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March 2, 2017 Provider News – WA

This is a document version of web content originally posted to our provider website. If the links in the content below have changed, you can find complete information on our medical and payment policies on our provider website.

Contents

Medical Policy and Coding Updates

Special Notice: New Pharmacy Policy
Effective June 2, 2017

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Soliris (eculizumab), 5.01.571

When criteria are met, Soliris may be considered medically necessary for the FDA-labeled indications of paroxysmal nocturnal hemoglobinuria (PNH) for those 18 and older, and atypical hemolytic uremic syndrome (aHUS). It is considered investigational in those under the age of 18 who have diagnosed PNH and for any diagnosis other than aHUS. Soliris is also subject to site-of-service review. Read the full policy.

New Medical Policy

Effective March 1, 2017

Polysomnography for Non–Respiratory Sleep Disorders, 2.01.99

Non-respiratory sleep disorders were previously addressed in policy 2.01.503 and are covered in this policy. Polysomnography is considered investigational for the diagnosis of non-respiratory sleep disorders not meeting the criteria. Note that the policy requires that sleep apnea be assessed and treated prior to evaluation for periodic limb movement disorder. Read the full policy.

Revised Medical Policies

Effective March 1, 2017

Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer, 12.04.36

EndoPredict, Breast Cancer Index, Mammaprint, and Prosigna—previously considered investigational—are now considered medically necessary for the same indications as Oncotype DX. BluePrint and TargetPrint are considered investigational. Gene expression assays in men with breast cancer are considered investigational. Read the full policy.

Bariatric Surgery, 7.01.516

Routine cholecystectomy (gallbladder removal) may be considered medically necessary when performed with bariatric surgery. Read the full policy.

Gender Reassignment Surgery, 7.01.557

Procedures for preservation of fertility (e.g., procurement, cryopreservation, and storage of sperm, oocytes, or embryos) performed prior to gender reassignment surgery are considered not medically

necessary, unless the contract includes an assisted reproductive benefit that covers these services. Read the full policy.

Knee Arthroplasty in Adults, 7.01.550

When submitting requests for knee replacement due to osteoarthritis or degenerative joint disease, a copy of the radiologist's report must be submitted for diagnostic imaging performed within the past 12 months. The report must be read by an independent radiologist. To provide a Kellgren-Lawrence score an x-ray must have been done in the past several years. Read the full policy.

Knee Arthroscopy in Adults, 7.01.549

A copy of the radiologist's report for diagnostic imaging (MRI, CT, etc.)—done within the past 12 months prior to surgery—demonstrates the diagnosed defect. Imaging must be performed and read by an independent radiologist. If there are discrepancies in the interpretation of the imaging, the radiologist's report will supersede. This is consistent with other policies. Read the full policy.

Mastectomy for Gynecomastia, 7.01.521

Policy statement changed from cosmetic to not medically necessary when criteria are not met. Read the full policy.

Moderate Penetrance Variants Associated with Breast Cancer in Individuals at High Breast Cancer Risk, 12.04.126

Content from policy 12.04.516 Genetic Testing for CHEK2 Mutations is combined with this policy. PALB2 testing changed from investigational to medically necessary when criteria are met. Policy statement added that genetic testing for ataxia-telangiectasia mutated variants is considered investigational. Policy title changed. Read the full policy.

Non-Pharmacologic Treatment of Rosacea, 2.01.519

Policy statement changed from cosmetic to not medically necessary when criteria are not met. Read the full policy.

Panniculectomy and Excision of Redundant Skin, 7.01.523

Policy statement changed from cosmetic to not medically necessary when criteria are not met. Read the full policy.

Polysomnography and Home Sleep Study for Diagnosis of Obstructive Sleep Apnea, 2.01.503
Moved statement related to testing to rule out other sleep disorders into policy 2.01.99 Polysomnography for Non-Respiratory Sleep Disorders. Read the full policy.

Reduction Mammaplasty for Breast-Related Symptoms, 7.01.503
Policy statement changed from cosmetic to not medically necessary when criteria are not met. Read the full policy.

Effective March 15, 2017

Mobile Cardiac Outpatient Telemetry, 2.02.510
Implementation, originally scheduled for March 1, 2017, is now March 15, 2017. Policy criteria are unchanged. Read the full policy.

