

# Practitioner Guidelines

## Availability, Accessibility, and Continuity of Services

### Appointment Availability

Primary care practitioner appointments for preventive and routine care should be available to members in a timely manner. Practitioners must have a system in place in order to evaluate the urgent and emergent needs of members and to determine the appropriate site for care in a timely fashion. Regence BlueShield has established the following access and availability standards that are used to monitor and measure practitioner accessibility and availability to our members, including government programs. Hours of operation and appointment availability for Healthy Option enrollees must be consistent to those for all other commercial enrollees.

Type of Care/ Need of Member	Acceptable Time frame
Routine, symptomatic or chronic care	within 72 hours
Routine, non-symptomatic preventive care	within 4 weeks
Urgent exam	within 24 hours
Emergent exam	same day
Behavioral health	within 24 hours for emergencies, 7 days for non-emergency care
After-hours care	available 24 hours a day, 7 days a week
Specialty referral	within 14 days
Waiting room time, all visits	no longer than 30 minutes

### After-Hours Access

Primary care practitioners are required to provide coverage 24 hours a day, seven days a week. The practitioner or the designated covering practitioner will be available on a 24-hour basis to provide care or to direct members to the most appropriate setting for treatment. Messages on after-hours electronic answering machines need to include the name and telephone number of the on-call practitioner. A tape-recorded telephone message instructing members to call a hospital emergency room is not adequate for 24-hour coverage.

### Access to Phone Service

It is important that members be able to obtain information regarding the process for accessing clinical care, resolving problems they experience, and making appointments. The member's health care practitioner must provide a response to member telephone calls within a reasonable time. The timeliness of a response needs to be appropriate to the member's stated condition.

Telephone requests from other practitioners requesting approval to treat members must be responded to in a timely manner and evaluated for appropriate action.

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## Access for Special Needs Members

Practitioners must be aware of the need, and make us aware of those needs, for the following types of facility support that may be required for access by the population they serve:

- Wheelchair access
- Ramp or street level access
- Corridor railings
- Elevators that are operable from a wheelchair
- Restrooms that are wheelchair accessible

In addition, the practitioner and office staff should be prepared to meet the special needs of visually and hearing impaired members.

## Casting

### Billing Guidelines for Casting

*For casting with orthotics, see “Orthoses” in this section.*

For an initial visit, Regence BlueShield allows an office call, cast application and cast materials. On subsequent visits, we allow the office visit and, if necessary, the charge for recasting and cast material.

Procedure	Guideline
Casting With a Surgical Procedure	Fees for casts or splints applied at the time of surgery are included in the global service package (flat fee) for the surgical procedure.
Recasting Following a Surgical Procedure	Recastings are allowed during the flat fee period, including the cast application and cast materials.
Facility Fee	A facility fee or cast room fee is not covered for casting or recasting.
Casting Materials/Supplies	When billing for casting materials and casting supplies please use the appropriate HCPCS codes.

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## Consultations

A physician whose opinion or advice is requested by another physician regarding evaluation and/or management of a specific problem provides consultation services:

- The consulting physician may initiate diagnostic and/or therapeutic services.
- A written or verbal request may be made by the requesting physician and must be documented in the member's records.
- The consultant's opinions and services must be in the member's record.
- Consultation codes may not be used for member-initiated consultations.

## Emergent and Urgent Care

An emergency is the sudden or acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Emergent services to screen and stabilize a member are covered if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Urgent care, while not considered life threatening, cannot comfortably be delayed. Practitioners must have a system in place to evaluate the needs of members calling or presenting at the office that enables them to identify conditions requiring urgent and emergent care.

## Injectables

Regence BlueShield will pay for the amount of the drug that was actually administered to the member and will not pay for "wastage," or the part of a vial that was not administered.

- Regence BlueShield uses Medicare published fees for injectable and biologicals.
- Codes that do not have Medicare fees have fees set by the Regence BlueShield Pharmacy Services Department.

