



# The Connection<sup>SM</sup>

For participating physicians, other health care professionals and facilities

## In this issue

### 2026 product and network updates

Each year, we conduct a comprehensive review of our provider networks and product offerings to ensure we serve our members' diverse health care needs and deliver high-quality, cost-effective health care solutions.

### Enforcement of deadlines for requested records

Our *Timely Receipt of Medical Records* (Administrative #145) reimbursement policy will be updated clarify that incomplete requests and records received after the 90-day period will not be accepted and will not change the adjudication of the claim. Providers will need to follow the dispute process to have records reviewed after the 90-day deadline.

### Change to colonoscopy site-of-care exceptions

Effective January 1, 2026, providers will no longer be able to cite a lack of ambulatory surgical center (ASC) privileges when requesting to perform a screening or surveillance colonoscopy in an outpatient hospital setting. These reviews will be subject to our new *Surgical Site of Care – Colonoscopy* (Utilization Management #20) commercial medical policy.

### OncoHealth builds relationships with oncologists for clinical alignment

OncoHealth oncologists work collaboratively with you to review treatment plans and pre-authorization requests for radiation oncology services and medications for our Medicare Advantage members. Pre-launch webinars will begin December 2, 2025.

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## Get the latest news

We publish the latest news and updates in the [What's New & Publications](#) section on the homepage of our provider website.

[Subscribe](#) to receive email notifications when new issues of our publications are available.

### The Connection

This publication includes important news, as well as notices we are contractually required to communicate to you.

In the table of contents on page 1, this symbol indicates articles that include critical updates: . Click on article titles to go directly to that page, and return to the table of contents by clicking the link at the bottom of each page.

We publish issues of *The Connection* on the first of February, April, June, August, October and December.

*The Connection* includes information for all four of our Regence Plans. In this publication, "Regence" refers to the following: Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah and Regence BlueShield (in select counties of Washington). When information does not apply to all four Plans, the article will identify the Plan(s) or state(s) to which that information applies.

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via [Availity Essentials](#).

### The Bulletin

Published monthly, *The Bulletin* summarizes updates to medical and reimbursement policies, including policy changes we are contractually required to communicate to you.

## Attend an upcoming webinar

We encourage providers and office staff to register today for these upcoming 60-minute webinars:

### Medicare Advantage incentive programs

For providers interested in learning about Medicare Star Ratings and their connection to our quality incentive programs. We'll review the measures in our programs and best practices for closing the gaps through the remainder of the year and into the future.

**Tuesday, November 11, 2025, 10 a.m. (PT)/11 a.m. (MT)**

[REGISTER](#)

### Regence BlueShield of Idaho 2026 networks

Join us for a comprehensive review of 2026 Idaho product offerings and networks. This training session will provide essential updates on our product portfolio, including new features, network changes and key information needed to effectively support members in the upcoming year. This webinar will be offered twice:

**Tuesday, November 18, 2025, 10 a.m. (PT)/11 a.m. (MT)**

[REGISTER](#)

**Thursday, November 20, 2025, 10 a.m. (PT)/11 a.m. (MT)**

[REGISTER](#)

### Behavioral health

In this webinar for behavioral health providers and PCPs, we'll review tips, tools and requirements for providing behavioral health services to our members.

**Tuesday, December 9, 2025, 10 a.m. (PT)/11 a.m. (MT)**

[REGISTER](#)

## Using our website



When you visit [regence.com](#), enter a ZIP code for your location and then select an audience type from the menu. Selecting For Providers will give you quick access to the sections on our provider website.



# Maximize your clinical impact with PRIA's enhanced ED analytics

Transform how your clinical team identifies and manages high-risk patients with the Provider Reporting Insights & Analytics (PRIA) platform. Our enhanced tools help you pinpoint members with high emergency department (ED) risk, high ED utilization, and potentially avoidable ED visits—enabling smarter resource allocation and better patient outcomes.

- **Focus limited clinical resources:** Direct specialized staff toward patients who will benefit most from intervention.
- **Reduce wasted outreach efforts:** Eliminate time spent on patients unlikely to need or benefit from intensive management.
- **Increase return on staff investment:** Generate better outcomes with existing staffing through targeted interventions.
- **Optimize caseloads:** Structure case manager workloads based on patient complexity and intervention potential.

## Powerful tools to drive clinical excellence

### 1. ER Utilizers report: Identify high-risk members

Quickly identify your top ED utilizers and high-risk members with comprehensive, member-level insights, including:

- Two-year ED utilization summary with primary diagnoses
- Inpatient hospitalization history and medications
- Provider network (including specialists)
- Complete expense breakdown (medical and pharmacy)

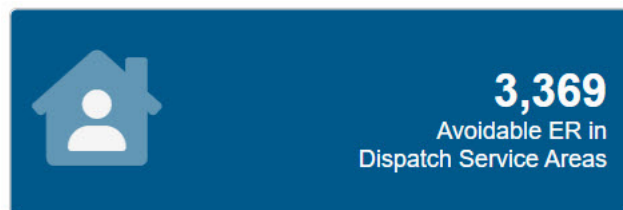
### 2. Identify members with potentially avoidable ED visits

Compare costs and identify intervention opportunities by analyzing:

- Members with potentially avoidable ED visits
- Actionable diagnoses suitable for alternative care settings

### 3. Regence: New! Avoidable ER in Dispatch Service Areas widget

Our newest widget identifies members in DispatchHealth service areas who had potentially avoidable ED visits. DispatchHealth delivers on-demand urgent medical care directly to high-acuity patients at home, with credentialed professionals capable of treating 95% of common ED diagnoses.



DispatchHealth offers urgent in-home, same-day medical care 365 days a year, including after-hours. Services are available to members in [select ZIP codes](#).

Learn more about DispatchHealth in the [Care Options Toolkit](#), available on the homepage of our provider website.

## New PRIA clinical guide

We've created a guide specifically for clinical teams to maximize PRIA's ED analytics capabilities to develop precisely targeted interventions that maximize their impact on patient outcomes. View the new PRIA clinical guide *Identifying Actionable ED Data* in the PRIA user guide library on our provider website: [Contracting & Credentialing>APM Resources>PRIA>User Guides](#).

## Administrative Manual updates

The following updates were made to our manual on October 1, 2025:

### Facility Guidelines

- Added information about reimbursement updates for Medicare Advantage skilled nursing facilities (SNFs)
- Added a link to SNF claim accuracy tips and best practices, available on our provider website: [Claims & Payment>Claims Submission>Other Billing Information](#)
- Streamlined the information about extenuating circumstances

### Medical Records Requirements

- Clarified requirements and added tips and examples for retrieving accurate signature information from electronic medical records (EMRs)

Our manual sections are available in the [Administrative Manual](#) section of our provider website.

## 2026 brings code changes for services and supplies

Please remember to review your 2026 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

- **CDT manual:** Available online through the [American Dental Association](#) or by calling 1 (800) 947-4746
- **CPT and HCPCS manuals:** Available through your preferred vendor or online through the [American Medical Association \(AMA\)](#)

Access current reimbursement schedules on Availity Essentials: [Claims & Payments>Fee Schedule Listing](#).

This notice serves as an Amendment to your Participating Agreement. You have the right to terminate your Agreement in accordance with the amendment provisions of the Participating Agreement.

## Correct coding updates

### Claims received on or after November 7, 2025

Providers are expected to follow correct coding guidelines. We are providing courtesy notice that our pre-pay correct coding editors will apply denials for claims received on or after November 7, 2025, for incorrect reporting in the following circumstances:

- A diagnosis that requires an additional diagnosis is missing from claims data (e.g., a diagnosis of hypertensive retinopathy requires both an ICD-10 code for the eye condition and a separate code for the underlying systemic hypertension)
- Durable medical equipment requiring a rental or purchase modifier is billed without the appropriate modifier
- Modifier 59 is appended to services when no other non-evaluation & management (E&M) services are reported on the same date of service by the same provider
- Modifier XS is reported with an anatomic modifier on the same line
- Repeat genetic testing is billed for disorders that can only be tested once in a patient's lifetime

These reviews are supported by industry standards and our reimbursement policies, including *Correct Coding Guidelines* (Administrative #129). View our *Reimbursement Policy Manual* on our provider website: [Policies & Guidelines>Reimbursement Policy](#).