Revised Pharmacy Policies

Effective March 1, 2017

Excessively High Cost Drug Products with Lower Cost Alternatives, 5.01.560
Added brand name EpiPen, Adrenaclick, Fortamet and its generic, Riomet, and Alcortin-A. Read the full policy.

Medical Necessity Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits, 5.01.547
Added Copaxone 40mg quantity limit and removed Forteo quantity limit from the table. Removed Fenoglide and Lipofen from step-therapy table. Read the full policy.

Medical Necessity Criteria for Pharmacy Edits, 5.01.605
Removed travoprost from alternatives for brand-name ophthalmic drops due to drug no longer being available on the market as generic. Also removed brand non-insulin diabetic criteria as this is addressed in policy 5.01.569 Pharmacotherapy of Type I and Type II Diabetes Mellitus. Read the full policy.

Miscellaneous Oncology Drugs, 5.01.540
Added two new indications for Opdivo (nivolumab), recurrent or metastatic squamous cell carcinoma of the head and neck and urothelial carcinoma. Read the full policy.

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Multiple Receptor Tyrosine Kinase Inhibitors, 5.01.534
Added two indications for Imbruvica (ibrutinib), small lymphocytic lymphoma and marginal zone lymphoma. Read the full policy.

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523
Added "Aria" to Simponi to designate intravenous formulation. Read the full policy.

Effective March 15, 2017

Medical Necessity Criteria for Pharmacy Edits, 5.01.605
Added Emflaza (deflazacort) for the FDA-labeled indications for Duchenne muscular dystrophy in patients five years of age and older. Criteria added to the policy on March 15, 2017.

Archived Policy
An archived policy is one that's no longer active and is not used for reviews.

Archived on Feb. 28, 2017

Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening, 2.04.29

Botulinum Toxin, 5.01.512

Deleted Policy
A deleted policy is one whose number is no longer used but the content is either moved into another policy or replaced with a new policy and number.

Deleted on Feb. 28, 2017

Genetic Testing for CHEK2 Mutations for Breast Cancer, 12.04.516
(Information from this policy is added to 12.04.126)

Payment Policy and Coding Updates

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Modifier FX: X-ray Taken Using Film

The Centers for Medicare and Medicaid Services (CMS) recently created a new radiology code modifier FX: X-ray taken using film, effective with dates of service January 1, 2017 and after. Medicare requires this modifier be appended to any radiologic service that represents an x-ray that was taken using film rather than digital methodology. Medicare will also be reducing payment for the technical component of the radiology service by 20 percent.

Healthcare providers use modifier FX when coding film x-rays for Medicare beneficiaries. You should use modifier FX for your non-Medicare patients as well, when coding any radiology service that was taken using film.

Unlike Medicare, Premera will **not** be reducing the technical component of the radiologic service at this time.

Premera is reviewing claims submissions to determine if this modifier will be a requirement with a payment reduction on the technical component only. We'll provide a 90-day notice of any decision through our online Provider News.

ICD-10 CM Diagnosis Coding Tips

We're often asked about the correct ICD-10 CM diagnosis codes to submit on a claim for a general health exam provided to a newborn, infant, or child. Let's take a look at how to approach this type of coding.

Just like the same general health examination diagnosis codes used in ICD-9 CM, the ICD-10 CM diagnosis codes are also "age banded." Each diagnosis code has a specific age range to differentiate between a newborn, an infant, and a child.

Use the list of diagnosis codes below to select the correct ICD-10 CM diagnosis code: Z00.110 – Health exam for newborn, **under 8 days old**

- Z00.111 – Health exam for newborn, **8-28 days old**
- Z00.121 – Encounter for routine child health exam, child **over 28 days old**, with abnormal findings
- Z00.129 – Encounter for routine child health exam, child **over 28 days old**, without abnormal findings

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For further details and explanation, refer to Chapter 21 "Factors Influencing Health Status and Contact with Health Services" in the "2017 Official Guidelines for Coding and Reporting" in the ICD-10 CM Code Book.

Coding Update for Outpatient Lab Tests

The Centers for Medicare and Medicaid Services (CMS) recently made a change related to codes accepted for hospital outpatient lab services. On December 22, 2016, CMS ended use of modifier L1 for dates of service January 1, 2017 and after. The modifier has been deleted by CMS as a valid modifier and has been removed from Healthcare Common Procedure Coding System (HCPCS) code set, maintained by CMS. Read more about the CMS changes (page 3).

Premera follows CMS's updated policy, even if our agreement with you states a different process. If you have questions about your contract, contact your Provider Network Executive.