**Note:** *For a copy of our reimbursement policy, please contact your provider relations representative at 1 (800) 562-2156.*

## Chemotherapy injectables

Claims for either injectable or chemotherapy drugs must state the complete name of the drug (do not abbreviate) and the total milligrams, micrograms, units, etc., administered to the member in the narrative comment field of your electronic format, or in the unit field for a paper claim. If the comment field of your electronic claim is not completed, the claim will be rejected and must be resubmitted with the correct information.

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## Immunizations

- Immunizations are covered if the plan has preventive benefits.
- Regence BlueShield reimburses for administration as well as the vaccines in some cases.
- State-supplied vaccines are billed with the modifier –SL and will be reimbursed for the storage and handling.

## Billing Guidelines For Immunizations

- Vaccine administration codes 90471 and 90472 must be submitted with the vaccine and toxoid code(s)
- Use 90476-90749 for the actual vaccine/toxoid
- When multiple immunizations are given, use **both** procedure codes 90471 and 90472
- Indicate **how** many units of service were given on the same line as procedure code 90472
- Use modifier 25 on well visit and/or E/M procedure, if billing 90471 or 90472
- Modifier SL is used to report state supplied immunizations for Healthy Option and BHP+

## Interpretation Service

It is the policy of Regence BlueShield to seek practitioners who speak other languages in addition to English and who have an awareness of the social/cultural composition of the community. In addition, translation services are provided according to plans for specific product lines, such as Healthy Options, Basic Health Plan and Public Employees Benefits Board (PEBB). Refer to the “Healthy Option” or “PEBB” sections within this manual.

## Laboratory Panel

Regence BlueShield requires the use of our participating clinical reference laboratories for all out-of-office lab services. Please refer to our provider directory for a list of the laboratories that participate with Regence BlueShield or call provider customer service at **1 (800) 322-1737**.

## Medical Record Confidentiality Requirement

Providers and practitioners must abide by all statutes, laws and regulations governing the confidentiality of any information concerning our members. They must also maintain all confidential information obtained from us in a confidential manner and apply the same level of confidentiality and security to such information as it applies to similar information within their own business.

Member eligibility data are to be used for the purpose of preparing and filing an accurate claim with Regence BlueShield. Providers and practitioners may submit claims on behalf of those members who have given their written authorization.

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## Member Rights and Responsibilities

Regence BlueShield is committed to maintaining a mutually respectful relationship with its members and has established the expectation for cooperation among members, practitioners, and the health plan. Regence BlueShield and its subcontractors will comply with all current and potential new Federal and State laws related to enrollee rights. All members have the following rights:

- To be treated with dignity, respect, and courtesy.
- To have their privacy protected and their information handled in a confidential manner. (The release of identifiable personal information requires written consent form, from the individual or guardian.)
- To participate with practitioners in the decision-making process regarding their health care.
- To have candid discussions regarding appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- To have information about advance directives and the opportunity to include it in the medical record.
- To receive information about the health plan, organization, services practitioners and providers, and member rights and responsibilities.
- To have a copy of the policy on member rights and responsibilities.
- To receive member information that is written in readable and easily understood, consumer-tested language.
- To have member information available in the languages of the major population groups served.
- To express questions, concerns, or complaints regarding Regence BlueShield or the care provided.
- To be informed regarding the right to appeal an action or denial and the process involved.
- To receive assistance in selecting a new PCP upon termination of a primary care delivery office or site.
- To have interpreters available during the visit.
- To receive a copy of the provider directory, including Healthy Options, if requested.

In addition to the rights identified on the previous page, the members have the following responsibilities:

- To provide information required by Regence BlueShield, practitioners and providers in order to care for the member or dependent.
- To follow the plans and instructions for care that were established with the practitioner.
- To arrive on time for appointments or call in advance to reschedule.
- To review the health plan handbook to understand the benefits covered by the plan.
- To notify Regence BlueShield and the practitioner of any changes, such as name, address, phone number, employment, births, deaths, or divorce.
- To communicate questions or the need for clarification to Regence BlueShield or the practitioner, as needed.

