



The ConnectionSM

For participating physicians, other health care professionals and facilities

Help patients know where to go for care

There can be big differences between visits to a PCP, urgent care or the emergency department (ED), including cost, time spent waiting for care and whether or not follow up care is provided. We encourage you to talk to your patients about their care options before they need sudden medical care.

Care options

In-person care

- Share your office hours with your patients, especially if you offer extended hours.
- If your patient does not have a PCP, encourage them to use the [Find a Doctor](#) tool on our website or call Customer Service at the phone number on the back of their member ID card for help finding an in-network provider.

In-home care

- With [DispatchHealth](#), an in-network provider, members can receive urgent medical care in the comfort of their home to avoid a trip to an urgent care clinic or ED.
- They are available 7 days a week, including holidays, in the Portland, Oregon; Salt Lake City, Utah; and Olympia, Seattle and Tacoma, Washington, areas.

Nurse line

- For questions about common health issues and whether they should see a provider, most members can contact Regence Advice24.

Virtual care

- If you offer telehealth services, share information with your patients about how they can schedule a virtual appointment with you. To indicate whether you offer telehealth services, update your provider directory information on our provider website: [Contact Us>](#) [Update Your Information](#).
- Our members have access to in-network telehealth vendors and behavioral health providers.
- Blue Cross Blue Shield Federal Employee Program® (BCBS FEP®) members have access to [Teledoc](#).



Alternative payment model (APM) providers

Improve your financial and quality performance with the PRIA platform. Learn more on page 4.



Subscribe today

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



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.



Stay up to date

View the [Whats New & Publications](#) section on our provider website for the latest news and updates.

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About The Connection

This publication includes important news, as well as notices we are contractually required to communicate to you. In the table of contents, 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 [Availity Essentials](#).

The Bulletin

The Bulletin, published monthly, provides you with updates to medical and reimbursement policies, including any policy changes we are contractually required to communicate to you.

Share your feedback

Are our publications meeting your needs? [Send us your comments](#).



Urgent care

- Remind patients to consider urgent care clinics for illnesses and injuries beyond the scope of virtual care, such as migraine; abdominal pain; sprains, strains and cuts; and severe cold and flu symptoms. Many urgent care clinics are conveniently located and more accessible than EDs, allowing members to save time and money.

ED care

- Educate patients about visiting the ED if they are experiencing acute or life-threatening symptoms, such as chest pain, shortness of breath, signs of a possible stroke, uncontrollable bleeding, severe burns, head injuries (especially loss of consciousness) or seizures.
- To help our members have a better understanding of their care options, our care advocates contact members who had three or more ED visits in a six-month period or who had one or more avoidable ED visits to provide information about alternative treatment options.

Resources for providers and members

Our [Care Options Toolkit](#), available on the homepage of our provider website, includes:

- Information for providers about members’ care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.
- A link to the *Know Where to Go* member flyer with information about the symptoms that can be treated, cost of treatment and average wait times when seeking virtual, in-person (including urgent care centers) or emergency care.

Related

- *DispatchHealth: In-home urgent medical care* on page 5
- *Appointment accessibility results* on page 8
- *Tools for PCPs* on page 19

Are you?

- ✓ **Scheduling visits with your Medicare Advantage patients:** It’s time to schedule annual wellness visits (AWVs) or preventive care visits (PCVs) with your Medicare Advantage patients. **Related:** See *MA QIP reminders and update* on pages 27-28.
- ✓ **Helping your patients know where to go for care:** Help your patients save time and money, by reminding them about their care options before they need sudden medical care. **Related:** See *Help patients know where to go for care* on page 1 and *DispatchHealth: In-home urgent medical care* on page 5.
- ✓ **Educating your patients about the importance of routine immunizations:** Providers play a key role in educating patients and parents about the importance of vaccinations. Your recommendation can help protect your patients against serious diseases. **Related:** See *National immunization month* on page 21, *Childhood immunizations* on page 22 and *Flu season is just around the corner* on page 23.

Drive high-value care and control costs with PRIA

To further support our alternative payment model (APM) providers, we created Provider Reporting Insights & Analytics (PRIA), a new business intelligence and analytics platform to help improve your financial and quality performance. PRIA is part of a suite of services we offer providers on APM arrangements to ensure you meet or exceed your contractual and patient care goals.

Access your data at your convenience

With interactive dashboards, self-service reporting and data available at summary, claims and patient levels, PRIA gives you access to your information at your convenience and at an unprecedented depth of detail:

- Easily navigate layers of population health information, from the organization to patient level
- Visualize and generate clinical insights
- Quickly identify care gaps and treatment opportunities that represent the greatest clinical and financial impact to your office
- Identify trends, download and share reports across your organization within minutes

Drive high-value care, accelerate performance and control costs

PRIA is designed to help you create and execute data-driven population health management interventions that improve quality while reducing the total cost of care—ultimately improving your APM financial and quality performance.

Created for you

This dynamic, interactive tool was developed for you. Whether you have a team of analysts, have superior actuarial skills, are a member of the care team, or are simply an end user viewing reports—PRIA's ease of navigation and sophisticated on-demand data allows anyone to decide how much information they want, when they want it, and how deep they want to dive.

Support to help you succeed

We are dedicated to the success of our APM provider partners. PRIA users can expect:

- Training on the PRIA platform provided by our Provider Relations team
- Ongoing support and collaboration with our Regence teams to help improve affordability and health outcomes of your patients
- Extensive user guides and resources on our provider website

Provider comments about PRIA



"We like that we can schedule reports to automatically generate each month. The scheduler feature ensures we'll routinely get the reports that are most important to us."

"PRIA will allow us to work collaboratively with our clinics. We can get together more often to review with other team members."

"I like all the information in PRIA, and that I can access it at any time."



"I like the look and ease of the navigation, and how I can drill-down into member and provider data. I like that I can export data in spreadsheets to share with providers or as a PowerPoint to present to leadership."



"PRIA is easy to navigate and intuitive. The gap list is very helpful and will be used quite often."

Onboarding

Several large provider groups have been trained and are currently exploring all that PRIA can do for their organizations. Our Provider Relations team is actively offering PRIA training and access to additional select providers on APM arrangements with more than 1,000 attributed members.

Learn more about PRIA and view helpful resources, including frequently asked questions, user guides, videos and training modules, on our provider website: [Contracting & Credentialing>APM Resources](#).

DispatchHealth: In-home urgent medical care

DispatchHealth, a provider of in-home urgent medical care for non-life-threatening medical needs, is part of our provider network for members living in select ZIP codes in Portland, Oregon; Salt Lake City, Utah; and Olympia, Seattle and Tacoma, Washington.

[DispatchHealth](#) complements and extends your practice by delivering on-demand urgent medical care to high-acuity patients at home. Their credentialed medical professionals can treat [95% of the most common ED diagnoses](#).

What sets DispatchHealth apart:

- **Accessible:** DispatchHealth operates from 8 a.m. to 8 p.m. in Oregon and from 8 a.m. to 10 p.m. in Utah and Washington 365 days a year—weekends and holidays included.
- **Affordable:** DispatchHealth’s services are in-network and a visit is often billed the same as a walk-in urgent care clinic.
- **Comprehensive:** DispatchHealth can treat a wide range of conditions, including UTIs, injuries, swelling, confusion, weakness, nausea, vomiting, diarrhea, rash, cellulitis, abscesses and more.
- **Seamless:** After the visit, DispatchHealth sends detailed notes to provider on record for continuity of care and directs patients back to you for follow-up if necessary. They also call in prescriptions and handle billing through the patient’s insurance.

In-home care for patients after discharge

DispatchHealth Bridge Care is a proactive, high-acuity medical intervention in a patient’s home within 72 hours post-discharge from the hospital or skilled nursing facility (SNF).

Designed for moderate- to high-risk patients with a medical condition that warrants reevaluation after discharge, this service helps ensure a smooth transition from facility to home to optimize recovery; avoid readmission; and safely “bridge” patients back to their PCP or specialist.

