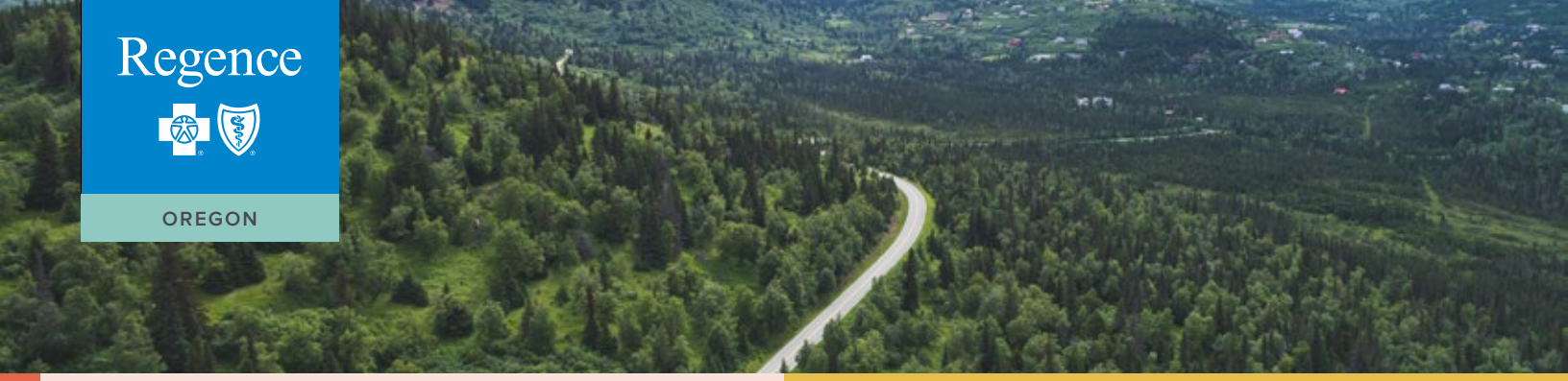

Regence

OREGON

The Connection

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

Talking to your patients about diabetes

According to the Centers for Disease Control and Prevention (CDC), more than 37.3 million people in the U.S. have diabetes, and 1 in 5 of them don't know they have it. The U.S. Preventive Services Task Force (USPSTF) recommends that providers consider screening non-pregnant patients ages 35 to 70 who are overweight or obese and have no current symptoms of diabetes.

Disparities in diabetes prevalence disproportionately affect some racial and ethnic minority groups and groups with lower socioeconomic status and, therefore, clinicians should consider screening at an earlier age or lower BMI for these patients as appropriate. For valuable information to help support health equity in your practice, read the USPSTF's *Final Recommended Statement Prediabetes and Type 2 Diabetes: Screening*, available at **uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes#bootstrap-panel--6**.

In addition to diagnosing diabetes, providers play an important role in helping their patients manage their diabetes—whether their patients are newly diagnosed or have been living with diabetes for a while. We encourage you to discuss the importance of diabetes management with your patients, including eating well, getting regular exercise, controlling blood sugar levels, scheduling eye exams and discussing ways to keep their feet healthy.

Best practices for diabetes management in the primary care office

- Leverage your electronic health records and use registries and prompts to alert providers and staff when it's time to order recommended diabetic screenings and tests (e.g., A1c, urine microalbumin, lipid panel, eye exam, foot exam).
- Consider support staff that can help with outreaching to patients who are due for diabetic screenings and tests.
- Complete diabetic labs and screenings in the primary care office during the office visit to ensure that patients due for screenings or tests get the care they need.
- Utilize clinical pharmacists to help manage patients who may need more support managing their diabetes.

CONTINUED ON PAGE 3

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.

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.

Contents

- Critical update
- Dental must read
- Radiology must read
- DME must read

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

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.

Regence

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 at **availity.com**.

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.

Disclaimer

CVS Caremark, Doctor on Demand Inc., DispatchHealth, Great Call Inc., MDLive Inc. and Papa Inc. do not provide BlueCross BlueShield services and are separate companies solely responsible for their products/services.

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Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

CONTINUED FROM PAGE 1

- Consider additional resources that patients may need to help manage their diabetes (e.g., health coaches, diabetic specialists, nutritionists).

