Premera Blue Cross Blue Shield of Alaska

Network News

NOVEMBER 2015

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

Contents

Company Updates

Prior Authorization Changes – Provider Liability

On Oct. 1, 2015, we sent a News Brief about prior authorization and the change from member to provider liability if a provider does not secure a required prior authorization for services. This change is effective for dates of service on or after January 1, 2016.

Here are some frequently asked questions from providers on this topic.

Am I affected by these changes? Which codes require prior authorization?

Prior authorization is required for major procedures or services that could be a health and safety issue for our members. The following non-exclusive list highlights some common services that require prior authorization:

- All planned inpatient stays
- Admission to a skilled nursing facility or rehabilitation facility
- Elective (non-emergent) air ambulance transport
- Some outpatient services
- Organ transplants
- Supplies, appliances, durable medical equipment (DME), and prosthetic devices over $500 (purchase)
- Provider-administered drugs

See the Clinical Review by Code List for all codes needing prior authorization.

How do I get a prior authorization?

- Online with the Prospective Review Tool (log-in and member ID required)
- Fax a request form

Where can I get more information?

Visit our Prospective Review page.

Register Today for Free ICD-10 Webinar

Don't miss the last webinar in our ICD-10 "Ready, Set, Go!" series.
Go! ICD-10 Coding and Risk Adjustment
November 17, from 12 to 1 p.m.
Presented by Tonya Owens, Premera Coding Quality Educator
All systems go! Now that you've successfully transitioned to ICD-10, join this webinar to learn the top 10 tips for risk adjustment coding under ICD-10. Are you seeing more patients with metallic bronze, silver, or gold plans this year? We'll give you tips to prepare for audits that are just beginning in 2016 as a result of the Affordable Care Act. (Continuing Education Units may be available)
To sign up, email providerengagementteam@premera.com or call 800-722-4714, option 4.

Reporting PCP Status and Provider Availability

Premera has many health plans that require members to select a primary care provider (PCP). These plans often have lower copay amounts and a more efficient use of benefits. With the increased demand for PCPs, it's critical for us to know your availability to accept new Premera members.

Our Find a Doctor online directory helps our members easily find a PCP to manage their healthcare needs. Our directory, however, is only as accurate as the data sent to us by our contracted providers. The directory identifies primary care providers in addition to the provider's specialty and identifies if the provider is accepting new patients.

PCP vs. Specialist
PCPs are limited to certain provider types and specialties, such as family medicine, general practice, internal medicine, and pediatrics. It's important that your patients (our members) have access to an accurate directory that correctly classifies contracted providers as PCPs and shows their availability to see new patients.

- If your specialty is defined as a PCP type and you no longer practice as a primary care provider, please note to have that stated in the directory. This will prevent members from selecting you as their PCP.
- PCP provider types can also practice as preceptors, hospitalists, float pool, and walk-in clinic providers. These types also prevent members from selecting you as their PCP.

Panel Status: Accepting New Patients
If you're a PCP provider, please let us know your current patient capacity, such as:

- Open – accepting new patients
- Established – current patients only
- Closed – Not accepting new patients and Members cannot select provider as a PCP

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

New Address for Behavioral Health Claims for Providence Employees in 2016

Providence Health & Services employees in Alaska are Premera members and, beginning Jan. 1, 2016, their claims for behavioral health services will be 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.

Providers Offer Best Practices for Annual Health Reviews

Premera's Provider Engagement Team would like to thank all 306 clinics across Alaska, Washington, and Oregon who've provided Annual Health Review visits to our members so far this year. These visits help our members with chronic conditions by offering them a free visit to ensure those conditions are consistently managed with their providers. It's been a privilege to work with provider teams dedicated to the wellbeing of their patients.

Some providers were gracious enough to share their best practices for making sure these visits are completed as smoothly as possible:

1. Dedicate a single point person to ensure the overall process runs smoothly across all clinic locations.
2. Streamline the process by assigning tasks using Premera's implementation guide tool. For example, have the same person handle all calls (both in and outbound) and make appointments. This ensures the correct provider visit type is selected so that the provider has the time needed for review of chronic or complex conditions during the visit.
3. Develop a how-to procedure for conducting these visits within your office so that it's as seamless as possible for both the provider and the patient.

Providers have until Dec. 31, 2015, to complete the Annual Health Review visits for patients enrolled in the Enrollee Health Assessment Program. If you have questions or need assistance, reach out to our Provider Engagement Team at providerengagementteam@premera.com or call Physician and Provider Relations at 800-722-4714, option 4.

Medical Records Requests: What You Need to Know

Medical records requests are necessary to help us manage risk and make sure our members have access to quality, affordable healthcare. Your office may receive medical records requests through the following:

- Commercial and Medicare risk adjustment
- Marketplace (Exchange) HEDIS (from Verisk)
- Medicare HEDIS (5-Star Rating)

The success of these programs relies on provider partnership in four key areas:

- Complete, accurate, and timely claims coding
- Medical record documentation that validates completion of clinical care to support claims
- Submission of select medical records to support coding and documentation reviews and audits

- Submission of select medical records that validates completion of clinical care to supplement claims data

We'd like to make sure the right person in your office receives the medical records requests – send us an email with the name and email address of the ideal contact in your office.

