Premera Blue Cross Blue Shield of Alaska

Network News

FEBRUARY 2016

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

Contents

Company Updates

2016 Customer Experience Strategy: Customer Obsession

Most everyone can agree there's a lot of room for improvement in the healthcare industry. From a member's perspective, issues ranging from cost, complicated insurance-speak, and paperwork hassles can result in problems for providers, too.

We're eager to work with our providers to deliver a better patient experience to our joint customer – your patient, our member. Curtis Kopf, our new vice president of customer experience, is helping us to create this effort through our 2016 customer experience strategy.

"Our customer experience goal is to improve customers' lives by being the most customer-obsessed health plan on the planet," noted Kopf. "It's a bold goal and I hope it inspires you as much as it inspires me! To achieve that, we're focused on four objectives."

Our key objectives include:

- Embed the customer's voice in everything we do
- Create a customer-obsessed culture
- Simple, easy, and caring: continuously improve the customer experience
- Partner with providers to create an exceptional customer experience

To learn more about the experience our members have when seeing our contracted network providers, we're putting some survey strategies in place to gather feedback and better measure customer satisfaction. This will help us better understand the experience our members have after provider visits and how that ties to overall member satisfaction.

Learning more about what our customers are experiencing (what's working, what's not)—means that we can target specific provider partner work streams.
To learn more or participate, contact customer.experience@premera.com and watch for updates on this effort in *Network News*.

Continuing to Improve the Quality of Care to Our Members and Your Patients

Measuring how well we're succeeding at quality in healthcare is challenging. But we all have the same goal—putting our mutual customer (your patient) at the center of everything we do.

The best way we currently assess quality is through specific, validated measures, such as those published by the National Committee for Quality Assurance (NCQA) and the Healthcare Effectiveness Data Information Set (HEDIS). NCQA and HEDIS help you see how you're doing by evaluating performance over time compared to your peers in the quality of care delivered.

It's important for you to understand what HEDIS measures are, how they work, and how to execute clear plans to improve performance.

Here are two examples of core indicators of the quality of care provided to patients that help demonstrate how HEDIS measures work.

Appropriate Use of Antibiotics for Respiratory Conditions Commonly Found in Children as Measured by HEDIS

It's cold and sore throat season again, and as you know, overuse of antibiotics can lead to many problems for patients—unnecessary cost, increased bacterial resistance to antibiotics, unpleasant side effects such as vomiting and diarrhea, and occasionally more significant reactions like new medication allergies.

There are two HEDIS measures that show how you're doing in caring for children with these symptoms. For children with sore throats, Appropriate Testing for Children with Pharyngitis measures the frequency of testing children for strep as compared to all children given the diagnosis of acute pharyngitis, acute tonsillitis, or strep pharyngitis. The more frequently you test and bill for strep with a rapid strep test or culture before treating, the more you meet the evidence-based guideline and the higher your HEDIS score.

Most providers typically don't prescribe antibiotics for colds. Children with upper respiratory infections (URIs) are best treated with rest, fluids, and increased environmental humidification. However, if antibiotics are used for a likely bacterial infection as a complication to the URI, make sure to include the indication for the antibiotic as a diagnosis for the visit (see Children with URIs HEDIS tip sheet for more information).

Screening for Colorectal Cancer as Measured by HEDIS

Some cancer screening guidelines can be complicated and occasionally have conflicting recommendations. Fortunately, most providers agree with the U.S. Preventive Services Taskforce guideline for colorectal cancer screening, as does NCQA and HEDIS. (View the Colorectal Cancer Screening HEDIS tip sheet.)

Patients with normal risk factors should begin screening at 50 years of age and continue through age 75. While a colonoscopy every 10 years has historically been the standard, more and more providers and patients are opting for annual fecal immunochemical testing (FIT). Patients who have been appropriately screened (divided by the total number of eligible patients) determine your compliance with the standard recommendations and your HEDIS score.

Source: ncqa.org/

Verisk Health Requesting Medical Records for HEDIS, February through May

Verisk Health is assisting us this year with medical records retrieval for the Healthcare Effectiveness Data and Information Set® (HEDIS). HEDIS is a set of standardized performance measures that ensure consumers have the information they need to compare healthcare quality. Medical records are required in order to compile the necessary HEDIS data. This effort is one way we collaborate with our network providers to accomplish our goal of improving the quality of care provided to our members.

You may receive a request from Verisk Health for records retrieval by secure online upload, fax, or mail. Instructions for submitting the requested records are included with the request. The National Committee for Quality Assurance (NCQA) limits all health plan medical records collection to a specific timeframe of February to early May.

You may get a call from us or Verisk if notes are incomplete, illegible, or indeterminate. You won't be asked for (and you shouldn't provide) any medical records related to psychotherapy, HIV, substance abuse, or genetic testing.

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 healthcare operations of the health plan, provided the plan had a relationship with the patient and the information requested pertains to that relationship. See 45 CFR 164.506(c)(4).

