Regence BlueShield of Idaho

October 2018

The Connection℠

FOR PARTICIPATING PHYSICIANS, DENTISTS, OTHER HEALTH CARE PROFESSIONALS AND FACILITIES

Contents

Click on a title below to read the article.

▶ This symbol indicates articles that include critical information.

We're adding new features for your electronic authorizations

In April 2018, we introduced the authorization tool in the Availity Provider Portal for standard medical pre-authorizations requests to be submitted.

We continue to enhance the online tool so it's easier for you to submit pre-authorization requests electronically and manage them more effectively. The following enhancements are coming over the next few months. They will provide you with additional benefits and information for pre-authorizations submitted using the authorization tool on Availity® at **availity.com**.

Early eligibility check

September 16, 2018

The authorization tool will let you know before you submit your request if your patient has:

- Current Regence coverage
- Coverage through one of our joint administration plans
- Other primary insurance (coming October 21, 2018, for Blue Cross and Blue Shield Federal Employee Program® [BCBS FEP®] members)

Authorization Dashboard with status check

October 21, 2018

A new dashboard will provide a single location to view and manage the electronic authorization requests that your organization has submitted **via the Availity Portal**. You can view:

- All requests finished and submitted
- The status (e.g., approved) of each submitted request, including the individual status for requested services and/or inpatient levels of care

continued on page 2

Electronic authorizations, continued from page 1

Pre-authorization and benefits check

Later this year

The authorization tool will let you know during the process (prior to completion and submission) if the service or inpatient level of care:

- Is excluded from the patient's benefits
- Doesn't require pre-authorization
- Requires pre-authorization through one of our vendor partners (e.g., AIM Specialty Health [AIM] or eviCore healthcare [eviCore])
- Requires pre-authorization/medical review by Regence

Provide direct clinical information

Later this year

Providers can indicate whether their patient meets certain clinical criteria for a specific service (except for their Medicare Advantage patients). Using this information, we will give immediate approval to those services that meet the criteria. Providers will also be able to check whether a service requires pre-authorization before submitting the request.

Note: Dental predeterminations and medical drug pre-authorization requests cannot be submitted using the authorization tool. Please continue to follow the current process to submit them.

New features and enhancements

We'll continue to update you about new features and enhancements in this newsletter and messages posted on the home page of our provider website at **regence.com**.

Training

To learn how to use this tool to submit electronic authorizations, review Availity's *Authorization Submission Training for Regence – Training Demo*. You can find this demo in the Availity Learning Center: Help & Training>Get Trained.

Your feedback matters

Thank you for using the authorization tool to submit pre-authorization requests and for providing feedback. We appreciate your feedback and are continuing to make improvements so that it can be a valuable, effective tool for you to submit your pre-authorization requests. Please continue to tell us about your experiences using the authorization tool by using the feedback form on the Availity Portal. ■

About *The Connection*

This publication includes important updates for you and your staff, in addition to information about updates to policies and procedures, and notices we are contractually required to communicate to you. In the table of contents on page 1, this symbol indicates articles that include critical updates: ▶. To save time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

The Connection includes information for all four of our Regence Plans. In this publication, "Regence" refers to the following: Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah and Regence BlueShield (in select counties of Washington). When information does not apply to all of these Plans across the four states, this publication will identify the Plan(s) or state(s) to which that specific information applies.

Issues are published on the first of the following months: February, April, June, August, October and December.

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via the Availity Portal at **availity.com**.

The Bulletin

We publish a monthly bulletin as a supplement to this bimonthly provider newsletter. *The Bulletin* provides you with updates to medical and dental policies, including any policy changes we are contractually required to communicate to you.

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Are our publications meeting your needs? Send us your feedback at **provider_communications@regence.com**. ■

Using our website

When you first visit **regence.com**, you will be asked to select an audience type (Individual, employer, producer or provider) and enter a ZIP code for your location. This allows our site to display content relevant to you. Our site remembers your selection and automatically directs you to the same site settings the next time you visit. For most users, this is a convenient, time-saving feature. For more tips, refer to our *Website User Guide*, available on the home page of our provider website under Getting Started. ■

Stay up to date

View the **What's New** section on the home page of our website for the latest news and updates.

Regence BlueShield webinars and workshop

Regence BlueShield (in select counties in Washington) medical providers: We hope you can join us for our upcoming webinars and online fall workshop.

Webinars

Our webinars are held the first Thursday of every month, except November, from noon to 12:30 p.m. (PT). Here are the upcoming dates and topics:

- **October 4, 2018, Fee schedules and the eContracting Center**: Learn how to access fee schedules and sign agreements online via the eContracting Center.
- **December 6, 2018, 2019 products and networks**: Learn about the changes we're making to our products and provider networks.

Please let us know if you will attend any or all webinars by sending an email with the subject line "Webinar RSVP" to **WA_Provider_Relations@regence.com**. Please indicate the dates you'll attend. We hope you'll join us.

Online fall workshop

Due to low registration numbers, we are canceling the in-person workshops scheduled on October 2, 4 and 10, 2018, and will be presenting the workshop materials via webinar on Wednesday, November 7, 2018, from 9 to 11 a.m.

Here are some of the topics we'll cover:

- Appeals
- BlueCard® Program
- Medicare Quality Incentive Program

Please let us know if you will attend the webinar by sending an email with the subject line "Online fall workshop RSVP" to **WA_Provider_Relations@regence.com**. ■

Pre-authorization updates

***Commercial* and *Uniform Medical Plan (UMP) Pre-authorization List* updates**	
Procedure/medical policy	**Added CPT codes effective September 1, 2018**
Genetic Testing: Evaluating the Utility of Genetic Panels (Genetic Testing #64)	81413
Magnetic Resonance (MR) Guided Focused Ultrasound (MRgFUS) and High Intensity Focused Ultrasound (HIFU) Ablation (Surgery #139)	0398T
Procedure/medical policy	**Added CPT codes effective October 1, 2018**
Cytochrome p450 and VKORC1 Genotyping for Treatment Selection and Dosing (Genetic Testing #10)	0070U–0076U
Panniculectomy (Surgery #12.01)	15830
Pectus Excavatum (Surgery #12.02)	21740-21743
Ventral Hernia Repair (Surgery #12.03)	49560, 49565, 49654, 49656
Laser Treatment for Port Wine Stains (Surgery #12.34)	17106-17108
Chemical Peels (Surgery #12.50)	15788, 15789, 15792, 15793, 17360
Rhinoplasty (Surgery #12.28)	30120, 30400, 30410, 30420, 30430, 30435, 30450
Blepharoplasty and Brow Ptosis Repair (Surgery #12.05)	15820-15823, 67900-67904, 97906, 97908, 67909, 67950

HTCC changes for UMP members effective January 1, 2019

UMP members are subject to Health Technology Clinical Committee (HTCC) decision for the following:

- Screening and Monitoring for Osteoporosis and Osteopenia: CPT 77080 and 77081.
- Upper Endoscopy for GERD and GI Symptoms: CPT 43200, 43202, 43235, 43237–43239 and 43242.

