Later this year, Medical Network News will transition to an online-only format and will no longer be printed and mailed to Premera contracted providers. You’ll find it online at premera.com/wa/provider and will be initially notified of the first few issues via a postcard mailer. This new format means a more efficient, timely, and sustainable way to keep you informed.

If you’d like email notices when a newsletter is published, we encourage you to sign up for an email subscription on our secure website at premera.com/wa/provider.

Healthcare Transparency: Premera’s Position on All Payor Claims Database in HB 2572

You may have seen recent news articles about state legislative issues that mentioned Premera and healthcare transparency. The issue receiving the most attention was House Bill 2572 for the state’s Healthcare Innovation Plan, which includes an “All Payor Claims Database.”

We feel that Premera’s position on this issue was not clearly represented in the media so we’d like to take this opportunity to explain our concerns about the database as it was proposed in HB 2572.

Premera strongly supports empowering our providers and members with information to help make informed choices about healthcare delivery. That’s why we continue to develop tools to share that information with our members because we know informed choices help improve both quality and affordability of care. There is a difference, however, between meaningful transparency and a tool such as the proposed All Payor Claims Database discussed in Olympia during the recent legislative session.

The database bill as first proposed did not pass. According to the March 13, 2014, Seattle Times article, the bill that was passed removed the requirement that insurance companies share their cost information. So, while it’s still a database, it is limited to the healthcare prices paid by plans covering...
state employees and Medicaid. Also, large companies who self-insure can opt to voluntarily share their cost data.

Here are Premera’s primary concerns about the All Payor Claims Database:

- **Lack of actionable information for consumers**
  The database would have shown reimbursements from health plans to providers to pay for medical claims, but it would not have been able to filter that information through the lens of the consumer’s specific benefit plan. Without that filter, consumers would not know their true out-of-pocket costs. Knowing the actual cost of a procedure, based on their specific plan, can make all the difference for members trying to make the most informed purchasing decisions – this is the true value of transparency. This has been a consistent, major flaw in states where All Payor Claims Databases have been launched.

- **Potential direct costs for employers**
  The cost of the database may have resulted in higher premiums if the state chose to tax employees and/or payors to build and maintain it.

- **Personal privacy concerns**
  The database presented significant concerns for personal privacy, since personal medical claim information would be stored in a state government database. This can and should be a concern for consumers, as it would significantly expand access to personal health information, entailing additional, unnecessary security risks. The use of the data was not specified in legislation, which posed another security concern.

  We’ll watch to see the results of the pilot database and we have committed to proactively discussing the issue further with the Governor’s office before the next legislative session.

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**Significant January Enrollment Volumes Result in Service Delays**

Early 2014 was a unique time for the health plan industry as millions of consumers and small businesses enrolled in new health plans across the country.

We’re very pleased that our new plans were so popular with new and returning members; however, we realize that the influx of new members led to delays in our ability to respond to calls, which resulted in long wait times for many, including our providers.

New enrollment levels at the beginning of the year greatly exceeded our expectations. Additionally, consumer confusion associated with announced changes to enrollment and payment deadlines led to many unanticipated last-minute applications, which further affected all aspects of our business.

Despite careful preparation, the addition of staff and extended shifts, the volumes exceeded our capacity to provide our standard level of customer service. We apologize for the inconvenience many of you experienced. We continue to evaluate and increase staffing, and explore alternative solutions to restore a customer service experience that meets your needs.

Thank you for your patience as we continue to address the work associated with our new enrollees, many of whom were previously uninsured.
T
o help our members reduce out-of-pocket costs and get the most out of their benefits, we encourage you to refer them to in-network providers (such as specialists and labs) whenever possible. With products that now include specific networks, it is more important than ever to check the provider’s network status when referring Premera patients.

To help members find in-network providers, check out our Find a Doctor tool at premera.com/wa/provider or call the customer service number on the back of the member ID card. If your patient needs services that are not available from an in-network provider, our customer service team is just a phone call away and happy to help.

If you have general questions about in-network provider referrals, please call Physician and Provider Relations at 877-342-5258, option 4.

Reminder: Premera Blue Cross Medicare Advantage HMO-POS Plans Have Out-of-Network Benefits

Premera Blue Cross Medicare Advantage members on our HMO-POS plans have out-of-network plan benefits, while those on our HMO plans need to access care from in-network providers.

HMO-POS Plans

If you’re contracted with Premera Blue Cross, but you’re not in our Medicare Advantage provider network, you can still see our Medicare Advantage HMO-POS plan members. Members on the HMO-POS plans can receive care outside of the network. Look for “HMO-POS” on the member’s ID card (see example below). Providers outside of Premera’s Medicare Advantage network must accept Medicare for care to be covered.

