

August 2015

Network News is published quarterly in February, May, August, and November.

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## Company Updates

### New Affordable Care Act (ACA) Medical Record Audits Coming Soon

The Department of Health and Human Services (HHS) will soon require all health plans to conduct a random, annual medical record review for members who've purchased individual and small group insurance plans on or off the Exchange.

At this time, we've not received details about this audit, but wanted to notify you so you're prepared to provide member medical records once HHS announces the audit date.

Here's what we know so far:

- HHS will audit all health plans.
- HHS will require all health plans to conduct an annual random medical record review for members who've purchased individual and small group insurance plans **on** or **off** the Exchange.
  - The first data validation audit is expected to occur in the second half of 2015.
- HHS will require all health plans to collaborate with an independent initial validation auditor to assist with the collection and review of medical records from providers.
  - HHS will provide a list of the member audit samples.
  - HHS is looking for accurate and complete diagnosis recording between the medical records and the claim.

As business partners, it's important that we work collaboratively to meet the Affordable Care Act audit obligations. To ensure this, we ask that you provide the requested copies of medical records within the required timeframe. Once HHA announces the audit date, we'll provide more details.

## Washington Legislative Session Update

The Washington State Legislature convened on Jan. 12, 2015, and adjourned the regular session on April 24. They reconvened for two special sessions focusing on the budget and adjourned on July 10, 2015. 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.

**[SB 5557 Pharmacist Reimbursement](#)**: Requires health carriers to reimburse for services provided by a pharmacist acting within the scope of practice effective January 1, 2017. Premera will begin implementation of these new requirements.

**[HB 1471 Prior Authorization](#)**: Establishes certain requirements for health carriers related to prior authorization.

**[SB 5175 Telemedicine](#)**: Requires health carriers to reimburse for certain health care services delivered through telemedicine or store and forward technology.

**[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's Checkup Challenge Offers Incentives to Use Preventive Benefits

Premera recently launched Checkup Challenge, a social media interactive campaign to emphasize the importance of getting a regular doctor's checkup and appropriate preventive screenings to maintain good health. It also encourages adults to take advantage of the preventive benefits included in Affordable Care Act individual plans and many other health plans at little or no cost.

Running now through October 31, 2015, the added incentive to get a checkup is a contest that adult residents of Washington or Alaska can enter at [checkupchallenge.com](http://checkupchallenge.com), pledging to schedule a checkup by Dec. 31, 2015. Premera will automatically enter them into weekly drawings for a \$200 Amazon gift card, awarded on Premera's Facebook and Twitter pages. Follow campaign social media posts using the hashtag #checkupchallenge on Premera's [Facebook](#) page and [Twitter](#) profile.

For providers, Checkup Challenge can help address patient confusion about preventive health, which may also be contributing to the underutilization of regular preventive exams, by:

- Stressing the importance of getting preventive screenings appropriate for their age/gender/family history to diagnose conditions early on, when they are most preventable and treatable.
- Reinforcing (for women) that a preventive exam is more than a Pap smear. Due to recent guidelines around the frequency of Paps, some women may think they are not due for the test, so they don't need an overall checkup.
- Reminding adults (who are new to insurance or don't use their plan's preventive benefits) about the importance of checkups and demonstrating the value of having a plan, not only in emergencies, but for overall good health.
- Encouraging an initial consult through a preventive checkup which can lead to a mutually beneficial relationship with the patient's health as the focus.

Providers should note that this campaign may result in an increase in patients calling to schedule their checkups. If you see Premera members from now through October, be sure to tell them about the contest – they could win \$200! You don't have to be a Premera member to enter the Checkup Challenge. See [our contest rules and eligibility](#).

## Provider Groups Offer Tips for Success in Implementing Enrollee Health Assessment Program

Our Enrollee Health Assessment (EHA) Program launched just over a year ago with the goal of partnering with primary care providers to help members with chronic conditions. The success of this program is only possible with the dedicated help of our providers. We'd like to take a moment to offer some best practices from two provider groups.

### **Columbia Medical Associates**

Columbia Medical Associates created an efficient process and seamlessly implemented it into their daily workflow. Part of their success is a single point of contact, Jolene Black. Jolene reaches out to all targeted members to schedule Annual Health Review (AHR) visits and then sends the necessary appointment information to all the providers via EMRs. Her role is key to ensuring the program runs smoothly.

Last year Columbia Medical Associates saw 60 percent of their eligible patients for AHR visits. And, even with a member roster that nearly quadrupled this year, they've already seen more than 20 percent of their members.

### **Olympic Internal Medicine**

Although they're a smaller clinic compared to many of our larger provider groups, Olympic Internal Medicine clearly made their mark in our EHA program. One of the secrets to their success is careful review of the EHA mailings and close adherence to the guidelines. They also have a single point of contact in their office—a designated staff member who receives the mailings and then coordinates with additional office staff to bring members in for AHR visits.

And, their coding and documentation practices are exceptional. Each diagnosis on the claim is supported by chart documentation, each diagnosis in the chart note makes it onto the claim, and each note is appropriately signed off by the provider—missing or incorrect signatures are one of our program's biggest, but easiest to fix, challenges.

We appreciate the exceptional efforts of these two provider groups in supporting our members with chronic conditions. To sign up for the EHA Program or get more information about best practices, [check out our website](#) or email us at [ProviderEngagementTeam@Premera.com](mailto:ProviderEngagementTeam@Premera.com).

## New PersonalCare Partner Systems Network Effective January 1, 2016

Beginning Jan. 1, 2016, Premera will launch a new PersonalCare Partner Systems network that will support our new PCP referral-based benefit plans (PersonalCare Plans) offered in Snohomish, Pierce, and King counties. This network will only include Accountable Care Organizations (ACOs).

## What is an ACO?

An ACO is a system of healthcare providers who work collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients. Today, our contracted ACOs (PersonalCare Partners) are Northwest Physicians Network, UW Medicine, EvergreenHealth Partners, and MultiCare Connected Care.

## What is a PersonalCare Partner?

A PersonalCare Partner is a contracted ACO provider included in the PersonalCare Partner Systems network.

## What is a PersonalCare Plan?

We're offering our new PersonalCare Plans (Gold, Silver, Bronze) to individuals and small groups on and off the Exchange beginning this fall for 2016 open enrollment. PersonalCare Plans are also an option for our large group benefit plans in 2016. Members on PersonalCare Plans must select a PersonalCare Partner and a primary care provider (PCP). PersonalCare Plans require a referral from the member's PCP for specialty services.

**Note:** A PersonalCare Partner PCP can refer a patient outside of the PersonalCare Partner Systems network for specialty services in the Heritage Signature/Heritage Prime network at the in-network benefit level.

We'll provide more details about the new PersonalCare Partner Systems network as we get closer to the go-live date so you're aware of the plan requirements when you see a member in your office.

If you have any questions about this new provider network, please call Physician and Provider Relations at 877-342-5258, option 4.

## HEDIS Measure: Prevention and Screening

Your patients who have purchased individual or small group plans under the Affordable Care Act may not realize that preventive screenings are part of their health plan benefits, especially if they've never had coverage. (Older plan benefits don't include free preventive screenings.) You can offer your patients a [preventive benefit list](#) and mark the ones you recommend and when they should be scheduled. To learn more, check out [HEDIS Measures Prevention and Screening](#).

## HEDIS Measure: Adult BMI and Children/Adolescent Weight Assessment and Counseling

It's a good idea to offer your patients some tools to help them plan and track their physical activity and nutrition. **Here are some resources you can share with your patients:**

- [Six Easy Ways to Fit Exercise in Your Workday](#) – Premera Healthsource article
- [choosemyplate.gov](#) – Daily food plans based on weight and height; SuperTracker can help patients plan, analyze, and track their diet and physical activity level. You can show your patients where they are on the BMI chart.

