

[www.wa.regence.com/provider](http://www.wa.regence.com/provider)*Feature:***Consumerism in health care reaches tipping point**

By Jeff Robertson, MD  
Executive Medical Director, Regence

It wasn't long ago that the Internet was a new frontier—a cyber-world of information previously undiscovered. Today, the Internet is part of nearly every aspect of our lives. We socialize, get news, shop, pay bills and bank online. In this new era, the ease of access to information has spurred a movement of consumerism touching nearly every industry.

Until recently, health care had been one of the few exceptions in this movement of online consumerism. But it doesn't take more than a few mouse clicks to realize this is changing; we are at a tipping point. Quality and cost information are becoming more readily available online and, in the era of Zagat, Yelp and Angie's List, conversations about health care experiences that used to occur over the backyard fence are taking place online. Social networks created on the Web inform our personal health care decisions more than ever before.

Well-informed patients are more likely to be engaged in their own health care. This involvement is key to transforming the health care system. Our goal is to provide our members with online tools that bring information to them quickly, easily and efficiently, so they can use it to weigh the value of health care choices.

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This spring, we will launch the first of these tools—the Member Feedback feature—giving Regence members the opportunity to provide feedback on their experiences with individual providers, including physicians, dentists, other health care professionals and facilities.

In evaluating whether Regence would pursue member feedback as part of our information transparency efforts, the primary drivers were our members' demand for this information and the reality that member-to-member dialogue is not only where the market is moving, it is already here. Regence is certainly not the first entity or insurer giving members the ability to share information with one another online. Health insurers including Wellpoint, Aetna and UnitedHealthcare have announced their own programs, as have Internet giants such as Microsoft, Yahoo and Google. Thousands of patients are already using and submitting feedback on provider office visits through consumer Web sites like RateMDs.com and Revolution Health.

Our goal in sharing member feedback information is to create a venue for our more than three million members to support, engage and dialogue with one another. This feature is not intended to be a substitute for the important dialogue that occurs between doctors and patients. This is simply about members and their experiences, or as I like to say, "by the people, for the people."

As with any change, the more you know, the better prepared you are. We have chosen to embrace this shift in Web culture and health care consumerism and look forward to the positive impacts shared patient satisfaction information can have for our members and the health care system as a whole.

Should you have questions or comments about the launch of the Member Feedback feature, please contact your provider consultant or e-mail us at [providerfeedback\\_wa@regence.com](mailto:providerfeedback_wa@regence.com).

The policies and procedures in this section were reviewed due to:

- The addition, deletion or revision of codes published in the 2008 *Current Procedural Terminology (CPT®)* and *Health Care Procedure Coding System (HCPCS)* manuals
- A regularly scheduled review
- Requests from physicians, other health care professionals or facilities
- Updates from the Centers for Medicare & Medicaid Services (CMS)

Policies are reviewed using CMS' National Correct Coding Initiative (NCCI) rules and edits, language and descriptions contained in the American Medical Association's (AMA) CPT and HCPCS manuals, the AMA's *CPT Assistant*, other recognized coding publications, and state and federal regulations.

Remember to check our *Provider Web Site* for monthly updates to codes that require clinical information. A complete list of the following code groupings may be found in the Claims & Billing section under the Coding Toolkit on our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider):

- Cosmetic and potentially cosmetic codes
- Regence invalid codes
- Investigational and potentially investigational codes

Medical policies are also available in the Provider Library section of our *Provider Web Site*. If you have questions about our policies, please contact Customer Service or your provider consultant. Our contact information is on page 20 of this newsletter.

## 2008 brings code changes for many services and supplies

Please remember to review your 2008 CPT and HCPCS coding publications for codes that have been added, deleted or changed and to use only valid codes.

## Correct Coding Editor (CCE) updated

The Regence BlueShield Correct Coding Editor (CCE) identifies code pair edits used in addition to CMS' NCCI edits. These code pair edits are compiled using CMS' NCCI written rules, CPT language and other recognized sources.

Our CCE is updated quarterly (January, April, July and October) and is available online at [www.wa.regence.com/provider/claims/toolkit/CCE/](http://www.wa.regence.com/provider/claims/toolkit/CCE/). Additional CCE code pair edits are added in April and October, and include any changes and additions to CPT and HCPCS codes. Updates are clearly labeled with the corresponding version of CMS' NCCI. Regence BlueShield's CCE update coming in April will correspond to NCCI Version 14.1.

The code pair edits included in CMS' NCCI and our CCE are followed for all lines of business, including the Federal Employee Program (FEP).

## Provider Manual begins the new year with a new name

The *Provider Manual* will have a new name in 2008. Effective this month, our *Provider Manual* will be called the *Administrative Manual*. This change is part of an effort toward consistency across our Plans in Idaho, Oregon, Utah and Washington. You will continue to find the same important information in this newly named manual. The manual is available in the Library section of our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).

### Coordination of Benefits (COB) change to payer rules and new form introduced

The November 2007 issue of *The Connection* included an article about COB changes that were effective January 1, 2008 for all group and Individual plans except Employee Retirement Income Security Act (ERISA) self-funded groups, Boeing, Federal Employee Program (FEP) and Healthy Options. For your convenience, here is a brief summary:

- A secondary payer must process a claim using the “highest allowable expense” among the paying plans, and
- If primary payment information is not submitted with a claim, the secondary payer must make a reasonable estimate of the primary payment, base their payment on that estimate and process the claim within 45 days.

We are working with other health plans in Washington to share primary and secondary allowable and payment information to ensure that claims are processed quickly and accurately. However, if we cannot obtain payment information from the primary plan, the claim will be pended for up to 30 days while we continue to seek primary plan payment information. These pended claims will be listed in the ‘Claims Pending Investigation’ section of your payment voucher.

If a patient supplies you with new or updated information about his or her other health care coverage, you may now complete a *Coordination of Benefits Questionnaire* and submit it to us with the paper claim. This will help decrease the number of claims delayed or rejected due to other health care coverage investigation. A link to the form may be found in the Forms section of the Provider Library on our *Provider Web Site* [www.wa.regence.com/provider](http://www.wa.regence.com/provider).

