Premera Blue Cross Blue Shield of Alaska

Network News

May 2016

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

Contents

Company Updates

Premera Listens Program Launches in June

Honest, real-time feedback is one of the best business practices for improving member satisfaction. That's why we're launching a new *Premera Listens* program this June.

The program focuses on receiving continuous feedback from members who've recently interacted with us through our customer service, website, or visit with their primary care provider. These members receive an email asking for their honest feedback—this helps us identify dissatisfied members, solve their problems, and retain their business. (If you've flown on Alaska Airlines recently, you may have received a similar type of email survey.)

Bob gave excellent advice and I left the call feeling confident.

The goal is to receive daily member feedback through a short survey coupled with immediate follow-up on positive and constructive feedback.

We're currently working out the final details and will reach out to our contracted providers directly with any feedback we receive about their experience in a primary care setting. This information will be used to improve the customer experience and provide kudos or suggestions where appropriate.

Premera Listens will launch with a small number of customers and expand as we gain experience with the feedback and process.

HEDIS Measure: Adult Body Mass Index (BMI) Assessment

More than two-thirds of U.S. adults are considered overweight and more than one-third are considered obese. Recent studies found that obesity contributes to nearly 1 in 5 deaths in the United States. Total healthcare costs attributable to obesity could exceed $800 billion by 2030, accounting for more than 16 percent of U.S. health expenditures.

Measuring and acting on higher than expected BMIs could improve this trend. Even modest weight loss—such as 5–10 percent of total body weight—can improve blood pressure, blood cholesterol, and blood glucose, and can decrease risk factors for chronic diseases related to obesity.

To do well on HEDIS, measure a patient's weight and calculate their body mass index (BMI) during an outpatient office visit at least once every two years and report it on a claim. The ICD-10 codes that need to be included all start with Z68 and end with the BMI percentage for BMIs from 20-39.9. For example, the ICD-10 code for a BMI of 29.5 is Z68.29. The exceptions are only those under 20 (Z68.1) and over 40 (Z68.4X).

HEDIS Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents 3-17 Years of Age

As you know, adult obesity often starts in childhood. Intervening by identifying at-risk kids early and providing nutritional and exercise counseling and support can have a real impact on the overall health of your patients.

To do well on HEDIS, continue to measure your patient's height and weight at least annually, determine their BMI percentile by plotting it on a growth chart or automatically calculating it through your electronic health record, and then submit the BMI as a code on a claim, for example:
- Z68.51 – BMI less than 5th percentile for age
- Z68.52 – BMI 5th percentile to less than 85th percentile for age
- Z68.53 – BMI 85th percentile to less than 95th percentile for age
- Z68.54 – BMI greater than or equal to 95th percentile for age

Documentation of Counseling for Nutrition can be as simple as using a checklist indicating nutrition was addressed, writing a referral for nutrition education, or documenting educational materials on nutrition were provided and then submitting ICD-10 code Z71.3 on a claim.

Documentation of Counseling for Physical Activity is also as simple as documenting current physical activity behaviors, the provision of educational materials on physical activity, or discussing anticipatory guidance for physical activity and including Z71.89 on a claim. Highly successful practices include these two codes on every EHR well-child order set or paper billing slip.

Alaska 2016 Legislative Session Update

The Alaska State Legislature convened on January 17 and has currently extended its session and is still meeting. Here are the key bills we worked on that passed in the 2016 legislative session.

HB 234 Telemedicine: Requires health plans that cover mental health benefits to provide coverage for mental health benefits through telehealth by a provider licensed in the state and may not require prior in person contact.

HB 372 Insurance Omnibus: Makes a number of technical fixes to the insurance code.

SB 74 Medicaid Reform: Includes a number of reform changes including telemedicine, enhancing fraud and abuse detection, reforming behavioral health, and exploring care coordination demonstration projects.