### Claims in process on or after February 1, 2026

Claims will be reviewed by a new third-pass pre-payment editor that supports our medical and reimbursement policies. The editor will review provider-submitted commercial and Medicare Advantage claims to reduce post-payment recoveries.

Types of affected claims include:

- Inpatient and outpatient professional
- Inpatient and outpatient facility
- Inpatient and outpatient hospital

The editor will not affect claims-processing times or the appeals process.

## Hearing aid professional reimbursement schedule update

Effective January 1, 2026, we are increasing professional reimbursement rates for hearing aids, subject to the member's benefit. This change will apply to all commercial lines of business and plans, including Uniform Medical Plans (UMP). **Excluded:** Facilities and Medicare Advantage members.

The updated commercial reimbursement schedule will be available on Availity Essentials after January 1, 2026. View our commercial reimbursement schedules by selecting Claims and Payments>Fee Schedule Listing.

If a Regence member chooses to upgrade to a hearing aid product that costs more than the reimbursement or benefit amount, the Regence member should complete a *Non-Covered Services Member Consent Form*. Our *Professional Services Agreements* outline what is required on the waiver form. The *Professional Services Agreement* also indicates that the waiver form must be signed by the Regence member in advance of services being rendered and maintained by the medical group. A sample non-covered services waiver form is available in the [Forms & Documents](#) section of our provider website.

## New Professional VBR program reporting metrics flyer available

**Regence BlueShield providers:** A new flyer outlining updated reporting metrics for the Washington Professional Value-Based Reimbursement (VBR) program is now available. This resource details the metrics that will be reflected in July 2026 scorecard reports for the October 2026 adjustment. The metrics will first apply to claims with dates of service in 2025.

These new metrics are a subset from Regence's Provider Performance Ratings program, using select measures from the vendor Motive Medical Intelligence in the quality and appropriateness of care domains. Learn more about Provider Performance Ratings on Availity Essentials: Regence Payer Spaces>Resources>Provider Performance Ratings.

Visit our provider website to access the Professional VBR metrics flyer: [Contracting & Credentialing>APM Resources](#).

**Note:** These updated metrics do not affect the current VBR program measurement cycle. The reports posted in July 2025 detail the October 2025 adjustments.

## Updates to Part 2 rules for SUD records

In 2024, the U.S. Department of Health and Human Services (HHS) updated the Part 2 rules that protect the confidentiality of substance use disorder (SUD) patient records.

Providers and payers are expected to be in compliance with the updated regulations by February 16, 2026. Regence is updating its contract language and billing guidelines to conform to the revisions.

Updates include:

- A new sample consent form—titled *Consent for Disclosure of Patient Identifying Information and Substance Use Disorder Patient Records*—has been added to our provider website:
  - [Forms & Documents](#)
  - [Claims & Payment>Claims Submission>Other Billing Information](#)
- Part 2 disclaimer language, which is required on Part 2 claims, has been updated on our provider website: [Claims & Payment>Claims Submission>Other Billing Information](#). The disclaimer language is prescribed by rule.
- Providers will receive updated contract language by November 15, 2025, that clarifies the type of patient consent providers are expected to obtain.

Part 2 rule changes are already in effect, and providers should begin using the newly updated consent guidelines and Part 2 disclaimer as soon as possible, in accordance with their agreement, and by no later than February 16, 2026.

## Provider write-off for medical necessity denials

As a reminder, in the August 2025 issue of *The Connection*, we announced that providers must write off services we have denied because they do not meet medical necessity, as well as any other services related to the denial, effective November 1, 2025. The provider cannot balance bill the member for services that do not meet medical necessity.

If a Regence member elects to receive services that are not medically necessary, the Regence member may accept financial responsibility by signing a waiver that meets certain requirements. Our *Provider Services Agreements* outline what is required on the waiver form. The *Provider Services Agreement* also indicates that the waiver form must be signed by the Regence member and maintained by the medical group. A sample non-covered services waiver form is available in the [Forms & Documents](#) section of our provider website.

# Medicare crossover claim reminders

When you submit claims to Medicare for members with Medicare as their primary coverage, wait 30 calendar days from the Medicare remittance date before sending the claim to Regence.

## Why wait 30 days?

In most cases, you won't need to submit the claim to us because Medicare will send it through the crossover process. This process allows Medicare to forward the claim to the appropriate Blue Cross or Blue Shield Plan (Blue Plan) for processing.

## Crossed-over claims

If the Medicare remittance advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to the appropriate Blue Plan for processing. You don't need to file a claim for the Medicare supplemental benefits.

The Medicare crossover process can take up to 14 business days. This means the Blue Plan is receiving the claim from Medicare for processing at the same time you receive the Medicare remittance advice. As a result, it may take up to 30 additional calendar days for you to receive payment or instructions from the Blue Plan after you receive the Medicare remittance.

We will return or reject any Medicare primary claims that you submit directly to Regence that crossed over and are received within 30 calendar days of the Medicare remittance date or contain no Medicare remittance date.

## Receiving payment

After processing the claim, we will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid directly, and you will need to bill the member.

## Claims that don't crossover

If the Medicare remittance advice does not indicate the claim was crossed over (claim status code 1: "Paid as primary" may appear; claim status 19 will not appear), file the claim and the payment advice to Regence. Regence or the member's Blue Plan will pay you the Medicare supplemental benefits.

## Statutorily excluded services

When you provide services or supplies that Medicare excludes (e.g., home infusion therapy and hearing aids), you can submit the claim directly to Regence without waiting 30 days after the Medicare remittance date. Submit claims for services that are excluded or not covered by Medicare with modifier GY on each line.

Learn more about Medicare crossover and claims for statutorily excluded services on our provider website:

- [Claims & Payment>Claims Submission>Benefit Coordination>Medicare Crossover](#)
- [Claims & Payment>Claims Submission>Medicare Statutorily Excluded Services](#)

# Pre-authorization updates

Commercial	
Procedure/medical policy	Added codes effective September 1, 2025
eviCore Spine - Interspinous and Interlaminar Stabilization and Distraction Devices (Spacers) (Surgery #155)	• 22867, 22868
Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders (Surgery #221)	• 0569T, 0570T, 0646T
Procedure/medical policy	Added codes effective October 1, 2025
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	• Q4391
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	• 0585U
Radiofrequency and Ultrasound Ablation of the Renal Sympathetic Nerves as a Treatment for Uncontrolled Hypertension (Surgery #235)	• 0338T, 0339T, 0935T, C1735, C1736
Procedure/medical policy	Changing applied policy beginning January 1, 2026
Surgical Site of Care – Colonoscopy (Utilization Management #20) <b>Related:</b> See <i>Colonoscopy site-of-care exception changing</i> on page 12.	• 44388, 44389, 44391, 44392, 44394, 44408, 45378, 45379, 45380-45382, 45384-45386, 45388, 45389, 45390-45393, 45398, G0105, G0121
Uniform Medical Plan (UMP)	
Procedure/medical policy	Added codes effective September 1, 2025
Interspinous and Interlaminar Stabilization and Distraction Devices (Spacers) (Surgery #155)	• 22867, 22868
Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders (Surgery #221)	• 0569T, 0570T, 0646T
Procedure/medical policy	Added codes effective October 1, 2025
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	• Q4391
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	• 0585U
Radiofrequency and Ultrasound Ablation of the Renal Sympathetic Nerves as a Treatment for Uncontrolled Hypertension (Surgery #235)	• 0338T, 0339T, 0935T, C1735, C1736
Whole Genome Sequencing – HTCC Decision 20240614A	• 0582U, 0583U