HMO Plans

Members on the HMO plans need to access care from in-network providers and facilities. HMO plan members who receive non-emergent care out of the network without a prior authorization may be required to pay for the cost of services. Look for “HMO” on the member’s ID card, for example:

If you have any questions, please call Customer Service at 888-850-8526, 8 a.m. to 8 p.m., Monday through Friday.
Premera Blue Cross Medicare Advantage Plans: Visit Our Website for Online Tools and Policy Updates

In January, we welcomed more than 8,400 members to our Premera Medicare Advantage Plans in King, Pierce, Snohomish, Thurston, and Spokane counties. If your practice is seeing patients from these plans, remember that our Medicare Advantage Plans use unique forms, online tools and policies, all of which can be accessed from our secure provider website via the “Get Started” button at premera.com/wa/provider/medicare-advantage.

Provider landing page (non-secure) for Premera Blue Cross Medicare Advantage Plans:

Premera Blue Cross Medicare Advantage Plans

Premera Blue Cross Medicare Advantage Plans offer four Medicare Advantage plans in Soundview, King, Pierce, Thurston, and Spokane counties for Medicare-eligible individuals who have Medicare Parts A and B and are:

- Age 65 or older
- Under age 65 who have certain disabilities
- Current residents of Snohomish, King, Pierce, Thurston, or Spokane County

Premera Blue Cross Medicare Advantage plans offer patients Medicare benefits — plus extra benefits for prescription drugs and fitness programs — all in one easy-to-use plan. Medicare open enrollment occurs October 15 through December 7 every year.

- Four Plans to Choose From
- Network for Premera’s Medicare Advantage Plans
- Medicare Advantage Training for Providers and Office Staff

Prospective Review Service Level Update

Since Jan. 1, 2014, our Care Management team has been experiencing an unprecedented number of phone calls and faxed requests. We understand that you may be experiencing long hold times. We’re working hard to restore our previous level of high-quality service and apologize for the impact these delays have had on your organization. We are adding additional resources and expect to have significant improvements in our service to you within the next month.

What we’re doing to solve these problems

To prepare for increased volumes, our Care Management team significantly increased staffing for 2014. Unfortunately, this has not fully supported the tremendous volume of calls and faxes we’ve received. We’re working overtime and continuing to streamline our procedures to ensure that we process your requests as quickly as possible. We continue to prioritize to meet mandatory turnaround times for requests and to improving your experience with us. We appreciate your patience as we work to resolve this situation as quickly as possible.

Learn how you can get your requests processed faster by reading the related News Brief located on our secure provider website.

Provider landing page (secure log in required) for Premera Blue Cross Medicare Advantage Plans:
Reminder: Massage Therapy Prescription Change

The Physical Medicine and Rehabilitation medical policy no longer requires the submission of a massage therapy prescription as of Feb, 15, 2014. An appropriate prescription and plan of care must be kept in the member’s medical record.

Below is the updated medical policy update, as published previously in the November 2013 issue of Network News:

8.03.502 Physical Medicine and Rehabilitation — Physical Therapy and Massage Submission of a massage therapy prescription and plan of care is no longer required, but must be kept in member’s medical record. This policy change is effective Feb. 15, 2014.

Reminder: Member Rights and Responsibilities in Reference Manual

A good provider-patient relationship benefits everyone involved in patient care. To promote that relationship, all of our members (except for our national accounts and the Washington Education Association) are sent an annual mailer that encourages them to read their member rights and responsibilities on Premera’s member website. To see the complete list of member rights and responsibilities, please refer to Chapter 6 of the Premera Reference Manual on our provider website at premera.com/wa/provider.

Starbucks Plan Names Similar to Metallic Plan Names

It has come to our attention that there may be some confusion between the names of two of our Starbucks commercial plans (Gold and Silver) and the new individual and small group metallic plans in the market (also called gold and silver). The new Starbucks Gold and Silver Plans were named as such because they matched the actuarial values for the gold and silver metallic plans in the Exchange marketplace, but they are NOT duplicates of Premera’s metallic plans and they do not use Premera’s new Heritage Signature network in Washington. The Starbucks plans use the same Heritage provider network as they did in 2013. We apologize for any confusion this may have caused for our providers.

ICD-10 Coding Update

On April 1, President Obama signed legislation that will delay the reduction of Medicare reimbursements to physicians. A last-minute provision was added to the bill that delays the adoption of ICD-10 coding to no sooner than Oct. 1, 2015. The specific compliance date has not yet been set.

Premera’s implementation planning is well underway, and we will meet the federal compliance date once it is established by the appropriate governing body.

For now, we will continue our previously planned testing with certain providers and clearinghouses, and adjust our implementation timeline as needed.

Eligibility & Benefits Tool

Verify member information in advance by using our online Eligibility & Benefits tool. On the Eligibility & Benefits summary page, you’ll find details about the member, subscriber, and group. The member search summary combines several separate pages of information into one with expandable sections, including: Plan Eligibility, Plan Messages, Deductibles and Maximums, Benefits, and Other Payer.