**And here are resources for providers:**

- [Adult BMI HEDIS Tip Sheet](#)
- [Children/Adolescent Weight Assessment and Counseling HEDIS Tip Sheet](#)
- [More Tip Sheets and HEDIS Measures Information](#)

## HEDIS Measure: Breast Cancer Screening



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Although we know you're encouraging breast cancer screening all year long, your patients might hear more about it in October during Breast Cancer Awareness Month. [The National Breast Cancer Foundation](#)<sup>®</sup> website offers an [Early Detection Plan](#) where your patients can sign up for reminders to do breast self-exams and schedule clinical breast exams and mammograms based on age and health history.

Patients can also sign-up for breast cancer screening reminders on the [American Cancer Society](#) website as well as an [email newsletter](#) about healthy living and ways to reduce cancer risk. A great resource for providers is our [Breast Cancer Screening Tip Sheet](#) on our [HEDIS web page](#).

## Medical Director Spotlight: Chelle Moat, MD

Dr. Chelle Moat has been at Premera for nearly six years as Medical Director for Clinical Policy and Coding. We had a chance to talk with Dr. Moat recently about her work at Premera.

### **What was it about Premera that appealed to you?**

I have been at Premera for almost six years. I love the people I work with and the collaborative work atmosphere. It's been constant change and I believe our work is slowly making healthcare better.

### **What do you want providers to know about your work here?**

I strongly believe that physicians need to be at the table in all settings that impact the healthcare decisions made between doctors and patients. Working for a health plan has been a good fit for me.

### **Where did you grow up? What brought you to this area?**

I grew up in Spokane, trained at the University of Washington, and did my residency in Utah. I've lived in Skagit County for 18 years, and another 18 years in Seattle area. I love the Pacific Northwest. My retirement plan is to live in Portland, Oregon—I'm buying a townhouse in the Sellwood neighborhood. I'm very happy that I can work one day a week from our Portland office.

### **What is something people would be surprised to know about you?**

I haven't eaten beef, pork, or red meat for 40 years.

### **What was your very first job? What's your dream job?**

My first job was working at a fabric store. I haven't considered what my dream job would be—there are always great parts and not-so-great parts in all work situations. When the people are great, any job is good.

### **If you could learn to do anything, what would it be?**

Speak Chinese, play an instrument.

### **What's the hardest thing you've ever done—something that made you a stronger person?**

I've been downsized twice. It was a challenge to recognize that this was not personal, but a business decision. Fortunately, I was always able to move on and find a position that provided more opportunity and growth.

### **What are your interests outside of work?**

I like to read, spend time with my family, and I love to cook. Someday, I plan to use all the fabric I've collected!

### **Favorite books?**

The best books I've read so far this year are *Life after Life* and *All the Light We Cannot See*.



### What's playing on your music lists?

The Decemberists, Modest Mouse, U2, Train (I'm a secret rock and roll lover!)

### What's the best piece of advice you've ever received?

Only look back to gain perspective.

## Five Coding and Documentation Tips for Providers and Coders

Accurate and timely documentation and coding are an essential part of practicing good medicine. And with Medicare and, more recently, the Affordable Care Act's commercial risk adjustment requirements, this is even more important for all providers.

Here are five tips for providers and coders:

1. Providers should make sure each current documented diagnosis has evidence of monitoring, evaluating, assessing/addressing or treating (MEAT) to support it:
  - Monitoring signs, symptoms, disease progression/regression
  - Evaluating test results, medication effectiveness, response to treatment
  - Assessing/Addressing by ordering tests, reviewing records, counseling, discussing
  - Treating with medications and therapies
2. Coders should code for every condition in the chart note that has evidence of MEAT, not just the condition for which the patient came in. Sometimes this means multiple diagnoses—including co-existing conditions and co-morbidities—need to be coded on the claim.
3. Providers should ensure that all chronic and complex conditions are coded for each patient annually. Here's how:
  - Primary care providers should review and document conditions that are managed by a specialist. (This counts as MEAT and can be coded on the claim.)
  - When seeing a patient who comes in infrequently, ensure that chronic conditions are reviewed at the visit, even if they are only presenting for an acute issue.
  - When refills are made outside of a visit, encourage the patient to schedule a checkup so that the condition can be reviewed and managed at least once a year.
4. Providers should ensure that each entry in the medical record is signed appropriately, including credentials, date signed, and one of these:
  - Legible full signature or first initial and last name
  - Illegible signature over a typed or printed name
  - "Electronically signed by" followed by the provider's name



5. Providers and coders should ensure that the current status of conditions is reported accurately:

- Providers should review and update a patient's active problem list at each visit. If a condition is no longer active, either remove it from the list or add "history of".
- Coders should avoid using the words "history of" for a condition that is chronic but currently stable, such as COPD, diabetes, or A-Fib.

If you have questions about coding and documentation, please email the [ProviderEngagementTeam@Premera.com](mailto:ProviderEngagementTeam@Premera.com).

## New CV Risk Calculator Helps Assess Patients

It's a fact that cardiovascular disease remains a major national health concern. To help providers evaluate patient risk, the American Heart Association (AHA) has developed a helpful prevention tool called the CV Risk Calculator.

Premera's Clinical Quality Improvement Committee recently endorsed the CV Risk Calculator as a tool to help you assess potential cardiovascular disease risk in your patients. Providers and patients simply enter key information (age, sex, race, cholesterol level, blood pressure, and diabetes and smoking status) to calculate estimated 10-year and lifetime risks for atherosclerotic cardiovascular disease. For your convenience, we've added a link to the tool on our provider website. [Try out the CV Risk Calculator right here.](#)



## Congratulations to 2015 Immunize Washington Winners



Immunize Washington, a coalition of health plans along with the Washington State Department of Health, created and developed a new initiative with the goal of recognizing providers and clinics that promote immunization excellence.

The initiative's goals include:

- Consistent messaging to clinics on improving their immunization practices and achieving higher immunization rates
- Establishment of a program that recognizes clinics for achieving immunization rates of 70% or higher
- Enhanced data sharing between health plans and the Washington State Immunization Information System

2015 is the first year provider offices received awards for the following:

- Childhood immunizations (percentage of 24- to 35-month-old patients who are up to date with: 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella, and 4 doses of PCV)
- Adolescent immunizations (percentage of the clinic's 13- to 17-year-old patients who are up to date with: 1 Tdap, 1 MCV, and 3 doses of HPV vaccine)

[View the list of winners.](#)

## Personal Health Support: Coaching Members on the Road to Better Health

While having a chronic medical condition can be overwhelming, our members are finding that our Personal Health Support services are a vital resource to support them to better manage their chronic conditions and ultimately get them back on the road to better health.

## How We Work with Members Identified with Chronic Conditions

Our Personal Health Support services are available to eligible health plan members with chronic conditions. These conditions are responsible for approximately 75 percent of healthcare costs among Americans and include:

- Diabetes
- Heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Asthma

Members eligible for Personal Health Support services are identified through claims analysis, physician referral, or self-referral. Once identified, members receive a call from a Personal Health Support clinician. Participation is voluntary.

## How to Use Personal Health Support Services

Our Personal Health Support clinicians can help providers with any delivery system issues, assist their patients in preparing for appointments, and remove any barriers following the provider's treatment recommendations.

Members who choose to participate receive condition-specific newsletters with helpful tips for goal setting and making healthy lifestyle changes. Participants also have the option to work with a Personal Health Support clinician to learn lifestyle behavior changes such as getting more exercise, improving nutrition, monitoring signs and symptoms, or taking medications as prescribed.

## How to Refer Your Patients for Personal Health Support Services or Consult with a PHS Clinician

Providers can refer eligible Premera members for Personal Health Support services by calling 888-742-1479. The team is available weekdays, 8 a.m. to 8 p.m. Pacific Standard Time, to take referrals by phone and answer questions about the program. You can also e-mail us at [healthhelp@premera.com](mailto:healthhelp@premera.com).