If you have questions about the retrieval of medical records and the HEDIS data collection process, contact your network contract specialist or Physician and Provider Relations at 800-722-4714, option 4. Thank you for your cooperation and participation in this important effort.

Provider Information Phone Survey Audit Begins in March

Starting March 2016, we're conducting a phone audit of our provider directory information to ensure we have the most current and relevant information for our customers in our Find a Doctor online tool. We've hired Pacific Market Research to conduct this effort on our behalf—they'll identify themselves as "Pacific Market Research calling on behalf of Premera." The call should only take about five to seven minutes and may involve verification of more than one provider in your office.

We'll be conducting these surveys on a quarterly basis and will be reminding you in Network News, on our provider website, and via on-hold messaging. If you have any questions or recommendations as to how we can make this easier for you, call Physician and Provider Relations at 800-722-4714, option 4. We appreciate your support in helping us provide our customers (your patients) with the most current information in our provider directory.

Medical Director Spotlight:
David Buchholz, MD, Provider Engagement

How long have you been at Premera? What was it about Premera that appealed to you? I started my new job in September 2015. I've always had positive feelings about Premera as a health plan. I've known and respected other physicians who've worked here including Meredith Mathews and Roki Chauhan. And, as a provider, Premera has always seemed to strive to do the right thing for the patient.

What do you want providers to know about your work here? Providers should know that I'll do everything possible to ensure that our members, their patients, receive the highest quality healthcare with the best experience at an affordable cost. I think the best way we can do that is by working together in a partnership that builds on each other's strengths.

Where did you grow up? What brought you to this area? I grew up in northern California. I spent eight years in Chicago going to college and medical school, and moved to Washington for residency at the University of Washington. I love the rain and how beautiful it makes everything look. After spending five years in California, I jumped at the opportunity to move back to Washington to work for Premera.

What's your most inspiring or memorable patient story? I have so many stories; it's really hard to pick just one. I'm a general pediatrician, so I find that it's remarkable how children and their families bond to their physician as if they're family. It's that closeness that makes the work so rewarding. I have one example of when I helped make the diagnosis of Langerhan cell histiocytosis (LCH) in an 18-month old boy that illustrates the point. LCH is a devastating disease. I supported the family as their thriving toddler suffered through years of treatment, had multiple organs fail, and lost the ability to walk. He's 21 now and doing okay and the family continues to keep in touch, asks my advice, and wishes me well as my career moves beyond direct patient care.

What's something people would be surprised to know about you? I love everything about vampires. My favorite movies are the Underworld series and I read all the Anne Rice novels. I even visited New Orleans to check out some of the sights described in the books.

What was your very first job? What's your dream job? I worked at a 76 station pumping gas when I was in high school…it lasted about eight weeks. My idea of a dream job seems to change regularly as I explore all the opportunities that exist for a physician. I once thought it would be great to be CEO of a large health system and now, maybe, CEO of a health plan.

What's something new you learned in the last week? I observed a focus group of members discussing a proposed program that would give patients tools to help maximize their time during a physician visit. I was surprised to learn that the members were totally unaware that their health plan has their diagnoses from claim history. They knew that their providers billed their insurance company but not that their diagnoses accompanied those claims. This revelation makes me think differently about how we approach members when asking them to seek preventive care or follow up for their chronic conditions.

If you could learn to do anything, what would it be? I have always wanted to learn Spanish. I'm pretty good with German.

What's the hardest thing you've ever done? I once had to make the decision to right-size a medical group for its long-term survival. I laid off physicians and staff and closed some clinics. It was tough, but it was the right thing to do for the community, for those who remained, and even for those who had to leave the organization.

What are your interests outside of work? Favorite vacation spot? I'm a foodie and I love dogs. I'm always looking for new tastes and ways to prepare food so vacations tend to evolve around places with great restaurants and that are dog friendly. That said, a trip to Hawaii during the darker months of winter is always nice.

What's on your favorite playlist? I have to admit that I like Celtic music so a little Enya or Bear McCreary is all that I need.

What's the best piece of advice you've ever received? If you want to be a good person and strong leader, you must listen far more than you talk.

Enhancements to AIM Clinical Appropriateness Guidelines for Advanced Imaging, Starting Feb. 22, 2016

The following changes for the AIM Clinical Appropriateness Guidelines for Radiology, Oncologic PET, and Cardiology begin Feb. 22, 2016:

Radiology guidelines

MRI and CT

- Expanded list of “red flag” indications for headache evaluation and added a requirement for conservative therapy in low-risk patients
- Developed comprehensive new criteria for venous sinus thrombosis based on risk factors

MRI/MRA or CT/CTA

- Developed new criteria for headache evaluation for appropriate simultaneous imaging

CT Neck (soft tissue) and CT Chest

- Added new requirement of short-course, conservative therapy for low-risk patients with hoarseness

