APRIL 2020

The Connection

For participating physicians, dentists, other health care professionals and facilities

COVID-19 updates and resources

Thank you for your tireless efforts to care for our members and the people in our communities during this global pandemic. We are committed to supporting the health and safety of our providers, members, customers and employees as we navigate this unprecedented time together.

The Coronavirus (COVID-19) update and resources alert on our provider website, **regence.com**, includes information about how we are caring for our members and supporting providers. Please check the alert frequently to view the latest information.

Claims payment

- We are working to expedite claims payment to 15 days on average.

Telehealth expansion

- We're temporarily expanding medical and behavioral health telehealth services to our Individual, group (including administrative only services groups who have the telehealth benefit) and Medicare Advantage members. This expansion will remain in effect through each state's emergency declaration.

- The visits are considered the same as in-person visits and are paid at the same rate as in-person visits.
- The member's copay, coinsurance and deductible will apply to telehealth services, if applicable. (**Note**: A telehealth visit related to COVID-19 testing will be covered at no member cost share.)

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Easily find information

Did you know that you can search for words in this newsletter by holding down the **Ctrl** key on your keyboard and then the letter **F**? A pop-up window will appear asking if there's a word or phrase you need to find.

Stay up to date

View the What's New section on the home page of our website for the latest news and updates.

Using our website

When you first visit **regence.com**, you will be asked to select an audience type (individual, employer, producer or provider) and enter a ZIP code for your location. This allows our site to display content relevant to you. Our site remembers your selection and automatically directs you to the same site settings the next time you visit. For most users, this is a convenient, time-saving feature.

Regence

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the Blue Cross and Blue Shield Association

100 SW Market Street | Portland, OR 97201

Contents

■ Critical update
✶ Behavioral health must read
▲ Dental must read

We encourage you to read the other articles because they may apply to your specialty.

Click on a title below to read the article.

About *The Connection*

This publication includes important updates for you and your staff, in addition to information about updates to policies and procedures, and notices we are contractually required to communicate to you. In the table of contents on page 2, this symbol indicates articles that include critical updates: ■. To save you time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

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 specific information applies.

Issues are published on the first of the following months: February, April, June, August, October and December.

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via the Availity Portal at **availity.com**.

The Bulletin

We publish a monthly bulletin as a supplement to this bimonthly provider newsletter. *The Bulletin* provides you with updates to medical policies, including any policy changes we are contractually required to communicate to you.

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It's easy to receive email notifications when new issues of the newsletter and bulletin are available. Simply complete the subscription form available in the Library section of our provider website at **regence.com**.

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Care management

- As we learn of members diagnosed with the virus, we're reaching out to provide personalized support, including help with food and other needs.
- We're in contact with high-risk members using our case management services to ensure they have the support they need.
- We're available to support discharge needs, including removing barriers to quickly discharge our members to alternate settings, to accommodate care needs of critical patients. **Related**: See *Discharging members to post-acute settings* on page 4.
- To ensure staff and patient safety during this pandemic, if your patient has services that are delayed, we will extend pre-authorizations for elective inpatient admissions. **Related**: See *Elective inpatient pre-authorization requests extended* on page 4.

Credentialing

- We're making an exception to our locum tenens policy and expediting credentialing to help meet emerging demands for health care providers and to ensure that our members have access to care.

Coverage for testing

- If a provider believes a member needs to be tested for COVID-19, no pre-authorization is required.
- We will cover the cost of a COVID-19 test including the associated office visit at no cost share to the member. (**Note**: For Medicare Supplement members, only the test is covered at no cost share.)

Pharmacy pre-authorizations and medication refills

- All pharmacy pre-authorizations that are due to expire between March 23, 2020, and June 30, 2020, will be extended six months from the date of the current expiration date to alleviate work by providers' offices.
- Our refill policy for medications, except opioids, has been adjusted to help members prepare as needed.
- For medications that treat chronic conditions, such as heart disease, asthma, diabetes and others, members can receive an extended supply of medications:
  - Commercial (with the exception of a few self-funded groups) members can receive a 90-day refill.
  - Medicare Advantage members who have medical and pharmacy benefits can receive a 100-day refill.
  - Members who have a Medicare Part D prescription drug plan only can receive a 90-day refill.
  - Some drugs are not eligible for an extended day supply, including controlled substances and certain specialty drugs. Members may reference our drug lists to confirm whether the medicine is eligible. Drugs in the "Narcotics" section or marked "SP" are not eligible for 90-day refills.
- Members can order home-delivery prescriptions prescriptions through their plan-approved mail-order pharmacy.

Quality and incentive program

- We are pausing outbound care gap calls and Healthcare Effectiveness Data and Information Set (HEDIS®) related medical record retrieval.
- We will communicate any impact to our quality and incentive programs at a later date.

Resources

- **Centers for Disease Control and Prevention Coronavirus (COVID-19) website**
- **World Health Organization COVID-19 outbreak page**
- **Healthwise Coronavirus Resource Center**
- **VitalTalk's COVID-19 Communications Skills**
- **CAPC's COVID-19 Response Resources**

Measures we're taking to support you and our members

- ✓ No pre-authorization for COVID-19 testing
- ✓ No member cost share for COVID-19 testing and an associated office visit
- ✓ Expanded telehealth services
- ✓ Early medication refills

Stay up to date

Visit the Coronavirus (COVID-19) update and resources to learn more.

You can also access the alert from the home page of our website.

Discharging patients to post-acute settings

During this challenging time, Regence is committed to supporting our hospital partners in removing barriers to quickly discharge our members to alternate settings to accommodate care needs of critical patients related to the COVID-19 pandemic.

Effective immediately, if hospitals need to transfer a patient quickly due to the COVID-19 impact and do not have time to secure pre-authorization for post-acute care settings or home-based care (i.e., skilled nursing facilities [SNFs], long-term acute care [LTAC] hospitals and inpatient rehabilitation), we will waive the pre-authorization requirements and instead require notification by both the discharging and receiving facility/provider within 24 hours for care coordination and concurrent review authorization.

We will continue to monitor the needs of our hospital partners and re-evaluate an extension beyond May 31, 2020, as needed.

These changes do not apply to BlueCard® and BCBS FEP members.

Elective inpatient pre-authorization requests extended

To ensure staff and patient safety during this pandemic, if your patient has services that are delayed, we will extend pre-authorizations for elective inpatient admissions.

Please contact us to request an extension to your elective inpatient admission pre-authorization request.