Please contact Customer Service or your provider consultant if you have any questions.

### Change in agreement effective dates

Regence recognizes that strong provider networks are essential for the delivery of quality health care services. Utilizing a thorough credentialing process ensures members have access to providers who meet basic qualifications and have appropriate licensing and certifications to practice their specialties. Providers must be credentialed before they can participate in our networks. Therefore, the effective date of a provider’s agreement will be contingent upon his or her credentialing date. Effective April 1, 2008, Regence Plans in Idaho, Oregon, Utah and Washington, are adopting the same contract effective date policy for all new physician and other health care professional agreements.

Beginning April 1, 2008, the following policy will apply to new provider agreements:

- The agreement effective date will be on the first day of the month in which the provider was credentialed (e.g., if your credentialing was approved on June 14, your agreement will be effective on June 1).
- If Regence does not receive a signed agreement in the same month as credentialing is completed, the agreement effective date will be the first of the month in which the signed agreement is received.
- If a participating provider contracts with an additional Regence network, the effective date of the new network will be the date the signed agreement is received.
- Regence will no longer establish retroactive agreement effective dates.
- Claims submitted to Regence for dates of service prior to the agreement effective date will be processed as out-of-network.

If you have any questions regarding this policy, please contact your provider consultant.

## Billing tips to help you submit your National Provider Identifier (NPI) correctly

The following information clarifies where to place the National Provider Identifier (NPI) on claims. **Remember, effective March 1, 2008, you must submit your electronic claims with an NPI.** Regence continues in dual-use mode for electronic claims; you may continue to submit your Regence provider number in addition to your NPI until May 23, 2008.

### Paper claims submission tips

- If you are using an NPI on a paper claim, you must also use the revised *CMS-1500* (08-05) claim form as it has specific fields to accommodate your NPI.
- 24I (shaded): Enter the rendering provider's identification (ID) qualifier only if it is different from the billing provider's and you are completing 24J (shaded).
- 24J (shaded): Enter the rendering provider's Regence ID number only if it is different from the billing provider's. (Billing provider is the provider who performed the service found in 33a.)
- 24J (unshaded): Enter the rendering provider's NPI only if different from the billing provider's.
- 32: Enter the rendering provider's address only if different from the billing provider's.
- 33: Enter the billing provider's name, address, ZIP code and telephone number.
- 33a (unshaded): Enter the billing provider's NPI.
- 33b (shaded): Enter the billing provider's ID number as assigned by Regence.
- If you are still using the *CMS-1500* (12-90) form version, please enter only your Regence provider ID number in box 33. Do not use your NPI with this version.
- Clearly type or print all the information on the claim form in a legible manner in black ink.

## Electronic claims submission requirement with regard to rendering provider

For professional claims, when a provider office uses the NPI in Loop 2310B Segment NM108 Qualifier "XX" (NPI) and NM109 as the actual NPI, the electronic claim should also include the secondary reference Segment REF01 Qualifier "EI" (tax ID) and REF02 as the actual tax ID number for the rendering provider.

### Tip for both paper and electronic claims

- Always use the same spelling of the provider or facility name (i.e., William not Wm; Central City Medical Center not CCMC).
- Always include your tax ID.

See the related NPI article on page 8.

## New Clinical Practice Guideline added

We recently added a new Clinical Practice Guideline for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease (COPD). Regence Clinical Practice Guidelines are no longer included in the *Administrative Manual* and are now located in the Care Management section of our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).

If you have questions about these guidelines, please contact your provider consultant.

## Fourth quarter claims processing results

Month	Claims Processed	Number in 30 Days	Percentage
October	1,063,567	1,040,766	97.9
November	797,181	782,657	98.2
December	884,327	866,151	97.9
<b>Total</b>	<b>2,745,075</b>	<b>2,689,574</b>	<b>98.0</b>

### Expedite your correspondence responses

The Customer Service correspondence team receives a large volume of correspondence from physicians and other health care professionals that does not include information necessary to identify the member and specific claim. If you or your staff send correspondence to Regence regarding a claim, please include the member's name, the member number exactly as it is shown on the member card, the date of service, the service rendered, the rendering provider's name and any other pertinent information. For your convenience, several forms are available in the Provider Library section of our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider) that you may print and include with your correspondence.

Forms available include:

- *Corrected Claim Cover Sheet*
- *Incident Report*
- *Supporting Documentation Form*

Providing adequate information with your correspondence will ensure your claims and inquiries are processed in the most efficient manner possible.

### Reminder: Purchasing invoices may be necessary

Regence requests submission of purchasing invoices when billing for certain radiopharmaceutical HCPCS codes, as defined and updated by CMS. When you receive a request for a purchasing invoice, it is because certain radiopharmaceuticals can be produced specifically for an individual patient's needs by the drug manufacturer. Your invoice tells us what you paid to have the drug manufactured, so we may accurately reimburse you.

### Reminder: Copying medical records for claims processing requests

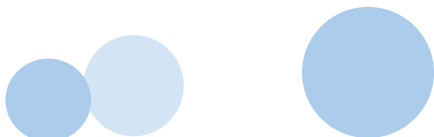
Regence may occasionally request submission of medical records as supporting documentation to ensure accurate processing of your claims. Copying and submitting these records for claims processing are a contractual obligation and, as such, are not separately reimbursable. Failure to submit records when requested will result in denial of the claim.

### Reminder: Upcoming medical record review and survey

Healthcare Effectiveness Data Information Set (HEDIS®) medical record reviews are scheduled from March through May. Outcomes, Inc. will collect information and contact you on behalf of Regence. Patient records in the selected sample may be reviewed at your office or sent via fax or mail for off-site review. Medical record information will be requested only if the required information cannot be obtained through claims data. All vendor data collection processes are Health Insurance Portability and Accountability Act (HIPAA)-compliant.