## Utilization Management Information for Providers:

### Access to Medical Necessity Criteria

Physician and nurse reviewers at Premera use written criteria to assist in the determination of medical necessity. The following medical necessity criteria are used and available to contracted physicians and providers upon request:

- Company medical policy and clinical guidelines (published on our external website and updated at least annually)
- American Society of Addiction Medicine Guidelines for Chemical Dependency
- Durable medical equipment regional carriers

A contracted physician or provider can request criteria related to a specific medical decision for a patient by calling Clinical Review at 877-342-5258, option 3, 8 a.m. to 5 p.m., Monday through Friday. [View our complete medical policies and clinical guidelines.](#)

### Access to Information About the Utilization Management Process

Providers can contact Clinical Review staff at 877-342-5258, option 3, during regular business hours, Monday through Friday, 8 a.m. to 5 p.m., Pacific Time, to discuss specific utilization management requirements/procedures or the process. If calling using a non-toll-free number, the call is answered by a corporate operator and routed appropriately. Corporate operators are allowed to accept collect calls.



## Ensuring Appropriate Service and Coverage

We are committed to covering our members' care and encourage appropriate use of healthcare services. Physicians, providers, and Premera staff who make utilization-related decisions must comply with the following policies:

- We base utilization management decisions on appropriateness of care and services and existence of coverage.
- We do not compensate physicians, providers, or other individuals conducting utilization review for denials of coverage or services.
- We do not provide financial incentives for utilization management decision-makers to encourage decisions that result in under-utilization.

## Physician-to-Physician Conversations (Peer-to-Peer)

Providers who receive an adverse decision (denial) related to clinical review for medical necessity or experimental/investigational status can discuss the decision with a physician reviewer. The request may be made by calling 877-835-5672 within seven days of the decision.

Please keep in mind the following:

- This discussion does not represent an appeal.
- Requestors must provide the name of the member, member ID, and specific services that were denied.
- Our Clinical Review Department will arrange for a conference call between the requesting provider and a plan medical director.
- The phone conversation will not necessarily be with a peer-matched specialty reviewer (specialty matched peer review is part of the Level I appeal process).

## Learn More About Clinical Practice Guidelines

You'll find our Clinical Practice Guidelines and Preventive Services Guidelines online at [premera.com/wa/provider/reference/clinical-practice-guidelines/](http://premera.com/wa/provider/reference/clinical-practice-guidelines/). Premera routinely reviews, adopts, and makes available, evidence-based clinical practice guidelines to help practitioners make decisions about appropriate clinical and behavioral health services.

## Premera Blue Cross Medicare Advantage

### FDA Announces New Warnings on Testosterone Products

In January 2015, the FDA published a safety alert regarding the use of testosterone, stating that the risks and benefits of testosterone replacement have not been established in patients with low testosterone levels due to aging, even when symptoms are consistent with low testosterone.<sup>1</sup> In addition, the FDA is now requiring that manufacturers add warning information to all product labeling regarding a possible increased risk of heart attack and strokes in patients taking testosterone. This warning comes from the results of five observational studies and two meta-analysis evaluating more than 75,000 patients.

Testosterone replacement therapy has significantly increased in the United States, with sales increasing 65 percent between 2009 and 2013.<sup>2</sup> This increase, in part, has been attributed to an increase in 'Low-T' advertising and its implications on aging.

Testosterone replacement therapy is FDA labeled to treat male hypogonadism. Clinical signs and symptoms of low testosterone generally include:

- Loss of libido
- Sexual dysfunction



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- Decrease in muscle mass and strength
- Fatigue
- Hot flashes
- Depression
- Difficulty concentrating<sup>2</sup>

Many of these symptoms are non-specific to hypogonadism and are also associated with normal aging, making an accurate diagnosis vital prior to testosterone replacement treatment.<sup>3</sup>

Guidelines from The Endocrine Society recommend making a diagnosis of androgen deficiency only in men with symptoms of hypogonadism and unequivocally low serum testosterone levels. Due to wide variation in testosterone levels throughout the day, diagnosis should only be made following measurement of two different morning total testosterone levels.<sup>4,5</sup>

Much of the inappropriate use of testosterone replacement therapy is related to perceived benefits in erectile dysfunction (ED). However, there is no clinical evidence from randomized controlled trials to support testosterone replacement therapy for this indication. In contrast, one study of 140 men with testosterone levels of less than 330 mg/dL showed that adding testosterone gel to optimized sildenafil therapy for 14 weeks did not improve erectile function.<sup>6</sup>

When discussing the need for testosterone replacement therapy with your older patients, remember that current guidelines limit testosterone use to patients who are symptomatic and have laboratory data confirming hypogonadism. Treating patients outside of this population may be dangerous as efficacy is unclear and potential for side effects are higher in older patients.

#### References:

<sup>1</sup> Testosterone Products: Drug Safety Communication – FDA Cautions About Using Testosterone Products for Low Testosterone Due to Aging; Required Labeling Change to Inform of Possible Increase Risk of Heart Attack and Stroke

<sup>2</sup> Tucker, Miriam E., FDA Advisory Panel Urges Restriction on Testosterone Use. September 18, 2014. <http://www.medscape.com/viewarticle/831897>

<sup>3</sup> Snyder, PJ. Clinical features and diagnosis of male hypogonadism. In: Post T, ed. *UpToDate*. Waltham, Mass.: UpToDate; 2015. [www.uptodate.com](http://www.uptodate.com). Accessed February 26, 2015.

<sup>4</sup> Bhasin S, Cunningham GR, Hayes FJ, et al. Testosterone therapy in men with androgen deficiency syndromes: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2010;95(6):2536-59.

<sup>5</sup> Qaseem A, Snow V, Denberg TD, et al. Hormonal testing and pharmacologic treatment of erectile dysfunction: a clinical practice guideline from the American College of Physicians. [Ann Intern Med 2009;151:639-49](http://annals.org/lookup/doi/10.1136/annintern-2009-021111).

<sup>6</sup> Spitzer M, Basaria S, Travison TG, et al. Effect of testosterone replacement on response to sildenafil citrate in men with erectile dysfunction: a parallel, randomized trial. [Ann Intern Med 2012;157:681-91](http://annals.org/lookup/doi/10.1136/annintern-2012-021111).

## Premera Medicare Advantage Plans Offer Home Health Assessments Through Matrix Medical Network

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage Plans to submit detailed documentation on the health status of our Medicare Advantage members. To meet this CMS requirement, Premera Blue Cross Medicare Advantage Plan has engaged the services of Matrix Medical Network to help perform free,

comprehensive health assessments for a select group of our Medicare Advantage members who don't regularly see their providers.

This assessment identifies members who may benefit from other medical management programs and helps fulfill the CMS requirement. It's possible that one of your patients may be asked to participate.

**The home health assessment includes:**

- Risk assessment for falls
- Blood pressure check
- Height and weight measurements
- Questions to check mental health
- Check of prescription medications
- Complete health history

**Here's how the program works:**

- Identified members receive a letter from Matrix and a possible follow-up phone call to inform them of the benefit and invite them to schedule the home visit.
- Matrix sends a licensed nurse practitioner (LNP) to perform a comprehensive assessment in the member's home.
- Matrix mails an assessment summary to the member's primary care provider.
- Matrix LNPs are available by phone if you have questions about the assessment.
- Matrix providers do not provide ongoing treatment or interfere with your patient's long-term treatment plan.

If you have questions about Matrix, please call Premera Blue Cross Medicare Advantage Customer Service at 888-850-8526, 8 a.m. to 8 p.m., Monday through Friday.

## Premera Blue Cross Medicare Advantage HMO and HMO-POS Plans: Note the Differences

Premera Blue Cross Medicare Advantage offers four different plans: two HMO plans and two HMO-POS (Point-of-Service) plans. It's important for all Premera-contracted providers to understand the differences between these two types of plans.

### HMO Plans

HMO plan members can only see providers within the Premera Blue Cross Medicare Advantage network for non-emergent care. Not all Premera-contracted providers participate in the Medicare Advantage network. Before you see a Premera Blue Cross Medicare Advantage HMO plan member, you can verify if you're a contracted Premera Blue Cross Medicare Advantage provider or facility by calling Customer Service at 888-850-8526, 8 a.m. to 8 p.m.,

Monday through Friday. HMO plan members do not have out-of-network benefits, except for emergency or urgently needed services. If they see an out-of-network provider for a non-urgent or emergent need, they may be responsible for the full cost of their care.