Here's an overview of requests that started in October 2015 and continue through December 2016:

Quality Program:	Commercial Risk Adjustment		Commercial/Marketplace (Exchange) HEDIS
Purpose of Record Retrieval:	Validation of diagnoses in the medical record to claims submitted	Initial validation audits by CMS (Centers for Medicare & Medicaid Services)	Data collection of Clinical Quality Measures to submit to NCQA (National Committee for Quality Assurance)
Vendor:	Altegra	Third-party auditor in conjunction with CMS	Verisk Health
Begins:	October 2015	2016 (summer–fall)	January 2016

Expected Increase in Prior Authorization Requests

Our clinical review teams are expecting prior authorization processing times to increase as 2015 comes to a close. This is a typical cycle we see as many of our members try to schedule procedures right before their new health plan year begins. Whenever possible, plan accordingly to allow for extra processing time.

Here are a few things you can do to help speed up the review process:

- **Use our Prospective Review Tool** to submit your requests and check status.
- **Print the fax cover sheet from the Prospective Review Tool and attach it to your records** so we can quickly match them to your request and update the system with a status. (If you use an electronic faxing system and don't use the cover sheet generated from the tool, be sure to include the reference number you receive from the tool on your documentation.)
- **Use the correct date of service.** When you enter the date of service into the tool, make sure it is for the scheduled date of the service or procedure. If the date changes, be sure to let us know by calling Care Management at 877-342-5258, option 3.
- **For a request with multiple dates of service,** enter the first date of service. Note in your documentation the date span and number of treatments or units. Watch for online tool updates and enhancements via News Flash notifications and *Network News* articles.
- **Most importantly, fax your request/records one time only.** Duplicate faxes cause a backlog and delay review.

HEDIS Measure: Colon Cancer Screening—Tips for Communicating with Your Patients

Colon cancer screening can be an uncomfortable topic, but it's an important one to discuss with your patients. Here's an article to our members about colon cancer screening that you're welcome to share with your patients. Check out the healthfinder.gov website for great tools to share with your patients about colon cancer screening. The site offers

newsletter content, tweets you can post, and e-card screening reminders you can personalize and email up to 10 of your patients.

There are two primary options for colon cancer screening: a convenient at-home test done every year (fecal immunochemical test or FIT), or a colonoscopy (recommended every 10 years). Other options include a sigmoidoscopy every five years. For more information, view our Colorectal Cancer Screening Tip Sheet.

HEDIS Measure: Appropriate Use of Antibiotics for Respiratory Conditions

Overuse of antibiotics is a well-recognized national health care concern, and can lead to many problems for patients—unnecessary cost, resistance to future bacterial strains (such as MRSA), unpleasant side effects (such as yeast infections and diarrhea), and occasionally more severe conditions like colitis.

NCQA has recognized this issue, and created quality measures to address it. One of those measures is whether or not a provider performed a strep test before administering or prescribing an antibiotic for a child with pharyngitis.

For the HEDIS measure Appropriate Testing for Children with Pharyngitis, if you prescribe or administer antibiotics for an entered diagnosis of acute pharyngitis, acute tonsillitis, or strep pharyngitis, but didn't perform or submit a claim for a rapid strep test, you will not meet the criteria for this evidence-based guideline or receive credit for this on your scores. For more information, view our Child Pharyngitis Tip Sheet. Source: ncqa.org/

Why Do I Need a Flu Shot Every Year?
Two Reasons to Share with Your Patients

Patients often ask why a flu shot is needed each year. Here are two good reasons for getting a flu shot to share with your patients.

1. First, flu viruses are constantly changing. Flu vaccines may be updated from one season to the next to protect against what research indicates may be the most common virus during the upcoming flu season.

2. Second, a person's immune protection from the flu vaccine declines over time, so an annual vaccination is recommended. The U.S. Centers for Disease Control (CDC) recommends that everyone who is at least six months of age should get a flu vaccine this season. According to the CDC, during a regular flu season (October through May), about 90 percent of flu-related deaths occur in people 65 and older. Children five years old and younger are also highly susceptible to flu complications.

Remind your patients that the flu vaccine is a preventive benefit, so there's little to no cost for a vaccine from an in-network provider or pharmacy. Nasal spray flu vaccine is also an option and is generally available for patients ages 2 through 49.

When you provider a flu vaccine to a patient, the patient's medical record should include:

- Vaccine documentation (injection or mist) and documentation of any additional recent vaccines the member has had, including where and when received

- Coding for all parts of this HEDIS measure

It's highly recommended that your office staff should get the flu shot early in the flu season so they're protected and able to care for patients when they're needed most. The vaccination is effective approximately two weeks after administration.

Flu Vaccine Resources

Check out the CDC's information and patient resources for National Influenza Week, Dec. 6-12.

View our Adult Flu Vaccine Tip Sheet.

Visit our HEDIS web page for providers.

Sources:
cdc.gov/flu

"Key Facts About Seasonal Flu Vaccine," Centers for Disease Control and Prevention, accessed September 15, 2015, cdc.gov/flu/protect/keyfacts.htm

Third-Party Payer Payments for Individual Members

As a reminder, the Department of Health and Human Services (HHS) released guidance related to third-party payments and, as such, Premera individual contracts prohibit payments from third parties for individual members except where required by law. This policy is designed to:

- Protect consumers from market instability
- Prevent employers from shifting liability for their employees to the individual market

The majority of our individual members pay for their health plans themselves and are not affected by this change. We'll continue to notify affected members of this requirement.

Guidance from CMS Website
HHS has broad authority to regulate the federal and state marketplaces (e.g., section 1321(a) of the Affordable Care Act). It has been suggested that hospitals, healthcare providers, and commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces. HHS has significant concerns with this practice because it could skew the insurance risk pool and create an un-level playing field in the marketplaces. HHS discourages this practice and encourages issuers to reject such third-party payments. HHS intends to monitor this practice and take appropriate action, if necessary.