Participation in this important quality assurance and improvement activity is a contractual requirement for Regence physicians and other health care professionals. Your cooperation during this brief data collection period is appreciated. Tracy Fitzgibbon, RN, from Regence Quality Programs is available to answer your questions or concerns. She may be reached at (360) 755-2755 or toll-free at 1 (800) 659-7229, extension 2755, or via e-mail at [tfitzgib@regence.com](mailto:tfitzgib@regence.com).

The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is sent to members to assess satisfaction with their health plan and health care providers. The CAHPS survey for 2008 will be administered during the same time as HEDIS for members of commercial products. The survey specific to Medicare members will be conducted during the summer.



## Investigational and medical necessity reviews

The following summaries outline recent changes to Regence medical policies.

*Note:* The summaries have been formatted by section, allowing you to easily locate medical policies. The policy name, section and number are included for your convenience. Detailed policies are available online at [www.regence.com/trgmedpol](http://www.regence.com/trgmedpol). Paper copies are available upon request by contacting your provider consultant.

This list does not include transplants, medications or Medicare medical policy exceptions. For additional information related to medication updates, see page 15.

### New or updated investigational or medical necessity policy criteria

#### Laboratory

**Genetic Testing for Initial Warfarin Dose**  
Laboratory 53

**New policy.** Genotyping to determine the cytochrome p450 2C9 (CYP2C9) and Vitamin K epoxide reductase subunit C1 (VKORC1) genetic polymorphisms is considered investigational for the purpose of guiding the initial warfarin dose.

#### Surgery

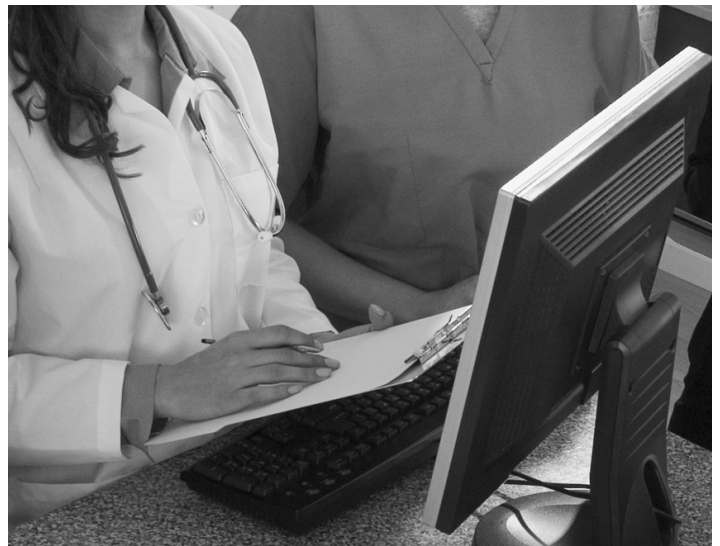
**Minimally Invasive Surgery for Snoring, Obstructive Sleep Apnea Syndrome/Upper Airway Resistance Syndrome**  
Surgery 142

**Policy updated.** Added partial glossectomy as investigational in the treatment of obstructive sleep apnea.

## Join our medical policy discussions

Regence would like your input as we develop our medical policies. If you are interested in providing feedback on policies in draft form, please join our e-mail reviewer list. You may complete an online request at <https://www.regence.com/trg/contact>.

While we prefer to receive input as policies are being developed, we also have a formal provider appeals process that allows you to submit additional information, such as clinical trial results, that may warrant a policy review. The Appeals section of your *Administrative Manual* outlines the appeals process. It can be found online in the Provider Library section of our *Provider Web Site* at [www.wa.regence.com/provider/library/manual](http://www.wa.regence.com/provider/library/manual).



## NPI deadlines are fast approaching

Dates to remember:

- **March 1, 2008** - Regence will require the submission of your NPI on all electronic claim submissions in the primary provider identifier fields (billing, pay-to and rendering).
- **Through May 22, 2008** - As part of the dual-use period, you may continue to submit your electronic claims with both your Regence provider number and your NPI.
- **May 23, 2008** - The dual-use period will end. Only your NPI will be accepted on electronic claim submissions.

## Regence promotes women's wellness screening exams in 2008

Screening mammograms and routine Pap smears are important for early cancer detection. In 2008, we will focus outreach efforts on members who, according to our claims data, have not had a mammogram or Pap smear as recommended in guidelines issued by the U.S. Preventive Services Task Force (USPSTF). We ask for your support in encouraging your female patients to have these screening exams in accordance with USPSTF guidelines. It is our goal that all eligible Regence members receive these very important tests.

## Personal Health Records (PHRs) now available to all members

Regence is dedicated to providing our members with resources and tools to enhance their health care experience. In the May 2007 issue of *The Connection*, we notified you that Personal Health Records (PHRs) were available to Regence employees and members of select employer groups. At the end of 2007, PHRs became available to all Regence members on our secure member Web site, **myRegence.com**.

We define PHRs as “any secure application that enables members to create, review, annotate or maintain a record of any aspect of their health.” This includes immunizations, medications, known allergies, health conditions, and provider and emergency contact lists. PHRs are secure files, created and maintained by the member.

In addition to creating their own PHR, members can create a PHR for any child under the age of 13 who is covered on a Regence policy. Due to HIPAA regulations, children age 13 and over can create their own PHR or give permission to a parent or guardian to create one on their behalf. Relevant information can be printed and shared with the child's physicians, schools, coaches or caregivers.

PHRs allow a comprehensive view of your patients' health information. This tool can improve overall management of multiple diseases or health concerns. The information the patient shares may contain health history and diagnoses, health assessments, orders for tests and current medications—information that can help reduce redundancies or complications in treatments and diagnostic tests.

We will keep you informed about enhancements to this member tool in upcoming issues of *The Connection*.

