The QSC initiative has consistently served as a forum for prominent medical leaders to share best practices.
Advanced Imaging Quality Initiative — Achieving Appropriate Utilization

Premera is working with our network providers to establish imaging management practices that align services with evidence-based standards of care. Our goal is to achieve appropriate utilization of advanced imaging scans without implementing a prior authorization program. This is why Premera implemented the Advanced Imaging Quality Initiative (AIQI) in partnership with American Imaging Management and their RQI process.

Premera seeks to achieve an appropriate balance in imaging in order to address patient safety concerns about unnecessary exposure to radiation, align imaging with evidence-based care, and do our part to control costs and support more affordable healthcare.

This initiative has been in place since July 7, 2008. We are continuing to reach out to providers and work with administrative staff throughout 2009 to achieve these goals.

If you are a referring provider, you can simplify the process by having the necessary clinical information on hand:
- Diagnosis - suspected or confirmed
- Symptoms (including duration, frequency and intensity)
- Treatment (including duration and type)

Premera recognizes that with lower premium and high-deductible plans, patient out-of-pocket costs continue to rise, and the burden of billing and collecting these costs falls on the providers of care. Historically, providers have had to wait until after they receive insurance payment to bill patients, often causing confusion for patients and long delays in settling accounts. Increasingly, consumers want to know their financial responsibility for medical procedures in advance or at the time of service.

In response, Premera is delivering new user-friendly, web-based technology to providers and office personnel that calculates the patient’s share of cost at the point of service.

Real-time Estimates

Providers also have the option of using the tool to submit real-time claims. Providers enter patient information and service details, such as procedure and diagnosis codes. Estimates are calculated in real-time to ensure accuracy; the calculation response is delivered within seconds based on:
- Contract pricing for each specific physician or provider
- Patient eligibility and benefit plan
- Patient current deductible, coinsurance or copay
- All accumulators met to date and out of pocket maximum

Benefits to the Provider

Using the tool, providers and office personnel can print a copy of the estimate for their patients that clearly explains how the patient share of cost was calculated.

This new web-based tool will be available mid-2009 to support the reduction of provider administrative and collection expenses.

Please watch for future announcements about this innovative and exciting new technology.
Federal Employee Health Benefits Program
Standard Option Plan

Mental Health/Substance Abuse Benefit Change

Premera would like to inform you of a new Mental Health/Substance Abuse (MHSA) benefit change requirement for the 2009 Federal Employee Health Benefits Program (FEHBP) Standard Option Plan. Effective Jan. 1, 2009, the FEHBP Standard Option Plan requires prior approval for all outpatient MHSA services for an in-network benefit.

What does this change mean for you?

› Prior approval is required before any visits (requirement mirrors current Basic Option plan). Prior to January 1, a Mental Health Treatment Plan was only required prior to the 9th visit. Prior approval may be obtained in either of the following ways:
  • Over the phone by calling 1-800-622-1379;
  • Submission of written data (i.e. chart notes, etc.);
  • A written treatment plan. Documents can be submitted by fax to 1-800-866-4198 or 1-800-843-1114, or by mail to BCBS Federal Employee Program Attn: Behavioral Health (PO Box 34299 – MS 438 Seattle, WA 98124-1299).
› Copayment charge for any office visit will be $20.00.

Is there anything else you should be aware of?

› The patient, patient-representative, or provider of service may obtain prior approval.
› The patient is ultimately responsible to ensure that prior approval is obtained prior to the service. The patient can do this by calling the mental health and substance abuse phone number listed on the back of their ID card.
› If prior approval is not obtained, the claim will process at the non-participating benefit rate through the 25th visit. After the 25th visit, the claim will deny as patient responsibility.
› Psychological Testing benefits will not change and will not require prior approval.
   If you have additional questions, please call the Federal Employee Program Customer Service at 1-800-562-1011.

Treating Self and Family Members

Premera follows many Medicare guidelines. Similar to Medicare, we do not reimburse for professional services or supplies that are usually provided free because of the relationship to the patient.

As a reminder, we do not reimburse physicians, providers, or suppliers who are Premera members, for professional services for any of the following when services are:

› Performed on themselves
› Rendered to family members residing in the home
› Provided to individuals related to them by blood, marriage, or adoption.

If you have questions, please call Physician and Provider Relations at 1-877-342-5258, option 4.

