The Inside Story

Scott & White Health Plan
The one Texans trust.

Volume 19 Issue 1 SPRING/SUMMER 2013

The warm Summer weather of Central Texas is just around the corner. This is the time most people think of getting in shape in order to show off a great beach body. Inside this edition of 'Inside Story' you will see that SWHP is gearing up for the hot months ahead. SWHP has rolled out a new nutrition and exercise program, Step Up, Scale Down and we are focusing on getting more activity into our daily lives.

In This Issue

We continue to prepare for Health Care Reform and focus on new product designs for the Exchanges and for those continuing to purchase insurance outside the Exchange. Many new benefits are being added and these will provide additional services for your patients. We will keep you up to date with the changes as they occur. We know this is a busy season for wellness exams and school fitness exams, so we want to remind you to focus on your own healthy lifestyle.

STEP UP AND SCALE DOWN WITH SCOTT & WHITE HEALTH PLAN

Scott & White Health Plan Rolls Out New Wellness Program

Scott & White Health Plan (SWHP) has partnered with Texas A &M AgriLife Extension to offer a 12 week program called Step Up Scale Down which features nutrition and exercise education. The program includes tools and support to change participant's lifestyle and incorporate healthy living choices.

Each week features a different topic including goal setting, reading nutrition labels, and meal planning, and starting or stepping up exercise programs. The classes are taught by nurses, clinical pharmacists, and wellness professionals with expertise in exercise and nutrition. This program began in January, 2013 and is showing great results already. Classes will be offered at selected Scott & White Clinics and Pharmacies across our service area as well as at SWHP.

The program is free for SWHP members and Scott & White employees, but it is open to anyone that would like to participate. Non-SWHP members or employees will be charged a small $30 fee to cover costs and supplies. This is a great way to get your patients on the track to a healthier lifestyle!

Space is limited, so please encourage your patients to register today. The next SUSD program begins early April and will be offered periodically after that.

For details and registration information, your patients can contact Ian Goodman at the Scott and White Health Plan at 254-298-3416 or by email at igoodman@sw.org.

Hard Math: Adding Up Just How Little We Actually Move

By SUMATHI REDDY

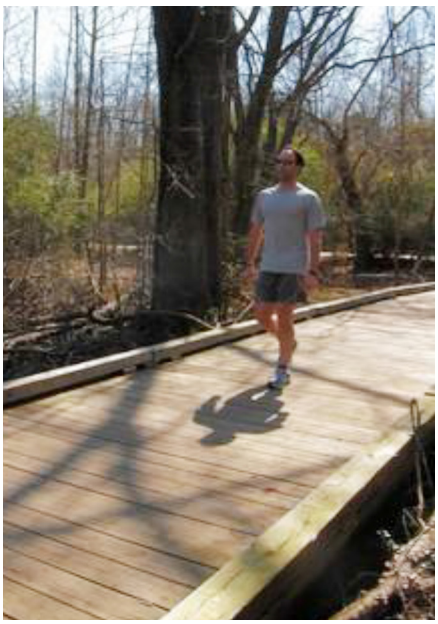
Getty Images.

Do the little steps, such as taking the stairs at work to a meeting, really help to add exercise? Sumathi Reddy reports on Lunch Break.

Working out at the gym might not be enough to stay fit if you spend much of the rest of the day sitting down.

Americans are more sedentary than ever, government surveys show. That is a problem even among people who exercise regularly.

Eric Lent, of Atlanta, wears a Jawbone UP on his wrist to track daily activity. The device made him 'aware of how much time I was sitting in my office,' he says.



Karen Lent

An increasingly popular way people are trying to coax more exercise into their lives is by tracking their movements using a bevy of small electronic devices from companies like Fitbit Inc., Jawbone and Nike NKE -1.94%. Some devices are pedometers, tracking steps. More sophisticated gadgets, known as accelerometers, measure the rate at which a person moves and convert this into calories expended.

"We've been very focused on exercise and making sure you get your half-an-hour a day of moderate and vigorous physical activity. But what we've not focused on so much is how you spend the rest of your day," says Bonnie Spring, director of the Center for Behavior and Health at Northwestern University.

Americans on average take 5,117 steps a day, according to a 2010 study published in the journal Medicine & Science in Sports & Exercise. A good daily goal, by contrast, is 10,000 steps, according to the American Heart Association

and other experts. Research studies have found that such a regimen results in modest weight loss, improved glucose tolerance in people at risk of developing diabetes and other benefits, says David Bassett Jr., co-author of the 2010 study and a professor in the department of kinesiology, recreation and sport studies at the University of Tennessee.

Walking a mile roughly equals 2,000 steps. Climbing a flight of stairs—roughly 10 steps—is equivalent to taking 38 steps on level ground, Dr. Bassett says.

Corbis

A study that followed more than 240,000 adults over 8 1/2 years found that watching a large amount of television was associated with a higher risk of death, including from cardiovascular disease—even for participants who reported seven or more hours a week of moderate-to-vigorous exercise. The research, published in 2012 in the American Journal of Clinical Nutrition, used TV viewing and overall sitting time as a proxy for sedentary behavior.

"Our results suggest that exercise alone may not be enough to eliminate risks associated with too much sitting," says Charles Matthews, lead author of the study and an investigator with the National Institutes of Health. He says estimates from government surveys indicate that people's sedentary time outside of work has increased by about 40% between 1965 and 2009.

Routine physical activities like walking and taking the stairs boost your metabolism and can make a big difference in terms of calories burned.