Elective inpatient admissions pre-authorization reminder

As a reminder, pre-authorization is required for all professional services that occur during an elective inpatient admission for the following plans:

- All Regence plans (group, UMP, Medicare Advantage)
- Members in Oregon and Utah with BCBS FEP Blue Focus, Basic Option or Standard Option plans

Elective inpatient admissions that do not receive pre-authorization are subject to administrative denial.

Facilities and service providers can check the status of any pre-authorization requests on which they're named that were submitted through the Availity Portal at **availity.com**. Service providers may include primary care providers (PCP), treating providers or admitting, attending and operating providers, in addition to facilities and independent laboratories.

Acute inpatient concurrent review to begin May 1

To better enhance care coordination, member transitions and payment transparency, we will implement concurrent review for acute inpatient medical and behavioral health hospital stays beginning May 1, 2020. Concurrent review is a method of reviewing patient care and services during a hospital stay to evaluate the course of treatment.

Concurrent review will help facilitate timely discharge of non-acute care patients to preserve beds for acute patients.

Please use the fax numbers below to provide medical records information:

Type of service or request	Fax number
Concurrent review notification for: - Skilled nursing facilities - In-patient rehabilitation - Long-term acute care Records can be faxed with the initial notification.	1 (855) 848-8220
Notifications for: - Inpatient admissions - Inpatient discharge	1 (800) 453-4341
Additional clinical information during concurrent review	1 (844) 629-4404

Note: We will not accept concurrent review notification through PreManage at this time.

New Effective July 1, 2020, any of the following types of admissions for Blue Cross and Blue Shield Federal Employee Program® (BCBS FEP®) members in Oregon and Utah will require concurrent review.

Concurrent clinical review will be required for the following types of facility admissions beginning May 1, 2020, in accordance with our provider agreements:

- Elective admissions that exceed the authorized goal length of stay for in-network facilities (commercial and self-insured plans only)
- Urgent medical admissions for in-network percentage-of-billed-charge or per diem facilities beginning two midnights or three days after admission
- Critical access hospitals for Medicare beginning two midnights or three days after admission
- Urgent behavioral health admissions for in-network percentage-of-billed-charge or per diem facilities, including critical access hospitals and freestanding psychiatric hospitals, beginning four midnights or five days after admission
- Urgent admissions for in-network diagnosis-related group (DRG) facilities beginning on day 21 of the admission
- Urgent medical and behavioral health admissions for out-of-network facilities beginning on the day of admission (commercial and self-insured plans only)
- Urgent or on-going elective admissions for DRG facilities beginning on day 21 of the admission (Medicare Advantage only)

Reminder: We require pre-authorization for all elective admissions, as well as notification of admission.

Related: See *Elective inpatient admissions pre-authorization reuqests extended* on page 4.

Risk adjustment medical record reviews beginning

Medicare Advantage and Affordable Care Act (ACA) health plans must report member diagnosis data to the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (HHS) annually to calculate risk-adjusted payments to health plans. Most of this data is collected via claims. To ensure we are reporting all relevant data to CMS or HHS, our retrospective and prospective programs collect information not reported through claims. CMS and HHS require all reported data to be fully supported by valid medical record documentation.

Retrospective medical record reviews underway

We are in the process of requesting and reviewing medical records to support the diagnosis data we submit to CMS or HHS. We have partnered with the vendor Advantmed to assist us in the collection of medical records. You may have already received, or may soon be receiving, a packet from this vendor that explains what information we need and how to submit your records for our review.

Audits

CMS and HHS conduct risk adjustment data validation (RADV) audits of the data submitted by health plans. These audits enable CMS or HHS to validate the diagnoses that were used to calculate payments made to health plans under risk adjustment. Providers and facilities play a critical role during the RADV audit process. In a RADV audit, diagnoses submitted for risk adjustment can be validated only by medical record review. If you treated a member identified in the RADV audit sample, CMS and HHS require you to submit medical records as requested by us. Your assistance and timely compliance to such requests enable us to meet our RADV audit obligations in the brief timeframe allowed by CMS and HHS.

Accurate documentation

Complete and accurate documentation is critical for risk adjustment. If your medical record documentation does not support the diagnosis data we submitted to CMS or HHS, they will be unable to verify the diagnosis data. This can result in CMS or HHS imposing significant payment penalties that can have negative effects on the products and services we offer to our members. We appreciate your efforts to ensure your Regence patients' medical records are thorough and accurate, and for responding to requests as quickly as possible.

2020 Regence BlueShield webinars

Regence BlueShield (in select counties in Washington) medical providers: Join us for our upcoming webinars held on the first Thursday of every month, from 9 to 9:45 a.m. (PT).

- **April 2**: Virtual care—Our policies and procedures for providing and being reimbursed for virtual care
- **May 7**: Credentialing—The credentialing and recredentialing processes
- **June 4**: Patient Cost Estimator—Availity's tool to estimate patient costs for professional services

Please let us know if you will attend any or all webinars by sending an email with the subject line "Webinar RSVP" to **WA_Provider_Relations@regence.com** and indicate the dates you'll attend. We hope you'll join us.

Attend our Utah roundtable webinar

Regence BlueCross BlueShield of Utah medical providers: We'll be hosting a roundtable discussion at our Thursday, April 9, 2020, webinar. Join us at 10 a.m. (MT) for a discussion about the topics most pressing for your practice, including COVID-19.

To register for the webinar, send an email to **ProviderRelationsUtah@regence.com** with the subject line "Webinar RSVP." If you have questions you'd like us to address at the webinar, include them in your email. We may also be reaching out to you for questions, and you'll be able to submit questions throughout the webinar via the chat box.

We hope to see you online!

The Bree Collaborative: Working to improve care in Washington

In 2011, Washington State Legislature established the Dr. Robert Bree Collaborative to give public and private health care stakeholders the opportunity to identify specific ways to improve health care quality, outcomes and affordability in Washington state. The governor appoints collaborative members to represent public health care purchasers for Washington state, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals and quality improvement organizations.

The partnership is named in honor of the late Dr. Robert Bree, a pioneer in medical imaging.

What is the mission of the Bree Collaborative?

Washington state, along with the rest of the country, is working to identify and promote strategies that improve patient health outcomes, health care service quality and the affordability of health care. Achieving these goals requires collaboration between the many different stakeholders in health care. The Bree Collaborative provides a setting in which collaboration can be successful.

How does the Bree Collaborative influence the health care system in Washington state?

Each year, Bree Collaborative members identify health care services with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues. For most topics, an expert workgroup develops evidence-based recommendations. Recommendations consider existing quality improvement programs and the work done by other organizations and are then sent to the Washington State Health Care Authority to guide the type of health care provided to Medicaid enrollees, state employees and other employer groups.