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## Advance Directives

The goal of the “Natural Death Act” (Chapter 70.122 RCW) is to provide the member with the knowledge and tools necessary to create an advance care document if he or she so desires and to ensure that it becomes part of the medical record.

“In recognition of the dignity and privacy which members have a right to expect, the legislature hereby declares that the laws for the state of Washington shall recognize the right of an adult person to make a written directive instructing such person’s physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition.

The legislature also recognizes that a person’s right to control his or her health may be exercised by an authorized representative who validly holds the person’s durable power of attorney for health care.” \*

Practitioners need to routinely ask all members, as part of the member registration process if they have implemented an Advance Directive. When a member presents the practitioner with an Advance Directive, it must be documented in the member’s record and a copy of the document made a part of the member’s record. There are two advance directive forms: The “Power of Attorney for Health Care”, and the “Living Will- Directives to Physicians.” If members have signed either of these forms, copies should also be included in the medical record.

\*Washington State Chapter 70.122 RCW, Natural Death Act, 1966.

The federal “Member Self-Determination Act” (Section 4751 of OBRA 1991) and the Washington “Natural Death Act” (Chapter 70/122 RCW) require that a process of member education be implemented by all institutions receiving reimbursement from Medicare and Medicaid. Members are to be advised of their right to execute an Advance Directive in the member record. For members’ 65 years old or older, documentation should include discussions of a member’s right to predetermine future health care and specific treatment preferences if expressed. Practitioners and staff members who make entries on member charts regarding this subject should identify themselves by signing or initialing each entry.

## Practitioner Resources

Practitioners are apprised of new and existing policies, changes within the Company, and updates through the Provider Manual, practitioner orientation, and newsletters.

Practitioners who identify additional educational needs are encouraged to contact their professional relations representative at **1 (800) 562-2156** or on our web site at <http://www.wa.regence.com/provider/contact/rep/>. The professional relations representative will assist you in determining where information is available to meet your needs.

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## Practitioner Clinic Roster

To ensure that our members have the best possible practitioner information and to appropriately coordinate referrals, at a minimum, an annual clinic roster will be required from all practitioner clinics holding Regence BlueShield clinic agreements. The format for these rosters should include practitioner's name, specific physical practice locations, and any other substantive information. Your professional relations representative will work with you to facilitate this process. Having up to date information about your practice eliminates confusion and enables your patients to efficiently seek care.

## Primary Care Practitioner (PCP)

PCPs have agreed to supervise, coordinate and provide initial and basic care to our managed care members, to initiate their referrals when medically necessary, and to maintain continuity of member care. Members covered under our Selections health care plans can select a designated naturopathic physician as their Primary Care Practitioner (PCP). PCPs can refer to you for specialty care.

At the time of enrollment into a managed care plan, the member selects a primary care practitioner (PCP). Generally, individual family members may choose the same or different PCPs from the directory of participating practitioners in the following practice areas:

- Medical doctor (M.D.), including internist, family practitioner, pediatrician and general practitioner.
- Osteopathic physician (D.O.).
- Physician's assistant certified in family practice or pediatrics.
- Advanced Registered Nurse Practitioner (ARNP), including family nurse practitioner, pediatric nurse practitioner, women's health practitioner or adult nurse practitioner.

The PCP provides primary care, including preventive health care, treatment for acute illnesses, minor accidents, and follow-up care for ongoing medical problems. In addition, the PCP manages all of the health care provided to the assigned member, such as initiating referrals for specialty care and coordinating inpatient admissions to assure continuity of care. The PCP coordinates referrals.