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<b>Uniform Medical Plan (UMP)</b>	
<b>Procedure/medical policy</b>	<b>Adding codes effective January 1, 2026</b>
Frenotomy and frenectomy with breastfeeding support - HTCC Decision 20250613A	<ul style="list-style-type: none"> <li>• 41010, 41115</li> </ul>
Hyperbaric oxygen therapy for sensorineural hearing loss and acute acoustic trauma - HTCC Decision 20250321A	<ul style="list-style-type: none"> <li>• 99183, G0277</li> </ul>
Treatment for chondral defects of the knee - HTCC Decision 20240920A	<ul style="list-style-type: none"> <li>• 27412, 27415, 27416, 29866, 29867, J7330, S2112</li> </ul>
<b>Procedure/medical policy</b>	<b>Changing applied policy beginning January 1, 2026</b>
<p>Surgical Site of Care – Colonoscopy (Utilization Management #20)</p> <p><b>Related:</b> See <i>Colonoscopy site-of-care exception changing</i> on page 12.</p>	<ul style="list-style-type: none"> <li>• 44388, 44389, 44391, 44392, 44394, 44408, 45378, 45379, 45380-45382, 45384-45386, 45388, 45389, 45390-45393, 45398, G0105, G0121</li> </ul>
<b>Medicare Advantage</b>	
<b>Procedure/medical policy</b>	<b>Added codes effective September 1, 2025</b>
eviCore spine	<ul style="list-style-type: none"> <li>• 22867, 22868</li> </ul>
Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	<ul style="list-style-type: none"> <li>• 0108U</li> </ul>
<b>Procedure/medical policy</b>	<b>Added codes effective October 1, 2025</b>
Biochemical and Cellular Markers of Alzheimer’s Disease (Laboratory #22)	<ul style="list-style-type: none"> <li>• 0596U</li> </ul>
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	<ul style="list-style-type: none"> <li>• A2036-A2039, Q4383-Q4397</li> </ul>
Biomarkers for Cardiovascular Disease (Laboratory #78)	<ul style="list-style-type: none"> <li>• 81439</li> </ul>
Laboratory Tests for Organ Transplant Rejection (Laboratory #51)	<ul style="list-style-type: none"> <li>• 0118U, 0319U, 0320U, 0493U, 0508U, 0509U, 0540U, 0544U, 0575U, 0581U</li> </ul>
Molecular Panel Testing for Identification of Microorganisms (Genetic Testing #85)	<ul style="list-style-type: none"> <li>• 0429U, 0590U, 0595U</li> </ul>
Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	<ul style="list-style-type: none"> <li>• 0335U, 0579U, 0584U, 0588U, 0589U, 0594U, 0598U</li> </ul>
Multimarker and Proteomics-based Serum Testing Related to Ovarian Cancer (Laboratory #60)	<ul style="list-style-type: none"> <li>• 0577U</li> </ul>

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Medicare Advantage (continued)	
Procedure/medical policy	Added codes effective October 1, 2025
Pharmacogenomic (PGx) Testing (Genetic Testing #10)	<ul style="list-style-type: none"> <li>0029U-0034U, 0070U-0076U, 0169U, 0173U, 0175U, 0347U-0350U, 0411U, 0419U, 0423U, 0434U, 0460U, 0461U, 0476U, 0477U, 0516U, 0533U, 81225-81227, 81230, 81231, 81247, 81283, 81306, 81328, 81335, 81350, 81355, 81374, 81377, 81381, 81383, 81400-81408, 81418, G9143</li> </ul>
Pneumatic Compression Devices (Durable Medical Equipment #78)	<ul style="list-style-type: none"> <li>E0658, E0659</li> </ul>
Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	<ul style="list-style-type: none"> <li>0464U, 0578U, 0586U, 0591U, 0592U, 0597U, 0599U</li> </ul>
Procedure/medical policy	Moving to OncoHealth review beginning January 1, 2026
Radiation oncology – OncoHealth <b>Related:</b> See <i>New workflow for Medicare Advantage oncology pre-authorization</i> on page 11.	<ul style="list-style-type: none"> <li>G6015, G6016, 77301, 77338, 77520, 77522, 77523, 77525</li> </ul>

FEP Blue Focus	
Procedure/medical policy	Moving to Regence review beginning January 1, 2026
Radiology and nuclear imaging <b>Related:</b> See <i>BCBS FEP pre-authorization changes</i> on page 11.	<ul style="list-style-type: none"> <li>0042T, 0648T, 0649T, 70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71250, 71260, 71270, 71271, 71275, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74712, 75557, 75559, 75561, 75563, 75572, 75573, 75574, 75635, 76391, 77046, 77047, 77048, 77049, 77078, 77084, 78071, 78072, 78429, 78430, 78431, 78432, 78433, 78451, 78452, 78459, 78469, 78491, 78492, 78494, 78608, 78609, 78803, 78811, 78812, 78813, 78814, 78815, 78816, 78830, 78831, 78832</li> </ul>

Our complete pre-authorization lists are available in the [Pre-authorization](#) section of our provider website. Please review the lists for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through Availity Essentials.

## HTCC decisions for 2026

The following Health Technology Clinical Committee (HTCC) changes for UMP members are effective January 1, 2026:

### Treatments for chondral defects of the knee

- New HTCC decision 20240920A—*Treatments for chondral defects of the knee* will replace 2011118B—*Osteochondral Allograft/Autograft Transplantation (OAT)*
- Under this new HTCC decision:
  - Treatments for chondral defects of the knee with matrix-induced autologous chondrocyte implantation (MACI) and other FDA-approved third-generation autologous chondrocyte implantation (ACI), osteochondral autologous transplantation (OATS) and osteochondral allograft transplantation (OCA) are covered benefits with conditions.
  - Uncorrected malalignment or ligamentous deficiency, unless a corrective procedure is performed prior to or concomitantly and cell-free implants and autologous matrix-induced chondrogenesis (AMIC) are not covered benefits.

### Vertebroplasty, kyphoplasty and sacroplasty

- New HTCC decision 20250131A—*Vertebroplasty, kyphoplasty, sacroplasty* will replace 20101210A—*Vertebroplasty, kyphoplasty, sacroplasty*.
- There are no new changes under this new HTCC. Vertebroplasty, kyphoplasty and sacroplasty will remain not a covered benefit.

### Hyperbaric oxygen therapy for sensorineural hearing loss and acute acoustic trauma

- Two HTCC decisions will apply concurrently: New HTCC 20250321A—*Hyperbaric oxygen therapy for sensorineural hearing loss and acute acoustic trauma*, and existing HTCC 20130322A—*Hyperbaric Oxygen Therapy (HBOT) for Tissue damage, Including Wound Care and Treatment of Central Nervous System Conditions*.

- The new HTCC decision 20250321A focuses specifically on two hearing conditions: Idiopathic sudden sensorineural hearing loss (SSNHL) and acute acoustic trauma (AAT), which are covered benefits with conditions.
- Existing HBOT restrictions and exclusions from 20130322A still apply.
- These decisions work together to provide comprehensive HBOT coverage guidelines.

### Continuous glucose monitoring

- New HTCC decision 20250321B—*Continuous glucose monitoring* will replace 20180119B—*Continuous glucose monitoring*.
- Continuous glucose monitoring (CGM) is a covered benefit with conditions.
- CGM for adults and children with type 2 diabetes not on insulin is not a covered benefit.
- CGM and supplies coverage is under UMP's prescription drug benefit, administered by Washington State Rx Services. CGM is not covered under the UMP medical benefit except for members with UMP Classic: Those members will follow HTCC benefit only.

### Frenotomy and frenectomy with breastfeeding support

- New HTCC decision 20250613A—*Frenotomy and frenectomy with breastfeeding support*.
- Under the new HTCC decision:
  - Lingual frenotomy with breastfeeding support is a covered benefit with conditions.
  - Labial frenotomy with breastfeeding support (labial frenotomy for breastfeeding difficulties) is not a covered benefit.

View full coverage determinations—including respective conditions of coverage—on the [HTCC website](#).

## Updates to AlSCO's specialty medication list

The following updates were recently made to the specialty medication pre-authorization list for AlSCO Inc. (group #70000002) members:

- **Drugs added:** 90283, J0401, J0401, J0402, J0402, J1568, J1628, J3590, J7682, J7686, J7686, J7686, J7686, J8999, J8999, J9041, J9044, J9046, J9048, J9049, J9145, J9275, J9999, Q5098, Q5114, Q5136, Q5158, Q5158, Q9996, Q9996, Q9997

View the current list of specialty medications that require pre-authorization for these members on [VIVIOS' website](#) or on our [Commercial Pre-authorization List](#).

# New workflow for Medicare Advantage oncology pre-authorization

Beginning January 1, 2026, OncoHealth will manage select oncology pre-authorization requests for our Medicare Advantage members.

