APRIL 2019

The Connection

For participating physicians, dentists, other health care professionals and facilities

Pre-authorization required for elective inpatient admissions

Note from the Editor, 4/13/19: Information below has been updated to reflect that these new pre-authorization requirements will not apply to Blue Cross and Blue Shield Federal Employee Program® (BCBS FEP®) Basic Option, Standard Option and Blue Focus plans in Idaho and Washington.

As a reminder, pre-authorization will be required for all services that occur during an elective inpatient admission. This includes all applicable professional and facility claims received on or after:

- April 1, 2019, for professional services
- May 1, 2019, for facility services

These requirements apply to all Regence plans (group, Individual, Uniform Medical Plan [UMP], Medicare Advantage) and FEP Blue Focus in Oregon and Utah. They do not apply to BlueCard® members outside of our four-state service area or to BCBS FEP Blue Focus, Basic Option and Standard Option members in Idaho and Washington.

Effective July 1, 2019, these requirements will apply to BCBS FEP Basic Option and Standard Option members in Oregon and Utah.

Reviewing inpatient stays, an industry standard, is part of our effort to ensure the member receives the right care in the right setting. An increasing number of procedures that have traditionally been done inpatient can now safely be performed in the outpatient setting for substantially less cost. Pre-authorizing these admissions and professional services helps members and providers:

- For members, it alerts them pre-service to potential liability, which could occur if:
  - The pre-authorization is declined
  - The procedure isn't covered by their benefits
  - They have a procedure at an out-of-network facility
- For providers, it confirms whether the procedure is a covered benefit and is considered medically necessary

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Regence

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the Blue Cross and Blue Shield Association

100 SW Market Street | Portland, OR 97201

Contents

Click on a title below to read the article.

■ Critical update

* Behavioral health must read

We encourage you to read the other articles because they may apply to your specialty.

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Responsibility for the costs of the associated claims will be assigned to the provider or member depending on the denial type. For example, the claim from an assistant surgeon for a cosmetic surgery has an associated claim. The claim from the surgeon is considered the primary claim; the claim from the assistant surgeon is the associated claim.

Professional claims may be reviewed post-payment; if pre-authorization was not obtained, we may request a refund. We will deny claims associated with denied services, including, but not limited to, administrative denials for lack of pre-authorization.

Submitting pre-authorization requests

Pre-authorization requests should be submitted through Availity®'s electronic authorization tool, which will ensure all required information is submitted:

- Pre-authorization requests for professional services must include the facility where the service and admission will occur. Without this information, the facility may not be notified of the pre-authorization.
- Including the facility information will allow us to notify facilities when a pre-authorization request is approved or denied. To confirm a pre-authorization, facilities should request the authorization number from the professional provider.
- You can begin pre-authorizing these services and admissions now. Availity's tool allows you to check the status of your request without having to contact us.

Extenuating circumstances

Extenuating circumstances may prevent a provider from receiving pre-authorization.

Some examples include:

- Member didn't provide or wasn't able to provide Regence coverage information
- Natural disaster
- Member was unable to communicate
- Provider attempted to obtain pre-authorization
- A surgery requiring pre-authorization was performed in an urgent or emergent situation

A complete list of scenarios is available in our *Extenuating Circumstances Policy Criteria Policy*, which is available in the Pre-authorization section of our provider website at **regence.com**.

For more information about the new pre-authorization requirement, read the answers to *Frequently Asked Questions*, which are available on the applicable pre-authorization lists.

Request an electronic authorization—it's easy!

Did you know there's an easy way to check whether pre-authorization is required and to request it? There's no need to call or fax.

Save time by using Availity's electronic authorization tool (online through the Availity Provider Portal at **availity.com**) to:

1. **Find out immediately if a medical service requires pre-authorization.** Simply enter some of the information that is needed, and you can see whether pre-authorization is required. Access the tool on Availity: Login>Patient Registration> Authorizations & Referrals>Authorizations.
2. If pre-authorization is required, just continue and you'll be able to submit your request quickly and easily. **Get a confirmation of receipt immediately.**
3. Check the status of pre-authorization requests you have submitted via the electronic authorization tool by using the Auth/Referral Dashboard. **Some of your requests may be approved the same day!**

Did you know?

