In September, we sent you a letter and important material regarding changes to the 2002 Blue Cross and Blue Shield Service Benefit Plan for Federal Employees and retirees.

**High Option Merged with Standard Option as of December 31, 2001**

Our research shows that many federal employees and retirees find our High Option no longer affordable and would prefer other health benefit options. Accordingly, at the end of 2001, we will merge our High Option enrollees into the Standard Option, and will simultaneously be offering a new option – Basic Option.

**Introducing Basic Option in 2002**

Basic Option offers a lower premium and no deductibles. Members will be able to select Basic Option as their health care plan for 2002 during the upcoming open enrollment period November 12 through December 10, 2001. You will be able to identify Basic Option members by the plan’s distinct ID card and enrollment codes of 111 (self only) and 112 (self and family).

The Basic Option program is an in-network only benefit program. Preferred providers can continue to see FEP patients as they do today. To receive benefits, members who enroll in Basic Option must seek care from a Preferred provider. In most cases, Participating or Non-preferred providers are not considered in-network providers for Basic Option. You should discuss members’ health options to ensure continuity of care.

Should you have any questions regarding benefits please contact our Customer Service Department at 1-304-424-7792 or toll free at 1-800-535-5266. If you have questions concerning your participation status, please contact our Provider Relations Department at 304-424-7795 or toll free at 1-800-798-7768.
United Concordia Dental Groups

Mountain State Blue Cross Blue Shield (MSBCBS) has formed a relationship with United Concordia Companies, Inc. (United Concordia). United Concordia, the fifth largest dental insurer in the country, is based in Harrisburg, PA, and is a subsidiary of Highmark, Inc.

As a participating dentist in the MSBCBS network, this relationship can benefit you by providing additional opportunities to grow your practice.

An addendum to your MSBCBS Participation Agreement was mailed to you on November 1, 2000, and provides the covered persons carrying a United Concordia ID card with access to the MSBCBS network of participating dentists. When the MSBCBS network of dentists is used in conjunction with a United Concordia dental product, the MSBCBS allowance will be used for payment of all covered services.

Your office should submit claims to the address listed on the back of the patient’s ID card. You will receive payment directly from United Concordia for covered services you provide to these patients. United Concordia patients, like MSBCBS members, are responsible for any applicable deductibles or copayments. Questions pertaining to a United Concordia patient’s benefits or claim status may be directed to United Concordia Customer Service as 1-800-332-0366.

If you should have any questions please contact your External Provider Relations Representative.
Medicare Reform Debate Expected to Heat Up This Fall

While Comprehensive Reform Unlikely, Smaller

The congressional debate on Medicare reform will intensify this fall with all three committees of jurisdiction (Senate Finance, House Ways and Means, and House Energy and Commerce) expected to consider legislation in September. Although an agreement on comprehensive reform appears unlikely this year amidst budget constraints and partisan disagreements on the structure of a drug benefit, a package of smaller reforms is possible.

While both parties have reiterated their commitment to comprehensive Medicare reform, including a prescription drug benefit, the shrinking budget surplus is prompting Democrats to charge that there is no money available for new programs this year. In addition, the prospects for a bipartisan compromise dimmed just prior to the August recess when Senate Finance Committee Chair Max Baucus (D-MT) criticized Ranking Member Charles Grassley’s (R-IA) reform proposal for devoting too much spending to reforms and not enough for a drug benefit. While the committee has targeted the third week of September for a markup, it remains questionable whether Finance Committee members can reach accord.

Despite the challenges facing comprehensive reform, a smaller package of reforms is possible, and BCBSA continues to work closely with the Administration and members of Congress to share key concerns and priorities for reform.