The PCP's responsibilities include the following aspects:

- Provide all of the member's primary health care services.
- Provide coverage 24 hours a day, seven days a week. (Members are instructed to contact the PCP prior to seeking care in all cases except emergencies. Members who require emergency care are instructed to notify the PCP within 24 hours of treatment.)
- Provide referral to a participating specialist when specialized care is indicated.
- Use designated network laboratories for clinical lab test.
- Review and incorporate the specialist's documentation into the member's primary medical record.

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## Self Referral Services

Women enrolled in managed care plans may self-refer directly to an approved OB/Gyn physician, licensed midwife specializing in women's health care, physician's assistant, or advanced registered nurse practitioner for maternity care or covered women's health care services.

## Eligibility Roster

Regence BlueShield provides each PCP with a monthly roster of his or her managed care members who are eligible to receive covered services.

## Physical Exams

The following services are covered on most plans, subject to member benefits, when they are performed as part of a routine physical examination:

- For smoking cessation, our plans indicate that coverage is provided for the services of a physician, psychologist, or smoking cessation practitioner for a smoking cessation program. There is a lifetime maximum benefit of \$500, which is payable if the course or program is completed through an approved practitioner.
- Prenatal/perinatal care is covered for subscribers with plans that include maternity benefits. Prenatal testing is covered for diagnosing congenital disorders of the fetus when medically necessary.
- Pap smear screening, when done as a preventive service, is covered for members with plans that include preventive benefits.
- Benefits are available for an initial lead-screening test in children who are determined to be at risk for lead poisoning. If the lead level is above normal, a second test is eligible for benefits for treatment planning. Adults who are at risk for lead poisoning may use benefits if the test is medically necessary.

If you have questions regarding a member's specific coverage, please call provider customer service at **1 (800) 322-1737**.

## Periodic Health Exams

Regence BlueShield covers periodic health exams according to the schedule in the member's plan. For specific benefit information on your member, please call provider customer service at **1 (800) 322-1737**.

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## Preventive Health Care

Services in the managed care products must be provided or referred by a participating PCP in order to be covered. Members may have a copayment. Please refer to the member identification card or confirm with provider customer service the amount of the copay. All copays should be collected from the member at the time of service. Preventive care includes the following:

- Periodic routine physical exams
- Well-baby care
- Routine eye exams
- Annual women's exams, including Pap smear
- Routine immunizations
- Pap smear \*
- Occult blood
- Cholesterol
- Hemoglobin/hematocrit
- Urinalysis
- Blood sugar

*\* Note: Procedure 00091 (obtaining conveyance and transport of the pap smear to the laboratory) and G0101 (pelvic and breast exam for cancer screening) are not separately reimbursed when billed in addition to 99381-99397. These services are considered an integral part of the preventive medicine evaluation and management service.*

## Preventive Health Guidelines

Preventive health guidelines are designed for the prevention and early detection of illness in asymptomatic people. Practice guidelines are based on scientific evidence and recommendations from nationally recognized professional organizations, including, but not limited to, AHCPR, US Preventive Services Task Force, ACS, NCI, AAP, ACIP, AAFP, NACOG, NIH, CDC and ALA.

The following preventive guidelines, available on our web site at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).

- Childhood immunizations
- Smoking cessation
- Prenatal/perinatal
- Cholesterol screening
- Pap smear screening
- Blood sugar

Childhood immunizations are covered under Regence BlueShield plans if a preventive care benefit has been elected. The Selections plan includes preventive care. However, on the PPO and Traditional products, preventive care is an option.

Mammography is a mandated benefit, and both screening and diagnostic services are covered under all of our standard plans.

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## Surgery Services

Regence BlueShield uses values on the Medicare Physician Fee Schedule Database (MPFSDB) to determine surgical global periods, codes eligible for assistants at surgery, codes eligible for co-surgeon and codes subject to multiple procedure discounts.

### Global Period

Surgical global periods include all services that are normally furnished before, during, and after the surgical event.