- The volume of pre-authorizations submitted through the Availity Portal has almost doubled since December 2018.
- Over 55% of the pre-authorizations submitted through Availity are receiving immediate notification that pre-authorization is not required.
- More than 4,200 requests have been submitted through Availity since it was introduced, resulting in drastically reduced pre-authorization wait times!

Using Availity to submit your pre-authorizations allows you to confirm whether pre-authorization is needed. If a pre-authorization is required, your request is automatically set up for medical review or you will receive an immediate, automated approval for certain requests! **This real-time review replaces the previous fax submission and having to call and wait for a response.**

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 you 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 four Plans, the article 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.

Subscribe today

It's easy to receive email notifications when new issues of the newsletter and bulletin are available. Simply complete the subscription form available in the Library section on our website.

Encourage everyone in your office to sign up.

Share your feedback

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

Stay up to date

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

Easily find information

Did you know that you can search for words in this newsletter by holding down the **Ctrl** key on your keyboard and then the letter **F**? A pop-up window will appear asking if there's a word or phrase you need to find.

Consultants to lead webinars for Utah providers

Regence BlueCross BlueShield of Utah medical providers: Join us at 10 a.m. Thursday, April 11, 2019, to learn about the hot topics addressed in this newsletter.

Our provider consultants plan to discuss the following topics during the 30-minute webinar:

- The May 1, 2019, pre-authorization requirement for facility services during elective admissions
- The July 1, 2019, pre-authorization requirement for applied behavioral analysis (ABA) services
- National Healthcare Decisions Day and National Drug Take-Back Day
- Viewing reimbursement schedules on Availity
- Joining our medical policy discussions
- Referring to in-network providers

You can submit questions throughout the webinar via the chat box.

To register for the webinar, send an email to **ProviderRelationsUtah@regence.com** with the subject line "Webinar RSVP".

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.

Regence BlueShield lunch and learn webinars

Regence BlueShield (in select counties in Washington) medical providers: Below is the schedule for our April, May and June lunch and learn webinars held on the following Thursdays from noon to 12:30 p.m. (PT).

Date	Topic
April 4, 2019	Medicare Quality Incentive Program
April 18, 2019	BlueCard Program
May 2, 2019	Medical and reimbursement policies
June 6, 2019	Claims and the Coding Toolkit

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.

Appointment accessibility results

Last autumn, we conducted a *Provider Access and Experience Survey* of primary care providers, behavioral health providers and providers in high-volume specialties. A portion of the survey was related to patient appointment access. Your answers helped us measure compliance with our published standards for after-hours phone coverage, office wait times and appointment wait times for various types of visits. Overall, we found that members' access to appointments has improved and meets or exceeds our standards.

After-hours phone coverage

Based on the survey results, it appears that many providers are not meeting our requirement that you provide clear direction about how patients may access care when your office is closed. If you do not have a live answering service, a recorded message that directs patients to call 911 or to go to the nearest emergency room for life-threatening emergencies **must** also include instructions about how to reach the practitioner on-call outside your regular office hours. Please review this standard and take action if needed to be sure patients are accurately informed about how to obtain care when your office is closed.

Access to behavioral health care

The survey also showed us that patient access to behavioral health appointments is improving but providers continue to have difficulty meeting our standards for appointment access. We recognize the growing demand for behavioral health services and are working to improve the availability of these services for our members who need care.

Our appointment access standards for behavioral health care are guided by the National Committee for Quality Assurance (NCQA) standards and include the following timeframes:

- Care for a non-life-threatening emergency or patient crisis within six hours
- Urgent patient situations or conditions within 48 hours
- Initial visit for routine care within 10 business days
- Follow-up care appointments within 10 business days

Please take steps to ensure your office provides patient appointments within these timeframes.

All our standards are published on our website: Programs>Cost and Quality>Quality Program> Accessibility and Availability Standards.