Quality Program Improves Care and Services for Our Members

Our Quality Program supports our mission to provide peace of mind to members about their healthcare. We do this by providing a framework for ongoing evaluation and communication designed to improve member health and the quality and safety of care and service experienced by our customers.

Our Quality Program benefits our members across every plan and service. We work with you to monitor and improve the care you provide. The Quality Improvement Committee conducts a formal, system-wide quality assessment annually, which includes an annual program evaluation of the quality of its health services. View 2014 Quality Program Report Card.

2015 Clinical Practice Guidelines Support Our Disease Management Program

To support you in the care of our members, we've adopted evidence-based national guidelines for conditions addressed by our disease management, quality, and pharmacy programs. You'll find the guidelines under Library, Health Management at premera.com/ak/provider.

Guidelines are reviewed and approved for adoption by our Clinical Quality Improvement Committee. The committee, comprised of providers representing a variety of medical specialties and geographic regions, reviews and updates clinical practice guidelines at least every two years. Additional guideline resources are available at the National Guideline Clearinghouse at **guideline.gov**.

Condition	Clinical Practice Guideline
Coronary Artery Disease (CAD)	AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2011 Update (American Heart Association/American College of Cardiology)
	2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology / American Heart Association Task Force on Practice Guidelines. (American Heart Association/American College of Cardiology)
	Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women, 2011 Update: A Guideline from the American Heart Association. (American Heart Association/American College of Cardiology)
Diabetes	Standards of Medical Care in Diabetes. January 2014 (American Diabetes Association)
	Guiding Principles for the Care of People With or at Risk for Diabetes. September 2014 (U.S. Department of Health Human Services/National Diabetes Education Program)
Heart Failure (HF)	2013 ACCF/AHA Guideline for the Management of Heart Failure. A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. (American Heart Association/American College of Cardiology)
Chronic Obstructive Pulmonary Disease (COPD)	Diagnosis and Management of stable Chronic Obstructive Pulmonary Disease. August 2011 (American College of Physicians/American College of Chest Physicians/American Thoracic Society/European Respiratory Society)
	Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease. January 2015 (Global Initiative for Chronic Obstructive Lung Disease)
Asthma (Adult and Pediatric)	Diagnosis and Management of Asthma. July 2012 (Institute for Clinical Systems Improvement)
Depression	Practice Guideline for the Treatment of Patients with Major Depressive Disorder, third edition. October 2010 (American Psychiatric Association)
	Adult Depression in Primary Care. September 2013 (Institute for Clinical Systems Improvement)
ADHD	ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. November 2011 (American Academy of Pediatrics)
Oncology	Clinical Practice Guidelines in Oncology (American Society of Clinical Oncology)
	Clinical Practice Guidelines in Oncology (National Comprehensive Cancer Network)
	*ACP Clinical Practice Guidelines (American College of Physicians) * access requires membership

Opportunity for Better Collaboration between Behavioral Health and Primary Care Providers

While sharing information can provide life-changing results for the patient, a recent survey found that only 11 percent of primary care providers (PCPs) say they consistently receive summary reports from behavioral health providers. Summary reports are important because they can help bridge the communication gap and improve coordination between primary care and behavioral healthcare providers.

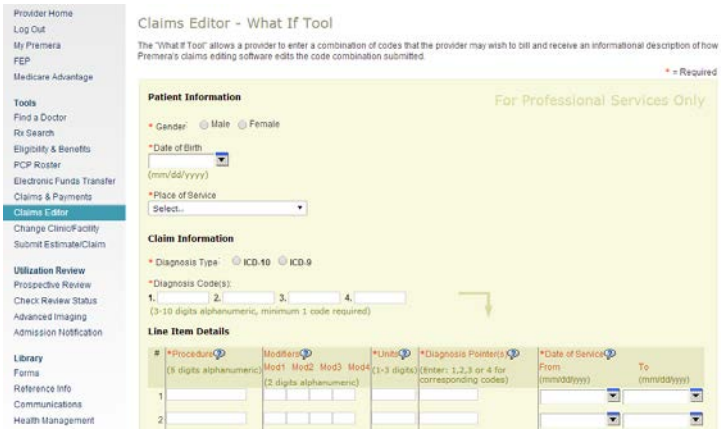
Integrating behavioral healthcare into medical care will result in better coordinated care for patients as well as cost savings.

To help facilitate the exchange of information between providers, PCPs can ask a patient to sign a request form, such as this sample sample Confidential Exchange of Information form. This form requests that contracted medical and behavioral health providers share information necessary to coordinate the patient's treatment with other providers involved in the patient's care. This form is provided as an example only. Please ensure that the form complies with your policies and any applicable laws before using.

Online Services Updates

And the Online Tool of the Quarter Goes To…The Claims Editor-What If Tool!

Have you ever had a claim that didn't process quite the way you expected? Or maybe the procedures you billed bundled, we denied a modifier, or applied an edit and you didn't understand why? Have you ever wondered what the outcome of billing certain code combinations would be? The Claims Editor – What If tool can help.



Using the tool is simple. Enter all the claim details with the exception of member-specific information. Once you submit your codes, the tool tells you if the codes are accepted or denied. If they're denied, you'll see a brief description under the line item for that code. To see the full policy rationale, click on 'See full explanation' and…*voila*! You'll get the full response that points you to the detailed rationale behind the decision. This tool can be used for past and future dates of service. Log in to our secure provider website and check it out today. *

*For professional services only.