### HMO-POS Plans

HMO-POS plan members can see any provider who accepts Medicare. However, members have a higher cost share if they receive care outside of the plan's Medicare Advantage network. Providers who are not contracted with Premera Blue Cross Medicare Advantage can bill Premera Blue Cross directly.

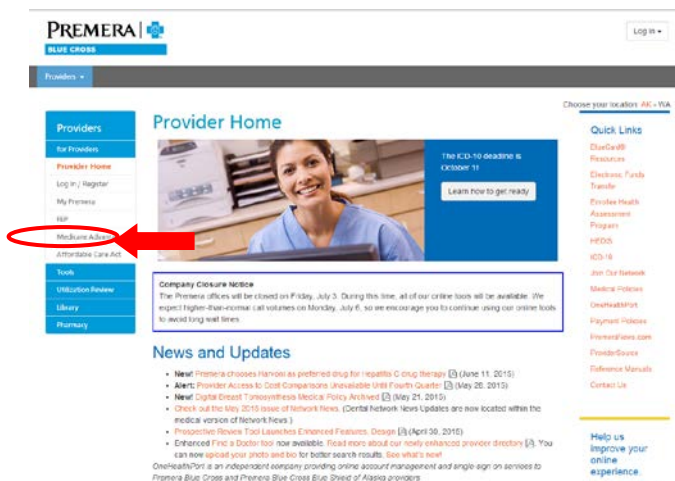
It's important for all Premera Blue Cross contracted providers who see Premera Medicare Advantage plan members to:

- Check the member's ID card to verify HMO or HMO-POS plan enrollment
- Know and verify participation in Premera Blue Cross Medicare Advantage's provider network
- Call Customer Service at 888-850-8526, 8 a.m. to 8 p.m., Monday through Friday, if you have questions.

Understanding the difference between our HMO and HMO-POS plans helps ensure that members are receiving the most from their plan benefits.

## Reminder: Secure Online Provider Tools Are Different for Medicare Advantage Members

It's important to note that our Medicare Advantage website uses different online tools and [forms](#) than our commercial plans. You'll find everything you need in the [Premera Medicare Advantage section](#) of our provider website in the left navigation:



Use the 'Get Started' link in the right column to log in and check member benefits and eligibility, submit prior authorizations, and more.

## Premera Blue Cross Medicare Advantage Plans

Premera Blue Cross offers four Medicare Advantage plans in Snohomish, 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 your patients Medicare benefits — plus extra benefits for prescriptions and fitness programs — all in one easy-to-use plan. Medicare open enrollment occurs October 15 through December 7 every year.

For more information about participating with Premera while caring for your Medicare Advantage patients, please see our [Provider Reference Manual](#).

→ Pharmacy Information

→ Network for Premera Blue Cross Medicare Advantage Plans

→ Training for Providers and Office Staff

→ Information for Your Patients

### Care Management Program

→ Program information

→ Annual Wellness Visits: Frequently Asked Questions (FAQs)

### Policy Updates

#### Tools and Resources for Providers

- Patient Inquiry
- Claims Inquiry
- Claim Connection
- Explanation of Payment
- PCP Roster
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- **Referral and**
- Policies

Get Started

#### Recent Policy Updates

Medical Policy Updates June 1, 2015

Pharmacy Policy Updates June 1, 2015

## Online Services Updates

### Managing Your Electronic Funds Transfer (EFT) Enrollment

Are you enrolled in EFT? Not sure what to do next? Here's everything you need to know:

- You only have to enroll once. Enrollment is by tax ID number (TIN) and automatically carries over to all Premera, Premera Blue Cross Medicare Advantage, and affiliate business (except FEP and NASCO, which are not supported by EFT).\*
- Once you enroll, we'll update your status on the EFT tool.
- Enrolling in EFT automatically turns off your paper Explanation of Payments (EOPs). This means that after you enroll, you'll access your EOPs online.
- Payments typically deposit into your account four days after the payment cycle. For most weeks, that falls on a Thursday.
- If you need to change your bank account information after you've enrolled, simply cancel your EFT via the online tool and re-enroll with your new bank information.

[Get additional tips](#) for locating payments and managing your EFT enrollment.

### 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.

## Updating Your Demographic Information is Easy!

Were you recently checking out the new Find a Doctor tool and need to send us an update? Or did you move or change your phone number? It's easy to send us your updates. Just make sure you include your TIN, your old and new information, and the effective date of the change, and send via fax or email:

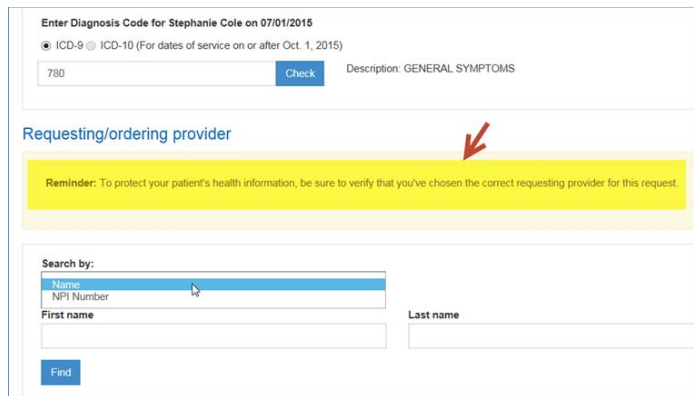
- Email to [provider.relationswest@premera.com](mailto:provider.relationswest@premera.com)
- Fax to ATTN: Provider Relations at 425-918-4937

If we need additional information to make the change, we'll contact you. Note that the update typically takes 15 to 30 days to complete. If you have any questions, contact Physician and Provider Relations at 877-342-5258, option 4.

## Protect PPI, Select the Right Ordering Provider on the Prospective Review Tool

When entering the ordering/requesting provider and servicing provider on the prospective review tool, make sure you're selecting the correct one. Check the provider's name and address. We've even included the provider's specialty to make your selection more precise. Choosing the correct provider means we send communications that contain protected health information to the right place and avoid unauthorized disclosure. Remember:

- '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



The screenshot shows a web interface for entering a diagnosis code. At the top, it says "Enter Diagnosis Code for Stephanie Cole on 07/01/2015". Below that, there are radio buttons for "ICD-9" and "ICD-10 (For dates of service on or after Oct. 1, 2015)". The "ICD-10" option is selected. A text input field contains "780" and a "Check" button is next to it. To the right, it says "Description: GENERAL SYMPTOMS". Below this is a section titled "Requesting/ordering provider" with a yellow background and a red arrow pointing to a "Reminder" box that says "Reminder: To protect your patient's health information, be sure to verify that you've chosen the correct requesting provider for this request." Below the reminder is a search section with "Search by:" and a dropdown menu showing "Name" selected. There are also input fields for "NPI Number", "First name", and "Last name", and a "Find" button.

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.

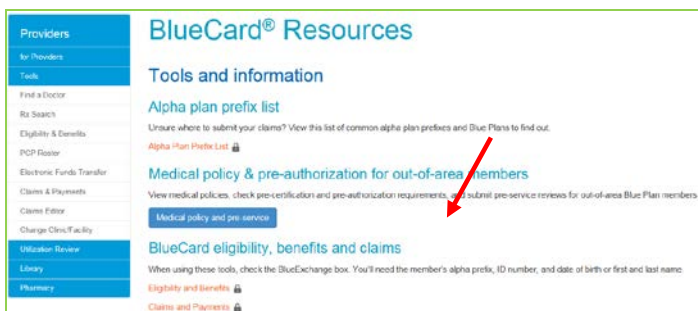


# New! Online Pre-Service Reviews for Out-Of-Area Members Now Available

We recently launched a one-stop shop for out-of-area pre-service review requests. With this new tool, you can access out-of-area members’\* Blue Plan provider websites to conduct online pre-service reviews. Previously, you needed to call or fax information to submit requests for pre-service reviews, check status, or determine if a review was needed. Now you can easily log in and get what you need.