The following topics are currently being addressed:

- Palliative care
- Maternity bundle
- Opioid prescribing
- Shared decision-making
- Risk of violence to others

Below is a list of some of the topics that have been addressed:

- Suicide care
- Oncology care
- Low back pain
- End-of-life care
- Hospital readmissions
- Obstetric (maternity) care
- Prostate cancer screening
- Opioid use disorder treatment
- Addiction and dependence treatment
- Alzheimer's disease and other dementias
- Total knee and total hip replacement surgery bundled payment model and warranty

We encourage you to visit the Bree Collaborative website at **breecollaborative.org** and learn more about:

- **Getting involved**: Attend a meeting, share feedback and receive updates via email.
- **Identifying topics**: View previous and current health care topics that The Bree Collaborative has addressed.
- **Assessing, comparing and implementing**: Assess your level of adoption to see how you compare to others in the community and take steps using topic-specific roadmaps to implement changes in your practice.

Provider tools and resources

We have several online tools and resources to help support your office.

Availity Provider Portal

The Availity Portal, **availity.com**, is your online source for current, detailed patient, medical pre-authorization and claims-related information. Registered users can quickly and easily:

- View the status of credentialing applications
- Review and sign contract documents
- Verify member eligibility and benefits
- Obtain an estimate of patient costs for professional medical services
- Submit medical pre-authorization requests using the Electronic Authorization Tool, including single sign on to eviCore heathcare (eviCore)
- Submit claims
- Use the Clear Claim Connection (C3) tool to see how a medical claim will be processed
- View remittance vouchers
- Access reimbursement schedules
- Register for electronic funds transfer (EFT)
- Access helpful applications and forms

OneHealthPort

Oregon and Washington providers: OneHealthPort, **onehealthport.com**, features a secure environment to access multiple health plans and hospitals using one account, eliminating the need for multiple accounts, passwords and user agreements.

Provider Contact Center

For information that is not available in the Availity Portal, our Provider Contact Center specialists are available to help you Monday through Friday, 7 a.m. to 5 p.m. (PT).

Provider Relations

Provider Relations representatives work with providers to resolve issues, acting as a liaison between your office and Regence. Reach out to our team for help with:

- Credentialing
- Contracting questions
- Inquiries that cannot be resolved through our Provider Contact Center

Provider consultants are the primary external contact, building relationships with clinics, provider offices and facilities. Consultants support providers by addressing issues and implementing solutions. Consultants can help with:

- Electronic tools
- Strategic initiatives
- Contracting questions
- New office orientations
- Educational workshops
- Office manager forum participation
- Office visits requested for problem solving
- Resolution of global issues (e.g., policies, medical review)
- Explanations of specific medical and reimbursement policies

Visit the Contact Us page on our website to learn more about registering for the Availity Portal and OneHealthPort. The Contact Us page also includes contact information for our Provider Relations team.

Single sign on access with Availity and eviCore

You can now choose to be routed to eviCore's provider portal from the Availity Portal, making it easier for you to submit electronic pre-authorization requests for physical medicine-related services (e.g., chiropractic, acupuncture, speech therapy, physical therapy, massage therapy and occupational therapy) that require pre-authorization from eviCore.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective January 1, 2020
Gender Affirming Interventions for Gender Dysphoria (Medicine #153) King County members (Group #10017241) only	CPT® 11970, 11971, 13100, 13101, 13102, 14000, 14001, 14040, 14041, 14301, 14302, 15100, 15101, 15570, 15572, 15574, 15576, 15757, 15758, 15824, 15825, 15826, 15828, 15829, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 19300, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21270, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54440, 58661, 58720, 64856, 64892 HCPCS C2622, L8630, L8631

Procedure/medical policy	Added CPT codes effective April 1, 2020
Laboratory and Genetic Testing for use of Thiopurines (Laboratory #70)	0169U
Whole Exome and Whole Genome Sequencing (Genetic Testing #76)	81415, 81416

Uniform Medical Plan (UMP)

Procedure/medical policy	Added CPT codes effective April 1, 2020
Laboratory and Genetic Testing for use of Thiopurines (Laboratory #70)	0169U
HTCC Decision: Pharmacogenomic testing for selected conditions	0169U
Whole Exome and Whole Genome Sequencing (Genetic Testing #76)	81415, 81416

Medicare

Procedure/medical policy	Added CPT code effective March 1, 2020
Multimarker and Proteomics-based Serum Testing Related to Ovarian Cancer (Medicare Laboratory #60)	81500

Procedure/medical policy	Added CPT codes effective April 1, 2020
Genetic and Molecular Diagnostics– Next Generation Sequencing and Genetic Panel Testing (Medicare Genetic Testing #64)	0169U
Hypoglossal Nerve Stimulation (Medicare Surgery #215)	0466T
Occipital Nerve Stimulation (Medicare Surgery #174)	0466T, 61885, 61886
Vagus Nerve Stimulation (Medicare Surgery #74)	0466T, 61885, 61886

Oxygen concentrators to require pre-authorization effective July 1, 2020

In our February 2020 issue, we notified that effective May 1, 2020, oxygen concentrators used by Medicare Advantage members for more than 90 days will require pre-authorization. The effective date of this requirement has changed to July 1, 2020.

Our complete pre-authorization lists are available in the Pre-authorization section of our website. Please review the lists for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through the Availity Portal, **availity.com**. Learn more on our website: Pre-authorization> Electronic Authorization.

Pre-authorization for specialty medications

Effective July 1, 2020, HCPCS J9145 and Q5111 will be added to the specialty medication pre-authorization lists for CHG Healthcare Services (group #70000004), IEC Group (group #70000000) and Alsco, Inc. (group #70000002) members. View the complete list of specialty medications that require pre-authorization for these members on our Commercial Pre-authorization List.

Non-reimbursable services

Our *Non-Reimbursable Services* (Administrative #107) reimbursement policy, which explains invalid services that are considered to be non-reimbursable, is located on our website: Library>Policies and Guidelines> Reimbursement Policy. If billed, non-reimbursable services (NRS) are considered not payable, are denied as a provider write-off and cannot be billed to our member.

View specific commercial CPT and HCPCS codes that are considered NRS in the *Clinical Edits by Code List* located on our website: Claims and Payment> Coding Toolkit.

If CMS has designated a medication or supply as product not available (PNA) for 90 days, we consider it an NRS and not eligible for reimbursement. We allow this time to use any existing supply. We review codes quarterly and update any medications or supplies with a PNA code status to NRS.