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 authorization 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 ***Provider****Portal*℠. 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.

Houston, We Have a Problem! 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 (IE11)—there are often issues using IE8. 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

If you can't change your browser and you're experiencing issues, our Service Desk is happy to help. You can contact us, Monday through Friday, 6 a.m. to 6 p.m. or email us 24/7 at support@premera.com.

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

Don't miss a single issue of 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

Documentation and Coding Best Practices: Spotlight on Mental Health and ICD-10

According to the National Institute of Mental Health (NIMH), an estimated 22.1 percent of Americans ages 18 and older suffer from a diagnosable mental disorder in a given year. And yet evidence shows that mental health conditions are commonly miscoded and under-reported on claims.

Choose the Most Specific Code Possible

Depression is one of the most unspecified diagnoses used. When a provider documents just the term "depression," the ICD-10 code F32.9 (major depressive disorder, single episode, unspecified) is assigned. However, the condition could be more specifically reported as acute reaction to major stress with depressive symptoms (F43.0) or depressive states associated with stressful events (F34.0-F34.9). It's important for providers to document the specific cause of the condition, such as stressful events or other underlying conditions, so that the final diagnosis selected can more accurately depict the patient's actual condition.

Documenting for Specificity
Since documentation is the basis of all coding, it's essential for providers to clearly document all criteria that figure into the code selection, and for depression those criteria are different under ICD-10, even more so than they were under ICD-9. For example, when a patient presents with symptoms of depression, it's critical to document the following:

- Episode (single or recurrent)
- Severity (mild, moderate, or severe, without psychotic features or severe with psychotic features)
- Clinical status of current episode (partial or full remission)

Reporting All Diagnosable Conditions Being Managed
Here are a couple more concepts worth noting to improve coding in practice:

- Chronic conditions should be coded as often as they're considered in the patient's care. Even if the patient presents with another acute or chronic condition, or if the patient is only present for an annual exam, when the mental health disorder is monitored (M), evaluated (E), assessed (A) or treated (T), the co-morbidity should be documented and coded.

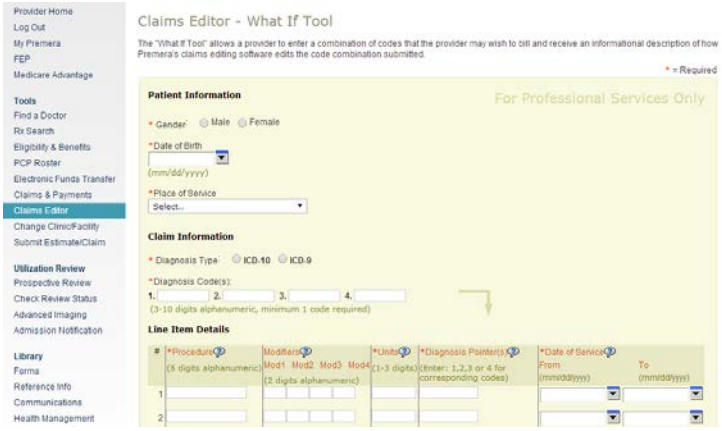
- Patients often get refills outside of a face-to-face visit for medications that treat mental health conditions. Annual, if not more regular follow-up, is important for the overall care of these patients.

There's no doubt that coding mental and behavioral disorders can be challenging. Proper documentation and coding, however, is critical to providing evidence of clinical care management, supporting provider billing practices, and helping patients gain access to additional care resources.
For training on coding and documentation by Premera, contact our Provider Engagement team via email at providerengagementteam@premera.com.

Using Modifiers Ensures Correct Reimbursement

The use of modifiers is an important part of coding and billing for healthcare services. These two-digit numeric or alpha-numeric characters provide additional information for CPT or HCPCS procedure codes. They help ensure that the services are properly represented based on provider documentation and properly reimbursed.
Providers are encouraged to review the list of modifiers in the American Medical Association's CPT Procedure Codebook in Appendix A as well as the modifiers found in the CMS Healthcare Common Procedure Coding System, Level II Codes Codebook.

In addition, you can use the Claims Editor - What If tool on the secure provider website. You can enter various billing scenarios (for professional services only) and code combinations against our claims editing software to determine any edits those code scenarios will encounter when submitted as a claim.



Once you enter the code combination you'll see the edits that may affect reimbursement, such as edits for unbundled procedures, maximum daily frequencies on a code exceeded, or inappropriate modifier to procedure code. This tool provides key information so you know what to expect before billing and understand the claims processing prior to appeal. The tool also shows the rationale behind the edit. You'll find the Claims Editor tool in the left menu of our secure website.

ICD-10-CM Diagnosis Codes Have New Key Feature: Laterality

ICD-10-CM diagnosis codes include a new concept called 'laterality.' This term refers to defining which anatomic side of the body the diagnosis relates to (right side, left side, or bilateral) and did **not** exist in ICD-9-CM coding. This concept comes with a risk of conflict between the anatomic location identified (or not) with the diagnosis code and the anatomic location identified on the CPT procedure code with modifiers RT, LT, or 50.

If the anatomic locations designated in the diagnosis and procedure codes differ, the line will encounter a claims edit resulting in the claim line or the entire claim being denied reimbursement. When selecting the ICD-10-CM diagnosis, make sure your diagnosis laterality matches the procedure code laterality to ensure reimbursement. Refer to your ICD-10-CM diagnosis codebooks for accurate selection of the correct diagnosis code(s).

