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December 2016 Provider News – WA

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

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MEDICAL POLICIES AND CODING UPDATES

Medical Policies

New Medical Policy
Effective March 1, 2017

Special note: Mobile Cardiac Outpatient Telemetry, 2.02.510
For dates of service March 1, 2017 and later, mobile cardiac outpatient telemetry (MCOT) is considered investigational. MCOT devices continuously record or use an auto-triggered memory loop to transmit data to a central recording station with real-time monitoring and analysis. Published studies have not evaluated whether real-time monitoring leads to reduced cardiac events and mortality. The evidence is insufficient to determine the effects of the technology on health outcomes. As a result, MCOT is considered investigational. Investigational services are not reimbursed. Read the full policy.

Revised Medical Policy
Effective February 1, 2017

Bioengineered Skin and Soft Skin Substitutes, 7.01.113
Implementation, originally scheduled for Dec. 1, 2016, is now Feb. 1, 2017. Policy criteria are unchanged. Read the full policy.

Revised Pharmacy Policies
Effective Dec. 1, 2016

Excessively High Cost Drug Product with Lower Cost Alternatives, 5.01.560
Added omeprazole/sodium bicarbonate (generic version of Zegerid) to the list of drugs that need to be reviewed. Read the full policy.

Ivacaftor (Kalydeco) and Lumacaftor/Ivacaftor (Orkambi), 5.01.539
Changed age criteria for Orkambi from 12 years to 6 years of age and older. This age is based on the FDA labeling. Read the full policy.

Medical Necessity Criteria for Pharmacy Edits, 5.01.605
Removed Benicar/HCT (olmesartan/HCT) and Benicar (olmesartan) from the criteria for brand angiotensin II receptor blockers. These two drugs are now generic. Read the full policy.

Miscellaneous Oncology Drugs, 5.01.540
Added new drugs: Lonsurf (trifluridine and tipiracil), Ninlaro (ixazomib), and Lartruvo (olaratumab). Updated the criteria for Tecentriq (atezolizumab) and Keytruda (pembrolizumab). Read the full policy.

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563
Clarified that Inflectra (infliximab-dyyb) is not approved for use in pediatric ulcerative colitis. Read the full policy.

Pharmacotherapy of Type I and Type II Diabetes Mellitus, 5.01.569
Added new agent to the *nonpreferred* GLP-agonist criteria: Adlyxin (lixisenatide). Read the full policy.

Coding Updates

Added Codes

Effective Dec. 1, 2016:

Monoclonal Antibodies for the Treatment of B-Cell Malignancies, 2.03.502
Medical Necessity and Prior Authorization

J9042 Injection, brentuximab vedotin, 1 mg

Miscellaneous Oncology Drugs, 5.01.540
Medical Necessity and Prior Authorization

J9228 Injection, ipilimumab, 1 mg

J9301 Injection, obinutuzumab, 10 mg

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563
Prior Authorization (Currently reviewed for Medical Necessity)

J0135 Injection, adalimumab, 20 mg

Removed Codes

Effective Dec. 1, 2016:

Sinus Surgery, 7.01.559
No longer reviewed for medical necessity
31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy, or debridement (separate procedure)

PAYMENT POLICIES

Find the latest payment policy updates
Link: https://www.premera.com/wa/provider/reference/payment-policies/recent-updates/

ONLINE SERVICES

Technical Website Help
Are you having problems with our website? For technical support, call 800-722-9780, weekdays, 6 a.m. to 6 p.m., Pacific Time, or email us at support@premera.com. We can help you with issues like error messages, blank pages, or unexpected/incorrect results.

For issues with your OneHealthPort user ID or password, contact OneHealthPort directly.

For issues related to Medicare Advantage secure pages and online tools (accessed via onehealthport.com), call 855-339-8141.

Use a browser we support
The most common cause of website issues is an unsupported browser. For the best online experience, we recommend upgrading to the latest version of Internet Explorer or other web browser that we support:

- Internet Explorer
- Mozilla Firefox
- Google Chrome

Providers using Internet Explorer (IE) 8 and IE 9 often experience issues; upgrade to IE 11 if at all possible.