Resources

The Healthwise Knowledgebase has several helpful resources for you and your patients:

- ***Diabetes Care Plan***: This can be shared with your patients and includes a list of what to bring to every appointment; current measurements for weight and blood pressure; home blood glucose testing goals; recent test results (e.g., A1c and cholesterol); and tests to schedule (e.g., foot exams and eye exams).
- ***Taking Medicines as Prescribed***: This content can help you discuss the importance of medication adherence with your patients.
- ***Dilated Eye Exam***: This content includes information about the exam (i.e., how it is performed and what to expect after the test).

For copies of these Healthwise materials, available in English and Spanish, email **Quality@regence.com**.

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. Learn about the programs we offer on our provider website: Programs>Medical Management> Diabetes Management.

Blue Cross and Blue Shield Federal Employee Program® (BCBS FEP®) Standard Option and Basic Option members can participate in the Diabetes Management Incentive Program. This program is designed to help educate and support members who take an active role in managing their diabetes. Learn more at **fepblue.org/diabetes**.

Do our publications meet your needs?

Do our publications meet your needs? Take a few minutes to share your feedback about our newsletter and bulletin by completing this short survey before December 31, 2022.

SHARE YOUR FEEDBACK

Thank you in advance for your time and input!

COVID-19 updates

As we enter the winter months, experts are predicting another surge of COVID-19 cases in the United States. We will continue to update the COVID-19 section of our website to make sure you have the latest COVID-19-related information and helpful resources. In addition, we will include updates in future issues of this newsletter.

Note: When we learn that the COVID-19 federal public health emergency is ending, we will provide as much notice as possible about any changes to members' benefits or provider reimbursement.

Updated after-hours availability requirement

We require all providers to meet our appointment accessibility and availability standards to ensure that our members–your patients–have access to quality care. This includes minimum requirements to provide or arrange for covered services to members on a 24/7 basis.

We have changed our appointment accessibility and availability standards related to after-hours care to improve understanding and compliance with the requirement. Please review this new standard and, if necessary, take steps to make sure that your office meets the requirements.

After-hours answering systems

To assist our members in accessing services after their provider's regular office hours, please instruct your patients about options for after-hours care. This coverage could include:

- An answering service that can contact the on-call provider or another designated network provider
- An on-call pager
- Call forwarding to the provider's home or other location
- A recorded phone message with instructions that direct the member to a provider for instruction in after-hours care; please avoid giving direction to another recording
- An after-hours recording on the office phone that instructs members to call 9-1-1 or go to a hospital emergency room (ER) for needed emergency services

You can view all of our accessibility and availability standards on our provider website: Programs> Cost & Quality>Quality Program>Accessibility & Availability Standards.

Attend our upcoming webinars

We encourage you to join us for one or more of the following webinars.

Idaho medical providers: Medicare Advantage (MA) Quality Incentive Program (QIP): Medication adherence and statins

Tuesday, December 6, 2022, 11 a.m. (PT)/ 12 p.m. (MT) (45-minute webinar): Learn about gap closure, best practices and member experience related to medication adherence and statin measures for our MA QIP.

REGISTER

All medical providers: Newsletter topics

Thursday, December 8, 2022, 10a.m. (PT)/ 11 a.m. (MT) (30-minute webinar): Learn about some of the most important topics addressed in this issue of our newsletter, *The Connection*.

Our provider relations executives will discuss the following topics:

- Administrative changes/updates
  - Claims that span calendar years
  - Provider appeals to require submission on Availity
  - 2023 code changes
  - FEP direction of pay updates
- Follow-up clinical requests for radiology services
- Prescription updates
  - Pegfilgrastim
- Behavioral health updates
  - New authorization forms for applied behavioral analysis (ABA) and transcranial magnetic stimulation (TMS) services
- Talking to your patients about diabetes
- Help your patients stop smoking

REGISTER

All medical providers: Provider website

Thursday, January 12, 2023, 10 a.m. (PT)/11 a.m. (MT) (60-minute webinar): Learn about navigating the provider website.

REGISTER

You'll be able to submit questions throughout the webinars via the chat box.

Administrative Manual updates

The following updates were made to our manual on December 1, 2022:

Facility Guidelines

- Added information about claims that span calendar years

Medical Management

- Updated information about diabetes prevention and maintenance programs

Provider Appeals

- Added requirement to submit provider appeals via Availity Essentials effective March 1, 2023

Our Administrative Manual is available on our provider website.