Attestation forms are required for claims processing. Forms may be submitted pre-service through the Availity Portal or by fax, or submitted with the claim. **Related**: See *2019 HTCC decisions* on page 6.

***Medicare Pre-authorization List* updates**	
Procedure/medical policy	**Added CPT codes effective September 1, 2018**
Microwave Tumor Ablation (Medicare Surgery #189)	32998
Radiofrequency Ablation (RFA) of Tumors (Medicare Surgery #92)	32998
Procedure/medical policy	**Added CPT codes effective October 1, 2018**
Genetic and Molecular Diagnostics – Next Generation Sequencing and Genetic Panel Testing (Medicare Genetic Testing #64)	0068U, 0037U
Genetic and Molecular Diagnostics – Single Gene or Variant Testing (Medicare Genetic Testing #20)	0069U – 0076U

continued on page 5

Pre-authorization updates, continued from page 4

***Medicare Pre-authorization List* updates (continued)**	
Procedure/medical policy	**Adding CPT code effective January 1, 2019**
Physical Medicine program: Spine	22856
Procedure/medical policy	**Adding requirement effective January 1, 2019**
Home Health Care	Pre-authorization will be required for subsequent episodes of treatment beginning with the 61st day of Home Health Care. (Pre-authorization will not be required for the first episode [60 consecutive days] of home health care.) *Note*: An episode is defined as a period of 60 consecutive days, not by the number of visits.

Medicare Advantage home health care pre-authorization requirement

Effective January 1, 2019, pre-authorization will be required for subsequent home health episodes of care beginning with the 61st day. Home health care that ends within the first 60 days will not require pre-authorization. This information was added to the Facility Guidelines section of the *Administrative Manual* on October 1, 2018.

As a reminder, home health agencies are required to provide written notification to Medicare patients before reducing or terminating an item and/or service and when home health services are ending.

The following beneficiary rights and protections notices should be issued to Medicare patients when required in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines:

- Notice of Medicare Non-coverage (NOMNC) Form CMS-10123
- Detailed Explanation of Non-coverage (DENC) Form CMS-10124
- Home Health Change of Care Notice (HHCCN) Form CMS-10280
- Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131

These forms are available on the CMS website at **cms.gov/Medicare/Medicare-General-Information/BNI**.

Our complete pre-authorization lists are available in the Pre-authorization section of our website. Please review the lists for all updates and pre-authorize services accordingly.

You can submit standard medical pre-authorizations through the Availity Portal, **availity.com**. Learn more on our website: Pre-authorization and Referrals>Electronic Authorization. **Related**: See *We're adding new features for your electronic authorizations* on pages 1-2. ■

2019 HTCC decisions

The following HTCC changes for UMP members are effective January 1, 2019.

New HTCC decisions

- Pharmacogenomic testing for patients on anticoagulants is not a covered benefit.
- Genomic microarray testing is covered with conditions and requires pre-authorization.
- Continuous glucose monitoring is covered with conditions and requires pre-authorization for all ages.
- Gene expression profile testing of cancer tissue is not a covered benefit for multiple myeloma or colon cancer.
- Gene expression profile testing of cancer tissue (related to breast cancer and prostate cancer) is covered with conditions and requires pre-authorization.
- Surgery for lumbar radiculopathy is covered with conditions and requires pre-authorization.
- Minimally invasive procedures that do not include laminectomy, laminotomy or foraminotomy, including but not limited to energy ablation techniques, automated percutaneous lumbar discectomy (APLD), percutaneous laser and nucleoplasty are not a covered benefit.

Revised HTCC implementations

- AIM will use HTCC criteria for breast magnetic resonance imaging (MRI) codes included in our Radiology Quality Initiative (RQI) program.
- AIM will use HTCC criteria for lymphoma positron emission tomography (PET) codes included in our RQI program.
- Screening and monitoring tests for osteopenia/osteoporosis require a *Provider Attestation*, which can be submitted via the Availity Portal, faxed to our intake team, or submitted with a claim.
- Testosterone testing is a covered benefit for diagnoses outlined in the HTCC. The decision does not apply to females or males younger than 18 or transgender individuals.
- Upper endoscopy for GERD and GI symptoms requires a *Provider Attestation*, which can be submitted via the Availity Portal, faxed to our intake team or submitted with a claim.

View all determination criteria on the HTCC website at **https://www.hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews**.

Massage, acupuncture and speech therapy authorization simplified

eviCore is simplifying the medical necessity review process for providers submitting massage, acupuncture and speech therapy authorization requests under our Physical Medicine program. The new model, called corePath, will replace the current authorization process on November 1, 2018.

We've been using corePath for physical therapy, occupational therapy and chiropractic services since March 1, 2018, and it has been well-received by providers.

How is corePath different?

corePath is designed to:

- Be member-centric, emphasizing the unique attributes of an individual patient's condition
- Streamline the process via simplified steps that focus on collection of minimal clinical information
- Provide condition-specific approvals, eliminating waiver visits and replacing them with a visit approval more aligned with each patient's needs

Attend a webinar

eviCore will hold hour-long webinars about corePath. *Note*: All times are Pacific Time.

Massage and acupuncture providers should register for one of the following trainings:

- Tuesday, October 16, 2018, at 9 a.m.
- Wednesday, October 17, 2018, at 11 a.m.
- Wednesday, October 24, 2018, at 1 p.m.
- Thursday, October 25, 2018, at 2 p.m.

Separate trainings will be held for speech therapy providers:

- Tuesday, October 16, 2018, at 1 p.m.
- Wednesday, October 17, 2018, at 8 a.m.
- Wednesday, October 24, 2018, at 10 a.m.
- Thursday, October 25, 2018, at noon

Register on the eviCore Webex Training page at

evicore.webex.com/mw3300/mywebex/default.do?siteurl=evicore&service=7.

AIM cardiology imaging and sleep guidelines to be revised

Effective January 28, 2019, AIM will revise its cardiology imaging and sleep guidelines.

Radiology program guideline revisions

- **Carotid duplex ultrasound**: Removing criteria for evaluation of syncope in patients with suspected extracranial arterial disease
- **Cardiac MRI**: Removing the allowance for annual left ventricular function evaluation when echocardiography is suboptimal
- **Resting transthoracic echocardiography (TTE)**: Adding criteria for evaluation of ventricular function in patients who have undergone cardiac transplantation
- **Myocardial perfusion imaging (MPI), stress echocardiography, cardiac positron emission tomography (PET) and coronary computed tomography angiography (CCTA)**: Clarifying exercise-induced syncope and exercise-induced dizziness, lightheadedness or near syncope in symptomatic patients with suspected coronary artery disease
- **MPI, stress echocardiography and cardiac PET**: Clarifying the definition of established coronary artery disease when diagnosed by CCTA; the definition will be more restrictive for patients diagnosed with coronary artery disease by prior coronary angiography, as fraction flow reserve must be ≤0.8

Sleep Medicine program guideline revision

- Removing HCPCS A7047

The guidelines, which are part of our radiology and Sleep Medicine programs, are published on AIM's ProviderPortal, **www.providerportal.com**.

eviCore pain and joint guidelines to be revised

Effective January 1, 2019, eviCore will revise its large joint and interventional pain management guidelines.