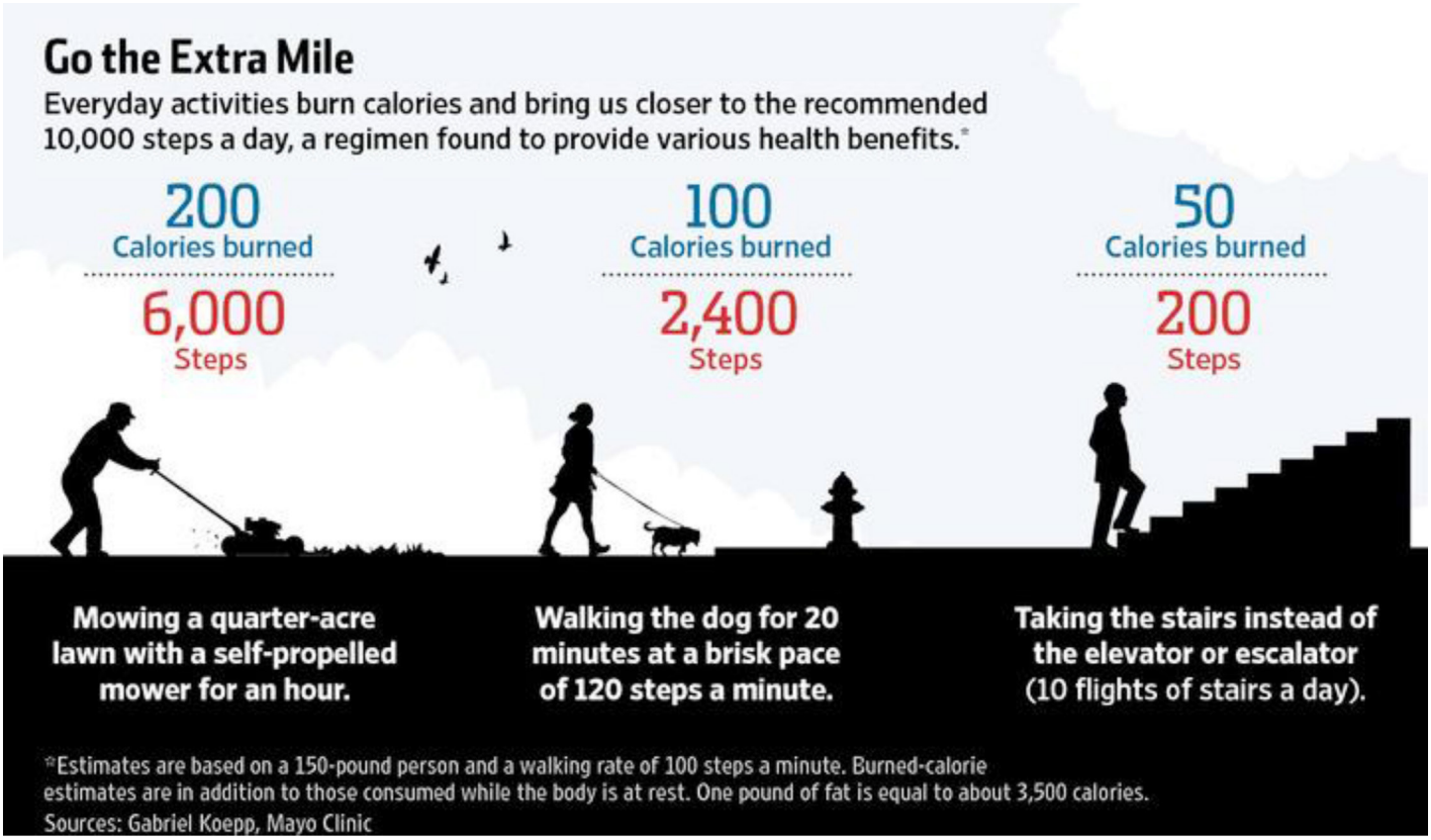
People who live in Colorado, where obesity rates are relatively low, take an average of 6,500 steps a day, a 2005 study found. By contrast, residents of Tennessee and Arkansas, where the obesity rates are much higher, take an average of 4,500 steps a day. "We don't know that it's cause and effect obviously, but the states with lower obesity rates have the higher number of steps," says James Hill, executive director of the Anschutz Health and Wellness Center at the University of Colorado.

All the movements a person does during the day—from getting up to close the garage to rocking in a chair—are non-scheduled physical activities that can make a big difference in terms of daily calorie expenditure by causing a person's metabolism to increase, says Gabriel Koepp, program manager of the Non-Exercise Activity Thermogenesis (NEAT) laboratory at the Mayo Clinic in Rochester, Minn. While walking is the main NEAT activity, other things can include washing the dishes instead of using a dish washer, making bread dough by hand rather than using a mixer, and even chewing gum, he says.

Health experts say people still need moderate to vigorous exercise, which has been shown to reduce risks of cardiovascular disease and other disorders. Dr. Bassett says a doctoral student in his department conducted a study in which 58 people watching 90 minutes of television marched in place in front of the TV during commercial breaks. "They increased their steps by about 3,000 per day just by doing this during commercials," says Dr. Bassett. "That's equivalent to about 30 minutes of walking." The study was published last year in the International Journal of Behavioral Nutrition and Physical Activity.

Pedometers have been shown, at least in the short term, to motivate some people to increase their daily activity if they chart progress toward a goal in a diary. More sophisticated accelerometers, with wireless synchronization, effectively log your progress for you.

In a 2007 analysis of several studies, people who used pedometers increased the number of steps taken by an average 2,491 a day and boosted overall physical activity by about 27% from previous levels, says Dena Bravata, a senior science affiliate at the Center for Primary Care and Outcomes Research at Stanford University.



Participants' body-mass index, a common measure of healthy weight, and blood pressure also declined, she says. The analysis, published in the Journal of the American Medical Association, involved a total of 2,767 participants who were followed on average for 18 weeks.

Taking the stairs helps burn calories.

Eric Lent, of Atlanta, says starting to use an accelerometer made him "aware of how much time I was sitting in my office." The device—after he lost his Nike FuelBand, he replaced it with a Jawbone UP—motivates him to regularly work out and to be less sedentary through the day, says the 44-year-old chief marketing officer for an entertainment company.

Mr. Lent says he makes a point of parking in the farthest spot from the entrance to work. And he sets the Jawbone UP to vibrate if he is idle for 30 minutes or more. He aims to do 10,000 steps each day.

Carrie Mundy, a stay-at-home mom and photographer in San Diego, bought her Fitbit in February. She says she is regularly hitting 15,000 steps a day and has already lost 4 1/2 pounds. To accumulate more steps, the 36-year-old says she walks down every aisle in the grocery store and makes extra trips back and forth when folding and putting away her laundry.

Ms. Mundy says her Fitbit also motivates her to get out and walk. "I'm constantly chasing these two people who I haven't caught up to," she says, referring to two friends whose total number of steps she can view on her device's display screen.

"It's like a videogame. I have such a competitive personality, so I'm going to beat these people today."

Write to Sumathi Reddy at sumathi.reddy@wsj.com

A version of this article appeared March 12, 2013, on page D1 in the U.S. edition of The Wall Street Journal, with the headline: Hard Math: Adding Up Just How Little We Actually Move.

Working Exercise Into Your Work Day

By Anusha Shrivastava

Getty Images.

Until December, I used to walk about 40 minutes every day as part of my daily commute. Since my job change, I've had to take the subway so the built-in exercise was eliminated.

To add some exercise into my daily life without having to carve out extra time for it, I've taken to climbing stairs wherever I go.
I've also made it a point to walk up six flights of stairs every single day while at work, often twice a day.

I've offered to put up informational posters on each floor and the work-study student who would otherwise have to do it has gladly handed over the task to me. So far, I've lost four pounds in 9 weeks.

Yes, it would be great if I could join a gym and workout on a more regular basis, but right now, between my full-time job, the daily two-hour commute and raising two children, I am not able to devote as much time to exercise as I should. So I am happy to find that my effort to build exercise into my daily routine is not such a bad strategy, after all.

A recent Wall Street Journal story described the ways that people are "trying to coax more exercise into their lives" by tracking their movements using small electronic devices.

The article points out that Americans take an average of 5,117 steps a day, according to a 2010 study published in the journal Medicine & Science in Sports & Exercise. The American Heart Association and other experts suggest a good daily goal is 10,000 steps.

Some people park their vehicles as far from their destination as possible so they are forced to walk, others add steps by doing more chores around the house and walking up and down flights of stairs.

As the weather improves, I will definitely be walking more, forcing myself to walk to the grocery store rather than pulling my car out each time I need a gallon of milk. (In addition to weaving walks into my daily life, I've signed up for a pool membership, so swimming a few laps a day will help burn some calories, too.)

These are all baby steps but I know that if I don't take at least those, all the pounds I packed on when I was expecting my second child will not melt away.

Readers, how have you built exercise into your daily routine?

Short Term Medical Coverage offered by Scott & White Health Plan

Scott & White Health Plan Short Term Coverage PPO provides affordable temporary health insurance for those transitional periods in life such as

- being between jobs,
- in your new hire waiting period at a new job,
- needing COBRA but the premium is too high,
- early retirement waiting on Medicare eligibility, or
- recent college graduate.