Reminders and Administrative Resources

2015 Holiday Business Closure Dates

Premera is closed on the following dates:
November 26-27—Thanksgiving Holiday
December 24-25—Christmas Holiday
Jan. 1, 2016—New Year's Day

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 Blue Cross
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

New Drug Approvals

There are new drugs to market and those with specific requirements that providers need to understand are highlighted below.

High Cholesterol drugs: PCSK-9 Inhibitors

Two new drugs designed for people who have an inherited condition called heterozygous familial hypercholesterolemia have been approved by the FDA to help lower LDL cholesterol. These drugs are called PCSK-9 inhibitors, and are used for people with extremely high cholesterol that hasn't been controlled through other drugs. PCSK-9 inhibitors target and inactivate a specific protein in the liver. Praluent® and Repatha® were approved by the FDA in July and August and are reserved for people with familial hypercholesterolemia who need additional lowering of LDL-cholesterol after diet, exercise and maximally tolerated statin therapy. Premera took proactive steps by asking our independent Pharmacy and Therapeutics Committee (P&T Committee) to review the evidence of PCSK-9 inhibitors prior to their approval by the FDA.

Praulent and Repatha are considered specialty medications and are non-preferred (reside on the highest copay tier). Prior approval based on medical necessity is required.

Biosimilars

A biosimilar is a new class of biologic medications that are highly similar to the original product. Biosimilars are a biological product made using living cells. Biosimilars have been used in Europe for several years and are just catching on in the U.S. due to the passage of the Patient Protection and Affordable Care Act in March 2010, which created the framework to allow the FDA to approve biosimilar products based on comparison to already licensed biological products. Since 2010, the FDA has developed rules that govern the approval process for biosimilars.

Our Pharmacy and Therapeutics Committee (P&T) reviews each drug before it's added to our drug list. In reviewing biosimilars, the P&T Committee looks at the safety and efficacy information on the biosimilar drug before approving.

The FDA decides if a biosimilar is interchangeable with the original biological:

- If the biosimilar is **interchangeable,** the pharmacy substitutes for the original product.
- If the biosimilar is **not interchangeable**, the physician needs to authorize biosimilar use by writing a prescription for the specific biosimilar.

We expect drug manufacturers to price biosimilars more competitively compared with the innovator product, although we won't know the exact costs until the drug is actually on the market. We're continually working with drug manufacturers to bring down costs for our members and reaching out to educate providers and members about these new drug classes.

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.

New Edits Included in the Pharmacy Prior Authorization Edit Program

Effective Sept. 1, 2015: Ibrance® (*palbociclib)* premera.com/medicalpolicies/5.01.540.pdf
Coverage Criteria
Ibrance® (palbociclib) may be considered medically necessary in combination with letrozole for the treatment of postmenopausal women with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer as initial endocrine-based therapy for their metastatic disease. All other uses of *palbociclib* are considered investigational. Ibrance® is a specialty pharmacy drug covered under the pharmacy benefit.

Effective Sept. 1, 2015: Lenvima® (*lenvatinib)* premera.com/medicalpolicies/5.01.534.pdf
Coverage Criteria
Lenvima® (Lenvatinib) may be considered medically necessary for treatment of patients with locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. All other uses of *lenvatinib* are considered investigational. Lenvima® is a specialty pharmacy drug covered under the pharmacy benefit.

Effective Aug. 1, 2015: Praluent® (*alirocumab)*, Repatha™ (*evolocumab)* premera.com/medicalpolicies/5.01.558.pdf
Coverage Criteria
Praluent® (alirocumab) or *Repatha™ (evolocumab)* may be considered medically necessary for treatment of familial hypercholesterolemia* when all five of the following criteria have been met. (Documentation from the patient's chart is REQUIRED):

1. Patient is ≥ 18 years old

2. Diagnosis of familial hypercholesterolemia is established by either:

    - LDL-C level ≥ 190 mg/dL on optimal LDL-C lowering therapy prior to adding a PCSK9 Inhibitor, or

    - Genetic typing indicating the presence of familial hypercholesterolemia, AND

3. Patient has tried both *atorvastatin* 80 mg daily, AND *Crestor® (rosuvastatin)* ≥ 20 mg daily for ≥ 8 continuous weeks and LDL-C level has not achieved a 50 percent reduction from baseline or remains ≥ 100 mg/dL; AND

4. Alirocumab (Praluent®) or evolocumab (Repatha™) is prescribed by, or in consultation with, a cardiologist or endocrinologist; AND

5. High-dose statin therapy is continued while receiving alirocumab or evolocumab therapy (unless not tolerated).

Praluent® (alirocumab) or Repatha™ (evolocumab) may be considered medically necessary for treatment of hyperlipidemia in patients with clinical atherosclerotic cardiovascular disease (ASCVD), when all four of the following criteria have been met. (Documentation from the patient's chart is required):

Patient is ≥ 18 years old; and

1. Patient has a history of at least one of the following:

    - Myocardial infarction (MI) or acute coronary syndrome (ACS)

    - Angina

    - Stroke or transient ischemic attack (TIA)

    - Coronary revascularization procedure; and

2. LDL-C level ≥ 100 mg/dL on optimal LDL-C lowering therapy prior to adding a PCSK9 Inhibitor:

- Patient has tried both atorvastatin 80 mg daily, and Crestor® (rosuvastatin) ≥ 20 mg daily for ≥ 8 continuous weeks, and LDL-C level has not achieved a 50% reduction from baseline or remains ≥ 100 mg/dL; and

3. High dose statin therapy is continued while receiving alirocumab or evolocumab therapy (unless not tolerated); and

4. Alirocumab (Praluent®) or evolocumab (Repatha™) is prescribed by, or in consultation with, a

cardiologist or endocrinologist.