CT Chest

- Developed new criteria for immune-suppressed patients with persistent pneumonia
- Aligned pulmonary nodule criteria with the Fleischner Society guidelines

MRI Pelvis

- Developed new criteria for sports hernia after sufficient initial evaluation and failed conservative management
- Revised criteria for advanced imaging in low-risk prostate cancer and in the surveillance of gynecologic malignancy

MRI Upper and Lower Extremity

- Expanded criteria for suspected occult fractures at high-risk sites following non-diagnostic radiographs

Oncologic PET guidelines

- Clarified language for surveillance PET imaging
- Clarified PET requirement for breast cancer to include invasive disease
- Expanded thyroid cancer to include well-differentiated follicular subtype
- Replaced “not covered” with “not medically necessary”

Cardiology guidelines

- Revised cardiac imaging criteria for management of patients with Kawasaki disease to align with published literature
- Clarified appropriate frequency of echocardiography in children with established congenital heart disease. For younger children with complex congenital heart disease, evaluation based on symptoms is difficult. Therefore, the guideline has been liberalized to allow more frequent echocardiography in this cohort.
- Clarified language to reduce variability of guideline interpretation based on user feedback

If you have any questions or comments regarding these enhancements to the guidelines, contact AIM via email at aim.guidelines@aimspecialtyhealth.com. View all current guidelines.

Premera to Handle Claims Administration for Municipality of Anchorage

As of Jan. 1, 2016, Premera Blue Cross Blue Shield of Alaska began handling claims administration for medical and dental coverage for the Municipality of Anchorage, one of the largest employers in Anchorage. They've asked us to communicate this change to the provider community; this process was formerly handled by MODA.

Please submit all bills to us at P.O. Box 240609, Anchorage, AK 99524-0609.

Learn More About Clinical Practice Guidelines

Premera routinely reviews, adopts, and makes available, evidence-based clinical practice guidelines to support practitioners in their decisions about appropriate clinical and behavioral health services. You'll find our Clinical Practice Guidelines and Preventive Services Guidelines online at premera.com/ak/provider/reference/clinical-practice-guidelines/.

Opioid Abuse Epidemic: Resources for Providers, Patients

The Federal Employee Program (FEP) recently shared information and online resources about the abuse of opiates. The U.S. Department of Health & Human Services recently published an overview of the opioid abuse epidemic, including information on abuse prevention, treatment for addiction, and responding to an overdose. Further information on the epidemic is also available in this recent White House memorandum.

Navigate Your Way to Comprehensive Documentation and Coding

Management, documentation, and coding of chronic and complex conditions on an annual basis for your patients are even more important now than ever.

We'd like to help you navigate the way by partnering with you to:

- Ensure your patients continue to have access to the highest quality healthcare, the resources they need, and the health coverage they deserve with premiums as low as possible
- Get credit for the work that you're already doing by making sure care is documented and submitted on a claim

Our research has shown that there are several simple things that can be done to make complete documentation easier for providers and comprehensive coding easier for coders and billers. Here you can link to the first three of nine tips on coding and documentation to help guide you as you care for your patients this year. Collect all nine of our quarterly documentation and coding tips and distribute them to everyone who plays a role in ensuring patients' conditions are managed, documented, and coded annually, including:

- Scheduler
- Nurse/MA
- MD/DO/NP/PA
- Coder/Biller
- Office Administrator

We've also learned that managing chronic and complex conditions at least annually requires that the right kinds of appointments are scheduled—this means providers and patients have to be on the same page at the time of scheduling. We're working to educate members about preventive vs. problem-focused visits and are urging them to schedule a visit with their provider to review their chronic conditions at least annually. In 2016, some of our members have two free visits built in to their Premera benefits. We want to make sure they get the most out of those visits by scheduling the right type of appointment.

For more great coding and documentation information, visit premera.com/ak/provider/commercial-risk-adjustment. If you have questions, call Physician and Provider Relations at 800-722-4714, option 4 or reach out to us at ProviderEngagementTeam@premera.com.

Stay Tuned for 2016 Coding and Documentation Webinars

We want to partner with you to successfully transition to the new world of risk adjustment that requires providers to manage, document, and code each patient's chronic and complex condition at least once annually. To support you in this effort, our Provider Engagement Team is developing and scheduling documentation and coding webinars for 2016. New webinars will soon be posted at premera.com/ak/provider/commercial-risk-adjustment/. If you have suggestions for webinar topics, or best practices to share, contact our team at 800-722-4714, option 4.

New Address for Behavioral Health Claims for Providence Employees in 2016

Providence Health & Services employees in Alaska are now Premera members. This means that as of Jan. 1, 2016, their claims for behavioral health services are coordinated through Optum. Here's how this affects provider billing and payment:

- Claims for these services submitted to Premera will be denied with messaging to bill Optum.
- Claims should be sent to Optum at:
  PBH
  P.O. Box 30602
  Salt Lake City, UT 84130

If you have any questions about this change, call Physician and Provider Relations at 800-722-4714, option 4.