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Go Online to Request Medical Necessity Review for Outpatient Rehab
After you complete your initial visit with a Premera member, submit your request through eviCore for a medical necessity review authorization. The sooner you submit the request after the initial visit, the faster you can create an appropriate treatment plan for your patient, based on the number of approved treatments.

Not sure if a member needs review through eviCore?
Check out our prospective review tool to see if a review is needed for a specific member. The tool instructs providers to go to eviCore healthcare only when services require a review. Employer groups may opt in or out of the program, so you may want to recheck member participation monthly.

When asking for an authorization, the provider should use the date of the initial evaluation date as the start date of their request.

- When you're submitting your request, make sure to use eviCore's page specifically for Premera members.
- Include the member's alpha prefix and number when submitting a request for services (such as "ABC123456789"—no space between the alpha and numeric characters).
- When you're checking a patient's eligibility for program requirements and the system gives you a "No authorization is required" message, take a screenshot for your records. Premera will consider this if a retrospective review is required.

For questions about eviCore's website or program requirements, call eviCore's dedicated number for Premera members at 800-792-8751, from 7 a.m. to 7 p.m., Monday through Friday.

Find a Doctor Tool Improvements
The latest release for the Find a Doctor search tool makes it easier for members to find the doctors and other providers they need.

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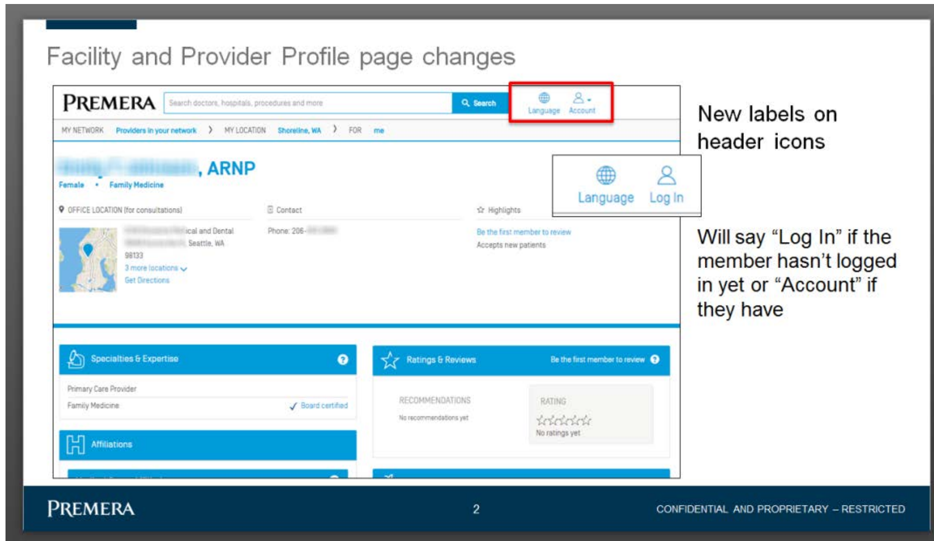

Improvements include:

- User-friendly labeling on the Facility and Provider Profile page

- Useful information across the top, including provider name, specialty, location, accepting new patients, average wait time

- Search display results indicating provider is within a member's network
- Improved search drop-down list. Now, when members search, they'll see more information about providers and facilities, such as location or specialty, making it easier and faster to find care.

These enhancements help our members more easily find the providers they need to care for themselves and their families.

Medicare Advantage

Medicare Advantage Plan Changes for 2017

2017 Medicare Advantage Plans Have no Out-of-Network Benefits

We no longer offer the HMO-POS (Health Maintenance Organization – Point of Service) plan for 2017. We have three HMO plans. This means our plans have no out-of-network benefits except for emergency

or urgently needed services. If a member sees an out-of-network provider, they may be responsible for the cost of their care. When referring Medicare Advantage members, confirm that the provider is in our Medicare Advantage network. Check our Medicare Advantage directory for a current list of our in-network providers and facilities.

