Effective January 1, 2015, we will no longer accept older versions of the HCFA/CMS 1500 claim form. If you aren’t sure which version you are using, look for the version date at the bottom of the form.

If you have not already done so, we encourage you to order OMB-0938-1197 FORM 1500 (02-12) from your vendor. Information about this form is available on cms.gov.

Order **OMB-0938-1197 FORM 1500 (02-12)** from your vendor.
Making Your Paper Claims Readable

Do you still submit paper claims? We often receive paper claims that are unreadable or difficult to read. These claims require manual investigation and data entry, and slow down our processing and payment time. To ensure your paper claims are processed accurately and timely, follow these guidelines:

- Print with black ink—blue ink is difficult for our scanners to read
- Use a standard, non-serif font such as Arial or Calibri
- Ensure the font produces individual characters that are clearly identifiable—characters that are smashed together or elongated are difficult for our scanners to read
- Use the red-ink version of the claim form—the contrast between the red lines and black typing provides a much clearer image when scanned

Incorrect

Correct

Characters that are smashed together or elongated are difficult for our scanners to read.
Credentialing for Physician Assistants

We believe that Physician Assistants (PAs) play an important role in the care of our members. As of September 1, 2013, PAs became eligible for individual credentialing consistent with their licensing requirements. Credentialing PAs allows us to reimburse them directly for their services. It also allows provider-specific tracking for quality improvement purposes and may allow PAs to participate in quality improvement activities in the future.

To participate on a SelectHealth network, the PA must be credentialed. He or she can be enrolled on any network in which his or her supervising physician participates. If there are PAs in your practice who are interested in becoming credentialed, or to learn more about PA credentialing, please contact your Provider Relations representative.

Taxonomy Reminder for Mid-level Providers

Taxonomy codes are administrative codes used to identify the provider type and area of specialization for healthcare providers. Each taxonomy code is a unique, ten character, alphanumeric code that enables providers to identify their specialty at the claim level. Taxonomy codes are assigned at both the individual provider and organizational provider levels.

SelectHealth uses taxonomy codes to select the correct provider ID to process and pay claims. Providers may have multiple provider IDs, each corresponding to a different fee schedule. SelectHealth uses the provider’s taxonomy code to assign the correct reimbursement to the claim.

Submitting Claims Using an Electronic ASC X12N or 837P (005010X222A1) Professional Claim Form

- Taxonomy codes to select a provider (not a facility) should be sent in the 2310B loop in the PRV segment (Rendering Provider Specialty Information).
- Contact your claims management software company if you are unsure where to put this information in your system.
- The qualifier to denote a taxonomy code is PXC.
Taxonomy Reminder  Continued from page 3

Submitting Claims Using an Electronic ASC X12N 837A (004010X096A1) or 837I (005010X223A1) Institutional Claim Form

> Taxonomy codes to select a facility (not a provider) should be sent in the 2000A loop in the PRV segment (Billing Provider Specialty Information).

> Contact your claims management software company if you are unsure where to put this information in your system.

> The qualifier to denote a taxonomy code is PXC.

Submitting Claims Using a HCFA or CMS 1500 Claim Form

If billing using the CMS-1500 form (new format), the taxonomy(s) must be listed in 33b in the shaded area.

Submitting Claims Using an UB-04 Claim Form

If billing using the UB-04 form, the taxonomy(s) must be listed in box 81. The indicator is B3.

DEA Update: Hydrocodone Reclassified as Schedule II Drug

Effective October 6, 2014, the Drug Enforcement Agency (DEA) reclassified all prescription products containing hydrocodone from a Schedule III to a Schedule II drug classification. As of October 6, 2014, members will need a new prescription every time they fill a medication that contains hydrocodone. Many commonly prescribed pain medications (e.g., Vicodin and Norco) and some cough medicines (e.g., Hydromet and Tussionex) contain hydrocodone. Prior to October 6, members have been able to fill these prescription medications up to six times with one prescription. After October 6, the DEA requires an office visit for each medication refill.

We have notified members with recent hydrocodone prescriptions of this new requirement. If you have questions, contact Provider Relations at 800-538-5054 or provider.relations@selecthealth.org.
M-Tech is the formal process used by SelectHealth to review emerging healthcare technologies (procedures, devices, tests and biologics) for the purpose of establishing coverage benefits. Existing technologies may also be examined through this process.