Medical policy updates

We publish updates to medical policies and Clinical Position Statements in our monthly publication *The Bulletin*.

We provided 90-day notice in the February and March 2020 issues of *The Bulletin* about the following medical policies:

- Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia (Transplant #45.36), effective May 1, 2020
- Oxygen Concentrators (Medicare Durable Medical Equipment #22), effective May 1, 2020
- Intensity Modulated Radiotherapy (IMRT) of the Thorax, Abdomen, Pelvis, and Extremities (Medicine #165), effective June 1, 2020

You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our website: Library>Bulletins.

The *Medical Policy Manual* includes a list of recent updates and archived policies: Library> Policies and Guidelines>Medical Policy> Recent Updates.

All policies and Clinical Position Statements are available on our website: Library> Policies and Guidelines.

Medical and dental reimbursement policy updates

We review our reimbursement policies on an annual basis. Included below are changes to our policies.

View our *Reimbursement Policy Manual* on our website: Library>Policies and Guidelines>Reimbursement Policy. Our *Dental Reimbursement Policy Manual* is also available our website: Library>Policies and Guidelines> Dental Policy.

To see how a medical claim will be processed, access the Clear Claim Connection tool on the Availity Portal at **availity.com**: Payer Spaces>Resources under the Claims and Payment category.

Medical policies	Description of changes
Administrative	**Effective April 1, 2020**
Virtual Care (#132)	- Added to place of service (POS) 02 definition that facility relative value units (RVUs) will be utilized based on CMS guidance - Updated links to the Oregon and Washington state legislative websites - **Note**: Please check the COVID-19 updates and resources alert on the home page of our website for information about temporary updates for telehealth services related to our Virtual Care policy
Anesthesia	**Effective April 1, 2020**
Anesthesia Reimbursement (#102)	- Removed mention of burn excision/debridement and deliveries from section about multiple anesthesia services
Modifiers	**Effective April 1, 2020**
Modifier 50; Bilateral Procedure (#108)	- Clarified policy to include facilities - Clarified that we will reimburse bilateral procedures billed as having one surgeon, a surgeon-assistant combination or co-surgeons • When billing as a surgeon-assistant combination, only one surgeon may be considered the primary surgeon for that procedure • Bilateral services, even if performed simultaneously, will be reimbursed as co-surgeons (with modifiers 50 and 62 appended to both claims) or as primary surgeon and assistant surgeon • We will not reimburse when components of a procedure are billed by more than one primary surgeon
Modifier 50; Bilateral Procedure (Medicare #108)	- Clarified policy to include facilities - Clarified that we will reimburse bilateral procedures billed as having one surgeon, a surgeon-assistant combination or co-surgeons • When billing as a surgeon-assistant combination, only one surgeon may be considered the primary surgeon for that procedure • Bilateral services, even if performed simultaneously, will be reimbursed as co-surgeons (with modifiers 50 and 62 appended to both claims) or as primary surgeon and assistant surgeon • We will not reimburse when components of a procedure are billed by more than one primary surgeon - Removed mention of endoscopic and non-endoscopic codes with CMS bilateral procedure indicator 1 being eligible for bilateral adjustment

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Dental policies	Description of changes
Diagnostic	**Effective April 1, 2020**
Biopsy of Oral Tissue (#47)	- Revised formatting and clarified policy statement - Combined policy with Oral Pathology Laboratory (#07) dental reimbursement policy with no change to intent
- Blood Glucose Level Test, in-office using a glucose meter (#71) - Gross Pulpal Debridement (#22C) - HbA1C In-office Point of Service Testing (#69) - Pulp Vitality Tests (#05)	- Revised formatting and made minor changes to policy statement for clarification with no change to intent
Endodontic Therapy, Root Canal (#26)	- Archived policy
Oral Pathology Laboratory (#07)	- Archived policy; policy's intent is addressed in Biopsy of Oral Tissue (#47) dental reimbursement policy
Pulp Capping, Indirect (#22A)	- Archived policy

Clinical Practice Guidelines review

Clinical Practice Guidelines are systematically developed statements on medical and behavioral health practices that help physicians and other health care professionals make decisions about appropriate health care for specific conditions.

View the guidelines on our website: Library>Policies and Guidelines.

AIM revising clinical guidelines

AIM Specialty Health (AIM) is revising the following clinical guidelines for our radiology program effective August 16, 2020:

- Sleep Disorder Management
- Advanced Imaging: Chest Imaging
- Advanced Imaging: Oncologic Imaging

Revised guidelines are available on AIM's website, **aimspecialtyhealth.com/ClinicalGuidelines.html**.

eviCore guidelines to be revised

Effective July 1, 2020, eviCore will revise its guidelines for several components of our Physical Medicine program.

Pain intervention guideline revisions

- **Epidural Steroid Injections**: Non-indications SNRB and Non-indications ESI: (#200.5 and 200.6)
- **Sacroiliac Joint Procedures**: Procedure Codes (#203.5)

Joint surgery guideline revisions

- **Shoulder Surgery**: Arthroscopic and Open Procedures (#315.4)

Spine surgery guideline revisions

- **Lumbar Microdiscectomy**: Procedure Codes (#606.5)

Redlined versions of these revisions are published on eviCore's website, **evicore.com/provider/clinical-guidelines**.

AIM and eviCore authorizations extended

AIM and eviCore are extending authorizations for six months. **You do not need to contact AIM or eviCore; your authorizations will be automatically updated, and requests going forward will automatically be extended.**

eviCore to begin site of service reviews for spine and joint surgeries

We are streamlining our process for procedures that should be performed in an outpatient setting or ambulatory surgical center.

Beginning July 1, 2020, when you request pre-authorization from eviCore for a spinal or joint surgery in an inpatient setting, eviCore will review and issue an authorization for both the professional service and the site of service.

If the professional service is medically necessary but the appropriate setting is not inpatient, the request will receive a partial denial. This will allow you to resubmit your request with the appropriate place of service or request a peer-to-peer call with eviCore.

The authorization issued by eviCore for both the professional service and the site of service will be applied in claims processing.

If the pre-authorization request is submitted through Availity, you will be able to check the status of both the professional and facility requests. Pre-authorization requests submitted directly to eviCore will not appear on the Availity Provider Dashboard.

Related: See *Single sign on access with Availity and eviCore* on page 8.