SB 142 Oral Chemo Mandate: Prohibits insurers from imposing a higher copayment, deductible, or coinsurance amount for patient-administered medication than for medications administered by a health care provider.

SB 18 Healthcare Sharing Ministries: Defines healthcare sharing ministries and makes an exemption from the insurance code.

SB 23 Opioids: Provides health care providers immunity from civil liability for providing, prescribing, or administering opioid overdose drugs.

SB 69 Chiropractors: Amends requirements for chiropractors licensing and regulation and makes a clarification that chiropractors within the scope of practice, may perform physical exams of children for school physical exams and pre-participation physical exams for sports and school activities.

Navigate Your Way to Comprehensive Documentation and Coding

Documenting and coding chronic and complex conditions annually for your patients are more important now than ever. There are several simple things you can do to make complete documentation easier for clinicians and comprehensive coding easier for coders and billers.

In the February edition of Network News, we featured a travel-themed guide with three simple tips to help you ensure members with chronic conditions get the care they need:

- Scheduling enough time and the right kinds of appointments for comprehensive review of conditions
- Reminders to code each condition annually
- Ways to set up your EMR to help facilitate good documentation and coding.

Check out the latest tips and find more coding and documentation resources right here.
If you have questions, call Physician and Provider Relations at 800-722-4714, option 4, or send an email to ProviderEngagementTeam@premera.com.

Coding and Documentation Recorded Webinars for 2016

The new world of risk adjustment means that providers must manage, document, and code all patients' chronic and complex conditions at least once a year. To support you in this effort, we've produced a series of condition-specific recorded webinars to guide you through the nuances of documenting and coding conditions such as diabetes, depression and anxiety, cancer, and more. Each webinar is only 20-25 minutes in length and can be viewed easily without signing up for a live webinar.

Check our provider website in June to see our first webinar on diabetes. If you need clarification on documentation and coding of other chronic and complex conditions, contact our team at 800-722-4714, option 4. We're here to help.

Quality Program Improves Care and Services for Our Members

Our Quality Improvement Committee annually conducts a formal, system-wide assessment that includes a program evaluation of the quality of our health services. View the 2015 Quality Program Report Card.

And, in case you're wondering, our Quality Improvement Committee is just one part of our quality program which supports our primary goal to improve customers' lives by making healthcare work better. We do this by working together with our providers, continually looking for ways to improve quality. Every part of the customer experience—

from customer service phone calls to doctor visits—is monitored and measured for quality. If you have any questions about our quality program, please contact Physician and Provider Relations at 800-722-4714, option 4.

Online Services Updates

Use Online Tools for Patients with Out-of-Area Coverage

There are several tools, such as BlueCard Resources, to help you manage care for patients with out-of-area plans. BlueCard Resources is located under Quick Links or you can access it directly at premera.com/ak/provider/bluecard-resources. You can view a list of common alpha prefixes to determine where to send your claims, get details by reading our BlueCard program provider manual, and submit prior authorizations online to participating plans via the medical policy and pre-authorization router.

Here's how you can submit BlueCard prior authorizations online:
First, click on the medical policy and pre-authorization router button on the BlueCard Resources page.
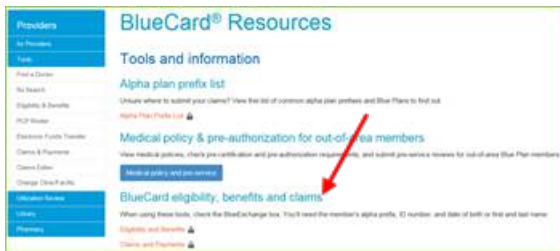
You'll then see two options—view medical policy or pre-service review information (including what supporting documentation to submit by entering the member's alpha prefix). You don't need to sign in to use this feature.