Following is a list of recent technologies reviewed and M-Tech Committee recommendations:

<table>
<thead>
<tr>
<th>TECHNOLOGY</th>
<th>DATE REVIEWED*</th>
<th>COMMITTEE DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Ankle Replacement</td>
<td>3/18/14</td>
<td>Cover in Select Circumstances. Current evidence has demonstrated durability out to approximately ten years for some of the ankle implants. These survival statistics compare favorably with ankle arthrodesis. See Medical Policy #358</td>
</tr>
<tr>
<td>Corus CAD Gene Expression Test</td>
<td>3/18/14</td>
<td>Deny as Investigational. Current evidence has not demonstrated the clinical utility of the test. See Medical Policy #442</td>
</tr>
<tr>
<td>Third Eye Retroscope</td>
<td>4/29/14</td>
<td>Deny as Investigational. There is a lack of evidence demonstrating improved health outcomes as it relates to morbidity from developing colon cancer or mortality. See Medical Policy #551</td>
</tr>
<tr>
<td>MammaPrint</td>
<td>4/29/14</td>
<td>Approved as Medically Necessary Effective 6/1/14. Current evidence has demonstrated clinical utility of this test for select patients meeting specified criteria. See Medical Policy #281</td>
</tr>
<tr>
<td>VWING Vascular Access Guide</td>
<td>4/29/14</td>
<td>Deny as Unproven. Current evidence is inadequate to determine the safety, efficacy, performance durability, or cost effectiveness of the device. See Medical Policy #550</td>
</tr>
<tr>
<td>UroLift for the Treatment of BPH</td>
<td>7/29/14</td>
<td>Deny as Investigational and Not Medically Necessary. Current evidence has not demonstrated the durability of this procedure beyond two years, which is important given the numerous other procedures available that do have long term-durability data. See Medical Policy #553</td>
</tr>
<tr>
<td>NeuroPace for Epilepsy</td>
<td>9/16/14</td>
<td>Cover in Limited Circumstances. Current evidence demonstrates responsive cortical stimulation to be safe and efficacious in adults with partial-onset seizures refractory to at least two antiepileptic medications. See Medical Policy #556</td>
</tr>
</tbody>
</table>

*Date Reviewed does not necessarily reflect the date of implementation of coverage policy.

Other technologies currently being assessed by the M-Tech Committee are listed below. As the reviews are completed, notices will be sent to stakeholders about the coverage determinations.

- Prolaris gene expression testing in prostate cancer
- Cologuard test for colon cancer screening
- Endovascular ablation of short saphenous and accessory saphenous veins
- MRgFUS for essential tremor
- MRgFUS for uterine fibroids
- MRgFUS for prostate cancer
- MRgFUS for bone metastases
- Oncotype DX for colon cancer
- Deciotype prostate cancer classifier
- iStent for glaucoma
- Knee resurfacing
- Vermillion OVA1 test for ovarian cancer
- Confirm MDx test for prostate cancer
- VEMP testing
- TENS for migraines
- Prosigna breast genetic test
- EpiFix bioengineered skin

If you have questions regarding coverage of these or any other technologies or procedures, or if you would like SelectHealth to consider coverage for an emerging technology, please email us at mtech@selecthealth.org or call Ken Schaecher, M.D. FACP, M-Tech Committee Chairman, at 801-442-7890.

All SelectHealth medical policies and technology assessments can be viewed on selecthealthphysician.org. Click on “Policies and Procedures.”
SelectHealth Quality Initiatives

If you participate in SelectHealth clinical programs, send us your data electronically. Electronic data submission enables clinics to send us historical and monthly data for all SelectHealth members in their EMR system.

Submitting clinical programs data electronically helps clinics achieve better performance on goals related to diabetes or blood pressure control. Clinical programs data typically includes these measurements:

- Height
- Weight
- Triglycerides
- LDL cholesterol
- HDL cholesterol
- Hemoglobin A1c
- Microalbuminuria
- Systolic blood pressure
- Diastolic blood pressure
- BMI (expressed as a ratio)
- BMI (expressed as a percentile)
- New procedures as measures are updated or added

