Soon, participating providers will find delivered to their computers a new version of HHIN, called HHIN 2.0.

HHIN 2.0 will have the same functionality it provides today, but with a new look and feel. More information will be provided in the weeks ahead.

To assure access to HMSA’s HHIN, contact Traci Tabladillo in Provider eCommerce at 1 (808) 948-5851 on Oahu or toll free via (800) 603-4672 ext. 5851 from the Neighbor Islands, or by e-mail at traci_tabladillo@hmsa.com.

**Confirm member info on HHIN**
Verify member information on HHIN to check if coverage changes occurred for 2010.

**HMSA’s Online Care**

**Provider Considerations**
As the practice of Online Care develops, providers are faced with various challenges and situations. To assist, HMSA has developed with a national working group the “Provider Considerations for the Practice of Online Care.”

**What’s Inside**

- Page 2  EUTF 80/20 changes
- Page 3  HMSA’s Online Care
- Page 7  MAC fee changes, POTP changes
- Page 8  TRIWEST iPod nano®

See page 3
**EUTF 80/20 plan**

Beginning February 1, 2010, the EUTF 80/20 plan, coverage code 690, will be in effect. Here are some of the coverage benefit highlights:

- Member copayment for an office visit is $14
- Member copayment for a consultation is $20
- Preventive services such as physical exams, well-baby and well-woman exams, and childhood immunizations, are covered at 100 percent of eligible charge (EC)
- Nutritional counseling and physical and occupational therapy are covered at 80 percent of EC
- HealthPass is covered at 100 percent of EC

Please look up this coverage code on HHIN for full benefit details, including precertification requirements and limitations.

**Eligible members covered for smoking cessation drugs**

Effective January 1, 2010, all smoking cessation prescription drugs for members of eligible HMSA drug plans are now covered.

Talk to your patients about their options for quitting. Visit HMSA’s Provider Resource Center for more information on the Clinical Practice Guidelines for Smoking Cessation.

According to the Surgeon General, smokers who combine smoking cessation drugs with behavior therapy almost triple their chances of successfully quitting. HMSA’s Ready, Set, Quit! program can assist members in designing a personalized quit plan.

For eligibility information and to enroll, members may call 952-4400 on Oahu or 1 (888) 225-4122 on the Neighbor Islands.

**Diagnosis, treatment of depression**

According to a recent study by the World Health Organization (WHO), people with depression have the lowest health scores when compared to those with other chronic diseases. In addition, researchers have found that depression is significantly associated with comorbid chronic conditions.

The need for timely diagnosis and treatment of depression is essential. Visit HMSA’s Provider Resource Center for information on the Clinical Practice Guideline for Depression.

Members may also be referred to HMSA’s Behavioral Care Connection (BCC) for additional support. The BCC program is private, confidential and offers members access to a health coach to support the provider’s treatment plan.

Contact 952-4400 on Oahu or toll free from the Neighbor Islands at 1 (888) 225-4122 for more information.
HMSA’s Online Care
Service expands with allied providers

Soon joining the ranks of enrolled physicians in HMSA’s Online Care service are APRNs, APRN-Psychiatric, podiatrists, certified nurse midwives, psychologists and optometrists.

“Broadening the provider base available to members via HMSA’s Online Care will increase patient access to valuable clinical services,” said Patricia Avila, M.D., director of HMSA’s Online Care. “Private conversations, either online or over the telephone, will provide the consumer timely access to care when needed.”

As part of HMSA’s Online Care Quality Assurance program, participation must be preceded by training within the program prior to going live as an Online Care provider. Potential providers are invited to register for hands-on training at HMSA by completing the on-line reservation form at https://physiciansonline.hmsa.com/sign-up/.

Once enrolled, providers are encouraged to notify their patient base about their availability through HMSA’s Online Care. Prior to accessing the system, members will have to register online. They will then be able to contact their provider for 10-minute sessions, with the possibility of a 5-minute extension, if necessary.

Providers with HMSA’s Online Care can choose the frequency with which they’ll be available for conversations. If members do not see their usual provider, they are given the option to choose from a roster of available providers.

For more information or questions, please contact HMSA’s Provider Relations & Advocacy unit in Provider Services. For assistance in identifying the staff, call 948-5190 on Oahu or 1 (800) 603-4672, ext. 5190, from the Neighbor Islands.