In-home hospital-alternative care (Tacoma, Washington only)

DispatchHealth’s Advanced Care (hospital-alternative care) delivers hospital-level care to qualified adult patients in the comfort of their homes. This service, available in Tacoma, Washington, provides advanced medical care, social support, and 24/7 patient monitoring for up to 30 days.

Get started today

- Use DispatchHealth’s HIPAA-compliant online care request platform, DispatchExpress, to request a visit for your patient within minutes.
 - If you are new to DispatchExpress, [request an account](#).
 - Already have an account? [Log in](#).
- You can also call DispatchHealth.
 - **Oregon:** (503) 917-4904
 - **Utah:** (801) 895-3071
 - **Washington:** (425) 651-2473

After submitting the visit request, DispatchHealth will contact your patient to finish scheduling their appointment.

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

Check your email for agreement documents

Regence BlueCross BlueShield of Utah providers: To ensure that agreement documents comply with current regulatory requirements, we are replacing individual provider agreements and *Medical Group Agreements* (MGAs) with a new, standardized *Professional Services Agreement* (PSA).

To ensure the recontracting process is completed:

- Update your legal contract signatory information and email address by completing our [Electronic Contracting Registration form](#).
- Add **@DocuSign.net** to your email contact list.
- Check your email and sign agreement documents promptly to retain your status as an in-network provider.

If your legal contract signatory information is incorrect, you will not receive recontracting notifications or agreement documents.

Providers for whom we do not have legal contract signatory information may also receive an email asking them to verify or provide this information. Providers who have not signed agreement documents within 120 days will be notified that their network participation will be terminated.

Notes:

- Reimbursement is not impacted.
- Network participation remains the same.
- All providers must be credentialed before they can join our network(s).
- All eligible providers under the same tax ID on the PSA must participate in the same networks.

View frequently asked questions about our recontracting efforts on our provider website: [Contacting & Credentialing>Contracting](#).

Changes coming to medical policies and forms

We have migrated our medical policies and online forms to a new platform. This migration brings design changes and increased security, as well as new features, to make using this content even easier.

The following content is now available on the same platform as the rest of our public websites:

- Commercial medical policies
- Medicare Advantage medical policies
- Clinical Practice Guidelines
- Provider forms

With this migration you'll find:

- Design of this content will be consistent with the rest of our provider website
- New search functionality will allow medical policies to be searched by line of business, CPT or HCPCS code or keywords
- All medical policies will display on the same page and can be browsed by category or section—reducing the number of clicks needed to find the appropriate policy
- New forms functionality will allow conditional display of content, formatted fields and calendar date pickers

Test drive soon

We invite you to visit the new-look for medical policies soon. In late-August, we will update our links to automatically send you to the new content. Look for announcements and links to visit the new content on the [homepage](#) of our provider website.

Join us for a webinar to improve patient experience

We recognize that access to care and its impacts on patient experience are a challenge across the health care industry. We have partnered with Press Ganey Consulting to offer a free webinar, providing best-in-class insights, tools and techniques to improve patient experience. Attendees can earn 1.0-hour of continuing education (CE) credit.

Redefining access to improve patient experience

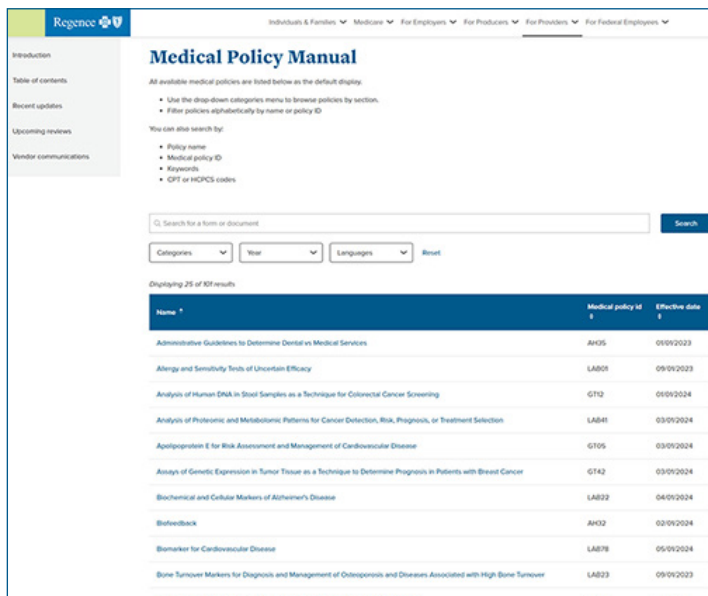
The webinar will cover the following topics:

- Redefining access to improve quality and experience
- Providing access throughout the patient journey
- Setting expectations to support access to care for both PCPs and specialty care
- Specific interventions that promote access beyond traditional face-to-face appointments
- Applying tactics that can be implemented starting your next day at the office

Join us for a 60-minute webinar on August 2, 2024, at noon (PT).

[REGISTER](#)

We are excited to offer this opportunity and hope you can join.



Reminder: Supporting our military communities with TriWest

TriWest Healthcare Alliance (TriWest) was awarded a contract to administer the U.S. Department of Defense's (DoD's) next generation TRICARE program—a uniformed services health care program for active-duty service members, family members and retirees, known as T-5—for its 26-state West Region territory. As part of our partnership with TriWest, Regence:

- Is creating and maintaining provider networks in Idaho, Oregon, Utah and Washington to support both TriWest's Community Care Network (CCN) and the TRICARE T-5 programs
- Provides credentialing and contracting for both the CCN and TRICARE provider networks in our service areas
- Will add our providers to the TRICARE networks beginning January 1, 2025

Contracting for TRICARE networks

Providers on standard agreements have been emailed contracts or amendments to add them to the TRICARE provider networks.

- **If you are already a participating CCN provider**, no action is needed. You should automatically be sent an amendment to be included in the networks.
- **If you are not currently a participating CCN provider**, you will need to electronically sign the agreement via DocuSign to be added to the T-5 program.
 - **Note:** Reviewing and signing your agreements now ensures you are ready to serve these members beginning January 1, 2025. We encourage you to sign these as soon as possible.

Learn more

To learn more about TRICARE provider networks, you can:

- Visit TriWest's [provider website](#).
- Email our [TriWest Contracting Team](#).

Administrative Manual updates

The following update was made to our manual on August 1, 2024:

Medicare Advantage Plans

- Updated reference to physician assistant to include physician associate for Oregon

Our [Administrative Manual](#) is available on our provider website.

Oregon PCP selection requirements

Oregon Senate Bill 1529 (2023), now in effect, intends to expand access to care and improve health outcomes for Oregon members covered by commercial medical plans. The bill has several components. On January 1, 2024, we implemented the component that addresses cost-share for the first three PCP visits.

PCP selection and assignment

Another key component of the bill, effective July 1, 2024, requires health insurers to assign a PCP to applicable members if members have not chosen a PCP by the 90th day of their plan year. These members are not required to see the PCP assigned to them, and they can switch to a different provider at any time.

We are contacting members, encouraging them to select a PCP before the 90th day of their plan year. For those who do not choose a PCP, we will automatically assign one, based on claims history, provider availability and/or proximity to the member's home address. We will do our best to find a good match.

Accepting new patients

For us to comply with this mandate, it is important that you keep us notified of your current practice capacity and any changes to your practice. Please report your status for accepting new patients or other demographic changes by following the instructions to verify your directory information on our provider website at least every 90 days: [Contact Us>Update Your Information](#).

Verification of member PCP assignment

You can verify whether a member has selected you or been assigned to you by viewing your PCP roster on Availity Essentials: Payer Spaces>Provider Reports for your Organization>Credentialing & Maintenance Reports. PCP information is also returned in an eligibility and benefits request on a per member basis.

Oregon physician associates title update

The Oregon legislature passed House Bill 4010, which changed the title of physician assistant to physician associate, effective June 6, 2024. There are no changes to licensing requirements or scope of practice for these providers.

We are in the process of updating references on our policies and website to reflect this change for Oregon providers. For more information, see the [Oregon Medical Board FAQ](#) on this topic.