Pre-authorization updates

Commercial Pre-authorization List updates

Procedure/medical policy	Adding codes effective July 1, 2019
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorders	CPT 0362T, 0373T, 97151-97158
eviCore; speech and occupational therapy	HCPCS G0515

Uniform Medical Plan (UMP) Pre-authorization List updates

Procedure/medical policy	Adding CPT code effective July 1, 2019
ABA therapy	97151 (pre-authorization is not required for initial assessments but is required for reassessments)

Medicare Pre-authorization List updates

Procedure/medical policy	Adding HCPCS code effective July 1, 2019
eviCore; speech and occupational therapy	G0515

New pre-authorization forms

New pre-authorization request forms have been created to improve request response time by being customized to the needs of specific specialties:

- Medical services
- Behavioral health services
- Durable medical equipment
- Medicare home health services
- Skilled nursing facility, long-term acute care and inpatient rehabilitation

The new forms include the option to provide the treating provider's contact information should a reviewing physician need a peer-to-peer discussion prior to a determination being made. Our goal is to reduce provider appeals when a quick peer-to-peer conversation could provide additional necessary information. The new forms are available on our pre-authorization lists.

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 *Request an electronic authorization—it's easy!* on page 2.

ABA services will require pre-authorization

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Starting July 1, 2019, pre-authorization will be required for applied behavioral analysis (ABA) services. This change will apply to all lines of business, including BCBS FEP members.

We are making this change to:

- Standardize pre-authorization requirements across lines of business
- Continue to advocate for quality of care for our members with autism spectrum disorder
- Support our members with ongoing care needs and providers through case management

View our *Applied Behavioral Analysis for the Treatment of Autism Spectrum Disorders* (Behavioral Health #18) medical policy, available in the *Medical Policy Manual* on our website: Library> Policies and Guidelines>Medical Policy.

New medical necessity criteria for psychiatric and eating disorders

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Our new internally developed medical necessity criteria for psychiatric and eating disorders will be effective May 1, 2019. The criteria will be used in place of MCG criteria and will allow us to provide greater transparency to our members and providers about how coverage determinations are made while remaining current with clinical evidence and literature.

The new medical policies address psychiatric and eating disorders for the following services:

- Eating Disorder Inpatient Treatment (#25)
- Eating Disorder Intensive Outpatient (#26)
- Eating Disorder Partial Hospitalization (#27)
- Eating Disorder Residential Treatment (#28)
- Inpatient Psychiatric Hospitalization (#29)
- Psychiatric Intensive Outpatient (#30)
- Psychiatric Partial Hospitalization (#31)
- Psychiatric Residential Treatment (#32)

Note: We use the American Society of Addiction Medicine (ASAM) criteria for substance use disorders.

These policies are available on our website: Library>Policies and Guidelines>Medical Policy. We will continue using MCG criteria until the May 1, 2019, effective date of these policies.

We provided 90-day notice in the February 2019 issue of *The Bulletin* about these new medical policies.

You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our website: Library>Bulletins.

The *Medical Policy Manual* includes a list of recent updates and archived policies: Library> Policies and Guidelines>Medical Policy> Recent Updates.

Non-reimbursable services

Our *Non-Reimbursable Services* (Administrative #107) reimbursement policy, which explains invalid 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.

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 the Centers for Medicare & Medicaid Services (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.

Clinical Practice Guideline update

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.

We reviewed the *Chronic Obstructive Pulmonary Disease (COPD)* Clinical Practice Guideline, effective February 1, 2019. We continue to endorse the Global Initiative for Chronic Obstructive Lung Disease (GOLD) recommendations for the diagnosis, management and prevention of chronic obstructive pulmonary disease.