Helpful Tips for Using the Updated Eligibility & Benefits Tool:
- Enter at least two pieces of member information to conduct a member search. This ensures that accurate member information is returned to you.
  1. ID number
  2. First and last name
  3. Date of birth
- Select the benefit you want from the drop-down box to narrow your selection.
- Know that the deductible applies to all benefits in the drop down box unless otherwise indicated.
- Find primary care provider (PCP) selection information by expanding the Plan Messages section.

Save a Phone Call – Check Pre-service Review Status Online with Our Prospective Review Tool

You can check the status of your pre-service review online using our Prospective Review Tool, even if you didn’t use the tool to submit it. The tool allows you to search by using either member ID or reference ID.

For more information, visit premera.com/wa/provider/utilization-review/prospective-review.

(Note: At this time, home health, durable medical equipment, and urgent requests must still be submitted by fax.)

Sign Up for Electronic Funds Transfer (EFT)

Did you know you can now sign up for Electronic Funds Transfer (EFT)? Find out more on our EFT Overview page at: premera.com/wa/provider/electronic-funds-transfer/.
Payment Policy Revision:
Medicare Indicator Status B
Services Reimbursement

Effective for claims processed on or after Aug. 10, 2014, CPT Code 99050 – “Services provided in the office at times other than regularly scheduled office hours or days when the office is normally closed (e.g., Saturday or Sunday), in addition to basic service” will no longer be considered a covered procedure. This code is identified as a Status B code on the National Physician Fee Schedule (NPFS) and will no longer be exempt from editing.

In conjunction with the Status B reimbursement policy, standard claims editing will be applied to this code, whether it is billed with other services on the same date of service on the same claim form or billed by itself on a claim. This code, because it is a Status B code on the NPFS, will no longer be eligible for separate reimbursement.

For a complete listing of Status B codes, select the most current NPFS Relative Value File release on the Centers for Medicare and Medicaid Services (CMS) website at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

New Payment Policy: Fetal Non-Stress Tests

As part of our ongoing review of maternity services, a new payment policy for CPT Code 59025 - Fetal Non-Stress Tests, will be implemented on Aug. 10, 2014.

For claims processed on or after Aug. 10, 2014, fetal non-stress tests will now be considered as part of the global obstetrical package of care (CPT codes 59400, 59510, 59610, 59618) and part of antepartum care only (CPT codes 59425, 59426) when submitted as part of routine maternity care.

Fetal non-stress tests billed for routine, uncomplicated maternity care will no longer be separately reimbursed. Fetal non-stress tests billed for high-risk pregnancies, such as (but not limited to) those pregnancies that are at high risk for still birth, will be reimbursed according to the terms of the provider’s contract and the member’s benefits.

Quarterly Claims Editing Updates

Premera routinely updates our claims editing software each quarter with the latest industry standard codes (CPT, HCPCS, and ICD-9-CM) as well as code-to-code edits and other coding guidelines. These quarterly updates allow Premera to keep pace with industry technology and coding changes.

The Code Editor was updated at the beginning of 2014 to include:
- major releases of CPT, HCPCS
- new, revised, and deleted ICD-9-CM codes
- Centers for Medicare and Medicaid Services (CMS) guidelines, including but not limited to the National Correct Coding Initiatives (NCCI), other specialty societies, and college directives and publications.

The Code Editor also will be updated quarterly in 2014. These updates are applied to all professional claims for our commercial products and individual plans.

If you need clarification about billing and coding rules, please refer to the industry resources noted above. Also available is the What If online tool at premera.com/provider under Tools/ Claims Editor. This tool allows you to test billing scenarios and code combinations to determine what (if any) edits may be encountered. The Claims Editor results show sourcing and rationale to support the edit. This tool does not apply member benefits, eligibility, provider contracting, or reimbursement information to the final Claims Editor results. Final payment of the service(s) is subject to the plan’s fee schedule, provider contract terms, and payment policies as well as the member’s eligibility and coverage benefits at the time the claim/service is processed.
New Payment Policy: Evaluation and Management Office and Home Visits

When a problem-focused Evaluation and Management (E&M) office visit (99201-99215) or home visit code (99341-99350) with modifier 25 is billed with a Preventive Medicine (99381-99397) examination there are certain elements of the Preventive Medicine examination that are duplicated in the E&M Office Visit or Home Visit. These certain elements include (but are not limited to) obtaining vitals, certain portions of taking the patient history, and preparation of the exam room.

Effective for dates of service Aug. 10, 2014, and after, when a problem-focused office or home visit is billed with a Preventive Medicine examination on the same day, for the same member, by the same provider, reimbursement for the problem-focused E&M visit will be limited to 50 percent of the contracted allowable amount. The reimbursement of the greater valued Preventive Medicine examination will remain at 100 percent of the provider’s contract allowed amount.