Editor's note (updated February 13, 2023): The incorrect vendor information was initially published for implanted device audits.

Implanted device, ED and DRG audits begin in 2023

For services delivered on or after March 1, 2023, we will conduct post-payment review of implanted devices, emergency department evaluation and management (ED E&M) and diagnosis-related group (DRG) claims for pricing and payment accuracy.

Performant will perform ED E&M or DRG audits. CERIS will perform implant audits. They will contact your office if your claim is selected for this review:

- To validate the services billed on the claim
- To verify the pricing method applied is correct
- To verify the payment rendered is appropriate to the member's benefits

If you disagree with our vendor's findings, you can appeal to vendor. Their contact information is provided on the determination letter. We will request recoupment via adjustment of a future claim payment.

These reviews will be conducted for our commercial, Medicare Advantage and Uniform Medical Plan (UMP) plans.

Battery code to be added to NRS list

Effective March 1, 2023, we will add HCPCS A4611 to our non-reimbursable services (NRS) list for commercial, Medicare Advantage and UMP claims. This durable medical equipment (DME) code will be added to the *Clinical Edits by Code List* on the Coding Toolkit section of our provider website. This change is supported by our *Non-Reimbursable Services* (Administrative #107) reimbursement policy.

Changes to ambulance reimbursement

Reimbursable ambulance services provided on or after March 1, 2023, will be limited to the base fee for transportation and mileage. Services including—but not limited to—oxygen, medications, additional attendants, supplies, electrocardiograms (EKGs) and night differentials will be denied when billed as part of an ambulance transportation service.

This change applies to claims for members with our commercial, Medicare Advantage and UMP plans.

More information

- Chapter 15 of CMS' *Medicare Claims Processing Manual*: **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf**
- Our *Ambulance Guidelines* (Administrative #121) reimbursement policy, available on our provider website: Policies & Guidelines> Reimbursement Policy

Changes to DME codes with no fees

Effective March 1, 2023, we will make the following reimbursement changes to DME:

- HCPCS E0118 (crutch substitute) and K0891 (pediatric power wheelchair) rental reimbursement rates will be reduced.
- The following HCPCS codes will no longer be reimbursable when billed with rental modifier RR: A4206-A4209, A4211, A4213, A4215, A4218, A4281-A4286, A4600, A4606, A4627, A4660, A4663, A4670, A6198, A6206, A6208, A6213, A6215, A6250, A6261, A6530, A6533-A6541, A6545, A9274, A9276-A9278, A9282, A9283, E0240, E0241, E0243-E0245, E0247, E0248, E0445, E0486, E0603, E2291-E2294, E2331, L3202, L3203, L3206, L3208, L3209, L3211, L3215, L3216, L3219, L3221, L3222, L3260, L3265, L8010, L8692, S1040, S8265, S8420-S8428, V5011, V5014, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5100, V5110, V5120, V5130, V5140, V5150, V5160, V5171, V5172, V5181, V5190, V5200, V5211-V5215, V5221, V5230, V5240-V5261, V5264, V5266, V5268-V5273, V5275, V5281-V5290 and V5336

2023 brings code changes for many services and supplies

Please remember to review your 2023 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

You can purchase the:

- CDT manual by calling the American Dental Association at 1 (800) 947-4746 or online at **store.ada.org**
- CPT and HCPCS manuals through your preferred vendor or online through the American Medical Association (AMA) at **commerce.ama-assn.org/store**

Reimbursement information is available on Availity Essentials.

This notice serves as an amendment to your participating agreement. You have the right to terminate your agreement in accordance with the amendment provisions of the participating agreement.

2023 VBA risk adjustment methodology

Effective January 1, 2023, we will use the Milliman Advanced Risk Adjusters (MARA) tool to risk adjust claims payment levels under our value-based agreements (VBAs) to reflect the underlying health status of providers' attributed members.

We will continue to use concurrent risk scores. Concurrent risk scores adjust for expected claims in the period being measured, rather than predicting future claims. Concurrent risk scores are generally more accurate than prospective risk scores and better adjust for year-over-year market fluctuations (e.g., pandemic flu).

Learn more about VBA risk adjustment methodology on our provider website: Contracting & Credentialing> VBA Resources.

