Company Updates

Washington State 2015 Legislative Session Update

The Washington State Legislature convened on Jan. 12, 2015, and adjourned on April 24. They reconvened on April 29 for a special budget session. We want to keep you informed on the latest changes coming from our state legislators. Here are the key bills we worked on that passed in the 2015 legislative session—you can link to each one for more details.

**SB 5084 All Payer Claims Database:** Expands the all payer claims database to require claims data from health carriers, certain third party administrators, and the Department of Labor and Industries in addition to Medicaid and the state employee program to improve health care quality and cost transparency. Premera supported the bill.

**SB 5557 Pharmacist Reimbursement:** Requires health carriers to reimburse for services provided by a pharmacist acting within the scope of practice. Premera will begin implementation of these new requirements.

**HB 1471 Prior Authorization:** Establishes certain requirements for health carriers related to prior authorization. Premera had concerns with earlier versions of the bill that would have created unworkable requirements.

**SB 5175 Telemedicine:** Requires health carriers to reimburse for certain health care services delivered through telemedicine or store and forward technology. Premera supported SB 5175.

**SB 5935 Biosimilars:** Authorizes a biological product to be substituted in the place of another biological product if determined by the federal Food and Drug Administration (FDA) to be interchangeable. The bill also includes a notice provision through electronic or other means from the pharmacist to the prescribing practitioner. Premera supported the final version of the bill.
Refer Your Premera Patients to In-Network Providers for Maximum Benefits

To 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.

To help members find in-network providers, check out our Find a Doctor tool or call the customer service number on the back of the member’s 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.

Premera Targeted by Cyberattack

Premera was recently the target of a sophisticated cyberattack. The security of our members’ personal information, as well as the information of those with whom we do business, is a top priority for Premera, and we regret any concern this incident may cause. Additional information and updates on how this affects you and your patients are available here.

New ICD-10 Prior Authorization Enhancement Effective July 1

Beginning July 1, Premera’s Prospective Review Tool will accept both ICD-9 and ICD-10 diagnosis codes, in order to support Premera’s current policy of accepting prior authorization requests 90 days prior to Date of Service. Important: We only require one prior authorization for each scope of treatment, even if treatment has multiple dates that cross the compliance date. Providers may submit either ICD-9 or ICD-10 diagnosis codes in their prior authorization request.

As we get closer to the ICD-10 compliance date (Oct. 1, 2015), we’ll notify you about any changes to our ICD-10 prior authorization process on premera.com/wa/provider/ under News and Updates. Learn more about ICD-10.

HEDIS Measures

Here are three Healthcare Effectiveness Data Information Set (HEDIS) measure summaries and links to our provider tip sheets. To find more HEDIS tip sheets, visit our HEDIS web page.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS Measure: Antidepressant Medication Management*

About one in six adults in the United States suffers from a major depressive disorder in their lifetime. One in eighteen adults suffers an episode of depressive disorder each year.1, 2 Fortunately, many people with depression can and do improve through treatment. A combination of counseling and medication is generally recommended.3
Antidepressants are important therapies for depression. However, studies estimate that many patients stop taking antidepressants soon after diagnosis:

- 30% stop after one month
- 68% stop within three months

Early medication discontinuation is linked to higher rates of depression relapse and more major depressive episodes.4, 5

Studies show that rates of antidepressant medication compliance are significantly improved when providers give more information about the prescribed drug. Examples include information about side effects, how long the treatment takes to work, and expectations about the duration of treatment.6, 7

For additional resources on antidepressant medication management, view our Antidepressant Medication Management HEDIS Tip Sheet.


*This information is from current medical literature and provided to you solely for informational purposes. It does not constitute medical advice and is not intended for use in medical diagnosis or treatment.

HEDIS Measure: Follow-Up Care for Children on Prescribed ADHD Medications*

Follow-up appointments for children newly diagnosed with ADHD are crucial for the initial management of new medications. These appointments are so important to understand why a patient:

- Stops taking the medication
- Takes the medication only partially (self-adjustment)
- Or discontinues the medication due to side effects

Please post or circulate Network News in your office. Visit premera.com/wa/provider for all Premera provider communications and secure tools. 001399 (05-2015)
Without appropriate assessment, undiagnosed or under-treated children with behavioral symptoms may suffer socially and academically. For children diagnosed with ADHD, about half also have learning disabilities. In-depth assessment and carefully developed treatment plans are designed to address each child’s symptoms.

How providers can help:

- Ensure that the patient receives a follow-up visit within 30 days of a new prescription
- Ensure that the patient receives at least two more follow-up visits within nine months to make sure the treatment is working properly

For more information, view our Follow-Up Care for Children Prescribed ADHD Medications HEDIS Tip Sheet.

1 Jane Tolman, “Follow-up doctor visits are key when treating ADHD with medication” April 2, 2011, Examiner.com

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HEDIS Measure: Controlling High Blood Pressure*

High blood pressure or hypertension increases the risk of heart disease and stroke and is one of the leading causes of death and disease in the United States.

Getting a patient’s blood pressure under control is a significant challenge considering the amount of uncontrolled hypertension in the United States. It’s so significant that up to 50 percent of those with hypertension are uncontrolled.

Here are some simple steps you can take to ensure accuracy of this vital measurement:

- Patient position: Back supported, feet on floor, arm at heart level, sitting quietly
- Cuff size: Most adults need a large cuff; make sure you have the necessary equipment in all your exam rooms
- Take it twice: If the patient has a high blood pressure reading at the beginning of the visit, retake and record it at the end of the visit

For more information, view our Controlling High Blood Pressure HEDIS Tip Sheet.