For prior authorization, 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. (This is not available for FEP and NASCO members.)
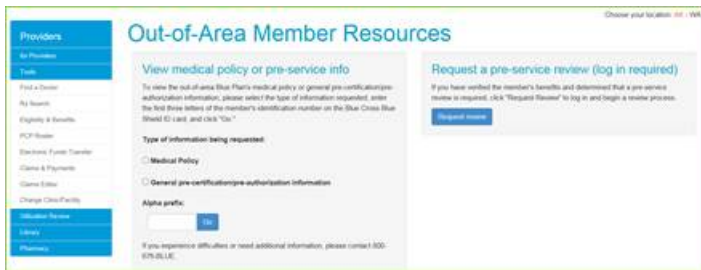
If you still need to get in touch with the member's home plan, call 800-676-BLUE (2583). When you enter the member's alpha prefix and ID number, you'll be routed to the member's home plan.

Alert: Scheduled Website Maintenance on Saturday, May 14

Please be aware that systems maintenance on our websites is scheduled for Saturday, May 14 from 4 p.m. to 12 a.m. During that time, all websites and online tools will be down, including the find a doctor and claims editor tools. Please contact us before May 14 if you have any questions or concerns.

Claims and Payments: Check Online First

Avoid wait times and check claim status online before calling.

- Look for a claim by member, provider, and even check for BlueCard members.
- Bookmark important claims for future reference. Once you locate the claim and click 'Bookmark' it will show up at the bottom of your 'My Premera' secure page for easy reference.
- For Premera members, you can download the EOP from the claim if it's processed.

Reminder: Use Eligibility and Benefits Tool To See Patient Status

Need to know where your patients are with their deductibles, maximums, premiums, and primary care provider choices? Use the eligibility and benefits tool to get the information you need.

- Your member doesn't have a card yet? That's ok! Look them up by name and date of birth.

- Once you've found your patient, you can verify their plan network under the Plan Eligibility section.

- The Deductible Maximum section provides everything you need in one place, including the member's status of individual and family deductibles, out-of-pocket maximums, and the amount met to date. We even call out the benefits excluded from the out-of-pocket maximum.

- The Plan Messages section gives you member PCP information and grace-period premium delinquency messages. If the member has selected a PCP, you'll see the PCP's name, phone number, and tax ID. Also, on the first day of the second month, if the member has a delinquent premium, we'll add a message letting you know, including the grace-period dates.

Provider Sites Updated Nightly

Staff at provider offices often ask us how frequently our websites are updated. All of our websites are refreshed on a nightly basis. Updates include content, tool improvements, navigation, and more. If you see an area on our website that you feel could be improved, please let us know by taking our online survey.

Use the Latest Browser Version When Accessing Online Tools

For the best online experience, please use a web browser we support, including Firefox, Chrome, or Internet Explorer 11—there are often issues using IE8 and IE9. 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

If you can't change your browser and you're experiencing issues, our Service Desk is happy to help. Contact us at 800-722-9780 Monday through Friday, 6 a.m. to 6 p.m., or email us at **support@premera.com**.

Claims and Payment Policy Updates

Durable Medical Equipment and Home Medical Equipment: Modifier Determines New, Used, or Rental

In order to identify whether a piece of DME/HME has been rented or purchased, it's critical to append a modifier to the equipment code. The following modifiers should be used to indicate this information:
Modifier:

- NU – New equipment
- RR – DME rental
- NR – New when rented (DME)
- UE – Used DME
- KR – Rental-billing for partial month
- LL – Lease/Rental

Using the modifier on the equipment code helps us identify the correct reimbursement to apply to the submitted service. When submitting a claim for a monthly equipment rental, indicate the beginning and end dates of service for the rental period, along with the number of units that represent the number of months rented. For example: E0604-RR DOS 1.12.16 – 2.11.16, one unit of service represents a one-month rental.

When using modifier KR to indicate that the equipment was rented for less than an entire month (daily rental), submit the beginning and end dates of service for the daily rental period and the number of days rented as the unit value. Example: E0935-RR DOS 1.12.16 – 1.31.16, 15 units of service represents the number of rental days.