OncoHealth proactively reviews oncology treatment plans and pre-authorization requests for radiation oncology services and medications (both medical and prescription benefits). As part of this cross-benefit review, their clinicians engage oncologists in peer-to-peer discussions about patients' treatment plans and may recommend changes.

Oncologists should look for a letter next month from OncoHealth about our partnership.

## Members currently in treatment

Members who start treatment before January 1, 2026, can continue to receive treatment under their approved authorization until it expires. Services for members in treatment prior to January 1, 2026, won't need an authorization from OncoHealth unless:

- There's a change to the existing treatment plan on or after January 1, 2026.
- Treatment extends past the authorization end date.

## Sign up for trainings today

OncoHealth will offer trainings starting December 2, 2025, through January 21, 2026. Providers who submit pre-authorization requests for radiation oncology or oncology drugs should plan to attend one pre-launch and one post-launch webinar.

- Webinars will be provided live and available for later viewing.
- [Register for a Tuesday training](#), offered at noon (PT) starting December 2, 2025.
- [Register for a Wednesday training](#), offered at 8:30 a.m. (PT) starting December 3, 2025.

## More information

- View our [OncoHealth Oncology Program FAQ](#).
- On our provider website:
  - [Pre-authorization>Medicare Advantage](#)
  - [Policies & Guidelines>Medication Policy Updates](#)
- OncoHealth will review radiation oncology codes that currently require pre-authorization. No new radiology oncology services will require pre-authorization January 1, 2026. **Related:** See *Pre-authorization updates* on pages 7-9.
- Affected medications are listed in the *Medicare Part B Oncology Review*, drum002, medication policy. **Related:** See *Medication policy updates* on page 13.
- **Coming soon:** We will update the Medical Management section of our *Administrative Manual* on January 1, 2026, to add information about OncoHealth.

# BCBS FEP pre-authorization changes

Starting January 1, 2026, Carelon Medical Benefits Management (Carelon) will no longer administer the cardiology and radiology programs for Regence Blue Cross and Blue Shield Federal Employee Program® (BCBS FEP®) members.

## Cardiology services

These services will no longer require pre-authorization for FEP Basic and Standard Option and FEP Blue Focus members.

## Radiology and nuclear imaging services

- These services will no longer require pre-authorization for FEP Basic and Standard Option members.

- Fewer advanced imaging services will require pre-authorization for FEP Blue Focus members.
- Pre-authorization requests for services delivered on or after January 1, 2026, should be submitted following our standard pre-authorization process:
  - Through Availity Essentials
  - By fax with the medical services pre-authorization form, available on the *FEP Blue Focus Pre-authorization List* on our provider website: [Pre-authorization & Referrals>FEP Blue Focus](#).
- The *FEP Blue Focus Pre-authorization List* has been updated to show which codes will continue to require pre-authorization as of January 1, 2026, through our standard process. **Related:** See *Pre-authorization updates* on pages 7-9.

# Colonoscopy site-of-care exception changing

Effective January 1, 2026, providers will no longer be able to cite a lack of ambulatory surgical center (ASC) privileges when requesting to perform a screening or surveillance colonoscopy in an outpatient hospital setting.

Colonoscopies performed in an outpatient hospital setting already require pre-authorization for commercial and UMP members. We announced in the October 2025 issue of *The Bulletin* that we will begin reviewing these procedures under a new medical policy: *Surgical Site of Care – Colonoscopy* (Utilization Management #20).

**Related:** See *Pre-authorization updates* on pages 7-9.

Under this policy, providers may continue to perform diagnostic colonoscopies in an outpatient hospital setting if:

- Clinical criteria are met, and
- The provider lacks ASC privileges, or an in-network ASC is not available locally

## Site-of-care reviews

We assess the site of care for select services to determine whether the requested location is appropriate. This ensures care is delivered in the most appropriate and cost-effective setting. Our reviews consider an individual's health status, facility and geographic availability, specialty requirements and other relevant factors.

### Notes:

- We currently review colonoscopies under our *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19) medical policy.
- A site-of-care pre-authorization denial is not a denial of services; it is only a denial of the requested outpatient hospital setting.
- Blank forms will not be accepted and will be voided.

## The Bulletin recap

We publish updates to medical and reimbursement policies in our monthly publication, *The Bulletin*. You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our provider website: [What's New & Publications>Bulletins](#).

### Medical policy updates

We provided 90-day notice in the August 2025 issue of *The Bulletin* about changes to the *Extravascular (Substernal) Implantable Cardioverter-Defibrillator* (Surgery #17) commercial medical policy, which are effective November 1, 2025.

No medical policies in the September 2025 issue of *The Bulletin* required 90-day notice.

### Save time and effort with Availity

For the fastest review, submit requests through Availity Essentials' Electronic Authorization application. Some requests will receive automated approvals. The Availity process incorporates additional questions related to site of care, so you don't need to complete and submit attestation-based supporting documentation.

For colonoscopies performed on or after January 1, 2026, faxed pre-authorization requests must include the new *Surgical Site of Care (Colonoscopy) Additional Information Form*, which will be available on our provider website in December. **Failure to submit a completed and signed form will delay review.**

### More information

Review these resources on our provider website:

- The new policy in our *Medical Policy Manual: [Policies & Guidelines>Medical Policy](#)*
- The policy announcement in the October 1, 2025, issue of *The Bulletin: [What's New & Publications>Bulletins](#)*
- **Coming soon:** Additional information in the December 2025 issue of this newsletter

The *Medical Policy Manual* includes a list of recent updates and archived policies: [Policies & Guidelines>Medical Policy](#).

### Reimbursement policy updates

No reimbursement policies in the August and September 2025 issues of *The Bulletin* required 90-day notice.

View our *Reimbursement Policy Manual* on our provider website: [Policies & Guidelines>Reimbursement Policy](#).

To see how a claim will pay, access the Clear Claim Connection tool on Availity Essentials: [Payer Spaces>Resources>Claims and Payment>Research Procedure Code Edits](#).

## Updates to timely records policy

When we request records to support claims/ reimbursement, providers have 90 calendar days to submit them. **Effective January 1, 2026:** We will no longer accept requested records after the 90-day deadline. Providing records after this deadline will not change adjudication of the claim.

This requirement applies to clinical records, as well as financial records (i.e., itemizations and invoices) that aren't available by EMR.

### Impact to providers

To have records reviewed after the 90-day deadline, providers will need to follow the dispute process as stated in section 1.4 of the Appeals for Providers section of our [Administrative Manual](#), available on the homepage of our provider website.

Failure to submit timely records may result in claims denied as provider liability. Providers cannot balance bill members for provider liability denials.

### More information

Review the *Reimbursement Policy Manual* on our provider website: [Policies & Guidelines>Reimbursement Policy](#).

We announced updates to our *Timely Receipt of Medical Records* (Administrative #145) reimbursement policy, which applies to commercial and Medicare Advantage, in the October 2025 issue of *The Bulletin*, available on our provider website: [What's New & Publications>Bulletins](#).

## Medication policy updates

Effective January 1, 2026, we will make changes to the following medication policies:

- *Drugs for Chronic Inflammatory Diseases (Standard Plus Formulary)*, dru444
- *Enzyme Replacement Therapy*, dru426
- *Medicare Part B Step Therapy*, dru-m001
- *Medications for Hereditary Angioedema*, dru535
- *Medications for Epidermolysis Bullosa*, dru759
- *Medicare Part B Oncology Review*, dru-m002  
(**Related:** See *New workflow for Medicare Advantage oncology pre-authorization* on page 11.)
- *Non-Preferred Blood Glucose Test Strips and Blood Glucose Meters*, dru505
- *Non-Preferred Drugs*, dru760
- *Products with Therapeutically Equivalent Biosimilars/ Reference Products*, dru620
- *Site of Care review*, dru408
- *Synagis, palivizumab, Respiratory syncytial virus (RSV) immune prophylaxis*, dru029
- *Yondelis, trabectedin*, dru440

View medication policy additions and changes on our website: [Policies & Guidelines>Medication Policy Updates](#). This content is updated with new required notifications and information about the changes on the first of the following months: February, April, June, August, October, December. Providers are responsible for obtaining pre-authorization as required in our medication policies.