These short term policies are for individuals, families, or child only and are issued in 1 through 11 month calendar durations. Some of the best attributes of short term policies are

- affordability – they are typically 20-40% lower in cost than "reform ready" plans.
- flexibility – effective and term dates: buy just what you need.
- fast – real time approval or next day, email policy and ID.
- financial safety net – provides peace of mind with coverage from unexpected, catastrophic loss.

Scott & White Health Plan will begin selling these policies this Spring.

Scott & White Health Plan and Health Care Reform

Scott & White Health Plan is planning to participate in the upcoming Health Care Marketplace, formerly called the Health Care Exchange. Enrollment in the Marketplace will begin in October 2013, and the first effective date will be January 1, 2014.

What is the Marketplace and why does Scott & White Health Plan want to participate?

The Marketplace is intended to be a place where competitive insurance companies will offer their health plans to those who need them within any given state. By participating in the Marketplace, thousands of people will be able to see the suite of Scott & White Health Plan's products and compare them to products offered by other companies. This could potentially bring members to Scott & White Health Plan who otherwise may not have known about us.

There is an ongoing effort underway to ready the Health Plan for participation in the Marketplace. Many teams have been created, each specializing in a different facet of readiness preparation. The teams include Product Development, Marketing and Communications, IT and Exchange Connectivity, Implementation, Medical Delivery, Underwriting, and Pricing.

HELPFUL TIPS FOR PROVIDERS

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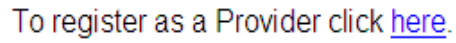
Scott & White Health Plan
My*Benefits* Provider Portal
Quick Reference Guide

Access to My*Benefits* Provider Portal	1. Go to: http://www.swhp.org/ 2. Click on:  3. Click on :  4. Complete the Provider Information that has a * next to it. 5. Click on **Next** 6. Complete the User Information that has a * next to it. 7. Make sure in the User Preferences box you choose what you need access for. a. Do you have authorization to view eligibility searches? **Click YES or NO** b. Do you have authorization to view claims? **Click YES or NO** 8. Click on **Submit** a. If there is a successful match to our claims payment system, you will be prompted to sign in to the site. b. If your Provider ID and Tax ID did not match our claims payment system, then you will receive a message that gives you a Request ID # and we will receive that request in a workgroup file to handle manually. You will be contacted by email once you are approved. *Please keep your Request ID # for future reference.*
Claim Status Search	1. Go to https://swhpah.swhp.org/ and login 2. Click the **Claims** link on the left side of the page 3. Click on the **Claim Status Search** link 4. Enter data in the **Patient/Subscriber Information** and/or **Claim Information** section 5. Click the **Search** button to view the Claim Status List a. Click on the 12-digit alphanumeric claim number link under the **Claim No** heading on the Claim Status List page to view detailed information regarding the claim
Member Search	1. Go to https://swhpah.swhp.org/ and login 2. Click the **Members** link on the left side of the page 3. Click the **Member Eligibility Search** link to go to the inquiry page 4. Enter member's information a. DOB* and Last Name* are required fields 5. Click the **Search** button to view the Member Eligibility List

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Scott & White Health Plan
My*Benefits* Provider Portal
FAQs & TROUBLESHOOTING

NEW PROVIDER SETUP or NEW ACCESS FOR EXISTING PROVIDER	• Go to http://www.swhp.org/ • Click on the **Providers** tab at the top of the page • Click on the **My*Benefits*** link under the "Provider Quick Links" column on the left side of the page • The My*Benefits* information page will be displayed with instructions for signing up and how to use the portal once you have self-registered

SECURITY ACCESS Password Reset or Forgot Password	• Go to http://www.swhp.org/
	• Click on the **My*Benefits*** tab at the top of the page
	• Enter your User Name
	• Click on the **Forgot Password?** link
	• You will receive an email with a new password
	  ○ **The email address is key** (a new password is sent to the original user's email address that is on file)
	  ○ Please be sure to check your *Junk E-Mail* folder to ensure that the email containing your new password did not go to it

SECURITY ACCESS Account Locked	• This is usually caused by too many unsuccessful login attempts • To have your account unlocked, contact Scott & White Health Plan's (SWHP) Provider Relations Department at (254) 298-3064, ext 7 or send an email to swhpproviderrelationsdepartment@sw.org ○ Please include the provider's name, tax ID number, NPI number, username and phone number in your email
MEMBER ELIGIBILITY SEARCHES Summary of Benefits (SOB)	• If the Summary of Benefits (SOB) PDF document is missing, please call or email SWHP's Provider Relations Department and provide the group name and group number
MEMBER ELIGIBILITY SEARCHES PDF Documents	• If the PDF documents are there but won't generate, please contact your web technician or internet help desk for assistance
MEMBER ELIGIBILTY SEARCHES Cannot View History	• You should enter the member's appointment date or any previous date to verify the actual date that the member became eligible with SWHP • The member number is specific to the group or individual plan that the member is enrolled in with SWHP • You can also try to perform a name search using the member's first and last name to see if the member was enrolled in another group or individual plan ○ To search by the member's name, enter the member's first and last name in the appropriate fields located under the **Member No.** box

CLAIM SEARCHES Cannot View a Certain Claim	• If you cannot view a certain claim, but you are able to view other claims, then one of the following may be the issue:
	  ○ SWHP has not received the claim
	  ○ There may be an issue with the claims clearinghouse
	  ○ The claim is billed with a provider number/NPI number that you do not have access to view
	  ○ The claims clearinghouse did not send the claim to SWHP

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	▪ Please verify with the claims clearinghouse that the claim has been sent to SWHP ○ The rendering provider on the claim is new and has not been setup in SWHP's claims payment system ○ The claim is billed using a different TIN or provider number/NPI number than what you are setup with for access to My*Benefits*
REMITTANCE ADVICE SEARCH	• This function can be used to view detailed information on paid amount, total charges, contractual adjustments (*based on contracted reimbursement rates*), and patient responsibility (*deductible, copay, and coinsurance*) ○ The EOB/EOP function is currently under construction • Click on the **Claims** link on the left side of the page • Click on the **Remittance Advice Search** link • Enter as much information as possible in the **Search** box in order to narrow your search results • Click the **Search** button to view the Remittance Advice List

What exactly is Scott & White SeniorCare?

SeniorCare from Scott & White Health Plan is a Medicare Cost plan. It is not a Medicare Advantage plan. A Cost Plan provides beneficiaries with the full Medicare benefit package. SeniorCare does not take over a beneficiary's Original Medicare like a Medicare Advantage plan.

In other words, when the beneficiary uses contracted network providers, the beneficiary will pay their copayment or coinsurance depending on the SeniorCare plan in which they are enrolled. If the beneficiary uses a non-network provider for non-emergent services, the beneficiary has coverage under their Original Medicare (Part A&B) and pays their Medicare deductible and any charges not covered by Original Medicare.

PRIOR AUTHORIZATIONS

Current Prior Authorizations can be found under MyBenefits in the Provider Portal.

http://www.swhp.org/homepage/providers/mybenefits-registration

Prior Authorizations are updated periodically, so check the list if you are unsure if a procedure is covered.