Supporting our dental networks with USAble Life

We are committed to providing top-tier dental care to our members. To best serve our members and participating dental providers, we are partnering with USAble Life to support our Regence dental networks in early 2023.

Under this partnership, USAble Life will provide the administration for Regence dental networks, including:

- Credentialing and contracting
- Reimbursement schedules
- Provider data management

We will also launch a new dental-specific website to give you access to credentialing and contracting information, dental policies, forms, resources and who to contact for support. **Note**: Dental providers should continue to use Availity Essentials to access eligibility, benefits and claims-related information.

Additional information will be published in the February 2023 issue of this newsletter.

Claims that span multiple years

Centers for Medicare & Medicaid Services (CMS) coding guidelines require institutional claims that span from one calendar year to another to be split into separate claims by year. This allows proper processing of all aspects of the claim. CMS' general guidance is:

FL 6. Statement covers period (from - through)

- These fields cannot exceed eight positions in either "from" or "through" portion, allowing for separations (non-numeric characters) in the third and sixth positions.
- The "from" date must be a valid date that is not later than the "through" date.
- The "through" date must be a valid date that is not later than the current date.

Facility claims (ANSI 837I claims) that span from one calendar year to the next (e.g., December 28, 2022, to January 3, 2023) will be denied automatically if they are submitted on the same claim. The following claim types are exceptions that do not need to be split:

- Home health prospective payment system (PPS) claims
- Outpatient hospital observation or emergency room visits
- Facility inpatient claims

The Facility Guidelines section of our Administrative Manual was updated on December 1, 2022, with this information.

Out-of-network BCBS FEP claims direction of pay

Beginning April 2023, FEP claims submitted by out-of-network providers will be paid directly to the provider for all provider types. **Note**: If a member submits an FEP claim, payment will be made directly to the member.

Compliance program requirements

We want to remind you that all providers and their staff, including any board or trustee members, must meet our Government Programs compliance requirements, including monthly verification that they are not on an exclusion list and that they are completing annual trainings about compliance and fraud, waste and abuse (FWA).

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 (QHPs). 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.

Exclusion lists

All Medicare- and QHP-contracted providers, medical groups, facilities and suppliers are required to check the Office of Inspector General (OIG) and General Services Administration (GSA) federal exclusion lists for all employees prior to hire and monthly thereafter. If an employee is confirmed to be excluded, they must immediately be removed from working on our government programs. We are prohibited from paying government funds to any entity or individual found on these federal lists:

- GSA exclusion list: **sam.gov/content/exclusions**
- OIG exclusion list: **oig.hhs.gov/exclusions**

Documentation of these verifications must be maintained and made available upon request by either Regence or CMS. We ask contracted entities to verify that the entity is compliant with this requirement during initial credentialing and at recredentialing.

Required compliance training

FWA and general compliance trainings are a contractual requirement for participation in our Medicare Advantage and QHP networks. This training must be completed within 90 days of hire and annually thereafter.

Please ensure that your staff complete required training and maintain documentation for auditing purposes.

Compliance for board and/or trustee members

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 OIG and GSA screenings prior to appointment and monthly thereafter
- Completing FWA and general compliance training within 90 days of appointment and annually thereafter

Documentation must be maintained and made available upon request by either Regence or CMS.

Learn more

More information about our compliance program and related resources are available on our provider website:

- Products>Medical>Medicare>Medicare Compliance Training
- *Government Programs Compliance Tips* flyer: Forms & Documents
- Administrative Manual
  - Qualified Health Plans
  - Medicare Advantage Compliance Requirements

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: **nppes.cms.hhs.gov/**.

Provider appeals must be submitted via Availity

Effective March 1, 2023, we will require all post-service provider appeals to be submitted using the Appeals application on Availity Essentials.

The only disputes and appeals that **should not be** submitted via Availity Essentials are:

- Pricing disputes, which are not appeals and are subject to a separate pricing dispute process
- Disputes that meet our "extenuating circumstances" criteria, which must be submitted via fax
- Appeals that Availity cannot process because of file size limits, which may be submitted via our secure file transfer protocol

Providers must submit all other provider appeals via the Availity Essentials Appeals application. Provider appeals sent via an improper method will be returned to the provider with directions to submit using the Appeals application on Availity Essentials.