## Regence Online Network Panel offers input into our future direction

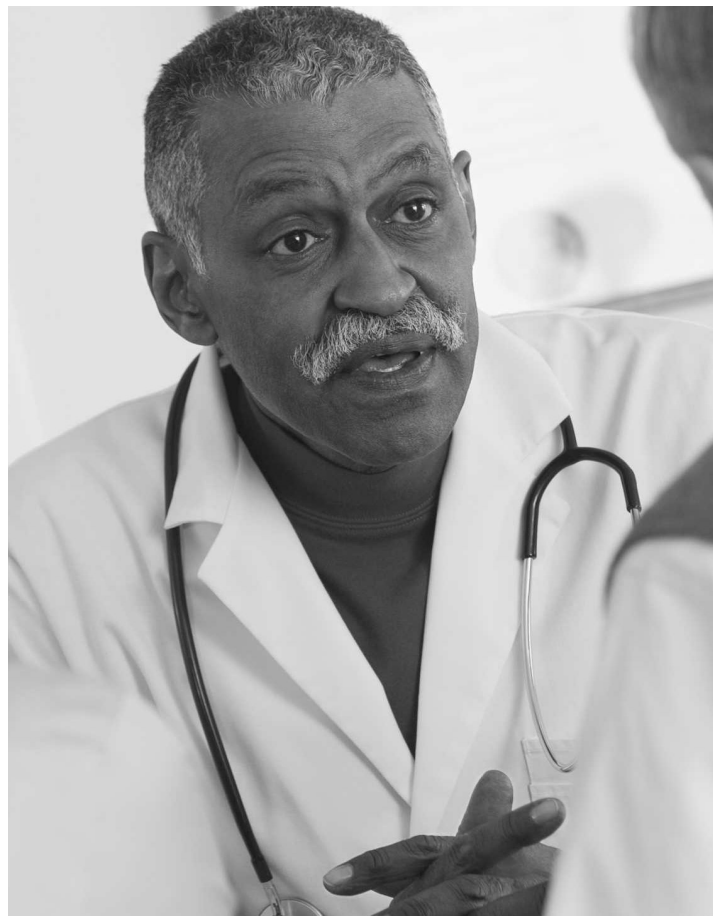
In an effort to receive feedback from a diverse group of network physicians, other health care professionals and their staff across Regence's four-state service area in a timely, cost-effective manner, Regence has organized an online survey panel. Panelists are invited to participate in periodic surveys to share opinions about issues that impact Regence and our community.

The panel currently consists of 952 participants from Idaho, Oregon, Utah and Washington. Panelists include physicians, nurse practitioners and clinic administrators. We launched six surveys last year. The response rates for each survey ranged from 53 percent to 67 percent.

The following topics were surveyed in 2007:

- **Quarterly Provider Satisfaction and Engagement** gathered feedback from providers on our performance, the performance of other health plans and what we could do to improve the provider and patient experience. We also included questions about our *Provider Web Site* usage and features.
- **Provider Demographics and Patient Satisfaction** assessed providers' willingness to supply information about their practice and their comfort level with having us collect patient satisfaction information.
- **Transparency** assessed providers' awareness of transparency and its role in health care. Additionally, the survey requested feedback about the value of cost and quality information as it pertains to health care delivery and patient engagement.
- **Self Reported Quality Measures** explored varying approaches to sharing quality performance information with patients and, specifically, providers' willingness to self-report quality information.
- **Provider Experience and Transactions** collected feedback about providers' interest in and willingness to participate in real-time electronic transactions related to benefits, eligibility, claims processing and payment.

The survey results from this online discussion group provide us with input from physicians about various health issues, trends and initiatives. The feedback will be used to help drive our business decisions and future direction.



## Innova<sup>SM</sup> and Engage<sup>SM</sup> membership grows

Our Innova and Engage membership continues to rise as new and existing smaller employer groups choose these products for their employees. At the time this newsletter went to press, over 1,350 groups and 27,500 members had enrolled in these products across Regence since they launched on November 1, 2007. Innova and Engage will be offered to larger employer groups later this year.

In the fall, we hosted provider workshops across the state that focused on these products. We are making improvements to the Innova and Engage member cards based on feedback from these meetings.

As a reminder, you can find benefit and eligibility information for your Innova and Engage patients on Regence Online Services for Providers. For more information about this free Web-based tool, see the related article on page 19.

We appreciate the vital role you play in the success of Innova and Engage by being part of our provider networks. We will continue to share updates to these products with you in upcoming issues of *The Connection*. Additional information can be found in the Products section of our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).



## 2008 Federal Employee Program (FEP) benefit changes

The following is a summary of the benefit changes effective January 1, 2008 for members enrolled in the Federal Employee Program (FEP).

### Standard Option Only

- The calendar-year deductible increased to \$300 per person and \$600 per family.
- The catastrophic out-of-pocket maximum increased to \$4,500 per year for preferred provider services and \$6,500 for a combination of preferred and non-preferred provider services.
- Benefits for outpatient facility care (except related to an accident or maternity care) at a preferred hospital are paid at 85 percent of the Plan allowance and 70 percent of the Plan allowance at a non-preferred hospital.

### Standard and Basic Options

- Hearing aids are covered for children up to age 22. The benefit is limited to \$1,000 per calendar year. In addition, bone-anchored hearing aids are now covered for adults when medically necessary due to traumatic injury or malformation of the external or middle ear. The benefit is limited to \$1,000 per calendar year.
- Inpatient and outpatient hospital care related to the treatment of severe dental caries is covered for children up to age 22.
- Pre-enrollment visits for home hospice care when provided by a hospice-employed physician are covered.
- Ambulance transportation is covered in full after a \$50-per-day copayment. Medically necessary emergency care provided at the scene when transport services are not required is covered.
- Office visits and diagnostic tests related to morbid obesity are covered.

If you have questions or would like more details about these changes, please contact FEP Customer Service at 1 (800) 552-0733.

## FEP care coordination—the right care at the right time

The goal of FEP care coordination is to create a seamless, integrated health care experience for our FEP members. Care coordination is free and voluntary. The program provides individually tailored services to meet each member's specific health care needs through timely access, expert care and compassionate support.