Improving Collaboration Between Medical, Behavioral Healthcare Providers

Coordination between providers can improve treatment and outcomes results for patients. Following a behavioral health referral for treatment, results from a 2015 Premera survey showed a decrease in the exchange of communication. Significantly fewer behavioral health providers shared a summary report of the treatment plan to primary care providers (PCPs) in 2015 (30 percent) compared to 39 percent in 2014.

PCPs stated that summary reports bridge the communication gap and improve treatment coordination for patients. Information most valued by PCPs includes diagnosis, medications, and the plan of patient care and treatment. We encourage providers and behavioral health practitioners to improve the exchange of information for patient safety and well-being.

Online Services Updates

Plan Messages Note If Benefits Unavailable

In addition to PCP, grace period, and other important messaging, the benefits and eligibility tool's plan messages section tells you if benefits are unavailable. This is typically caused by a member's plan not being fully loaded in our system. This happens more frequently during the first quarter of the year as a result of open enrollment. The message says: **active coverage, benefit information currently unavailable; please call for this information.** If you see this message, call Customer Service for benefit information directly; don't call our service desk as it's not a technical issue.

Verifying Deductible, What Applies to Out-of-Pocket Max Online

With all of the new plan options, it can be harder than ever to figure out which plans include or exclude certain services from the out-of-pocket maximum. Our eligibility and benefits tool calls out these exclusions under the deductibles and maximums section. All services apply to the out-of-pocket maximum unless they're specifically called out in this section.

Here's an example of the copay and deductible excluded from the in-network, out-of-pocket maximum:

Deductibles and Maximums

Deductible	Amount	Period	Amount Satisfied	Amount Remaining
Individual				
In Network	$400.00	Plan Year	$47.62	$352.38
Out of Network	$1,200.00	Plan Year	$0.00	$1,200.00
Family				
In Network	$1,200.00	Plan Year	$122.76	$1,077.24
Out of Network	$3,600.00	Plan Year	$0.00	$3,600.00

Individual - Maximum	Amount	Period	Amount Satisfied	Amount Remaining
Out-of-Pocket Maximum				
In Network	$2,500.00	Plan Year	$0.00	$2,500.00
• EXCLUDES COPAY AND DEDUCTIBLE				
Out of Network	$5,000.00	Plan Year	$0.00	$5,000.00
• EXCLUDES COPAY AND DEDUCTIBLE • EXCLUDES HOSPITAL - EMERGENCY ACCIDENT • EXCLUDES HOSPITAL - EMERGENCY MEDICAL • EXCLUDES EMERGENCY SERVICES				

Family - Maximum	Amount	Period	Amount Satisfied	Amount Remaining
Out-of-Pocket Maximum				
In Network	$7,500.00	Plan Year	$0.00	$7,500.00
• EXCLUDES COPAY AND DEDUCTIBLE				
Out of Network	$15,000.00	Plan Year	$0.00	$15,000.00
• EXCLUDES COPAY AND DEDUCTIBLE • EXCLUDES HOSPITAL - EMERGENCY ACCIDENT • EXCLUDES HOSPITAL - EMERGENCY MEDICAL • EXCLUDES EMERGENCY SERVICES				

Calling All PCPs – Download Your PCP Roster

With more and more plans requiring PCP selection, we're making it easy for you to identify those members who've selected you as their PCP.

The roster includes information to make it easier for you to manage members' care, including:

- Member name, ID, date of birth, gender, address, phone, and plan name
- PCP provider name, the effective date, and status (active vs. terminated)
- Whether or not there is a referral requirement for the patient's plan

Tips for Downloading Your PCP Roster

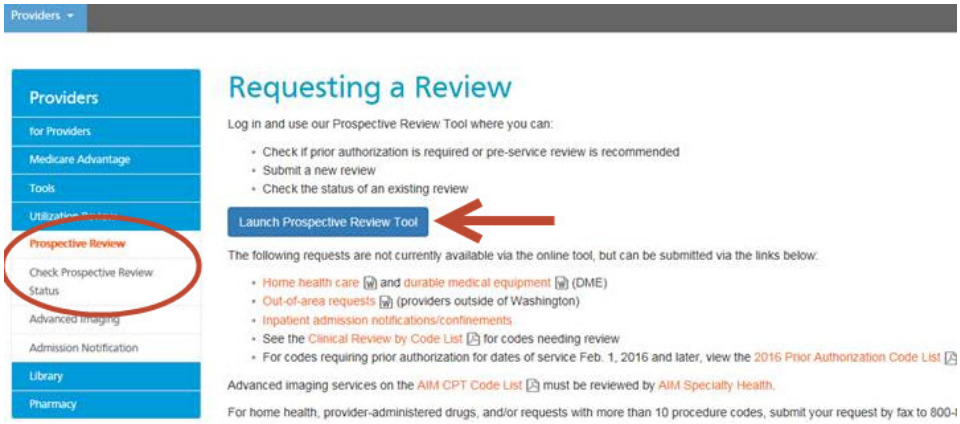
- Download your PCP roster via Tools in the left menu of our secure provider website.
- In the search field, enter the PCP's last name or leave the field blank to pull a roster for all PCPs associated with your tax ID.
- When entering the last name of a PCP, include a comma after the first name (instead of hitting the space bar) so that the auto-match feature continues to find the provider you're looking for.
- Download your results as a spreadsheet. You can save it, format it, and filter the report however you'd like.