Large joint guideline revisions

- Updating imaging criteria and requirements
- Updating physical examination requirements
- Updating non-surgical management timeframe
- Updating type of pain and pain duration requirements
- Adding criteria for in-office diagnostic needle arthroscopy

Interventional pain management guideline revisions

- Updating trial criteria to include Ashworth information
- Updating the length of conservative treatment required
- Adding requirement for reduction in systemic opiate usage
- Adding requirement for advanced imaging within the past 12 months

The guidelines, which are part of our Physical Medicine program, are published on the eviCore website, **www.evicore.com**.

Clinical Practice Guidelines review

Clinical Practice Guidelines are systematically developed statements on medical and behavioral health practices that help physicians and other health care professionals make decisions about appropriate health care for specific conditions.

View these guidelines on our website: Library> Policies and Guidelines.

Use modifiers for surgeries during global period

As a reminder, providers should check for correct usage of surgical modifiers when billing within the global period to prevent claims from being denied.

All claims are subject to pre-authorization requirements, member eligibility and benefits, and provider contracting.

The following examples illustrate appropriate usage of these modifiers.

Modifier 58

Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

Description: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. *Note*: For treatment of a problem that requires a return to the operating or procedure room (e.g., unanticipated clinical condition), see modifier 78.

Example: If a patient has excision CPT 11606 with a 10-day global period and a complex repair closure CPT 13101 planned for five days after the surgical date, append modifier 58 to the closure code.

Modifier 76

Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

Description: It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. *Note*: This modifier should not be appended to an evaluation and management (E&M) service.

Example: The patient has a closed treatment of a right tibial shaft fracture without manipulation performed in the emergency room (CPT 27750-RT). If the patient goes home, falls and returns to the emergency room to have the fracture reset by the same surgeon, append modifier 76 (CPT 27750-76-RT).

Modifier 77

Repeat Procedure by Another Physician or Other Qualified Health Care Professional

Description: It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. *Note*: This modifier should not be appended to an E&M service.

Example: The patient has a closed treatment of a right tibial shaft fracture without manipulation performed in the emergency room (CPT 27750-RT). The patient goes home, falls and returns to the emergency room to have the fracture reset by a different surgeon, append modifier 77 (CPT 27750-77-RT).

Modifier 78

Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

Description: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating or procedure room, it may be reported by adding modifier 78 to the related procedure. *Note*: For repeat procedures, see modifier 76.

Example: The patient undergoes a knee replacement arthroplasty on her right knee (CPT 27440-RT). The patient ends up with a severe knee joint infection. Thirty days later, the surgeon performs a knee arthrotomy (CPT 27310). Because the knee arthrotomy was performed less than 90 days after the original procedure, the procedure is reported as CPT 27310-78-RT.

continued on page 9

Global periods modifiers, continued from page 8

Modifier 79

Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

Description: The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. *Note*: For repeat procedures on the same day, see modifier 76.

Example: A right inguinal hernia repair (CPT 49505-RT) was performed. One month later, a right femoral hernia repair (CPT 49550-79-RT) was billed. The procedures involve hernias from different areas; even though they are the same side of the body, they are unrelated.

Additional modifiers

The following modifiers should be used where appropriate during the global period to prevent denial:

- LT/RT – Left side or right side, used to identify procedures performed on those respective sides of the body
- E1-E4 – Anatomical modifiers for eyelids
- F1-FA – Anatomical modifiers for hand digits
- T1-TA – Anatomical modifiers for foot digits

Reimbursement policy updates

We review our reimbursement policies on an annual basis. Included below are updates to existing policies that will be added to our *Reimbursement Policy Manual*.

View our reimbursement policies on our website: Library>Policies and Guidelines>Reimbursement Policy.

To see how a claim will pay, access the Clear Claim Connection tool on the Availity Portal at **availity.com**: More>Claims>Research Procedure Code Edits.

Updated policies	Description of addition or change
Medicine	**October 1, 2018**
Urine Drug Testing (#106)	▶ Removed deleted American Medical Association (AMA) code CPT 0020U
Administrative	**November 1, 2018**
Associated Claims (#119)	▶ Adding contract exclusions as an example of a type of non-covered service

Non-reimbursable services

Our *Non-Reimbursable Services* (Administrative #107) reimbursement policy, which explains services that are considered to be non-reimbursable, is located on our website: Library>Policies and Guidelines> Reimbursement Policy. If billed, non-reimbursable services (NRS) are considered not payable, are denied as a provider write-off and cannot be billed to our member.

Effective January 1, 2019, we will deny HCPCS S9480 when billed by professional providers for commercial and UMP members. HCPCS S9480 is already considered an NRS for Medicare Advantage.

View specific commercial CPT and HCPCS codes that are considered NRS in the *Clinical Edits by Code List* located on our website: Claims and Payment>Claims Submission> Coding Toolkit.

If CMS has designated a medication or supply as product not available (PNA) for 90 days, we consider it an NRS and not eligible for reimbursement. We allow this time to use any existing supply. We review codes quarterly and update any medications or supplies with a PNA code status to NRS. ■

Medical policy updates

We publish updates to medical policies, dental policies and Clinical Position Statements in our monthly publication *The Bulletin*.

We provided 90-day notice in the August and September 2018 issues of *The Bulletin* about the following medical policies:

- Spinal Fusion (Surgery #187), effective November 1, 2018
- Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46), effective December 1, 2018

You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our website: Library>News and Updates. The *Medical Policy Manual* includes a list of recent updates and archived policies: Library>Policies and Guidelines> Medical Policy>Recent Updates.

All policies and Clinical Position Statements are available on our website: Library>Policies and Guidelines. ■

Medication policy updates

Listed below is a summary of medication policy additions and changes. Links to all medication policies, medication lists and pre-authorization information for our members, including real-time deletions from our pre-authorization lists, are available on our website: Programs>Pharmacy.

Expert feedback: We routinely assess our medication policies based on updated medical literature, national treatment guidelines, practicing provider feedback and pharmaceutical market changes. If you'd like to provide feedback or be added to our distribution list, please email us at **RegenceRxMedicationPolicy@regence.com** and indicate your specialty.

New U.S. Food & Drug Administration (FDA)-approved medications: New-to-market medications are subject to pre-authorization based on their FDA-labeled indication and dosage limitations until we complete a full medication review and develop a coverage policy.