Diabetic Glucose Monitors and Supplies

For our 2017 Medicare Advantage plans, Premera will only cover glucose monitors and supplies from the Medicare list of preferred manufacturers and products. We'll not cover other brands or manufacturers unless there is a medical need to use a different product. Review this list with your patients to ensure they're using the preferred brands. If the patient is using a different brand, we ask that you transition them to products from the preferred list.

Medicare Advantage Network Changes

Effective Jan. 1, 2017, Franciscan Health System will not be a part of our Medicare Advantage provider network. Be sure to check our provider directory before referring your Medicare Advantage patient to ensure that their services are covered by in-network providers and facilities.

MedXM to Provide In-Home Eye Exams

Premera frequently hears from many of our primary care physicians that it can be difficult to encourage patients with diabetes to receive much-needed eye exams. We've partnered with MedXM to offer mobile eye exams for some of our members that haven't received an exam in the last 12 months.

Regular eye exams are important for these members to help detect diabetic-related eye problems like diabetic retinopathy, which can lead to loss of vision or even blindness if not identified early.

A MedXM optometrist or technician performs the simple, comprehensive eye exam in the comfort of the member's own home. Both the member and their provider will receive the results from the exam.

MedXM clinicians will not treat or prescribe medications to members, and providers are encouraged to follow up with MEDXM with any questions or concerns.

To learn more, visit visit MedXM.

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COMPANY UPDATES

Provider News Now Monthly

Provider News—formerly Network News—is now posted monthly. Our new format makes it easy to share articles with your colleagues—just click the email icon at the end of each article.

Sign up for email from Premera to receive an alert when each issue is posted. Call 877-342-5258, option 4 with any questions.

Landmark Health Expands Into Spokane and Thurston Counties

Premera and Landmark Health teamed up in November 2015 to provide in-home medical care to members with chronic, complex conditions in King, Pierce, and Snohomish counties. In 2017, Landmark will start caring for eligible Medicare Advantage members in Spokane and Thurston counties.

Members receive:

- 24/7 access to care from Landmark providers in their own home
- Scheduled ongoing visits determined by their clinical needs
- Access to a team of Landmark providers, including pharmacists, dietitians, nurses, and social workers
- Direct communication with their primary care provider regarding the care they receive from Landmark

This service is available to members as part of their coverage with Premera Blue Cross. The patient's usual cost shares will apply. There are no additional costs for our Medicare Advantage members. Refer members with questions about their benefits to our Customer Service team.

If you have any questions about Landmark, contact your network executive or call us at 877-342-5258, option 4.

Holiday Business Closure Dates

Premera is closed on the following dates:
December 23 and 26—Christmas Holidays (Observed)
January 2—New Year's Day (Observed)

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Premera Benefits Support Telemedicine

Premera has benefits that support telemedicine, complying with updated Washington State laws Senate Bill 5175 (2015 session) and Senate Bill 6519 (2016 session). We want to make sure our providers are aware of the payment policy for telemedicine.

When covered by a member's benefits, the following methods of exchange of medical information from one site to another site via electronic communications are allowed:

Synchronous/Asynchronous Communications: Methods include interactive video, television, teleconferencing, videoconferencing, and store-and-forward transmissions. These methods involve billing for services rendered by the provider at the distant site to indicate that services were rendered to a member located at the originating site using a telecommunications system. The distant site **provider** services must be billed with an appropriate modifier (i.e., Modifier 95, Modifier GT and Modifier GQ).

Telephone Assessment and Management: Telephone services for non-face-to-face evaluation and management (E&M) services rendered by a physician or qualified non-physician healthcare provider who may report E&M services using the telephone. A defined set of CPT codes are allowed for both physician and qualified non-physician healthcare providers. Medical record documentation needed for the use of these codes is defined in the current payment policy.