Medical policy reviews

Our medical policies are reviewed for the following reasons:

- Updates from CMS
- Regularly scheduled review
- Changes in published scientific literature
- Requests from physicians, other health care professionals or facilities
- Addition, deletion or revision of codes published in the CPT, HCPCS and ICD-10 manuals

Medication policy updates

Listed below is a summary of medication policy additions and changes. Links to all medication policies, medication lists and pre-authorization information for our members, including real-time deletions from our pre-authorization lists, are available on our website: Programs>Pharmacy.

Pre-authorization: Submit medication pre-authorization requests through **covermymeds.com**.

Expert feedback: We routinely assess our medication policies based on updated medical literature, national treatment guidelines, practicing provider feedback and pharmaceutical market changes. If you'd like to provide feedback or be added to our distribution list, please email us at **RegenceRxMedicationPolicy@regence.com** and indicate your specialty.

New U.S. Food & Drug Administration- (FDA-) approved medications: New-to-market medications are subject to pre-authorization based on their FDA-labeled indication, pivot trial criteria and dosage limitations until we complete a full medication review and develop a coverage policy.

Product not available (PNA) status: We allow a 90-day grace period to use any existing supply for medications that CMS has designated as PNA before they become ineligible for reimbursement. **Related**: See *Non-reimbursable services* on page 10.

Revised medication policy	Effective date	Description
Non-preferred pegfilgrastim products, dru563	July 1, 2020	- Adding Ziextenzo as a preferred pegfilgrastim product in addition to Udenyca - Preferred pegfilgrastim products must be ineffective, not tolerated or contraindicated before we will cover non-preferred pegfilgrastim products
New medication policy	**Effective date**	**Description**
Non-Preferred Products with Available Biosimilars, dru620	July 1, 2020	- Preferred products will not require pre-authorization (see below) - Coverage of non-preferred products will be limited and require documented intolerance or contraindication to all preferred product(s) (see below)

Biosimilar products

The available biosimilar products and their preferred or non-preferred status effective July 1, 2020, are as follows:

Product	Preferred	Non-preferred
bevacizumab	Zirabev	Avastin, MVASI
rituximab	Ruxience	Rituxan, Truxima
trastuzumab	Trazimera	Herceptin, Herzuma, Kanjinti, Ogivri, Ontruzant

Reviewing medications with members

One important role a primary care provider (PCP) has when caring for their patients is being a trusted resource for information regarding all the medications the patient is taking. Regence members, including our Medicare Advantage members, often take several medications, vitamins, herbal remedies and supplements. They face the risk of duplicate therapy or potentially adverse interactions if they have prescriptions from multiple prescribers or take over-the-counter medications, vitamins or supplements.

By completely reviewing the patient's medications during their visits, the PCP can identify potentially duplicate or dangerous combinations of medications. We know that many of these reviews do occur. In a survey conducted of our Medicare members in 2019, about 84% responded affirmatively to a question about whether their provider had talked with them about all the prescription medications they were taking.

Even though this is a good rate, the results indicate that many of our members are not having the conversation. In order to facilitate the conversation about medications, one approach many offices use is to ask members to bring all their medications to their next visit, including vitamins, supplements, herbal remedies and other products they are taking for their health needs.

During that visit, the PCP, nurse or pharmacist can review the medications, identify any concerns and make sure the patient understands the medications' purpose and is taking them as prescribed.

To help facilitate these conversations, the following patient education flyers that address medication management are available:

- Your Health: Tips for Taking Medications Safely
- Your Health: Staying Safe When You Take Several Medications
- Your Health: Questions to Ask About Your Medicines

The last flyer includes space where a patient can list their medications, including the dose and frequency. Offices can ask patients to complete this form in advance or in the waiting room to provide a starting point for a conversation about their medications with their provider. If you would like copies of these flyers, please contact your provider relations representative or send an email to **Quality@regence.com**.

Medicare Quality Incentive Program updates

The 2020 Medicare Quality Incentive Program is underway. Current member and gap information has been added to the Care Gap Management Application (CGMA), and you can now close eligible gaps through the CGMA.

We also want to remind you that the Hierarchical Condition Category (HCC)/chronic diagnosis gap closure performance bonus requires you to have 66% of your total HCC gaps closed by August 31, 2020.

To ensure that we have the information necessary to count your gaps as closed, please adhere to the following deadlines for each method of gap closure submission:

- Claims—August 15, 2020
- Supplemental electronic medical record (EMR) data extract—August 15, 2020
- CGMA—August 31, 2020

Learn more about the program criteria on our website: Programs>Medicare Quality Incentive.

Medication reconciliation post-discharge measure

Medication reconciliation is a focused review of the medications prescribed at the time of discharge from an inpatient setting (i.e., hospital, skilled nursing facility, etc.) and reconciliation with the medication list in the outpatient record. The review:

- Must be completed within 31 days of discharge (discharge date + 30 days) for members 18 and older; documentation must list the admission date and discharge date
- Must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse; documentation must include the date the review was completed and the credentials of the person conducting the review
- May be performed during an office visit or other type of patient encounter; documentation must reflect that the office visit or interaction is related to the inpatient stay and evidence that the reconciliation was performed

Additional documentation requirements

As you complete medication reconciliation for your patients, it's important to understand what meets the Healthcare Effectiveness Data and Information Set (HEDIS®) criteria for this measure. Any of the following meet criteria:

- Notation that no medications were prescribed or ordered upon discharge
- Documentation of the current medications (e.g., current medication list) with a notation that the provider reconciled the current and discharge medications
- Documentation of the current medications (e.g., current medication list) with a notation that references the discharge medications (e.g., "no changes in medication since discharge," "same medications at discharge," "discontinue all discharge medications")
- Documentation of the member's current medications (e.g., current medication list) with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service
- Documentation of the current medications (e.g., current medication list) with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review; evidence that the member was seen for post-discharge follow-up requires documentation that indicates that the provider was aware of the member's hospitalization or discharge
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record; there must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days)

Note: A discharge summary with a list of medications the patient should start, continue or stop taking is not considered evidence that the discharge medications were reconciled with the most recent medication list in the outpatient medical record and does not meet criteria for this measure. This is because the medication instructions could be limited to the medications the patient was taking as an inpatient. If the discharge summary references the medications the patient was taking prior to admission (in addition to the discharge medications) or stated that medication reconciliation had been performed or contained documentation that the discharge medications were reconciled with the medications in the outpatient chart, this would meet criteria for medication reconciliation.

BCBS National Coordination of Care overview

A new Blue Cross and Blue Shield (BCBS) National Coordination of Care℠ program to support Medicare Advantage (MA) members was launched on January 1, 2020. The program aims to increase the quality of care BCBS MA members receive wherever they access care.

