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Feature:

Consumerism in health care reaches tipping point



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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 Asuris members the opportunity to provide feedback on their experiences with individual providers, including physicians, dentists, other health care professionals and facilities.

In evaluating whether Asuris 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. Asuris 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.

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.asuris.com/provider:

- Cosmetic and potentially cosmetic codes
- Asuris 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 16 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 Asuris 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.asuris.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. Asuris' 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.

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*. 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.asuris.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 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.asuris.com/provider.

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

Change in agreement effective dates

Asuris 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.

Beginning April 1, 2008, the following policy will apply to all new physician and other health care professional 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 Asuris 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 Asuris network, the effective date of the new network will be the date the signed agreement is received.
- Asuris will no longer establish retroactive agreement effective dates.
- Claims submitted to Asuris 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.** Asuris continues in dual-use mode for electronic claims; you may continue to submit your Asuris 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 Asuris 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 Asuris.
- If you are still using the *CMS-1500* (12-90) form version, please enter only your Asuris 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). Asuris 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.asuris.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	53,862	52,144	96.8
November	42,035	41,059	97.7
December	47,173	45,536	96.5
Total	143,070	138,739	96.9

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 Asuris 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.asuris.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

Asuris 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

Asuris 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 Asuris. 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 Asuris physicians and other health care professionals. Your cooperation during this brief data collection period is appreciated. Tracy Fitzgibbon, RN, from Asuris 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.

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 Asuris 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. 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 13.

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

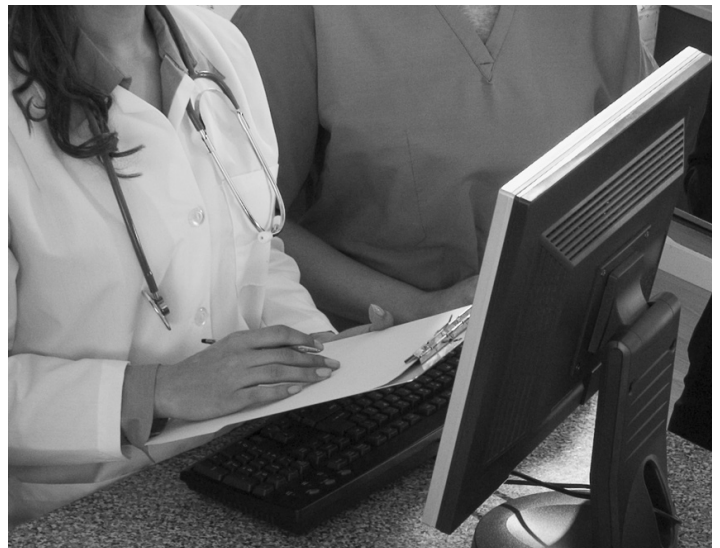
Minimally Invasive Surgery for Snoring, Obstructive Sleep Apnea Syndrome/Upper Airway Resistance Syndrome
Surgery 142

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

Join our medical policy discussions

Asuris 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.asuris.com/provider/library/manual.



NPI deadlines are fast approaching

Dates to remember:

- **March 1, 2008** - Asuris 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 Asuris provider number and your NPI.
- **May 23, 2008** - The dual-use period will end. Only your NPI will be accepted on electronic claim submissions.

Asuris 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 Asuris members receive these very important tests.

Personal Health Records (PHRs) now available to all members

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

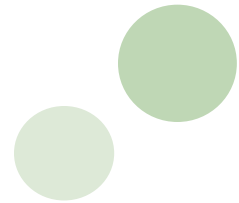
EmbarkSM and VantageSM membership grows

Our Embark and Vantage 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 110 groups and 2,500 members had enrolled in these products since they launched on November 1, 2007. Embark and Vantage 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 Embark and Vantage member cards based on feedback from these meetings.

As a reminder, you can find benefit and eligibility information for your Embark and Vantage patients on Asuris Online Services for Providers. For more information about this free Web-based tool, see the related article on page 15.

We appreciate the vital role you play in the success of Embark and Vantage 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.asuris.com/provider.



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.

Asuris 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 Asuris to process your secondary claims. If we do not successfully receive your secondary claims, please contact Customer Service at 1 (888) 344-5587.

The importance of network referrals for Asuris TruAdvantage

Over the past year, we have encountered several situations in which Asuris TruAdvantage (previously called 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 Asuris TruAdvantage. To verify a provider's participation, please reference the Asuris TruAdvantage directory on our *Provider Web Site* at www.asuris.com/provider.