The addition of modifier 25 on the E&M visit code should only be reported when a significant and separately identifiable E&M visit is documented in the member’s medical record as satisfying the relevant criteria for the respective level of E&M service reported (e.g., history, examination, medical decision making).

Billing Preventive Colonoscopy with Polyp Removal

To ensure that member claims are paid consistent with their benefits, for patients age 50-75, please submit preventive colonoscopy with or without polyp removal using the most appropriate revenue, diagnosis, and procedure codes noted below.

This is in accordance with guidelines issued on Feb. 20, 2013, by the Obama Administration stating that:

“…[Because] polyp removal is an integral part of a colonoscopy, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. On the other hand, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.” Source: dol.gov/ebsa/faqs/faq-aca12.html

Many, but not all, of our plans cover preventive services without cost-sharing. In general, this means that the polyp removal is 100 percent covered if performed during a preventive colonoscopy exam. If a polyp is discovered during a preventive colonoscopy exam, but is removed at a later time, standard medical benefits apply.

Revenue, diagnosis, and procedure codes for preventive colonoscopy with or without polyp removal, for patients age 50-75:

Revenue:
0360 Operating room
0361 Operating room minor surgery
0490 Ambulatory surgical
0750 Gastrointestinal services general

Diagnosis:
V10.05, V10.06, V12.72, V12.73, V12.74, V12.75, V12.76, V12.77, V12.78, V12.79, V16.0, V18.51, V70.0, V76.41, V76.50, V76.51 211.3

Procedure:
45355 Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379 Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45383 Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
G0105 Colorectal cancer screening; colonoscopy on individual at high risk
G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

More information regarding preventive services can be found at premera.com/wa/provider.
Premera ProviderSource™ Credentialing Requirement

Premera Blue Cross requires contracted providers to use the online ProviderSource™ application as the single source for submitting initial credentialing and recredentialing information. We made this change in support of Washington Senate Bill 5346 that promotes administrative simplification between payers and providers.

New practitioners applying for participation with Premera are required to complete an online ProviderSource application as part of Premera’s credentialing process. Premera is notifying existing contracted practitioners to complete the online ProviderSource application prior to their recredentialing due date.

Once you enter your data in the system, you only need to update and complete the attestation process on a periodic basis. Health plans and hospitals that credential you can access the data as they need it.

Visit the ProviderSource page at onehealthport.com/pdsindex.php to learn more about the credentialing application process and to view training materials, videos, and an extensive credentialing FAQ.

If you don’t have time for full data entry and review, click on the ProviderSource Credentialing Assistance Services link at providersource.com/washington to learn more about this new service, available through Medversant for a nominal fee.

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<tr>
<th>Medversant Services</th>
<th>Cost</th>
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<tbody>
<tr>
<td><strong>Application Data Entry:</strong> Fax your paper credentialing application and Medversant will enter all of your information and alert you when it’s complete and ready for you to log in and attest.</td>
<td>$30 per application, per provider</td>
</tr>
<tr>
<td><strong>Scan, Index, and Upload:</strong> Fax supporting documents (e.g., license copies, liability face sheets) and Medversant scans and uploads them to your account in minutes.</td>
<td>$15 per request, per provider</td>
</tr>
<tr>
<td><strong>Application Review:</strong> Medversant specialists can review your application and notify you if anything is missing or inaccurate. Once everything is complete, Medversant emails you for final confirmation.</td>
<td>$15 per application, per provider</td>
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To get started, visit onehealthport.com/pdsindex.php. If you have specific credentialing questions, call Physician and Provider Relations at 877-342-5258, option 4.

Practitioner Credentialing Notifications

**Practitioner’s Right To Review Credentialing File**

A practitioner has the right to review their credentialing file by notifying the Credentialing Department and requesting an appointment to review their file. Please allow up to seven days to coordinate schedules.

**Practitioner’s Right To Correct Erroneous Information**

A practitioner has the right to correct erroneous information. We will notify the practitioner in writing in the event that credentialing information obtained from other sources varies from that supplied by the practitioners. The practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof available.

**Practitioner’s Right To Be Informed of Application Status**

Practitioners have the right upon request to be informed of the status of their credentialing application. Please note that after the initial credentialing process, practitioners who are in the recredentialing cycle are considered approved unless otherwise notified.

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

Send Provider Updates and Changes 30 Days in Advance

Please notify Premera of any updates or changes to your practice information 30 days prior to the change. This allows us to update our payment systems and provider directory so your patients have accurate contact information and your payments are sent to the correct address.

Providers can notify Premera of any new information or changes by email, using the Contracted Provider Information Change Form. The form is located at premera.com/wa/provider, Library >Forms > Miscellaneous.

