Regence
BlueShield of Idaho

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The Connection Online℠

Welcome to *The Connection Online*

This publication contains important information, including updates to policies and procedures, for physicians, dentists, other health care professionals, facilities and their staff.

If you haven't already, please subscribe to receive email notifications when new editions are available

Provider Center—Your first contact for member eligibility, benefits and claims information

Beginning March 1, we will require providers to access the Provider Center to locate information regarding eligibility, benefits and simple claims status.

Medical multi-year accumulators now available
The Provider Center now displays medical multi-year accumulators that are applicable to each member's product.

Learn more >

News and Updates

- View all of our recent updates in the What's New section of our website.
- View Availity's HIPAA 5010 Frequently Asked Questions, including a list of common error messages and how to resolve them.

Administrative and Billing updates

- *Administrative Manual* update
- Clinical practice guidelines updated
- Credentialing reminder
- Medical record documentation requirements
- Pre-authorization List update
- Regence Group Administrators (RGA) claims filing instructions to change in April

Medicare

- Annual update on network accessibility results
- HEDIS® medical record review coming for Idaho Medicare members
- ZIP+4 code required for Regence MedAdvantage claims

Networks

- Healthcare Management Administrators (HMA) members began using our provider networks in January

Policies

Changes to our medical policies are listed below. Learn how policies are reviewed. Our Coding Toolkit includes codes that require clinical information (updated monthly), a complete list of code groupings and our Correct Code Editor (updated quarterly).

Medical

- Investigational and medical necessity reviews

Reimbursement

- 2012 genetic testing code use

Dental

View our *Dental Policy Manual*.

Medication

Learn how obsolete medication codes are reviewed on a quarterly basis.

Summaries of past changes and detailed policies are available in our *Medication Policy Manual*.

- Reimbursement for HCPCS S0265 Genetic counseling code
- Uniform Medical Plan (UMP) hip surgery benefit change

View our group and Individual products *Preferred Medication List/Formulary*.

Search the Regence MedAdvantage + Rx and Medicare Part D formulary.

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Provider Center-Your first contact for member eligibility, benefits and claims information

Beginning March 1, we will require dentists, physicians, other health care professionals and facilities to access the Provider Center to verify information regarding eligibility, benefits and simple claims status.

Most providers have found it's faster to obtain this information online rather than waiting on hold for a Customer Service specialist. Using this free, online tool can save you up to five minutes per inquiry, and the information is available for most members Monday through Saturday 24 hours a day and on Sunday (except from 8 a.m. to noon for maintenance).

Customer Service will continue to be available to answer complex inquiries or questions you have about the information you are unable to view online.

Note:

- Benefits for Federal Employee Program (FEP) members are available through FEP's website. For detailed information or questions, please contact our FEP Customer Service team.
- Eligiblity and benefits for BlueCard® members are available by calling 1 (800) 676-BLUE (2583) or via an American National Standards Institute (ANSI) 270 electronic transaction. Learn more. For claims status, please continue to contact our BlueCard Customer Service team.

Medical multi-year accumulators now available
The Provider Center now displays medical multi-year accumulators that are applicable to each member's product. This information is not currently available for Federal Employee Program (FEP) or BlueCard members.

The following information is displayed:

- Benefit maximums
- How much of the benefit the member has remaining
- How much of the benefit the member has used to date

Included below is a screenshot showing how the information is displayed. To see this information for your patients, simply navigate to the Medical Benefits, Multi-year Accumulators tab. From the drop-down menu, select the service. Then select submit. The multi-year accumulator information will be displayed below.

Medical Benefits

Effective:	**01/01/2011**
Status/End Date:	**Active**
Effective:	**01/01/2011**
Status/End Date:	**Active**

All information shown as of 01/17/2012

Benefits | Accumulators | Booklets | Multi-year Accumulators

Multi-Year Limits

Service Frames Submit

Period: Calendar beginning January 1 — **Per: 2 Years**

Effective Dates 01/01/2011 to 12/31/2012

Limit	Used	Remaining
$40.00	$40.00	$0.00

View our Eligibility and Benefit Guide (PDF) for step-by-step instructions on verifying member information on the Provider Center.