2 cdc.gov/mmwr/preview/mmwrhtml/mm6135a3.htm and nhlbi.nih.gov/files/docs/guidelines/express.pdf
Medical Director Spotlight: Ted Conklin, MD

Dr. Ted Conklin started at Premera in July 2011 as a Medical Director and was recently promoted to Vice President, Quality & Medical Management. Prior to joining Premera, Dr. Conklin worked as a Family Physician at Swedish Partners Medical Group and he taught at the Swedish Family Practice Residency Program.

He also started his own company (Carena, Inc.) in 2000—Carena provides home visits to Microsoft members. **We had a chance to talk with Dr. Conklin recently about his work at Premera.**

**What was it about Premera that appealed to you?**
I'd been working with a number of Premera individuals in my prior job (Roki Chauhan, Ken Chandler, Jen Jones) on the Microsoft account. I enjoyed the collaboration and success we achieved, ultimately winning a Microsoft innovation award. I also realized working with Premera would allow me to participate in creating a sustainable healthcare system on a much larger scale.

**What do you want providers to know about your work here?**
I'm part of a great team that's focused on collaborating with provider groups to improve member and provider experience, while continuously working to increase quality and reduce patient harm and waste.

**Where did you grow up? What brought you to this area?**
I grew up in New Jersey and spent several years living in Lucerne, Switzerland. I spent part of my summers with my mother’s parents in Medina. At age 15, I started teaching sailing on Lake Washington; I taught for several years and loved being on the lake. After completing my family medicine residency in Portland, Oregon, my wife and I decided it was a natural transition to move to Seattle.

**What is your most inspiring or memorable patient story?**
I was doing house calls for an 86-year-old patient dying from prostate cancer. We discussed his life goals—he wanted to finish writing a book and get it published, as well as see his next great grandchild born. He accomplished both with a huge smile, but he was almost kicked out of hospice when they arrived once to find him splitting wood in the backyard!

**What is something people would be surprised to know about you?**
I love playing ice hockey with a number of other old guys.

**What was your very first job? What’s your dream job?**
At age 15, I delivered the Sunday New York Times from 3 a.m. until 10 a.m. I soon realized teaching sailing in the sun was a lot easier. My dream job is making a difference in healthcare and I’m doing it!
What is something new you learned in the last week?
Perceived senile dementia can be reversible. Two years ago we helped my 93-year-old mother-in-law move into an assisted living facility. She persistently seemed to get more confused and go downhill. About six months ago, she informed us she was moving back to the Philippines where she grew up. We were very worried, however, last week I learned she'd launched herself into dealing with some old family property and had successfully closed a business deal! She's thrilled every time we talk to her and seems smarter than ever.

If you could learn to do anything, what would it be?
Become a better guitar player.

What are your interests outside of work?
Running, fishing, and traveling with my family—I love the New Jersey shore where my family has a 100-year-old boat house on a natural lagoon that was initially used for repairing boats.

What's the best piece of advice you've ever received?
“Show up” as the person you aspire to be.

Anything else you’d like to add?
I spent eight years teaching in a Family Practice residency program and 12 years doing a start-up. But the most fun I’ve ever had in my career has been my time at Premera.

Premera Blue Cross Medicare Advantage

Medication Therapy Management Helps Keep Members Safe, Reduces Costs
Medication Therapy Management (MTM) is provided at no additional cost to qualifying Premera Blue Cross Medicare Advantage members. MTM helps members work with pharmacists to review medications, identify potential problems, and reduce costs. Studies show that MTM programs can also help decrease hospitalizations and emergency room visits.¹

Members who qualify for the MTM program are sent a welcome packet that tells them how to schedule a phone appointment with a pharmacist for a comprehensive medication review which includes:

- Reviewing the patient’s medications
- Answering member questions
- Identifying cost-saving opportunities

We may contact your office before the review to gather information on the patient’s current medications and conditions. Following the review, the pharmacist sends the member a summary letter, action plan, and medication list for the member and primary care provider to review together.
We may contact you by phone or fax-back form with pharmacist-suggested medication changes. The form asks you to:

- Review the pharmacist's recommendations and mark a response
- Contact your patient and the pharmacy to make any therapy changes
- Sign and fax a copy of the form within 30 days to the MTM team at 800-249-7714
- Make any entries into the patient’s medical chart or electronic health record that you consider necessary; note receipt of the MTM letter, describe the suggested change, and indicate your plan of action and reasons

If ongoing review identifies new drug interactions, dosage issues, or cost-saving opportunities, we may contact you to suggest changes. Learn more about the MTM program.


Prescribers of Medicare Part D Medications: Submit Medicare Enrollment Applications by June 1, 2015

Effective December 1, 2015, the Centers for Medicare and Medicaid Services (CMS) will require prescribers of Part D medications to have a Medicare enrollment application or opt-out on file with CMS. To ensure applications are processed by December 1, 2015, CMS is requiring all applications or opt-outs by June 1, 2015.

We encourage all prescribers of Part D medications to go the CMS website to file their application by June 1 so there is no interruption to their patients’ claims. This includes all medical and dental providers who care for Medicare patients.

From the Centers for Medicare and Medicaid Services website:

CMS finalized CMS-4159-F, Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs on May 23, 2014. This rule requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to:

- Be enrolled in Medicare in an approved status, or
- Have a valid opt-out affidavit on file for their prescriptions to be covered under Part D

Learn more at CMS.gov.
Benefits of Statins Likely Outweigh Risks, According to Guidelines

One in three Americans will die from heart disease or stroke, and fully 60 percent will have a major vascular event before they die. Recognizing this burden on public health, in 2013 the American Heart Association and American College of Cardiology released four clinical practice prevention guidelines for lifestyle, obesity, cholesterol, and risk assessment.¹

There are many questions about the new cholesterol treatment guidelines, especially when it comes to taking cholesterol-lowering drugs called statins to prevent heart disease and stroke. While it’s generally agreed that statin therapy reduces the risk of ASCVD (arteriosclerotic cardiovascular disease) events, there’s concern that following the new guidelines could result in statin-based therapy for millions of new patients.¹,²