In June, Health and Human Services Secretary (HHS) Tommy Thompson released the Administration’s legislative proposal for contractor reform. With the Administration and all three committees with jurisdiction committed to making changes, it appears likely that some form of Medicare contractor reform will be enacted. To promote the Blues’ legislative recommendations, BCBSA president and CEO Scott Serota in June testified before the House Energy and Commerce Subcommittees on Health (see Legislative Report 20-01). BCBSA staff is also working with Plans to educate members about the importance of contractor functions and identify members on each of the key committees who are willing to champion our recommendations for reform.

House Ways and Means Committee Chair Bill Thomas (R-CA) and Ways and Means Health Subcommittee Chair Nancy Johnson (R-CT) recently announced plans to introduce legislation to reform the Medicare contractor program, shore up the Medicare+Choice program, and make other changes. BCBSA continues to advocate an immediate increase in funding for Medicare+Choice, as well as extension of cost contracts to new entrants. BCBSA also has proposed the development of alternative payment arrangements for private plans to encourage participation of PPO’s in Medicare and help address the needs of rural areas. A draft discussion document outlining several new payment approaches was developed by the Senior Markets Advisory Group upon request from Administration officials.

For additional information, Plans may contact Jenny Bryant at 202-626-4837.
HIPAA Update

Presented below is general information on the status of the Health Insurance Portability and Accountability Act (HIPAA). Mountain State will continue to provide updated information in each issue of the Provider News.

HIPAA Privacy Rules

On July 6, 2001 the Department of Health and Human Services (HSS) issued its first guidance document for the HIPAA Privacy Rules. The following are some highlights from the guidance document:

The Privacy Rule provides the first comprehensive federal protection for the privacy of health information. All segments of the health care industry have expressed their support for the objective of enhanced patient privacy in the health care system. At the same time, HHS and most parties agree that privacy protections must not interfere with a patient’s access to or the quality of health care delivery.

The guidance provided by HHS is meant to communicate as clearly as possible the privacy policies contained in the privacy rule that must be complied with in April of 2003. HHS emphasized that the guidance document is only the first of several technical assistance documents that we will issue to provide

clarification and help covered entities (providers and health plans) implement the rule. In addition, HHS indicated it will issue proposed modifications as necessary in one or more rulemakings to ensure that patients’ privacy needs are appropriately met.

♦ Referral Appointments – A change will permit direct treatment providers receiving a first time patient referral to schedule appointments, surgery, or other procedures before obtaining the patient’s signed consent (see the “Consent” section of HHS’s guidance for more discussion).

♦ Minimum Necessary Scope – A change will increase covered entities’ confidence that certain common practices, such as use of sign-up sheets and X-ray lightboards, and maintenance of patient medical charts at bedside, are not prohibited under the rule (see the “Minimum Necessary” section of HHS’s guidance for more discussion).

In addition, HHS may reevaluate the Privacy Rule to ensure that parents have appropriate access to information about the health and well-being of their children. This issue is discussed further in the “Parents and Minors” section of HHS’s guidance.

The following Q & A’s are excerpted from the HIPAA Privacy guidance document you can access at the following website: http://www.hhs.gov/ocr/hipaa:

Q: Will the consent requirement restrict the ability of providers to consult with other providers about a patient’s condition?

A: No. A provider with a direct treatment relationship with a patient would have to have initially obtained consent to use that patient’s health information for treatment purposes. Consulting with another health care provider about the patient’s case falls within the definition of “treatment” and, therefore, is permissible. If the provider being consulted does not otherwise have a direct treatment relationship with the patient, that provider does not need to obtain the patient’s consent to engage in the consultation.

Q: May consent be obtained by a health care provider only one time if there is a single connected course of treatment involving multiple visits?

A: Yes. A health care provider needs to obtain consent from a patient for use or disclosure of PHI only one time. This is true regardless of whether there is a connected course of treatment or treatment for unrelated conditions. A provider will need to obtain a new consent from a patient only if the patient has revoked the consent between treatments.

Q: Does the Privacy Rule require hospitals and doctors’ offices to be retrofitted, to provide private rooms, and soundproof walls to avoid any possibility that a conversation is overheard?

