

The Connection OnlineSM



February 2012

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

- [Clinical practice guidelines updated](#)
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Networks

- [Annual update on network accessibility results](#)
- [Healthcare Management Administrators \(HMA\) members have access to our provider networks](#)

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

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*

Investigational and medical necessity reviews

Reimbursement

- [2012 genetic testing code use](#)
- [Reimbursement for HCPCS S0265 Genetic counseling code](#)

Manual at

<http://blue.regence.com/policy/medication/>

View our group and Individual products

[Preferred Medication List/Formulary.](#)

Search the [Asuris TruAdvantage + 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.

Medical multi-year accumulators now available

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

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

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.

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

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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. Clinical Practice Guidelines are available at <http://blue.regence.com/trgmedpol/index.html> or upon request by contacting your [provider consultant](#).

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 Asuris 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

Asuris 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

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Submit claims for 2011 dates of service

Effective January 1, claims for all of our members enrolled in group and Individual products are being processed on our new claims system. You should now be receiving one type of payment voucher for all your Asuris patients with dates of service on or after January 1. **Please note:** Healthy Options has not been moved to our new claims system.

To avoid claims processing delays, please submit claims for all 2011 dates of service for these members as soon as possible. Our goal is to have these claims all processed by April 30, 2012.

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HEDIS[®] medical record review coming for Asuris Medicare and Medicaid 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 Asuris 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 Asuris TruAdvantage 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, Asuris TruAdvantage 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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Annual update on network accessibility results

In September 2011, a survey was completed by a statistically valid sample of family practice, general practice, internal medicine and behavioral health Asuris TruAdvantage and Healthy Options physician offices. The survey measured a variety of different accessibility standards. Listed below is a brief summary of the results for [Asuris TruAdvantage](#) and [Healthy Options](#) along with our planned [interventions](#).

Asuris TruAdvantage 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	100%	Met
Urgent, acute care	95% of offices schedule appointments for urgent, acute care within 24-hours	100%	Exceeded
Non-urgent, symptomatic care	95% of offices schedule non-urgent care for symptomatic conditions within seven days	100%	Exceeded
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	95%	Partially compliant - see explanation below
Advance directives			
Availability	100% of offices provide copies of advance directives or advise patients on how to obtain one	90%	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	90%	Not met - see explanation below

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.
- 5% were in partial compliance, but no offices were non-compliant.
-

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, 90% 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 90% met this requirement. Complete our [online advance directives workshop](#) to learn more.

Healthy Options 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	100%	Met
Urgent, acute care	95% of offices schedule appointments for urgent, acute care within 24-hours	100%	Exceeded

Non-urgent, symptomatic care	95% of offices schedule non-urgent care for symptomatic conditions within seven days	100%	Exceeded
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
Waiting room wait time	100% of offices surveyed shall have wait times less than 30 minutes in the waiting room	100%	Met
Treatment room wait time	100% of offices surveyed shall have wait times less than 30 minutes in the treatment room	100%	Met
After hours availability			
Phone coverage	100% of offices direct patients to an answering service or an on call provider when their office is closed	100%	Met
Behavioral Health appointment wait times			
Emergent care	100% of behavioral health providers shall schedule appointments for emergent care within 24-hours	33%	Not met - see explanation below
Non-emergent care	95% of behavioral health providers shall schedule appointments for non-emergent care within seven days	100%	Met

Behavioral health emergent care: This standard requires that 100% of providers surveyed shall schedule appointments for emergent care within 24-hours. The majority of providers did not meet this standard. However, we recognize that this is the first year we have measured compliance with this standard and we will further evaluate the questions and examples provided in the survey to ensure that we get a more accurate representation of the care provided to our members in the future.

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. A full copy of our network access and availability findings is available upon request.

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](#), the [standards for Regence MedAdvantage](#), and [Healthy Options \(PDF\)](#).

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[Healthcare Management Administrators \(HMA\) members have access to our provider networks](#)

As a reminder, 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. 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 Asuris Participating and Preferred Provider Plan networks as the provider network for their HMA Preferred product. Reimbursement is the same as Asuris' Participating and/or Preferred Provider Plan 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

The complete *Medical Policy Manual* is available at <http://blue.regence.com/trgmedpol/index.html> or upon request by contacting your provider consultant. 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	New investigational policy.

Adipose-derived Stem Cells (#182)

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.

Asuris 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 Asuris Medical Policy.

We encourage providers to bill using the same process as requested by CMS. This applies to all products, including group, Individual and Asuris TruAdvantage.

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 an Asuris invalid code and be a provider write-off.

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