Provider Considerations: Navigating the Online Care landscape

From page 1

Given the potential growth of HMSA’s Online Care, the document “Provider Considerations for the Practice of Online Care” was created by a national working group comprised of Online Care practitioners and others. It is expected that the guide will evolve. Please note that it is not to influence or substitute the existing application of appropriate state or federal regulations, clinical guidelines or other professional codes of conduct.

Subjects include:

• Patient overuse/abuse of Online Care
• Prescription practice
• Reactions when patients may harm themselves, others
• Approach to patients with signs of abuse or neglect
• Declining a patient seeking an Online Care encounter
• Physician-patient relationships in Online Care encounters
• Interacting with patients after Online Care encounters
• Working with legally authorized representatives on a patient’s behalf
• Waiving Online Care fee
• Exchanging secure messages with a patient

Policy News

Annual review of medical policies

The following policies have undergone annual review and have been updated:

- 3-D Reconstruction
- Allogeneic Hematopoietic Stem-Cell Transplantation for Genetic Diseases and Acquired Anemias
- Bone (Mineral) Density Studies
- Brachytherapy, Noncoronary
- Drug Tier Exception
- Genetic Testing for Hereditary Breast and/or Ovarian Cancer
- Growth Hormone Therapy (Effective May 1, 2010)
- Hematopoietic Stem-Cell Transplantation for Miscellaneous Solid Tumors in Adults
- Hematopoietic Stem-Cell Transplantation for Autoimmune Diseases
- Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma
- Single or Tandem Courses of Hematopoietic Stem-Cell Transplantation for Multiple Myeloma
- Hematopoietic Stem-Cell Transplantation for CNS Embryonal Tumors and Ependymoma
- Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma
- Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia
- Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood
- Hepatitis C Treatment with Interferons and Ribavirin (Effective May 1, 2010)
- Home Health Care
- Nonmyeloablative Allogenic Transplants of Hematopoietic Stem Cells for Treatment of Malignancy
- Oscillatory Device for Bronchial Drainage (The Vest)
- Radiology Guidelines
- Sorafenib (Nexavar) (Effective May 1, 2010)
- Sunitinib (Sutent) (Effective May 1, 2010)
- Polysomnography (Effective May 1, 2010)

Please refer to the Provider E-Library to view the individual policies. Copies of the policies are available upon request.

Genetic Testing – Oncology – Effective May 1, 2010

This new policy is effective May 1, 2010, and is available in the Provider E-Library.
Provider input solicited for annual policy review – February

HMSA’s medical directors welcome comments and suggestions from participating physicians regarding existing medical policies that are undergoing annual review.

Following is a list of policies for which HMSA is currently soliciting input. Comments are due by February 28, 2010. Physicians may comment by fax at 948-6340 (Oahu) or via e-mail to medical_policy@HMSA.com.

Comments will be taken into consideration during the annual review process. However, HMSA does not guarantee any specific proposed change will be included in the final policy. HMSA’s policies rely on the use of evidence-based medicine, typically from peer-reviewed literature. Physicians submitting comment should include supportive citation source material to assist HMSA’s medical directors in evaluating the comment or proposed change.

- Autologous Chondrocyte Implantation
- Erlotinib (Tarceva)
- Grenz Ray Therapy
- Home IV Anti-Infective Therapy
- Home Enteral Nutrition Therapy
- Home IV Hydration Therapy for Adults
- Home IV Hydration Therapy for Hyperemesis Gravidarum
- INTACS
- Immune Globulin Therapy
- Oncotype
- Oral Pharmacological Treatment for Erectile Dysfunction
- Oxycodone HCl Controlled Release
- Speech Therapy
- Cognitive Rehabilitation and Sensory Integration Therapy

FDA-approved drugs requiring precertification
- Pralatrexate Injection (Folotyn) (Effective May 1, 2010)
- Rilonacept Injection (Arcalyst) (Effective January 1, 2010)

Additional Codes that Do Not Meet Payment Determination Criteria

The following codes will be added to the list of Codes That Do Not Meet Payment Determination Criteria:

- HCPCS Code L5973 (Effective January 1, 2010)
- CPT Code E0676 (Effective May 1, 2010)
Coding Reviews and Medical Necessity

HMSA’s Medical Management department, as part of its utilization management activities, periodically conducts post-payment reviews of evaluation and management (E/M) coding to determine whether services were coded at the appropriate level of care and, when applicable, whether criteria for the use of modifiers were met.

Coding reviews are conducted by a certified professional coder (CPC). All findings of incorrect coding are reviewed with a medical director.

The medical director will determine medical necessity when the chief complaint and established reason for the visit does not warrant the level of care billed. In accordance with the Medicare Claims Processing Manual, medical necessity is the over-arching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level is warranted.