Save a Call—View Codes Requiring Pre-service Review Online

Did you know that you can check online to see if a code requires pre-service review? All you need is the member ID or name and date of birth, date of service, and the code(s) you're checking on.

- You can check up to 10 codes at a time
- We'll take into account the member's eligibility for the date of service
- You'll get results within seconds
- You can check status of an existing review, even if you didn't submit the original request online!

You'll find the Prospective Review Tool under the Utilization Review section on the left menu: premera.com/ak/provider/utilization-review/prospective-review



AIM Specialty Health Makes Website Enhancements

You may have noticed some enhancements to the AIM Specialty Health website, including:

- Redesign of the intake workflow for chest and breast exams and allowing auto-auth for some services
- New security enhancement requiring a patient's health plan **member number** when initiating a new order or checking on the status of a previous order on the AIM *ProviderPortal*SM. In addition, you'll be prompted to enter either the patient's first and last name or date of birth.

AIM is continually making site improvements—watch for more information from AIM about the latest enhancements. If you have any questions about AIM's website, call 800-252-2021.

Got Three Minutes to Spare? Take Our Provider Survey

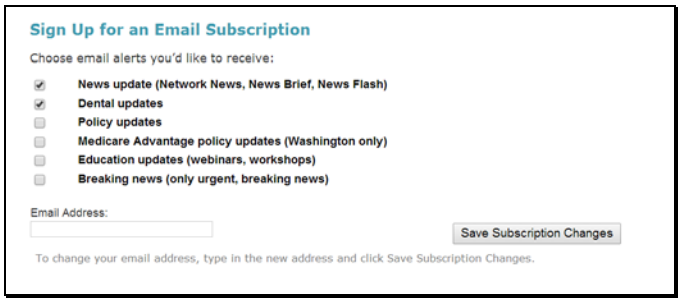
We recently revised our provider survey, asking for your feedback about online Network News and our online tools. Please take a few minutes to give us your opinion. We'd love to hear from you! You'll find the survey on our provider landing page. Take the survey.

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, Google Chrome

Sign Up for Email Updates for Network News

Sign up today for an email subscription—simply log in to our provider website and look for the email subscription sign up at the bottom of the My Premera home page.



Claims and Payment Policy Updates

Using Modifier 22: Increased Procedural Services

Per the American Medical Association's CPT Professional Codebook, modifier 22 is used to indicate that services provided for the procedure code being modified are substantially greater than that typically required for the procedure rendered and greater than the Relative Value Units calculated for the specific procedure; that the complexity of the procedure, the length of time usually allotted for the procedure, the difficulty and the risk for the procedure have all been exceeded. As a result, modifier 22 is usually added to the procedure code to indicate increased procedural services.

Per our payment policy on Modifier 22, any submission of modifier 22 on a procedure code must be accompanied by documentation that describes and supports the need for increased time, effort, complexity, and risk to perform the submitted procedure. This documentation helps in the review of these modified codes to determine if additional reimbursement is warranted for the procedure code being modified.
The documentation that accompanies the claim should identify the extra work needed to perform the procedure and should include such information as:

- Increased intensity of the work that's above and beyond those services that would be rendered for the non-modified procedure and a description of the additional work
- Technical difficulty and additional time involved in the procedure that isn't described by another more comprehensive code
- Severity of the patient's condition
- Physical and mental effort involved above and beyond the regular performance of the procedure

Modifier 22 is not appropriate for evaluation and management (E&M) codes. The addition of modifier 22 to a procedure code does not guarantee an increase in the maximum allowance for the reported service. Refer to the Premera payment policy for full details on the use of Modifier 22.

Laterality Update Conflicts Between ICD-10 CM Diagnosis Codes and Procedure Codes

Coding guidelines indicate that when a specific anatomic side is identified with a procedure code using the LT, RT, or 50 modifiers, the corresponding laterality should also be reflected in the assigned diagnosis code unless a specific code for laterality is not available in ICD-10 Clinical Modification (CM). At just over four months into ICD-10 CM diagnosis coding on claims, it's a good opportunity to remind you about the new coding concept of laterality.

Review of claims submitted during these past four months shows that claims continue to be submitted with diagnoses and procedure codes that conflict when it comes to identifying the correct laterality of both the procedure code and the diagnosis code.