Product not available (PNA) status: We allow a 90-day grace period for medications that CMS has designated as PNA before they become ineligible for reimbursement. **Related**: See *Non-reimbursable services* on page 10.

New medication policy	Effective date	Description
Crysvita, burosumab, dru547	August 1, 2018	▶ Limits coverage to children with symptomatic X-linked hypophosphatemia (XLH) who are non-responsive to conventional therapy (activated vitamin D and phosphate supplements) and the setting in which it was studied ▶ Considered not medically necessary (and therefore not eligible for coverage) for adults
Luxturna, voretigene neparvovec, dru527	August 1, 2018	▶ Limits coverage to patients with biallelic RPE65 mutations who have remaining visual function and have a sufficient level of viable retinal cells, the setting in which it was studied and the use for which it has a labeled indication
Testosterone replacement products, dru548	September 1, 2018	▶ Replaces individual drug coverage policies for testosterone replacement products (dru297, dru411 and dru415)
Jynarque, tolvaptan, dru552	October 1, 2018	▶ Limits coverage to patients with rapidly progressing autosomal dominant polycystic kidney disease (ADPKD), the setting in which it was studied and the use for which it has a labeled indication ▶ The other tolvaptan product, Samsca, will not require pre-authorization
Medications for PKU, dru551	October 1, 2018	▶ Includes the following products: Kuvan (sapropterin) and Palynziq (pegvaliase-pqpz) ▶ Limits coverage of Palynziq to patients in which Kuvan is ineffective, not tolerated or contraindicated and those with baseline blood phenylalanine (Phe) levels greater than 600µmol/L, the setting in which it was studied ▶ Replaces individual drug coverage policy for Kuvan (dru152)
Potassium Binders for Hyperkalemia, dru554	October 1, 2018	▶ Includes the following products: Lokelma (sodium zirconium cyclosilicate) and Veltassa (patiromer) ▶ Limits coverage to patients with hyperkalemia or whom non-pharmacologic therapies (such as diet modification) have been ineffective

continued on page 12

Medication policy updates, continued from page 11

New medication policy (continued)	Effective date	Description
Blood Factors for Hemophilia A, extended half-life products, dru549	January 1, 2019	▶ Includes the following products: Adynovate, Afstyla, Eloctate and Jivi ▶ Limits coverage to patients who have been on a short half-life (SHL) agent for at least 50 exposure days and the SHL agent is ineffective ▶ Adds dose limitations ▶ Requires pharmacokinetic (PK) studies for reauthorization
Blood Factors for Hemophilia B, extended half-life products, dru550	January 1, 2019	▶ Includes the following products: Alprolix, Idelvion and Rebinyn ▶ Limits coverage to patients who have been on a short half-life (SHL) agent for at least 50 exposure days and the SHL agent is ineffective ▶ Adds dose limitations ▶ Requires pharmacokinetic (PK) studies for reauthorization
Revised medication policy	**Effective date**	**Description**
Tecentriq, atezolizumab, dru463	August 1, 2018	▶ Updated coverage criteria for urothelial carcinoma in line with updated FDA labeling
Keytruda, pembrolizumab, dru367	August 1, 2018	▶ Updated coverage criteria for urothelial carcinoma in line with updated FDA labeling
Trulicity, dulaglutide, dru347	August 7, 2018	▶ Trulicity no longer requires pre-authorization ▶ The other products in dru347 will continue to require pre-authorization
Botulinum toxin type A injection, dru006	September 1, 2018	▶ Clarified that use in combination with Aimovig is considered investigational and not covered
Monoclonal antibodies for migraine, dru540	September 1, 2018	▶ Added coverage criteria for episodic migraine with functional impairment ▶ Clarified that use in combination with Botox is considered investigational and not covered
Opdivo, nivolumab, dru390	September 1, 2018	▶ Added coverage criteria for new FDA-approved indications: frontline use in unresectable locally advanced or metastatic renal cell carcinoma (RCC) and for MSI-H metastatic colorectal cancer (CRC) when Yervoy is used in combination with nivolumab (Opdivo)
Perjeta, pertuzumab, dru281	September 1, 2018	▶ Considered not medically necessary (and therefore not eligible for coverage) for patients with HER2+ breast cancer when used in the adjuvant treatment setting
Yervoy, ipilimumab, dru238	September 1, 2018	▶ Added coverage criteria for new FDA-approved indications: frontline use in unresectable locally advanced or metastatic renal cell carcinoma (RCC) and for MSI-H metastatic colorectal cancer (CRC) when Yervoy is used in combination with nivolumab (Opdivo)

continued on page 13

Medication policy updates, continued from page 12

Revised medication policy (continued)	Effective date	Description
Compounded Medications, dru135	October 1, 2018	▶ Clarified that if an active ingredient in the compound requires pre-authorization, then specific medical necessity criteria for that medication must also be met
Drugs for chronic inflammatory diseases, dru444	October 1, 2018	▶ Added tildrakizumab (Ilumya) to the policy as a non-preferred provider-administered option for psoriasis ▶ Added baricitinib (Olumiant) to the policy as a non-preferred self-administered option for rheumatoid arthritis ▶ Added infliximab-qbtx (Ixifi) to the policy as a non-preferred provider-administered option for all Remicade indications, in line with the other Remicade biosimilars ▶ Added coverage criteria for Remicade in patients with pyoderma gangrenosum ▶ Added coverage criteria for new FDA-approved indications for Xeljanz for patients with psoriatic arthritis and ulcerative colitis ▶ Added coverage criteria for a new FDA-approved indication for Cimzia in patients with psoriasis ▶ Added coverage criteria for a new FDA-approved indication for Taltz in patients with psoriatic arthritis ▶ Updated step-therapy requirements for Entyvio from two preferred TNF-antagonist products to one ▶ For Crohn's disease, updated the coverage criteria for first-line use of a biologic medication
Non-Preferred GLP-1-Agonist-containing medications, dru347	October 1, 2018	▶ Updated step therapy to require use of all four preferred GLP-1 products (exenatide, dulaglutide, liraglutide and semaglutide)
Archived medication policy	**Effective date**	**Description**
Buphenyl, sodium phenylbutyrate, dru323	September 1, 2018	▶ Products no longer require pre-authorization
Sustol, granisetron extended-release injection, dru469	September 1, 2018	▶ Products no longer require pre-authorization

NDC on medical drug claims

In preparation for a requirement that will be effective in 2019, we ask that you include a National Drug Code (NDC) on all claims for drugs administered in an office by a physician or other health care professional or administered in an outpatient facility setting. If you're not already including the NDC, please begin doing so now before the requirement goes into effect. We will notify you 90 days in advance of the effective date in a future issue of this newsletter.

The 11-digit NDC number must be accompanied by the basis of measurement (UN, ML, etc.) and the NDC units. The claim should also include the corresponding HCPCS and CPT codes and the units administered for each code.

