolemic heterozygotes with LDL greater than 200 mg/dl and documented coronary artery disease

If LDL apheresis is provided for any other indication, Mountain State Blue Cross Blue Shield considers it not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service.

Most patients with high cholesterol levels can be treated using a combination of diet, exercise, and drugs. Some patients who have dangerously high cholesterol, however, do not respond to strong drug treatments.

LDL apheresis describes a variety of technologies used to acutely remove LDL from the plasma. The patient initially undergoes an apheresis procedure to isolate the plasma. The LDLs are then selectively removed from the plasma by immunoadsorption, heparin-induced extracorporeal LDL precipitation, or dextran sulfate adsorption.

LDL apheresis must be distinguished from plasma exchange (plasmapheresis). In plasma exchange, the plasma is collected during a pheresis procedure, then discarded and replaced with crystalloids. In contrast, LDL apheresis is a selective procedure in which only pathogenic LDLs are removed. The plasma is then returned to the patient.

MA Does not apply to Medicare Advantage.

Medical Policy Bulletin S-185 (Transplantation for Chondral Defects)
Open osteochondral autograft of the talus considered not medically necessary.
Effective: February 11, 2008

Mountain State Blue Cross Blue Shield considers repair of a chondral defect of the talus (code 28446—open osteochondral autograft, talus [includes obtaining graft(s)])—not medically necessary. It is not eligible for reimbursement. A participating, preferred, or network provider may not bill the member for this service.

MA Also applicable to Medicare Advantage.

Medical Policy Bulletin E-80 (I-Port Injection Port)
I-Port Injection Port not eligible for reimbursement.
Effective: December 10, 2007

Mountain State Blue Cross Blue Shield considers the I-Port Injection Port™ experimental or investigational. It is not eligible for reimbursement.

Despite the fact that this device has been approved by the Food and Drug Administration, there is a lack of long-term studies demonstrating its safety and effectiveness. A participating, preferred, or network provider may bill the member for the denied service.

According to manufacturer information, the I-Port is a simple medication delivery device that provides both adults and children with diabetes and other chronic conditions a simple way to administer prescribed medications without the repeated skin punctures. When applying the I-Port, an insertion needle guides a soft cannula under the skin. Once applied, the insertion needle is removed and only the cannula remains below the skin, acting as the gateway into the subcutaneous tissue. To inject through the I-Port, the needle of a syringe or insulin pen is used. The needle remains above the surface of the skin, while the medication is immediately delivered through the cannula and into the subcutaneous tissue. The I-Port can accommodate 75 injections, and can be worn for up to 72 hours.

Report code E1399 for the I-Port. When you report code E1399, please include the term “I-Port injection port” in the narrative section of the electronic or paper claim.

MA Also applicable to Medicare Advantage.
Medical Policy Bulletin M-30  (Gait Analysis)
Gait analysis now eligible for payment.
Effective:  March 3, 2008

Effective March 3, 2008, Mountain State Blue Cross Blue Shield will pay for gait analysis for the pre-surgical assessment of patients with cerebral palsy who have gait disorders.

When gait analysis is performed for any other condition, Mountain State Blue Cross Blue Shield considers it not medically necessary. A participating, preferred, or network provider may not bill the member for the denied service.

Use ICD-9-CM diagnosis codes 343.0–343.9 for cerebral palsy. Choose the diagnosis code that best represents the member’s condition. Please remember to report diagnosis codes to the highest level of specificity.

Use these codes, as appropriate, to report gait analysis:
• 96000—comprehensive computer-based motion analysis by videotaping and 3-D kinematics
• 96001—comprehensive computer-based motion analysis by videotaping and 3-D kinematics, with dynamic plantar pressure measurements during walking
• 96002—dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
• 96003—dynamic fine wire electromyography, during walking or other functional activities, 1 muscle
• 96004—physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report

MA  Does not apply to Medicare Advantage.

Medical Policy Bulletin O-30  (Functional Electrical Stimulation {FES})
Functional electrical stimulation devices considered investigational.
Effective:  January 1, 2008

Mountain State Blue Cross Blue Shield considers functional electrical stimulation (FES) devices experimental or investigational, except for the Parastep. A participating, preferred, or network provider may bill the member for the denied service.

Functional electrical stimulation devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. The FES attempts to replace stimuli from destroyed nerve pathways with computer-controlled sequential electrical stimulation of muscles.

MA  Does not apply Medicare Advantage.

Medical Policy Bulletin L-83  (RedPath – PathFinder TG)
RedPath’s PathFinder TG considered investigational testing.
Effective:  November 26, 2007

Mountain State Blue Cross Blue Shield considers RedPath Integrated Pathology’s PathFinderTG experimental or investigational. It is not eligible for payment. A participating, preferred, or network provider may bill the member for the denied test.

Mountain State Blue Cross Blue Shield does not cover this test because there is a lack of independent clinically-validated testing of RedPath’s technology involving correlation of RedPath’s PathFinderTG to patient outcome data.

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.

PathFinderTG is a molecular DNA-based cancer diagnostic test that obtains a genetic fingerprint of
mutations from routine histology and cytology slides as well as fluid samples. RedPath uses a proprietary process that begins with the microdissection of cells from targeted areas of interest from chemically fixed histology and cytology slides. RedPath is also able to test acellular fluids. The process incorporates DNA amplification, as well as molecular profiling against a broad panel of mutations (15 to 20 different markers) that include tumor suppressor genes and oncogenes known to be part of the mutational profile for each tumor type. Combined with the morphologic review, PathFinderTG provides a comprehensive analysis and report. A written summary of the number and type of mutations found, if any, is provided and the temporal sequence of mutation acquisition is described. A diagnosis with detailed commentary, including a summary of the molecular profile of the patient’s specimen, is provided in the context of available clinical history and pathology information.

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

---

**Medical Policy Bulletin S-112  (Co-Surgery)**  
**Additional procedures eligible for co-surgery.**  
**Effective: January 1, 2008**

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

- 48140—pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy
- 57285—paravaginal defect repair (including repair of cystocele, if performed); vaginal approach
- 57423—paravaginal defect repair (including repair of cystocele, if performed); laparoscopic approach
- 58570—laparoscopy, surgical, with total hysterectomy, for uterus 250g or less
- 58571—laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
- 58572—laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
- 58573—laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
- 61559—extensive craniectomy for multiple suture craniosynosostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)
- 63055—transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; thoracic
- 63056—transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)
- 63057—transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; each additional segment, thoracic or lumbar (list separately in addition to code for primary procedure)
- 63744—replacement, irrigation or revision of lumbosubarachnoid shunt

Please be aware that other Mountain State Blue Cross Blue Shield medical policies may affect the eligibility of these procedures.

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

---

**Medical Policy Bulletin Z-66  (Telemedicine)**  
**Online medical evaluations or assessments are not covered.**  
**Effective: January 1, 2008**

Mountain State Blue Cross Blue Shield does not cover online medical evaluations or assessments using the Internet.

There is a lack of scientific evidence that these services are medically and diagnostically equivalent to face-to-face care. Therefore, these services are not covered. A participating, preferred, or network provider may bill the member for the denied services.

Use procedure code 99444 to report on-line non-face-to-face evaluation and management (E/M) services by a physician. Use procedure code 98969 to report online non-face-to-face assessment and management services performed by a qualified health care professional.

**MA**  Does not apply 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:

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

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

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

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