Healthcare providers worry that statins may have too many adverse effects to be broadly prescribed for primary prevention as recommended by the guidelines. However, not all side effects are serious and the benefits of statins likely outweigh the risks in most patients.¹

Here are clinical management suggestions from the American Heart Association and the American College of Cardiology for common statin side effects:

<table>
<thead>
<tr>
<th>Muscle-related symptoms</th>
<th>Cognitive impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms such as muscle pain, soreness and weakness after starting statin therapy are commonly reported by patients and can increase with the dose.</td>
<td>In 2012, the Food and Drug Administration issued new safety labeling requirements for statins based on reports of cognitive impairment, such as memory loss, forgetfulness and confusion.³</td>
</tr>
<tr>
<td>More severe side effects, such as myopathy and rhabdomyolysis, occur infrequently and are very rarely serious or life-threatening.</td>
<td>Since then, continued post marketing surveillance and systematic reviews have not found a true association between statin use and cognitive impairment.⁴, ⁵, ⁶</td>
</tr>
<tr>
<td>• For severe muscle-related symptoms, consider discontinuing therapy and evaluating for possible myopathy or rhabdomyolysis.</td>
<td>• For cognitive impairment symptoms, evaluate the patient for causes other than statin therapy, including exposure to other medications, neuropsychiatric and other systemic reasons.¹</td>
</tr>
<tr>
<td>• For mild to moderate symptoms, discontinue therapy until the patient’s symptoms subside. Resume therapy with the original or a lower dose of the same statin.</td>
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<tr>
<td>• If your patient’s symptoms return, switch to another statin. Consider a low-dose and titrating, depending on your patient’s tolerance level.</td>
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<tr>
<td>• If symptoms continue after two months, consider other causes and resume statin therapy at the original dose.</td>
<td></td>
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</tbody>
</table>

Visit premera.com/wa/provider for all Premera provider communications and secure tools. ⁰⁰¹³⁹⁹ (05-2015)
Liver enzymes
Some patients may experience increases in liver enzymes during routine use of statin therapy. These effects are often transient and LFT’s often return to normal after statin therapy ceases.

Recently, the FDA has concluded that liver injury is very rare with statin use and is not predicted by transient, elevated liver enzymes. 3, 4

- Measure baseline liver function values before starting statin therapy. 1
- Routine monitoring of liver function is not recommended unless signs or symptoms of hepatotoxicity (unusual fatigue, abdominal pain, dark-colored urine, yellowing of the skin or sclera) develop. 1, 4 In this case, interrupt therapy and determine the cause of symptoms. If statin therapy is not the cause of symptoms, consider restarting therapy.

Incident diabetes
Statin use has been shown to increase the risk of developing Type 2 diabetes. However, in clinical trials and meta-analyses, the incidence of new-onset diabetes is relatively low. 7

The ACC/AHA guidelines recognize there is an increased risk of developing diabetes with statin-based therapy, but overall, the benefits of therapy are believed to outweigh the risks for most patients with a 10-year ASCVD risk ≥ 7.5 percent.

- Patients on statin-based therapy should be monitored for diabetes according to current screening guidelines.
- Asymptomatic patients receive a screening at least every three years, starting at age 45.
- If patients are overweight and have additional risk factors, such as physical inactivity or a first-degree relative with diabetes or hypertension, screenings may start earlier. 8
- For patients with diabetes, statin therapy should be continued as the benefits associated with ASCVD risk reduction outweigh the risks associated with new-onset diabetes. 1

Vaccine Coverage for Medicare Advantage Members
Medicare coverage for vaccines can be complicated. Premera Blue Cross Medicare Advantage plans encourage members to work with their providers and our Customer Service team to understand vaccine coverage upfront. This helps your patients avoid unexpected bills for vaccines given in your office.


3U.S. Food and Drug Administration. FDA Drug Safety Communication: Important safety label changes to cholesterol-lowering statin drugs. (Accessed 1 August 2014)

4U.S. Food and Drug Administration. For consumers: FDA Expands Advice on Statin Risks. (Accessed 1 August 2014)


Some vaccines, such as flu and pneumonia, are covered at no cost to the member when given in an in-network provider’s office. Others, such as Hepatitis B, may be covered at no cost to the member depending on the patient’s medical history. The Zostavax® shingles vaccine is only covered with a member cost share under the member’s Part D prescription drug coverage.

Premera Medicare Advantage members generally pay less for Part D vaccines when they’re administered at an in-network preferred pharmacy. If your patient needs help finding a pharmacy offering vaccine services, please direct them to Premera Medicare Advantage Customer Service at 888-850-8526, Monday through Friday, 8 am to 8 pm Pacific Time.

Reminder: Check ID Cards for Medicare Advantage Patients

Be sure you check your patients’ ID cards to confirm that they are Premera Blue Cross Medicare Advantage members. Submitting incorrect forms or requests can cause delays in things like:

- Prior authorization/pre-service review
- Pharmacy forms
- Referrals to specialists

Here’s a sample ID card:

Secure Online Provider Tools Are Different for Medicare Advantage Members

It’s important to note that our Medicare Advantage website uses different online tools than our commercial plans. You’ll find everything you need in the Premera Medicare Advantage section of our provider website. Use the ‘Get Started’ link in the right column to log in and check member benefits/eligibility, submit prior authorizations, and more.

If you have any questions, please call Premera Medicare Advantage Customer Service at 888-850-8526, Monday through Friday, 8 am to 8 pm Pacific Time.
Online Services Updates

New! Enhancements to Prospective Review Tool

Our prospective review tool is launching soon with a great new look and additional features that make submitting prospective reviews much easier.

These tool enhancements set the stage for more upcoming improvements to this essential, often-used tool.