Appointment accessibility results

This past winter, we conducted our annual Provider Access Survey related to patient appointment access for:

- PCPs
- Behavioral health providers
- Providers in high-volume and high-impact specialties

Your answers helped us measure compliance with our published standards for after-hours phone coverage and appointment wait times.

Our findings include:

- **Primary care:** We found that members' access to primary care appointments met our standards, with some delays for urgent appointments and for non-urgent appointments for persistent symptoms.
- **Behavioral health care:** Timely access to routine behavioral health care for established patients met our standards. Access for non-life-threatening crisis behavioral health and routine behavioral health care for new patients fell a little short of our standards.
- **Specialty care:** Timely access to specialty non-urgent care met our standards. Access for specialty urgent care fell a little short of our standards.

We recognize and appreciate your efforts to deliver timely care for our members despite ongoing challenges. After the survey, Provider Relations contacted a sample of providers to learn more about the challenges you are facing in meeting access standards. Your open and honest responses have helped us better understand the challenges you and our members face when it comes to timely access to care.

During our discussions with providers, common themes emerged:

- Many clinics are facing staffing shortages and are struggling to hire in a highly competitive environment, particularly when recruiting in rural locations.
- Some offices experience challenges accommodating member preferences of provider and time of service availability.
- Some offices remain inundated even after this long post-COVID-19 pandemic.
- Despite these obstacles, offices try to schedule patients as quickly as possible or help them find care elsewhere if they cannot be seen in the office as soon as needed.

Related: See *Help patients know where to go for care* on page 1 and *DispatchHealth: In-home urgent medical care* on page 5.

Access to specialty care

The survey showed us that scheduling patients for urgent specialty care appointments within 24 hours remains difficult, while patient access to non-urgent appointments within 30 calendar days improved following the scheduling difficulties of the last few years.

From our outreach, we learned that the urgent appointment requirement in rural locations is still a challenge due to lack of practitioner's availability for many specialties. However, many providers have processes in place to triage members and help them get the right care at the right time, which may or may not be within 24 hours. We ask that you remain mindful of the urgent care requirement to ensure patients can get timely care when needed.

Access to behavioral health care

The survey data shows us that scheduling patients for behavioral health care continues to be difficult, particularly to see a new patient within 10 business days. We recognize the huge demand for behavioral health care services, and from our outreach, we learned of ways that you are working hard to meet this growing need: Offering extended hours, adding and recommending virtual visit opportunities are helping members receive behavioral health care as quickly as possible.

We appreciate your commitment to meeting our members' behavioral health needs and working to provide them access to care. We recognize the need for additional behavioral health providers and are actively recruiting providers to increase accessibility.

Please be mindful of the access requirements for behavioral health care:

- Non-life-threatening emergency (crisis) will be treated within six hours or directed to the nearest emergency room, crisis line or crisis unit.
- Urgent care appointments will be scheduled within 48 hours or directed to the nearest emergency room, crisis line or crisis unit.
- Routine office visits will be scheduled within 10 business days.

Our standards are published on our provider website: [Programs>Quality>Quality Program>Accessibility & Availability Standards](#).

Reminder: DME billing during an admission

During an admission, durable medical equipment (DME) is only payable if billed on the admission date or within 48 hours of discharge.

Learn more

We apply the following CMS policies to billing DME during admission:

- Section 110.3 of Chapter 20 of the [Medicare Claims Processing Manual](#) describes scenarios for pre-discharge DME delivery.
- The [Medicare DMEPOS Payments While Inpatient MLN Fact Sheet](#) addresses DME billing during admission, including prior to discharge.

Payable DME periods during admission		
	Payable	Not payable
On admission date	✓	
Within 48 hours of discharge	✓	
After admission date but more than 48 hours prior to discharge		✓

Update your directory information

Accurate provider directories are essential to help members find providers who best meet their health care needs and individual preferences. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

The Consolidated Appropriations Act (CAA), 2021, requires health plans to establish a process to verify and update provider directory information no less frequently than every 90 days. Accurate provider directories are also a requirement for compliance with CMS, the Affordable Care Act (ACA) and your agreement as a network provider with Regence.

Our *Provider Directory Attestation Requirements for Providers* policy requires:

- Providers to review for accuracy and submit all updated information about their practice at least every 90 days
- Providers to continue to notify us promptly of changes to directory information
- All participating providers who are eligible to display in directories based on their specialty and current credentialing status to be displayed in our provider directories
- All participating providers to comply with our policies and procedures related to furnishing information necessary to ensure provider directories are up-to-date, accurate and complete pursuant to federal and state law, including 45 C.F.R. 156.230(b); this information includes, but is not limited to, accepting new patients, provider practice location, contact information, specialty, medical group and other institutional affiliations

- Providers to review, update and return roster validation requests

Please follow the instructions to verify your directory information on our provider website at least every 90 days: [Contact Us>Update Your Information](#).

As part of your routine review of provider directory information, also review your National Provider Identifier (NPI) data in CMS' National Plan & Provider Enumeration System (NPPES). Visit [NPPES help](#) for more information.

We have expanded our provider directory information to help our members connect with providers they feel best meet their health care needs and individual preferences. Update your demographics and indicate if your office offers LGBTQIA+-affirming care, culturally-specific services, expanded language access and disability competent care by completing the *Provider Information Update Form* on our provider website: [Contact Us>Update Your Information](#).

To learn more about providing culturally competent and linguistically appropriate services, view *An Implementation Checklist for the National CLAS Standards* (available in English and Spanish). Links to these checklists are included in our [Health Equity Toolkit](#), available on the homepage of our provider website.

BlueCard tips for expediting claims processing

The BlueCard® Program connects participating health care providers and the Blue Cross and Blue Shield Plans (Blue Plans) across the country and around the world through a single electronic network for claims processing and reimbursement. Use these tips to improve your claims-processing experience when an out-of-area Blue Plan member seeks medical care from your office.

Identify members

Ask patients for their current member ID card, regularly obtain new copies of the front and back of it and share the key information with your billing staff. The main identifiers of BlueCard-eligible members are a prefix and suitcase logo. View sample member cards on our provider website: [Claims & Payment>BlueCard Program>Identifying BlueCard Members](#).

Note: Some Blue Plans administer Medicaid programs, providing comprehensive Medicaid benefits to the eligible population. Blue Plan Medicaid member ID cards do not include the suitcase logo. However, the cards for these members do include a disclaimer about benefit limitations.

Verify eligibility and benefits

Have the member's complete ID number, including prefix, available when checking eligibility and benefits by:

- Using Availity Essentials
- Submitting an ANSI 270 transaction (eligibility inquiry) to Regence
- Calling BlueCard Eligibility at 1 (800) 676-BLUE (2583)

Enroll with Medicaid

When submitting an eligibility or benefit inquiry, you will be notified whether you are required to enroll in another state's Medicaid program. If you are notified of this requirement, you must enroll in that state's Medicaid program before submitting a claim for services provided to a Medicaid beneficiary in order to be reimbursed for services.

Obtain medical policy and pre-authorization/pre-certification requirements

Pre-authorization or pre-certification contact information for a member's Blue Plan is included on the member ID card. Verify requirements by:

- Submitting a pre-authorization request using Availity Essentials' Electronic Authorizations application, which uses Electronic Provider Access (EPA) to securely route you to an out-of-area member's Blue Plan provider portal or website and provides access to electronic pre-service review capabilities

- Launching the tool on our provider website that routes you directly to the member's Blue Plan requirements: [Pre-authorization>BlueCard Program](#)
- Submitting an ANSI 278 transaction (referral/authorization) to Regence
- Calling BlueCard Eligibility at 1 (800) 676-BLUE (2583)

Notes:

- Contracted facilities are required to obtain pre-authorization or pre-certification for inpatient admissions for BlueCard members from the member's Blue Plan according to the Plan's requirements.
- Blue Plan Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, a Medicaid member may receive care in another state, which generally requires pre-authorization.