NOTE: Authorizations returned stating "authorization not required" does not mean the service is a covered benefit.

Please contact Customer Service Advocacy to confirm benefits
1-800-321-7947 ext. 3000 or 254-298-3000

UPDATES TO MAIN PHONE LINE FOR SWHP PROVIDER RELATIONS 254-298-3064

When calling Scott & White Health Plan Provider Relations at 254-298-3064 you will hear the pre-recorded message below:

You have reached Scott & White Health Plan Provider Relations. Our menu has changed. Please listen carefully to the following options.

If you know your parties 6 digit extension, press 1.

For questions on how to become a SWHP provider or questions concerning the status of a request, press 2. (Routes to bridge with Tammy, Eden and Sarah)

For questions about an existing contract, press 3. (Routes to bridge with Katie, Rebecca, and Shaun)

For questions about Medicaid eligibility, claims or claim status questions, press 4. (Routes to Rightcare)

For Beacon Behavioral Health Services, press 5. (Routes to Beacon)

For Block Vision Services, press 6. (Routes to Block Vision)

For MyBenefits, press 7. (Routes to Judy)

For any other questions, press 0. (Routes to customer service advocacy)

SeniorCare Policy Holder Claims

SeniorCare is an enhancement program to Medicare Coverage. Scott & White Health Plan (SWHP) has a contractual arrangement with CMS to administer this program. SWHP acts as the Medicare intermediary for some Part B services for SeniorCare members only. Please refer to your contract for further details.

Part A Services – All claims billed on a UB04 for Part A services should be filed with Medicare Part A. Effective 5/1/2011, SWHP is accepting cross over claims from Medicare. If you bill secondary claims to SWHP for Medicare primary claims, we are now receiving daily electronic files from Medicare and will be processing provider payments from these electronic Medicare submissions.

Part B Services – Check your provider contract for specifics on Part B billing.

(Exception: CPT codes 90801 – 90899 for psychiatric services and 90918 – 90999 for dialysis should be filed directly with Medicare.)

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A Guide for Completing the

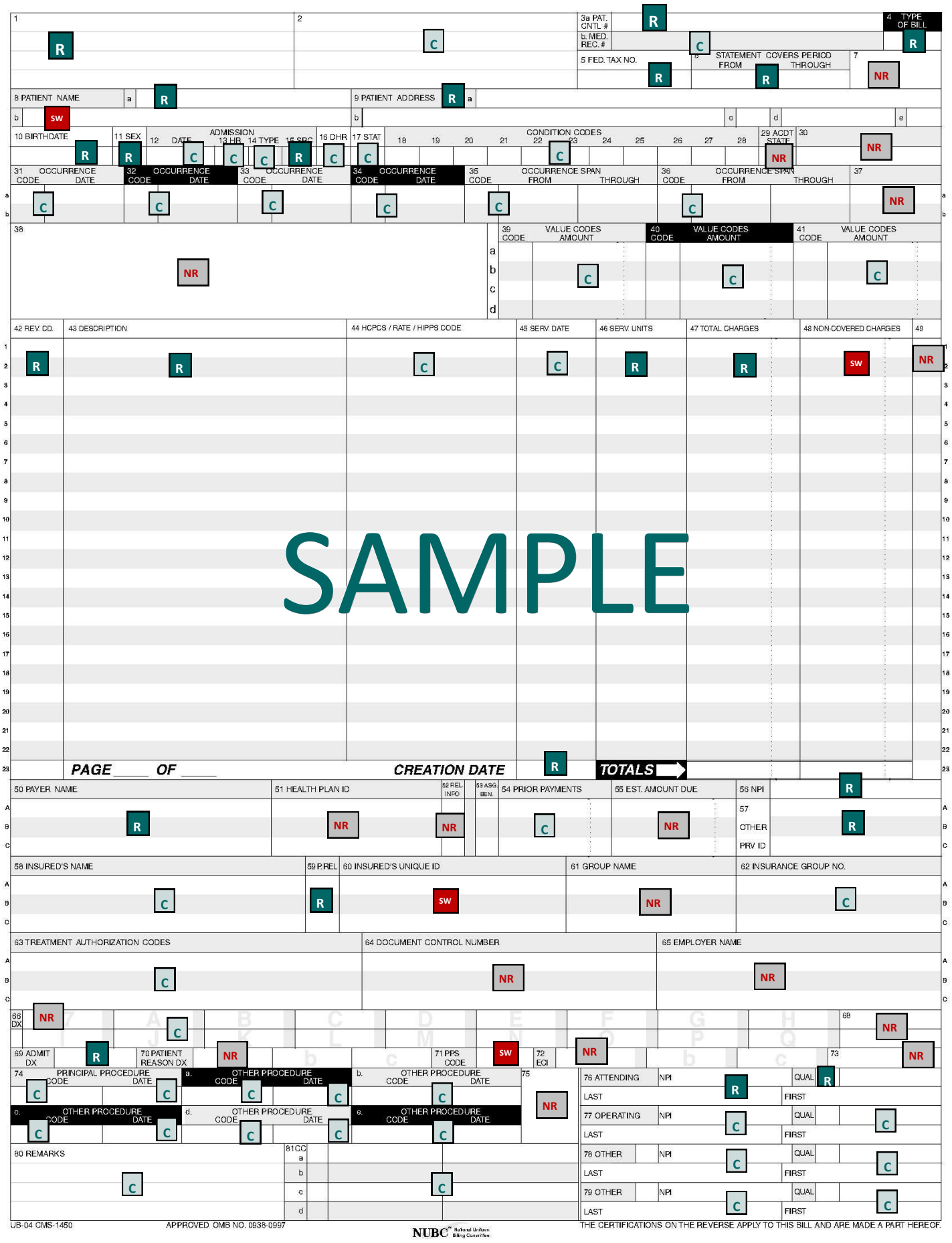
UB-04 Form

The Uniform Bill (UB-04) is the standardized billing form for institutional services. Scott & White Health Plan offers this guide to help you complete the UB-04 form for your patients with the Scott & White Health Plan coverage.

Thank you for helping us to process your claims efficiently and accurately.

MAIL CLAIMS TO:

Scott & White Health Plan
P.O. Box 21800
Eagan, MN 55121-0800


SAMPLE
PAGE _____ OF _____
CREATION DATE
TOTALS
UB-04 CMS-1450
APPROVED OMB NO. 0938-0997
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

KEY

- R — TDI Requirement
- C — Conditional
- SW — SWHP Requirement
- NR — Not Required

1. **BILLING PROVIDER NAME, ADDRESS & TELEPHONE NUMBER** R Enter the billing name, street address, city, state, zip code and telephone number of the billing provider submitting the claim. Note: this should be the facility address.

2. **PAY TO NAME AND ADDRESS** C Enter the name, street address, city, state, and zip code where the provider submitting the claims intends payment to be sent. Note: This is required when information is different from the billing provider's information in form locator 1.

3a. **PATIENT CONTROL NUMBER** R
Enter the patient's unique alphanumeric control number assigned to the patient by the provider.

3b. **MEDICAL RECORD NUMBER** C
Enter the number assigned to the patient's medical health record by the provider.

4. **TYPE OF BILL** R
Enter the appropriate code that indicates the specific type of bill such as inpatient, outpatient, late charges, etc.