Learn more about submitting these claims on our website: Claims and Payment>Claims Submission> Medication Claims. ■

Updated formularies for 2019

Our formularies reflect the safest, highest quality and most cost-effective medications available. We update our formularies when new drugs come to market or new scientific findings are available. For 2019, our formulary list names are simpler and more descriptive: Programs>Pharmacy.

Annual updates

Effective January 1, 2019, annual formulary updates include cost share and tier changes; Affordable Care Act (ACA) medication removals; and exclusions for certain medications, medical foods and over-the-counter medications.

Changes that will lower costs and improve access for members include moving more than 300 medications to lower-cost tiers, removing several medications from the *High Cost Drug Exclusion* list, and adding medications to the *Optimum Value List* for common conditions such as seizures, heart disease and mental illness.

Ongoing updates

Formulary maintenance includes adding new FDA-approved medications, removing medications because of safety concerns and adjustments based on new clinical information.

Note: Brand-to-generic changes occur throughout the year as new generic medications come to market. Once a generic alternative is available, it is usually added to the formulary right away. Most members are moved to generic alternatives by their pharmacists immediately when generics are available. For medications that will move to a higher-cost tier, we wait six months before moving the brand name version to non-preferred to allow time for members to switch to the generic.

Member outreach

We will notify affected members by mid-November so they can take action related to changes to one or more of their medications. ■

2019 group and Individual networks and products

Each year, we evaluate our provider networks and product portfolio to ensure our members receive the best value for their health care dollar. In 2019, we will be making a few minor changes to our medical products. Some are additions or adjustments to our product portfolio, while others are to comply with ACA requirements and mandates. We are not making any changes to our dental or vision products in 2019.

Employer group product and network updates

The products below will be added to our group metallic portfolio in 2019.

2019 group metallic products	
State	**Products**
Regence BlueShield of Idaho	▶ Silver 3000 Embedded Health Savings Account (HSA) ▶ Bronze 7900
Regence BlueCross BlueShield of Oregon	▶ Silver 3000 Embedded HSA (in Oregon and Clark County in Washington) ▶ Bronze 7900 (in Clark County)
Regence BlueCross BlueShield of Utah	▶ Silver 3000 Embedded HSA ▶ Bronze 7900
Regence BlueShield (select counties of Washington)	▶ Silver 3000 Embedded HSA ▶ Bronze 7900

Provider network changes

The changes below will be made to our Accountable Health Networks (AHN) in Washington:

- The Everett Clinic AHN will no longer be offered.
- The EvergreenHealth Partners-Overlake AHN will be renamed Eastside Health Network AHN.

Reminder: HSA copays, on our group metallic products, apply after the deductible is met. Please do not collect the copay unless the member has already met their annual deductible.

Benefit changes

A summary of the benefit changes coming in 2019, including changes for Uniform Medical Plan members, will be available on our website by October 15, 2018: Products>Medical. The changes include the expansion of retail health benefits.

2019 BCBS FEP changes

We will share information about the 2019 benefit changes, including details about a new product in the December issue of this newsletter.

Related

- 2019 retail clinic benefit

Page 17

Individual networks and products

Our product portfolio will include HSA-qualified products, which can be paired with health savings accounts (HSAs). In addition, we offer exclusive provider organization (EPO) products in Oregon, Utah and Washington. EPO members only have in-network benefits and will be responsible for 100 percent of out-of-network costs. In Idaho, we offer point of service (POS) products. POS members have limited out-of-network coverage.

The 2019 open enrollment period is from November 1, 2018, through December 15, 2018. Individuals may qualify for special enrollment periods outside of these periods if they experience certain events.

Members whose plans are being discontinued have received notice from us about options available to them in 2019.

continued on page 16

Group and Individual networks and products, continued from page 15

2019 Individual and family networks and products		
State	**Networks and service areas**	**Products and selling areas**
Regence BlueShield of Idaho	**Individual and Family Network** (statewide) *Note*: The name of the Clearwater Medical Neighborhood will be changed to St. Mary's Clearwater Medical.	▶ Silver HSA 2500 POS ▶ Silver 3000 POS ▶ Bronze HSA 5000 POS ▶ Bronze Essential 7150 POS Products are available statewide.
	Preferred (statewide)	▶ Silver HSA 2500 Product is available statewide.
Regence BlueCross BlueShield of Oregon	**Individual and Family Network** (statewide)	▶ Standard Silver Plan EPO ▶ Silver HSA 2500 EPO ▶ Standard Bronze Plan EPO ▶ Bronze HSA 5000 EPO Products available to residents of Baker, Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco and Wheeler counties.
	OHSU Plus Network (Clackamas, Multnomah and Washington counties)	▶ Standard Silver Plan EPO ▶ Silver 3000 EPO ▶ Silver HSA 2500 EPO ▶ Standard Bronze Plan EPO ▶ Bronze HSA 5000 EPO Products available to residents of Clackamas, Multnomah and Washington counties.
	PeaceHealth Network (Clark County, Washington)	▶ Gold 1000 EPO ▶ Silver 3000 EPO ▶ Silver HSA 2500 EPO ▶ Bronze HSA 5000 EPO ▶ Bronze Essential 7150 EPO Products available to residents of Clark County.
Regence BlueCross BlueShield of Utah	**Individual and Family Network** (Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Sanpete, Summit, Tooele, Uintah, Utah and Weber)	▶ Silver HSA 2500 EPO ▶ Silver 3000 EPO ▶ Bronze HSA 5000 EPO ▶ Bronze Essential 7150 EPO Products available to residents of Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Sanpete, Summit, Tooele, Uintah, Utah and Weber counties.

continued on page 17

Group and Individual networks and products, continued from page 16

Regence BlueShield (select counties of Washington)	Individual and Family Network (Clallam, Clark, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom and Yakima counties)	▶ Gold 1000 EPO ▶ Silver 3000 EPO ▶ Silver HSA 2500 EPO ▶ Bronze HSA 5000 EPO ▶ Bronze Essential 7150 EPO Products available to residents of Columbia, Walla Walla and Yakima counties.

Benefit changes

Benefit changes coming next year include, but are not limited to:

- Retail health benefits to be expanded; **Related**: See *2019 retail clinic benefit* below.
- **For Oregon and Washington members**: Reproductive health benefits expanded
- **For Idaho members**: Treatment of autism spectrum disorders using applied behavioral analysis (ABA) therapy will be covered under the mental health benefit when members seek treatment from licensed providers qualified to prescribe and perform ABA therapy services

More information

More information is available in the Products section of our website. Please verify your patients' eligibility and benefits on the Availity Portal at **availity.com** and use the Find a Doctor tool on our website to verify network participation prior to referring patients. ■

2019 retail clinic benefit

All of our Individual and group members have a retail clinic benefit. Beginning January 1, 2019, a lower cost-share for retail clinics will be applied to plans with primary office visit copays. This benefit highlights our commitment to providing members with convenient and low-cost care options, expanding the choices a member has when seeking care.