### The FEP triage coordinator

Referrals for care coordination are made by contacting the triage coordinator who works closely with members, providers and family members to assess each member's current health care needs. Conditions that can be effectively managed when screened and referred into the appropriate care coordination program include complex or chronic health issues, behavioral health needs, hospice, home health, disease management, pharmacy programs and wellness programs for health maintenance. Members who decline or do not meet care coordination criteria will be offered resources, support and information.

If you would like to make a care coordination referral, please contact Monica Vanek, FEP triage coordinator in Medical Services at (503) 525-6510 or 1 (800) 547-0939, extension 6510, or by e-mail at [FEP\\_CM\\_Intake@regence.com](mailto:FEP_CM_Intake@regence.com).



## Medicare crossover update

CMS recently changed the way in which claim-based crossover information is sent to secondary insurers. Claim-based crossover occurs when the physician, other health care professional or facility bills Medicare as the primary payer and, on that claim, supplies secondary payer information. As of October 1, 2007, CMS requires providers to obtain a Coordination of Benefits Agreement (COBA) identification number to add to these claims.

Regence already shares its eligibility files with Medicare and receives secondary crossover claims directly from Medicare. **Therefore, it is not necessary for you to include a COBA number on these claims.**

Please allow 30 days after you receive an *Explanation of Medicare Benefits* (EOMB) for Regence to process your secondary claims. If we do not successfully receive your secondary claims, please contact Customer Service at 1 (800) 544-4246.

## The importance of network referrals for Regence MedAdvantage

Over the past year, we have encountered several situations in which Regence MedAdvantage providers referred members to out-of-network providers. To ensure members receive the in-network benefit, please refer members to a provider or facility that is contracted with Regence MedAdvantage. To verify a provider's participation, please reference the Regence MedAdvantage directory on our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).

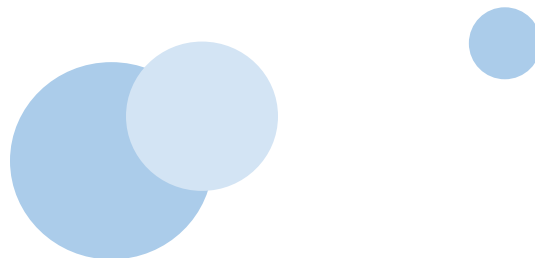
## Notice of Medicare Non-Coverage (NOMNC) Form revised

CMS recently revised the *Notice of Medicare Non-Coverage (NOMNC) Form*. The form is used to notify patients of the date that coverage for facility services will end and describes the process for appealing the decision.

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities are required to use the revised form no later than February 11, 2008. Facilities should have received information about this change via a letter we sent to skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities in January. A copy of the latest form is available in the Forms section of the Provider Library on our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).

## New coding guideline for CPT 80050 for Regence MedAdvantage members

In 2005, CMS determined that **CPT 80050** *General health panel* was ineligible for benefits as Medicare does not cover routine care. To be consistent with Medicare guidelines, effective May 1, 2008, Regence will also deny payment for **CPT 80050** when billed for Regence MedAdvantage members. Tests that are typically included in **CPT 80050** must be billed separately if medically necessary.



## Reminder: Pre-authorization required for inpatient services for Regence MedAdvantage members

As a reminder, pre-authorization is required for inpatient rehabilitation and skilled nursing admissions for Regence MedAdvantage members. This is not a change to existing requirements. A comprehensive list of services and supplies requiring pre-authorization is available in the Care Management section of our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).

To pre-authorize services for your Medicare patients, please contact our pre-authorization department at 1 (800) 824-8563 or by fax at 1 (800) 453-4341.

## Reminder: Revenue codes for mammography

This is a reminder that there are specific revenue codes for diagnostic and screening mammographies. Please review the following mammography-related revenue codes to ensure the proper code is being billed.

### Revenue code 0401

Diagnostic mammography should be billed whenever there is a suspected or confirmed abnormal situation.

### Revenue code 0403

Screening mammography should be used for screening mammograms only. This code indicates a routine exam with no suspected problems.

Billing with accurate codes helps ensure claims are processed correctly.

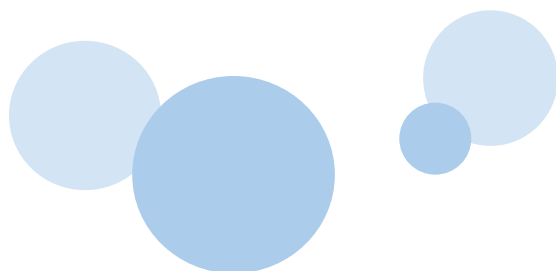
## Reminder: Document your patients' advance directives

The Federal Patient Self-Determination Act (Section 4751 of OBRA 1991) requires that physicians and other health care professionals document the existence of an advance directive in the patient's medical record. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient. These documents explain the patient's wishes concerning the provision of health care in the event the patient becomes incapacitated and is unable to make those wishes known.

Regence recommends that patients be asked if they have executed an advance directive as part of the patient registration process. In addition, for Regence MedAdvantage members:

- The provider must document in the patient's medical record if they have discussed whether or not the patient has executed an advance directive.
- When a patient presents the provider with an advance directive, it must be documented and a copy prominently placed in the patient's medical record.

We ask that you review advance directive processes with your staff to ensure compliance with these requirements.



## Annual update on Medicare accessibility results

We are committed to continuously improving access to care for our Regence MedAdvantage members. To gauge access, a survey was mailed to randomly selected primary care physician (PCP) offices contracted with Regence MedAdvantage to measure a variety of different accessibility standards. The survey included six questions about appointment wait times, two questions about after-hours phone coverage and two questions about advance directives. A statistically valid sample of completed surveys was returned. Listed below is a brief summary of the results.