Rental-to-Purchase Durable Medical Equipment and Home Medical Equipment

In an effort to be transparent and define our existing process for reimbursing rented durable medical equipment, we're primarily using the Centers for Medicare and Medicaid Services (CMS) Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule, as a baseline to identify equipment that's considered a rental-to-purchase piece of equipment.

A rental-to-purchase piece of equipment is one that can be rented for a period of 10 months. After the patient rents it for 10 months, the member owns the piece of equipment, and we no longer pay rental payments toward the equipment. In addition, those pieces of equipment considered as daily rentals (equipment rented on a daily basis, for fewer than 30 days) or continuous rentals (equipment such as oxygen needed for an extended period of time) are not subject to the 10-month capped rental period.

In order to identify the correct status of the equipment and to reimburse the equipment appropriately, it's critical to append the code with the correct modifiers noted previously.

A new payment policy being released later this year addresses these two sections in detail. Providers are encouraged to start using the correct modifiers before the payment policy's release.

Drug Waste: Modifier JW-Drug Amount Discarded/Not Administered to Any Patient

When the prescribed dosage of a single-use drug vial(s) or a single-use package(s) of drugs is administered and a portion of the drug remains in the vial or package, submit a modifier for the leftover portion of the drug that cannot be administered to another patient, along with the code for the administered drug.

To correctly represent the drug waste or leftover drug, the modifier called 'JW-Drug amount discarded/non-administered to any patient' should be appended to the same drug HCPCS code that was administered, to represent that portion of the drug that was left over/wasted. For example:

- J9039 – Injection, blinatumomab, 1 microgram: administered drug portion, 28 mcg (28 units)
- J9039-JW - Injection, blinatumomab, 1 microgram: wasted drug portion, 7 mcg (7 units)

The drug code without modifier JW should be billed on one line with the appropriate administered units corresponding to the drug amount in the code description and the drug code with modifier JW on a second line (to represent the wasted portion) with the appropriate units to reflect the wasted amount of drug in the single use vial or package. Modifier JW is only valid when appended to a drug code that's packaged as a single dose vial or a single dose package.

Reminders and Administrative Resources

Medical Necessity Review Required for Outpatient Rehabilitation Services Effective July 1, 2016

Premera is implementing an authorization and medical necessity review process for outpatient rehabilitation services. Our goal is to ensure members receive high-quality, cost-effective care consistent with best practices.

eviCore healthcare (formerly known as CareCore National) is a medical benefits solutions company managing outpatient rehabilitation services for Premera. The start date for this change is for dates of services on and after July 1, 2016. (We mailed a notification about this change to providers on March 28, 2016.)

A full list of the outpatient rehabilitation codes were included in the provider notification and are also posted on our provider website at premera.com/ak/provider/utilization-review/outpatient-rehabilitation/. In mid-June, we'll be adding helpful links on our provider website to a Quick Reference Guide, Clinical Guidelines, FAQ, and the Medical Necessity Review Authorization Request Form.

To create an account and/or initiate an authorization **for dates of service on or after July 1, 2016**, you can:

- Visit eviCore healthcare

- Call 800-792-8751 from 7 a.m. to 7 p.m., Monday through Friday

- Fax an eviCore healthcare request form (available mid-June on our provider website) to 800-540-2406

eviCore healthcare will be leading free web-based orientation sessions. The sessions will include information about the requirements for Premera members and how to locate additional training materials to navigate eviCore healthcare's website. Time and participation permitting, the sessions will be followed by a question and answer discussion. If you want to attend one of the following one-hour sessions, you must register in advance.