What to know about the coding change

Before creating modifier L1, CMS published hospital outpatient clinical diagnostic laboratory test payment and billing guidelines. Premera continues to follow these established guidelines when processing hospital outpatient lab services. Read the guidelines (published in 2014).

CMS now uses conditional packaging as a mechanism to package labs submitted with other services and to allow the lab when it is the only service submitted. **At this time, Premera is not using conditional packaging.** Premera continues to allow the use of bill type 14x when providers meet CMS criteria for separate reimbursement of clinical lab services.

Providers may use a 14X bill type when:

- The test involves a non-patient laboratory specimen (patient is not present at the hospital).
- The hospital only provides a lab test to the patient, and the patient doesn't receive other outpatient services for the encounter.

For more information on these coding changes, visit the CMS website.

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Company Updates

Helping Patients with Chronic Conditions
Coordinating care for patients with multiple chronic health conditions can be difficult. It becomes especially challenging when patients lack access to basic human services, such as transportation. Premera and Landmark are working to identify patients like this to help them get the care they need. Landmark has a team of providers available 24/7 to care for patients with chronic conditions in their homes or even out in their communities, all in collaboration with existing primary care practitioners (PCPs) and other providers.

One patient's story
Last August, a 54-year-old woman enrolled in the Landmark Health program after hospitalization from a suicide attempt. She was dealing with relationship issues and lost her housing. Although she was homeless for several months, she still received frequent visits from Landmark providers at convenient and safe locations.

Landmark visited the patient at her uncle's home and even at a coffee shop to help her with various urgent needs, including a COPD exacerbation, a consultation about managing her psychiatric medication, and social work assistance to access low-income housing.

Recently, Landmark attended the patient's visit with her PCP, and together they worked to reconcile her medications and create her safety plan for any future mental health crises.

Connecting with Landmark
Landmark is currently offering services to qualified members in King, Pierce, Snohomish, Spokane, and Thurston counties. If Landmark contacts your patient, we hope you'll encourage participation in this service. Landmark welcomes collaboration with you and will communicate with you, including sending visit summaries to each patient's PCP. The Landmark team is available as your eyes and ears in the home, after hours, and on weekends.

If you have questions about the Landmark program, call them at 206-962-3491.

Shared Decision-Making Resources
Our customers can now use a shared decision-making tool on our website to help make treatment decisions for joint replacements, cancer treatments, coronary artery disease, and other issues.

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For example, a patient who's considering hip replacement can compare surgery options, rehabilitation involvement, and recovery times. Our case managers already use this knowledgebase from our partner Healthwise, but now we're making the resources easily available to our customers.

These decision aids take into account scientific evidence and a patient's preferences, enabling patients and providers to make informed decisions together. Your patients might bring these decision aids with them to appointments.

We're excited to provide resources that help you and your patient work better together. If you'd like more information or would like to get involved with this effort, contact Dick Shoemaker at 425-915-6326 or dick.shoemaker@premera.com.

Free Credit Monitoring Concludes

In 2015, Premera offered two years of free credit monitoring from Experian to its customers and some providers after a cyberattack. You might have been offered monitoring services for your personal information.

The two years of free credit monitoring from Experian, a global leader in consumer and business credit reporting, will begin to expire March 17, 2017. If you signed up for this program, you will have the option to continue the service for a fee.

Experian began notifying program participants at the end of February in order to provide 30 days' notice before the service ends. Email notification will continue through the end of October.

You don't have to take any action to cancel the credit monitoring service. Enrollees who don't purchase the service will continue to receive Experian's ExtendCare package, which provides access to professional assistance in the event of identity theft.

Reminders and Resources

Changes to Massage Therapy Guidelines

Effective February 20, 2017, eviCore healthcare (eviCore) updated their clinical guidelines for massage therapy. eviCore is Premera's partner for outpatient rehabilitation services review.

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You can locate the updated massage therapy services clinical guidelines on eviCore's dedicated Premera website. Here's a summary of the updates you'll see:

- New guideline added for fibromyalgia
- Addition of ICD-10 codes listed under some conditions
- Notation added under each condition: "Pain may be acute or chronic."
- Addition under the Scope of Musculoskeletal Examination section: Includes "Inquiry about pain levels and functional abilities."
- Changes to Massage Therapy Management and Referral Guidelines sections: Information emphasizes transition to active care and appropriate discharge or referral.
- Changes to Self-Management Techniques section: Added techniques and modified the list order to better emphasize active rehabilitation.
- Changes to Alternatives/Adjuncts to Massage Therapy section: Added alternatives and changed the list to alphabetical order.