The 2019 benefit includes:

- **Low copay**: The copay will never be more than the primary care copay. In some cases, it will be less. *Note*: Some of our health plans will not have the lower copay. Verify your patients' benefits using the Availity Portal at **availity.com**.
- **Convenience**: Quick access to care without having to wait to schedule with a primary care provider. Multiple, often on-demand, appointments available daily, without the wait associated with an emergency room or urgent care visit.
- **Accessibility**: Many locations may be readily available both in and out of our service area. Not all networks have the same retail clinics, so please check using the Find a Doctor provider search tool by searching for **retail clinic** or **retail health center** under the **Places** by type category to see which centers are in network. Since not all states have retail clinics, there may be some areas where no options are available.

A retail clinic is a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. Examples of retail clinics are clinics within big box retailers, often with a pharmacy on site as well. A retail clinic does not include an office or independent clinic outside a retail operation or an ambulatory surgical center, urgent care center/facility, hospital, pharmacy, rehabilitation facility or skilled nursing facility.

To have your clinic listed as a retail clinic in the Find a Doctor tool, complete the *Provider Information Update Form* on our website: Contact Us> Update Your Information. ■

2019 Medicare Advantage options

Several changes to our Medicare Advantage PPO and HMO products will affect members, providers and dentists on January 1, 2019. These changes will better meet the needs of our members and the marketplace and ensure that we remain financially sustainable for the long term. There are no service area changes in 2019.

Benefit changes

Medicare Advantage members will receive the *Annual Notice of Changes*, which highlights the changes to their plan for 2019.

Some key changes we are making for next year include:

- The emergency care copay is increasing to $90.
- Some products will have lower in-network out-of-pocket maximums.
- Palliative care services will be covered without episodes of care limits.
- Home health services require pre-authorization beginning January 1, 2019. **Related**: See *Pre-authorization updates* on pages 4-5.
- Podiatry, mental health and hearing exam services provided by a primary care provider (PCP) will be subject to the PCP copay.
- The copay for outpatient laboratory, tests/procedures and X-rays will be subject to the same copay amount regardless of the place of service.
- The minimum copay for wound care services received at an ambulatory surgery center (ASC) or outpatient hospital setting will match the specialist office visit copay.
- On select products, the maximum copay for ASC, outpatient hospital services and outpatient hospital observation will change from a percentage to a dollar amount.
- A new disease management program for diabetic patients who meet specific criteria will be available. **Related**: See *Livongo for Diabetes program* on page 20.

Supplemental benefits

The following supplemental benefits are not covered by Medicare but are covered by some or all of our Medicare Advantage products:

- Virtual PCP visits will be covered via MDLive or a PCP.
- Select products in Idaho will include chiropractic and/or acupuncture benefits with a $20 in-network copay and a limit of 18 visits per year total. These benefits are not subject to our Physical Medicine program.
- Select products in Oregon and Washington will include chiropractic, acupuncture and/or naturopathic benefits with a $20 in-network copay and a limit of 18 visits per year total. These benefits are not subject to our Physical Medicine program.
- Select products in Utah will include chiropractic benefits with a $20 in-network copay and a limit of 18 visits per year total. These benefits are not subject to our Physical Medicine program.
- Virtual Diabetes Prevention Program services from Retrofit will be available for eligible pre-diabetic members at $0 in-network copay.
- In 2019, there are no changes for the embedded or optional supplemental benefit packages for hearing, dental and vision.

Medicare Part D coverage

There are some changes to the prescription drug coverage and formulary for all our Medicare Advantage Part D plans, whether coverage is included with the member's medical plan or purchased as a stand-alone product:

- We will introduce a simplified five-tier Medicare formulary.
- Members will have a low $3 copay on preferred generic medications (tier 1) at our preferred pharmacy network.
- Prescription deductible will be waived on tier 1 and tier 2 medications that include medications to treat chronic conditions, such as diabetes, osteoporosis, high blood pressure and high cholesterol.
- Discounts are available by mail-order or retail pharmacies for 90-day prescription fills.

This is not a comprehensive list of benefit or copay changes. Please check your patient's specific benefits on the Availity Portal at **availity.com** and use the Find a Doctor tool on our website to verify network participation prior to referring patients. ■

Medicare Quality Incentive Program updates

We are in the final few months of our Medicare Quality Incentive Program for 2018. If your patients still have gaps that require an office visit or screening to be complete this year, we encourage you to contact them for scheduling now. You can review your patients' open gaps on the Care Gap Management Application (CGMA).

Gap closure submission deadlines

To ensure that we have the information necessary to close your gaps for the 2018 program, we will accept claims or documentation until March 31, 2019, for each method of gap closure submission:

- CGMA
- Medical claims
- Pharmacy claims
- Electronic medical record (EMR) data extract

Controlling blood pressure measure changes

The National Committee for Quality Assurance (NCQA) has revised the Healthcare Effectiveness Data and Information Set (HEDIS) controlling blood pressure measure to reflect a new blood pressure target of <140/90 mm Hg for all adults ages 18 to 85 with hypertension, in accordance with updated clinical recommendations. NCQA has also updated the administrative methods allowed to collect the measure and added telehealth encounters to satisfy certain components of the measure.

We will incorporate the new measure criteria in our 2019 Medicare Quality Incentive Program. We want you to be aware of it now so you can be working with your patients to meet the new targets as soon as possible. As a reminder, compliance is determined by the reading documented in the medical record corresponding with the patient's last outpatient encounter date during the year with any provider.

Learn more about the Medicare Quality Incentive Program on our website: Programs> Medicare Quality Incentive Program. If you have questions, please email us at **QIPQuestions@regence.com**. ■

Medicare compliance reminder

All Medicare-contracted providers, medical groups, facilities and suppliers are required to check the Office of Inspector General (OIG) and General Services Administration (GSA) federal exclusion lists for all employees prior to hire and monthly thereafter. If an employee is confirmed to be excluded, he or she must immediately be removed from working on our Medicare program. We are prohibited from paying Medicare funds to any entity or individual found on these federal lists:

- GSA exclusion list: **sam.gov**
- OIG exclusion list: **oig.hhs.gov/exclusions**

Documentation of these verifications must be maintained and made available upon request by either Regence or CMS. We will ask contracted entities to verify that the entity is compliant with this requirement during initial credentialing and at recredentialing.

For information regarding the Regence Medicare Compliance program and related resources, including training links, please visit our website at **regence.com/fdr-resources**. ■

Encouraging use of statins in diabetic patients

Statin Use in Persons with Diabetes (SUPD) is a HEDIS measure and is included in our Medicare Quality Incentive Program. The measure is supported by the 2013 American College of Cardiology and American Heart Association blood cholesterol guidelines and the 2017 American Diabetes Association guidelines. Statins have been shown to reduce cardiac events in non-diabetic and diabetic patients.