# BCBS FEP medical medication prior approval

Effective January 1, 2026, prior approval will be required for the medications listed below that are covered under the medical benefit for BCBS FEP members for services rendered for Standard Option, Basic Option and Blue Focus plans. **These medications will require prior approval if they will be administered by a provider and billed to the member's medical benefit.**

## Notes

- View [associated medication policies](#).
- Medication-specific prior approval request forms are available on our provider website: [Policies & Guidelines>Medication Policy>Federal Employee Program](#).
- If you have received an advance benefit determination (ABD) for a patient on one of these medications, you do not need to request prior approval unless treatment will continue after the end date of the ABD.

FEP Medical Policy Manual number	Medications	HCPCS codes
5.21.019	Adcetris (tralokinumab-ldrm)	J9042
5.85.001	Aranesp (darbepoetin alfa)	J0881
5.21.004	Avzivi (bevacizumab-tjnj)	HCPCS code not yet assigned NDC: 821432-0002-01
5.21.004	Jobevne (bevacizumab-nwgd)	HCPCS code not yet assigned
5.30.017	Bomynta (denosumab-bnht), Connexence (denosumab-bnht), Jubbonti (denosumab-bbdz) Osenvelt (denosumab-bmwo), Ospomyv (denosumab-dssb), Stoboclo (denosumab-bmwo), Wyost (denosumab-bbdz), Xbryk (denosumab-dssb)	Q5136, other HCPCS codes not yet assigned
5.85.011	Bkemv (eculizumab-aeeb), Epysqli (ecluizumab-aagh)	HCPCS code not yet assigned
5.60.057	Briumvi (ublituximab-xiiy)	J2329
5.21.070	Darzalex (daratumumab)	J9144
5.75.009	Hyaluronic acid derivatives (Durolane, Euflexxa, Gel-ONE, GelSyn-3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Synojoynt, Synvisc, Synvisc-ONE, Triluron, Trivisc, Visco-3)	J7318, J7320-J7327, J7328, J7331, J7332
5.21.138	Enhertu (fam-trastuzumab deruxtecan-nxki)	J9358
5.21.032	Kadcyla (ado-trastuzumab emtansine)	J9354
5.21.020	Perjeta (pertuzumab)	J9306
5.90.004	Pyzchiva (Ustekinumab-ttwe, Selarsdi (Ustekinumab-aekn), Steqeyma (Ustekinumab-stba), Wezlana (Ustekinumab-auub), Yesintek (Ustekinumab-kfce)	HCPCS code not yet assigned
5.75.015	Spinraza (nusinersen)	J2326
5.30.064	Tepezza (teprotumumab-trbw)	J3241

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FEP Medical Policy Manual number	Medications	HCPCS codes
5.70.012	Tofidence (tocilizumab-bavi), Tyenne (tocilizumab-baviaazg)	Q5133, Q5135
5.60.013	Tyruko (natalizumab-sztn)	Q5134
5.50.039	Zymfentra SQ (infliximab-dyyb)	J1748

**Regence BlueShield and Regence BlueShield of Idaho**

Effective January 1, 2026, these medications will require pre-authorization for BCBS FEP members:

FEP Medical Policy Manual number	Medications	HCPCS codes
5.70.012	Actemra IV (tocilizumab), Tofidence (tocilizumab-bavi), Tyenne (tocilizumab-baviaazg)	J3262, Q5133, Q5135
5.20.003	IVIG (intravenous immunoglobulin) - Asceniv, Bivigam, Flebogamma, Gammagard, Gammagard S/D, Gammaked, Gammplex, Gamunex-C, Octagam, Panzyga, Privigen	J1459, J1554, J1556, J1557, J1561, J1566, J1568, J1569, J1572, J1599
5.21.050	Keytruda (pembrolizumab)	J9271
5.20.008	SCIG (subcutaneous immunoglobulin) - Cutaquig, Cuvitru, Hizentra, Hyqvia, Xembify	J1551, J1555, J1558, J1559, J1575
5.30.017	Prolia (denosumab)	J0897
5.60.013	Tysabri (natalizumab)	J2323
5.30.018	Xgeva (denosumab)	J0897

**Regence BlueCross BlueShield of Oregon and Regence BlueCross BlueShield of Utah**

Effective January 1, 2026, these medications will no longer require pre-authorization for BCBS FEP members:

- Bavencio (avelumab), J9023
- Cimzia (Certolizumab pegol), J0717
- Cinqair (Reslizumab), J2786
- Entyvio (Vedolizumab), J3380
- Fasenna (benralizumab), J0517
- Ilumya (tildrakizumab-asmn), J3245
- Imfinzi (durvalumab), J9173
- Lemtrada (alemtuzumab), J0202
- Libtayo (cemplimab-rwlc), J9119
- Nucala (mepolizumab), J2182
- Intravenous Orencia (abatacept), J0129
- Sandostatin LAR (octreotide acetate), J2353
- Signifor LAR (pasireotide pamoate), J2502
- Somatuline Depot (lanreotide), J1930
- Tecentriq (atezolizumab), J9022
- Xolair (omalizumab), J2357
- Yervoy (ipilimumab), J9228

## About behavioral health corner

This section highlights the articles that affect behavioral health providers. We also recommend you use the search function (**Ctrl + F**) on your computer to search for keywords that concern your practice.

Articles in this issue with behavioral health content	Page
Attend an upcoming webinar	2
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Quality in Action articles <ul style="list-style-type: none"> <li>• <i>Screening for behavioral health conditions in primary care</i> is published in the <a href="#">Quality in Action</a> section of our provider website.</li> </ul>	22
2026 APM quality program updates	22

## Virtual mental health provider Rula

As the demand for mental health support continues to rise, availability of timely, high-quality care remains one of the biggest challenges members face.

Access to mental health services is critical. Members who want to begin therapy often give up trying to find care, and when they do find a therapist, most wait more than 30 days for their first appointment.

Rula, a virtual-forward provider group, helps meet those demands by providing fast, personalized access to mental health care, matching 98% of patients with a provider who meets their unique clinical and personal preferences (e.g., specialty, gender, language, ethnicity).

Rula offers:

- **Speed to care:** Rula's platform lets members book a virtual therapy appointment in less than 3 minutes. Appointments are available with a licensed provider in as little as 24 hours.
- **Network size:** Rula's network includes more than 18,000 therapists and psychiatric providers across 90+ specialties and diverse backgrounds.
- **Services offered**
  - Therapy for individuals (ages 5 and up), families and couples
  - Medication management (ages 13 and up)

[Rula](#) is featured in the In-Network Providers section of our [Behavioral Health Toolkit](#), available on the homepage of our provider website. The toolkit includes information about many resources and tools available to PCPs and behavioral health providers.

## FreeStyle Libre discontinuations

Abbott is discontinuing FreeStyle Libre 2 and FreeStyle Libre 3 continuous glucose monitor sensors by September 30, 2025, replacing them with the FreeStyle Libre 2 Plus and FreeStyle Libre 3 Plus sensors.

The Plus sensors:

- Are still compatible with the existing smartphone apps and readers
- Have extended wear time, up to 15 days
- Are compatible with selected insulin pumps
- Are suitable for ages 2 and up

You will need to submit new prescriptions for your patients to transition to the Plus sensors. Learn more about the [FreeStyle Libre transition for prescribers](#).

## Preferred diabetes supply manufacturer change

Starting January 1, 2026, we are changing our preferred manufacturer of diabetes supplies and will stop covering LifeScan products in retail and home delivery pharmacies. We will cover Ascensia or Abbott products on all lines of business.

### How this affects your patients

Members will need to switch to products from Ascensia or Abbott when they need a new glucometer or test strips on or after January 1, 2026. We are notifying members of the steps they should take for this transition, including any coupon codes that they can use to reduce costs.

### What you should do

- Start prescribing Ascensia or Abbott glucometers and test strips now for patients who are new to treatment.
- Be prepared to issue new prescriptions on or after January 1, 2026, for patients who use a LifeScan product so they can easily switch to the new products.