For more information on Type of Bill, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

5. **FEDERAL TAX NUMBER** R
Enter the provider's Federal Tax Identification number.

6. **STATEMENT COVERS PERIOD (From/Through)** R
Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For example: 010107.

7. NR Reserved for assignment by the NUBC. Providers do not use this field.

8a. **PATIENT NAME/IDENTIFIER** R
Enter the patient's identifier. Note: The patient identifier is situational/conditional, if different than what is in field locator 60 (Insured's Subscriber/Insured's Identifier).

8b. **PATIENT NAME** SW
Enter the patient's last name, first name and middle initial.

9. **PATIENT ADDRESS** R
Enter the patient's complete mailing address (fields 9a – 9e), including street address (9a), city (9b), state (9c), zip code (9d) and country code (9e), if applicable to the claim.

10. **PATIENT BIRTH DATE** R
Enter the patient's date of birth using an eight-digit date format (MMDDYYYY). For example: 01281970.

11. **PATIENT SEX** R
Enter the patient's gender using an "F" for female, "M" for male or "U" for unknown.

12. **ADMISSION/START OF CARE DATE (MMDDYY)** C
Enter the start date for this episode of care using a six-digit format (MMDDYY). For inpatient services, this is the date of admission. For other (Home Health) services, it is the date the episode of care began.
Note: This is required on all inpatient claims.

13. **ADMISSION HOUR** C
Enter the appropriate two-digit admission code referring to the hour during which the patient was admitted. **Required for all inpatient claims, observations and emergency room care.**

For more information on Admission Hour, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

14. **PRIORITY (TYPE) OF VISIT** C
Enter the appropriate code indicating the priority of this admission.

For more information on Priority (TYPE) of Visit, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

15. **POINT OF ORIGIN FOR ADMISSION OR VISIT** R
Enter the appropriate code indicating the point of patient origin for this admission or visit.

For more information on Point of Origin for Admission or Visit, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

16. **DISCHARGE HOUR** C
Enter the appropriate two-digit discharge code referring to the hour during which the patient was discharged. **Note: Required on all final inpatient claims.**

17. **PATIENT DISCHARGE STATUS** C
Enter the appropriate two-digit code indicating the patient's discharge status. **Note: Required on all inpatient, observation, or emergency room care claims.**

18-28. **CONDITION CODES** C
Enter the appropriate two-digit condition code or codes if applicable to the patient's condition.

29. **ACCIDENT STATE** NR
Enter the appropriate two-digit state abbreviation where the auto accident occurred, if applicable to the claim.

30. NR Reserved for assignment by the NUBC. Providers do not use this field.

31-34. **OCCURRENCE CODES/DATES (MMDDYY)** C
Enter the appropriate two-digit occurrence codes and associated dates using a six-digit format (MMDDYY), if there is an occurrence code appropriate to the patient's condition.

35-36. **OCCURRENCE SPAN CODES/DATES (From/Through) (MMDDYY)** C
Enter the appropriate two-digit occurrence span codes and related from/through dates using a six-digit format (MMDDYY) that identifies an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time.

37. NR Reserved for assignment by the NUBC. Providers do not use this field.

38. Enter the name, address, city, state and zip code of the party responsible for the bill. NR

39-41. **VALUE CODES AND AMOUNT** C
Enter the appropriate two-digit value code and value if there is a value code and value appropriate for this claim.

42. **REVENUE CODE** R
Enter the applicable Revenue Code for the services rendered.

For more information on Revenue Codes, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

43. **REVENUE DESCRIPTION** R
Enter the standard abbreviated description of the related revenue code categories included on this bill. (See Form Locator 42 for description of each revenue code category.) **Note: The standard abbreviated description should correspond with the Revenue Codes as defined by the NUBC.**

For more information on Revenue Description, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

44. **HCPCS/RATES/HIPPS CODE** C
Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also report HCPCS modifiers when a modifier clarifies or improves the reporting accuracy.

45. **SERVICE DATE (MMDDYY)** C
Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services, SNF\PPS assessment date, or needed to report the creation date for line 23. **Note: Line 23 - Creation Date is Required.**

For more information on Service Dates, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

46. **SERVICE UNITS** R
Enter the number of units provided for the service line item.

47. **TOTAL CHARGES** R
Enter the total charges using Revenue Code 0001. Total charges include both covered and non-covered services.

For more information on Total Charges, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

48. **NON-COVERED CHARGES** SW
Enter any non-covered charges as it pertains to related Revenue Code.

For more information on Non-Covered Charges, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

49. NR Reserved for assignment by the NUBC. Providers do not use this field.

Instructions continued on next page

KEY

- R — TDI Requirement
- C — Conditional
- SW — SWHP Requirement
- NR — Not Required

50. **PAYER NAME** R
Enter the health plan that the provider might expect some payment from for the claim.

51. **HEALTH PLAN IDENTIFICATION NUMBER** NR
Enter the number used by the primary (51a) health plan to identify itself. Enter a secondary (51b) or tertiary (51c) health plan, if applicable.

52. **RELEASE OF INFORMATION** NR
Enter a "Y" or "I" to indicate if the provider has a signed statement on file from the patient or patient's legal representative allowing the provider to release information to the carrier.

53. **ASSIGNMENT OF BENEFITS**
Enter a "Y", "N" or "W" to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigning payment to the provider for the primary payer (53a). Enter a secondary (53b) or tertiary (53c) payer, if applicable.

54. **PRIOR PAYMENTS** C
Enter the amount of payment the provider has received (to date) from the payer toward payment of the claim.

55. **ESTIMATED AMOUNT DUE** NR
Enter the amount estimated by the provider to be due from the payer.

56. **NATIONAL PROVIDER IDENTIFIER (NPI)** R
Enter the billing provider's 10-digit NPI number.

57. **OTHER PROVIDER IDENTIFIER** R
Required on or after the mandated NPI Implementation date when the 10-digit NPI number is not used in FL 56.

58. **INSURED'S NAME** C
Enter the name of the individual (primary – 58a) under whose name the insurance is carried. Enter the other insured's name when other payers are known to be involved (58b and 58c).

59. **PATIENT'S RELATIONSHIP TO INSURED** R
Enter the appropriate two-digit code (59a) to describe the patient's relationship to the insured. If applicable, enter the appropriate two-digit code to describe the patient's relationship to the insured when other payers are involved (59b and 59c).

60. **INSURED'S UNIQUE IDENTIFIER** SW
Enter the insured's identification number (60a). If applicable, enter the other insured's identification number when other payers are known to be involved (60b and 60c).

61. **INSURED'S GROUP NAME** NR
Enter insured's employer group name (61a). If applicable, enter other insured's employer group names when other payers are known to be involved (61b and 61c).

62. **INSURED'S GROUP NUMBER** C
Enter insured's employer group number (62a). If applicable, enter other insured's employer group numbers when other payers are known to be involved (62b and 62c).

Note: BCBSTX requires the group number on local claims.

63. **TREATMENT AUTHORIZATION CODES** C
Enter the pre-authorization for treatment code assigned by the primary payer (63a). If applicable, enter the pre-authorization for treatment code assigned by the secondary and tertiary payer (63b and 63c).

64. **DOCUMENT CONTROL NUMBER (DCN)** NR
Enter if this is a void or replacement bill to a previously adjuudicated claim (64a – 64c).