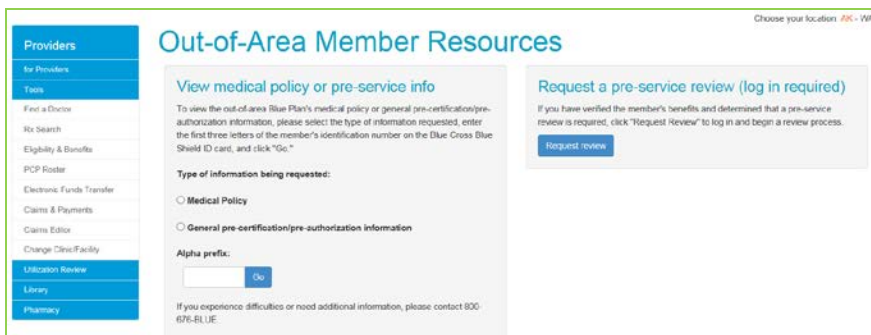
## How Do I Use the Tool?

To get started, log in to [Premera's provider website](#) and click on BlueCard Resources under Quick Links. From there, click on the “Medical policy and pre-service” button.



Once you click on the button, you’ll have two options. You can view medical policy or pre-service review info including what supporting documentation to submit by entering the member’s alpha prefix. You don’t need to sign in to use this feature.

To request a pre-service review for an out-of-area member, select “Request review.” You’ll need to sign in to use this feature. We’ll ask for the member’s alpha prefix; once we confirm that the plan participates, we’ll transfer you to the member’s home plan pre-service review tools.



## If You Experience Technical Issues

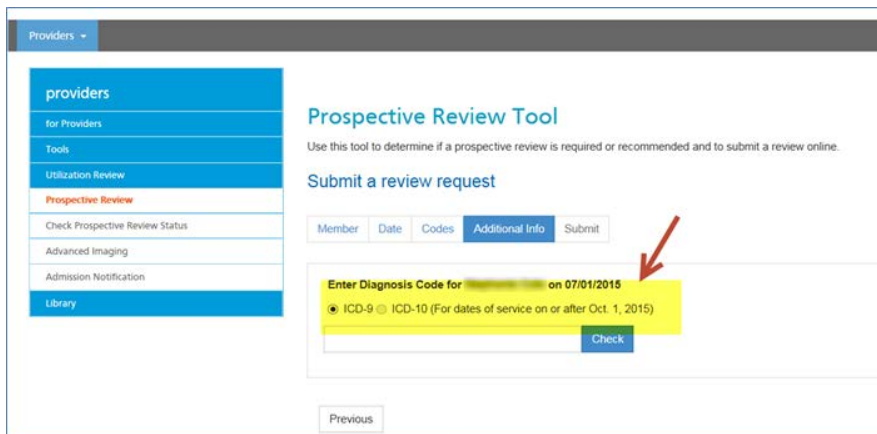
If you experience technical issues on the Premera website, [contact us](#) for assistance. Once you’ve been routed to the member’s home plan website, you’ll need to contact that plan for technical issues or questions about their online tools.

\*Pre-service review for FEP and NASCO members are not available via this tool.

## Our Prospective Review Tool is Ready for ICD-10!

Beginning July 1, our prospective review tool began accepting both ICD-9 and ICD-10 diagnosis codes for dates of service October 1, 2015, and later. 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/](http://premera.com/wa/provider/) under News and Updates. [Learn more about ICD-10.](#)



## 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.](#)

## 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](http://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

## October 1 Deadline for ICD-10 is Fast Approaching – Are You Ready?

Here's what you need to know about the ICD-10 October 1 deadline.

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

- We'll require ICD-10 codes on claims as of Oct. 1, 2015. Claims using ICD-10 codes sent prior to Oct. 1, 2015, will be returned. [Learn more about ICD-10.](#)
- CMS has created the [Road to 10 website](#) (a free resource provided by CMS) to help providers jump start the transition to ICD-10. Here's what you'll find on the CMS Road to 10 website:
  - ICD-10 Overview – learn how your practice will benefit from using ICD-10
  - Physician Perspectives – stories from the road and physician champion insights
  - Events and Webcasts – specialty documentation
  - FAQs and Videos
  - Quick References and Template Library

As we get closer to the ICD-10 compliance date, we'll notify you about any changes to our ICD-10 prior authorization process via our provider website under News and Updates. Also check out our Online Services Updates in Network News for updates to our online tools as we prepare for ICD-10.

## Register Today for Premera's Ready, Set, Go! Free ICD-10 Webinar Series

Is your practice ready for ICD-10? Premera is offering a free webinar series to meet the needs of providers at various stages of the ICD-10 transition process.

### **Get Ready. ICD-10 Implementation and Documentation, August 12, 12 p.m. to 1 p.m.**

#### **Presented by Tom Curry, MD, on behalf of CMS**

Does your clinic need help getting ready for the transition to ICD-10? This webinar will take you through the basics and help you to identify important work you can do now to help make the transition smoother. This webinar specifically targets providers and administrators to learn about how documentation of the patient visit might need to change under ICD-10. We'll work through a couple of case studies so we can get the most out of the webinar.

### **Get Set. ICD-10 Coding and Documentation, August 27, 12 p.m. to 1 p.m.**

#### **Presented by Teresa Stallman, MBA, ICD-10 Trainer**

Get set to learn about common coding issues you might face with the conversion to ICD-10. This webinar is specially designed for coders (CEUs may be available) and will provide tips on how coders can work with clinicians to ensure patient visits are coded accurately under ICD-10.

### **Go! ICD-10 Coding and Risk Adjustment, November 17, 12 p.m. to 1 p.m.**

#### **Presented by Tonya Owens, Coding Quality Educator – Premera Blue Cross**

All systems go! Now that you've successfully transitioned to ICD-10, join this webinar to get the top 10 tips for risk adjustment coding under ICD-10. Are you seeing more patients with bronze, silver or gold plans this year? We'll help you prepare for government audits that are just beginning in 2015 as a result of the Affordable Care Act. (CEUs may be available)

To learn more or sign up for the free webinars, email [providerengagementteam@premera.com](mailto:providerengagementteam@premera.com) or call 877-342-5258, option 4.

## Using Modifier 33 for Colonoscopies: Preventive vs. Diagnostic

The American Medical Association created modifier 33 to allow providers to identify a preventive service for which (under the Patient Protection and Affordable Care Act) there is no patient cost sharing.

Providers should use modifier 33 with a CPT code for a service performed as a preventive service, such as a screening colonoscopy, even if a polyp was found and removed. Modifier 33 identifies a procedure as being “preventive in nature.”

If modifier 33 is added to the CPT code, this tells us that the service was preventive and should process as such. Please note, though, that the use of modifier 33 varies by health plan. For Premera members, we advise providers to not use modifier 33 for patients receiving colonoscopy procedures related to signs or symptoms or to rule out or confirm a suspected diagnosis.

Here’s a [link to our payment policy](#) and some examples:

If the service is a:	Submit the claim using:
Screening colonoscopy for a low-risk patient with no findings during the colonoscopy	Procedure code 45378 or G0121  Screening diagnosis code V76.51
If the service is a:	Submit the claim using:
Screening colonoscopy where a polyp in the large intestine was found, removed with a snare, and sent to pathology.	Procedure code 45385 with modifier 33 indicating preventive  Screening diagnosis code V76.51 and code 211.3 for the condition found

## Reminders and Administrative Resources

### New Process for Remittance Address Changes

As part of our ongoing efforts to enhance security and prevent fraud, Premera has implemented a new process for remittance address changes. Effective July 6, 2015, when you request a change to your remittance address, a letter will be sent to both your current and new addresses confirming the change.

### Important Notice about CellNetix Pathology/Laboratory Services

CellNetix is a provider of pathology/laboratory services that is no longer in Premera’s network. We are asking that you send our members’ pathology work to an alternative pathology provider. If our members receive pathology tests performed by CellNetix it could result in higher out-of-pocket costs.