Submit claims and check claims status

- Submit claims electronically with your other Regence claims.
- Do not send duplicate claims. Sending another claim or having your billing agency resubmit claims automatically may delay the claims payment process.
- Claim submission guidelines for ambulance, laboratory and DME providers are outlined on our provider website.
 - **DME providers:** As a reminder, the service facility location (location where DME was picked up or shipped) should be included in Loop 2310C (claim level) on the ANSI 837 or Field 32 on the CMS-1500 claim form.
- Medicaid claims must include the national drug code (NDC) and rendering and billing providers' National Provider Identifiers (NPIs).

Quickly and easily access the status of your claims by:

- Using Availity Essentials
- Submitting an ANSI 276 transaction (claims status request) to Regence

Respond to medical record requests

Our preferred method for requesting and returning medical records is through Availity Essentials. If faxing medical records, please keep each patient's documents/medical records on a separate fax.

Learn more

Learn more on our provider website: [Claims & Payment>BlueCard Program](#).

Pre-authorization updates

Commercial	
Procedure/medical policy	Added codes effective July 1, 2024
Anterior Abdominal Wall (Including Incisional) Hernia Repair (formerly Ventral [Including Incisional] Hernia Repair) (Surgery #12.03)	Diagnosis code K42.9
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	0473U
Invasive Prenatal Fetal Diagnostic Testing for Chromosomal Abnormalities (Genetic Testing #78)	0469U
KRAS, NRAS, and BRAF Variant Analysis and MicroRNA Expression Testing for Colorectal Cancer (Genetic Testing #13)	0471U
Procedure/medical policy	Added codes effective August 1, 2024
Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders excluding Transcatheter Edge-to-Edge Repair (TEER) (Surgery #221)	0483T, 0484T
Procedure/medical policy	Adding codes effective September 1, 2024
Applied Behavior Analysis for the Treatment of Autism Spectrum Disorders (Behavioral Health #18)	0362T, 0373T, 97151-97158
Procedure/medical policy	Adding codes effective November 1, 2024
Cardiology	36901-36909, 37241-37244, 93600, 93602, 93603, 93610, 93612, 93618-93620, 93624, 93642, 93644, 0823T, 0825T, C7513-C7515, C7530
Uniform Medical Plan (UMP)	
Procedure/medical policy	Added codes effective July 1, 2024
Anterior Abdominal Wall (Including Incisional) Hernia Repair (formerly Ventral [Including Incisional] Hernia Repair) (Surgery #12.03)	Diagnosis code K42.9
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	0473U
Invasive Prenatal Fetal Diagnostic Testing for Chromosomal Abnormalities (Genetic Testing #78)	0469U
KRAS, NRAS, and BRAF Variant Analysis and MicroRNA Expression Testing for Colorectal Cancer (Genetic Testing #13)	0471U
Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders (Medicine #148)	0889T-0892T
Procedure/medical policy	Added codes effective August 1, 2024
Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders excluding Transcatheter Edge-to-Edge Repair (TEER) (Surgery #221)	0483T, 0484T

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Medicare Advantage	
Procedure/medical policy	Added codes effective July 1, 2024
Biochemical and Cellular Markers of Alzheimer’s Disease (Laboratory #22)	0469U
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	Q4311-Q4333
Coronary Intravascular Lithotripsy (Surgery #233)	92972, C1761
Electrical Stimulation and Electromagnetic Therapy Devices (Durable Medical Equipment #83)	0082T, 0083T
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	0455U-0457U
Genetic and Molecular Diagnostics – Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	0020M, 0450U, 0451U, 0467U, 0470U, 0471U, 0473U
Genetic and Molecular Diagnostics - Testing for Inherited Cancer Risk (Genetic Testing #02)	0474U, 0475U
Investigational (Experimental) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services (Medicine #149)	0888T, 0893T, 0897T, 0898T
Leadless Pacemakers (Surgery #217)	C1605
Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders (Medicine #148)	0889T-0892T
Transurethral Water Vapor Thermal Therapy and Transurethral Water Jet Ablation (Aquablation) of the Prostate (Surgery #210)	0867T
Procedure/medical policy	Added codes effective August 1, 2024
Cosmetic and Reconstructive Procedures (Surgery #12)	67950
Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Uncontrolled Hypertension (Surgery #235)	0338T, 0339T
Procedure/medical policy	Adding codes effective November 1, 2024
Cardiology	36901-36909, 37241-37244, 93600, 93602, 93603, 93610, 93612, 93618-93620, 93624, 93642, 93644, 0823T, 0825T, C7513-C7515, C7530

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BCBS FEP Basic Option and Standard Option	
Procedure/medical policy	Added codes effective July 1, 2024
Gene therapy and cellular immunotherapy <i>Regence BCBSO and Regence BCBSU only</i>	J3393, J3394
Genetic testing	0452U-0454U, 0456U, 0460U, 0461U, 0463U-0467U, 0469U-0471U, 0473U-0475U
Organ/tissue transplant <i>Regence BCBSO and Regence BCBSU only</i>	0894T-0896T
Reproductive services	J1675, J3315, J3316, J9155, J9202, J9225, J9226

BCBS FEP Blue Focus	
Procedure/medical policy	Added codes effective July 1, 2024
Gene therapy and cellular immunotherapy <i>Regence BCBSO and Regence BCBSU only</i>	J3393, J3394
Genetic testing	0452U-0454U, 0456U, 0460U, 0461U, 0463U-0467U, 0469U-0471U, 0473U-0475U
Organ/tissue transplant <i>Regence BCBSO and Regence BCBSU only</i>	0894T-0896T
Prosthetic devices	E0738, E0739, L5783, L5841
Radiology (CT scan/MRI/PET scan)	0501T-0504T, 0588T, 0899T, 0900T
Reproductive services	J1675, J3315, J3316, J9155, J9202, J9225, J9226

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 the Availity Essentials Electronic Authorization application.

Submit pre-authorization appeals in Availity

Availity's Appeals application has been expanded to include medical pre-authorization determinations. The application streamlines the appeals process, making it faster and easier to submit appeals directly from Availity Essentials.

A medical pre-authorization determination appeal can be submitted with required documentation directly from the Authorization dashboard, allowing you to receive immediate confirmation of submission and the ability to check the status of their appeal—all in one place.

Any pre-authorization on the Authorization dashboard can be appealed using the new appeals function. This can be through submitting a pre-authorization request using the Authorization application on Availity Essentials, or by submitting an inquiry and pinning the authorization to the Authorization dashboard.

The Authorization/Referral dashboard shows the status of submitted appeals. Access it from Availity Essentials: Patient Registration>Authorization & Referrals>Authorization/Referral Dashboard.

Get trained for free

View the training options available by clicking the Help & Training link in the Availity Essentials menu.

Specialty medication pre-authorization updates

The following updates have been made to the specialty medications section of our [Commercial Pre-authorization List](#).

Employer group and number	HCPCS codes added	Effective date
Northwest Carpenters Health and Security Plan (group #10057623)	J0801, J0802, J1576, J2781, J3399, J7213, J7214, J9334 and Q5131	July 1, 2024
WinCo (group #10034043)	J1306, J2327, J3357, J3558, Q9989, Q9487	July 1, 2024

Cardiology program to include additional services

We are expanding our cardiology program to review additional outpatient cardiovascular tests and procedures for commercial and Medicare Advantage members. The program will require pre-service medical necessity review and pre-authorization through Carelon Medical Benefits Management (Carelon) for the following types of cardiac services delivered on or after November 1, 2024:

- Dialysis access circuit evaluations and procedures
- Electrophysiology (EP) studies
- Transcatheter septal defect closure
- Vascular embolization or occlusion

About the program

Carelon administers the program, which reviews outpatient cardiovascular tests, procedures and implantable cardiac devices. **Note:** Procedures performed in an inpatient setting or on an emergent basis are not subject to this program's pre-authorization requirements.

Providers will be able to contact Carelon to request pre-authorization for these additional services in October 2024. Read the October 2024 issue of this newsletter for more details.

- **Online:** The [Carelon ProviderPortal](#) is available 24/7 and processes requests in real-time using clinical criteria.
- **By phone:** Call Carelon at (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT).

If a provider does not verify that a pre-authorization request has been approved before performing an outpatient cardiac service, the claim may be denied as provider responsibility or pended for post-service review, depending on the line of business.