65. **EMPLOYER NAME** NR
Enter when the employer of the insured is known to potentially be involved in paying claims.

For more information on Employer Name, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

66. **DIAGNOSIS AND PROCEDURE CODE QUALIFIER** NR
Enter the required value of "9". Note: "0" is allowed if ICD-10 is named as an allowable code set under HIPAA.

For more information, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

67. **PRINCIPAL DIAGNOSIS CODE AND PRESENT ON ADMISSION INDICATOR** R
Enter the principal diagnosis code for the patient's condition.

For more information on POAs, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

67a-67q. **OTHER DIAGNOSIS CODES** C Enter additional diagnosis codes if more than one diagnosis code applies to claim.

68. Reserved for assignment by the NUBC. Providers do not use this field.

69. **ADMITTING DIAGNOSIS CODE** R
Enter the diagnosis code for the patient's condition upon an inpatient admission.

70. **PATIENT'S REASON FOR VISIT** NR
Enter the appropriate reason for visit code only for bill types 013X and 085X and 045X, 0516, 0526, or 0762 (observation room).

71. **PROSPECTIVE PAYMENT SYSTEM (PPS) CODE** SW
Enter the DRG based on software for inpatient claims when required under contract grouper with a payer.

72. **EXTERNAL CAUSE OF INJURY (ECI) CODE** NR
Enter the cause of injury code or codes when injury, poisoning or adverse affect is the cause for seeking medical care.

73. NR Reserved for assignment by the NUBC. Providers do not use this field.

74. **PRINCIPAL PROCEDURE CODE AND DATE (MMDDYY)** C
Enter the principal procedure code and date using a six-digit format (MMDDYY) if the patient has undergone an inpatient procedure.

Note: Required on inpatient claims.

74a-e. **OTHER PROCEDURE CODES AND DATES (MMDDYY)** C
Enter the other procedure codes and dates using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedure.

Note: Required on inpatient claims.

75. NR Reserved for assignment by the NUBC. Providers do not use this field.

76. **ATTENDING PROVIDER NAME AND IDENTIFIERS** R
Enter the attending provider's 10-digit NPI number and last name and first name. Enter secondary identifier qualifiers and numbers as needed.
*Situational: Not required for non-scheduled transportation claims.

For more information on Attending Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

77. **OPERATING PROVIDER NAME AND IDENTIFIERS** C
Enter the operating provider's 10-digit NPI number, Identification qualifier, Identification number, last name and first name. Enter secondary identifier qualifiers and numbers as needed.

For more information on Operating Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

78-79. **OTHER PROVIDER NAME AND IDENTIFIERS** C
Enter any other provider's 10-digit NPI number, Identification qualifier, Identification number, last name and first name. Enter secondary identifier qualifiers and numbers as needed.

For more information on Other Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

80. **REMARKS** C
Enter any information that the provider deems appropriate to share that is not supported elsewhere.

81CC a-d. **CODE-CODE FIELD** C
Report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Note: To further identify the billing provider (FL01), enter the taxonomy code along with the "B3" qualifier. For more information on requirements for Form Locator 81, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

Line 23 The 23rd line contains an incrementing page and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

49199.0508

SCOTT&WHITE HEALTH PLAN

The one Texans trust.

A Guide for Completing the

CMS-1500 Form

The Form CMS-1500 is the standard claim form used by Physicians and Ancillary Providers to bill professional services and Durable Medical Equipment. Scott & White Health Plan offers this guide to help you complete the CMS-1500 form for your patients with the Scott & White Health Plan coverage.

Thank you for helping us to process your claims efficiently and accurately.

MAIL CLAIMS TO:

Scott & White Health Plan
P.O. Box 21800
Eagan, MN 55121-0800

1500

HEALTH INSURANCE CLAIM FORM

SAMPLE

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) — R

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — R

3. PATIENT'S BIRTH DATE MM DD — R — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) — R

5. PATIENT'S ADDRESS (No., Street) — R

6. PATIENT RELATIONSHIP TO INSURED Self Spouse — R — Child Other

7. INSURED'S ADDRESS (No., Street) — R

CITY — STATE

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) — C

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER — R

a. OTHER INSURED'S POLICY OR GROUP NUMBER — C

a. EMPLOYMENT? (Current or Previous) YES — R — NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — C — SEX M F

b. AUTO ACCIDENT? YES — R — NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME — C

c. OTHER ACCIDENT? YES — R — NO

c. INSURANCE PLAN NAME OR PROGRAM NAME — R

d. INSURANCE PLAN NAME OR PROGRAM NAME — C

10d. RESERVED FOR LOCAL USE — C

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES — R — NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. — R

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. — R

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD — C — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — NR

17a. — NR

17b. NPI — C

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE — C

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ — R

3. _____

2. _____

4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER — C

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 — R	R		R		R	R	R		NR NPI	NR C
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN — R

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES — C — NO

28. TOTAL CHARGE $ — R

29. AMOUNT PAID $ — C

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) — R

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION — SW

a. — C PI — b. — NR

33. BILLING PROVIDER INFO & PH # ( ) — R

a. — R PI — b. — NR

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

KEY

R TDI Requirement

C TDI Conditional Element

N Not Required/Not Used

S Scott & White Health Plan Requested Element

1. Type of Health Insurance

1a. Insured ID Number: Enter the ID number found on the insured's Scott & White Health Plan card.

2. Patient's Name: Enter patient's Last name, First name, middle initial . R

3. Patient's Birth Date/Sex: Enter patient's date of birth using an eight-digit format (MM/DD/CCYY), Enter "X" in appropriate box to indicate patient's sex. R

4. Insured's Name: Enter insured's Last name, First name, Middle initial. R

5. Patient's Address/Telephone Number: Enter patient's permanent mailing address and telephone number, Street, City, State, Zip Code. R

6. Patient's relationship to Insured: Place an "X" in the appropriate box for patient's relationship to the insured. R

7. Insured's Address: Enter insured's Street, City, State, Zip Code (complete if different than patient's address). R

8. Patient Status: Place "X" in the appropriate box for patient's marital, student and employment status.

9. Other Insured's Name: Enter other insured's Last name, First name, Middle initial, if applicable. When the patient has other insurance coverage complete 9 through 9d. This C

9a. Other insured's policy or group number: Enter group number and name, Medigap Policy number, Employee ID number of the other insured. C

9b. Other insured's date of birth and sex: Enter other insured's date of birth using (MM/DD/CCYY) format and mark an "X" to indicate insured's sex. C

9c. Employer's name or school name: Enter other insured's employer. C

9d. Insurance plan name or program name: Enter other insured's group name. C

10 a-d. Is patient's condition related to

10a. Employment: For employment related indicator, place an "X" in the appropriate box R

10b. Auto Accident: For auto accident related indicator, place an "X" in the appropriate box. If yes, enter the state in which the accident occurred. Use two-character abbreviation, R

10c. Other Accident: For other accident related indicator, place an "X" in the appropriate box. R

10d. Reserved for local use: If claim is a duplicate claim, a "D" is required. If claim is a corrected claim, a "C" is required. C

(11 thru 11d, refer to Scott & White Health Plan subscriber coverage) R

11. Insured's policy group or FECA number: Enter the group number from the subscriber's insurance card.

11a. Insured's date of birth and sex: Enter insured's date of birth using (MM/DD/CCYY) format and mark an "X" to indicate insured's sex.