Review these guidelines with your staff so your office is referring to the updated version. If you have further questions, call eviCore healthcare at 800-792-8751, from 7 a.m. to 7 p.m., Monday through Friday.

Changes to Physical and Occupational Therapy Guidelines

Effective March 1, 2017, eviCore healthcare (eviCore) updated some of their clinical guidelines for physical and occupational therapy. eviCore is Premera's partner for outpatient rehabilitation services review.

eviCore updated the physical and occupational therapy clinical guidelines listed below. You can locate the updated guidelines on eviCore's dedicated Premera website. Review these guidelines with your staff so your office is referring to the updated versions.

- Pelvic pain syndrome
- Urinary incontinence
- Head, neck and upper back dysfunction
- Back pain and dysfunction
- Orthopedic upper extremity (21 guidelines for the elbow, wrist, and hand)
- Autism spectrum disorder
- Congenital muscular torticollis
- Neuromuscular disorders

If you have questions about the updates, call eviCore healthcare at 800-792-8751, from 7 a.m. to 7 p.m., Monday through Friday.

Quality Programs

Access to Practitioners
Premera conducts annual research with our customers and providers about access to practitioner appointments as part of our commitment to healthcare safety and quality.

This research focuses on the customers' ability to access appointments. We have a documented *Practitioner Accessibility of Services Policy* to ensure our networks include sufficient numbers and types of primary care, behavioral healthcare, and specialty care practitioners to meet our customers' needs.

Read more below about access to different types of practitioners.

Primary Care Practitioners
As part of our research, we review data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) conducted by the federal government.

The 2016 CAHPS survey of our customers showed satisfaction with access to primary care practitioners (PCPs) (in all service areas) was just one-half percent below the 83 percent national average for access to a routine care appointment. Customer satisfaction regarding access to a PCP for urgent care was 86 percent, 2 percent below the national average and a 3 percent decrease from 2015.

Behavioral Healthcare Practitioners
We captured behavioral healthcare practitioner (BHP) information through a telephone survey with a random sample of practitioners in Washington and Alaska. Among all BHPs, 89 percent reported they were available to clients within 10 business days for a routine care appointment, while 85 percent were available for follow-up care appointments. For urgent care appointments, 77 percent of Washington BHPs were available to clients within 48 hours, and 67 percent of Alaska BHPs had an available appointment open for urgent care.

For the majority of BHPs, it was challenging to provide access to care within 6 hours for a non-life-threatening emergency. Among the BHPs surveyed, 48 percent of Washington practitioners and 35 percent of Alaska practitioners stated they were available to clients within 6 hours for a non-life-threatening emergency.

Specialty Care Practitioners
Washington

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In Washington, Premera has an extensive commercial market share. The network is robust, with more than 90 percent of the state's physicians contracted. New in 2017, specific specialty care practitioner (SCP) CP types will be identified and surveyed as high-volume or high-impact specialists.

Alaska
The Alaska market poses unique challenges to practitioner contracting and member access to appointments. Although Alaska specialists also had gaps in appointment availability, Alaska members were very satisfied with their ability to get a specialist appointment when needed. The 2016 CAHPS survey results showed an overall improvement of 10.4 percent in member satisfaction from the previous year.

An important commitment
By evaluating how well our customers can access appointments, Premera can better support customer safety and improve customer satisfaction with practitioners and the health plan.

Out-of-area Medical Records Requests

One use of medical records is to provide evidence of the quality of care you deliver. Plans, including Premera, regularly review medical records to supports the success of risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS), and the Medicare Advantage HEDIS/5-Star rating programs.

As part of the medical records review process, you might receive a request from a Blue Cross Blue Shield Association (BCBSA) plan outside of our area. Your office may receive these medical records requests starting October 2016 and continuing through December 2017. All BCBSA plans use the same vendor, Verscend.

We appreciate your partnership in three key areas:

- Complete, accurate, and timely claims coding
- Medical records documentation that validates completion of clinical care and confirms claims
- Submission of select medical records to support coding and documentation reviews and audits, and to validate completion of clinical care to supplement claims data

If you have questions about these requests, contact our Physician and Provider Relations team at 877-342-5258, option 4.