Providers can also send updates by fax at 425-918-4937, or by email at Provider.RelationsWest@Premera.com or mail to:

Premera Blue Cross
P.O. Box 327, MS-453 • Seattle WA 98111-0327

2014 Holiday Business Closure Dates

Premera will be closed on the following dates:

<table>
<thead>
<tr>
<th>Date</th>
<th>Holiday</th>
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<tr>
<td>Monday, May 26</td>
<td>Memorial Day</td>
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<tr>
<td>Friday, July 4</td>
<td>Independence Day</td>
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<tr>
<td>Monday, Sept. 1</td>
<td>Labor Day</td>
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<tr>
<td>Thursday, Nov. 27</td>
<td>Thanksgiving Day</td>
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<tr>
<td>Friday, Nov. 28</td>
<td>Day after Thanksgiving</td>
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<tr>
<td>Thursday, Dec. 25</td>
<td>Christmas Day</td>
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<tr>
<td>Friday, Dec. 26</td>
<td>Day after Christmas</td>
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Prior Authorization Required for Compounded Drug Claims of $200 or More

On Jan. 1, 2014, Premera implemented a new pharmacy prior authorization policy for individual and small group metallic plans for compounded drugs. Prior authorization is required for any compounded drug claims equal to or greater than $200 per claim.

As of June 1, 2014, our fully insured and select self-funded groups will also require prior authorization for compounded drug claims equal to or greater than $200 per claim.

If a provider fails to get a prior authorization, the prescription claim will not be paid and the member will be responsible for the full cost of the prescription. Prior authorization requests may be denied due to lack of medical necessity. If this occurs, Premera will not pay these claims, and the member will either need to pay the out-of-pocket expense, request an appeal, or ask the provider to prescribe an alternate medicine.

Here is a summary of the medical necessity criteria for compounded medications:

- Primary active ingredient in the compounded medication must be a legend medication.
- Active ingredients must be in therapeutic amounts, based on FDA indication or adequate medical and scientific evidence.
- Safety and effectiveness of the compounded medication and its route of administration (including delivery system) must be supported by FDA indication or adequate medical and scientific evidence (such documentation is the responsibility of the prescriber to provide).

If a compounded medication is similar to a commercially available product, but differs from the commercially available products in dosage, dosage form, and/or omission of a sweetener, dye, flavoring, or preservative, clinical documentation is required from the prescriber supporting the need for the compound.

If any active ingredient in the compound otherwise requires prior authorization, the member must meet criteria established for medical necessity for that ingredient.

To read the full policy, visit premera.com/wa/provider, click on Quick Links, then Medical Policies and search for medical necessity criteria for Compounded Medications, policy 5.01.546.

If you have questions about the medical necessity criteria, call 888-261-1756.

First Over-The-Counter Intranasal Steroid Approved

On Oct. 11, 2013, the U.S. Food and Drug Administration (FDA) approved Nasacort® Allergy 24HR as the first over-the-counter (OTC) intranasal steroid for treatment of the symptoms of allergic rhinitis. Patients with allergic rhinitis will now be able to self-manage their allergy symptoms without having to visit a provider and obtain a prescription. In addition, this OTC product may be less expensive for patients than comparable prescription brand or generic products. As a result of the Nasacort® Allergy 24HR FDA approval, other manufacturers will likely explore similar prescription-to-OTC conversions of intranasal steroids.
Pharmacy Prior Authorization Edit 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, length of therapy, and utilization of specific drugs while improving the overall quality of care.

Drugs may be added or deleted from this list without prior notification. If you have questions concerning the Pharmacy Prior Authorization Edit Program, please call the Pharmacy Services Center at 888-261-1756 or fax 888-260-9836, Monday through Friday, 8 a.m. – 5 p.m.

To read the full policy, go to premera.com/wa/provider, Quick Links and click on Medical Policies. Search for Medical Necessity Criteria for Compounded Medications, policy 5.01.546. For additional questions regarding the criteria, call 888-261-1756.

New Edits Included in the Pharmacy Prior Authorization Edit Program
Effective April 15, 2014:

**Zohydro™ ER (hydrocodone bitartrate) extended release capsules**

https://www.premera.com/medicalpolicies/CMI_124343.htm

**Coverage Criteria**

**Zohydro™ ER extended release capsules** may be considered **medically necessary** in patients that meet **all** of the following criteria:

- Treatment of severe chronic pain that requires around-the-clock opioid pain management
- Documented therapeutic failure of **two** preferred long-acting opioids (e.g., fentanyl citrate, fentanyl transdermal, hydromorphone, morphine er, Oxycontin)

And, have **none** of the following characteristics:

Currently receiving concomitant therapy with:

- Central nervous system depressants (e.g., sedatives, anxiolytics, hypnotics, neuroleptics or other opioid medication)
- Inhibitors of CYP 3A4
- History of chronic obstructive pulmonary disease (COPD)
- Current or recent head injury
- Under the age of 19

If approved, quantities will be limited to **60 capsules per 30 days**.