11b. Employer's name or school name: Enter insured's employer or school.

11c. Insurance plan name or program name: Enter insured's insurance name.

11d. Is there another health insurance benefit plan: Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other

12. Patient or authorized person's signature: Signature required but may indicate "Signature on File". R

13. Insured's or authorized person's signature: Signature required but may indicate "Signature on File". R

14. Date of current illness, injury, pregnancy: Enter date using (MM/DD/CCYY) format. C

15. If patient has had same or similar illness give first date: Enter date using (MM/DD/CCYY) format.

16. Date patient unable to work: From date, To Date. Enter date using (MM/DD/CCYY) format.

17a. Other ID#: Not required.

17b. NPI#: Enter the 10-digit NPI number of the referring, ordering, or supervising provider.

20. Outside lab/charges: If lab was performed outside the physician's office, place an "X" in "yes" box and enter total charges.

21. Diagnosis or nature of illness or injury: Enter the ICD-9-CM codes. The primary diagnosis should be first, followed by other diagnoses. Enter up to 4 ICD-9-CM codes. R

22. Medicaid Submission Code: Enter Medicaid Submission Code, if applicable.

23. Prior Authorization Number: Required if a Preauthorization or Verification is done. C

24. Shaded Area– Supplemental Information: The shaded area of field 24a-24h was created to accommodate supplemental information (i.e. Anesthesia.) R

24a. Date(s) of service: From, To. Enter dates of service using (MM/DD/CCYY) format. R

24b. Place of service: Enter the appropriate 2 digit Place of Service code (must be valid industry standard codes). R

24c. EMG: Emergency indicator—Y for "Yes" or N for "No." R

24d. Procedures, Services, or Supplies: Enter the CPT or HCPCS code for the procedures, service or suppiers and enter a modifier, if applicable. (Must be valid industry codes.) R

24e. Diagnosis Code: Enter one OCD-9-CM diagnosis code for each procedure performed, Enter onele one code per line of service. R

24f. Charges: Enter charge for each line of service. (This should be original charge not the balance due or patient liability. Do not include discounts.) R

24g. Days or Units: Enter number of days or units. R

24h. EPSTD Family Plan: For Early & Periodic Screening, Diagnosis, or Treatment or family planning services.

24i. ID Qualifier: Not required.

24j. Rendering Provider ID.#: Shaded Field—Not Required. Non-Shaded Field– Enter performing provider 10-digit NPI number. C

25. Federal Tax I.D. Number: Enter the provider of services' Federal Tax ID number. Place an "X" in the appropriate box or SSN or EIN. R

26. Patient Account Number: Enter account number assigned to patient, if applicable.

27. Accept Assignment: Enter "Yes" if the provider should be paid or enter "No" if the patient should be paid. C

28. Total Charge: Enter total charges. This should total all charges in 24hr. R

29. Amount Paid: Enter any amount paid by the patient. C

30. Balance Due: Enter the difference, if any, between the total charge and amount paid.

31. Signature of Physician or Supplier: The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated using an eight-digit date format (MM/DD/CCYY). R

32. Service Facility Location: Enter location where services were rendered. According to Texas state law, this field is required if the services were performed somewhere other than the patient's home.

32a. NPI#: Enter the 10-digit NPI number of the service facility location. C

32b. Provider ID#: Not required.

33. Billing Provider Info & Phone: Enter provider's or supplier's information that is requesting to be paid for services rendered. R

33a. NPI#: Enter the 10-digit NPI number of the service facility location. R

33b. Provider ID#: Not required.

P&T (Pharmacy and Therapeutic) Committee Meeting

The P&T Committee meets the 4th Monday of every month with the exception of July and December. There is not a P&T meeting in July or December.

For the Mondays that fall on a holiday, the meeting is postponed to another date within the month.

Monthly formulary updates are discussed and changes are made accordingly. The updates are posted to the SWHP website. The path to that website is: http://www.swhp.org/homepage/providers/pharmacy

SWHP P&T Formulary Changes (January and February 2013)

Medication	Copay	Comments	Indication(s)	SWHP Formulary Alternatives	Effective Date
Veletri® (epoprostenol sodium-arginine)	**Specialty Formulary- Tier 2**		For the treatment of pulmonary arterial hypertension (PAH)(WHO Group 1) to improve exercise capacity	Flolan® epoprostenol sodium	4/1/13
Bydureon (exenatide microspheres)®	**Tier 3** **MCD-Tier 3**	PA MN	Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus	Byetta®	4/1/13
escitalopram	**Tier 1** **MCD-Tier 1**	MN	Indicated for treatment of major depressive disorder in adults and adolescents aged 12 to 17 years and for treatment of generalized anxiety disorder in adults	fluoxetine paroxetine sertraline citalopram	4/1/13
Rebif® (interferon beta-1A)		Removal of PA requirement			4/1/13
Pomalyst® (pomalidomide)	**Specialty Formulary- Tier 1** **MCD- Tier 4**	PA (SWHP specialty formulary only)	For patients with multiple myeloma who have received at least 2 prior therapies including lenalidomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of the last therapy		4/1/13
Promacta® (eltrombopag)	**Specialty Formulary- Tier 2** **MCD-Tier 4**	PA	For the treatment of thrombocytopenia in 1)patients with chronic immune thrombocytopenia (ITP) who have had insufficient response to corticosteroids, immunoglobulins or splenectomy and 2)patients with hepatitis C to allow initiation and maintenance or interferon-based therapy		3/1/13

Medication	Copay	Comments	Indication(s)	SWHP Formulary Alternatives	Effective Date
Nucynta®/ Nucynta ER® (tapentadol)	**MCD-Tier 3**	PA (SWHP specialty formulary only)	For the relief of moderate to severe acute pain in patients 18 years or older	oxycodone Oxycontin®	3/1/13
Cometriq® (cabozantinib)	**Specialty Formulary- Tier 1** **MCD- Tier 4**	PA (SWHP specialty formulary only)	For the treatment of patients with progressive, metastatic medullary thyroid cancer		3/1/13
Iclusig® (ponatinib)	**Specialty Formulary- Tier 1** **MCD- Tier 4**	PA (SWHP specialty formulary only)	For the treatment of adult patients with chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) resistant or intolerant to prior tyrosine kinase inhibitor therapy or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) resistant or intolerant to prior tyrosine kinase inhibitor therapy		3/1/13
venlafaxine, venlafaxine ER		MN			3/1/13
bupropion, bupropion SR, bupropion XL		MN			3/1/13
budesonide EC capsules		Removal of PA requirement			3/1/13
Humira® (adalimumab), Cimzia® (certolizumab), Remicade® (infliximab)		Revision of PA criteria for CD and UC			3/1/13
Tradjenta® (linagliptin)	**Tier 2** **MCD-Tier 2**	ST- requiring previous use of metformin; MN		Januvia® Onglyza®	1/1/13
Jentadueto® (linagliptin/ metformin)	**Tier 2** **MCD-Tier 2**	MN	For the treatment of type 2 diabetes mellitus in adults as an adjunct to diet and exercise to improve glycemic control	Janumet® Kombiglyze XR®	1/1/13

MCD=SWHP Medicare Part D Formulary (SeniorCare Rx); **PA**=prior authorization required; **MN**=maintenance eligible; **ST**=step therapy restriction

SCOTT&WHITE Healthcare

Drug Information Center
March 18, 2013

RX Statgram
Azithromycin
QT Risk

The Food and Drug Administration has updated the "Warnings and Precautions" section of the azithromycin product labeling to include information about an increased risk for QT prolongation and torsades de pointes.