Learn more

- Program details are available on our provider website: [Programs>Medical Management>Cardiology](#).
- **Related:** See *Pre-authorization updates* for a complete list of affected codes on pages 11-13.

Carelon revising defibrillator guidelines

Effective November 17, 2024, Carelon will implement revised Implantable Cardioverter Defibrillators clinical guidelines.

View the [revised guidelines](#) on Carelon's website.

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 June 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective September 1, 2024:

- *Charged Particle (Proton) Radiotherapy* (Medicine #49)
- *Screening for Vertebral Fracture or Fracture Risk with Dual X-ray Absorptiometry (DXA)* (Radiology #48)
- *Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders* (Medicine #148)

We provided 90-day notice in the July 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective October 1, 2024:

- *Anterior Abdominal Wall (Including Incisional) Hernia Repair* (Surgery #12.03)
- *Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products* (Medicine #170)

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

Related: See *Changes coming to medical policies and forms* on page 6.

Reimbursement policy updates

We provided 90-day notice in the June 2024 issue of *The Bulletin* about changes to the following reimbursement policies:

- *Global Days* (Administrative #101)
- *Modifier 25; Significant, Separately Identifiable Service* (Modifiers #103)

Updates to these policies have been postponed.

Related: See *Modifier 25 and Global Days reimbursement policy updates* on this page.

No reimbursement policies in the July 2024 issue of *The Bulletin* required 90-day notice.

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

Modifier 25 and Global Days reimbursement policy updates

We are postponing updates to the *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies.

We had previously announced in the June 2024 issues of *The Bulletin* and *The Connection* that we would update these policies effective September 1, 2024.

Look for more information in the October 2024 issues of our bulletin and newsletter.

View the current policies in our *Reimbursement Policy Manual*, available on our provider website: [Policies & Guidelines>Reimbursement Policy](#).

Updates to secondary editor modifier reviews

We implemented a secondary claims editor program in 2021 to ensure consistent application of our policies and billing standards.

We are providing courtesy notice that we will regularly enhance our secondary editor to capture quarterly and mid-year coding rule changes and to enforce current medical and reimbursement policies. If we identify an overpayment, the secondary editor will apply a change prepayment with a detailed explanation that can be reviewed on the remittance advice.

Learn more about our secondary editor in the [Coding Toolkit](#), available on the homepage of our provider website.

Effective for claims received on or after September 6, 2024

Our secondary editor will start applying denials when:

- Modifiers RT or LT are incorrectly reported with a contradictory right or left diagnosis
- Modifiers 76 or 77 are incorrectly reported

These changes are supported by our *Correct Coding Guidelines* (Administrative #129) reimbursement policy.

Effective for services provided on or after November 1, 2024

Claims for anesthesia services must include a role modifier (i.e., AA, AD, QK, QX, QY or QZ). Our secondary editor will start applying denials when appropriate role modifiers are not included on these claims.

This change is supported by revisions to our *Anesthesia Reimbursement & Services Reporting* (Anesthesia #102) commercial and Medicare Advantage reimbursement policies, which we announced in the August 2024 issue of *The Bulletin*.

eviCore updating pain and joint guidelines

Effective November 1, 2024, eviCore healthcare (eviCore) will revise the following interventional pain and joint surgery clinical guidelines:

Interventional pain

- Ablations/Denervations of Facet Joints and Peripheral Nerves
- Anesthesia Services for Interventional Pain Procedures
- Discography
- Epidural Steroid Injections
- Facet Joint Injections/Medial Branch Blocks
- Greater Occipital Nerve Blocks
- Implantable Intrathecal Drug Delivery Systems
- Sacroiliac Joint Procedures

Joint surgery

- Knee Replacement/Arthroplasty
- Knee Surgery—Arthroscopic and Open Procedures
- Lumbar Decompression
- Lumbar Microdiscectomy

Visit eviCore's website and select the **Future** tab to view the [revised guidelines](#).

Clinical Practice Guideline reviews

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.

We renewed the following Clinical Practice Guidelines, effective July 1, 2024, with no changes to the guidelines' recommendations:

- Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: We continue to recommend the Veterans Affairs and Department of Defense (VA/DoD) guidelines.
- Management of Chronic Noncancer Pain with Opioids in Adults: We continue to recommend the Substance Abuse and Mental Health Services Administration (SAMHSA) TIPS publication.
- Preventive Services Guideline for Adults: We continue to recommend the U.S. Preventive Services Taskforce (USPSTF) screening recommendations.
- Screening and Management of Substance Use Disorders in Adults: We continue to recommend the VA/DoD guidelines.

View the guidelines on our provider website: [Policies & Guidelines>Clinical Practice Guidelines](#).

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 provider website: [Programs>Pharmacy](#). **Note:** Policies are available online and pre-authorization requests can be submitted on the effective date of the addition or change, but not before.

Pre-authorization: Submit medication pre-authorization requests through [CoverMyMeds](#).

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 our Medication Policy team](#) us and indicate your specialty.

New 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. See our *Non-Reimbursable Services* (Administrative #107) reimbursement policy on our provider website: [Policies & Guidelines> Reimbursement Policy](#).

Effective October 1, 2024	Description
New medication policy	
Imcivree, setmelanotide, dru788	<ul style="list-style-type: none"> Will limit coverage to patients with obesity due to POMC, PCSK1 or LEPR deficiency confirmed by genetic testing or Bardet-Biedl syndrome (BBS)
Effective November 1, 2024	Description
Revised medication policies	
Complement Inhibitors, dru385	<ul style="list-style-type: none"> Adding two recently FDA-approved drugs for paroxysmal nocturnal hemoglobinuria (PNH) to policy: Fabhalta (iptacopan) and Voydeya (danicopan) For Empaveli, removing step therapy requirement through Ultomiris in treatment-naive PNH to align with standard of care High-dose Soliris (doses above 900mg every 12 days) will be considered not medically necessary, and therefore not covered for PNH due to several available options for breakthrough PNH
Synagis, palivizumab, Respiratory syncytial virus (RSV) immune prophylaxis, dru029	<ul style="list-style-type: none"> In alignment with Academy of Pediatrics (AAP) Red Book and CDC recommendations, coverage of Synagis will require documentation that Beyfortus (nirsevimab-alip) is contraindicated unless prior therapy was not tolerated or Beyfortus is unavailable due to manufacturer shortage

Regence LevelRx™ updates

As a reminder, the Provider-Administered Specialty Drugs benefit is in effect as plans renew throughout 2024 for fully insured group and Individual plan members. To ensure a smooth transition, our implementation timelines for benefit administration transition to the IntegratedRx – Medical network are as follows:

October 1, 2024:

- Regence BlueShield of Idaho
- Regence BlueCross BlueShield of Utah

January 1, 2025:

- Regence BlueShield
- Regence BlueCross BlueShield of Oregon

Before the transition date

From now through the transition date listed above for each service area, all Regence network providers are considered designated providers in the Prime IntegratedRx - Medical Network under the Provider-Administered Specialty Drugs benefit and are eligible to provide medications included in the Regence LevelRx program (subject to otherwise applicable conditions) to members with this benefit. **This means members can continue to receive medications from you as they do today, and claims for medications included in this program will be processed based on the terms of your existing agreement.**

Note: Medications included in this program must be pre-authorized according to our medication policies; these medications are listed in the *Provider-Administered Specialty Drugs* (dru764) policy, available on our provider website: [Policies & Guidelines>Medication Policies>Commercial Policies](#). We'll notify you in advance of any additions or changes to the medications included in the program through this newsletter.

On or after the transition date

Providers must be included in the IntegratedRx - Medical Network to be considered a designated provider under the benefit and reimbursed for administering medications included in the Regence LevelRx program to members with this benefit.

- The medication portion of the claim will be adjudicated under the terms and rates applicable to your participation in the IntegratedRx – Medical Network. The administration portion of the claim will be adjudicated under the terms and rates of the agreement you have with Regence.