All other uses of Zohydro™ ER are considered **investigational**.

**Please note:**

Criteria will apply to **all** requests. Current members will **not** be grandfathered if on therapy prior to **April 15, 2014**.
Reminder: Lumbar Spine Decompression Surgery Reviews Begin in May

Medical necessity reviews for non-emergent lumbar spine decompression surgery — discectomy, foraminotomy, laminotomy, laminectomy — begin May 18, 2014. A pre-service review is strongly recommended for all surgical indications. If a pre-service review is not obtained, we will conduct a retrospective medical necessity review. Services that are not medically necessary will not be covered.

Medical necessity is established by documentation of clinical symptoms, confirmed with physical examination and diagnostic imaging findings, which demonstrate lumbar nerve root compression. A report from lumbar spine imaging, such as MRI or lumbar spine CT with myelogram, performed within the previous six months must be submitted.

Symptoms of lumbar nerve root compression often resolve without surgery. The records must show trial and failure of at least six weeks of conservative non-surgical interventions, such as activity modification, oral analgesic and/or anti-inflammatory medications, physical therapy, or epidural steroid injections when appropriate.

Requesting reviews
You can submit your request one of three ways:
1. Use the online Prospective Review Tool (preferred method) on our provider website
2. Fax your request
   a. Fill out the Pre-Service Request Form on our provider website
   b. Fax to 800-843-1114
3. Call Care Management
   877-342-5258, option 3

Review the full policy, 7.01.551 Lumbar Spine Decompression Surgery: Discectomy, Foraminotomy, Laminotomy, Laminectomy, on the provider website, under Quick Links, Medical Policies.

Investigational procedures
Remember, the following services are considered investigational based on Premera medical policy and are not covered under our member contracts. If you provide these services to our members, you are responsible for notifying them in advance that the following services may not be covered:

- Automated percutaneous and endoscopic discectomy (medical policy 7.01.18, effective since 1997)
- Percutaneous intradiscal electrothermal and/or radiofrequency annuloplasty (medical policy 7.01.72, effective since 2004)
- Laser discectomy and nucleoplasty (medical policy 7.01.93, effective since 2004)
- Image-guided minimally invasive lumbar decompression for spinal stenosis (medical policy 7.01.126, effective since 2012)
Include K-L Scoring To Expedite Knee Arthroscopy, Knee Arthroplasty Reviews

Understanding the degree of knee osteoarthritis is critical for determining the medical necessity of specific knee procedures. Kellgren-Lawrence (K-L) scoring provides a standard measure for documenting this information. Including the K-L score for knee arthroscopy and knee arthroplasty procedures, as outlined in our medical policies, expedites the review.

If a K-L score is not included for the specific indications and ages detailed in the knee arthroscopy and knee arthroplasty policies, we will contact your office to request this information.

Kellgren-Lawrence grading scale

- Grade 1: Doubtful narrowing of joint space and possible osteophytic lipping
- Grade 2: Definite osteophytes, definite narrowing of joint space
- Grade 3: Moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour
- Grade 4: Large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour

If you are not receiving these scores as part of your radiology reports, please speak with your radiology group about including K-L scoring on all knee x-rays where osteoarthritis is present, or add the score in the office notes you’re sending to us based on your x-ray review.

We strongly recommend a pre-service review for all knee arthroscopy and knee arthroplasty indications. You can review the full policies on the provider website, under Quick Links, Medical Policies.

- 7.01.549 Knee Arthroscopy, Adults
- 7.01.550 Knee Arthroplasty, Adults

Hyaluronan Injections: Limited Medical Necessity

Effective July 1, 2014, intra-articular hyaluronan injections to treat osteoarthritis of the knee will be considered not medically necessary for most patients with knee arthritis. This change in coverage is based on recent analyses by credible research organizations (Hayes, Inc.; Agency for Healthcare Research and Quality; and others) of the published literature during the past several years.

Oregon State’s Health Evidence Review Commission recommended against coverage of hyaluronans in 2012. Washington State Technology Evaluation Commission implemented a policy of limited coverage in March 2014. Please see medical policy 2.01.531 for more details, including documentation requirements needed for individual patient consideration.

REMINDER: Vitamin D Testing Medical Policy

To avoid potential claim denials, please be sure to follow our medical policy on vitamin D testing (2.04.507). The policy states that screening is only considered medically necessary in patients with a clinically documented disease or condition specifically associated with vitamin D deficiency, decreased bone density, or a disease specifically associated with vitamin D overproduction and toxicity. You can read the complete policy at premera.com/medicalpolicies/cmi_134366.htm
Premera Medical Policies

Premera medical policies are guidelines used to evaluate 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 regarding a specific service or treatment does not guarantee that the member’s contract covers that service.

You’ll find our medical policies in the Library > Reference Info at premera.com/wa/provider or you can send us an email request for medical policy information at medicalpolicy@premera.com.