When a procedure code is submitted with a LT, RT, or 50 modifier to indicate that the procedure was performed on the left, right or bilaterally, respectively, the associated ICD-10 CM diagnosis should **also** indicate the same anatomic location when an applicable ICD -10 CM diagnosis code exists.

Submitted claims to date continue to contain the following errors (conflict in the laterality of the procedure and diagnosis):

1. LEFT wrist x-ray billed with unspecified fracture, distal humerus
2. RIGHT knee x-ray billed with osteoarthritis knee, unspecified and pain knee, unspecified
3. LEFT hip x-ray billed with pain, unspecified hip
4. LEFT extremities, duplex scan of veins billed with synovial cyst, RIGHT ankle
5. RIGHT shoulder x-ray billed with pain, LEFT shoulder
6. RIGHT foot insert billed with Achilles tendonitis, unspecified leg, synovitis unspecified and pain unspecified foot
7. LEFT knee orthosis billed with pain, unspecified knee
8. RIGHT endovenous ablation therapy, lower extremity billed with varicose veins, unspecified lower extremity

Always refer to your ICD-10 CM codebooks or electronic coding applications to identify and select the most specific diagnosis code to match the laterality identified with the submitted procedure code.

Billing for Casts and Cast Supplies

When submitting a claim for cast application(s), there are CPT codes available that describe the application and/or removal of a cast. These CPT codes are in the range 29000 through 29750. However, there are no CPT codes available that indicate what type of casting materials have been used for the cast (typically plaster or fiberglass).

In the HCPCS Codebook, there are specific HCPCS codes that mirror the type of cast applied as described in the CPT code description as well as the materials used and the age class of the patient. This series of HCPCS codes can be found in the Q-series of codes in the HCPCS codebook (codes Q4001 through Q4051). These codes identify cast length, whether the patient is adult or child and whether the cast was plaster, fiberglass or some other type of material.

For example, for cast application code 29305, application of hip spica cast, one leg, the appropriate cast supply code is one of the following, depending on the patient's age and cast material:

- Q4025-Cast supplies, hip spica (one or both legs), adult (11 years+); plaster
- Q4026- Cast supplies, hip spica (one or both legs), adult (11 years+); fiberglass
- Q4027- Cast supplies, hip spica (one or both legs), pediatric (0-10 years); plaster
- Q4028-Cast supplies, hip spica (one or both legs), pediatric (0-10 years); fiberglass

When you bill for casting supplies, per coding guidelines, use the most specific code that represents services rendered—in this case, the specific Q-series HCPCS codes that describe the cast type, materials used, and patient age. Refer to your HCPCS codebooks for further clarification of the codes Q4001 through Q4051.

Submitting Corrected Claims

Submitting a corrected claim may be necessary if the original claim was submitted with incomplete information (procedure code, date of service, diagnosis code). The preferred process for submitting corrected claims is to use the 837 transaction (for both professional and facility claims), using claim frequency code 7. Be sure to bill all of the original lines so that the claim won't be rejected.

If submitting a paper corrected claim, remember to:

- Submit as a replacement claim, clearly marking it as "corrected" so that it won't result in a duplicate claim denial
- Bill all original lines—not including all of the original lines will cause the claim to be rejected
- Attach a completed Corrected Claim Standard Cover Sheet

If you have questions about corrected claims, contact Physician and Provider Relations at 800-722-4714, option 4.

Reminders and Administrative Resources

2016 Holiday Business Closure Dates

May 30—Memorial Day
July 4—Fourth of July
September 5—Labor Day
November 24-25—Thanksgiving Holiday
December 23, 26—Christmas Holiday

2016 Spring Alaska Provider Workshops

April 11: Fairbanks, Westmark Hotel and Conference Center
April 12: Wasilla, Evangelo's Restaurant
April 13: Anchorage, Anchorage Marriott Downtown
April 14: Juneau, Centennial Hall Convention Center

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

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 800-722-4714, option 4.

Send Provider Updates and Changes 30 Days in Advance

Please notify us of any updates or changes to your practice information at least 30 days prior to the change. This allows us to update our payment systems and provider directory so your patients have accurate contact information and your payments are sent to the correct address. You can notify us of any new information or changes by email, using the Contracted Provider Information Changes form. Providers can also send updates by fax at 425-918-4937, email at ProviderRelations.West@premera.com, or mail to Premera at:

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

For more information, call Physician and Provider Relations at 800-722-4714, option 4.

Pharmacy Updates

Reviewing Patient Prescriptions: Generic Metformin ER for Diabetes Therapy

In the past six months, the price of Glumetza (metformin ER) has increased nearly tenfold. The average total cost of a prescription for patients rose to approximately $6,000 per month. This cost is far out of line with other diabetes medications, including insulin, GLP-1s and SGLT-2s.