# 2026 commercial products and networks

Each year, we conduct a comprehensive review of our provider networks and product offerings to ensure we serve our members' diverse health care needs and deliver high-quality, cost-effective health care solutions. As part of this process, we also implement changes to comply with Affordable Care Act (ACA) requirements and state and federal mandates.

Below is an overview of the changes to our product portfolio for 2026.

## Group network and product updates

We are increasing vision allowances for small employer (1 to 50) group metallic products and fully insured groups (51+).

### Fully insured groups of 51+

- **Regence BlueShield of Idaho**
  - Adding new Mountain View network
  - Introducing new HSAPlus plan
- **Regence BlueCross BlueShield of Oregon**
  - Adding new Premium PPO network
  - Introducing new HSAPlus plan
- **Regence BlueCross BlueShield of Utah**
  - Adding new CareVia BlueHPN network (101+ only)
  - Introducing new HSAPlus plan
- **Regence BlueShield**
  - Introducing new HSAPlus plan
- **Administrative services only (ASO) groups**
  - Introducing Regence® ClearSpend™ for select ASO groups

### More information

Information about our 2026 small and large group products and networks will be available on our provider website in January 2026: [Products>Commercial](#).

## Individual network and product updates

Our product portfolio will include:

- **Idaho:** Point-of-service (POS) products; POS members have higher out-of-network cost-shares.
- **Oregon, Utah and Washington:** Exclusive provider organization (EPO) products will have in-network benefits, and members will be responsible for 100% of out-of-network costs except:

- Out-of-network emergency room, ambulance and urgent care services will be covered at the in-network benefit level. Services may be subject to balance billing.
- When traveling out of our service area, urgent care, emergency room and ambulance services are covered with no balance billing if the member sees a participating Blue Plan provider.
- High-deductible health plans (HDHP) that can be paired with a health savings account (HSA)

The open enrollment period for individuals seeking coverage beginning on January 1, 2026, will be:

- **Idaho:** October 15, 2025, through December 15, 2025
- **Oregon, Utah and Washington:** November 1, 2025, through January 15, 2026

Individuals may qualify for special enrollment periods outside of this period if they experience certain life events. Members whose plans are being discontinued have received notice from us about options available to them in 2026.

### Regence BlueShield of Idaho

In Idaho, the following networks will support our products.

#### New – Individual Connect

- Supports on- and off-exchange products
- **Network service area:** Ada, Bannock, Bear Lake, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Butte, Canyon, Caribou, Camas, Cassia, Clark, Clearwater, Elmore, Franklin, Fremont, Gem, Gooding, Idaho, Jefferson, Kootenai, Latah, Lewis, Lincoln, Madison, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Valley and Washington counties
- **Sales area:** Ada, Bannock, Bear Lake, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Butte, Canyon, Caribou, Camas, Cassia, Clark, Clearwater, Elmore, Franklin, Fremont, Gem, Gooding, Idaho, Jefferson, Kootenai, Latah, Lewis, Madison, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Valley and Washington counties

#### Preferred

- Supports on- and off-exchange products
- **Network service area:** Statewide Note: If you refer a member on a Preferred plan to an out-of-state provider in Oregon, Utah or Washington, be sure to refer them to an Individual Connect provider instead of a Preferred Network provider to ensure they receive in-network coverage in these states.
- **Sales area:** Adams, Blaine, Camas, Cassia, Custer, Elmore, Gooding, Jerome, Lemhi, Lincoln, Minidoka and Twin Falls counties

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### Regence BlueCross BlueShield of Oregon

In Oregon and Clark County, Washington, the following networks will support our products.

#### New – Individual Connect

- Supports on- and off-exchange products
- **Network service and sales area:** Statewide (Oregon) and Clark County, Washington
- Subscribers in Oregon and on-exchange subscribers in Washington will be required to select a PCP.
- Clark County, Washington, members have access to Blue Cross and/or Blue Shield providers in the state of Washington outside of the Regence service area through the BlueCard Program.

#### Legacy

- Supports on- and off-exchange products
- **Network service area:** Clackamas, Columbia, Marion, Multnomah and Washington counties in Oregon and Clark County, Washington
- **Sales area:** Clackamas, Columbia (ZIP codes: 97054, 97064, 97018, 97051, 97053, 97056), Marion (ZIP codes: 97071, 97032, 97137, 97002, 97026, 97362, 97375, 97381), Multnomah and Washington counties in Oregon and Clark County, Washington
- Subscribers in Oregon and on-exchange subscribers in Washington will be required to select a PCP.

### Regence BlueCross BlueShield of Utah

In Utah, the following network will support our products.

#### New – Individual Connect

- Supports on- and off-exchange products
- **Network service and sales area:** Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Summit, Tooele, Uintah, Utah and Weber counties
- Subscribers will be encouraged to select a PCP.

### Regence BlueShield

In Washington, the following network will support our products.

#### New – Individual Connect

- Supports on- and off-exchange products
- **Network and sales service area:** Clallam, Columbia, Grays Harbor, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla and Yakima counties
- On-exchange subscribers in Washington will be required to select a PCP.
- Members have access to Blue Cross and/or Blue Shield providers in the state of Washington outside of the Regence BlueShield service area through the BlueCard Program.

**Note:** The Washington Healthplan Finder includes Cascade Select plans (public option plans that are not available through Regence) and Cascade Care plans (that are available through payers, including Regence). If you are part of the Individual Connect network in Washington, you are in-network for the corresponding Cascade Care plan.

#### More information

Information about our 2026 Individual products and networks is available on our provider website: [Products>Commercial](#).

## Verify your network participation for 2026 to help ensure members can continue in-network care

We are introducing a new Individual Connect network for our Individual and family plans in 2026. To ensure your patients continue to receive in-network services, please verify your participation in the new Individual Connect provider network and refer patients to in-network providers. You can find 2026 in-network Individual Connect providers using our provider search tool, available on our website. We are sending letters to members with their 2026 network and plan options.

If you need help finding an in-network provider for your patient, please contact the Provider Contact Center.

### Benefit highlights for all commercial products

- In addition to having access to telehealth services from in-network providers, members will have access to telehealth services for urgent care and behavioral health through the national telehealth provider [Doctor on Demand](#). Some groups will have access to medical and behavioral health providers through [MDLIVE](#).
- Most members will have access to either telephone or chat nurse triage lines (depending on their plan), available 24/7.
- [Hinge Health](#), a personalized virtual exercise program, is available to help eligible members manage mobility and pain in joints, spine and muscles.
- Our Pregnancy Program is available to support parents-to-be.

### Verify network participation

**Participating providers:** For a list of the networks that you participate in, refer to your *Professional Network Addendum*. You can also verify your network participation and find other in-network providers using our provider search tool on our website.

- **Regence BlueShield of Idaho providers:** Please refer to the provider search tool to verify participation in the Individual Connect network.

### Verify eligibility and benefits

You can verify your patients' eligibility and benefits on Availity Essentials.

## 2026 updates to Washington state Essential Health Benefits

Washington state has announced significant updates to its Essential Health Benefits (EHB) that will take effect on January 1, 2026, as plans renew. These changes will impact coverage for your patients on commercial plans, depending on your patients' coverage. The 2026 updates include modifications to the following benefit areas.

### Individual and small group

- **Acupuncture**—Visit limits removed
- **Artificial insemination**—New coverage for qualifying plans limited to simple preparation (sperm washing and isolation) and placement of sperm into cervix or uterus to achieve pregnancy.
- **Neurodevelopmental/habilitative/rehabilitative support**—Enhanced flexibility
  - **Note:** When someone with a neurodevelopmental diagnosis uses all their neurodevelopmental therapy benefits, they will be able to start charging that same therapy against their rehabilitative benefits and then their habilitative benefits. If you have questions about your patients' benefits after checking Availity Essentials, contact the Provider Contact Center.
- **Hearing instruments and services**—Expanded coverage
- **Inpatient donor breast milk**—Added to maternity benefits
- **Foot care and pediatric dental**—Language clarifications

### Large group

- **Neurodevelopmental/rehabilitative**—Enhanced flexibility
  - **Note:** When someone with a neurodevelopmental diagnosis uses all their neurodevelopmental therapy benefits, they will be able to start charging that same therapy against their rehabilitative benefits. (Large group products do not have habilitative benefits.) If you have questions about your patients' benefits after checking Availity Essentials, call the Provider Contact Center. (Large group products do not have habilitative benefits.) If you have questions about your patients' benefits after checking Availity Essentials, contact the Provider Contact Center
- **Hearing instruments and services**—Expanded coverage
- **Foot care**—Language clarifications

Effective January 1, 2026, you can verify your patients' updated benefits using Availity Essentials.