Claims Editing Updates (WA)

We are committed to providing you with the best possible customer service to support efficiency and claims payment accuracy. With this in mind, we routinely update the claims editor each quarter with the latest industry standard claim codes and code-to-code combinations.

The editor was recently updated to include all new codes as of January 2009. The next update will be April 2009. These quarterly updates allow us to keep pace with industry technology and coding changes, stay current with CPT and other related standards, and help pay claims correctly and timely. The software is applied to all professional claims for our commercial products and individual plans.

Changes to our editing software are supported by industry standards that include Centers for Medicare and Medicaid Services (CMS), Medicare Correct Coding Initiative (CCI), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and other specialty society directives or publications.

If you have questions about this article, please contact Physician and Provider Relations at 1-877-342-5258, Option 4. For claims related questions, please call the Customer Service phone number on the back of the member’s ID card.

Final payment is subject to the plan’s fee schedule, payment policies and the member’s eligibility, coverage benefit limits at the time of service.
Physicians, Providers and Office Staff

Premera medical policies are guides in evaluating the medical necessity of a particular service or treatment. We adopt policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, we reserve the right to review and update our policies as appropriate. When there are differences between the member's contract and medical policy, the member's contract prevails. The existence of a medical policy does not guarantee that the member's contract allows the service. Note: When a policy is deleted, this means it is removed from the website and is no longer maintained or available for reference.

Medical policies are available on premera.com/provider. Go to the Library and click on Reference Info, and then Medical Policies. If you would like a copy of a particular medical policy and are unable to obtain it from the website, email your request to medicalpolicy@premera.com. If you do not have Internet access, you may call the Provider Relations team in your region at 1-877-342-5258, option 4.

**Note: All policy numbers begin with CPMP.**

The following policy changes are effective for dates of service of May 4, 2009, and later, instead of October 14, 2008, as stated in the copy you received in the mail:

<table>
<thead>
<tr>
<th>BC.2.01.07</th>
<th>Psoralens with Ultraviolet A (PUVA). This policy has been deleted and replaced with PR.2.01.518.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR.2.01.518</td>
<td>Psoralens with Ultraviolet A (PUVA). New Policy. PUVA may be considered medically necessary to treat severe, disabling psoriasis, which is not responsive to other forms of conservative therapy (e.g., topical corticosteroids, coal tar preparations, and ultraviolet light) and results in a physical functional impairment. In the absence of a physical functional impairment, PUVA is considered not medically necessary to treat psoriasis. PUVA is also considered not medically necessary to treat vitiligo since this condition does not result in a physical functional impairment.</td>
</tr>
</tbody>
</table>

The following policy changes are effective for dates of service of October 14, 2008, and later:

<table>
<thead>
<tr>
<th>BC.2.01.49</th>
<th>Water-induced Thermotherapy as a Treatment of Benign Prostatic Hypertrophy. This policy has been deleted and will no longer be reviewed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC.2.02.14</td>
<td>Transcoryonary Ablation of Septal Hypertrophy (TASH). This policy has been deleted and will no longer be reviewed.</td>
</tr>
<tr>
<td>BC.5.01.14</td>
<td>Combined Androgen Blockade for the Treatment of Metastatic Prostate Cancer. This policy has been deleted and will no longer be reviewed.</td>
</tr>
<tr>
<td>PR.5.01.514</td>
<td>HER2 Inhibitors. Policy title changed from Off-label Uses of Trastuzumab to HER2 Inhibitors. Policy statement revised. Use of trastuzumab (Herceptin®) or lapatinib (Tykerb®) may be considered medically necessary for treatment of any state of breast cancer that over-expresses HER2/neu. (HER-2 over-expression may be confirmed by immunohistochemistry, FISH or by both. Documentation of a positive test – by at least one of these methods – should be present in order to establish medical necessity.)</td>
</tr>
<tr>
<td>BC.6.01.07</td>
<td>Transcranial Doppler Ultrasound. This policy has been deleted and replaced with PR.6.01.517.</td>
</tr>
<tr>
<td>PR.6.01.517</td>
<td>Transcranial Doppler Ultrasound. New Policy. Transcranial doppler ultrasound may be considered medically necessary for several indications including assessing cerebral circulatory arrest as a measure of brain death. Transcranial doppler ultrasound is considered investigational for all other indications.</td>
</tr>
<tr>
<td>BC.7.01.53</td>
<td>Transjugular Intrahepatic Portosystemic Shunt (TIPS). This policy has been deleted and will no longer be reviewed.</td>
</tr>
<tr>
<td>AR.7.01.61</td>
<td>Transcatheter Closure of Patent Ductus Arteriosus. This policy has been deleted and will no longer be reviewed.</td>
</tr>
<tr>
<td>PR.7.01.503</td>
<td>Reduction Mammooplasty. Policy statement revised. In the absence of a demonstrated physical functional impairment or not meeting the Schnur Sliding Scale requirement for minimum breast tissue to be removed, reduction mammoplasty is considered not medically necessary.</td>
</tr>
<tr>
<td>PR.7.01.516</td>
<td>Morbid Obesity Surgery. Policy statement added. Biliopancreatic bypass with duodenal switch (CPT 43845) is considered medically necessary in the treatment of morbid obesity that has not responded to conservative measures such as supervised diet, exercise and behavior modification programs.</td>
</tr>
<tr>
<td>BC.7.01.108</td>
<td>Artificial Intervertebral Disc: Cervical Spine. This policy has been deleted and replaced with PR.7.01.537.</td>
</tr>
</tbody>
</table>
| PR.7.01.537 | Artificial Intervertebral Disc: Cervical Spine. New Policy. FDA-approved prosthetic intervertebral discs (e.g. the Prestige Cervical Disc, ProDisc-C Total Disc Replacement) may be considered medically necessary for certain indications. Prosthetic intervertebral discs are considered investigational in patients.
with isolated axial neck pain without cervical radiculopathy or myelopathy; or when requested adjacent to a prior fusion; or when more than one level is requested.