Online/Internet Communications: Online services for non-face-to-face E&M services by a physician or qualified non-physician healthcare provider using secure and encrypted Internet resources in response to a patient inquiry. Reportable services involve the provider's total time responding to the patient's inquiry and must involve permanent storage of the encounter. A defined set of CPT codes are allowed for both physician and qualified non-physician healthcare providers. Medical record documentation needed for the use of these codes is defined in the current payment policy.

These new methods of electronic exchange are allowed for members **when covered by their benefit plans** effective on or after Jan. 1, 2014. As always, please verify the member's benefits before providing services.

This new legislation (SB 5175) does not cover "Inter-professional telephone/internet consultations (99446-99449)" as these consultations would not meet the definition of "telemedicine" as defined in the RCW since the member is **not** present during the exchange. Based on the CPT guidelines as stated in the AMA CPT Codebook, these inter-professional consults are between physicians without the presence of the patient.

For more information, see the current payment policy for Telehealth/Telemedicine Services or contact Physician and Provider Relations at 877-342-5258, option 4.

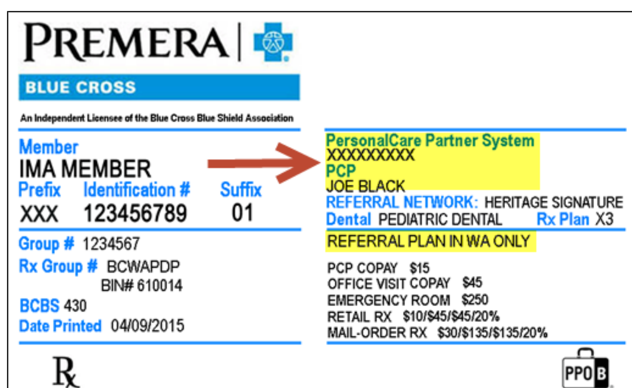
PersonalCare Partner Systems Network Reminder

Premera's PersonalCare plans offer coordinated care within a group of Washington doctors and hospitals. The PersonalCare Partner Systems network supports our primary care provider (PCP) referral-based PersonalCare Plans offered in Snohomish, Pierce, and King Counties. This network includes Accountable Health Systems (AHS) only. AHS are systems of healthcare providers that collaborate and take collective accountability for the cost and quality of care for members that select them.

Here's what you need to know before you see PersonalCare Plan members in your office:

- Contracted AHS (Partner Systems) are responsible for coordinating referrals for their PersonalCare Plan patients. View a complete list of provider types and services that don't require a referral.
- Referrals within a Partner System or its designated referral network are managed by the Partner System.
- Partner Systems send referrals to Premera when the PCP refers a PersonalCare Plan member outside the Partner System network or its designated referral network, but within the Heritage Signature/Prime network.
- If a referral is outside the Heritage Signature/Prime network, a prior authorization is also required.

The member's PersonalCare Plan card includes the name of the PersonalCare Partner System and PCP they selected. If a patient calls your office for an appointment and says they're covered by Premera Blue Cross, ask if the patient is on one of our PCP referral-based PersonalCare Plans.



Remember to always verify the member's eligibility and benefits prior to seeing them in your office. That way, you'll ensure that PersonalCare plan patients come to you with referrals.

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

Federal Employee Program (FEP) and Prior Approval

New for 2017, prior approval (also known as prior authorization) must be obtained for the following services for members with FEP Standard or Basic Option:

- Outpatient sleep studies performed outside the home
- Applied behavior analysis (ABA)
- Gender reassignment surgery

These services continue to require prior approval:

- Inpatient hospital admission or inpatient residential treatment center admission
- Certain prescription drugs and supplies
- BRCA testing
- Surgery for morbid obesity
- Outpatient surgical correction of congenital anomalies
- Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth
- Outpatient intensity-modulated radiation therapy (IMRT), except IMRT related to the treatment of head, neck, breast, anal, or prostate cancer.
- Hospice care
- Organ/tissue transplants
- Blood or marrow stem cell transplants
- Clinical trials for certain blood or marrow stem cell transplants

Find more information on our FEP web page, including forms, where to submit a prior approval request with related billing codes, and FEP medical policies.