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

Medical policy reviews

Our medical policies are reviewed for the following reasons:

- Updates from CMS
- Regularly scheduled review
- Changes in published scientific literature
- Requests from physicians, other health care professionals or facilities
- Addition, deletion or revision of codes published in the CPT, HCPCS and ICD-10 manuals

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 change
Administrative	**Effective April 1, 2019**
Ambulance Guidelines (#121)	- Revised definitions section to define "the vehicle" as any vehicle designed and equipped to respond to medical emergencies and capable of transporting members with acute medical conditions - Added definition for ground ambulance - Removed modifier QL from secondary modifiers list and moved it to the list of modifiers eligible for reimbursement
Medicine	**Effective April 1, 2019**
Maternity Care (#107)	- Clarified that routine lactation services are included in postpartum and global maternity care - Clarified that if the prenatal record is not initiated during the confirmatory visit, then the confirmatory visit may be separately reported - Clarified that once the pregnancy is confirmed, any preventive screening or exam service will be considered part of the initial or subsequent obstetrics visit - Added CPT 59610 to the list of global maternity package codes - Clarified that for global maternity care, modifier 22 is appropriate when **any** of the conditions are met
Medicine	**Effective May 1, 2019**
New Patient Visit (#101)	- Clarifying "any professional services" to mean an evaluation and management (E&M) service or other face-to-face services - Clarifying that if a provider has seen the patient within the past three years and then joins a different group practice or goes to a private practice and the patient follows, the provider should assign an established E&M code for the services provided

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Updated policies	Description of change
Administrative	**Effective July 1, 2019**
Implants, Implant Components, Medical and Surgical Supplies for All Surgical Procedures (#125)	- Updating policy title to emphasize that existing supply language applies to all surgical procedures - Expanding the definition of “implant” to include temporary (provisional and external fixation) devices - Adding definition of “medical and surgical supplies” - Adding definition of “provisional implants” - Clarifying that provisional/temporary implants will not be separately reimbursed when they are removed for permanent implant placement - Adding a new subsection “Medical and Surgical Supplies” to call out non-reimbursable supplies for **all** surgical procedures (not just supplies for implant procedures); additional language added to specify that this applies based on provider contract - Adding guide wires to the list of non-reimbursable supplies

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.

Pre-authorization: Submit medication pre-authorization requests through **covermymeds.com.**

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 **MedicationPolicy@regence.com** and indicate your specialty.

New 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 the CMS has designated as PNA before they become ineligible for reimbursement. **Related**: See *Non-reimbursable services* on page 7.

New medication policies	Effective date	Description
Abortive medications for Migraines, dru576	April 1, 2019	- Replaces dru475 (triptan products) and dru477 (ergot alkaloid products) - Use of more than 12 doses of butalbital-containing products per month is considered not medically necessary and is not covered
Arikayce, amikacin liposome inhalation suspension, dru572	April 1, 2019	- Limits coverage to patients with amikacin-susceptible, treatment refractory Mycobacterium avium complex (MAC) lung disease, when lower-cost conventional amikacin (generic amikacin injection) is ineffective, is not tolerated or use is contraindicated
Azedra, Iobenguane I 131, dru574	April 1, 2019	- Pre-authorization required only when used for treatment; use of Azedra for diagnosis does not require pre-authorization - Limits coverage to iobenguane scan positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma that require systemic anticancer therapy
Copiktra, duvelisib, dru573	April 1, 2019	- Considered not medically necessary and is not covered
Galafold, migalastat, dru575	April 1, 2019	- Limits coverage to patients with Fabry with an amenable GAL mutation in whom agalsidase beta (Fabrazyme) has been ineffective, is not tolerated or use is contraindicated
Libtayo, cemiplimab-rwlc, dru565	April 1, 2019	- Limits coverage to patients with cutaneous squamous cell carcinoma (cSCC)
Lumoxiti, moxetumomab pasudotox-tdfk, dru564	April 1, 2019	- Limits coverage to patients with relapsed or refractory hairy cell leukemia