### Assistant Surgery

The assistant claim must be billed with the *same CPT code(s)* and in the same manner as the primary surgeon. If the surgeon's claim must be reviewed, the same determinations will apply to the assistant's claim. Codes that are eligible for assistant surgery are reimbursable.

#### Modifier Use

- A physician acting as an assistant at surgery should bill modifiers 80, 81 or 82.
- Non-MD provider's acting as an assistant at surgery should bill with modifier AS.

**Note:** *Exception for OB care and delivery services when using procedure code 59510. If the primary surgeon bills with 59510, the assistant should use 59414 and the appropriate modifier.*

### Co-Surgery

Each surgeon billing must bill the same CPT codes, using modifier 62. Codes that Medicare has approved for co-surgery are reimbursed to the maximum allowed for the surgeon and assistant combined to one fee and divided between the co-surgeons. Multiple procedure guidelines apply.

#### Modifier Use

- When procedures are performed with the co-surgeon, they must bill the **same CPT®** code with modifier –62 on each bill.

### Team Surgery

Each surgeon for qualified procedures will be reimbursed for the procedure he/she performed at 100% of the allowable. The team surgeon may assist each other on their respective surgeries. If more than one surgical procedure is performed per surgeon, multiple surgery administrative cuts apply.

#### Modifier Use

- Each surgeon will bill using the procedure code describing their portion of the total treatment using modifier 66.
- If the team surgeon is assisting, use modifier 80 in the first position and modifier 66 in the second position on the appropriate procedure code.

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## **Multiple Procedures**

Multiple procedure discounts are applied to CPT® and HCPCS codes eligible for discounts and are paid at 100% on the code with the highest allowable. Procedure discounts are applied on subsequent procedures based on Medicare indicators.

### **Modifier Use**

- Multiple procedures should be appended with a 50 or 51 modifier with 1 unit of service per claim line, depending on whether or not the procedure is considered a bilateral or a multiple procedure.

## **Bilateral Procedures**

### **ASC Providers**

For bilateral procedures that are eligible for bilateral reimbursement, the same procedure code is reported on two lines.

### **Modifier Use**

- Report modifier 50 on the second line.

### **Professional Providers:**

For bilateral procedures that are eligible for bilateral reimbursement, report the procedure code on one line.

### **Modifier Use**

- Report modifier 50 on the first line.

**Note:** *For a copy of our reimbursement policy, please contact your provider relations representative at 1 (800) 562-2156.*

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## Specialty Practitioner

When the PCP determines the need for specialty care, a referral is generated. Upon receipt of a referral, written acknowledgment of the referral will be issued to you, the member and the member's PCP. Please send treatment recommendations or records back to the PCP so that the member's complete medical history can be maintained.

Collaboration between the PCP and the specialist is extremely important to achieve continuity of care, and the following aspects may be identified as specialty practitioner responsibilities:

- Obtaining a referral authorization for services to be eligible for health plan reimbursement.
- Treating the member as necessary within the parameters of the referral from the PCP.
- Obtaining authorization from the health plan for procedures requiring pre-authorization.
- Documenting the services provided and ensuring that it is incorporated into the member's primary care medical record.
- Advising the PCP when follow-up care is necessary.

The specialty practitioner may provide treatment authorized by the referral, which may include ordering appropriate lab tests, x-rays, or physical therapy. If a procedure that requires pre-authorization, including hospitalization, is needed, the specialty practitioner is responsible for calling the health plan to obtain authorization.

## Referred Cases

Patients for most Regence BlueShield plans receive their highest level of benefits, when they utilize the services of participating providers. For patients with Regence BlueShield PPO plans to receive their highest level of benefits, they must utilize the services of Preferred Plan Providers. Please make sure you refer your patients to the appropriate practitioners or providers. If you submit claims for a patient who was referred to you by another practitioner, indicate that practitioner's name in box 17 of the HCFA-1500 claim form. For current lists of either participating or preferred plan providers, please call provider customer service at **1 (800) 322-1737**.