A: No, the Privacy Rule does not require these types of structural changes be made to facilities.

Governors Ask Congress to Amend HIPAA

Governors called on Congress on August 22, 2001 to give states more time to enact complicated regulations intended to simplify and standardize the way hospitals, health insurance companies, the Medicaid program, and others in the nation’s health care system collect and process patients’ information.

continued on page 5
In a National Governors Association (NGA) letter sent to the chair and ranking members of the Senate Finance and House Commerce Committees, the governors requested amending the 1996 Health Insurance Portability and Accountability Act (HIPAA) to give states a longer and more clearly structured implementation period.

Under HIPAA, the U.S. Department of Health and Human Services was to issue a series of regulations that would direct states on how to implement the simplification and standardization policies. Currently, HHS has only finalized one regulation, and it is unclear how many additional rules will be necessary and when those rules might be finalized.

States and insurers have two years and two months after a regulation is finalized to comply. The law calls for significant financial penalties to be imposed for noncompliance.

The unintended impacts of moving forward without more time for states to effectively implement the changes are widespread. For instance, hospitals and state public health agencies might be unable to share information about communicable diseases or doctors and nurses may go unpaid for services provided to Medicaid recipients.

Once fully implemented, however, the law would greatly simplify the complex system that currently exists. The law, for example, would enable a health insurance company to fill out the same electronic form for private health insurance as they would for Medicaid instead of completing the myriad of forms that exist today.

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**ELECTRONIC NOTES**

Please send any changes regarding tax ID numbers, address changes and other information to the Provider Relations Department as soon as possible. This will enable the staff to update the files in a timely manner to ensure the provider’s payment is made under the correct tax ID number and sent to the proper office.

REMINDER!

PLEASE USE YOUR CORRECT PROVIDER NUMBER AND SUFFIX ON ALL CLAIMS.

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MOUNTAIN STATE BLUE CROSS BLUE SHIELD MANAGED CARE
REFERRAL/AUTHORIZATION/PRECERTIFICATION
NOTIFICATION GUIDE

THIS APPLIES TO SUPER BLUE SELECT POS MEMBERS ONLY
THIS DOES NOT APPLY TO PPO OR TRADITIONAL MEMBERS

DEFINITIONS:

**Referral:**
PCP referring patient for evaluation or evaluation and treatment for specialty care.
You may phone your requests to 1-800-269-6389 or fax to 1-888-383-7081.

**Authorization:**
Outpatient or office services that require notification to MSBCBS.

**Pre-Certification:**
Pre-Certification includes pre-admission certification for all inpatient stays.
For pre-certification call Medical Management at 1-800-344-5245.

**Referrals, Authorizations, and Pre-certification must be completed prior to treatment.**

**ER Visits:** Members must notify their PCP prior to going to the ER unless it is a life-threatening situation. Member must notify their PCP as soon as possible of the ER visit. The PCP must notify MSBCBS of the ER authorization within 5 business days from the date of the ER visit.

**Laboratory/Radiological Services:** A participating facility must be used. Authorization of a Non-Network facility is required. A referral is not required from the PCP when ordering laboratory/radiological testing (with the exception of MRI, MRA, and Dexa Scan) when performed at a Network facility.

Patients may self refer for routine gynecological exams or suspected pregnancy. Please reference medical management bulletin #15.

**When you contact the referral unit for an evaluation, evaluation and treatment, authorization for outpatient surgery or other care please be sure to include the following information:**
- **Member’s identification number**
- **Patient name and date of birth**
- **Member’s name**
- **PCP name**
- **Specialist full name and address**
- **Facility full name and address**
- **ICD9 code or diagnosis**
- **Current Procedural Terminology (CPT) code**
- **Start and end date for span of treatment**
- **Number of visits requested**

When possible referral/authorizations should be made 7 days in advance.