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Administrative Manual update

The Appeals section of our *Administrative Manual* will be updated effective May 1 and will include the following changes to the Provider Appeals information:

- Dental providers will now follow the same provider appeals process as other professional providers.
- The up-front filing fee for second level external provider appeals will be reduced to $50. That fee is reimbursable to the provider if Regence's determination is overturned.

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Clinical practice guidelines updated

Clinical practice guidelines are systematically developed statements on medical and behavioral health practices that help physicians and other health care professionals make decisions about appropriate health care for specific conditions. View our guidelines.

Listed below is a summary of the recent changes to our clinical practice guidelines.

Medical	
Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (COPD)	Routine review, no changes made.
Perinatal Care	Added section on Regence resources and updated standard language for consistency with other guidelines.
Preventive Services Guideline for Adults	Routine review, no changes made.
Preventive Services Guideline for Children	Routine review, no changes made.

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Credentialing reminder

We contract with physicians, dentists, other health care and dental professionals and facilities to form provider networks essential for delivery of health care and dental services to our members. All providers must be credentialed before they can participate in our provider networks.

Credentialing is required when:

- A new provider joins your practice
- A provider would like to participate in the TRICARE network
- A current contracted provider is notified that recredentialing is necessary
  (*Note:* **Recredentialing is required every three years.**)

Credentialing applications are usually processed within 45 days of receipt. During peak application periods this processing time may increase.

Please ensure that applications are completed in their entirety to avoid delays in processing, as Regence does not allow retroactive effective dates for network participation or contract effective dates. Your credentialing application **must** include:

- Your signature
- All supporting documentation
- An email address of the individual responsible for any follow-up related to the application

Credentialing our providers ensures the quality of our networks and helps us verify that your license or certification, education and professional conduct meet participation criteria required by network standards. Our credentialing criteria are consistent with national accreditation standards as established by URAC, the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state and federal agencies, such as TRICARE.

View our credentialing guidelines and forms.

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Medical record documentation requirements

Regence has a responsibility to ensure that our members' health care dollars are spent appropriately. In order to do so, we rely on medical records which contain an accounting of medical care. That record should contain all the necessary documentation to support the services rendered and billed, as well as the medical necessity of those services. When the appropriate documentation is not included, we are unable to confirm that payment was made appropriately which can result in request for refunds from providers.

Please ensure that your patients' medical records include:

- Specific and clear treatment plans
- Complete, accurate and legible documentation
- Complete history, examination and medical decisions
- Diagnostic testing, laboratory tests and radiology reports and results
- Complete descriptions of the patient's concerns and reason for seeking medical care
- Evaluation and assessment of the provider's findings and a complete list of all diagnoses

Each entry or page in the medical record must include:

- The patient's name, date of service, and the rendering provider's name and signature
- Progress notes, any improvement in the patient's condition, changes in the treatment plan and updates to the diagnosis

Current Procedural Terminology (CPT®) codes and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes must be supported by the patient's medical record.

We follow Medicare standards for proper documentation, including record retention. For Medicare patients, records must be retained for 10 years. Review our documentation standards, Guide to documentation (PDF) and learn more about Medicare's documentation protocols.

Our audit rule is, "if it isn't documented, it isn't billable to the health plan and, therefore, isn't payable." Proper and accurate medical documentation is essential to proper and accurate payment of claims.

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Pre-authorization List update

We are in the process of simplifying the Pre-authorization pages of our website. Over the next few months, the older versions of the Pre-authorization Lists will be removed, ensuring that you have access to the most current version of each list. If you need access to the older Pre-authorization Lists, please contact your provider consultant.