Date	Time
Tuesday, June 7	2:00 PM Pacific
Wednesday, June 15	12:00 PM Pacific
Wednesday, June 22	2:00 PM Pacific
Tuesday, June 28	10:00 AM Pacific

Please read the instructions below carefully to register and participate in a session:
1. Once you've chosen a date and time, visit medsolutions.webex.com/
2. Click on the "Training Center" tab at the top of the web page
3. Find the date and time of the conference you want to attend by clicking the "Upcoming" tab. All of the sessions are named "Premera Provider Orientation Session."
4. Click "Register"
5. Enter your registration information

After you've registered for the conference, you'll receive an email containing:
- The toll-free phone number and pass code you'll need for the audio portion of the conference
- A link to the web portion of the conference
- The conference password

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

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

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.

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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 provider.relationswest@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

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.

Cambia® (diclofenac potassium for oral suspension)
premera.com/medicalpolicies/5.01.605.pdf
Coverage Criteria
Cambia®(diclofenac potassium for oral suspension) may be considered **medically necessary** when all of the following criteria are met:
Patient must have had a trial of generic diclofenac that was ineffective or not tolerated and had therapy with two other generic NSAIDS that were ineffective or not tolerated.

Duexis® (ibuprofen/famotidine)
premera.com/medicalpolicies/5.01.605.pdf
Coverage Criteria
Duexis®(ibuprofen/famotidine) may be considered **medically necessary** when ALL of the following criteria are met:
Patient must have had a trial of generic ibuprofen **in combination** with generic famotidine that was ineffective or not tolerated and had therapy with two other regimens of a generic NSAID in combination with either a generic proton pump inhibitor or an H2 blocker that was ineffective or not tolerated.

Glumetza® (*metformin HCL extended release)*
premera.com/medicalpolicies/5.01.560.pdf
Coverage Criteria
Glumetza® (metformin HCL extended release) is considered not medically necessary for all indications. These products are excessively high-priced and have lower-cost alternatives that are equally safe and effective. Suggested alternatives are listed here:

High-Cost Drug Product:	Suggested Alternative(s):
Glumetza	Generic metformin extended-release

Definition of Medical Necessity:
Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician, or other healthcare provider, and
4. **Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results** as to the diagnosis or treatment of that patient's illness, injury or disease.

Orkambi™ (lumacaftor/ivacaftor)
premera.com/medicalpolicies/5.01.539.pdf
Coverage Criteria
Orkambi™ (lumacaftor/ivacaftor) may be considered **medically necessary** for the treatment of cystic fibrosis (CF) in patients age 12 years and older who have are homozygous for the F508del mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene. Orkambi may also be considered **medically necessary** for any mutation subsequently added to the FDA-approved indication.

All other uses of **lumacaftor/ivacaftor** are considered **investigational.** Initial approval for **six months** requires all of the following:
Genetically confirmed diagnosis of CF with the above genotype, and the patient does not have persistent Burkholderia cenocepacia, dolosa, or Mycobacterium abcessus present in sputum, and the patient does not have liver function tests (LFT) above three times the upper limit of normal (ULN).

Continued therapy will be approved for periods of one year as long as the above conditions are met, and the patient has shown and continues to show improvement in FEV1, symptoms or stabilization of disease. **Orkambi**™ is a specialty pharmacy drug covered under the pharmacy benefit.

Vimovo® (*naproxen/esomeprazole magnesium*)
premera.com/medicalpolicies/5.01.605.pdf
Coverage Criteria
Vimovo® (naproxen/esomeprazole magnesium) may be considered **medically necessary** when <u>all</u> of the following criteria are met:

- Patient must have had a trial of generic naproxen <u>in combination</u> with generic esomeprazole that was ineffective or not tolerated <u>and</u>

- Patient must have had therapy with <u>two</u> other regimens of a generic NSAID <u>in combination</u> with either a generic PPI that was ineffective or not tolerated.