At-Home Fecal Immunology Testing Kits

We're sending at-home fecal immunochemical test (FIT) kits to our members (including Medicare Advantage members) who are due for a colorectal cancer screening, according to our claims data. We'll mail the members their results and will encourage them to make an appointment with you if they have a positive FIT result. We'll also send you a letter about your patients' results so that you can follow up with them. If you have questions, call Physician and Provider Relations at **877-342-5258**, **option 4**.

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 if 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

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 the Credentialing Department at 425-918-5080.

REMINDERS AND ADMIN RESOURCES

Manage COB for Faster Claim Payments
Problems with coordination of benefits (COB) contribute to incorrect claims and payment delays, affecting providers and patients.

About COB
Some patients have more than one insurance policy covering their medical/dental/vision/pharmacy needs. In these situations, insurers coordinate benefits, ensuring that plans pay claims in a certain order. One plan will be designated as primary and the other as secondary.

Inaccurate COB information on claims can delay payment. COB research and claims resubmission is a

high administrative cost for providers and insurers alike.

What to do

By knowing which plan is primary and secondary, you can submit claims appropriately. Claims get paid faster, and you reduce your administrative costs too.

Steps to take

Ask patients if they have additional health insurance plans and gather that information (plan name, additional ID number, etc.) Try to find out if the additional plan is primary or secondary. The patient can find out by calling the plan. You can also call us, and we can help you confirm the correct order for the insurance plans.

When you receive a claim denial, check the explanation of payment (EOP) to confirm whether the patient has a primary insurance plan other than Premera. The Explanation of Payment tool shows how to check an EOP online.

Communicate with your billing team about the reason for the denial, so they don't simply re-submit the claim.

If you have questions related to Coordination of Benefits, call our Customer Service team at 877-342-5258, option 2.

Annual 2017 Code Updates and Quarterly Updates

Starting in 2017, code updates for CPT, HCPCS, and ICD-10 CM diagnosis and PCS procedure codes will be uploaded into our two claims processing applications (Claims Editor and FACETS).

This update includes new codes along with code deletions and revisions. Make sure your office is prepared and has updated your billing systems and electronic health records with these new 2017 codes. If you use codebooks, purchase the 2017 editions and keep your 2016 editions for reference, in case you still have outstanding 2016 claims to submit.

The Claims Editor and the FACETS claim application will be updating codes on a quarterly basis in 2017 as the codes are released by the American Medical Association (CPT codes), CMS (HCPCS codes) and the National Center for Health Statistics (ICD-10 CM and PCS codes).

DME/HME Claims Edit Goes Live on December 11

As announced last May, a new claim edit on Durable Medical Equipment/Home Medical (DME/HME) is going live Dec. 11, 2016. In order to identify whether a piece of DME/HME has been rented or purchased, a modifier will need to be added to the code to indicate whether new, used, or rented.

You can read the full DME payment policy on the provider website. Note that the payment policy provides instructions on how to submit a code for “daily rentals” (rentals less than 30 days) by adding modifier “KR-Rental billing for partial month” to the specific equipment code.

DME/HME codes submitted without a modifier will result in a denial of reimbursement.

QUALITY PROGRAMS

HEDIS: Coming In Early February 2017
During February to early May of 2017, you may be contacted by Verscend, a Premera partner organization, about a medical records review. (Verscend was previously known as Versik Health.)

The medical records review is part of our data collection for the Clinical Effectiveness of Care Measures, part of the Healthcare Effectiveness Data Information Set (HEDIS)®.

What is HEDIS?
HEDIS is a set of quality measures used by more than 90 percent of US health plans to assess performance on important dimensions of quality and service. HEDIS is managed by the National Committee for Quality Assurance (NCQA), a private, nonprofit organization dedicated to improving healthcare quality.

How are we involved?
Medical records from our members’ physicians are required in order to compile the necessary data for some of the HEDIS measures.

Reporting HEDIS measures is also required for our participation in the Affordable Care Act’s Health Insurance Marketplace, formerly known as the Exchange.