Group and Individual Medical List **changes**

The following new 2012 Current Procedural Terminology (CPT®) codes have been added to the *Group and Individual Medical Pre-authorization List* and *Medicare Products Pre-authorization List* effective January 1, 2012:

- **CPT 22633** added to the Spinal Surgery section
- **CPT 38232** added to the Transplants section

CPT 38232 was also added to the *Uniform Medical Plan Pre-authorization List* effective January 1.

Idaho Power Pre-authorization List **reminder**

Idaho Power, group #100006786, has a specific *Idaho Power Pre-authorization List* that is in effect now. Use this specific list for all Idaho Power members instead of using the *Group and Individual Medical Pre-authorization List*.

We have recently added specific CPT codes to some of the existing sections for ease of use of this List. Existing procedures that have been clarified include:

- Transplants
- Parenteral, enteral and oral nutrition therapy
- Outpatient cardiac and pulmonary rehabilitation
- Blepharoplasty under potentially cosmetic procedures

We have also added services that were previously required when using the *Group and Individual Medical Pre-authorization List* that should also appear on the *Idaho Power Pre-authorization List*. These include:

- Orthognathic surgery
- Varicose vein surgery
- Long Term Acute Care (LTAC)
- Chemical Dependency and Mental Health admissions

Beginning March 1, specific inpatient surgeries identified on the list by CPT codes will require pre-authorization. In addition, we have further defined the CPT codes for the following:

- Hysterectomy
- Abdominal wall hernia repair
- Spinal surgery and related procedures, in addition to spinal fusion
- Hip, knee, or shoulder total joint replacement and revision of hip, knee or shoulder joint replacement

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Regence Group Administrators (RGA) claims filing instructions to change in April

This year, employer group members of Regence Group Administrators (RGA) will be presenting member cards with new claims filing instructions to bill RGA directly for claims incurred in Idaho rather than billing your local Blue Plan through BlueCard®.

Claims will still be accepted and processed when filed through Regence BlueShield of Idaho. However, beginning in April, the preferred billing method will be to send claims directly to RGA.

These members are covered by self-funded health plans administered by RGA, a wholly owned subsidiary of Regence BlueShield (in Washington). RGA provides third-party administrative services to over 100 self-funded employer groups primarily located in Oregon and Washington.

These members may live in or travel to our service area and seek services from you. The RGA product uses the BlueCard network and the Regence BlueShield of Idaho Participating and Preferred Provider Organization (PPO) networks as the local health plan.

Learn more about:

- Identifying members
- Submitting claims to RGA
- Receiving vouchers and payment
- Obtaining pre-authorization, eligibility and claims status

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Annual update on network accessibility results

In September 2011, a survey was completed by a statistically valid sample of family practice, general practice and internal medicine Regence MedAdvantage physician offices. The survey measured a variety of different accessibility standards. Listed below is a brief summary of the results and our planned interventions.

Regence MedAdvantage standards

	Standard and goal	Percent of compliance with standard	Results
Appointment wait times			
Emergent care	100% of offices surveyed assess, treat or refer emergent patients within five minutes	89%	Not met - see explanation below
Urgent, acute care	95% of offices schedule appointments for urgent, acute care within 24-hours	99%	Exceeded
Non-urgent, symptomatic care	95% of offices schedule non-urgent care for symptomatic conditions within seven days	94%	Not met - see explanation below
Non-urgent, asymptomatic care	95% of offices schedule non-urgent appointments for asymptomatic conditions within 30 calendar days	100%	Exceeded
Preventive care	95% of offices schedule appointments for extended visits (e.g., comprehensive exam, preventive care) within 30 days or the community standard	100%	Exceeded
After hours availability			
Phone coverage	100% of offices direct patients to an answering service or an on call provider when their office is closed	83%	Partially compliant - see explanation below
Advance directives			
Availability	100% of offices provide copies of advance directives or advise patients on how to obtain one	76%	Not met - see explanation below

Documentation	100% of offices have a procedure to document when there is an advance directive in the patient chart and that it is prominently displayed	65%	Not met - see explanation below

Emergent care: The standard of assessing, treating or referring an emergent patient within five minutes was met by 89% of offices surveyed, rather than the goal of 100%. Most non-compliant offices indicated 6 to 30 minutes as their wait time for emergent care.