The SUPD measure focuses on diabetic patients ages 40 to 75. Patients are identified as diabetic if they filled two or more prescriptions of diabetes medications during the year; hospice and end-stage renal disease patients are excluded from the measure. To be compliant with the measure, the patient must also fill a prescription for at least one statin medication during the year.

Even with these guidelines, some diabetic patients may be unwilling to take statins and some providers may be hesitant to prescribe statins for a variety of reasons, including:

- **The patient's total cholesterol is normal**. Even if a diabetic patient does not have high cholesterol, there is good evidence that reducing their LDL cholesterol to below 70mg/dl with a moderate-intensity statin can reduce the incidence of heart attack and stroke.
- **There may be an increase in the patient's blood glucose**. Since 2012, the FDA has required that all statins carry the side effect warning of possible hyperglycemia, which would make prescribing a statin to a diabetic patient seem counterproductive. While this side effect is a possibility, evidence suggests that it is low and that the cardioprotective effect of a statin outweighs this side effect. As always, monitor the patient's A1C levels closely and if changes are noted, consider lowering the dose or possibly changing the type of statin.
- **The patient has a history of myalgia and cannot tolerate statins**. If a patient has a history of myalgia with statin use, try using the same statin at a lower dose or trying a different statin all together. *Note*: Pravastatin and fluvastatin have the lowest incidence of myalgia, and Rosuvastatin is recommended for patients with cardiovascular disease and a history of myalgia.
- **The patient is already taking a non-statin cholesterol-lowering agent**. There is no evidence that taking a non-statin medication reduces the incidence of heart attack or stroke. The strongest evidence, through the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial, supports a moderate- or high-intensity statin in diabetic patients to reduce the risk of heart disease.

Livongo for Diabetes program

Livongo helps reduce the daily burdens of living with diabetes by combining consumer health technology, personalized recommendations and real-time support.

The program includes the following:

- **Free strips and lancets, plus a new free blood glucose meter**: Strips and lancets are shipped to the member's home. Members can order refills of strips and lancets from Livongo online or through their meter.
- **Better diabetes monitoring**: Livongo's smart meter comes with a cellular chip that automatically uploads the member's readings—no more log books. The meter also provides real-time tips and, if desired, it can notify the member's family if a reading is out of the member's range. Members can also use the meter to send a report to their provider.
- **Answers to questions 24/7**: Certified diabetes educators are available to provide nutrition and lifestyle tips by phone, email, text or mobile app. In addition, coaches are available to support members 24 hours a day and can reach out to members directly if readings indicate help may be needed.

Livongo for Diabetes will be available for BCBS FEP members in Oregon and Utah and Cambia Health Solutions (group #60018408) members later this year. It will be available for Medicare Advantage members effective January 1, 2019. Members with type 1 or type 2 diabetes and who meet other program criteria will receive a letter from Regence with information about how to enroll in the program. We will notify you in this newsletter when the program will be available to additional members.

Information about this program is available on our website: Programs>Medical Management>Diabetes Management. The Medical Management section of our *Administrative Manual* also includes information: Library>Administrative Manual. More information is available on Livongo's website at **livongo.com**. ■

How to start the ACP conversation process

As part of our ongoing effort to inspire, educate and empower the public and providers, we continue to encourage you to begin or resume advance care planning (ACP) conversations with all of your patients.

In our August 2018 issue, we shared the billing codes to be reimbursed for ACP conversations with your patients with our two-minute video, Billing and Coding for Advance Care Planning Conversations:

- Regence BlueShield of Idaho: **https://youtu.be/UPxK_VISgzc**
- Regence BlueCross BlueShield of Oregon: **https://youtu.be/NaDN9LDID1Y**
- Regence BlueCross BlueShield of Utah: **https://youtu.be/bErk7OnjWiw**
- Regence BlueShield: **https://youtu.be/BpU_h9MsG2I**

Now, we offer you two more short videos that equip you to start the conversation process with your patients:

- **Starting an ACP Conversation—for Providers, Part 1**: **Questions**, available at **https://youtu.be/LIzvquo60Gw**, introduces Dr. Atul Gawande's five recommended questions to prepare for engaging with patients for the first ACP conversation, and three more questions that can help continue the conversation at the next visit.
- **Starting an ACP Conversation—for Providers, Part 2**: **Broaching the Topic of ACP**, available at **https://youtu.be/mg7B8I9C9_o**, provides easy-to-use guidelines for approaching your patients with the concept of ACP for the first time.

For more detailed guidelines, view Vidant Health's conversation scripts for providers at **vidanthealth.com/Manage-My-Health/Advance-Care-Planning/Conversation-Scripts-for-Providers**.

As a reminder, ACP conversations are eligible for reimbursement when you complete these steps:

1. Have the conversation with your patient.
2. Document the conversation(s) in the patient's chart or electronic medical record (EMR).
3. Submit a claim for the conversation using CPT 99497 and 99498, *in addition to* other E&M codes for services provided during the visit.

In previous issues of this newsletter, we busted six myths about ACP conversations to equip you with truth and tools to better understand your vital role in some of the most important conversations between you and your patients.

To recap these truths:

1. ACP conversations are valuable for your patients at any age and health status. The Conversation Project, **theconversationproject.org**, offers free resources you and your patients can view, download and print.
2. ACP conversations are a process occurring over a period of weeks, months or years. You are not required to have one conversation that covers the multiple topics and documents in a single visit.
3. Having ACP conversations lets your patients know their wishes will be honored, so your patients can focus on their health and what matters to them. The conversations do not need to be depressing!
4. Since 2015, we have reimbursed participating providers for ACP conversations with all patients who are Regence members of any age and any health status.
    - *Note*: BCBS FEP members' benefits for advance care planning are available only when there is an approved hospice treatment plan on file. Please refer to the Blue Cross Blue Shield Service Benefit Plan for more information at **https://www.fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms**.
5. The benefit allows for unlimited ACP encounters and during any provider appointment. ACP can be the sole reason for the visit, or a conversation can occur during any office visit for other treatments. This is not "double-dipping."
6. ACP conversations are not role-specific. We reimburse any contracted primary or specialty care provider with an National Provider Identifier (NPI) who bills CPT 99497 and 99498 in addition to other services during the patient's visit.

Visit our website for more information: Programs> Medical Management>Personalized Care Support. ■

Adoption of ASAM criteria for treatment of substance abuse

We are committed to ensuring members have access to and receive quality substance abuse treatment—including treatment for opioid use—at the right time in the right setting. To support this objective, we are adopting American Society of Addiction Medicine (ASAM) criteria effective January 1, 2019.

We believe adopting the ASAM criteria will make it easier for you to understand the levels of care definitions and the criteria used to make coverage determinations.