All other uses of alirocumab (Praluent®) or evolocumab (Repatha™) are considered investigational.

Praluent® and Repatha™ are specialty pharmacy drugs covered under the pharmacy benefit.

Dental Updates

Prescribers of Medicare Part D Medications: New CMS Enrollment Date

The Centers for Medicare and Medicaid Services (CMS) delayed the enrollment deadline for prescribers of Part D drugs. The deadline to enroll is now Jan. 1, 2016 for a June 1, 2016 effective date. This means on June 1, 2016, all prescribers of Part D drugs, **including dental providers**, are required to have a Medicare enrollment application with CMS. If prescribers do not have applications on file, prescription drug claims will be denied at the pharmacy. 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 Jan. 1, 2016, to avoid delays in patient claims.

Resources
To enroll or learn more about the Provider Enrollment, Chain, and Ownership System (PECOS), visit the CMS website.

Dental Benefits and Eligibility Tool is Back Online

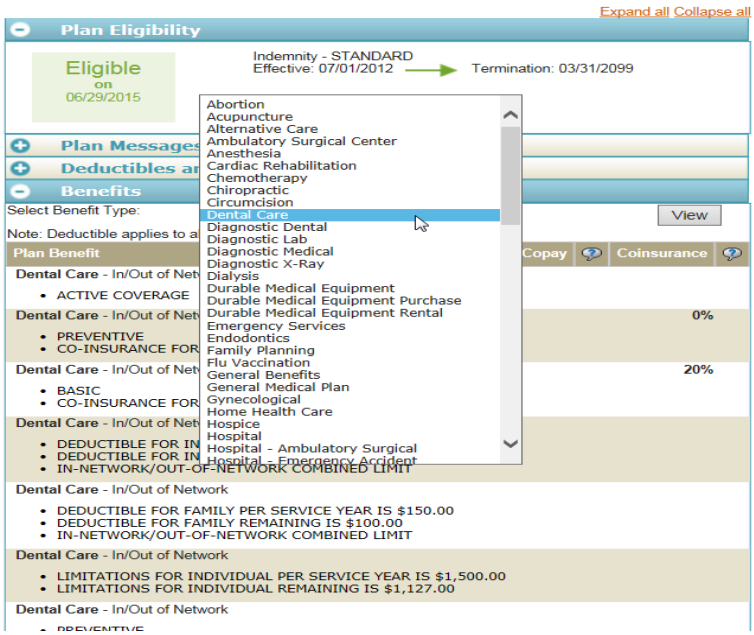
Benefits for dental members via the Eligibility and Benefits tool is back online. You can now see complete benefit information including:

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

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

Tips for verifying benefits:

1. Visit our provider website at premera.com/ak/provider.
2. Select *Eligibility & Benefits* in the left navigation menu to open the tool.
3. Sign in using your OneHealthPort user ID and password to get to our secure website. (Note: you need to have OneHealthPort access to use the tool.)
4. In the drop-down box *For Benefit Type*, select *Dental Care* or any one of the other dental categories such as: Diagnostic dental, Endodontics, Maxillofacial prosthetics, Periodontics, Orthodontics, Prosthodontics, Restorative, Routine Preventive Dental.



You'll need two of the following three pieces of information to search for your patient: Member ID number, member first and last name, or member date of birth. Once you've found your patient, be sure to open up the plan messages section to get all of the information you need.

Claims status, upfront estimates, electronic claim submissions, and electronic funds transfer are all still available. If you have questions about using our online tools, please call Physician and Provider Relations at 800-722-4714, option 4.

Medicare Guidelines: Treating Self, Family Members, or Volunteers

Premera follows many Medicare guidelines, including not reimbursing for professional services or supplies usually provided for free because of the relationship to the patient. This means we don't reimburse physicians, dentists, providers, or suppliers for professional services for any of the following:

- Services or supplies that you furnish to yourself or to an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent, or spouse of grandchild.

- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit.

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

Sign Up for Email Alerts for Dental News Updates

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

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

Ronald Cantu, DDS, MPA, Premera Dental Director

Last September, I had the pleasure of being part of Premera's presentation to a large Seattle healthcare insurance brokerage firm. My presentation discussed the increasingly important role of dental insurance in not only maintaining the member's oral health, but also as an early indicator of overall health.

A recent study by a large Blues plan on the East Coast demonstrated the very real cost savings that comprehensive treatment of periodontal disease produced for members with chronic medical conditions, such as diabetes or cardiovascular disease. Not only did the individual's oral health greatly improve, but their chronic conditions became much more manageable and less debilitating.

The study also confirmed the mutually beneficial value of having medical and dental coverage through the same company. The goal of same-company coverage is to enhance the member's healthcare experience by having the member's healthcare status available to both the medical and dental offices. A patient's medication compliance can impact the success of both medical and dental care, such as hypertensive and diabetic drug regiments. The health plan's cross-referral services support communication with email access.

The once-siloed healthcare worlds of traditional medical and dental practices are now transitioning to a more integrated, open environment. Healthcare information that benefits the member's overall healthcare experience, including better management of chronic ailments for our aging patient populations, is readily shared.