To better support all BCBS MA PPO members in our service area, we are working to improve care by providing you with additional information about your patients' open care gaps and the process for requesting medical records as needed to give other Blue Plans a complete understanding of their member's health status.

You can identify MA PPO members included in this program by the member address in our service area and the following logo included on their Blue Cross and/or Blue Shield ID cards:

What you can expect

This program will result in some changes that will be beneficial to you, your practice and your patients. The program serves all MA PPO members that reside in our service area, and some of the benefits that you may see include:

- There may be an increase in the number of patients who are a part of our Medicare Quality Incentive Program because of the inclusion of more BCBS MA PPO members who reside in our service area. This may result in greater opportunities for your practice to meet the threshold of the incentive program and increase your incentive payment. Learn more about our Medicare Quality Incentive Program on our website: Programs>Medicare Quality Incentive.
- You will receive consolidated information on Medicare Stars and risk adjustment gaps for all BCBS MA PPO members enrolled with Regence and other Blue Plans who reside in our service area through the Care Gap Management Application (CGMA). You do not need to be in contact with any Blue Plan that you are not contracted with for the purposes of gap closure.
- You will receive consolidated medical record requests for all BCBS MA PPO members enrolled with Regence and other Blue Plans who reside in our service area related to gaps in care and risk adjustment. You do not need to be in contact with any Blue Plan that you are not contracted with for the purposes of medical record retrieval.
- The MA members who you see may come into your practice setting more frequently for care due to Regence and other Blue Plans doing outreach to request care gap closures, allowing for greater continuity in care.

Note: As a reminder, your contract with Regence requires you to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Regence related to this program.

HIPAA/privacy

Consistent with HIPAA and any other applicable laws and regulations, Regence and our vendors are contractually bound to preserve the confidentiality of health plan members' protected health information (PHI) obtained from medical records and provider engagement on Medicare Stars and/or risk adjustment gaps. You will only receive requests from us that are permissible under applicable law and, consistent with your current practices, patient-authorized information releases are not required in order for you to fulfill medical records requests and support closure of Medicare Stars and/or risk adjustment gaps received pursuant to this care coordination program.

Member care and administrative reminders

Please review the following resources to learn more about gap closure, improving member care and risk adjustment:

- Learn more about our risk adjustment program, including coding and documentation tips on our website: Programs>Risk Adjustment.
- The Medicare Quality Incentive Program information on our website, Programs>Medicare Quality Incentive, will help you understand:
  - Documentation and criteria for gap closure
  - Preventive care visits, including annual wellness visits and physicals
  - How to use the CGMA to view gaps, submit gap closure information and view your performance
- Provider checklist for member surveys, available on our website: Library>Printed Material, will help you understand the ways you can impact your Consumer Assessment of Health Care Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS) scores for your patients.

Healthmap partnership improves care for chronic kidney patients

We've partnered with Healthmap Solutions (Healthmap) to provide more comprehensive care for our members with chronic kidney disease. If you have a patient with chronic kidney disease, Healthmap may contact you to partner and provide recommendations through workflow-friendly clinical decision support.

Healthmap's Kidney Health Management population health solution integrates into your existing practice workflow to complement your patient's current plan of care. Healthmap supplies you with actionable information, based on proven best practices powered by data analytics, to more effectively anticipate and deliver the right clinical care, at the right time, in the right setting.

All patients identified as at risk for chronic kidney disease stage 3 and higher are included in Kidney Health Management. A predictive algorithm is used to identify patients, detect opportunities for interventions, and surface disease-specific coding opportunities, offering you greater insight to individually tailored patient care.

Individualized patient recommendations are addressed in two ways to achieve best outcomes: 1) patient opportunities and 2) care navigation. All patients are monitored for opportunities to address gaps in care related to medications, lab testing, specialty referrals and selective quality metrics.

Patients who may benefit from more interventional support are offered care navigation, a complex care coordination service to support health care needs between office visits. Care navigation supports the patient's overall care and focuses on identifying and removing barriers that prevent a patient from achieving their optimal health.

Healthmap supplies providers with actionable information, aggregated patient treatment data and predictive modeling to more effectively anticipate and deliver care.

Kidney Health Management offers providers and members the following benefits:

Practice benefits

- Utilizes algorithms based on claims and electronic medical record (EMR) data to uncover care gaps
- Recommends patients who may benefit from care navigation
- Recommends behavioral health and disease-specific coding
- Delivers identified opportunities in an easy-to-read format

Provider benefits

- Facilitates increased information-sharing among the care team
- Promotes communication of patient adherence to the plan of care
- Maps individual health status to chronic kidney disease guidelines
- Reduces provider fatigue by streamlining patient information

Patient benefits

- Improves outcomes through the avoidance of emergency department visits and hospital admissions
- Serves as a resource to overcome social determinant barriers to care
- Provides complex care management to patients at stage 3 chronic kidney disease and beyond, including dialysis care
- Educates patients on alternatives to in-center dialysis

Healthmap is endorsed by the National Kidney Foundation. Learn more at **healthmapsolutions.com**.

Preventive care services

We cover a wide variety of preventive services with no copay and no deductible when members see participating in-network providers. Included below are some of the highlights:

- **For children and teens**: Well-child exams; vision and behavioral health screenings
- **For women**: Annual physical exams, contraceptives, breast and cervical cancer screenings, osteoporosis screening, breastfeeding support and supplies, and screenings for sexually transmitted diseases
- **For men**: Annual physical exams, blood pressure and cholesterol screenings, diabetes screenings and screenings for sexually transmitted diseases
- **Vaccinations**: Many recommended vaccinations, including flu shots, measles vaccinations and pneumonia vaccinations
- **Counseling**: Depression screenings; obesity screenings and counseling; and tobacco use counseling and treatments

View the complete list of the preventive care services we cover at: **regence.com/member/members/preventive-care-list**.

Important reminders to share with your patients

There are times when our members might need to pay a copay, coinsurance or deductible for a covered preventive service. That might happen when:

- The provider bills the member for an office visit in addition to the covered preventive service or when the preventive service is not the main purpose of the visit.
- The member sees an out-of-network provider when an in-network provider could have provided the service.
- The member comes in for a preventive screening and the provider determines additional services are needed because of a suspected condition. These services are diagnostic care (e.g., an office visit, tests and procedures needed to diagnose and monitor a medical condition).

To avoid surprises and confusion, please ask members to contact Customer Services using the phone number on the back of their member card or log in to **regence.com** to:

- Use the Find a Doctor tool to make sure their provider is in-network.
- Use the Patient Cost Estimator to view cost estimates for medical treatments and procedures (e.g., mammogram).