### Appointment wait times:

- **Urgent, Acute Care:** This standard was met. Of the offices surveyed, 95 percent of offices schedule a patient for an appointment within 24 hours.
- **Non-urgent, Symptomatic Care:** This standard was met. The percentage of offices surveyed that schedule a patient for an appointment within seven days for non-urgent, symptomatic care improved from the previous year.
- **Non-urgent, Asymptomatic Care:** The standard for an appointment scheduled within 30 calendar days for non-urgent, asymptomatic care was met.
- **Emergent Care:** The standard of assessing, treating or referring an emergent patient within five minutes was not met. The standard was met by only 75 percent of offices surveyed, rather than the goal of 100 percent. Most non-compliant respondents indicated a timeframe of six minutes to half an hour as the wait time for emergent care.
- **Preventive Care:** This standard, an appointment scheduled within 42 calendar days for preventive care, was not met.
- **Reception Area Waiting:** This standard, that waiting time in the reception area does not exceed 15 minutes, was not met and had the lowest compliance of all appointment time measures. A large percentage of respondents had wait times between 16 to 30 minutes.

### After-hours phone coverage:

Ninety-seven percent of PCP offices surveyed were in full compliance with this standard. An additional three percent were in partial compliance. The standard requires that PCPs have a provision for coverage 24 hours a day, seven days a week. It is important for offices to give complete and clear instructions to patients so they may reach their PCP or an on-call provider after hours. A recorded message indicating that the patient should call 911 or go to the emergency room does not meet this standard and is considered only partial compliance.

Planned interventions include provider workshops and visits by provider consultants to educate PCP offices about these standards and the importance of compliance.

Though our survey measures only PCP offices, we urge all participating physicians and other health care professionals to be aware of our standards and make efforts to meet them. These standards can be found in the Medicare Advantage Plans section of our *Administrative Manual* available on our *Provider Web Site* at [www.wa.regence.com/provider](http://www.wa.regence.com/provider).



## Regence medication policy updates

Regence uses medication policies for coverage decisions within the member's benefits. Summaries of recent changes to our medication policies, including policy numbers, are listed below. Detailed policies and the complete *Medication Policy Manual* are available online at [www.regence.com/policy/medication](http://www.regence.com/policy/medication).

Medication policy name and number	Summary of changes
<b>Tasigna</b> ®, Policy #dru151	New policy covering Tasigna for chronic myelogenous leukemia that has inadequately responded to Gleevec®.
<b>Gleevec</b> , Policy #dru043	First-line treatment of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) added as medically necessary indication.
<b>Tykerb</b> ®, Policy #dru145	Requirement of prerequisite therapy for HER-2 positive breast cancer removed.
<b>Nexavar</b> ®, Policy #dru134	Hepatocellular carcinoma added as medically necessary indication.
<b>Emend</b> ®, Policy #dru091	Increased quantity limit to two tri-fold packs per month (from one tri-fold pack every three weeks) to be consistent with Medicare Part D formulary recommendations.
<b>Zofran</b> ®, Policy #dru046	Increased quantity limit to 90 four mg or eight mg tablets per month or 30 twenty-four mg tablets per month. Removed coverage criteria for cancer chemotherapy, hyperemesis gravidarum and other severe nausea and vomiting.
<b>Synagis</b> ®, Policy #dru029	Clarified duration of approval to five doses per respiratory syncytial virus (RSV) season (from six doses) to be consistent with the American Academy of Pediatrics <i>Red Book: 2006 Report of the Committee on Infectious Diseases</i> .
<b>Off-Label Use of the U.S. Food and Drug Administration (FDA)-approved Medications</b> , Policy #dru031	Criteria updated to clarify medications and vaccines requiring review.
<b>Remicade</b> ®, Policy #dru036	Policy criteria clarified for initial coverage and re-authorization for Crohn's disease and ulcerative colitis. Remicade is coverable for fistulizing or steroid-resistant disease, or when disease modifying agents are inadequate. 5-ASA products are no longer needed prior to coverage of Remicade.
<b>Cerezyme</b> ®, Policy #dru002	Policy simplified by combining adult and pediatric coverage criteria. Clarified that Cerezyme is considered investigational when used in combination with Zavesca®.
<b>Zavesca</b> , Policy #dru109	Niemann-Pick C disease added as an investigational condition. Clarified that Zavesca is considered investigational when used in combination with Cerezyme.
<b>Zomig</b> ®/ <b>Zomig ZMT</b> ®, Policy #dru057; <b>Imitrex</b> ®, Policy #dru055	Criteria added for coverage of Zomig and Imitrex nasal spray for cluster headaches.
<b>Opioids for Chronic Non-Cancer Pain</b> , Policy #dru084; <b>OxyContin</b> ®, Policy #dru042; <b>Opana ER</b> ®, Policy #dru142	Incorporated RAND 36-Item Short Form Health Survey (SF-36) appendix as a suggested (not mandatory) tool for evaluation of functional impairment due to chronic pain.
<b>Epogen</b> ®, <b>Procrit</b> ®, Policy #dru012 <b>Aranesp</b> ®, Policy #dru076	Criteria updated to be consistent with Medicare proposal for coverage of erythropoiesis-stimulating agent (ESA) products for chemotherapy-related anemia, but not for cancer-related anemia that is not associated with chemotherapy. Coverage criteria added for myelodysplastic syndrome. Updated definition of anemia by specifying minimum laboratory values.
<b>Lyrica</b> ®, pregabalin Policy #dru122	Fibromyalgia added as a medically necessary condition when treatment with at least two specified formulary/preferred options is ineffective, contraindicated or not tolerated.

## Pharmacy prior authorization tips

Regence is committed to helping our members understand their prescription medication options. We also understand that having different formularies for each health plan you work with can be confusing. Information to help you understand our pharmacy program is outlined below.

### Facts about our formulary

Our pharmacists and physicians research medications for safety, effectiveness and overall value. Although we make this information available to you and our members, you and your patients still make the final decision on what medication is best.

Most medications do not need prior authorization. However, prior authorization is necessary when a medication has been proven to benefit only a limited number of people or if unusually large doses are requested.