Here are some highlights:

- User-friendly, easy-to-read display
- Diagnosis code description now included
- Search for requesting physician, servicing provider, and hospital/facility by NPI number
- Provider search results include provider type, specialty, and additional address line (i.e., for a suite number)
- Contact info now pre-populates (first name, last name – can be edited as needed)
- New! Check Prospective Review Status link accessible on left menu

For More Information

We’re always looking for ways to improve our website and tools so that our providers can serve our members as efficiently as possible. If you have any questions about the new tool enhancements, please call Physician and Provider Relations at 877-342-5258, option 4.

For Faster Claims, Enter Correct Provider Name on Prospective Review Tool

When entering the ordering/requesting provider and servicing provider on the Prospective Review tool, make sure you’re entering the correct one:

- ‘Requesting/Ordering’ is the provider recommending the service
- ‘Servicing’ is the provider who is providing the service and submitting a claim for the service being reviewed
When you submit your request, it’s important that the servicing provider matches the clinical information you’ve submitted. This ensures faster claims processing and approvals of your requests. If you have questions about using the Prospective Review Tool, please contact Physician and Provider Relations at 877-342-5258, option 4. For questions about pre-service reviews, please call Care Management, option 3.

Got Three Minutes to Spare? Take Our Provider Survey
We recently revised our provider survey, asking for your feedback about online Network News and our online tools. Please take a few minutes to give us your opinion. We’d love to hear from you! You’ll find the survey on our provider landing page. Take the survey.

New! Find a Doctor Provider Directory Tool
Here are some highlights of our new Find a Doctor tool:

- Enhanced, user-friendly display and easy-to-use features, showing everything the member needs to know about you, as a provider, including patient wait times, bios, and photos.

- Provider photo and bio upload capability, giving you more visibility in members’ provider comparisons. You can upload your photo and bio at premera.vitalsdata.com. It’s easy—complete the online form, upload your information, and we’ll have your new picture and bio on the website within three to five business days.

- Display of the same data-driven cost and quality information as the previous directory, just via a fresh interface.

Check out a short demo of the new directory, including a highlight of the new display and instructions for uploading your bio and photo.

Please help us keep our data current and accurate so that new patients can find you quickly and easily. Use our Provider Information Changes form (under Miscellaneous) to submit your demographic updates via email at provider.relationswest@premera.com or fax to Physician and Provider Relations, 425-918-4937.

Note: Secure provider access to cost comparisons will temporarily display in the old tool. We’ll update you via the secure provider website as soon as the new display is available.

If you have any questions about the new tool or how to submit information, please call Physician and Provider Relations at 877-342-5258, option 4.

Quick Tip: You Only Need Two for Member ID
Recent surveys and workshop feedback show that you’re wondering why you have to enter information for all three member identification sections (member ID, name, birth date) when checking eligibility and benefits online. We’ve got good news for you! You only need two pieces of verification when checking eligibility and benefits online for Premera members.
Completing two of the three sections makes sure we have an exact match for your search. If you have questions about using our online tools, please contact Physician and Provider Relations at 877-342-5258, option 4.

Reminder: Use the Latest Browser Version When Accessing Online Tools
For the best possible experience when using our online tools, we recommend that you upgrade to the latest version of Internet Explorer or other web browser that we support: Internet Explorer, Mozilla Firefox, and Google Chrome.

Sign Up for Email Updates for Network News
Don’t miss a single issue of Network News—sign up today for an email subscription. Simply log in to our provider website at premera.com/wa/provider and look for the email subscription sign up at the bottom of the My Premera home page.

Claims and Payment Policy Updates

Provider Claims Matching Reminder
To make sure your claims are processed as quickly as possible, please check and verify that the address you’re using for submitting claims is compliant with U.S. postal standards. Many providers are not billing according to the address we have on our files—this delays claims processing. To verify your address, please call Physician and Provider Relations at 877-342-5258, option 4.
Payment Policy Postcard and Online Updates

We’re now sending postcards as a more convenient way to inform you about new payment policies and updates. We’ve also updated our payment policy page so that you can see the date when the latest policy was added. Review our list of payment policies revised in the last 60 days.

Premera follows industry standard recommendations from sources such as the Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT), American Medical Association (AMA), and/or other professional organizations and societies. National Correct Coding Initiative (NCCI) editing is followed when applicable. Any exceptions are documented as Payment Policies.

If you have any questions, call Provider Relations at 877-342-5258, option 4. View all payment policies.

Note: Payment policies available at premera.com/wa/provider do not apply to Premera Blue Cross Medicare Advantage Plans. To access Medicare Advantage payment policies, click on the Get Started button at premera.com/wa/provider/medicare-advantage. Premera Blue Cross Medicare Advantage plans are offered in Washington in King, Pierce, Snohomish, Thurston, and Spokane counties only.

Reminders and Administrative Updates

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 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.

ICD-10 Deadline: Make Sure You’re Ready by October 1

The U.S. Department of Health and Human Services (HHS) set Oct. 1, 2015, as the new compliance date for healthcare providers, health plans, and healthcare clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

We’re moving forward with our planned testing with certain providers and clearinghouses in order to meet the federal compliance date. We’re not able to accept ICD-10 codes on claims until Oct. 1, 2015. Claims using ICD-10 codes sent prior to Oct. 1, 2015, will be returned. Note: Beginning July 1, we will accept prior authorization requests with ICD-9 or ICD-10 codes.

Important: Premera will continue to accept the former 1500 Health Insurance Claim Form (version 08/05) through Sept. 30, 2015. Please take this opportunity to use the forms you have on hand prior to Sept. 30, 2015. Effective Oct. 1, 2015, Premera will only accept claims submitted on the revised form (version 02/12). Learn more about ICD-10.
2015 Holiday Business Closure Dates

Premera is closed on the following dates:

May 25—Memorial Day
July 3—Fourth of July
September 7—Labor Day
November 26-27—Thanksgiving Holiday
December 24-25—Christmas Holiday

Practitioner Credentialing Notifications

Practitioner’s Right to Review Credentialing File

Practitioners have the right to review their credentialing files by notifying the Credentialing Department and requesting an appointment to review their file from outside sources (such as malpractice insurance carriers, state licensing boards). Allow up to seven business days to coordinate schedules. We will not make available references, recommendations, or peer-review protected information.