Referral/Authorization numbers will be assigned for all in-network and out of network specialist visits. Confirmation letters for referrals/authorizations will be mailed to PCP, Specialist and the member.

**Network providers must be used. All out of network providers require pre-approval.**

**AUTHORIZATION CERTIFICATION LIST**
Surgeries, all outpatient, excluding office procedures
Allergy testing
Ground Transportation (Except Emergency)
Cardiac Rehab Services
Emergency Room Visits Within 5 business days
Home care services/skilled-nursing services/hospice
Orthotics/Prosthetics/DME
Pain Management
Pulmonary Rehabilitation
Sleep Studies
Specialist to specialist services must be made through the PCP
Therapies: occupational, physical, speech, audio and rehab
TMJ services
Transplantation services.
MRI, MRA, DEXA SCAN, PET SCANS - regardless of referring physician
OB/GYN notification

*For complete information on patient’s benefits please call the customer service phone number located on the members identification card.*

**NOTE:** Referral/authorization does not guarantee payment for claims, which will be subject to eligibility and benefits verification.
Right to sue not a high priority for consumers

Consumers don’t consider the right to sue health insurers over coverage issues a high priority, according to a national consumer survey conducted by Knowledge Networks for the Blue Cross Blue Shield Association (BCBSA).

In fact, among the 21 major health issues that consumers were asked to rank in the national survey, the right to sue finished last (see accompanying chart below).

“When it comes to health care, American consumers are not fooled by all the political rhetoric,” says Scott Serota, president and CEO of the BCBSA. “Clearly, the most important health care priorities on their minds are access to affordable coverage, which ranked number one in the survey, and limiting the costs of prescription drugs, which was number two. These priorities should be of no surprise.

“With a slowing economy, the Blues believe now more than ever consumers are looking to the government and the private sector to help them make health insurance more affordable, not more expensive. Expanding the right to sue health plans will increase the cost of health insurance, which leads to more uninsured. The public clearly appears to understand this link,” Serota says.

“Two years ago, we released our proposal for addressing the issue of the uninsured. Today, we remain committed to working on a solution to this pressing problem,” says Serota. “This survey demonstrates that consumers continue to believe this is the most important issue for members of Congress to address. The question is, what is Congress waiting for?”

A national survey reports that consumers ranked affordable coverage as the number one health care issue, while the right to sue finished last.
Promising Initial Results of System’s Diabetes Collaborative Project

An estimated 16 million Americans suffer from diabetes mellitus – one of the leading causes of disability and death in the United States. The disease results in enormous costs for patients and the nation’s health care system.

Blue Plans have implemented disease management programs in the hopes of controlling costs and ensuring quality care for members suffering from diabetes. In 1997, the National Medical Management Forum focused attention on these programs in an effort to measure and improve the quality of care nationwide.

In 1998, the Collaborative Diabetes Disease Management Project (diabetes project) began with 10 Plans – collectively representing a total of 20.8 million covered lives with more than 80,000 members with diabetes – with the participation of the Blue Cross Blue Shield Association (BCBSA) and the Blue Cross and Blue Shield Foundation on Health Care. The diabetes project examined care across a three-year period to determine the efficacy of diabetes disease management interventions.

BCBSA now has interim results from two years of data analysis. During these years, Plans collected information on:

- The state of their diabetes care clinical outcomes, using Diabetes Quality Improvement Project measures.
- Cost and utilization of health services in their overall populations and in the diabetic populations.
- The structure of and resources used in their diabetes disease management programs.

The results are informative:

- Six of the eight outcomes measured demonstrated improvements during the first two years.
- Delivery of diabetic care nationally is relatively consistent, but sub-optimal.
- Plan-to-member interventions have achieved greater success than Plan-to-provider interventions.
- Members with diabetes incur total costs nearly four times that of the general population.

This program, the first of its kind within the Blue System, will serve as a model for future disease management collaborations and gives Blue Plans an information base for analyzing the outcomes and cost effectiveness of disease management programs.