What to expect
NCQA limits all health plan medical record collection to a set time period from February to early May. Medical records for one or more of your patients may be identified for review during those months, and our partner Verscend may contact you.

You may submit records through secure online upload, fax, or mail. When the Verscend team sends you a chart request, they will include instructions for submitting the records. Verscend will contact if you if the submitted records are incomplete, illegible, or otherwise unclear.

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Member authorization consent
In addition to being permitted under HIPAA, we secure the consent of our members for release of medical records upon enrollment. You should not provide to us (or to Verscend) any medical record information related to psychotherapy, HIV, substance abuse, or genetic testing—and we won't request this information either.

HEDIS® data and HIPAA guidelines
The HIPAA Privacy Rule permits a provider to disclose protected health information to a health plan for the quality-related health care operations of the health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506(c)(4). A provider may disclose protected health information to a health plan for the plan's Health Plan Employer Data and Information Set (HEDIS) purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

If you or your staff have questions regarding the retrieval of medical records and the HEDIS data collection process, please contact Physician and Provider Relations at 1-877-342-5258, option 4 or your network contract specialist.

Thank you for your collaboration in improving quality of care.

Free Blood Pressure Monitors for FEP Enrollees
The Blue Cross and Blue Shield Federal Employees Program (FEP) has initiated a program to provide free blood pressure monitors to FEP enrollees over age 18 who have a diagnosis of hypertension, or high blood pressure without a hypertension diagnosis.

Here's how it works for your eligible FEP patients:

- Ask your patient to complete a Blue Health Assessment (BHA) – this is the first step in the FEP Wellness Incentive Program.
- Discuss home blood pressure monitoring with your patient.
- Patient receives a free home blood pressure monitor from FEP.

Studies have shown that home blood pressure monitoring helps patients better manage their condition, especially when combined with patient counseling.

This program is a partnership between FEP and the American Medical Association. It's also part of the Million Hearts® Initiative, a national initiative with a goal of preventing 1 million heart attacks and strokes by 2017.

Check out the American Medical Association's printable blood pressure fact sheets and patient handouts.

PHARMACY

Pharmacy Prior Authorization Edit Expansion
Premera has added new review criteria based on clinical best practice and approval by an independent pharmacy and therapeutics committee. The program is designed to promote appropriate drug selection, length of therapy, and utilization of specific drugs while improving the overall quality of care.

Drugs may be added or deleted from this list without prior notification. If you have questions concerning the Pharmacy Prior Authorization Edit Program, call the Pharmacy Services Center at 1-888-261-1756 or fax us at 1-888-260-9836, Monday through Friday, 8:00 a.m. – 5:00 p.m. Pacific Time.

Which new edits are included in the Pharmacy Prior Authorization Edit Program?

Effective Dec. 1, 2016:

Lonsurf® (trifluridine and tipiracil)

Read the full policy.

Coverage Criteria

Lonsurf® (trifluridine and tipiracil) may be considered medically necessary for treatment of patients with metastatic colorectal cancer who have been previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and if RAS wild-type, an anti-EGFR therapy.

All other uses of trifluridine and tipiracil are considered investigational.

Initial approval period for the above agent will be three months. Continued approval beyond the first three months will require documentation of objective response to therapy (depending on the type of malignancy).

Lonsurf is a specialty pharmacy drug covered under the pharmacy benefit.

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Effective Dec. 1, 2016:

Ninlaro® (ixazomib)

Read the full policy.

Coverage Criteria

Ninlaro (ixazomin) may be considered medically necessary when used in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.

All other uses of ixazomib are considered investigational.

Initial approval period for the above agent will be 3 months. Continued approval beyond the first 3 months will require documentation of objective response to therapy (depending on the type of malignancy).

Ninlaro is a specialty pharmacy drug covered under the pharmacy benefit.

Diabetes Drug List Changes Reminder

We're updating our diabetes medication therapy policies to help control costs for our members. As of November 1, 2016, Novo Nordisk insulin is the preferred insulin for our commercial lines of business. These changes won't affect our Medicare Advantage members. Read the full article about this change.