- Medications included in this program must be pre-authorized according to our medication policies and require administration by a designated provider (participating IntegratedRx - Medical provider) to be covered under the member's benefits.
- If you are not designated as a participating IntegratedRx - Medical Network provider, provider-administered medications under the Regence LevelRx program will not be covered for members with the Provider-Administered Specialty Drugs benefit and claims will be denied as provider responsibility.

Note: We have begun outreach to specific members in Idaho and Utah who are receiving a Regence LevelRx medication from a provider who is not yet participating on the IntegratedRx - Medical network. Oregon and Washington providers, if you haven't yet contracted with Prime by 120 days before the transition date listed above, we'll work closely with you and our members to ensure they have uninterrupted access to their treatment on and after the implementation date.

Specialty pharmacy option for nonparticipating providers

If you are not a designated provider in the IntegratedRx - Medical network on or after the transition date, you can continue to provide medications included in the Provider-Administered Specialty Drugs benefit to your patients when you use [Accredo Specialty Pharmacy](#) participating specialty pharmacy.

The pharmacy will work with you and Regence to ensure the medication is pre-authorized before distributing it to your office for administration.

Prime Therapeutics contracting and credentialing

If you haven't already, please reach out to your Prime contact now to complete the process of credentialing and contracting for the IntegratedRx - Medical Network. Your Prime contact will help you complete the process. If you don't have a Prime contact established, please email [Prime Provider Relations](#).

To start IntegratedRx - Medical Network credentialing, you can also visit [Prime's credentialing website](#).

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	Pages
Help patients know where to go for care	1, 3
Changes coming to medical policies and forms	6
Join us for a webinar to improve patient experience	6
Appointment accessibility results	8
Clinical Practice Guideline reviews	16
Reminder: Upcoming ABA changes	19
Tools for PCPs	19
Screening for behavioral health conditions in primary care	20
Improving care for patients treated with antipsychotics	20
New <i>Quality Measures Guide</i> coming soon	21
Fall prevention: How you can help	23
Discussing urinary incontinence with members	24
Improving health care for all	25
Social determinants of health resources	25

Additionally, the following recurring articles often have policy updates that may affect your practice:

- Update your directory information
- *Administrative Manual* updates
- Pre-authorization updates
- *The Bulletin* recap
- Medication policy updates

Reminder: Upcoming ABA changes

The following changes to applied behavioral analysis (ABA) services are effective September 1, 2024.

Pre-authorization for members younger than 18

We will require pre-authorization for services provided to commercial and Medicare Advantage members younger than 18. ABA services for members 18 and older currently require pre-authorization for these lines of business.

Failure to receive pre-authorization may result in an administrative denial, claim non-payment and provider liability. Members may not be balance billed.

Reimbursement rates

We are increasing reimbursement rates for all ABA services provided to our commercial members (group and Individual products).

The updated reimbursement rates will be posted by the effective date in Availity Essentials: Claims & Payment>Fee Schedule Listing.

Tools for PCPs

We recognize that PCPs serve a vital role in discussing, diagnosing and treating behavioral health conditions.

Our [Behavioral Health Toolkit](#), available on the homepage of our provider website, includes condition-specific screening tools and trusted resources for 12 diagnoses or challenges, as well as information about:

- In-network virtual care providers
 - Virtual providers can improve access to care, don't require a referral, and are available to treat many specialty areas.
- No-cost psychiatric consultations, available to providers in Oregon, Utah and Washington
- Ongoing condition management
- Our care management services, including case management
- Determining the best path forward in the early stages of a patient's evaluation and treatment

Related: See *Screening for behavioral health conditions in primary care* on page 20.

Additionally, PCPs are often uniquely suited to discussing members' social risk factors and social needs. Tracking members' social determinants of health (SDoH) helps us understand barriers to care and support equitable access to quality health care and health education. **Related:** See *Social determinants of health resources* on page 25.

Screening for behavioral health conditions in primary care

Reminder: We reimburse PCPs for behavioral health screening and encourage them to screen patients for behavioral health conditions.

Because some patients may not schedule routine wellness exams, we recommend that PCPs also include behavioral health screening during non-preventive encounters. View the [USPSTF recommendations](#) regarding screening for anxiety, depression and suicide risk in children, adolescents and adults.

We have expanded our network of behavioral health providers to treat members with positive screening results, and we continue to broaden the number of network providers, resources and treatment options available to our members.

Our networks include specialized virtual behavioral health providers with diverse areas of focus to treat a variety of age ranges, from age 6 through adulthood, including:

- Eating disorders
- Substance use disorders (SUD)
- Comprehensive therapy programs
- Obsessive compulsive disorder (OCD)

Find out more about these virtual providers, including contact information, in the Resources section of the [Behavioral Health Toolkit](#), available on the homepage of our provider website. **Related:** See *Tools for PCPs* on page 19.

To find in-network behavioral health providers, members should call Customer Service at the number on their member ID card or use the Find a Doctor tool on our [member website](#).

Improving care for patients treated with antipsychotics

We continue to monitor the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures evaluating the care of children, adolescents and adults who are prescribed antipsychotics. Results for each of these measures remain below national benchmarks:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics assesses annual glucose and cholesterol testing for children and adolescents on antipsychotics
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses annual diabetes screening for people with schizophrenia or bipolar disorder taking antipsychotic medications
- Diabetes Monitoring for People with Diabetes and Schizophrenia assesses annual glucose and cholesterol monitoring for people with diabetes and schizophrenia

Collaborating with primary care and behavioral health providers attending our Provider Advisory Council (PAC), we work to identify actions that can improve patient care. Providers acknowledged that metabolic testing and monitoring recommended for patients taking antipsychotics can require additional coordination between primary care and psychiatry. The PAC developed these suggestions to improve the safety of care for patients treated with antipsychotics.

Best-practice suggestions for PCPs

- Ensure you are aware of antipsychotic prescriptions by encouraging patients to bring all medications to their scheduled wellness appointments.
- When children, adolescents or adults are taking antipsychotics, ensure recommended annual HbA1c and cholesterol tests are ordered.

Best-practice suggestions for psychiatrists

- When prescribing antipsychotics, communicate with the PCP to confirm roles in ordering tests, reviewing results, following up and managing the patient's health based on lab results.
- Establish a process for ordering labs if you are practicing telehealth exclusively.
- Coordinate care with your patients' PCPs to co-monitor and co-manage abnormalities associated with prescribed psychiatric medications.

New Quality Measures Guide coming soon

Editor's note (8/29/24): Updated the date for when the guide will be available to September 13, 2024

We are updating our *Quality Measures Guide* for 2024. 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:

- HEDIS medical record reviews
- Medicare Advantage Quality Incentive Program (MA QIP)
- Commercial QIP
- Value-based agreements (VBAs)
- UMP

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

You can view the guide in the [Forms & Documents](#) section of our provider website on September 13, 2024.

Commercial QIP reminders

Opt-in for 2024 QIP

As a reminder, our 2024 program requires you to opt-in. To do this, you must sign in to the Care Gap Management Application (CGMA) by October 1, 2024, and indicate that you wish to participate in the 2024 program. **Note:** If you have already opted in for 2024 for the Commercial QIP and also participate in MA QIP, you were automatically enrolled in all of our QIP programs and do not need to opt-in again until the 2025 program year.

Risk adjustment care gap reports

As a reminder, reports highlighting risk adjustment care gaps are available in the CGMA as a separate downloadable report. This report enhances your overall understanding of each member to ensure all health conditions are being addressed during their visit.

Note: Risk adjustment care gaps are accessible to offer additional insights to a patient's health and wellbeing. We do not currently offer an incentive for closing risk adjustment care gaps.

2023 program year payout

Thank you for participating in our 2023 program. Payout checks for the 2023 program have been sent to participants. If you did not receive your payout or have questions, please email QIPQuestions@regence.com.

National immunization month

National Immunization Awareness Month (NIAM) is observed each August to highlight the importance of routine vaccination for people of all ages.

Providers play a key role in educating patients and parents about the importance of vaccination. Your recommendation can help protect your patients against serious diseases, such as whooping cough, influenza, COVID-19, HPV, meningitis and shingles.