Practitioner’s Right to Correct Inaccurate Information

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

Corrections must be submitted in writing within 30 days of notification and can be submitted by mail, fax, or email:

Provider Credentialing Department, MS 263
P.O. Box 327
Seattle, WA 98111-0327
Fax: 425-918-4766
e-mail: Credentialing.Updates@Premera.com

Practitioner’s Right to Be Informed of Application Status

Upon request, practitioners have the right to be informed of their credentialing application status. 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 us of any updates or changes to your practice information at least 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.

You can notify us of any new information or changes by email, using the [Contracted Provider Information Changes form](mailto:). Providers can also send updates by fax at 425-918-4937, email at [PremeraBlueCross.DentalProviderRelations.West@premera.com](mailto:PremeraBlueCross.DentalProviderRelations.West@premera.com), or mail to:

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

For more information, call Physician and Provider Relations at 877-342-5258, option 4.

Dental Updates

Dental Network News Transitions to New Section in Medical Network News

Dental Network News is now part of the medical version of Network News and no longer a separate newsletter. From now on, you’ll find it under “Dental Updates” in the right column. Dental providers who’ve signed up for email alerts will continue to receive quarterly email notices when Network News is posted online. To sign up for email alerts, [log in](http://) to our secure provider website.

Look for Premera Dental Team at 2015 Dental Conferences

Premera Blue Cross and Premera Blue Cross Blue Shield of Alaska’s dental provider relations teams are participating exhibitors at the annual Washington and Alaska dental conferences.

The dental conferences provide an excellent educational opportunity for all attendees. Exhibitors have the opportunity to showcase products and services to hundreds of dental professionals. We look forward to meeting more members of the dental community in 2015!

**Mark Your Calendar:**

Alaska Dental Society Conference  
Homer, AK: May 29-30, 2015

Pacific Northwest Dental Conference  
Bellevue, WA: June 11-12, 2015

Please post or circulate Network News in your office.  
Visit [premera.com/wa/provider](http://premera.com/wa/provider) for all Premera provider communications and secure tools.  
001399 (05-2015)
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Learn more at CMS.gov.

Consultant’s Corner: Dentists Have Key Role in Patient’s Overall Health
Ronald D. Cantu, DDS, MPA, Premera Dental Director

I’d like to take a moment to focus on the epidemiology of chronic disease and set the stage for further discussion about the key role dentists play in a patient’s primary care.

The majority of the United States population has seen a dentist in the past 24 months, and as the dentist must increasingly monitor chronic disease problems of their patients, there is consideration that a dentist could serve as an extension of the patient’s primary care provider.

Recent statistics most certainly paint the picture of the nature of chronic disease in the U.S. Chronic disease increases with age; the number of adults over 65 has dramatically increased over the past 30 years—there are now approximately 300 million individuals over age 65. Seven out of 10 deaths are caused by chronic disease; it accounts for 75 percent of all health care expenses.¹

The most common chronic diseases include heart disease, diabetes, stroke, cancer, asthma, obesity, and oral disease. By 2050, five percent of the adult population will have periodontal disease, 12 percent will have diabetes, 20 percent will have cardiovascular disease, and two thirds (67 percent) will either be obese or overweight. The burden of these diseases can be lessened by prevention, early diagnosis, and professional follow-up.²
General dentists can play a key role in identifying patients who need consultation for chronic ailments. In my office, for example, we routinely screen our patients for high blood pressure. We also seek to understand their willingness to have age-related procedure referrals, their adherence to diabetes prevention and smoking cessation, and their general level of stress management. As many practitioners do, we keep a referral list of Premera network primary care providers and specialists.

I encourage our dental network providers to ask follow-up questions and provide a referral if a medical issue is suspected. Most patients value your concern for their general welfare, as well as their oral health. Premera understands the increasing dual role of dentists in medical screening of our members and is establishing expedited and efficient referral systems for our medical and dental network providers.

References:


Pharmacy Updates

Zarxio™ Approved as First Biosimilar in United States

The 2010 Affordable Care Act created the approval pathway for biosimilars. A biosimilar product is a biological product that’s approved based on being highly similar or interchangeable with a Food and Drug Administration (FDA)-approved biological product (known as a reference product). It has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.1

On March 6, 2015, the FDA approved Zarxio™ (filgrastim-sndz) as the first biosimilar in the United States. Increased competition among biologic drugs can lead to better patient access and lower overall healthcare costs.

Zarxio was approved in Europe (by the European Medicines Agency) in 2008 and is already sold in more than 60 countries. Providers must prescribe Zarxio by name since it can’t be substituted by the pharmacist.

Zarxio has the same FDA-approved indications as Neupogen, which include:

- Cancer patients receiving myelo-suppressive chemotherapy
- Patients with acute myeloid leukemia receiving induction or consolidation chemotherapy
- Cancer patients receiving bone marrow transplantation
- Patients undergoing peripheral blood progenitor cell collection and therapy
- Patients with severe chronic neutropenia
Four additional biosimilars are under FDA review for possible approval this summer:

- Remsima (infliximab – Celltrion), a biosimilar to Janssen’s Remicade®
- Pegfilgrastim (Apotex), a biosimilar to Amgen’s Neulasta®
- Retacrit™ (epoetin alfa – Hospira) a biosimilar to Epogen®/Procrit® (epoetin alfa – Amgen/Janssen)
- Grastofil (filgrastim – Apotex) a biosimilar to Neupogen®

Learn more about biosimilars.