Visit the ASAM website to learn more about their criteria at **https://www.asam.org/resources/the-asam-criteria/about**. ■

USPSTF sets the standard for cervical cancer screening

If your practice provides preventive exams for women, you are aware of the current inconsistency in cervical cancer screening guidelines. Whether your professional opinion aligns with the U.S. Preventive Services Task Force (USPSTF), the American College of Obstetricians and Gynecologists (ACOG) or the American Cancer Society (ACS), we are confident that you consider each patient's needs when providing advice and screening.

The national standard used to evaluate the quality and appropriateness of cervical cancer screening is the 2012 USPSTF guideline for average-risk women. This preventive guideline is the basis for annual HEDIS measurement by all health plans reporting HEDIS to NCQA, the metric used by regulatory agencies monitoring the health of populations and the guideline we use to evaluate your practice.

The HEDIS measurement for cervical cancer screening assesses the percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria:

- Cervical cytology performed every 3 years
- Cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Exclusions include women who have experienced a hysterectomy and have no residual cervix, cases of cervical agenesis or acquired absence of cervix at any time in the member's history through the end of the measurement year. Patients in hospice are also excluded from the measurement.

To "measure up" to this national standard, please consider applying it in your practice for care of your Regence patients and BCBS FEP patients. FEP covers preventive screenings with no member out-of-pocket costs. ■

2019 Regence BlueShield medical fee schedule notification

Regence BlueShield (in select counties in Washington) medical providers: We recently sent notification to medical providers in Washington state who are participating with Regence BlueShield about updates to our 2019 fee schedules. If you did not receive a letter, please contact your provider relations representative.

The fee schedules are posted on the Availity Portal at **availity.com**. View the fee schedules using these steps:

1. Select **Payer Spaces** from the menu
2. Select the **Regence logo**
3. Select **Washington** from the list of states
4. Select **Fee Schedule** from the list in the Resources tab
5. Select **Participating and Preferred Fee Schedules**
6. Submit your contracted NPI, provider last name and tax ID number
7. Select your fee schedule from the index of fee schedules

Professional services agreements issued

In June 2018, we began issuing professional services agreements (PSAs) to professional providers (clinics, medical groups and individual providers) practicing under the same tax ID. This replaces our prior process of issuing contracts directly to individuals and allows the PSA to cover all providers under the same tax ID.

The PSA makes it easier for you to add participating providers to your practice, as providers receive approval from the Regence credentialing team, without needing to recontract as a group. The PSA also standardizes our professional provider agreement documents across our service area.

In the coming months, your participating agreement with Regence may be updated to move to the PSA. We hope this streamlined document makes it easier for you to do business with us. ■

Contract and provider effective date policy

Our *Contract and Provider Effective Date* policy applies to all new provider agreements. As a reminder:

- A professional services agreement (PSA) is offered to physicians, dentists, other professional providers, groups and clinics after the credentialing process has been approved and completed.
- The effective date for participation in any given network, or the effective date of a new or renewed agreement, will be limited to the 1st or 15th day of the month depending on when a signed agreement is received:
  - Between the 1st and 15th of the month, the effective date for participation will be the 1st of the following month.
  - Between the 16th and the end of the month, the effective date for participation will be the 15th of the following month.
- A *Provider Information Update Form* should be completed for providers who are already credentialed with us, and who wish to add new location or tax ID. The form is available on our website: Contact Us> Update Your Information.
- Existing provider agreements in which only payment terms are revised or extended will be limited to an effective date of the 1st or 15th of the month, whichever date provides at least 10 business days prior to the effective date of the new agreement terms.
- Notification of a provider joining a delegated credentialing group can be received at any time, and participation effective date is determined by the delegate.

If you have questions about this policy, please contact your provider relations representative. View the policy or learn more about the credentialing process on our website: Contracting and Credentialing>Credentialing. ■

Administrative Manual updates

The following updates were made to our manual.

September 15, 2018

Appeals for Providers

- Corrected the timeframe for submitting an appeal or dispute

October 1, 2018

Alternative Care (Regence Blue Shield [in select counties in Washington] only)

- Removed references to ICD-9

Facility Guidelines

- Updated the information about Medicare Advantage home health quality program
- Added notification and pre-authorization requirements for home health

Medical Management

- Added information about the Livongo for Diabetes program

Our manual sections are available on our website: Library>Administrative Manual. ■

We're here for you

Our Provider Relations and Provider Contact Center teams are dedicated to helping you. Visit the **Contact Us** section of our website for details.

Coding Toolkit updates

Our Coding Toolkit lists our clinical edits and includes information specific to Medicare's National Correct Coding Initiative (NCCI). These coding requirements are updated and posted on a monthly basis in the *Clinical Edits by Code List* in the Coding Toolkit and apply to claims for our commercial products and BlueCard.

We have enlisted the support of Change Healthcare and their claims management solution for ClaimsXten bundling edits. Additional ClaimsXten correct coding edits will continue to be implemented on an ongoing basis. The Coding Toolkit provides a high-level description of the ClaimsXten-sourced edits. These edits are proprietary to Change Healthcare and, therefore, we cannot provide the editing detail.

Our Correct Code Editor (CCE), also located in the Coding Toolkit, has additional CPT and HCPCS code pair edits that we have identified and are used as a supplement to Medicare's NCCI. This supplemental list of code groupings in the CCE is updated quarterly in January, April, July and October. We reserve the right to take up to 30 calendar days to update our systems with CCE updates, CMS-sourced changes and Change Healthcare-sourced changes. Claims received before our systems are updated will not be adjusted.

The Coding Toolkit is available on our website: Claims and Payment>Claims Submission>Coding Toolkit.

We perform ongoing retrospective review on claims that should be processed against our clinical edits. We follow our existing notification and recoupment process when we have overpaid based upon claims processing discrepancies and incorrect application of the clinical edits. View our notification and recoupment process on our website: Claims and Payment>Receiving Payment> Overpayment Recovery.

Please remember to review your current coding publications for codes that have been added, deleted or changed and to use only valid codes. ■

Help our members find you

Our members, BlueCard members and BCBS FEP members rely on the information in our online provider search tool, Find a Doctor, to determine whether physicians, other health care professionals and facilities are included in their health plan's provider network.

When information is missing or inaccurate, members may be denied care or receive unexpected medical bills. We require you to verify your practice information and the networks you participate in at least once every 30 days.

Validate your practice information

Take time now to validate your practice information by following the steps outlined on our website: Contact Us>Update Your Information.

Submit changes or corrections

Please let us know immediately if you have changes to your practice information. Submit the *Provider Information Update Form* or contact your provider relations representative directly for changes as listed on our website: Contact Us>Update Your Information.

Thank you for helping our members connect with you. ■

Publications team

Sara Perrott: Publications editor and writer

Cindy Price: Managing editor and writer

Paula Russell: Designer and writer

Sheryl Johnson: Writer

Jayne Drinan: Writer

Janice Farley: Writer

Regence BlueShield of Idaho