We recommend that you review your patient's medical record and see if the generic metformin ER, or another effective but less expensive drug can be used for their diabetes therapy. Because Glumetza uses a different polymer than generic metformin ER to release the active drug into the body, your patient's pharmacy can't substitute metformin ER for Glumetza without a specific prescription. For more information, call Physician and Provider Relations at 800-722-4714, option 4.

New! Electronic Prior Authorization Now Available

Log in and register with ExpressPAth® from Express Scripts where you can:

- Check eligibility and determine if prior authorization is required
- Submit a new request or a renewal
- Attach chart notes to a request
- Check status of a submitted review request

Requests are often approved in real time when established clinical criteria are met.

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/ak/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/ak/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.

Dental Updates

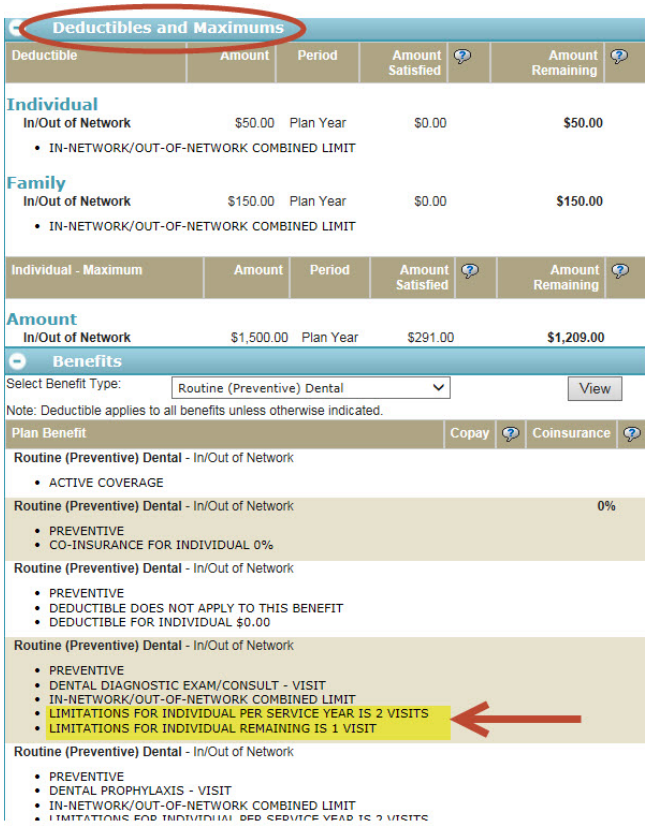
Don't Get Stuck On Hold! Check Dental Benefits Online

When you log in to premera.com/wa/provider and click on Eligibility and Benefits, you can access:

- Current eligibility status
- Effective date and plan name
- Visit limits used and remaining

- Deductible amounts and amount remaining
- Annual maximum limit and amount used
- Coinsurance (preventive, basic, major)
- Plan limitations and key messages (use “control F” to find keywords)

You can view the benefits by selecting “Dental Care” in the dropdown box or by the service type including: preventative, endodontics, periodontics, and orthodontia. Don’t have a member ID number? No problem! Simply search by member name and date of birth.



Note: We’re working on bringing you full mouth and panoramic x-ray limitations, and we’ll update you when they’re available. *See the Online Services Updates section for more online tool news.*

Consultant’s Corner: New Medical/Dental Coverage for Code E0485

Ronald Cantu, DDS, MPA, Premera Dental Director

Premera Blue Cross has initiated coverage for E0485 effective May 15, 2016. This code is listed in the HCPCS guide to Durable Medical Equipment section [E0100-E9999] and is the primary replacement for E0486.

Both codes are designed for oral devices/appliances, used to treat and reduce upper airway collapsibility described in medical literature as Obstructive Sleep Apnea (OSA).

The difference between the two appliances is the pre-fabricated nature of E0485 as opposed to a custom-fabricated E0486. Pre-fabricated appliances are considerably less costly and more easily dispensed by practitioners.

Through discussion with the medical and dental professionals who treat OSA, Premera has learned that in the vast number of cases of mild to moderate sleep apnea **(**apnea-hypopnea index (AHI) < than 30) individually fitted, ready-made oral appliances are as effective as custom made mandibular advancement appliances (MAD, E0486).

Our goal is to appropriately increase the use of these alternative oral appliances (E0485) by simplifying the pre-authorization and review process. The cost savings to our members should further encourage those who suffer from sleep apnea and prefer an oral appliance over a CPAP device to try one out.

Our medical policy 2.01.532 Intraoral Appliances for the Treatment of Obstructive Sleep Apnea (effective May 15, 2016) outlines the coverage requirements for both oral appliances and when and how a medical or dental provider can request coverage for a custom-fitted appliance or MAD.

Here's a list of manufacturers of ready-made oral appliances accepted for E0485 coverage:

- Narval CC™ Lamberg SleepWell-Smarttrusion
- 1st Snoring Appliance
- Full Breath Sleep Appliance
- PM Positioner
- Snorenti
- Snorex
- Osap
- Desra
- Elastomeric Sleep Appliance
- Snoremaster Snore Remedy
- Snore-no-More
- Napa
- Snoar™ Open Airway appliance
- The Equalizer Airway Device

This list is informational only. Premera does not recommend or endorse any particular appliance listed here.