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New medication policies (continued)	Effective date	Description
Onpattro, patisiran, dru577	April 1, 2019	- Limits coverage to patients with a confirmed diagnosis of hATTR (by genetic testing) when there is documented functional impairment because of polyneuropathy - Added to the Site of Care Program; when administered by a health care professional, this medication must be given at an approved location
Orilissa, elagolix, dru580	April 1, 2019	- Limits coverage to women with moderate to severe pain associated with endometriosis who have had prior treatment with less-costly first-line standard-of-care options
Oxervate, cenegermin-bkbj, dru578	April 1, 2019	- Limits coverage to patients with stage II or III neurotrophic keratitis
Poteligeo, mogamulizumab-kpkc, dru562	April 1, 2019	- Limits coverage to patients with relapsed or refractory mycosis fungoides and Sézary syndrome
Talzenna, talazoparib, dru566	April 1, 2019	- Limits coverage to patients with recurrent or metastatic, BRCA-mutated, HER2-negative breast cancer; this parallels coverage of olaparib (Lynparza) in this setting, as well as National Comprehensive Cancer Network (NCCN) guidelines
Tegsedi, inotersen, dru579	April 1, 2019	- Limits coverage to patients with a confirmed diagnosis of hATTR (by genetic testing) when there is documented functional impairment due to polyneuropathy
Tibsovo, ivosidenib, dru558	April 1, 2019	- Limits coverage to patients with relapsed or refractory AML when an IDH1 mutation is present
Vizimpro, dacomitinib, dru581	April 1, 2019	- Limits coverage to patients with untreated metastatic EGFR-mutated (exon 19 deletion and exon 21 [L858R] substitution) NSCLC
Non-preferred pegfilgrastim Products, dru563	July 1, 2019	- This policy will now be effective July 1, 2019, with the changes below; we previously communicated that this policy would be effective April 1, 2019 - Pre-authorization will be required for Neulasta PFS, Neulasta OnPro and Fulphila PFS; Udenyca will not require pre-authorization - **Fulphila PFS**: Limits coverage to patients who have a documented medical rationale that Udenyca is not a treatment option - **Neulasta PFS**: Limits coverage to patients who have a documented medical rationale that Udenyca and Fulphila are not treatment options - **Neulasta Onpro**: Limits coverage to patients who have a documented medical rationale which impairs the ability to administer the drug at home with a PFS *and* they live greater than a certain distance from the provider's office

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Revised medication policies	Effective date	Description
abiraterone-containing medications, dru252	April 1, 2019	- Added Yonsa, a new formulation of abiraterone
Adcetris, brentuximab Vedotin, dru264	April 1, 2019	- Removed requirement for prior therapy for use in pcALCL - Added coverage for the following subtypes of CD30-expressing PTCL: sALCL, PTCL (NOS) and AITL
Alpha-1 proteinase inhibitors, dru382	April 1, 2019	- Added requirement for pretreatment AAT serum levels
Cycle Management Program, dru404	April 1, 2019	- Added Imbruvica, Zytiga and Xtandi to the cycle management program
Enzyme Replacement Therapies, dru426	April 1, 2019	- Added Revcovi, a newly FDA-approved product - Added to the Site of Care Program; when administered by a health care professional, this medication must be given at an approved location
Extended-release (ER) Opioid Medication Products for Pain, dru515	April 1, 2019	- Removed requirement for documentation of PDMP check and urine drug screen
Immediate-release (IR) Opioid Medication Products for Pain, dru516	April 1, 2019	- Removed requirement for documentation of PDMP check and urine drug screen
Repatha, evolocumab, dru407	April 1, 2019	- Repatha manufacturer launched new NDCs at a significant discount; there are no differences between these new NDCs and the previous ("legacy") NDCs - Legacy NDCs are considered not medically necessary and are not covered
Site of Care Review, dru408	April 1, 2019	- Onpattro and Revcovi added to the Site of Care Program; when administered by a health care professional, these medications must be given at an approved location
Tecentriq, atezolizumab, dru463	April 1, 2019	- Added coverage criteria for use in the front-line treatment of SCLC based on new Phase 3 data
Venclexta, venetoclax, dru462	April 1, 2019	- Added coverage criteria for AML and combination use with rituximab in CLL/SLL, two newly FDA-approved indications

Pharmacy timely response reminder

When a pre-authorization request or an appeal is submitted for a member's prescription medication, we review the patient's clinical documentation to ensure that the coverage criteria are met.