### Advocating for alternatives

Prior authorization is sometimes required when an equally effective but less costly alternative is available. We support generic alternatives in place of brand-name prescriptions. The Generics First Antidepressant Program is one example of our support of generic alternatives. *The Connection* featured an article on these prescription alternatives in our August 2007 issue.

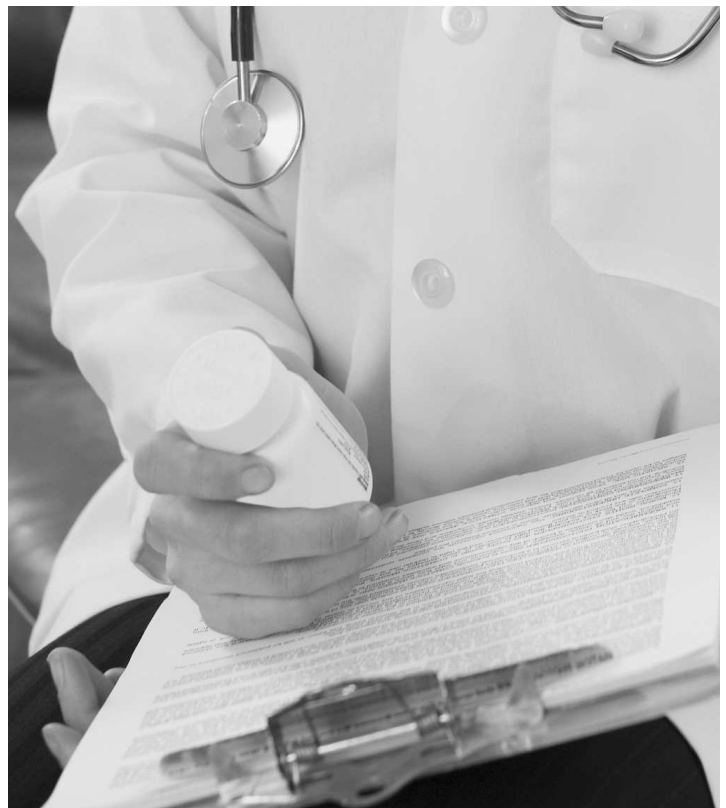
### Accessing information

Our medication policies are accessible on our pharmacy Web Site at [www.regencrx.com](http://www.regencrx.com). The policies include our position on a medication based on our review of the scientific evidence. The *Prior Authorization Form* is also available online.

### The prior authorization process

After a decision has been reached in response to a prior authorization request, we contact the pharmacy and the member. If alternatives are available, we provide the member with information to discuss with you. This includes ConsumerRx medication summaries that are mailed to members to help them understand prescription options. Regence sees value in the prior authorization process by helping our members understand factors affecting safety and cost.

Please contact our Pharmacy Services department at 1 (800) 732-9157, if you have any questions.



## NASCO® claims were migrated to our new system on January 1, 2008

National Account Service Company (NASCO) claims were migrated to our new claims system on January 1, 2008. You will receive a Regence Life and Health payment voucher for any NASCO claims received prior to December 31, 2007 and any adjustments or recoveries to these claims. You will receive our new voucher (the same voucher used for your Innova, Engage and BlueCard® patients) for NASCO claims received on or after January 1, 2008. For inquiries, please call the Customer Service number that appears on the voucher.

## Demographic information verified biannually

The Blue Cross and Blue Shield Association conducts biannual verifications of physicians' and other health care professionals' demographic data as it appears in our *Provider Directories*. Phone calls are made to randomly selected provider offices in our service area to verify that the information in our directories is current and valid. Please be aware that your office may be contacted by the Association for this information in May or November.

Please take this opportunity to review your information in our directories at [www.wa.regence.com/provider/directory](http://www.wa.regence.com/provider/directory) to ensure that it is correct and up-to-date. If you notice any discrepancies, send an e-mail to [WA\\_Prov\\_Info\\_Change\\_Request/WA/Regence@regence.com](mailto:WA_Prov_Info_Change_Request/WA/Regence@regence.com), or complete a *Change Request Form* which may be found in the Forms section of the Provider Library on our *Provider Web Site* at [www.wa.regence.com/provider/library/form](http://www.wa.regence.com/provider/library/form). We appreciate your assistance in ensuring our members—your patients—have access to current information.

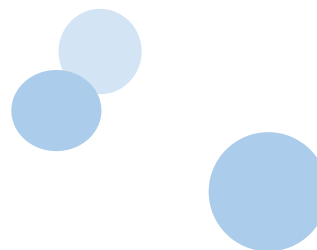
## Wal-Mart Stores, Inc. introduces health care credit

Effective January 1, 2008, Wal-Mart Stores, Inc. added a health care credit feature to its traditional product, Value Plan, for its employees.

Below is a description of this new feature:

- The health care credit is an up-front medical allowance that pays for covered expenses before the employee meets the annual deductible.
- Employees can choose a \$100, \$250 or \$500 health care credit.
- The health care credit does not cover routine services and other services not covered by the Value Plan.
- Each individual covered by the Value Plan has a separate health care credit.
- Providers should submit claims to the local Blue Plan—Regence BlueShield—to receive the payment from the health care credit.
- After the health care credit has been exhausted, claims apply to the annual deductible.
- Once the annual deductible has been met, the Value Plan will pay coinsurance benefits.

For benefit and eligibility information, please call the phone number on the back of the member card.



## TriWest Web site enhanced

Several enhancements were recently made to the TriWest Web site for TRICARE West Region beneficiaries, providers and government partners. They were made based on market research, including feedback from physicians, other health care professionals and beneficiaries.

The Web site features new sections on the Provider Connection page such as In the Spotlight, Quick Links and Popular Links that allow easy navigation to some of the more frequently used sections, including:

- Reimbursement Rates
- NPI information
- Provider Handbook
- Claims information
- Referrals and Authorization information
- Resource Library

In addition, registered providers can now access the Provider Connection page without leaving the secured site.