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 Visit [premera.com/wa/provider](http://premera.com/wa/provider) for all Premera provider communications and secure tools. 001399 (08-2015)

## Reminder: Bill Subrogation-Related Claims to Premera

If a Premera member is injured in an accident and is not at fault but has related medical expenses, Premera pays the member's claims. Our subrogation team then seeks reimbursement from the insurance plan of the person who caused the injury.

Here are a couple of things to note about subrogation claims:

- Please bill all Premera members' subrogation-related claims directly to us. While these claims may initially deny since another party is responsible for payment, if the claim is adjusted by the third-party payor we can then adjust for payment per the member's benefits.
- Even if a settlement is in process, send all related claims to directly. If claims aren't submitted within 365 days of the date of service, the provider is required to write off any charges incurred by the member. These charges may not be included in the settlement because of these contract terms.

If you have any questions, please contact Physician & Provider Relations at 877-342-5258, option 4.

## 2015 Holiday Business Closure Dates

Premera is closed on the following dates:

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

email: [Credentialing.Updates@Premera.com](mailto: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.



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## 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](#).

Providers can also send updates by fax at 425-918-4937, email at [ProviderRelations.West@premera.com](mailto:ProviderRelations.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 Benefits and Eligibility Tool Back Online

Benefits for dental members via the eligibility and benefits tool is back online. You can now see complete benefit information including:

- Deductibles satisfied
- Coinsurance (preventative, basic, major)
- Limits/limits used
- Plan-specific contract messages

You can view the benefits by selecting 'Dental Care' in the dropdown box or by service type including: preventative, endodontics, periodontics, and orthodontia.

#### Tips for verifying benefits:

1. Visit our provider website at [premera.com/wa/provider](http://premera.com/wa/provider)
2. Select *Eligibility & Benefits* in the left navigation menu to open the tool
3. Sign in using your OneHealthPort user ID and password to get to our secure website
4. In the drop-down box *For Benefit Type*, select *Dental Care* or any one of the other dental categories
5. You're in!



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Expand all Collapse all

**Plan Eligibility**

Eligible on 06/29/2015

Indemnity - STANDARD  
Effective: 07/01/2012 → Termination: 03/31/2099

**Plan Messages**

**Deductibles and Benefits**

Select Benefit Type:

Note: Deductible applies to a Plan Benefit

**Dental Care - In/Out of Network**

- ACTIVE COVERAGE

**Dental Care - In/Out of Network**

- PREVENTIVE
- CO-INSURANCE FOR

**Dental Care - In/Out of Network**

- BASIC
- CO-INSURANCE FOR

**Dental Care - In/Out of Network**

- DEDUCTIBLE FOR IN-NETWORK
- DEDUCTIBLE FOR IN-NETWORK
- IN-NETWORK/OUT-OF-NETWORK COMBINED LIMIT

**Dental Care - In/Out of Network**

- DEDUCTIBLE FOR FAMILY PER SERVICE YEAR IS \$150.00
- DEDUCTIBLE FOR FAMILY REMAINING IS \$100.00
- IN-NETWORK/OUT-OF-NETWORK COMBINED LIMIT

**Dental Care - In/Out of Network**

- LIMITATIONS FOR INDIVIDUAL PER SERVICE YEAR IS \$1,500.00
- LIMITATIONS FOR INDIVIDUAL REMAINING IS \$1,127.00

**Dental Care - In/Out of Network**

- PREVENTIVE

Claims status, upfront estimates, electronic claim submissions, and electronic funds transfer are all still available. If you have questions about using the eligibility and benefits tool, call Physician and Provider Relations at 877-342-5258, option 4.

## 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 to our secure provider website](#).

## Consultant's Corner: The Importance of Oral Health for Seniors

Ronald Cantu, DDS, MPA, Premera Dental Director

Good oral health is well recognized as an integral part of the total healthcare picture that complements the overall well-being of our patients. Patients who care about their oral health are typically taking good care of their overall health as well. Poor oral health can affect the course of many systemic diseases and has a strong association in the development of other diseases.

Many of us have patients in their eighties and nineties who certainly keep our practices interesting, but also increase the clinical complexities we face. Many academics who study senior healthcare issues encourage a team-based approach across all health specialties for successful early intervention and management of oral disease.



In our current geriatric population, a group referred to as the "oldest old" describes individuals defined as above a particular age cutoff, generally above age 85. In the United States, those age 85 to 94 years old were the most rapidly growing age group, increasing from 3.9 to 5.1 million in 2010 and expected to exceed 19 million by 2050.<sup>1</sup>

A second term, 'successful aging,' refers to individuals with the least decline in physical or mental function with chronological aging.<sup>2</sup> Substantial healthcare research and funding is directed on what behavioral, dietary, lifestyle,

and psychosocial factors may foster longer, healthier lifestyles. Clearly, maintaining excellent dental health is a key component in this demographic phenomenon.

<sup>1</sup>Werner CA. The older population: U.S. Department of Commerce, Economics and Statistics Administration; 2011.2010 Census Briefs

<sup>2</sup>Rowe J, Khan R. Successful aging. New York; Pantheon: 1998

## 2015 Pacific Northwest Dental Conference

We were pleased to participate for the fourteenth consecutive year as an exhibitor at the annual Pacific Northwest Dental Conference, June 11-12, 2015 in Bellevue. With more than 7,000 attendees, this conference is the largest gathering of dental professionals, staff, and students in Washington State.

Presented by the Washington State Dental Association, the conference offered two days of continuing education with over 50 nationally renowned speakers and an exhibit hall featuring more than 150 companies with the latest in dental technology and services.

We appreciate everyone who stopped by our booth to say hello to our Dental Provider Relations team, pick up Premera promotional items, and enter to win our giveaways. What a valuable opportunity to meet members of the dental community and see many familiar faces from Washington and Alaska.

This year Premera held a drawing for two \$50 Visa gift cards. Congratulations to our two lucky winners, Hannah Eberle, receptionist for Kathryn Onishi, DDS, in Mukilteo and David Henrichsen, Registered Dental Hygienist for Michael Conway, DDS, in Kenmore.

We look forward to seeing you at next year's conference, June 16-17, 2016.

## Community Connection: 2015 Inland Northwest Dental Conference Contest Winners

Thanks to all who stopped by Premera's booth at this year's Inland Northwest Dental Conference in Spokane on April 16-17. We received more than 300 entries for the two \$50 Visa gift cards. Congratulations to our two lucky winners, Catherine A. Schuller of Colville Community Dental Clinic and Mallory Mott with dental providers Psomas, Bourekis and Warnica, Spokane Valley.

## Pharmacy Updates

### Premera Chooses Harvoni<sup>®</sup> as Preferred Medication for Hepatitis C Drug Therapy

Based on the recommendation from our Pharmacy and Therapeutics Committee, Premera Blue Cross has chosen Harvoni as its preferred drug therapy for Genotype 1 of the Hepatitis C Virus (HCV). The committee made this recommendation, after a review of the scientific literature, because Harvoni provides the following benefits:

- Simpler for the member to take
- Easier for the provider to prescribe and manage
- Most-prescribed drug in our market

This choice means your patients benefit from better adherence and increased cure rates from their course of



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treatment. For most patients, Harvoni requires only one tablet per day for 12 weeks.

[Read our complete medical policy for HCV drug therapy.](#)

[For more information about this disease and its treatment.](#)

[Learn more about Harvoni drug therapy.](#)

## Pharmacy Management Information for Providers: Access to Pharmacy Prior Authorization and Other Utilization Management Criteria

Pharmacy reviewers at Premera apply company medical policy to assist in the determination of medical necessity. Our medical policies are available to contracted physicians and providers upon request. Specific criteria related to a medical decision for a patient can be requested by calling Pharmacy Services at 888-261-1756, option 2.

You'll find our medical policies in the Library, Reference Info, at [premera.com/wa/provider](http://premera.com/wa/provider).