**Note:** All policy numbers are listed here in numeric order.

The following policy changes are effective for dates of service of Jan. 13, 2014 and later:

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.04.54</td>
<td><strong>Microarray-based Gene Expression Testing for Cancers of Unknown Primary</strong></td>
<td>12.04.504</td>
</tr>
<tr>
<td></td>
<td>Gene expression profiling (including MRIReview and CancerTypeID tests).</td>
<td></td>
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<tr>
<td>12.04.93</td>
<td><strong>Genetic Cancer Susceptibility Panels Using Next Generation Sequencing</strong></td>
<td>12.04.506</td>
</tr>
<tr>
<td></td>
<td>Genetic cancer susceptibility panels using next generation sequencing is considered (including BROCA and COLESEQ tests).</td>
<td></td>
</tr>
</tbody>
</table>

Genetic Testing for Hereditary Breast and/or Ovarian Cancer
Genetic testing for a BRCA1 or BRCA2 mutation, associated with genetic counseling, may be considered medically necessary in unaffected individuals when criteria are met. *(See policy for details.)*

Genetic Testing for Lynch Syndrome and Other Inherited Polyposis Syndromes
Genetic testing for BRAF V600E or MLH1 promoter methylation may be considered medically necessary to exclude a diagnosis of Lynch syndrome when MLH1 protein is not expressed in a colorectal cancer on immunohistochemical (IHC) analysis.

The following policy changes are effective for dates of service of Feb. 10, 2014 and later:

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01.525</td>
<td><strong>Postsurgical Outpatients Use of Limb Compression</strong></td>
<td>7.03.509</td>
</tr>
<tr>
<td></td>
<td>Outpatient use of limb compression devices to prevent venous thromboembolism is considered not medically necessary except for conditions listed in policy. <em>(See policy for details.)</em></td>
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</tr>
<tr>
<td>1.01.527</td>
<td><strong>Power Operative Vehicles (Scooters) (Excluding Motorized Wheelchairs)</strong></td>
<td>7.03.510</td>
</tr>
<tr>
<td></td>
<td>New policy. Mobility vehicles with three or four wheels (scooters) for in-home use to accomplish the tasks of daily living may be considered medically necessary when criteria are met. <em>(See policy for details.)</em></td>
<td></td>
</tr>
<tr>
<td>2.01.90</td>
<td><strong>Navigated Transcranial Magnetic Stimulation (nTMS)</strong></td>
<td>12.04.43</td>
</tr>
<tr>
<td></td>
<td>New policy. Navigated transcranial magnetic stimulation is considered investigational.</td>
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<tr>
<td>5.01.17</td>
<td><strong>Repository Corticotropin Injection</strong></td>
<td>12.04.33</td>
</tr>
<tr>
<td></td>
<td>New policy. Repository corticotropin injection may be considered medically necessary for treatment of infantile spasms (West syndrome).</td>
<td></td>
</tr>
<tr>
<td>7.01.132</td>
<td><strong>Transcatheter Aortic-Valve Implantation (TAVI) for Aortic Stenosis</strong></td>
<td>12.04.92</td>
</tr>
<tr>
<td></td>
<td>Transcatheter aortic-valve implantation using the transapical approach to treat aortic stenosis may be considered medically necessary.</td>
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</tr>
<tr>
<td>7.01.548</td>
<td><strong>Hysterectomy Surgery</strong></td>
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<tr>
<td></td>
<td>Hysterectomy surgery for symptoms of pelvic pain and dysmenorrhea may be considered medically necessary when criteria are met. <em>(See policy for details.)</em></td>
<td></td>
</tr>
</tbody>
</table>

Solid Organ Transplants
Re-transplantation of a heart or heart/lung may be considered medically necessary following a failed transplant of the same organ(s).

Isolated Small Bowel Transplant
Re-transplantation of a small bowel may be considered medically necessary following a failed small bowel transplant.

Gene-Based Tests for Screening, Detection, and/or Management of Prostate Cancer
Genetic tests for the screening, detection, and management of prostate cancer are considered medically necessary (including ConfirmMDx).

Genetic Testing for Cardiac Ion Channelopathies
Genetic testing for catecholamine-induced polymorphic ventricular tachycardia (CPVT) may be considered medically necessary when criteria are met. Genetic testing for Brugada and short QT syndromes is considered investigational.

General Approach to Evaluating the Utility of Genetic Panels
Genetic panels that use next generation sequencing or chromosomal microarray may be considered medically necessary when criteria are met. *(See policy for details.)*
The following policy changes are effective for dates of service of March 10, 2014 and later:

**1.01.05 Ultrasound-Accelerated Fracture Healing Device**
Low-intensity ultrasound may be considered medically necessary to treat delayed unions and nonunions of fractured bones when criteria are met. (See policy for details.)