**BC.8.01.04 Oncologic Applications of Interleukin-2 (aldesleukin) when Used as Monotherapy.** This policy has been deleted and will no longer be reviewed.

**BC.8.01.26 Hematopoietic Stem Cell Transplantation for Acute Myelogenous Leukemia.** Policy description and rationale extensively updated.

The following policy changes are effective for dates of service of November 11, 2008, and later:

<table>
<thead>
<tr>
<th>Policy Code</th>
<th>Policy Title</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **PR.8.03.500** | Sensory Integration Therapy | Policy statements revised. Sensory integration interventions may be considered medically necessary when specifically targeted.
| **BC.8.01.24** | Hematopoietic Stem Cell Transplant for Miscellaneous Solid Tumors in Adults | Policy description and rationale extensively updated.
| **BC.8.01.25** | Hematopoietic Stem Cell Transplant for Autoimmune Diseases | Policy description and rationale extensively updated. Autologous or allogeneic stem cell transplant is considered investigational as a treatment of autoimmune diseases, including but not limited to multiple sclerosis (MS), rheumatoid arthritis (RA), systemic lupus erythematosus (SLE) and systemic sclerosis/scleroderma.
| **BC.8.01.30** | Hematopoietic Stem Cell Transplantation for the Treatment of Chronic Myelogenous Leukemia | Policy description and rationale extensively updated. Policy statements added. Allogeneic stem cell transplantation is investigational to treat AML relapsing soon (6 months or less) after prior therapy with high-dose chemotherapy and autologous stem-cell support.
| **PR.8.01.521** | Selective Internal Radiation Therapy for Primary and Metastatic Tumors of the Liver | New Policy. Selective internal radiation therapy may be considered medically necessary for either: the treatment of liver metastases and as a primary or salvage treatment for newly diagnosed; or recurrent hepatocellular carcinoma or unresectable hepatocellular carcinoma in patients who may be waiting for a liver transplant.
Real Time Rx Cuts Costs

Real Time Rx is a new pharmacy program for members with Health Savings Accounts (HSA) that saves members time and money at the point-of-sale and contributes to claims efficiency.

Previously, HSA members were required to pay the full price for prescriptions up-front at the pharmacy window. If the provider was contracted, the prescription claim processed electronically. If not, the member had to submit a paper claim and wait for reimbursement. Mail-order service was not available.

Effective Jan. 1, 2009, with the new Real Time Rx program, the member now pays only their share of the prescription at the point-of-sale. In addition, mail-order access is now available to these members, and that means time and money cost savings on prescriptions. Members using certain classes of preventive prescriptions will no longer have to pay in advance.