If the documentation is incomplete, we will request additional information from the prescribing provider and do the following to ensure that a timely coverage determination can be made:

- Outline the information that is missing and the additional documents that are required
- Contact you within two calendar days of the initial pre-authorization request; for expedited requests, we will attempt to contact you immediately
- Make up to three attempts to contact you

For Medicare patients, if we do not receive the additional requested information promptly, the request may be automatically forwarded to a third-party independent review organization for review. This can cause unnecessary frustration and may delay authorization of the requested treatment.

When you receive a request for additional information for prescription medication pre-authorizations or appeals, please respond promptly to ensure that a timely and accurate coverage determination can be made for your patient.

Pregnancy and postpartum support

Sometimes it takes help beyond what is done in the provider's office to meet a patient's needs during pregnancy and after delivery. Programs available to Regence and BCBS FEP members are included below.

BabyWise

Pregnant members have access to education and support through our maternity program, BabyWise. Our maternity nurses provide patient education, decision support and information about community resources. We also follow up with new mothers to schedule postpartum appointments at two weeks and six weeks after delivery. This is the timeframe supported by national standards of care and measured for the Healthcare Effectiveness Data and Information Set (HEDIS).

Additional information about the BabyWise program is available on our website: Programs> Medical Management>Member Programs.

Pregnancy Care Incentive Program

Pregnant members on the BCBS FEP Standard and Basic Option products may be eligible to participate in the FEP Pregnancy Care Incentive Program to receive online support and incentives throughout their pregnancy.

With the Pregnancy Care Incentive Program, expectant members earn a free Pregnancy Care Box filled with items that help support a healthy pregnancy. Members will receive the Pregnancy Care Box when they complete the Blue Heath Assessment and enroll in the My Pregnancy Assistant tool in the MyBlue® member portal. Members can also earn $75 on their MyBlue Wellness Card when they have a first trimester prenatal doctor's visit. Additional information on this FEP incentive program, as well as helpful resources and healthy pregnancy tips, can be found at **fepblue.org/wellness-resources-and-tools/incentive-programs/pregnancycare**.

BCBS FEP members in Oregon and Utah who are pregnant and have diabetes are also eligible for the enhanced support of the Livongo Diabetes Management program. The program supports improved diabetes management and provides members with free supplies (strips and lancets, plus a blood glucose monitor). Members can call the Customer Service phone number listed on the back of their member ID card to learn more about the program.

Home pregnancy tests and global billing make it difficult for us to identify our members who are pregnant. To help members get the prenatal and postpartum attention they need, encourage them to contact us or **fepblue.org** to learn about the maternity programs that are available.

Oregon mandate for diabetes during pregnancy

Oregon members who are pregnant may be eligible to receive medically necessary services, medications and supplies for the management of diabetes during pregnancy through six weeks postpartum without member cost-sharing. Learn more about this benefit and how to refer your patient for coverage on our website: Programs>Medical Management> Diabetes Management.

April health awareness activities

World Health Day

April 7 marks the annual celebration of World Health Day. Since being created in 1950, two years after the World Health Organization's (WHO's) First Health Assembly, the celebration aims to promote annual awareness of a health area of concern for the WHO.

The celebration serves as an opportunity to focus worldwide attention on important aspects of global health, such as diabetes, blood pressure, mental health, and maternal and child care. The theme for 2019 is universal health coverage with an aim to help ensure that everyone can get the care they need when they need it. More information about this year's campaign is available at **who.int/campaigns/world-health-day/world-health-day-2019**.

World Immunization Week

World Immunization Week—celebrated the last week of April—aims to promote the use of vaccines to protect people of all ages against disease. Immunization saves millions of lives every year and is widely recognized as one of the world's most successful and cost-effective health interventions. Yet nearly 20 million children in the world are unvaccinated or under-vaccinated.

This year's theme is *Protected Together: Vaccines Work!* The campaign will celebrate vaccine heroes from around the world—from parents and community members to health care providers and innovators—who help ensure protection through vaccines. More information about this year's campaign is available at **who.int/news-room/events/detail/2019/04/24/default-calendar/world-immunization-week-2019**.

We appreciate your efforts to encourage your patients whose vaccination statuses are not current to come in for immunizations.

National Drug Take-Back Day

The Drug Enforcement Administration (DEA) sponsors two National Prescription Drug Take-Back days each year. We encourage our members to take advantage of the next opportunity to dispose of unused or expired prescription medications on April 27, 2019.