According to the [National Vaccine Advisory Council](#) disparities in immunization rates exist for many underserved and underrepresented populations, including racial or ethnic minorities, rural communities, people with disabilities, and the LGBTQIA+ community. Addressing immunization disparities is an opportunity to improve health outcomes for individuals and increase protection in the overall health of our communities. To learn more, visit the [Partnering for Vaccine Equity Resource Hub](#).

We appreciate your continued efforts to ensure your patients receive necessary vaccinations. Ensuring patients are up to date on all vaccines and other preventive care can protect them and help them maintain good health. This is important because many people, especially children, are often behind on regular vaccinations.

Resources

Preventive care lists: Most of our health plans cover preventive care services at 100%. View our lists:

- [Commercial members](#) (available in English and Spanish)
- [Medicare members](#)
- [BCBS FEP members](#) (includes annual physical exams and other preventive care services that are covered when BCBS FEP members seek services from Preferred providers)

Healthwise's Knowledgebase: This resource has helpful immunization information and tools. Our [Quality Improvement Toolkit](#) has a link to the Healthwise Knowledgebase, where you can search for materials in English and Spanish to share with your patients:

- Immunizations
- Vaccinations
- Or search for specific vaccines (e.g., coronavirus, hepatitis B)

CDC: Visit the [CDC's NIAM website](#) for resources to help you discuss routine vaccinations with your patients and parents during NIAM and throughout the year.

Related: See *Childhood immunizations* on page 22 and *Flu season is just around the corner* on page 23.

Childhood immunizations

On-time vaccination throughout childhood helps provide immunity before children are exposed to potentially life-threatening diseases. Childhood immunization rates for our health plan currently fall below the national average. These lower rates may have contributed to a whooping cough outbreak identified in Oregon earlier this year, in which at least 178 cases were reported.

The CDC has observed [disparities in childhood immunization rates](#) for racial and ethnic minorities, children living in rural communities, and low-income families. Addressing immunization disparities is an opportunity to improve health outcomes for individuals and increase protection in the overall health of our communities. To learn more, visit the [Partnering for Vaccine Equity Resource Hub](#).

As a PCP, you are a trusted resource and educator to parents and caregivers about the importance of routine checkups and recommended vaccination schedule. Scheduling office visits in advance can help parents and caregivers ensure their child stays on track.

Vaccine schedules recommended by agencies and organizations, such as the [CDC](#), the [American Academy of Pediatrics](#) and the [American Academy of Family Physicians](#), include different vaccine types, frequencies, intervals and considerations for special situations.

Sometimes, parents and guardians are concerned about the safety of vaccines. View the CDC's resources to help you and your staff prepare for conversations around vaccine hesitancy.

- [Vaccinate with confidence](#)
- [Encourage routine vaccinations](#)
- [Prepare for questions parents may ask about vaccines](#)

Here are some tips for talking to parents who are hesitant to vaccinate their children:

- Tailor your message
- Counter any misinformation
- Ask why the parent is hesitant
- Understand the parent's concerns
- Address the parent's fears about side effects
- Prepare your staff to answer questions

In addition, as part of our efforts to improve childhood immunizations, our Commercial Quality Incentive Plan (QIP) provides incentives for administering all of the immunizations required for children. **Related:** See *Commercial QIP Reminders* on page 21.

Resources

Healthwise's Knowledgebase has helpful information and tools about immunizations and vaccinations to share with your patients. Our [Quality Improvement Toolkit](#) has a link to the Healthwise Knowledgebase. Search Healthwise's Knowledgebase for materials in English and Spanish:

- *Childhood Immunization Schedule: Ages 0 to 6 Years*
- *Childhood Immunization Schedule: Ages 7 to 18 Years*
- *Why Get Your Child Immunized?* video

BCBS FEP Childhood Immunizations

Routine vaccines are covered in full for all BCBS FEP® members when the member seeks services from a preferred provider. The [BCBS FEP website](#) provides additional information, including well-child visits, other health topics, and BCBS FEP member eligibility and enrollment information.

Flu season is just around the corner

The CDC estimates there were at least 31 million flu illnesses, 14 million medical visits, 360,000 hospitalizations and 21,000 deaths from flu during the 2022-2023 flu season. It's difficult to know what the 2024-2025 flu season will bring, so prevention is the best protection.

The CDC recommends that everyone six months and older (with rare exceptions) be vaccinated every flu season to reduce flu illness and serious outcomes. The flu vaccine is especially important for those considered high-risk, including older adults because they are at a higher risk of getting seriously ill from influenza and serious cases of flu can lead to hospitalization or death.

Tips to consider as we approach flu season:

- Educate support staff about the importance of the flu vaccine.
- Update your standing orders and protocols for the 2024-2025 flu season.
- If you don't currently have standing orders and protocols for vaccines, consider creating them.
- Make resources about the flu vaccine available to patients to encourage informed decision-making.
- If vaccines are not included in your pre-visit planning, consider adding vaccines to your pre-visit workflow.
- With pre-visit planning, consider adding the word "flu" to the appointment note for patients who are due for their vaccine. This will help remind the care team that a patient needs their vaccine when they come in for their appointment.
- Consider hosting flu clinics or outreach campaigns to schedule patients for a vaccination appointment with a nurse or medical assistant.

Patient resources

Educational flyers about the importance of the flu vaccine are available in English and Spanish. You can use these to reinforce the conversation with your patient or make them available for review in the waiting room before an appointment. Look for the **Influenza immunization** category in the [Quality Improvement Toolkit](#), available in the Toolkits section on the homepage of our provider website.

Fall prevention: How you can help

It's estimated that 25% of people ages 65 and older will experience a fall this year. Fewer than half of the people who experience a fall speak to their provider about it.

The Fall Risk Management Medicare Star Ratings measure is included in our 2024 MA QIP for providers participating in our Hybrid CAHPS/HOS survey. Our score for this measure is based on memorable and impactful conversations you have with your patients regarding falls.

The discussions you have with our members can help them prevent falls and fall-related injuries. You may want to:

- Conduct regular fall-risk screenings (screening annually or biannually) either during or outside of the AWW.
- Implement prompts within your electronic medical record (EMR) to alert providers and staff that a patient is due for a conversation regarding falls and fall prevention.
- Implement the CDC Stopping Elderly Accidents, Deaths & Injuries (STEADI) algorithm within your EMR.
- Consider implementing group visits focused on fall prevention (e.g., Matter of Balance-coached events).
- Know and refer patients to community resources focused on preventing falls (e.g., fall prevention classes, tai chi, Matter of Balance).
- Encourage regular physical activity, focusing on strengthening the core muscles.
- Regularly review and discuss medications with patients; some medications can cause issues with balance.
- Remind Medicare Advantage patients that they may have extra benefits available, such as bathroom safety device coverage (available on some plans) and the Silver & Fit fitness program.

Patient resources

Educational flyers about the importance of fall prevention are available in English and Spanish. You can use these to reinforce the conversation with your patient or make them available for review in the waiting room before an appointment. Look for the **Fall risk coaching** category in the [Quality Improvement Toolkit](#), available in the Toolkits section on the homepage of our provider website.

Osteoporosis management in women who had a fracture

The Osteoporosis Management in Women Who had a Fracture (OMW) HEDIS and Star measure assesses the percentage of Medicare Advantage women ages 67 to 85 who have suffered a bone fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after their fracture. Multiple organizations recommend that postmenopausal women who experience a fragility fracture be tested or treated for osteoporosis, including the National Osteoporosis Foundation and the U.S. Department of Health and Human Services (HHS).

We consider bone mass measurements performed by in-network providers as preventive services covered at no cost to the patient as a qualified individual, every 24 months or more frequently if medically necessary.

If your patient is interested in receiving a BMD test at home, have them call us at 1 (800) 541-8981 to see if this service is available through our partners. Test results are shared with both you and your patient.