Corlanor®(*ivabradine)*
premera.com/medicalpolicies/5.01.605.pdf
Coverage Criteria
Corlanor® (ivabradine) may be considered **medically necessary** when <u>all</u> of the following criteria are met:

- Patient has a diagnosis of stable, symptomatic heart failure <u>and</u>

- Patient has normal sinus rhythm with a resting heart rate of ≥ 70 beats per minute <u>and</u>

- Patient has a left ventrical ejection fraction (LVEF) ≤ 35 percent <u>and</u>

- Previous therapy with a beta blocker was ineffective or not tolerated <u>or</u>

- Patient still has a resting heart rate of ≥ 70 beats per minute while on the maximally tolerated dose of beta blocker

All other uses of *ivabradine* are considered **investigational.**

Entresto™ (sacubitril/valsartan)
premera.com/medicalpolicies/5.01.605.pdf
Coverage Criteria
Entresto™ (sacubitril/valsartan) may be considered **medically necessary** when <u>all</u> of the following criteria are met:

- Patient has a diagnosis of Chronic heart failure with reduced ejection fraction <u>and</u>

- Patient has had previous therapy with a beta blocker that was ineffective or not tolerated

All other uses of sacubitril/valsartan are considered **investigational.**

Valchlor® (*mechlorethamine)*
premera.com/medicalpolicies/5.01.532.pdf
Coverage Criteria
Valchlor® (mechlorethamine) may be considered **medically necessary** for the topical treatment of Stage 1A and 1B mycosis fungoides-type cutaneous T-cell lymphoma when at least 2 of the following skin-directed therapies have been tried and failed:

- Topical corticosteroids (prednisone, triamcinolone, etc.)

- Topical imiquimod

- Phototherapy

- Local radiation

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All other uses of *mechlorthamine* are considered investigational.
Valchlor® is a specialty pharmacy drug covered under the pharmacy benefit.

Movantik®(naloxegol)
premera.com/medicalpolicies/5.01.605.pdf
Coverage Criteria
Movantik™ (naloxegol) may be considered **medically necessary** when all of the following criteria are met:

- The patient is an adult with a diagnosis of opioid-induced constipation and

- The patient is being treated for chronic non-cancer pain

All other uses of naloxegol are considered investigational.

Effective April 15, 2016:

Alecensa® (alectinib)
premera.com/medicalpolicies/5.01.538.pdf
Coverage Criteria
Alecensa® (alectinib) may be considered medically necessary for the treatment of advanced or metastatic non-small cell lung cancer that is anaplastic lymphoma kinase (ALK)-positive in patients who have experienced progression of their cancer while taking crizotinib.
All other uses of **Alecensa®** (alectinib) are considered **investigational**.
Alecensa® is a specialty pharmacy drug covered under the pharmacy benefit.

Tagrisso® (osimertinib)
premera.com/medicalpolicies/5.01.603.pdf

Coverage Criteria
Tagrisso® (osimertinib) may be considered medically necessary for:
- Patients 18 years of age or older with a confirmed diagnosis of metastatic NSCLC.
- Patients with demonstrable disease progression on or after therapy with a Tyrosine Kinase Inhibitor (TKI).
- Patients must test positive for EGFR T790M mutation on the FDA-approved companion diagnostic test (cobas® EGFR Mutation test v2; Roche).

All other uses of **Tagrisso®** (osimertinib) are considered investigational.
Tagrisso® is a specialty pharmacy drug covered under the pharmacy benefit.

Dental Updates

Credentialing Requirement Every Three Years

All participating dentists must meet and maintain credentialing standards every three years to begin or continue to participate in our dental health plans. The majority of our dentists complete this process within 60-90 days.

Part of Premera's contractual agreement requires all new associate or employee dentists go through the credentialing process. When a new associate or employee dentist agrees to join your practice, please let your provider representative know as soon as possible to help with the credentialing process.

Associate and employee dentists are required to provide their name as the treating dentist in box 53 of the claim form.