Our formulary, including prior authorization criteria, restrictions and preferences, and plan limits on dispensing quantities or duration of therapy can also be accessed on our provider website via Pharmacy, Rx Search at [premera.com/wa/provider/pharmacy/drug-search/rx-search/](http://premera.com/wa/provider/pharmacy/drug-search/rx-search/).

Drugs requiring review are identified by the symbols **PA** (prior authorization), **ST** (step therapy) or **QL** (quantity limits). Click the symbol to view the requirements for approval.

### How to Use Pharmaceutical Management Procedures

Providers can contact pharmacy management staff at 888-261-1756, option 2, to discuss specific prior authorization, step therapy, quantity limits, exception request criteria for unusual cases, and other utilization management requirements/procedures for drugs covered under the pharmacy benefit. Review requests for medical necessity can also be faxed to 888-260-9836. Formulary updates are communicated on a quarterly basis in Network News.

## 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.

[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](http://premera.com/medicare-advantage/pharmacy-services).

## New Edits Included in the Pharmacy Prior Authorization Edit Program

Effective June 1, 2015: Lynparza™ (olaparib) [premera.com/medicalpolicies/CMI\\_134370.htm](http://premera.com/medicalpolicies/CMI_134370.htm)

Coverage Criteria: Lynparza™ (olaparib) may be considered medically necessary for the labeled indication, as monotherapy in patients with deleterious or suspected deleterious gBRCAm-associated ovarian cancer who have recurrent disease after 3 or more prior lines of chemotherapy regimens. All other uses of Lynparza are considered investigational. Lynparza™ is a specialty pharmacy drug covered under the pharmacy benefit.

Effective June 1, 2015: Mekinist™ (*trametinib*) [premera.com/medicalpolicies/CMI\\_125837.htm](http://premera.com/medicalpolicies/CMI_125837.htm)

Coverage Criteria: Trametinib (Mekinist™) may be considered medically necessary as monotherapy for the treatment of patients with unresectable or metastatic melanoma with BRAF<sup>V600</sup> mutations that have failed to tolerate BRAF inhibitor therapy (dabrafenib or vemurafenib). (Testing will be covered whenever use of trametinib is contemplated. Treatment of patients that have progressed on BRAF inhibitor therapy is considered not medically necessary

Trametinib (Mekinist™) may be considered medically necessary in combination with dabrafenib for the treatment of patients with unresectable or metastatic melanoma with BRAF<sup>V600</sup> mutations. (Testing will be covered whenever use of trametinib is contemplated.) All other uses of Mekinist are considered investigational. Mekinist™ is a specialty pharmacy drug covered under the pharmacy benefit.

## Medical Policy Updates

### Reminder: Check Genetic Testing Policies Before Referring Members

Premera is experiencing increasing volumes of appeals related to genetic testing. That's why it's a good time to share a reminder to please check our [genetic testing medical policies](#) before referring members for these services. When the reason for the testing is not covered under our policies, the financial liability becomes the member's. We appreciate your help reviewing the policies before making a referral.

### BRCA Testing for Individuals Without Cancer

Testing BRCA1 and BRCA2 mutations is well supported for those with a strong personal history of BRCA-related cancer. The National Comprehensive Cancer Network (NCCN) outlines the testing criteria in its Hereditary Breast and/or Ovarian Cancer Syndrome Guideline. However, because BRCA1 and BRCA2 gene mutations are rare in the general population, NCCN does not recommend routine BRCA testing.

In limited high-risk situations, BRCA testing is covered for individuals who do not have a personal history of cancer. Unaffected individuals must have family member(s) who meet the criteria for BRCA testing *and* those family members are themselves not available for testing.

The NCCN guideline states, "Testing of unaffected individuals should only be considered when an appropriate affected family member is unavailable for testing." Regarding criteria for family history only, NCCN states, "Significant limitations of interpreting test results for an unaffected individual should be discussed."

Our medical policy statement on hereditary breast and/or ovarian syndrome is based on the current NCCN guideline and the specific criteria for patients with family history only. These are listed in our medical policy.

Please review [medical policy 12.04.504](#), Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1/BRCA2) for full criteria.

## Vitamin D Supplementation Rather Than Testing Recommended

Vitamin D is critical to good health but many people living in the northern latitudes have low serum levels. Sun exposure stimulates vitamin D production and certain foods are another source of vitamin D. Diet alone, however, usually doesn't provide enough of this nutrient.

The Endocrine Society's Task Force on Vitamin D recommends vitamin D supplementation, with daily dose related to age and clinical circumstances.<sup>1</sup> Similarly, Choosing Wisely<sup>®</sup>, an initiative of the American Board of Internal Medicine, recommends that vitamin D deficiencies are usually best addressed by lifestyle changes or supplementation.<sup>2</sup> No national primary care professional organization currently recommends population-wide screening for vitamin D deficiency. In 2015, the U.S. Preventive Services Task Force concluded that the evidence for vitamin D deficiency screening in asymptomatic adults to improve health outcomes was insufficient. The task force rated screening in the general population as insufficient.<sup>3</sup>

We encourage vitamin D<sub>2</sub> or D<sub>3</sub> supplementation for all members (with dose depending on age and clinical circumstances as described by The Endocrine Society's Task Force of Vitamin D), except in those rare cases when vitamin D supplementation would pose a specific risk for the member.

Screening is considered appropriate only for those individuals with a clinically documented disease or condition associated with vitamin D deficiency, decreased bone density, or a disease specifically associated with vitamin D overproduction and toxicity. Please review [medical policy 2.04.507 Vitamin D Testing](#), adopted in 2012, for the indications considered medically necessary for vitamin D testing.

<sup>1</sup> Holick, MF, Binkley, NC, Bischoff-Ferrari, HA, et al. Evaluation, treatment, and prevention of vitamin D deficiency: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2011 Jul;96(7):1911-1930.

[endocrine.org/-/media/endsociety/Files/Publications/Clinical%20Practice%20Guidelines/FINAL-Standalone-Vitamin-D-Guideline.pdf](http://endocrine.org/-/media/endsociety/Files/Publications/Clinical%20Practice%20Guidelines/FINAL-Standalone-Vitamin-D-Guideline.pdf).

<sup>2</sup> Choosing Wisely. AIBM Foundation in conjunction with the American Society for Clinical Pathology. Vitamin D tests. When you need them – and when you don't. [choosingwisely.org/doctor-patient-lists/vitamin-d-tests](http://choosingwisely.org/doctor-patient-lists/vitamin-d-tests).

<sup>3</sup> Screening for Vitamin D Deficiency in Adults: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2015;162:1-28. PMID: [25419673](https://pubmed.ncbi.nlm.nih.gov/25419673/).

## 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](mailto:medicalpolicy@premera.com).

**Note:** This information does not apply to our Premera Blue Cross Medicare Advantage plans. The Premera Blue Cross Medicare Advantage policies are updated and available on the secure Medicare Advantage provider website at [premera.com/wa/provider/medicare-advantage/](http://premera.com/wa/provider/medicare-advantage/) using the 'Get Started' button.

All policy numbers are listed here in numeric order.

**The following policy changes are effective for dates of service April 14, 2015 and later:**

1.01.524	Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea	Reformatted and rewrote Policy Guidelines for ease of use. Coding table removed. Purchase and Repair subsections added.
2.01.526	Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders	Added additional criterion that allows use of an augmenting agent. Removed pregnancy as a contraindication.
3.01.510	Applied Behavior Analysis (ABA)	Includes additional ICD-10 diagnosis codes. Added a <b>not medically necessary</b> statement for conditions other than Autism Spectrum Disorder. Added visual field analysis to the list of services not considered to constitute ABA services.
5.01.535	Erythropoiesis-Stimulating Agents	Clarified target hemoglobin level ranges. Adjusted ferritin level threshold for chronic kidney disease. For cancer patients, documentation of iron stores is indicated only if there is no improvement in hemoglobin level with ESA use.
5.01.547	Medical Necessity Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits	Updated quantity limits for specific drugs. Updated drugs to reflect changes in prior authorization requirements.
5.01.605	Medical Necessity Criteria for Pharmacy Edits	Added Natesto to the list of testosterone therapy agents. Added a <b>not medically necessary</b> statement for branded non-stimulants for



5.01.606

Hepatitis C Antiviral  
Therapy

psychiatric conditions for  
which there is no credible  
published scientific evidence.