**1.01.528 Hearing Aids (excludes implanted devices) New policy**
Hearing aids worn on ear or in ear may be considered medically necessary for moderate hearing loss when criteria are met. (See policy for details.)

**1.04.502 Myoelectric Prosthetic Components for the Upper Limb Policy re-numbered. (Clarification)**
When provided as a sole prosthesis, full or partial myoelectric prosthetic hand attachments with mechanical fingers (digits) with independently powered joints are investigational.

**2.01.503 Diagnosis of Obstructive Sleep Apnea (Clarification)**
When the primary concern for testing is the rare diagnosis of periodic limb disorder movement (PLDM), facility-based testing may be considered medically necessary only when obstructive sleep apnea has already been ruled out.

**5.01.520 Antidepressants: Pharmacy Medical Necessity Criteria for Brands**
Cymbalta, which is now available generically, is considered medically necessary as a first-line alternative to treat depression.

**5.01.527 Dalfampridine (Ampyra™)**
Dalfampridine (Ampyra™) may be considered medically necessary for the treatment of symptoms of multiple sclerosis when the criteria are met. (See policy for details.)

**5.01.547 Medical Necessity Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits**
The following drugs have been added to the list of those considered medically necessary for anticoagulant treatment:
- Enoxaparin is approved for first-step therapy.
- Eliquis is approved for second-step therapy.

**5.05.550 Pharmacotherapy of Autoimmune Disorders New policy**
Criteria for coverage of medication therapy for the following conditions have been incorporated into a single policy: ankylosing spondylitis, juvenile idiopathic arthritis, rheumatoid arthritis, Crohn’s disease (regional enteritis), ulcerative colitis, lupus, Wegener’s granulomatosis, multiple sclerosis, psoriasis, psoriatic arthritis, and thrombocytopenia. Changes include:
- Trial of Rituximab as medically necessary to treat lupus patients who have failed other standard therapies.
- In patients with MS, beta interferon agents are considered medically necessary as first-line agents; use of Copaxone and Tysabri are considered medically necessary as second-line agents for patients who have failed or been intolerant to beta-interferons.

**5.01.605 Medical Necessity Criteria for Pharmacy Edits**
Brand stimulants and non-stimulants for ADHD and other psychiatric conditions may be considered medically necessary when criteria are met. (See policy for details.)

**7.01.553 Posterior Tibial Nerve Stimulation (PTNS) for Voiding Dysfunction**
Modified policy statement, new numbering. PTNS may be considered medically necessary as a treatment for non-neurogenic overactive bladder syndrome when criteria are met. (See policy for details.)

**8.01.15 High-Dose Chemotherapy with Hematopoietic Stem-Cell Support for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma**
Change in policy statement, and numbering. Autologous hematopoietic stem-cell transplantation is considered investigational to treat chronic lymphocytic leukemia or small lymphocytic lymphoma.

**12.04.113 Analysis of MGMT Promoter Methylation in Malignant Gliomas New policy**
MGMT promoter methylation testing for prognostic value or as a predictive biomarker for response to treatment with alkylating agents is considered investigational.

**12.04.114 Genetic Testing for Dilated Cardiomyopathy**
New policy. Genetic testing for dilated cardiomyopathy is considered investigational in all situations.
The following policy changes are effective for dates of service of May 18, 2014 and later:

7.01.551  **Lumbar Spine Decompression Surgery: Discectomy, Foraminotomy, Laminotomy, Laminectomy** *New policy.*

Lumbar spine decompression surgery may be considered medically necessary when criteria are met. *(See policy for details.)*

The following policy changes are effective for dates of service of July 1, 2014 and later:

2.01.531  **Intra-articular Hyaluronan Injections for Osteoarthritis**

*Change in policy statement, and numbering.* Intra-articular hyaluronan injections to treat osteoarthritis of the knee are considered not medically necessary for most patients with knee arthritis. *(See policy for details.)*

The following policy changes are effective for dates of service of Aug. 19, 2014 and later:

5.01.551  **Granulocyte Colony-Stimulating Factor (G-CSF) Use in Adult Patients** *New policy.* Medical necessity review for use of granulocyte colony-stimulation factors (G-CSF) for adult patients considered to be at risk of severe febrile neutropenia will be conducted as follows:

- Tbo-filgrastim (Granix®) may be considered medically necessary as first-line therapy to decrease the incidence of neutropenia related infection in cancer patients when criteria are met.
- Filgrastim (Neupogen®) and pegfilgrastim (Neulasta®) may be considered medically necessary as second-line therapy to decrease the incidence of neutropenia related infection in cancer patients when criteria are met.
- Filgrastim (Neupogen®) may be considered medically necessary as first-line therapy in patients with acute myeloid leukemia (AML) when criteria are met.
Please post or circulate this newsletter in your office.

Network News
Back issues of Network News are on our website at premera.com/wa/provider in the Library under Communications.