Medical Policy Updates

Reminder: Endoscopic Sinus Surgery Policy Effective January 2016

Effective for dates of service Jan. 1, 2016, and later, we'll review functional endoscopic sinus surgeries for medical necessity. A pre-service review is strongly recommended for non-emergent sinus surgeries. Effective for dates of service Feb. 1, 2016, and after, a prior authorization is required. If a procedure does not meet medical necessity criteria, the procedure and associated services (e.g., anesthesia) will be denied.

Chronic sinusitis is a common condition among adults—most individuals with this diagnosis will not 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 Rhino-sinusitis and Nasal Polyposis.

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.

Email Subscriptions Give You the Latest Medical Policy Updates

The snow won't stop this delivery! Get the latest news and policy updates by signing up for an email subscription today! Sign up by logging in to premera.com/ak/provider—the subscription box is at the end of our secure landing page.

Additional Services Added to 2016 Prior Authorization List

The following services require prior authorization for services Feb. 1, 2016 and after:

- Cardiac devices: trans-catheter aortic valve replacement (TAVR/TAVI) added
- Chemotherapy administration into the peritoneal cavity
- Cryosurgical ablation of tumors
- Extracorporeal photo-pheresis
- Gait trainers
- Gastric restrictive procedures
- Genetic testing
- Medical food, nutritionally complete, oral administration
- Nasal/sinus surgery
- Nursing care in the home / private duty nursing
- Radiation therapy: high-dose rate electronic brachytherapy added
- Surgeries related to gender reassignment
- Surgical treatments for the temporo-mandibular joint
- Therapeutic apheresis
- Trans-catheter occlusion or embolization for tumor destruction
- Vascular embolization or occlusion for tumors, organ ischemia or infarction

These services are in addition to the current services requiring prior authorization. Prior authorization is based on member benefits and eligibility at the time of service and prospectively determines medical necessity and appropriateness of treatment.

Please use our Prospective Review Tool to check if pre-service review is required or recommended and check the status of an existing review. You can also review the 2016 Prior Authorization Code List.

Medical Policy Updates

Premera medical policies are guidelines used to evaluate the medical necessity of a particular service or treatment. We adopt policies after careful review of published, peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, we reserve the right to review and update our policies as appropriate.

When there are differences between the member's contract and medical policy, the member's contract prevails. The existence of a medical policy regarding a specific service or treatment does not guarantee that the member's contract covers that service. View complete medical policies or email requests to medicalpolicy@premera.com.

All policy numbers are listed here in numeric order.

The following policy changes are effective for dates of service **July 14, 2015** and later:		
2.01.98	Orthopedic Applications of Platelet-Rich Plasma	**New policy.** Platelet-rich plasma is considered **investigational** for all orthopedic indications. Content previously in policy 2.01.16.
2.02.506	Wearable Cardioverter-Defibrillator as a Bridge to Implantable Cardioverter-Defibrillator Placement	Policy statement and policy guidelines rewritten for clarification; coverage is unchanged.
2.04.507	Vitamin D Testing	List of medically necessary diagnoses was updated. Policy statement is unchanged. Vitamin D testing only covered for medical diagnoses.
5.01.521	Pharmacologic Treatment of Neuropathy, Fibromyalgia and Seizure Disorders	Duloxetine was added as a treatment qualifier for Generalized Anxiety Disorder.
5.01.534	Multiple Receptor Tyrosine Kinase Inhibitors	Lenvima may be considered **medically necessary** to treat locally recurrent or metastatic, progressive, radioactive iodine refractory differentiated thyroid cancer. Votrient may be **medically necessary** to treat soft tissue sarcoma.
5.01.540	Miscellaneous Oncology Drugs	Ibrance may be considered **medically necessary** in combination with letrozole as initial endocrine-based therapy for metastatic disease for postmenopausal women with ER-positive, HER2-negative advanced breast cancer.
5.01.607	Continuity of Coverage for Maintenance Medications	**New policy.** Continuation of certain maintenance medications a member has been receiving with coverage from another health plan may be **medically necessary** when criteria are met. Sample use is not a criterion for approval of continuity.

7.01.09	Prophylactic Mastectomy	**New policy.** When criteria are met, prophylactic mastectomy may be considered **medically necessary** in high-risk individuals, those with lobular carcinoma in situ, or when extensive mammographic abnormalities would make adequate biopsy or excision impossible. It is considered **investigational** for all other indications.
7.01.149	Amniotic Membrane and Amniotic Fluid Injections	**New policy.** Injections of micronized amniotic membrane and amniotic fluid are considered **investigational**.
7.01.150	Vagal Nerve Blocking Therapy for Treatment of Obesity	**New policy.** Intra-abdominal vagal nerve blocking therapy for treatment of obesity is considered **investigational** in all situations.
7.03.04	Isolated Small Bowel Transplant	***Policy renumbered.*** A small bowel transplant using cadaveric intestine may be considered **medically necessary** when criteria are met.
8.01.61	Focal Treatments for Prostate Cancer	**New policy.** Use of any focal therapy modality to treat patients with localized prostate cancer is considered **investigational**.
8.01.62	Electronic Brachytherapy for Nonmelanoma Skin Cancer	**New policy.** Electronic brachytherapy for squamous cell carcinoma and basal cell carcinoma is considered **investigational**.
10.01.511	Medical Policy and Clinical Guidelines: Definitions and Procedures	Policy rewritten for clarity. List of sources now includes DynaMed. New definitions added and title changed.
12.04.132	Mutation Testing for Limb-Girdle Muscular Dystrophy	**New policy.** Genetic testing for mutations for limb-girdle muscular dystrophy may be considered **medically necessary** when criteria are met. Testing is **investigational** in all other situations.