If your office doesn't have a collection site, we've teamed up with Walgreens by sponsoring safe medication disposal kiosks in certain Walgreens stores. The list of Walgreens with kiosks is available at **walgreens.com/topic/pharmacy/safe-medication-disposal.jsp**. The DEA also offers a list of year-round collection sites nationwide at **apps.deadiversion.usdoj.gov/pubdispsearch**.

We support safe disposal of prescription medications, particularly opioids. Opioid abuse is a public health crisis, and our communities are affected. The *National Survey on Drug Use and Health* in 2015 showed that most abused prescription medications were obtained from family and friends—often from a home medicine cabinet, according to the DEA.

We are committed to helping decrease opioid abuse while supporting appropriate pain management for our members who can benefit from opioid treatment. To help support you as you care for patients needing pain management or who are struggling with opioid addiction, we have created a Pain Management Toolkit that includes guidelines, tools and resources for intervention strategies and treatments. The toolkit is available on our website: Programs>Pharmacy> Pain Management Toolkit.

National Healthcare Decisions Day

National Healthcare Decisions Day (NHDD), observed annually on April 16th, exists to inspire, educate and empower the public and providers about the importance of advance care planning.

We encourage you to begin or continue advance care planning (ACP) conversations with all your patients. We reimburse providers for ACP conversations with any member, regardless of age or health status, across all plans, except BCBS FEP. Submit claims for ACP conversations using CPT 99497 for the first 30 minutes and CPT 99498 for subsequent 30-minute increments, separately from all other services performed in the same visit. You can actively engage your patients at any time. *Note*: If your patient is a BCBS FEP member, please refer to the Blue Cross Blue Shield Service Benefit Plan brochure for more information, available at: **fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms**.

Conversations with your patients without a serious illness diagnosis can be about:

- Conducting ACP conversations
- Reviewing family history health issues
- Encouraging your patients to get their recommended health screenings

Conversations with your patients who are dealing with a serious illness diagnosis can focus on:

- Reviewing previous ACP conversation notes
- Helping your patients determine the necessary legal documents for your state, such as advance directives, power of attorney and, if warranted, a *Physician Orders for Life-Sustaining Treatment* (POLST) form in Oregon, Utah and Washington or a *Physician Orders for Scope of Treatment* (POST) form in Idaho

Visit these websites for more information:

- NHDD: **nhdd.org**
- National POLST Paradigm: **polst.org**
- The Conversation Project: **theconversationproject.org**
- The National Hospice and Palliative Care Organization: **caringinfo.org**
- The American Bar Association's Commission on Law and Aging: **americanbar.org/groups/law_aging/resources**

Learn about our Personalized Care Support program and our members' benefits on our website: Programs>Medical Management> Personalized Care Support.

Administrative Manual updates

The following updates were made to the Medical Management section of our manual on April 1, 2019:

- Added O.C. Tanner to the list of members participating in the Livongo Diabetes Management program
- Added information about the new *Pharmacy Peer-to-Peer Review Request* form to be used to request a conversation with a clinical reviewer about the denial of a pre-authorization request for a provider-administered medication

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

Are you?

- ✓ **Including National Drug Codes (NDCs) on all medical drug claims**: Effective with claims received on or after March 1, 2019, NDCs must be included on medical drug claims with a HCPCS code that starts with "J." Claims billed with a J code that do not have NDC information will be rejected with a request to complete the additional claim fields. Learn more on our website: Claims and Payment> Claims Submission>Medication Claims.

- ✓ **Viewing reimbursement schedules on Availity**: You can view our reimbursement schedules (formerly known as fee schedules) on the Availity Provider Portal at **availity.com**. View the schedules using the steps below:

  1. Select **Payer Spaces** from the menu.
  2. Select your **Regence Plan** from the drop-down list of logos.
  3. Select the applicable reimbursement schedule from the list of **Resources**.