Source:
2. FDA Guidance Documents
3. Biosimilars – U.S. and International Update
4. Update on the Development and Approval of Biosimilar Products-FDA Presentation

Granix: Medical Necessity Review No Longer Required

Granix® (tbo-filgrastim), which is therapeutically equivalent to Neupogen® (filgrastim), no longer requires medical necessity review. Though we are removing the review requirement for Granix only, we strongly encourage that you review medical necessity criteria in policy 5.01.551 Granulocyte Colony-Stimulating Factor (G-CSF) Use in Adult Patients for information about appropriate use of Granix and other white blood cell growth factors.

The American Society of Clinical Oncology (ASCO) recommends the prophylactic use of G-CSF when the risk of febrile neutropenia is greater than 20 percent, due to either specific chemotherapy regimens or patient risk factors such as age, medical history, or disease characteristics. This guidance is reiterated in ASCO’s Choosing Wisely initiatives. Our policy echoes professional society recommendations, which also state that G-CSFs should not be used routinely for afebrile neutropenia.

Premera Formulary and Pharmacy Prior Authorization Criteria

Premera updates the formulary and pharmacy prior authorization criteria routinely throughout the year. The Pharmacy and Therapeutics Committee approves all formularies in May. To see the most current information, visit our pharmacy pages.

Pharmacy Prior Authorization Edit Expansion

Premera has added new review criteria based on clinical best practices 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. to 5 p.m.
New Edits Included in the Pharmacy Prior Authorization Edit Program

Effective April 1, 2015:

**Aubagio® (teriflunomide)**

premera.com/medicalpolicies/5.01.550.pdf

**Coverage Criteria**

Teriflunomide (Aubagio) may be considered **medically necessary** as a **first line** agent for the treatment of relapsing forms of **multiple sclerosis** when the following criteria are met:

- Patient must have an Expanded Disability Status Score (EDSS) of less than six
- Teriflunomide is not to be used concurrently with other multiple sclerosis disease modifying drugs

All other uses of teriflunomide are considered investigational. Aubagio is a specialty pharmacy drug covered under the pharmacy benefit.

**Esbriet® (pirfenidone)**

**Ofev® (nintedanib)**

premera.com/medicalpolicies/5.01.555.pdf

**Coverage Criteria**

Pirfenidone (Esbriet®) or Nintedanib (Ofev®) may be considered **medically necessary** for the treatment of idiopathic pulmonary fibrosis (IPF) when **all** of the following conditions are met:

- IPF was diagnosed within the last five years, in accordance with the 2000 ATS/ERS criteria (see policy guideline link above)
- Forced vital capacity (FVC) ≥ 50% of the predicted value
- DLCO between 30-79% of the predicted value
- HRCT performed within the last 12 months

Combination therapy with nintedanib plus pirfenidone is considered **investigational**. Use of these agents for any indication other than the above is considered **investigational**.

**Esbriet®** and **Ofev®** are specialty pharmacy drugs covered under the pharmacy benefit.

View complete policies here.

Note: This information does not apply to our Premera Blue Cross Medicare Advantage plans. For more information on the Premera Blue Cross Medicare Advantage formulary, Prior Authorization Criteria, or Pharmacy Network, visit premera.com/medicare-advantage/pharmacy-services.
Imbruvica® (ibrutinib)
premera.com/medicalpolicies/5.01.534.pdf

Coverage Criteria

Ibrutinib (Imbruvica®) may be considered medically necessary for treatment of the following hematologic malignancies:

- Mantle cell lymphoma
- Chronic lymphocytic leukemia

All other uses of ibrutinib are considered investigational. Imbruvica® is a specialty pharmacy drug covered under the pharmacy benefit.

Inlyta® (axitinib)
premera.com/medicalpolicies/5.01.534.pdf

Coverage Criteria

Axitinib (Inlyta®) may be considered medically necessary as a second line agent for the treatment of renal cell carcinoma (RCC) in patients that have inadequate response or intolerance to pazopanib (Votrient), sorafenib (Nexavar) or sunitinib (Sutent). All other uses of axitinib are considered investigational. Inlyta® is a specialty pharmacy drug covered under the pharmacy benefit.

Effective May 1, 2015:

Cosentyx® (secukinumab)
premera.com/medicalpolicies/5.01.550.pdf

Coverage Criteria

Secukinumab (Cosentyx®) may be considered medically necessary as a second line agent for the FDA-approved indication for the treatment of moderate to severe plaque psoriasis in patients who are candidates for systemic therapy that have an inadequate response or intolerance to etanercept (Enbrel) and adalimumab (Humira). All other uses of secukinumab are considered investigational. Cosentyx® is a specialty pharmacy drug covered under the pharmacy benefit.
Medical Policy Updates

Policy Update: Intra-articular Hyaluronan Injections

Effective July 1, 2015, Premera will consider hyaluronic acid products for osteoarthritis of the knee not medically necessary. Scientific data has not shown clinically meaningful symptom improvement for most individuals, and no data indicates these products improve health outcomes.

However, pain and disability due to progressive knee arthritis is common in adults and can be difficult to manage. Some of our providers have reported that a small subset of their patients have achieved improved functional status. Our claims data show that only nine percent of our members who begin this treatment continue it consistently for 18 months or longer. To accommodate this small subset of members, we have implemented interim policy 2.01.534 Intra-articular Hyaluronan Injections for Osteoarthritis.

If you have patients who’ve had success with these products for osteoarthritis of the knee for 18 months or longer, prior to July 1 please submit medical records documenting the following:

- The presence of moderate to severe osteoarthritis is documented by x-ray studies that show a Kellgren-Lawrence Score of two or greater
- Pain interferes with functional activities, such as walking or prolonged standing
- Objective evidence of functional improvement and decreased pain after prior courses of therapy. Objective documentation can be shown using a number of validated clinical instruments, such as Knee Injury and Osteoarthritis Outcome Score (KOOS), International Knee Documentation Committee (IKDC), Oxford Knee Score (OKS), and Lysholm Knee Scoring Scale

We’ll review the information to determine whether the member meets the criteria of the interim policy. If so, the member will be grandfathered for ongoing use.