Submitting data electronically can be accomplished in just a few minutes each month, as opposed to the two to three days it typically takes to manually search records and submit the data. When submitting data, always submit it with columns in the same order as those shown below, using the same column titles.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>O</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>LASTNAME</td>
<td>FIRSTNAME</td>
<td>DATEOFBIRTH</td>
<td>SEX</td>
<td>USER_DEFINED_FIELD</td>
<td>TESTNAME</td>
<td>TESTDATE</td>
<td>RESULT1</td>
<td>RESULT2</td>
<td>UNIT</td>
<td>STARTDATE</td>
<td>ENDDATE</td>
<td>CLINIC</td>
<td>Brief technical notes (this is not a column in your data)</td>
</tr>
<tr>
<td>2</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>F</td>
<td>NULL</td>
<td>HYPO</td>
<td>8/22/2013</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>OGDEN</td>
<td>refer to Hyperalbumin spreadsheet</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>M</td>
<td>NULL</td>
<td>AC</td>
<td>8/2/2013</td>
<td>44</td>
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<td>NULL</td>
<td>NULL</td>
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<td>refer to LGG/HAC spreadsheet</td>
<td></td>
</tr>
<tr>
<td>4</td>
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<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>F</td>
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<td>8/24/2013</td>
<td>23</td>
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<td>NULL</td>
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<td>CANVIEW</td>
<td>refer to LDL spreadsheet</td>
</tr>
<tr>
<td>5</td>
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<td>TESTEE</td>
<td>XX/XX/XXXX</td>
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<td>8/2/2013</td>
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<td>refer to LDL spreadsheet</td>
</tr>
<tr>
<td>6</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>M</td>
<td>NULL</td>
<td>TRIGLYCERIDES</td>
<td>8/12/2013</td>
<td>54</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>OLYMPUS</td>
<td>enter triglyceride value in RESULT1</td>
</tr>
<tr>
<td>7</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>F</td>
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<td>BF</td>
<td>8/15/2013</td>
<td>130</td>
<td>80</td>
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<td>NULL</td>
<td>GRANGER</td>
</tr>
<tr>
<td>8</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>M</td>
<td>NULL</td>
<td>HEIGHT</td>
<td>8/14/2013</td>
<td>6.5</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>CLMC</td>
<td>include height value in RESULT1 and height unit (FT, INCHES, CM)</td>
</tr>
<tr>
<td>9</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>F</td>
<td>NULL</td>
<td>WT</td>
<td>8/2/2013</td>
<td>178</td>
<td>NULL</td>
<td>LBS</td>
<td>NULL</td>
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<td>NULL</td>
<td>GRANGER</td>
</tr>
<tr>
<td>10</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>M</td>
<td>NULL</td>
<td>BMI_RATIO</td>
<td>8/2/2013</td>
<td>178</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>CANVIEW</td>
<td>unify BMI metric (a ratio) and map the testname to ‘BMI_RATIO’ and enter value in RESULT1, enter ‘NULL’ under UNIT column</td>
</tr>
<tr>
<td>11</td>
<td>TEST</td>
<td>TESTEE</td>
<td>XX/XX/XXXX</td>
<td>F</td>
<td>NULL</td>
<td>BMI_PERCENTILE</td>
<td>8/26/2013</td>
<td>55</td>
<td>NULL</td>
<td>PCT</td>
<td>NULL</td>
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<td>NULL</td>
<td>OGDEN</td>
</tr>
<tr>
<td>12</td>
<td>NULL</td>
<td>=</td>
<td>Leave blank</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>UNIT</td>
<td>=</td>
<td>Only enter values into UNITS where the testname is Weight or Height</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For more information about setting up data submission for clinical programs, contact your Provider Relations representative at 800-538-5054.
Care Coordination Payment for Medicaid Restricted Patients

The Restriction Program was developed for Utah Medicaid following implementation of a state law that promotes the appropriate use of quality medical services by identifying and correcting over-utilization of services. (42CFR 531.54 (e) and 456.3, 1994 ed.)

A SelectHealth Community Care member that has been designated as “restricted” is limited to one primary care provider, one pharmacy, and one urgent care center close to his or her home. Members are placed on this program due to overuse of medical services. Members who do not comply with these restrictions risk having claims go unpaid by SelectHealth or the state.

SelectHealth is offering a monthly care coordination payment to primary care providers on the SelectHealth Community Care network who are willing to accept restricted members. Program requirements include approving referrals to other specialists/providers, approval or denial of any prescriptions of potentially abused medications, educating the patient on appropriate use of services, on-call coverage during non-office hours, and notification to the SelectHealth care manager of any changes in the plan of care for the patient. The additional monthly care coordination payment requires the provider to sign an addendum to his or her Participating Provider Service Agreement.

If you are interested in learning more about this program, please contact Kim Barrus at 801-442-7399 or via email at kim.barrus@selecthealth.org.
Appeals

The Provider Appeals Process addresses disputes that arise between healthcare providers and SelectHealth. Examples of provider appeals include issues regarding modifiers, multiple surgeries, bundling of codes, unlisted code issues, and medical necessity. To file an appeal, complete the form available in the Provider Appeals section of the Provider Reference Manual at selecthealthphysician.org, and fax it to 801-442-6708.