The volume of documentation should not be the primary influence upon which a specific level of service is billed; documentation should support the level of service reported. In addition, the service should be documented during or as soon as practicable after it is provided in order to maintain an accurate medical record.

For more information on HMSA’s coding reviews and documentation requirements, please refer to Coding Reviews of E/M Services in the Provider E-Library.

Survey distributed to 65C Plus members

HMSA Medicare Programs would like to alert you to a member survey that was distributed to all 65C Plus members enrolled for plan year 2010 in late January.

The survey is called the HMSA Health Survey and it was created specifically to assess the health of the older adult population.

The survey results will help HMSA produce health-related programs and services specifically for this population in addition to Medicare benefits. The survey will not impact insurance coverage. Participation is voluntary. Members may ask for help in filling out the survey.

Questions about this survey may be directed to a special telephone line at HMSA: 432-9220 on Oahu and 1 (800) 525-6548 from the Neighbor Islands. TTY users should call 711 for relay operator service. Representatives will be available Monday - Thursday, 8:00 a.m. – 4:00 p.m.; and Friday, 8:00 a.m. – 3:30 p.m.

REMEMBER: CMS 1500 (08-05)

All claims must be filed via the new CMS 1500 (08-05) version. Any claims submitted on old CMS 1500 claims forms will be returned.
HMSA’s MAC fee changes

The December 2009 immunization fee review resulted in updates for 10 Maximum Allowable Charges (MACs). The MACs for the following vaccines were updated effective January 1, 2010.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>New MAC 01/01/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>90648</td>
<td>Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use</td>
<td>25.71</td>
</tr>
<tr>
<td>90691</td>
<td>Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use</td>
<td>57.26</td>
</tr>
<tr>
<td>90698</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, hemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP–Hib–IPV), for intramuscular use</td>
<td>80.53</td>
</tr>
<tr>
<td>90700</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use</td>
<td>23.41</td>
</tr>
<tr>
<td>90703</td>
<td>Tetanus toxoid adsorbed, for intramuscular use</td>
<td>29.57</td>
</tr>
<tr>
<td>90713</td>
<td>Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use</td>
<td>26.95</td>
</tr>
<tr>
<td>90717</td>
<td>Yellow fever vaccine, live, for subcutaneous use</td>
<td>91.18</td>
</tr>
<tr>
<td>90721</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use</td>
<td>48.77</td>
</tr>
<tr>
<td>90733</td>
<td>Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use</td>
<td>117.74</td>
</tr>
<tr>
<td>90734</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use</td>
<td>115.49</td>
</tr>
</tbody>
</table>

Place of Treatment Program (POTP) change

Effective April 1, 2010, the following update to the Outpatient Place of Treatment Program (POTP) list. If an inpatient setting is required precertification must be obtained.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Added to the POTP Outpatient List</th>
</tr>
</thead>
<tbody>
<tr>
<td>27438</td>
<td>Arthroplasty, patella; with prosthesis</td>
</tr>
</tbody>
</table>
TRICARE online referral and authorization submissions could win you an iPod nano

One weekly winner starting January 4, 2010

Here’s another way to get your www.triwest.com/provider account working for you. Use it to make online referrals and authorizations for TRICARE beneficiaries to be entered into drawings for an iPod nano.

Real-time answers for real-time care is what you get when you submit a referral or authorization online. And all you have to do is keep submitting your requests online.

Include your request reason or supporting clinical information in the note field or as an attachment, and automatically be entered into the drawing.

Not registered on www.triwest.com? Visit www.triwest.com/eRegister and follow the simple steps. Then take advantage of the self-service tools and this chance to win an iPod nano.

In most cases, making referrals and authorizations online means an immediate response. However, a response may be delayed if additional information is required to process the request.

Each week a different winner will be randomly chosen until the promotion ends on March 15, 2010. An office can win more than once, but the same individual cannot.

Start today and listen to the sweet sounds of saving more than time!

Enter for a Chance to Win When You Use the Online Referral and Authorization Request

1) Register on www.triwest.com
2) Submit electronic referral and authorization request
3) Get immediate answers
4) Watch and win!

For further information, please contact your local representative at 948-5213, e-mail providerservices@triwest.com, or call 1 (888) TRIWEST (874-9378).

Correction:

Federal Employee Program (FEP) participants who wish to complete the Blue Health Assessment, as mentioned in the January 2010 Provider Update, may do so by downloading it through their plan and bringing it to their visit with their personal physician.