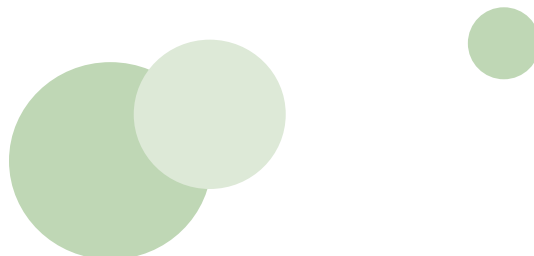
Notice of Medicare Non-Coverage (NOMNC) Form revised

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.asuris.com/provider.

New coding guideline for CPT 80050 for Asuris TruAdvantage 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, Asuris will also deny payment for **CPT 80050** when billed for Asuris TruAdvantage members. Tests that are typically included in **CPT 80050** must be billed separately if medically necessary.



Reminder: Pre-authorization required for inpatient services for Asuris TruAdvantage members

As a reminder, pre-authorization is required for inpatient rehabilitation and skilled nursing admissions for Asuris TruAdvantage 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.asuris.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.

Asuris recommends that patients be asked if they have executed an advance directive as part of the patient registration process. In addition, for Asuris TruAdvantage 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 Asuris TruAdvantage members. To gauge access, a survey was mailed to randomly selected primary care physician (PCP) offices contracted with Asuris TruAdvantage 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:

One-hundred percent of PCP offices surveyed were in full compliance with this standard. 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.asuris.com/provider.



Asuris medication policy updates

Asuris 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.

Medication policy name and number	Summary of changes
Tasigna ®, Policy #dru151	New policy covering Tasigna for chronic myelogenous leukemia that has inadequately responded to Gleevec®.
Gleevec , Policy #dru043	First-line treatment of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) added as medically necessary indication.
Tykerb ®, Policy #dru145	Requirement of prerequisite therapy for HER-2 positive breast cancer removed.
Nexavar ®, Policy #dru134	Hepatocellular carcinoma added as medically necessary indication.
Emend ®, 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.
Zofran ®, 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.
Synagis ®, 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> .
Off-Label Use of the U.S. Food and Drug Administration (FDA)-approved Medications , Policy #dru031	Criteria updated to clarify medications and vaccines requiring review.
Remicade ®, 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.
Cerezyme ®, Policy #dru002	Policy simplified by combining adult and pediatric coverage criteria. Clarified that Cerezyme is considered investigational when used in combination with Zavesca®.
Zavesca , Policy #dru109	Niemann-Pick C disease added as an investigational condition. Clarified that Zavesca is considered investigational when used in combination with Cerezyme.
Zomig ®/ Zomig ZMT ®, Policy #dru057; Imitrex ®, Policy #dru055	Criteria added for coverage of Zomig and Imitrex nasal spray for cluster headaches.
Opioids for Chronic Non-Cancer Pain , Policy #dru084; OxyContin ®, Policy #dru042; Opana ER ®, 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.
Epogen ®, Procrit ®, Policy #dru012 Aranesp ®, 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.
Lyrica ®, 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.

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 today. Please submit your comments or suggestions for further improvements to 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. 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. Asuris 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.

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.

Asuris Online Services for Providers can save you time

Asuris 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 Asuris members. It is easy to learn and use.

This online tool allows your office to:

- Verify Asuris 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 Embark and Vantage patients, you can also:

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

Access to Asuris 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. OneHealthPort will notify your administrator that the account has been created. Your administrator can then give other users in your office access to Asuris Online Services for Providers.

Asuris 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.).

Asuris 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.asuris.com/provider/onlineServices.

Contact Us

Behavioral Health	1 (800) 780-7881
Healthy Options	1 (866) 240-9560
Pharmacy Services	1 (800) 732-9157
TriWest	1 (888) TRIWEST (874-9378)
Washington Health Forum Web site	www.wahealthcareforum.com
Claims address Asuris Northwest Health P.O. Box 30271 Salt Lake City, UT 84130-0271	Spokane Office Asuris Northwest Health P.O. Box 13368 Spokane, WA 99213-3368

Provider Services contact information is listed on the next page.



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We're here for you

Contact Provider Customer Service or Provider Relations with your questions or concerns. Find additional resources on our *Provider Web Site*.

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Toll-free: 1 (800) 462-5680
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Provider Web Site
www.asuris.com/provider

*The Connection*SM is published quarterly by Asuris 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 15 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.asuris.com/provider/contact** and in the Address and Numbers You'll Need section of your *Administrative Manual*.



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