National Healthcare Decisions Day

National Healthcare Decisions Day (NHDD), observed annually on April 16th, exists to inspire, educate and empower the public and providers about the importance of advance care planning. We encourage you to begin or continue advance care planning (ACP) conversations with all your patients. We reimburse providers for ACP conversations with members, regardless of age or health status, across all plans, except BCBS FEP.

Submit claims for ACP conversations using CPT 99497 for the first 30 minutes and CPT 99498 for subsequent 30-minute increments, separately from all other services performed in the same visit. You can actively engage your patients at any time.

As part of our Medicare Quality Incentive Program (QIP), participating providers who have ACP conversations with at least 10% of their attributed Regence Medicare Advantage members will earn an additional incentive of $50 per member when CPT 99497 is appropriately billed.

Advance care planning conversations may include:

- Current medical status and prognosis
- Designating a medical decision-maker
- Management of physical/psychological symptoms
- Reviewing or editing previous ACP conversation notes and documents
- Social, cultural and/or spiritual strengths; values, practices, concerns and goals of care
- Advance care planning documents (e.g., advance directives, Durable Power of Attorney, Physician's Orders for Life-Sustaining Treatment [POLST] form) with or without completing these and/or relevant legal forms

Visit these websites for more information:

- National POLST Paradigm: **polst.org**
- The Conversation Project: **theconversationproject.org** and **theconversationproject.org/nhdd**
- The National Hospice and Palliative Care Organization: **caringinfo.org**
- The American Bar Association's Commission on Law and Aging: **americanbar.org/groups/law_aging/resources**

Learn about our Personalized Care Support program and our members' benefits on our website: Programs> Medical Management>Personalized Care Support.

Note: If your patient is a BCBS FEP member, please refer to the Blue Cross Blue Shield Service Benefit Plan brochure for more information, available at: **fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms**.

Diabetes prevention and management programs

We are committed to ensuring that our members who are living with diabetes receive the best care, treatment and information about how to manage their chronic condition. We offer the following diabetes prevention and management programs.

Diabetes prevention programs

- **Livongo Diabetes Prevention Program (DPP)**, available to administrative services only (ASO) group and qualified Medicare Advantage members, is a fully Centers for Disease Control and Prevention-(CDC-) recognized program that helps members focus on lifestyle behavioral change to prevent diabetes. The program includes a Wi-Fi-enabled scale, food and activity tracking, lessons, health challenges, one-on-one coaching and coach-led online meet-ups for support and accountability.
- **Omada**: Uniform Medical Plan (UMP) members ages 18 to 64 with risk factors for prediabetes have access to Omada, an online program. The program combines proven science with personalized support to help participants build healthy habits that last—whether that means improving eating habits, activity levels, sleep or stress management.

Diabetes management programs

- **Regence care management programs**: Regence care management and Regence Condition Manager (a disease management buy-up program for ASO members delivered in partnership with Optum) include registered nurses and/or care advocate staff focused on helping members with diabetes and supporting your care plan.
- **Livongo Diabetes Management**: This program is for members with type 1 or type 2 diabetes. The program includes free testing strips and lancets—plus a new, free blood glucose meter; better diabetes monitoring; and answers to questions 24/7. It is available to Medicare Advantage members and employees of employer groups that have purchased the program. **Note**: View the list of participating employer groups on our website: Programs> Medical Management>Diabetes Management.

More information about our diabetes prevention and management programs, including eligibility criteria, is available on our website: Programs> Medical Management>Diabetes Management.

BCBS FEP residential treatment center benefit

BCBS FEP members have access to residential treatment centers (RTC) for medically necessary inpatient care. Case management and pre-authorization/pre-certification prior to admission are required for this benefit. Pre-authorization is also required for outpatient RTC services for any condition.

A preliminary treatment and discharge plan must be developed and agreed to by the member, provider (RTC) and case manager in the state where the RTC is located prior to admission.

BCBS FEP benefit plans cover inpatient care provided and billed by an RTC for members enrolled and participating in case management through the local Blue Plan when the care is medically necessary for treatment of a medical, behavioral health and/or substance use condition. This includes: room and board (such as semiprivate room), nursing care, meals, special diets, ancillary charges and covered therapy services when billed by the facility.

Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house or similar type of facility. Benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; outward bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long-term care; and domiciliary care provided because care in the home is not available or is unsuitable.

Claim submission reminder

All providers are responsible for submitting accurate and complete claims for all medical, dental, surgical services, supplies and items rendered to members using industry standard coding guidelines. Please refer to our *Correct Coding Guidelines* reimbursement policy (Administrative #129) on our website: Library>Policies and Guidelines>Reimbursement Policy.

If you provide services at a facility that are billed separate from the facility claim, the claim for the services you provided must include the service facility National Provider Identifier (NPI) where the service was rendered.

When appropriate, the service facility NPI should be included in loop 2310, segment NM109 on an ANSI 837p claim.

Administrative Manual updates

The following updates were made to our manual sections on April 1, 2020:

Accountable Health Network Guidelines (Washington only):

- Added sample member cards for each of the Accountable Health Networks
- Removed alpha prefixes from the table on page 1

Risk Adjustment

- Revised program information

Our manual sections are available on our website: Library>Administrative Manual.

Changes to outpatient facility MUEs

Note from the Editor, February 1, 2021: This article was updated to reflect that the effective date for this change is based on dates of service.

For dates of service on or after September 1, 2020, editing for outpatient facility medically unlikely edits (MUEs) will move to ClaimsXten clinical editing. The ClaimsXten MUE edits will allow reimbursement up to the specified MUE limitation and deny any units exceeding the specified value. Read more about ClaimsXten on our website: Claims and Payment> Claims Submission>Coding Toolkit>ClaimsXten.

Using modifier GZ on facility claims to bill units exceeding MUE limits will no longer be required. For more information, read our *Maximum Daily Units* (Administrative #120) reimbursement policy: Library>Policies and Guidelines>Reimbursement Policy.

Massage billing reminders

If you or your office bill units of massage therapy, please review these important reminders.

Check massage therapy billing habits

As a reminder, **rendering providers must submit claims using their National Provider Identifier (NPI) and only for the services they provide directly to the patient**. Your NPI is unique to you, and it is to be used by only you. If another provider in your office is providing massage services, their NPI must be used when submitting a claim for those services.

Massage therapists unlikely to bill CPT 97112

Massage therapists generally perform services billed with CPT 97124 (massage). Occasionally, when prescribed, massage therapists perform CPT 97140 (manual therapy).