Some points to remember:

- If a BMD test was completed more than two years prior to the fracture, it is time for the patient to get a new one.
- Consider ordering a BMD test for all women 65 and older, as recommended by the Bone Health and Osteoporosis Foundation.
- Always check that fracture codes are not used before a fracture has been confirmed through imaging. Submit a corrected claim to fix fracture codes submitted in error to ensure the patient is removed from the measure.
- If your patient has frailty and advanced illness, please submit the diagnosis codes in a medical claim to remove your patient from the measure. Our *Quality Measures Guide* includes additional details. You can view the guide in the [Forms & Documents](#) section of our provider website.

If your patient has had a fracture, order a BMD test or prescribe osteoporosis treatment within six months for better bone health and long-term fracture prevention.

Discussing urinary incontinence with members

Urinary incontinence can dramatically impact a person's quality of life. It can cause people to avoid activities (e.g., exercise), limit social outings, increase their risk of falls, affect their mental health and disrupt their sleep.

Discussing urinary incontinence can be uncomfortable; however, the more often these conversations happen with patients, the easier they become. With repetition, providers and patients can become comfortable discussing the topic.

There are many reasons to include urinary incontinence among the list of topics discussed at primary care visits.

- Many patients may see urinary incontinence as a sign of aging and just accept it as a part of life.
- Patients may hint at having issues with urinary incontinence and may want to have a conversation about it.
- Patients may be waiting for their provider to bring up the subject because they are embarrassed and do not want to bring it up on their own.
- Your patient may plan to discuss the topic when scheduling their appointment, but then forget about it as the visit takes place.

Many providers screen for urinary incontinence issues as part of the patient completing an annual health risk assessment for their AWW. You may also consider discussing issues about urinary incontinence during conversations about fall risk and physical activity because building core strength can help reduce the risk of falling, as well as address incontinence, especially if Kegel exercises are discussed. **Related:** See *Fall prevention: How you can help* on page 23.

Improving Bladder Control is a Medicare Star Ratings measure and a health issue that we closely monitor. We rely on our provider partners for the bladder control scores, and we have room for improvement with a few of our Medicare Advantage plans being at 3 Stars.

Patient resources

Educational flyers about the importance of managing urinary incontinence are available in English and Spanish. You can use these to reinforce the conversation with your patient or make them available for review in the waiting room before an appointment. Look for the **Incontinence management** category in the [Quality Improvement Toolkit](#), available in the Toolkits section on the homepage of our provider website.

Improving health care for all

We believe that everyone should have access to affordable, quality care. That's why we're partnering with providers to address health disparities and advance health equity.

We recently updated the [Health Equity Toolkit](#) on our provider website. This toolkit includes resources to help you learn more about health disparities and to develop and improve your cultural competency and health literacy best practices as you and your staff provide care for our members.

What's inside?

- Explore tools, trainings, continuing medical education (CME) courses and other resources to help you and your practice develop the mindset and core capabilities to advance health equity.
- Find resources to support underserved and underrepresented groups that experience health disparities.
- Learn about accreditation or distinction programs that can help your organization develop foundational health equity capabilities and earn recognition in the industry.

Social determinants of health resources

Non-clinical factors can significantly impact the health and wellbeing of your patients. The majority of health outcomes (80%) are driven by the conditions in places where people live, work and play. Known as social determinants of health (SDoH), these powerful factors include housing stability, food security and transportation access, among others.

Connect your patients to:

- **Community resources:** Individuals can find support to address social needs, such as food insecurity, housing instability, transportation access and more by visiting 211.org or findhelp.org.
- **Regence Customer Service:** Members can call the number on the back of their member ID card for help with SDoH resources, finding a PCP, understanding their benefits and more.

We encourage you to include SDoH Z codes in your patients' medical records. Including these codes will help us identify opportunities to provide support to our members, such as transportation or in-home care, as well as connections to food banks and other community resources.

View our *Social Determinants of Health Z Codes* flyer, which includes a list of the codes that measure social risk factors and social needs, available in the [Forms & Documents](#) section of our provider website.

BCBS FEP provider toolkit for SDoH codes

SDoH affect health issues that may lead to medication non-compliance, hospital readmissions, unnecessary ED visits and other medical issues.

The *BCBS FEP SDoH Provider Coding Toolkit* documents specific SDoH challenges using ICD-10 Z codes. By including the SDoH ICD-10 Z codes on claims, Regence can identify members with case management needs and other needed follow-ups. These codes can apply to all your patient encounters. **Note:** These are supplemental diagnosis codes and should not be used as the admitting or principal diagnosis code to indicate the medical reason for the visit.

The toolkit is available on our provider website: [Products>Large Groups & Administrators>Federal Employee Program](#).

MA QIP reminders and update

The following important reminders about the 2024 Medicare Advantage Quality Incentive Program (MA QIP) will help you with gap closure.

Opt-in for 2024 QIP

As a reminder, our 2024 program requires you to opt-in. To do this, you must sign in to the CGMA by October 1, 2024, and indicate that you wish to participate in the 2024 program. **Note:** If you have already opted in for 2024 for the Commercial QIP and also participate in MA QIP, you were automatically enrolled in all of our QIP programs and do not need to opt-in again until the 2025 program year.

Attribution lock coming October 1

Your MA QIP member roster locks after our last attribution load in CGMA on October 1, 2024. We encourage you to prepare by reviewing your member roster on the CGMA.

- If there is a recycling bin icon next to a member's name on the member roster, you can remove the member from your roster if they are not one of your patients.
- If there is a lock icon, the member cannot be removed because of program rules that may include contractual obligations.

Learn about attribution adjustment options by member type on our provider website: [Programs>Medicare Advantage QIP](#).

Change to hemoglobin measure

For the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure, we are now accepting submission of glucose management indicator (GMI) data as allowed in the HEDIS measurement year (MY) 2024 specifications for Glycemic Status Assessment for Patients with Diabetes (GSD).

New denominator/eligible population:

- For claims or encounter data the member needs to have **at least two diagnoses of diabetes** on different dates of service during the measurement year or the year prior.

- For pharmacy data the member needs to be dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year **and** have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.
- The required exclusion for members who did not have a diagnosis of diabetes is removed.

Medical record documentation:

- At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result.
- GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The end date in the range should be used to assign assessment date.
- If multiple glycemic status assessments were recorded for a single date, use the lowest result.
- GMI results collected by the member and documented in the member's medical record are eligible for use in reporting. There is no requirement that there be evidence the GMI was collected by a PCP or specialist.

New numerator codes:

Include the appropriate CPT or LOINC code along with the CPTII code that correlates to the patients' results.

- **HbA1c blood test:** CPT 83036 or 83037
- **GMI:** LOINC 97506-0
- **CPT II** (do not include modifiers):
 - HbA1c Level <7.0%: 3044F
 - HbA1c Level ≥7.0-<8.0%: 3051F
 - HbA1c Level ≥8.0-≤9.0%: 3052F
 - HbA1c Level >9.0%: 3046F

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Preventive care visits

We encourage you to see every member every year for an AWV or PCV. PCVs and AWVs are the perfect visits at which to address your patient's MA QIP care gaps, as well as documenting the status of their chronic conditions. Conducting these visits increases gap closure rates for many measures at the same time.

Reminders:

- Codes that close the PCV gap:
 - CPT 99381-99387
 - CPT 99391-99397
 - HCPCS G0402
 - HCPCS G0438
 - HCPCS G0439
- The PCV gap can only be closed via claims submission.
- Members who have an in-home assessment are still eligible for an AWV/PCV.
- An in-home assessment conducted by a vendor does not close the PCV gap for the attributed PCP.

- Most preventive visits are covered without a member copay; check Availity Essentials for member eligibility.
- We cover AWVs and PCVs billed once per calendar year; there is no requirement to wait 11 months between visits.
- We will give credit for PCV visits completed in 2024, even if the member had other health plan coverage at the time of service. Please submit evidence of the previously performed PCV to QIPQuestions@regence.com.

2023 program year

If you participated in our 2023 MA QIP, your payout checks were mailed. If you did not receive your payout or have questions, please email QIPQuestions@regence.com.

Publications team

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Jayne Drinan: Writer

Janice Farley: Writer



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.

eviCore healthcare is a separate and independent company that provides health care management services for Regence members. Prime Therapeutics is a separate company that provides pharmacy benefit management services.