For dates of service July 1, 2015 and later, hyaluronic acid products for osteoarthritis of the knee will be considered not medically necessary for all non-grandfathered patients. Please review policy 2.01.31 Intra-Articular Hyaluronan Injections for Osteoarthritis for full details.

Medical Policy Updates

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. View complete medical policies or email requests to 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. 1, 2015 and later:

New utilization management guidelines: For each level of service below, treatment may be considered medically necessary when all criteria are met.

3.01.508 Behavioral Health: Psychiatric Residential Treatment
3.01.511 Behavioral Health: Eating Disorders, Inpatient Treatment
3.01.512 Behavioral Health: Chemical Dependency/Substance Abuse Residential Treatment
3.01.515 Behavioral Health: Inpatient/Residential Detoxification
3.01.516 Behavioral Health: Psychiatric Inpatient Treatment
3.01.517 Behavioral Health: Eating Disorders, Residential Treatment
3.01.518 Behavioral Health: Crisis Treatment/Crisis Stabilization Centers
3.01.519 Behavioral Health: Chemical Dependency/Substance Abuse Inpatient Treatment

The following policy changes are effective for dates of service Jan. 13, 2015 and later:

2.01.96 Autonomic Nervous System Testing New Policy. Autonomic nervous system (ANS) testing is considered medically necessary when criteria are met. ANS testing using portable, automated devices is considered investigational.
2.01.503 Polysomnography and Home Sleep Study for Diagnosis of Obstructive Sleep Apnea Added a definition for restless limb syndrome.
2.04.29 Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening New Policy. DNA analysis of stool samples is considered investigational to screen for...
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<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
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<tr>
<td>2.04.125</td>
<td>Proteomic Testing for Targeted Therapy in Non-Small-Cell Lung Cancer</td>
<td><strong>New Policy.</strong> Proteomic testing is considered <strong>investigational</strong> in the management of non-small-cell lung cancer.</td>
</tr>
<tr>
<td>5.01.539</td>
<td>Ivacaftor</td>
<td>Medically necessary statement updated with the addition of gene mutation R117H, recently approved by the FDA. Additional language added to include &quot;any mutation subsequently added to the FDA-approved indication.&quot;</td>
</tr>
<tr>
<td>5.01.550</td>
<td>Pharmacotherapy of Autoimmune Disorders</td>
<td>Table within policy updated to include indications for treatment.</td>
</tr>
<tr>
<td>5.01.556</td>
<td>Rituximab: Non-oncologic and Miscellaneous Uses</td>
<td>Rituxan (rituximab) is considered <strong>medically necessary</strong> for labeled indications and specific off-label uses when criteria are met.</td>
</tr>
<tr>
<td>6.01.58</td>
<td>Endobronchial Ultrasound for Diagnosis and Staging of Lung Cancer</td>
<td><strong>New Policy.</strong> Endobronchial ultrasound is considered <strong>medically necessary</strong> for diagnosis and staging of lung cancer when criteria are met.</td>
</tr>
<tr>
<td>7.01.143</td>
<td>Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy</td>
<td><strong>New Policy.</strong> Responsive neurostimulation is considered <strong>medically necessary</strong> for refractory partial epilepsy meeting criteria.</td>
</tr>
<tr>
<td>7.01.144</td>
<td>Patient-Specific Cutting Guides and Custom Knee Implants</td>
<td><strong>New Policy.</strong> Use of custom knee implants or custom surgical cutting guides for joint arthroplasty is considered <strong>investigational.</strong></td>
</tr>
<tr>
<td>7.01.542</td>
<td>Lumbar Fusion</td>
<td>Criteria added: 90 days smoking cessation is required prior to fusion; one year of conservative therapy for severe degenerative scoliosis is required prior to fusion.</td>
</tr>
<tr>
<td>7.01.557</td>
<td>Gender Reassignment Surgery</td>
<td>Added a policy statement addressing medical necessity criteria for reversal of partially or fully completed gender reassignment.</td>
</tr>
<tr>
<td>10.01.514</td>
<td>Cosmetic and Reconstructive Services</td>
<td>Policy updated to align with the rhinoplasty and septoplasty policy (7.01.558) adopted in Dec. 2014. Indications added for pharmaceutical agents that are considered <strong>cosmetic.</strong></td>
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<tr>
<td>Code</td>
<td>Policy Change</td>
<td>Description</td>
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<td>11.01.510 Skilled Nursing Facility (SNF): Guideline for Admission and Transition of Care</td>
<td>Added clarifying language, specific to FEP, about contract language related to reimbursement levels for SNF care.</td>
<td></td>
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<tr>
<td>5.01.606 Hepatitis C Antiviral Therapy</td>
<td>Policy section updated with addition of specific treatment regimen guidelines relative to the use of Viekira Pak.</td>
<td></td>
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<tr>
<td>1.01.519 Patient Lifts, Seat Lifts, and Standing Devices</td>
<td>Added a list of items which are non-covered or excluded by contract.</td>
<td></td>
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<tr>
<td>4.01.21 Noninvasive Prenatal Testing for Fetal Aneuploidies Using Cell-Free Fetal DNA</td>
<td>Concurrent nucleic acid sequencing-based testing of maternal plasma for trisomy 13 and/or 18 may be considered medically necessary in women eligible for and undergoing trisomy 21 testing. This testing is considered investigational in situations other than those listed in the policy. Nucleic acid sequencing-based testing for fetal sex chromosome aneuploidies is considered investigational.</td>
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<tr>
<td>5.01.514 Trastuzumab and HER2 Inhibitors</td>
<td>Clarification added to the medically necessary statement for pertuzumab to include its use as adjuvant, neoadjuvant therapy, and treatment of metastatic disease.</td>
<td></td>
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<tr>
<td>5.01.547 Medically Necessary Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits</td>
<td>Quantity limits updated for Relenza and Tamiflu.</td>
<td></td>
</tr>
<tr>
<td>7.01.519 Treatment of Varicose Veins/Venous Insufficiency</td>
<td>Sclerotherapy, previously considered investigational for the treatment of varicose greater or lesser saphenous veins, may now be considered medically necessary when criteria are met.</td>
<td></td>
</tr>
<tr>
<td>7.01.560 Anterior Cervical Spine Decompression and Fusion in Adults with or without Fusion</td>
<td>All information specific to posterior cervical removed from policy statement. Title revised to note that criteria apply to anterior cervical decompression and fusion to adults.</td>
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</table>
only. Posterior cervical fusion will not be reviewed for medical necessity.