The changes are related to the publication of a 2012 *New England Journal of Medicine* study that reported patients who received a five-day course of azithromycin were at a statistically significantly greater risk of cardiovascular death compared to study subjects who received amoxicillin (the primary comparator drug), ciprofloxacin or no drug.

The retrospective cohort study also included levofloxacin as a comparator antibiotic; no statistically significant difference was seen in risk of cardiovascular death with azithromycin versus levofloxacin.

Although the drug interactions profile for azithromycin is superior to erythromycin, azithromycin may now have a similar arrhythmogenic risk. The added azithromycin product labeling terminology:

Prolonged cardiac repolarization and QT interval, imparting a risk of developing cardiac arrhythmia and torsades de pointes, have been seen in treatment with macrolides, including azithromycin. Cases of torsades de pointes have been spontaneously reported during postmarketing surveillance in patients receiving azithromycin.

The risk increase in cardiovascular death (normalized by the study authors to deaths/one million courses of antibiotic therapy):

azithromycin: 85.2 deaths/1 million antibiotic courses
no antibiotic: 29.8 deaths/1 million antibiotic courses
amoxicillin (the primary study reference drug): 31.5 deaths/1 million antibiotic courses

When stratified by study subject cardiovascular risk, the greatest potential for CV death was in patients in the top 10% CV risk score groupings for all cohorts. The patients at greatest CV risk (information from the new product labeling):

- patients with known prolongation of the QT interval, a history of torsades de pointes, congenital long QT syndrome, bradyarrhythmias or uncompensated heart failure
- patients on drugs known to prolong the QT interval
- patients with ongoing proarrhythmic conditions such as uncorrected hypokalemia or hypomagnesemia, clinically significant bradycardia, and in patients receiving Class IA (quinidine, procainamide) or Class III (dofetilide, aminodarone, sotalol) antiarrhythmic agents

Elderly patients may also be more susceptible to drug-associated effects on the QT interval.

For further information, please contact the SWMH Drug Information Center at 254-724-4636 (INFO).

Provider Access & Availability Standards

Scott & White Health Plan (SWHP) developed access and availability standards in accordance with the National Association of Quality Assurance (NCQA) and Texas Department of Insurance (TDI), to ensure our members receive care that is timely and easily accessible. SWHP has established the following standards for timely accessibility of primary care, specialty care, emergency care and after-hour services:

Level of Care	Standard
New Patient Appointments	• Within 14 calendar days for *newborn* members • Within 14 calendar days for *behavioral health* appointment request • Within 60 calendar days for *eligible* members
Preventive Care Appointments Non-symptomatic office visits, including well/preventive care appointments (i.e. annual physicals, TX Health Steps, pediatric/adult immunization, annual well woman exams)	• Within 30 business days of member request
Routine Care Appointments Non-urgent symptomatic conditions (i.e. non-high risk prenatal appointments, colds, rash, headaches, joint/muscle pain)	• Within 5 business days of member request • Within 14 calendar days for prenatal request, except for high risk pregnancies or members presenting for 1st prenatal visit in the 3rd trimester
Urgent Medical Care (i.e. high fever, persistent diarrhea and vomiting)	• Within 24 hours of request
Emergency Care	• Upon presentation or same day
After-Hours Care Coverage available after normal posted business hours	• Coverage available 24 hours a day, 7 days a week, 365 days a year • Office phone is answered after hours by an answering service advising members of options for care • After-hour calls to be returned within or less than 30 minutes

All providers are expected to comply with the above access standards implemented by SWHP's Medical Delivery Development and Quality Improvement programs in accordance with their Participating Provider Agreement. Monitoring of the above standards is done at least quarterly on all contracted providers to ensure that our members receive the highest quality health care possible. Failure to comply with these standards or monitoring efforts may delay the re-credentialing process and provider contract determinations.

FRAUD WASTE and ABUSE

While financial identity theft can be devastating, it's only part of the story. The fastest area of identity theft is Medical Identity Theft (MIT). Just what is MIT? It occurs when criminals obtain information such as a health insurance identification or SSN and use it to get health care, medical test, Medicaid benefits or to obtain reimbursement from insurers and others for false claims. That means a patient's medical history and health care records can include someone else's information. This can be life threatening: for example, causing a transfusion of the wrong blood type or adding medical conditions that you don't have – can result in dangerous mistakes in an emergency.

Fortunately, there are ways that healthcare providers can minimize their risk and ensure greater protection of patient information. Each business should have an Identity Theft Prevention program outlining specific requirements for protecting client and employee's personal, sensitive information. Additionally, all businesses should conduct mandatory meetings to educate employees on the program about the risks and liabilities of data loss.

As MIT continues to grow as a crime, questions of liability to healthcare providers who fail to provide sufficient protection for patient data become more crucial. If unchecked, healthcare providers may never have certainty that the medical records they are relying on to provide care belong to the person who is being treated and patients may be equally uncertain that the records being used to treat them or determine whether a certain type of care is appropriate is based on their medical information, or fraudulently based on the records of an identity thief.

Scott & White Health Plan Medical Coverage Policies Update

Polices can be found on our website www.swhp.org

Number	Title	Comment
001	Acupuncture	
004	Physical Therapy	
009	Bone Growth Stimulators	
017	Cochlear Implants and Auditory Brainstem Implants	
041	High Frequency Chest Wall Oscillation Vest	
043	INR Home Testing	
045	Immune Globulin Therapy	
055	Insulin Pumps and CGMS	
072	Discography	
075	Prolotherapy	
103	Selective Internal Radiation Therapy (SIRT)	
106	Neuropsychological Testing	
116	Stem Cell Transplant Allogenic	
118	Stem Cell Transplant Autologous	
137	Psychologic Evaluation for Medical Procedures	
140	Breast Reconstruction Surgery and Prophylactic Mastectomy	
201	Ventricular Assist Device	
202	Virtual Colonoscopy	
203	Proton Beam Radiation Therapy	
206	Autism Coverage Policy	
204	Transcatheter aortic valve implantation or replacement (TAVI/TAVR)	
207	Bronchial Thermoplasty	

The Scott & White Health Plan Medical Coverage Policies are reviewed on an annual basis to assure continued relevance and to keep them current. This review is conducted by SWHP medical directors. Each policy is reviewed using a number of resources such as:

1. Medical literature
2. Hayes Technology® database
3. InterQual® guidelines
4. SW Technology Assessment Determinations
5. Specialty Society or other national guidelines

Once policies have been reviewed by the medical directors, they are sent for specialty review. Recommendations from the specialty reviewers are considered at a subsequent Medical Director Committee meeting and a final decision on the content of the policies under consideration is made.

The review process for the above policies has been completed and they have now been published to the website. Your comments and suggestions regarding the Medical Coverage Policies are always welcome and may be forwarded to Dr. David Krauss DKRAUSS@swmail.sw.org.

Reference to our Friday FOCUS editions may be found at http://www.swhp.org/homepage/providers/fridayfocus

SCOTT & WHITE HEALTH PLAN

The one Texans trust.

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