Non-urgent, symptomatic care: This standard was not met. Of the offices surveyed, 8% were not able to schedule a patient for an appointment within seven days for non-urgent, symptomatic care. Some indicated that wait times could be two weeks or more.

After-hours phone coverage: This standard requires that 100% of family practice, general practice and internal medicine offices 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 about how to reach their physicians or on-call providers 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, except for specific rural area contracted providers.
- 15% were in partial compliance, and 1% was non-compliant. We are following up with providers who were non-compliant separately.

Advance Directives: Provider offices were compliant if they indicated that copies of advance directives were available for patients or they advise patients on how to obtain one. Of the offices surveyed, 76% were compliant with this standard. Provider offices were in compliance with documentation requirements if they have a procedure to document whether there is an advance directive in the patient's chart and the document is prominently displayed (or stored in an electronic medical record). Of the offices surveyed, only 65% met this requirement. Complete our online advance directives workshop to learn more.

Interventions

Planned interventions for standards that were not met include contacting non-compliant offices and ongoing articles in our newsletter clarifying key standards and our expectations.

We strongly urge all participating providers to be aware of our standards and implement steps to meet them. Learn more about the access and availability standards for all providers, and the standards for Regence MedAdvantage.

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HEDIS® medical record review coming for Idaho Medicare members

We will begin our 2012 Healthcare Effectiveness Data and Information Set (HEDIS) medical record reviews in March, continuing through May. We have renewed our contract with Outcomes Health Information Solutions, LLC, to contact offices and collect data using a Health Insurance Portability and Accountability Act (HIPAA)-compliant process.

If the needed information cannot be reviewed through claims data, we may:

- Request records by fax or mail
- Request an on site review for select patient records

It is a contract requirement for Regence physicians, other health care professionals and facilities to participate in this important quality assurance and improvement activity. Your cooperation during this brief data collection period is appreciated. Learn more about the review.

If you have any questions, please email Janice Knight in our Quality Program department or call her at (253) 382-7252.

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ZIP+4 code required for Regence MedAdvantage claims

The Centers for Medicare & Medicaid Services (CMS) determines the correct payment locality for services on the Medicare Physician Fee Schedule (MPFS) based on the ZIP code where the services were performed. In some instances, the service may be performed in one county, but based on the ZIP code, fall into another county or payment locality. This causes a payment issue when counties have different payment amounts.

Effective May 1, Regence MedAdvantage claims requiring a ZIP+4 code that are submitted with only the five digit ZIP code will be denied and returned to the provider for correction with reason code "MA114 - Missing/incomplete/invalid information on where the services were furnished." Not all claims require a ZIP+4 code, but we encourage you to submit it on all claims in order to avoid claim processing delays.

To determine if this requirement applies to your office, please review the CMS ZIP codes requiring +4 extension file. *Note*: This file is updated quarterly, so it should be checked frequently to ensure that the requirement has not changed for your office.

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Healthcare Management Administrators (HMA) members began using our provider networks in January

We are pleased to announce that as of January 1, additional Individual and employer group members have access to our Participating and Preferred networks.

These members are covered by self-funded health plans administered by Healthcare Management Administrators (HMA), a wholly owned subsidiary of Regence BlueShield (in Washington). HMA provides third-party administrative services to over 100 self-funded employer groups primarily located in Oregon and Washington.

These members may live in or travel to our service area and seek services from you. The HMA Preferred product uses the Regence BlueShield of Idaho Participating and Preferred Provider Organization (PPO) networks as the provider network for their HMA Preferred product. Reimbursement is the same as Regence BlueShield of Idaho Participating and/or Preferred networks.