- ✓ **Interested in joining our medical policy discussions**: We welcome your input and feedback as we draft our medical policies. Join our email reviewer list to provide input as policies are developed. Our formal process also allows you to submit additional information, such as clinical trial results, that may warrant a policy review. Sign up at **assets.regence.com/trg/contact/index.html**.

Compliance for board and/or trustee members

We contract with CMS to provide health care services to members with coverage through our Medicare Advantage Plans, Medicare Part D prescription drug products and the exchanges through the Qualified Health Plans (QHP). Through these contracts, we must oversee the first-tier, downstream and related entities (FDRs) and downstream and delegated entities (DDEs) that assist us in providing services for our Medicare and QHP beneficiaries.

We would like to remind you that your organization's board or trustee members are required to participate in all Regence Government Programs compliance activities, including:

- Signing a conflict of interest disclosure at appointment and annually thereafter
- Completing fraud, waste and abuse (FWA) and general compliance training within 90 days of appointment and annually thereafter
- Completing Office of Inspector General (OIG) and General Services Administration (GSA) screenings prior to appointment and monthly thereafter

Documentation must be maintained and made available upon request by either Regence or CMS. Please refer to our *Government Programs Compliance Tips* for a list of all requirements: Library> Printed Material.

For additional information regarding our compliance program and related resources, including training links, please visit our website at **www.regence.com/fdr-resources**.

Make sure our members can find you

Our 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.

We require verification of 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 these steps:

1. Visit Find a Doctor from any page on our website. The link is located on the lower right side of every page.
2. Type the provider's last name, first name in the search field.
3. Verify demographic information for each location.
4. Verify whether the provider is accepting new patients or offering telehealth services at each location.
5. Confirm that patients can make appointments to be seen at each location listed for that provider.
6. Select the link for Networks Accepted to verify which networks apply for each provider at each location. You may need to review multiple types of networks (medical, dental or Medicare).

Ensuring your information is up-to-date and accurate helps our members find you, including BCBS FEP members. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

Verifying your information in our provider search tool is also a requirement for compliance with CMS, the Affordable Care Act (ACA) and your agreement as a participating provider. The CMS memo regarding these requirements is available 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,* available on the Contact Us page of our website, for the following changes:

- Specialty
- Phone number
- Organization address
- Accepting new patients
- Offering telehealth services
- eContracting email address
- Practice data validation email address
- National Provider Identifier (NPI) number
- Providers joining or leaving your clinic or practice
- Changing where your payments should be directed
- Changing your tax ID number (include a copy of your 147c letter from the IRS)

Contact your provider relations representative directly to let us know about any of the following changes:

- Closing a practice
- Changing organization ownership
- Terminating a network affiliation for any reason

If your clinic or facility emails monthly provider rosters to us, please submit changes, corrections, additions or terminations immediately so we can update the information that is displayed in our online directories as soon as possible. Your roster must be reviewed and validated in its entirety at least once per quarter and you must reply to any requests for roster review.

Respond to directory audits

We routinely audit the information in our provider database. **Please respond to any requests from us for validation of your provider directory information**. Even if the information we have is accurate, we need your response for confirmation.

Thank you for helping our members connect with you.

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.

Referring to in-network providers

As a reminder, except in cases of an emergency, you must refer members to participating in-network dental and medical providers, including laboratories.

Referring members to in-network providers is critical for our exclusive provider organization (EPO) members. EPO members in Idaho have limited out-of-network coverage and are responsible for 90 percent of out-of-network costs. In Oregon, Utah and Washington, EPO members are responsible for 100 percent of out-of-network costs.

Making referrals to in-network providers and facilities helps your patients make more informed choices about how they spend their health care dollars. By staying in-network, your patients will:

- Minimize their out-of-pocket expenses
- Receive the highest level of medical and dental benefits
- Ensure that they have convenient access to quality services

Referrals to non-participating providers should only be made after notifying the member in writing that services may not be covered or may result in higher out-of-pocket costs. *Note*: BCBS FEP Basic Option, FEP Blue Focus, and our Medicare Advantage HMO product have only in-network benefits.

Use the Find a Doctor tool on our website to verify your participation and locate in-network providers. Locate providers by name, location or specialty type.

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.

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