Reminder: Microsoft Dental Benefit Change

Effective Jan. 1, 2016, Premera's Microsoft dental plans no longer cover take-home drugs—including fluoride toothpaste and mouthwash—dispensed at a dental provider's office. The plan only covers prescription medications and drugs when dispensed by a dentist for in-office use.

Sign Up for Email Alerts for Dental News Updates

Get all the latest Premera dental news! Log in to our secure provider website to sign up for quarterly Network News email alerts.

Medical Policy Updates

ACA Preventive Colonoscopy Benefit Changes for 2016

On Oct. 25, 2015, the Departments of Labor, Health and Human Services, and Treasury issued an ACA clarification FAQ. Effective Jan. 1, 2016, or as groups renew, a pre-operative consultation that has been determined medically appropriate prior to a preventive screening colonoscopy will be covered without cost sharing. In addition pathology exams related to polyp biopsy conducted during a preventive colonoscopy will also be covered without cost sharing.

It's vital to accurately code services so they are covered under the member's preventive benefit. Consultation codes are not reimbursed, but a pre-operative evaluation will be paid under the preventive benefit when submitted with a standard E&M codes (99202, or 99212), with a diagnosis of code representing screening for colon cancer (Z12.10 - Z12.12).

Covering pathology services appropriately is challenging as the claim is submitted separately from the colonoscopy procedure, by a different provider and on a different date of service. Ideal coding to ensure appropriate payment as preventive includes the following: CPT 88305 (colon polyp) with any of the following diagnoses: K50.10, K51.00, K51.90, K63.5, Z00.00-Z00.01, Z12.10-Z12.12, and Z84.81.

Preventive colonoscopy is done in asymptomatic patients with average risk. If patients have a known history of polyps, or a prior diagnosis of colon cancer, the colonoscopy and associated tests is considered surveillance, and is covered under the medical benefit. Colonoscopy and associated tests for symptoms or abnormal findings is covered under the medical benefit.

Oral Appliances for Obstructive Sleep Apnea – Prior Authorization Required

NOTE: Effective date of this policy is now July 1, 2016. (update as of March 22, 2016)

Effective July 1, 2016, new dental/medical necessity criteria will be in effect for intraoral appliances used to treat obstructive sleep apnea.

- (E0485) Prefabricated, individually fitted, ready-made oral appliances:
  - A sleep study shows AHI between 5–30 events per hour, including a minimum of 10 events documented per sleep study

- (E0486) Custom molded and fabricated oral appliances:
  - Documented failure of a prefabricated device after appropriate trial; or
  - Presence of a malocclusion severe enough that a prefabricated appliance could not be successfully worn; or
  - For AHI 30 events per hour or greater, a positive airway pressure device either cannot be tolerated or its use is contraindicated

Review medical policy 2.01.532 Intraoral Appliances for the Treatment of Obstructive Sleep Apnea (effective July 1, 2016) for full dental/medical necessity criteria and policy guidelines. Prior authorization for this service is required. Prior authorization is based upon on member benefits and eligibility at the time of service. Prior authorization includes a determination of dental/medical necessity and the appropriate level of care using evidence-based dental/medical policies and guidelines. Services that are not medically necessary will not be covered.

New Policy: Prior Authorization Required for Adjustable Cranial Helmets

Effective May 1, 2016, Premera will conduct medical necessity review of adjustable cranial helmets. When criteria are met, adjustable helmets for infants may be considered **medically necessary** following cranial vault remodeling surgery for synostosis.

Adjustable helmets are considered **not medically necessary** in these situations:

- In the absence of cranial vault remodeling surgery
- For the treatment of plagiocephaly or brachycephaly without synostosis

Review medical policy 1.01.11 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses for full medical necessity criteria and policy guidelines.

Prior authorization for this service is required and is based upon on member benefits and eligibility at the time of service. Prior authorization includes a determination of medical necessity and the appropriate level of care using evidence-based medical policies and guidelines. Services that are not medically necessary will not be covered.

Reminder: Routine Vitamin D Testing Is Not Medically Necessary

Vitamin D screening is considered appropriate only for those individuals with a documented disease or condition associated with vitamin D deficiency, osteoporosis, or a disease specifically associated with vitamin D overproduction and toxicity. Testing vitamin D levels in asymptomatic patients is considered not medically necessary when individuals do not have risk factors for vitamin D deficiency. For complete details, review medical policy 2.04.135 Testing Serum Vitamin D Levels.

Looking for the Latest List of Medical Policy Updates?

Visit our provider website to see medical policy updates within the last 60 days. You can sort the list policies by title, policy number, or effective date, and you can link to each policy for complete details.