Visit the new Web site at [www.triwest.com/provider](http://www.triwest.com/provider) today. Please submit your comments or suggestions for further improvements to [feedback@triwest.com](mailto:feedback@triwest.com).

## TriWest NPI update

TRICARE will not deny claims for failure to include the provider's NPI on the HIPAA-standard electronic transaction before the compliance date. However, to facilitate the use of NPIs as a routine practice for the submission of HIPAA transactions, providers are strongly encouraged to use their NPIs as their primary provider identifier as soon as possible.

TriWest is committed to supporting the successful implementation of NPI on or before the compliance date of May 23, 2008.

To learn how to share your NPI with TriWest, visit the Your NPI Connection section of TriWest's Web site at [www.triwest.com/provider](http://www.triwest.com/provider). If you need more information or would like to send test transactions, contact a Wisconsin Physicians Service (WPS) Electronic Data Interchange (EDI) consultant at 1 (800) 782-2680.

## TRICARE spring seminars

TriWest will be hosting provider education seminars this spring. New providers must attend a seminar or complete an online learning course as outlined in the TRICARE contract. Regence also recommends that existing providers attend a seminar to refresh their knowledge regarding the TRICARE program.

The seminars are designed for physicians, other health care professionals or office staff. Watch for an invitation for the upcoming seminars in the mail. You can also register on TriWest's Web site at [www.triwest.com](http://www.triwest.com).

If you are a newly contracted TRICARE provider and are unable to attend a seminar near you, your contractual requirement can be fulfilled by completing an E-Seminar. Information on E-Seminars is available in the Provider Connection section of the TriWest Web site.

Please contact your provider consultant with any questions regarding your TRICARE contract.

## Regence Online Services for Providers can save you time

Regence Online Services for Providers is a free and secure Web-based tool that allows physicians and other health care professionals to access and input information for most Regence members. It is easy to learn and use.

This online tool allows your office to:

- Verify Regence patient benefits and eligibility, including copayment and deductibles
- Create new referrals or verify existing referrals
- Review the status of submitted claims and payment information
- Search for providers

For your Innova and Engage patients, you can also:

- View limited benefit information, including some benefit limitations and accumulations
- Search for payment vouchers

Registered users can also use Regence Online Services for Providers to verify eligibility and claim information for out-of-state members of other Blue Cross and/or Blue Shield Plans.

Access to Regence Online Services for Providers is provided by OneHealthPort™, which allows access to multiple health plans and hospitals using one account, eliminating the need for multiple accounts, passwords and user agreements. Registration is quick, easy and free. Simply determine who at your office or organization will act as your administrator and register with OneHealthPort at [www.onehealthport.com/register/index.php](http://www.onehealthport.com/register/index.php). OneHealthPort will notify your administrator that the account has been created. Your administrator can then give other users in your office access to Regence Online Services for Providers.

Regence Online Services for Providers is available Monday through Saturday (except from midnight to 12:30 a.m.) and Sunday (except from 7 a.m. to noon). The referrals add feature is available Monday through Thursday (except from 7 p.m. to 1 a.m.) and Saturday (except from 1 p.m. to 11 p.m.).

Regence Online Services for Providers offers information and resources that support you in doing what you do best—caring for your patients. For more information, visit [www.wa.regence.com/provider/onlineServices](http://www.wa.regence.com/provider/onlineServices).

### Contact Us

<b>Behavioral Health</b> • Selections • FEP	1 (800) 780-7881 1 (866) 873-9743
<b>Boeing Customer Service</b>	1 (800) 422-7713
<b>FEP Customer Service</b>	1 (800) 552-0733
<b>Healthy Options Basic Health</b>	1 (800) 669-8791
<b>Pharmacy Services</b>	1 (800) 732-9157
<b>TriWest</b>	1 (888) TRIWEST (874-9378)
<b>Washington Health Forum Web site</b>	<a href="http://www.wahealthcareforum.com">www.wahealthcareforum.com</a>
<b>Claims address</b> Regence BlueShield P.O. Box 30271 Salt Lake City, UT 84130-0271	<b>FEP claims address</b> Federal Employee Program P.O. Box 31207 Salt Lake City, UT 84131-0207

Provider Services contact information is listed on the next page.



### Executive Oversight

Audrey Nudd  
Vice President, Provider Services

Joseph Gifford, MD  
Senior Medical Director,  
Medical Services

Vicki McCarron  
Manager, Provider Services

Kathy Neys Hove  
Manager, Provider Communications

### Editors

Sara Perrott, Managing Editor  
Paula Russell, Issue Editor and Writer  
Jayne Drinan, Writer  
Margaret Jester Haining, Writer  
Carolyn Steele, Writer  
Laura Stevenson, Writer  
Darce Vassar, Writer

## Contact Us

### We're here for you

Contact Provider Customer Service or Provider Relations with your questions or concerns. If you have patients that are members of other Blue Plans, contact BlueCard Customer Service. Find additional resources on our *Provider Web Site*.

Provider Customer Service  
Toll-free: 1 (800) 322-1737  
Fax: 1 (877) 367-6551

BlueCard Customer Service  
Toll-free: 1 (800) 206-1244

Provider Relations  
Toll-free: 1 (800) 562-2156

*Provider Web Site*  
**[www.wa.regence.com/provider](http://www.wa.regence.com/provider)**

*The Connection<sup>SM</sup>* is published quarterly by Regence Provider Communications. It is written to keep our participating physicians, other health care professionals and facilities aware of our programs, guidelines and policies. Customer Service numbers listed on page 19 are for claims and benefit inquiries only. For information not related to claims or benefits, contact your provider consultant. A complete listing of contact information is available on our *Provider Web Site* at **[www.wa.regence.com/provider/contact](http://www.wa.regence.com/provider/contact)** and in the Address and Numbers You'll Need section of your *Administrative Manual*.



# Regence

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Mail Station S918 - MM #571M  
P.O. Box 21267  
Seattle, WA 98111

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