Credentialing offers you the following advantages:

- Builds your practice and increases your visibility in Premera's online directories
- Ensures consistent billing and simplification of claim payments
- Reduces enrollee confusion about which dentists are in-network or not, which can impact out-of-pocket costs
- Preserves patient relationships

To get started, complete the Dental Provider Credentialing Application or contact Physician and Provider Relations at 800-722-4714, option 4. You may also call this number for assistance with:

- Notification of retiring and moving dentists in your practice
- Change of address or tax identification updates
- Participating contract questions
- Name of the Provider Network Executive (PNE) assigned to your office

Enrollment Delayed for Medicare Part D Prescribers

The Centers for Medicare and Medicaid Services (CMS) announced they're delaying the enrollment date for all providers who prescribe Medicare Part D drugs. The **new start date for this rule is Feb. 1, 2017.**

To make the new start date, CMS is asking all prescribers of Part D drugs to **enroll with CMS by Aug. 1, 2016**. This includes dental providers.

If prescribers don't have applications on file, prescription drug claims will be denied at the pharmacy. To avoid delays in patient claims, we encourage our Premera Blue Cross Medicare Advantage Select Dental Network providers and all prescribers of Part D medications to submit their enrollment application by Aug. 1, 2016.

CMS recently posted a new video to help you understand the enrollment process and learn how to use the Provider Enrollment, Chain, and Ownership System (PECOS). To enroll or learn more, visit the CMS website.

Consultant's Corner: Intraoral Appliances for Treatment of Obstructive Sleep Apnea

Ronald Cantu, DDS, MPA, Premera Dental Director
Effective July 1, 2016, we're implementing a revised medical policy for the coverage of mandibular advancement appliances as treatment of mild to moderate obstructive sleep apnea.

Significant advances in the design and fabrication of individually fitted, ready-made appliances have made these devices an appropriate treatment choice for many patients with mild to moderate sleep apnea.

The new policy supports use of these devices as first-line therapy for appropriate patients. The code for this appliance is E0485. Coverage requires documentation of a sleep study showing an apnea hypopnea index (AHI) between five and 30 events per hour, with a minimum of 10 events per sleep study. When this simplified diagnostic criterion is met and sleep apnea coverage is available, mandibular advancement appliance coverage is limited to an E0485.

Benefits for custom-made intraoral appliances (E0486) is limited to plan members where a polysomnogram documents an AHI greater than 30 and the patient was unable to tolerate a continuous positive airway pressure

device. Additionally, benefits are available for E0486 when a member can't tolerate an E0485 due to severe malocclusion and/or a clinical history of failed attempts to wear an E0485. Please review medical policy 2.01.532 Intraoral Appliances for the Treatment of Obstructive Sleep Apnea (effective July 1, 2016) for full details.

Medical Policy Updates

Reminder: Endoscopic Sinus Surgery Policy Effective May 1, 2016

The effective date for the functional endoscopic sinus surgery policy is now **May 1, 2016.** Starting on that date, prior authorization is required for non-emergent sinus surgeries. If a procedure doesn't meet medical necessity criteria, the procedure and associated services (e.g., anesthesia) will be denied.

Chronic sinusitis is a common condition among adults, and most individuals with this diagnosis won't need surgery to manage symptoms. Both professional and primary care specialty societies recommend conservative treatments such as antibiotics and nasal steroids prior to functional endoscopic surgery. If conservative treatment fails, functional endoscopic sinus surgery may be considered medically necessary when criteria are met. For full criteria see policy 7.01.559 Functional Endoscopic Sinus Surgery (FESS) for Rhinosinusitis and Nasal Polyposis (OR) on the provider website.

Reminder: Prior Authorization Needed for Cranial Orthoses

For dates of service May 1, 2016 and later, we will review adjustable helmets for infants for medical necessity. Prior authorization for this service is required. Services that are not medically necessary will not be covered. Please review medical policy 1.01.11 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses (OR) for all criteria.

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.