## 2026 UMP benefit changes

Effective January 1, 2026, the following changes will apply to Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) UMP members.

### Benefit changes

- **Hearing aids:** Benefit limited to one hearing aid every three years for each ear affected by hearing loss.
- **COVID vaccine immunizations:** UMP Classic Medicare with Part D prescription drug plan (PDP) covers the vaccine under the medical benefit.

### Network changes

The Washington legislature passed budget legislation that effectively ended funding for the UMP Plus plans after 2025. As a result, UMP Plus will be discontinued, including the following plans:

- UMP Plus – Puget Sound High Value Network (PSHVN)
- UMP Plus – University of Washington Medicine Accountable Care Network (UWM ACN)

Members will have the opportunity to select another UMP plan during open enrollment. If they don't make a selection:

- PEBB members will automatically transition to UMP Classic
- SEBB members will automatically transition to UMP Achieve 2

This discontinuation of UMP Plus plans does not impact other UMP plans.

### Infusion Drug Site of Care policy

Certain provider-administered infusion medications covered on the medical benefit are subject to the *Site of Care review* (dru408) medication policy. Effective January 1, 2026, UMP Plus members who have transitioned to other UMP plans, and are receiving infusion therapy for drugs included in dru408 at

unapproved sites must either:

- Transition to an approved site for their infusion therapy, or
- Apply for a medical necessity exception to continue treatment at their current location.

View medication policy additions and changes on our website: [Policies & Guidelines>Medication Policy Updates](#).

### Deductible increase

The IRS raised the minimum deductible for high-deductible health plans (HDHP), including UMP HDHP (PEBB) and UMP High Deductible (SEBB):

- Deductibles will increase to \$1700 for single subscribers and \$3400 for families.
- The out-of-pocket maximum will not change.

### Learn more

We will update the UMP products page on our provider website by January 1, 2026: [Products>Large Groups & Administrators>Uniform Medical Plan](#).

Use Availity Essentials to check your patients' benefits and eligibility and view their member ID card to obtain up-to-date information for your patient at the time of service.

## Condition Manager will include chronic low back pain

Our Condition Manager buy-up program will include chronic low back pain at no additional cost to ASO groups, effective January 1, 2026. This enhancement builds upon our existing comprehensive care for members with the following chronic conditions:

- Asthma
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disorder (COPD)
- Diabetes (Type 1 and 2)
- Congestive heart failure (CHF)
- **Effective January 1, 2026:** Chronic low back pain

The program connects members with dedicated Care Advocates who provide:

- Personalized resources for navigating appropriate care
- Educational support for effective condition management
- Ongoing guidance throughout their health care journey

Learn more about the Condition Manager program on our provider website: [Programs>Medical Management>Care Management](#).

## New Quality Measures Guide available

Our updated Quality Measures Guide is now available in the [Forms & Documents](#) section of our provider website. The guide includes information about a variety of quality and member experience measures that are reported or monitored most frequently for the following programs and initiatives:

- Healthcare Effectiveness Data and Information Set (HEDIS®) medical record reviews
- Medicare Advantage incentive programs
- Value-based agreements (VBAs)
- UMP

We've also introduced critical and new measures this year. These measures may not be part of our current incentive programs but are important for patient safety and quality outcomes.

**Note:** The guide does not include information about all HEDIS- or Star-related measures

## Quality in Action articles

The [Quality in Action](#) section on our provider website is an extension of this publication.

Read the following recently published articles to improve your patients' experience and health outcomes:

- *Evidence-based bronchitis care for BCBS FEP patients*
- *Help your patients save money and improve medication adherence*
- *Closing the gap in early breast cancer detection*
- *Screening for behavioral health conditions in primary care*
- *The importance of medication reviews*

## 2026 APM quality program updates

We're excited to share important updates to our quality program for commercial alternative payment models (APMs), effective January 1, 2026. These enhancements reflect our continued commitment to supporting comprehensive, high-quality care for our members and apply to providers participating in Commercial Total Care Program and Accountable Health Network (AHN) agreements.

### Key program enhancements

#### New behavioral health focus

We recognize the critical importance of behavioral health in overall patient wellness. To better support these outcomes, we've added three new reporting-only behavioral health measures:

- Follow-Up After Emergency Department Visit for Substance Use (FUA)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)

**Note:** These measures are for informational purposes only and will help you track behavioral health care outcomes for your Commercial Total Care or AHN patients.

#### Revised measures

We made the following changes:

- Eye Exam for Patients with Diabetes (EED) replaced Plan All-Cause Readmissions (PCR) as a quality measure, with PCR becoming an alternate measure.
- Statin Therapy for Patients with Cardiovascular Disease (SPC) replaced Statin Therapy for Patients with Diabetes (SPD) as an alternate measure.
- Chlamydia Screening (CHL) replaced Weight Assessment and Counseling (WCC) as a quality measure in our Pediatric quality program.

All measures continue to focus on evidence-based practices that drive meaningful health outcomes.

### New 2026 APM quality program guide available

We've updated our APM quality program guide to reflect the 2026 program enhancements. You can access the new guide on our provider website: [Contracting & Credentialing>APM Resources](#).

# 2026 Medicare Advantage products

We are committed to delivering optimal value for our members by conducting annual reviews of our products and networks. In 2026, we are making significant changes to our Medicare Advantage offerings.

## Plan discontinuations

### Regence BlueShield of Idaho:

- We are discontinuing all individual MedAdvantage PPO and BlueAdvantage HMO plans in all counties. Affected members will be notified in October 2025 and can call the customer service number on their ID card with any questions.

## Plans available in 2026

### Regence BlueShield of Idaho:

- We will continue to offer Employer Group Waiver Plans (EGWP) using our MedAdvantage PPO network.
- We will continue to offer Medicare supplement plans.

### Regence BlueCross BlueShield of Oregon:

- There are no service area changes in 2026. We will continue to offer MedAdvantage PPO plans in Benton, Clackamas, Columbia, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties in Oregon and Clark County, Washington.
- We will continue to offer BlueAdvantage HMO in Lane County.
- We will continue to offer EGWP using our MedAdvantage PPO network.
- We will continue to offer Medicare supplement plans.

### Regence BlueCross BlueShield of Utah:

- There are no service area changes in 2026. We will continue to offer MedAdvantage PPO plans in Box Elder, Cache, Davis, Iron, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington and Weber counties.
- We will continue to offer EGWP using our MedAdvantage PPO network.
- We will continue to offer Medicare supplement plans.

### Regence BlueShield (select counties in Washington):

- There are no service area changes in 2026. We will continue to offer MedAdvantage PPO plans in King, Pierce, Snohomish, Thurston and Yakima counties.
- We will continue to offer BlueAdvantage HMO in Snohomish County.
- We will continue to offer EGWP using our MedAdvantage PPO network.
- We will continue to offer Medicare supplement plans.

## Benefit updates

Current Medicare Advantage members will receive the *Annual Notice of Changes*, which highlights the changes specific to their product for 2026. Some key benefit changes are listed below.

### Notes:

- This is not a comprehensive list of benefit or copay changes, and some benefits are only available on specific plans.
- Please check your patient's benefits on Availity Essentials.
- Before referring patients, please use the provider search tool on our provider website to verify network participation.

### Benefit changes

- Medical deductible for BlueAdvantage HMO plans in Oregon will be \$200.
- ED copay will increase to \$130.
- SNF copay will increase to \$218 per day (day limits vary by plan).
- Partial hospitalization copay will increase to \$130 per day.
- Outpatient hospital and ASC will change to a copay of \$275-\$450.
- New benefit for intensive outpatient program; copay will be \$130 per day.
- Primary care added to Additional Telehealth benefit, copay will be the same as PCP visit.
- Over-the-counter (OTC) and home safety benefits are available on Classic PPO and Valliance PPO only and are administered by PayForward. The OTC benefit allowance includes home and bathroom safety equipment reimbursement and certain OTC supplies and medications.