7.02.500  Monitored Anesthesia Care (MAC)  Policy statement clarified with the addition of medically necessary indication for prior complications with anesthesia or conscious sedation.

9.03.03  Orthoptic Training for the Treatment of Vision or Learning Disabilities  New Policy. Office-based vergence/accommodative therapy may be considered medically necessary if specific visual symptoms did not improve after 12 weeks of home-based therapy. Orthoptic eye exercises are not medically necessary for learning disabilities. Orthoptic eye exercises are considered investigational for all other conditions.

11.01.520  Infectious Disease: Guideline for Transition of Care  Policy section updated with additional criterion for meningitis/encephalitis patients.

12.04.131  Pharmacogenetic Testing for Pain Management  Genetic testing for pain management is considered investigational.

Each utilization management guideline below has been updated with indications specific to pediatric patients.

11.01.511  Burns: Guideline for Transition of Care
11.01.512  Cardiovascular: Guideline for Transition of Care
11.01.513  Endocrine/Metabolic: Guideline for Transition of Care
11.01.514  Gastrointestinal: Guideline for Transition of Care
11.01.515  Genitourinary: Guideline for Transition of Care
11.01.516  Hematologic/Oncologic: Guideline for Transition of Care
11.01.518  Orthopedic: Guideline for Transition of Care
11.01.519  Neurologic: Guideline for Transition of Care
11.01.521  Respiratory: Guideline for Transition of Care

The following policy changes are effective for dates of service March 10, 2015 and later:

1.01.30  Artificial Pancreas Device Systems  New Policy. FDA-approved artificial pancreas device may be considered medically necessary
for patients with type 1 diabetes who meet criteria. When criteria are not met the device is considered investigative.

1.03.05 Patient-actuated End Range Motion Stretching Devices

New Policy. Further high-quality comparative trials are needed to determine whether patient-actuated devices improve functional outcomes compared to alternative treatments; therefore these devices are considered investigational.

1.01.507 Electrical Stimulation Devices

New statement added to policy: Electrical stimulation for osteoarthritis or rheumatoid arthritis is considered investigational.

1.01.522 Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid

Information on artificial pancreas system removed from this policy and added to new policy 1.01.30.

2.03.07 Cytoreductive Surgery and Perioperative Intraperitoneal Chemotherapy for Select Intra-abdominal and Pelvic Malignancies

Added a policy statement to clarify that this policy refers only to the clinical setting where cytoreductive surgery and perioperative intraperitoneal chemotherapy are provided in the same operative setting. Policy title changed.

5.01.550 Pharmacotherapy of Autoimmune Disorders

Policy updated with Anti-CD52 alemtuzumab as a first-line treatment for multiple sclerosis and IL-17 inhibitors secukinumab as a second-line treatment for plaque psoriasis.

5.01.605 Medical Necessity Criteria for Pharmacy Edits

Vyvanse added for Binge Eating Disorder (BED) without requiring a trial of or a contraindication to a generic stimulant when BED diagnosis is confirmed.

5.01.534 Multiple Receptor Tyrosine Kinase Inhibitors

Axitinib is a second-line treatment for renal cell carcinoma. Ibrutinib is added for hematologic malignancies. Trametinib is added as combination therapy with dabrafenib for malignant melanoma with BRAFV600.

5.01.547 Medically Necessary Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits

Minor updates: Actonel, Atelvia, Binosto, Boniva, Exalgo, Detrol LA, Fosamax Plus D removed. Quantity limits for Embeda ER added.
<table>
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<tr>
<td>7.01.549</td>
<td>Knee Arthroscopy, Adults</td>
<td>Policy statements added indicating a meniscus tear may be repaired at the same time as an ACL repair when the ACL meets medical necessity criteria. Removed all policy statements for pediatric and adolescents and added “Adults” to policy title.</td>
</tr>
<tr>
<td>8.01.60</td>
<td>Extracorporeal Membrane Oxygenation for Adult Conditions</td>
<td><strong>New Policy.</strong> ECMO for adults is considered <strong>medically necessary</strong> for acute respiratory failure meeting criteria and as a bridge to heart, lung, and heart-lung transplant. ECMO is considered <strong>investigational</strong> for other indications.</td>
</tr>
<tr>
<td>12.04.121</td>
<td>Miscellaneous Genetic and Molecular Diagnostic Tests</td>
<td>DecisionDx-Melanoma, DecisionDx-Thymoma, DNA Methylation Pathway Profile, GI Effects® (Stool), Response DXColon added as <strong>investigational.</strong></td>
</tr>
<tr>
<td>12.04.126</td>
<td>Genetic Testing for PALB2 Mutations</td>
<td><strong>New Policy.</strong> Genetic testing for PALB2 mutations in patients with breast or pancreatic cancer or for cancer risk assessment in patients with or without a family history of breast or pancreatic cancer is considered <strong>investigational.</strong></td>
</tr>
</tbody>
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