Updated for treatment-naïve  
patients with addition of  
Harvoni for genotypes 4 and  
6; addition of Viekira Pak for  
genotypes 1 and 4; addition  
of Sovaldi /Olysio for  
genotype 1.

Updated for treatment-  
experienced patients with  
addition of Harvoni for  
genotype 4 and 6; addition of  
Viekira Pak for genotype 4;  
Sovaldi/Olysio for genotype  
1; addition of Sovaldi/RBV for  
genotype 4. Removed  
multiple regimens for each  
genotype in the “alternative  
therapy” column to reflect the  
current AASLD/IDSA  
guidelines.

Medical necessity criterion  
for proteinuria levels better  
defined.

“Exceptions” section updated  
with the application to  
genotypes 1 and 4 only;  
genotype 6 removed.

7.01.07

Electrical Bone Growth  
Stimulation of the  
Appendicular Skeleton

**New policy.** Replaces  
deleted policy 7.01.529. This  
service may be considered  
**medically necessary** to  
treat fracture nonunions or  
congenital pseudoarthroses  
when criteria are met.  
**Investigational** applications  
include immediate  
postsurgical treatment after  
appendicular skeletal  
surgery, stress fractures, or  
fresh fractures. Implantable  
and semi-invasive electrical  
bone growth stimulators are

		considered <b>investigational</b> .
7.01.109	Magnetic Resonance Imaging-Guided Focused Ultrasound	MRgFUS may now be considered <b>medically necessary</b> for pain palliation in adult patients with metastatic bone cancer who failed or are not candidates for radiotherapy. <b>Investigational</b> for all other conditions.
7.01.148	Endovascular Therapies for Extracranial Vertebral Artery Disease	<b>New policy.</b> Endovascular therapy, including percutaneous transluminal angioplasty with or without stenting, is considered <b>investigational</b> for extracranial vertebral artery disease.
7.01.542	Lumbar Spinal Fusion	Non-smoking requirement changed from three months to six weeks based on community standards.
8.01.502	Home Enteral Nutrition	Updated Policy Guidelines to include specific diagnoses for inborn errors of metabolism with appropriate ICD-9 and ICD-10 diagnosis codes.

**The following policy changes are effective for dates of service May 12, 2015 and later:**

2.01.533	Upper Gastrointestinal (UGI) Endoscopy for Adults	Added esophageal varices with or without bleeding to the "Follow Up of Known Conditions" list. Added new cirrhosis diagnosis to the "Other Indications" list.
5.01.522	Advanced Therapies for Pharmacological Treatment of Pulmonary Arterial Hypertension	Added Oral treprostinil (Orenitram) as a therapy.
5.01.541	Medical Necessity Exception Criteria for Closed Formulary Benefits and for Dispense	Added language indicating an additional formulary alternative must be tried for multisource brand

	as Written (DAW) Exception Reviews	medications. Requirement for MedWatch form for both multisource brand medications and dispense-as-written reviews was deleted.
7.01.508	Blepharoplasty, Blepharoptosis and Brow Ptosis Surgery	Blepharoplasty is considered <b>not medically necessary</b> when an eyelid ectropion or entropion fails to meet the criteria outlined in the policy. Lateral photos are required documentation for blepharoplasty. Medical necessity reviews for ptosis surgery for vision impairment require both margin reflex distance and photographs.
7.01.523	Panniculectomy and Excision of Redundant Skin	Procedures to excise redundant skin in other body areas are considered cosmetic, now listed in the Policy section. Statements added that clarify abdominoplasty and diastasis recti surgery are considered <b>cosmetic</b> . Title changed.
10.01.514	Cosmetic and Reconstructive Services	Added to the list of procedures considered cosmetic: abdominoplasty (includes mini or modified abdominoplasty), brachioplasty, diastasis recti surgery, labiaplasty, lipectomy (includes belt and circumferential lipectomy), lower body lift, tattoo removal, thigh lift, and torosoplasty. Kybella added to the list of <b>cosmetic</b> pharmaceuticals.
12.04.91	General Approach to Genetic Testing	Updated with new categories of genetic testing. For the category of testing an individual for the benefit of a

family member, criteria are for clinical utility rather than medical necessity.

12.04.129	Genetic Testing for Marfan Syndrome, Thoracic Aortic Aneurysms and Dissections, and Related Disorders	<b>New policy.</b> The use of panels for the detection of mutations in syndromes that may be associated with thoracic aortic aneurysms and dissection is <b>investigational</b> . In certain circumstances, individual mutation testing may be considered <b>medically necessary</b> .
12.04.504	Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1/BRCA2)	Revised <b>medically necessary</b> policy statement to be consistent with NCCN guidelines. Retained information on BART; deleted information on CHEK2. “Early age” terminology is now written with criteria-specific ages. Added clarification relating to family lineage and founder mutations.

**The following policy changes are effective for dates of service May 27, 2015 and later:**

5.01.540	Miscellaneous Oncology Drugs	Nivolumab and olaparib may be considered <b>medically necessary</b> for labeled indications. Opdivo for treatment metastatic squamous non-small cell lung cancer with progression on or after platinum-based chemotherapy may be considered <b>medically necessary</b> . All other uses of Erivedge, Lynparza, and Opdivo are considered <b>investigational</b> .
5.01.605	Medical Necessity Criteria for Pharmacy Edits	Xyrem dosage information added.

**The following policy changes are effective for dates of service June 9, 2015 and later:**

5.01.503	Migraine and Cluster Headache Medications	Added medically necessity criteria for Frova (frovatriptan) and Treximet (sumatriptan/naproxen combination). Clarified policy statement with criteria and indications for specific agents in the policy.
5.01.548	Pharmacotherapy of Cushing's Disease and Acromegaly	Expanded policy scope to address acromegaly. Policy title changed.
5.01.605	Medical Necessity Criteria for Pharmacy Edits	Updated with a new ADHD drug, Aptensio XR. Added criteria for Vyvanse regarding drug abuse or dependence. Removed Intuniv and criteria for Fulyzaq.
7.01.508	Blepharoplasty, Blepharoptosis and Brow Ptosis Surgery	Added policy statement to clarify that frontal/full face and lateral photos are required for blepharoplasty or blepharoptosis surgery in children.
7.01.519	Varicose Veins/Venous Insufficiency	Defined moderate to severe reflux as "greater than 0.5 seconds". Inserted abbreviation for transilluminated powered phlebectomy (TIPP) and added TRIVEX as example of TIPP. Both are considered <b>investigational</b> .
8.01.52	Orthopedic Applications of Stem-Cell Therapy (Including Allograft and Bone Substitute Products Used with Autologous Bone Marrow)	Expanded the policy to include bone products with stem cells. Use of allograft or synthetic bone graft substitutes that must be combined with autologous blood or bone marrow is considered <b>investigational</b> . Policy title changed.
10.01.503	General Anesthesia and	To reflect changing

	Facility Services Related to Dental Treatment	regulation, policy now applies to anesthesia services provided in a dental office setting.
12.04.33	Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer	Revised policy to focus on diagnostic testing (as well as SNP testing for cancer risk assessment). Policy title changed. Included an expanded list of diagnostic genetic and protein biomarker tests considered as investigational.
12.04.92	General Approach to Evaluating the Utility of Genetic Panels	Revised policy statement to correspond with genetic testing categories: hereditary/genetic condition panels, cancer panels, and reproductive panels.
12.04.514	Genetic Testing for Epilepsy	<b>Policy re-numbered.</b> Replaces policy 12.04.109. Genetic testing for early-onset (five years and under) epileptic encephalopathy syndromes may be considered <b>medically necessary</b> when conditions are met.