Point of Sale (POS) Edit Program Expansion

Premera has added new review criteria based on clinical best practice and approval by an independent Pharmacy and Therapeutics Committee. The program is designed to promote appropriate drug selection and length of therapy and utilization of specific drugs while improving the overall quality of care.

Newly added POS Program drugs are listed to the right. Drugs may be added or deleted from this list without prior notification. If you have questions concerning the POS Edit Program, please call the Pharmacy Services Center at 1-888-261-1756 of fax us at 1-888-260-9836, Monday through Friday, 8 a.m. – 5 p.m. Pacific Time.

Which new edits are included in the Point of Sale Program?

**Effective March, 1, 2009**

<table>
<thead>
<tr>
<th>Cymbalta (duloxetine)</th>
<th>Antidepressant: Second generation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage Criteria:</strong></td>
<td><strong>Medications requiring coverage review:</strong></td>
</tr>
<tr>
<td>1. Coverage of Cymbalta may be considered medically necessary in fibromyalgia patients that have failed a reasonable combination consisting of at least 2 of the following:</td>
<td>Cymbalta</td>
</tr>
<tr>
<td>a. A tricyclic antidepressant (e.g., amitriptyline)</td>
<td>Effcor XR</td>
</tr>
<tr>
<td>b. Cyclobenzaprine</td>
<td>Lexapro</td>
</tr>
<tr>
<td>c. Tramadol</td>
<td>Pristiq</td>
</tr>
<tr>
<td>Plus a trial of gabapentin</td>
<td>Prozac Weekly</td>
</tr>
</tbody>
</table>

**Coverage Criteria:**

1. Require a trial and failure of one generic second-generation antidepressant (any generic SSRI, bupropion or mirtazapine) prior to coverage of a branded medication on all new therapy starts.
2. The restriction would not apply to patients taking Cymbalta (duloxetine) for diabetic peripheral neuropathy or fibromyalgia.
Provider Portal Enhancement: Benefit Advisory/Certification Tool

Premera provides a published list of procedures that we review for medical necessity. We encourage providers to request a Benefit Advisory on these procedures up front to avoid a medical necessity review after submitting the claim.

You can now use the new Benefit Advisory/Certification Tool on our Provider Portal to determine if a Benefit Advisory is recommended or certification is required for the service scheduled for the patient. Once you have located the member in the system, you simply enter the procedure code and date of service. A message will appear indicating if a request is necessary and instructions on how to submit the request.

For additional information about our clinical review programs, go to the Provider Portal at premera.com/provider and then to Library. Click on Care Facilitation, and then click on Care Management.

New Look for Premera.com

On Nov. 13, 2008, we launched the new redesigned premera.com web site. If you visit the new premera.com, you’ll see that the look and feel is quite different from the previous design. On the right side of the page, you will find login fields for quick access to our secure portals, and important links for brokers, employers, and providers. Please take some time to check out the new and improved premera.com site.

Vision Benefits on Provider Portal

Did you know that you can find your patient’s vision benefits on the Provider Portal? Medical plans frequently contain vision coverage. Once you’ve located the member in the system, click on the member’s Plan Summary button shown below for vision coverage information.
Give Us Your Feedback: Join the Office Managers Research Forum

Premera is seeking office managers to participate in ongoing, online feedback forums. The purpose of the forums is to facilitate and enhance two-way, ongoing communication with office managers to ensure our programs and services are responsive to your needs and those of your patients. By participating, you have the opportunity to provide your expertise and point of view on important decision topics and projects that are relevant to your office functions.

Participating is easy. Those who volunteer will receive an e-mail containing an online link where you will receive information about new initiatives, services and programs and will be asked to provide your viewpoint and expertise. Your feedback will be used to refine and develop the services we offer. Participants will receive a gift certificate for Amazon.com for each topic area they participate in as a thank-you. If you have previously signed up to be on this panel, you do not need to sign up again.

If you are interested in joining the Office Managers Research Forum or would like more information, please contact Hector Fernandes at 1-425-918-4081 or email at Hector.Fernandes@premera.com.

The Office Manager Forum form is available through the Provider Portal. To find the form go to premera.com/provider, then Forms and then click Miscellaneous.

If you wish to fax your registration form, our fax number is 1-425-918-5081.

OFFICE MANAGERS Research Forum
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Back issues of Network News are on our Web site at www.premera.com/provider in the Library on the Provider page under “Communications.”