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### Benefits with no changes in 2026

- Hearing aids continue to be administered by TruHearing.
- Dental benefits are administered by United Concordia Dental, and the network is managed by USAble. Visit our [dental website](#) for more information.
- Medicare-covered chiropractic visits are available on all plans; supplemental visits available on Regence BlueShield MedAdvantage Enhanced PPO
- Medicare-covered acupuncture visits are available on all plans; supplemental visits available on Regence BlueShield MedAdvantage Enhanced PPO
- Naturopath services are covered (six-visit limit) are available on Regence BlueShield MedAdvantage Enhanced PPO plan.
- Therapeutic massage services are covered (six-visit limit) are available on Regence BlueShield MedAdvantage Enhanced PPO plan.
- Silver & Fit fitness program continues to support our members with the standard and premium networks, on-demand workouts and virtual 1:1 personal fitness training sessions.

### Benefits not available in 2026

- We are discontinuing our coverage of post-discharge meals delivered by Mom's Meals.

### Medicare Part D changes

- We are adding/increasing deductibles on pharmacy benefits. Deductibles do not apply on formulary tiers 1 and 2.
- Copay and coinsurance amounts for most tiers are changing slightly. While some have modest increases, many have been lowered.
- Members pay less when using preferred retail pharmacies and home delivery pharmacies. Amazon Home Delivery continues to be our preferred home delivery pharmacy.
- Our Medicare Part D formulary continues to offer several medications in all classes, as required by CMS. Some medications may have been removed from our formulary. To ensure coverage, use the real-time pharmacy benefit check tool from Arrive Health that can be embedded in your EMR. Learn more about this tool on our provider website: [Programs>Medical Management>Pharmacy](#).
- We encourage the use of generics and biosimilars whenever possible as a safe and easy way to help save on drug costs while still maintaining high-quality care.
- The Medicare Prescription Payment Plan is available to help members level out their out-of-pocket medication costs throughout the year.

## Medicare Advantage HMO referral requirements

As a provider, you play a critical role in supporting patients in making informed decisions about their health care. This includes directing them to in-network providers for all services and ensuring that referrals for specialty care are in place when required.

### Referral requirements

Our Medicare Advantage HMO plans in Oregon and Washington require referrals for in-network care not provided by a PCP.

The PCP must submit a referral prior to specialty services being rendered. Retroactive referrals can be submitted on Availity Essentials within 90 days of service. If it is more than 90 days but less than 12 months from date of service, contact our Provider Contact Center.

**Note:** If you need a retroactive referral for specialty care you provided to a member; contact the member's PCP to initiate the referral first instead of submitting a provider appeal with us.

### Services that do not require referrals

Some services and visits do not require a PCP to refer the patient for the claim to be paid. These include:

- Flu shots
- Palliative care services
- Behavioral health office visits
- When Regence is a secondary payer
- Emergency services or urgent care services
- Routine vision examinations by Vision Service Plan (VSP®) providers
- Routine women's health care, including breast exams, screening mammograms, Pap tests and pelvic exams
- Kidney dialysis services at a Medicare-certified dialysis facility when the member is temporarily outside the plan's service area

### Easily find in-network providers

Use the provider search tool on our provider website to locate in-network providers and verify network participation.

### Referral submissions

Referrals can be submitted through Availity Essentials. To refer a member to an out-of-network provider, complete and submit an *Out-of-network Organization Determination Request* form.

Learn about referrals on our provider website: [Preauthorization & Referrals>Referrals](#).

# Maximize your performance on our Medicare Advantage incentive programs

The fourth quarter presents a unique opportunity to make significant strides in closing gaps that will improve quality scores and performance in our incentive programs. By taking proactive steps now, you can finish the year strong and set the stage for continued success. We appreciate your dedication and action to support our Medicare Advantage members.

## Final attribution update

To provide your group with roster stability in the last three months of the program year, member attribution is locked after our last attribution file is loaded to the Care Gap Management Application (CGMA) in early October. You may see a reduction in your roster if patients lose eligibility after the final attribution file is loaded.

Even though new patients will not be added to your CGMA roster, you may continue to see new chronic condition assessment and quality gaps for existing patients in the CGMA.

## Chronic condition assessment gaps

New gaps added after October 1, 2025, will only be added to your performance denominator if the gap is closed. If you close a chronic condition assessment gap after October 1, 2025, the closed gap will be added to both your numerator and denominator.

## Medicare Star Rating and quality gaps

You may see new gaps but only for existing patients on your roster. Gaps that open after October 1, 2025, will be added to your denominator in accordance with the specifications for each measure.

## Prioritize patients with highest number of open gaps

If your patients still have gaps that require an office visit or screening to be completed this year, we encourage you to contact them to schedule now. You can review your patients and sort them by largest number of open gaps on the CGMA.

To ensure that we have the necessary information to close your gaps for the 2025 program, we will accept claims or compliant documentation until the dates listed below for each method of gap closure submission:

- December 31, 2025—Last day to perform services
- January 31, 2026
  - Last day to submit evidence through the CGMA to close gaps, including gaps for MA Coordination of Care (MACOC) members
  - Last day to submit structured supplemental data files
- March 31, 2026—Last day to submit medical or pharmacy claims

## CGMA user audit coming soon

Twice per year, we complete a user audit to verify that the appropriate users have access. **Note:** CGMA accounts that are inactive for 120 calendar days are locked and will need to be reactivated if the user still needs access. QIP Primary Contacts must respond to the audit to maintain access for themselves and others associated with their TIN. Thank you in advance for complying with this audit to ensure that protected health information remains safe.

## Resources

Learn about the incentive programs, attribution adjustment options by member type and read details about the measures in the *Quality Measures Guide* on our provider website: [Programs>Medicare Advantage Incentive Programs](#).

[Email our QIPQuestions team](#) if you have additional questions about the programs.

## Heartbeat Health helps prevent, manage and treat heart conditions

Heartbeat Health is a national cardiology practice that provides remote care to help prevent, manage and treat heart conditions from anywhere.

They provide comprehensive heart care, starting with virtual visits to address a patient's needs. Their team coordinates necessary testing, manages medications and works closely with the patient's providers when advanced care is needed.

They are available to Regence commercial and Medicare Advantage members.

As a health care provider, Heartbeat Health can help you with:

- Medical management for adults (18+) with comorbidities like hypertension, type 2 diabetes, heart failure, coronary disease, arrhythmias or high cholesterol
- Patients that need a workup for symptoms such as chest pain, dyspnea, palpitations or syncope
- Pre-operative assessments or post-discharge follow-up
- Individuals facing long wait times or limited access to local cardiology services

Learn more about Heartbeat Health, including how to submit a patient referral, in the Telehealth Vendors section of the [Care Options Toolkit](#) on the homepage of our provider website.

## DirectDerm: Virtual dermatology care for Medicare Advantage members

DirectDerm offers a seamless, efficient and effective solution for diagnosing and managing skin conditions remotely. This teledermatology service connects patients with board-certified dermatologists through a secure online platform, enabling expert dermatological care without the need for an in-person visit. DirectDerm ensures that patients have access to timely and accurate diagnoses, treatment plans and follow-up care.

As a health care provider, DirectDerm can help you and your Regence Medicare Advantage patients:

- When a condition or lesion needs to be evaluated sooner rather than later.
- If your patient needs a dermatology consult before an in-person visit is available.
- If location or circumstances (e.g., young children in the home, remote location or weather conditions) make it difficult for a patient to travel to a dermatologist.
- If you would like a dermatologist's opinion on a diagnosis or treatment choice for a patient's skin condition. DirectDerm can help with individual cases and provide educational support.

Learn more DirectDerm, including the conditions they treat and how to submit a patient referral, in the Telehealth Vendors section of the [Care Options Toolkit](#) on the homepage of our provider website.



### Publications team

Written, designed and edited by the Provider Communications team.



### Resources for you

Use our [Self-Service Tool](#), available 24/7, to review helpful answers to our most frequently asked questions and quickly navigate our provider website resources.

Amazon Pharmacy, DirectDerm, Heartbeat Health, OncoHealth, TruHearing and VSP are separate and independent companies that provide health care management services for Regence members.