12.04.515	Genetic Testing for Mental Health Conditions	***Policy renumbered.*** Genetic testing for mutations associated with mental health disorders is considered **investigational** in all situations.
The following policy change is effective for dates of service **Aug. 5, 2015** and later:		
5.01.558	Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors	**New policy.** Alirocumab (Praluent®) may be considered **medically necessary** as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults when criteria are met.
The following policy changes are effective for dates of service **Aug. 11, 2015** and later:		
1.01.10	Continuous Passive Motion in the Home Setting	**New policy.** Continuous passive motion in the home setting may be considered **medically necessary** when criteria are met.
4.01.21	Noninvasive Prenatal Screening for Fetal Aneuploidies Using Cell-Free Fetal DNA Policy	Nucleic acid sequencing-based testing of maternal plasma for trisomy 21 may be considered **medically necessary** in women with singleton pregnancies undergoing screening for trisomy 21.Screening remains **investigational** in women with twin or multiple pregnancies. Title changed.
5.01.532	Cutaneous T-cell Lymphomas (CTCL): Systemic Therapies	Mechlorethamine (Valchlor®) may be considered **medically necessary** for topical treatment of Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received prior skin-directed therapy.
5.01.606	Hepatitis C Antiviral Therapy	Hepatocellular carcinoma added to the prioritization list for coverage. Clarified that fatty liver infiltrations in the absence of nonalcoholic steatohepatitis is not a high-risk criterion. Use of daclatasvir (Daklinza®) and Technivie® may be considered **medically necessary** when

		criteria are met.
6.01.38	Percutaneous Balloon Kyphoplasty and Mechanical Vertebral Augmentation	Kiva® mechanical vertebral augmentation added as **medically necessary** when criteria are met.
8.03.05	Outpatient Pulmonary Rehabilitation	**New policy.** A single course of pulmonary rehabilitation may be considered **medically necessary**. Multiple courses are considered **investigational**.
11.01.522	Private Duty Nursing	**New policy.** Outlines criteria for extended skilled hourly nursing care in the home. Services may be considered **medically necessary** when criteria are met and the member has health plan benefits for the services.
12.04.111	Gene Expression Profiling and Protein Biomarkers for Prostate Cancer Management	Gene expression analysis (e.g., Prolaris, Oncotype DX Prostate, Decipher) and protein biomarkers (e.g., Promark) to guide management of prostate cancer are considered **investigational** in all situations. Title changed.
12.04.516	Genetic Testing for CHEK2 Mutations	**New policy.** Genetic testing for CHEK2 mutations is considered **medically necessary** when criteria are met.
The following policy changes are effective for dates of service **Sept. 8, 2015** and later:		
7.01.69	Sacral Nerve Neuromodulation/Stimulation	Trial stimulation period prior to implantation for incontinence changed to “at least 48 hours” instead of “at least one week.”
7.01.549	Knee Arthroscopy in Adults	Policy extensively rewritten. Kellgren-Lawrence scores as requirement for review has been removed. For meniscal tear for individuals age 50 and older, imaging must show absence of severe arthritis. Conservative care recommendation for anterior cruciate ligament tear changed to two weeks.

8.01.503	Immune Globulin Therapy	IVIG is considered **not medically necessary** for relapsing/remitting multiple sclerosis. IVIG for post-polio syndrome is considered **investigational**. Added **new medically necessary** indications for IVIG to include Stevens-Johnson syndrome, toxic epidermal necrolysis, CLL, SLL, B-cell indolent or aggressive lymphomas when criteria are met, and hemolytic disease of the fetus and newborn.

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

5.01.558	Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors	Evolocumab (Repatha™) may be considered **medically necessary** as an adjunct to diet and maximally tolerated statin therapy for familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease when criteria are met.
5.01.605	Medical Necessity Criteria for Pharmacy Edits	Removed edits on corticosteroids/beta agonists, proton pump inhibitors, and Abilify. Added edits for ADHD drug Ritalin LA (60 mg) and new antipsychotic drug Rexulti. Removed edits on combination antidiabetes agents containing metformin. Brand noninsulin diabetic agents are now a single step-edit.
5.01.606	Hepatitis C Antiviral Therapy	Re-treatment will be considered individually. Notes indicating prior treatment regimen, response, and timelines, and results of testing for resistance mutations must be submitted with request.
9.02.506	Dental: Restorations	**New policy.** Restorations, crowns, inlays/onlays and codes found in the D2XXX range of the HCPCS coding guide may be considered **dentally necessary** when criteria are met.

The following policy change is effective for dates of service **Sept. 16, 2015** and later:		
12.04.506	Genetic Testing for Lynch Syndrome and Other Inherited Colon Cancer Syndromes	Policy rewritten. Additional qualifying criterion of endometrial cancer. New **medically necessary** statement for testing of affected family member. Expanded list of Lynch-associated cancers. Combined MSI / IHC/ BRAF / MLH1 as initial tests. Added more detail for APC / MYH testing. Deleted EPCAM statement.

The following policy change is effective for dates of service **Jan. 1, 2016** and later:		
7.01.559	Functional Endoscopic Sinus Surgery (FESS) for Rhinosinusitis and Nasal Polyposis	Medical records must show trial and failure of maximal medical care before FESS may be considered **medically necessary** for recurrent acute bacterial rhinosinusitis and chronic rhinosinusitis with or without polyposis. Maximal medical therapy includes oral antibiotics and intranasal steroids. Imaging also required. See policy for details. Reviews for medical necessity begin Jan. 1, 2016.