CPT 97112 (neuromuscular reeducation) is primarily intended to identify therapeutic exercises to retrain a body part to perform a task it was previously able to do. It is not intended to describe massage therapy.

All services should be accurately documented in the patient's medical record, including the time spent performing each service. A total of four units are accepted unless otherwise noted in the patient's benefit. All claims are subject to further review.

It is expected that massage therapists document all services and retain a copy of each patient's prescription and treatment plan on file in the office. All documentation must be available upon request.

More information

Additional information about billing is available on our website: Claims and Payment>Claims Submission. Providers can read about our alternative care billing policies in the Alternative Care section of our *Administrative Manual*: Library>Administrative Manual.

Keep your information current

Regence and BlueCard members rely on the information in our online provider search tool, Find a Doctor, to determine whether physicians, dentists, other health care professionals and facilities are included in their health plan's provider network.

This is especially important during open enrollment because many people are making choices for the following year about their health care and providers. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

Validate your practice information

We require you to verify your practice information and the networks you participate in at least once every 30 days.

Take time now to validate your practice information by following the steps outlined on our website: Contact Us>Update Your Information.

Please verify that we have listed your specialty correctly as you complete these steps. This helps members find you when they need specialty care or a particular service. If your clinic is a retail health clinic, let us know so we can update your information.

Submit changes or corrections

Notify us immediately if you have changes to your practice information. Submit the *Provider Information Update Form* for changes as listed on our website: Contact Us>Update Your Information.

Thank you for helping our members connect with you.

New behavioral health form for clinical focus information

Our new *Behavioral Health Practitioner Areas of Clinical Focus Form* replaces the *Behavioral Health Information Form* and is **now used only for changes to your areas of clinical focus and modalities**. The information you share helps our members make informed decisions about their health care and who they select for services.

If you have changes to your practice information (e.g., the provider networks you participate in, your phone number, your address or whether you offer telehealth services), please notify us immediately by completing the *Provider Information Update Form*.

Both forms are available on the Forms page on our website: Library>Forms.

Behavioral health resources for PCPs

Many people experiencing mental health concerns often first disclose these concerns to their primary care provider (PCP). Others may not disclose these concerns at all and would benefit from a routine screening by their PCP.

To support PCPs with these conversations, we are pleased to offer new resources to use when screening patients for depression and anxiety:

- **Anxiety: Screening & Treatment in the Primary Care Setting** includes information about the Generalized Anxiety Disorder 7-item (GAD-7), a validated tool that can be used to diagnose several anxiety disorders and measure anxiety severity.
- **Depression: Screening & Treatment in the Primary Care Setting** includes information about the Patient Health Questionnaire-9 (PHQ-9), a validated tool that can be used to diagnose major depression and measure treatment response.

The resources are available on our website: Library>Printed Material. Not all plans will have the same benefits, so it is important for you to verify member eligibility and benefits using the Availity Portal at **availity.com**.

Related: Read *COVID-19 updates and resources* on page 1.

Referring to in-network providers

As a reminder, except in cases of an emergency, you must refer members to participating in-network dental and medical providers, including laboratories.

Referring members to in-network providers is critical for our exclusive provider organization (EPO) members. EPO members in Idaho have limited out-of-network coverage and are responsible for 90% of out-of-network costs. In Oregon, Utah and Washington, EPO members are responsible for 100% of out-of-network costs.

Making referrals to in-network providers and facilities helps your patients make more informed choices about how they spend their health care dollars. By staying in-network, your patients will:

- Minimize their out-of-pocket expenses
- Receive the highest level of medical and dental benefits
- Ensure that they have convenient access to quality services

Referrals to non-participating providers should only be made after notifying the member in writing that services may not be covered or may result in higher out-of-pocket costs. **Note**: BCBS FEP Basic Option, FEP Blue Focus and our Medicare Advantage HMO product have only in-network benefits.

Use the Find a Doctor tool on our website to verify your participation and locate in-network providers. Locate providers by name, location or specialty type.

Compliance for board and/or trustee members

We contract with CMS to provide health care services to members with coverage through our Medicare Advantage Plans, Medicare Part D prescription drug products and the exchanges through the Qualified Health Plans (QHP). Through these contracts, we must oversee the first-tier, downstream and related entities (FDRs) and downstream and delegated entities (DDEs) that assist us in providing services for our Medicare and QHP beneficiaries.

We would like to remind you that your organization's board or trustee members are required to participate in all Regence Government Programs compliance activities, including:

- Signing a conflict of interest disclosure at appointment and annually thereafter
- Completing fraud, waste and abuse (FWA) and general compliance training within 90 days of appointment and annually thereafter
- Completing Office of Inspector General (OIG) and General Services Administration (GSA) screenings prior to appointment and monthly thereafter

Documentation must be maintained and made available upon request by either Regence or CMS. Please refer to our *Government Programs Compliance Tips* for a list of all requirements: Library> Printed Material.

For additional information regarding our compliance program and related resources, including training links, please visit our website at **www.regence.com/fdr-resources**.

Coding Toolkit updates

Our Coding Toolkit lists our clinical edits and includes information specific to Medicare's National Correct Coding Initiative (NCCI). These coding requirements are updated and posted on a monthly basis in the *Clinical Edits by Code List* in the Coding Toolkit and apply to commercial and BlueCard claims.

We have enlisted the support of Change Healthcare and their claims management solution for ClaimsXten bundling edits. Additional ClaimsXten correct coding edits will continue to be implemented on an ongoing basis. The Coding Toolkit provides a high-level description of the ClaimsXten-sourced edits. These edits are proprietary to Change Healthcare and, therefore, we cannot provide the editing detail.

Our Correct Code Editor (CCE), also located in the Coding Toolkit, has additional CPT and HCPCS code pair edits that we have identified and are used as a supplement to Medicare's NCCI. This supplemental list of code groupings in the CCE is updated quarterly in January, April, July and October. We reserve the right to take up to 30 calendar days to update our systems with CCE updates, CMS-sourced changes and Change Healthcare-sourced changes. Claims received before our systems are updated will not be adjusted.

The Coding Toolkit is available on our website: Claims and Payment>Coding Toolkit.

We perform ongoing retrospective review on claims that should be processed against our clinical edits. We follow our existing notification and recoupment process when we have overpaid based upon claims processing discrepancies and incorrect application of the clinical edits. View our notification and recoupment process on our website: Claims and Payment> Payment>Overpayment Recovery.

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

We're here for you

Our Provider Relations and Provider Contact Center teams are dedicated to helping you. Visit the Contact Us section of our website for details.

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