Learn more about:

- Identifying members
- Submitting claims to HMA
- Receiving vouchers and payment
- Obtaining pre-authorization, eligibility and claims status

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Investigational and medical necessity reviews

Listed below are summaries of recent changes to our medical policies. View all detailed policies in the *Medical Policy Manual*. **This list does not include medications or Medicare medical policy exceptions.**

New or updated investigational or medical necessity policy criteria	
Medicine Name	
Charged Particle (Proton or Helium Ion) Radiation Therapy (#49)	Added olfactory neuroblastomas or esthesioneuroblastomas, pancreas tumors, and spinal cord tumors to list of investigational indications.
Intensity Modulated Radiation Therapy (IMRT) of the Prostate (#137)	Criteria change to consider IMRT medically necessary for treatment of prostate cancer without metastases. Also clarified criteria related to salvage therapy for failed prostatectomy and suspected recurrence of localized prostate cancer in the post-prostatectomy setting.
Transcutaneous Electrical Modulation Pain Reprocessing (#143)	New investigational policy.
Surgery	
Cochlear Implant (#8)	Clarified definition of hearing loss. Added indications and clarifications to list of contraindications.
Reconstructive Breast Surgery/Mastopexy and Management of Breast Implants (#40)	Criteria revised for clarity only.
New or updated investigational or medical necessity policy criteria effective May 1, 2012	
Surgery	
Autologous Fat Grafting to the Breast and Adipose-derived Stem Cells (#182)	New investigational policy.

Join our medical policy discussions
We welcome your input and feedback as we draft our medical policies. It's easy to join our email reviewer list. Simply complete our request form.

While we prefer to receive input as policies are developed, we also have a formal process that allows providers to submit additional information, such as clinical trial results, that may warrant a policy review.

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2012 genetic testing code use

Effective January 1, the American Medical Association (AMA) added 101 new Current Procedural Terminology (CPT®) molecular pathology (genetic testing) codes: **CPT 81200-81408**. While these codes are more specific than the existing codes, the Centers for Medicare & Medicaid Services (CMS) has given these new codes a Status Indicator of "B" (Bundled Code) and have not assigned any pricing.

Instead, CMS will reimburse the existing genetic testing codes according to their current policies. CMS has advised providers to bill both the existing codes and the new codes on the same claim. This will enable CMS to accumulate information to help establish pricing for these codes in 2013.

Regence has adopted the same approach regarding reimbursement of these new codes. We will not reimburse these new codes. The new codes will be denied as invalid or bundled. However, we will continue to reimburse the existing codes (e.g., **CPT 83890-83914**, **88363-88366**, **HCPCS G9143**, **S3800**, **S3818-S3890**), in accordance with Regence Medical Policy.

We encourage providers to bill using the same process as requested by CMS. This applies to all products, including group and Individual, Federal Employee Program, Uniform Medical Plan and Regence MedAdvantage.

View our Invalid Services (#107) reimbursement policy.

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Reimbursement for HCPCS S0265 Genetic counseling code

Health Care Common Procedure Coding System (HCPCS) S0265 code, *Genetic counseling, under physician supervision, each 15 minutes* is eligible for reimbursement in accordance with the Patient Protection and Affordable Care Act.

Effective May 1, for all other coding uses, **HCPCS S0265 will not** be a payable service. It will be denied as a Regence invalid code and be a provider write-off.

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Uniform Medical Plan (UMP) hip surgery benefit change

Effective May 1, a Health Technology Assessment (HTA) will apply to UMP members who have hip surgery for femoroacetabular impingement syndrome (FAI). When the FAI procedure is identified for a UMP member, benefits will be denied as member responsibility, subject to the HTA decision.

The following Current Procedural Terminology (CPT) codes should be used to identify FAI:

- **CPT 29914** *Arthroplasty, hip, surgical; with femoroplasty (ie, treatment of cam lesion)*
- **CPT 29915** *Arthroplasty, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)*
- **CPT 29916** *Arthroplasty, hip, surgical; with labral repair*

View HTA's Hip Surgery for Femoroacetabular Impingement Syndrome (PDF) policy.

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