The Appeals application is a more efficient way of receiving appeals and communicating determinations to providers. The application:

- Streamlines the appeals process by making it easy to submit appeals directly from the Claim Status screen
- Gathers all required information about the claim being disputed
- Prevents duplicate appeals submission

The Appeals dashboard shows the status and history of submitted appeals, eliminating the need for providers to contact us for status information.

Appeals application and exception criteria

Learn more about the Appeals application and view our exception criteria on our provider website: Claims & Payment>Receiving Payment> Pricing Disputes & Appeals.

Accessing the Appeals application

The Appeals application is available on Availity Essentials: Claims & Payments>Appeals. If you do not have access to the Appeals application, please contact your Availity Essentials administrator and request the Claim Status role.

Training resources

View guides on Availity Essentials: Help & Training> Find Help>Appeals. A recorded training demonstration is also available by searching for Appeals: Help & Training>Get Trained.

HMA and RGA reminders

As a participating Regence provider, you may see members from other companies that we partner with, including Healthcare Management Administrators (HMA) and Regence Group Administrators (RGA).

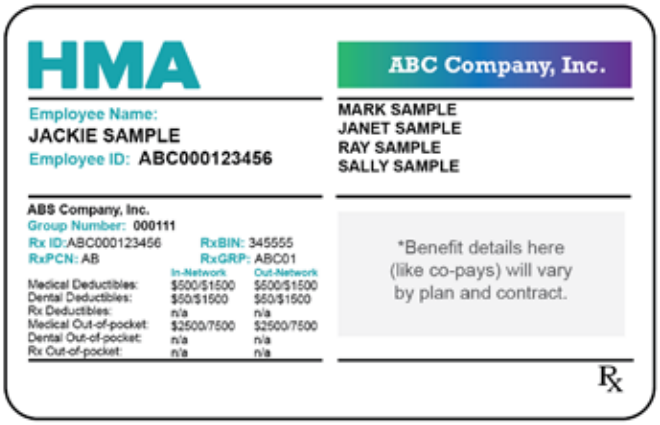
Provider networks

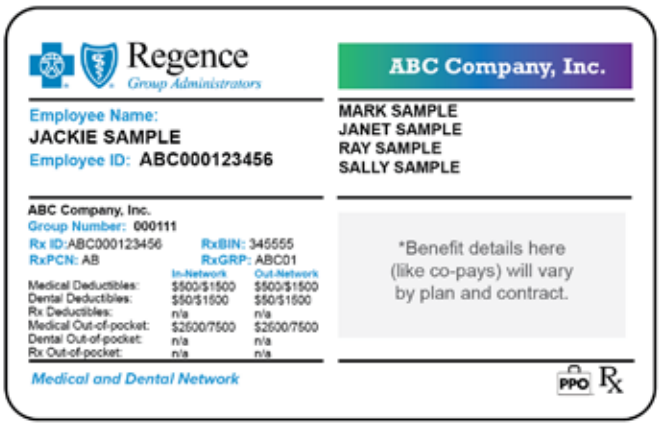
Regence provider networks and contracted rates support HMA and RGA as shown below.

	Regence BlueShield of Idaho	Regence BlueCross BlueShield of Oregon	Regence BlueCross BlueShield of Utah	Regence BlueShield
HMA	• Preferred	• Preferred	• Participating	• Preferred
RGA	• Preferred	• Preferred	• Preferred • ValueCare	• Preferred

Identifying members

Easily identify HMA or RGA members by the logo on the front of their member ID card.





Obtaining pre-authorization, eligibility or claims status

Access the link to HMA's and RGA's secure portals on their websites:

- HMA: **accesshma.com/for-providers**
- RGA in Oregon and Utah: **or.accessrga.com/for-providers**
- RGA in Washington and Idaho: **wa.accessrga.com/for-providers**

Submitting claims

Submit claims electronically for your HMA or RGA patients using Availity Essentials.

- **HMA payer ID**: HMA01
- **RGA payer ID**: RGA01

Receiving vouchers and payment

HMA and RGA will send vouchers and reimbursement checks. Claims information and vouchers for your HMA or RGA patients are available on Availity Essentials.

Contact

Visit the HMA and RGA websites, listed above, or contact Customer Care:

- **HMA**: 1 (800) 869-7093
- **RGA**: 1 (866) 738-3924

Bill & Melinda Gates Foundation moving to RGA in January

Effective January 1, 2023, the Bill & Melinda Gates Foundation (group #020541), a self-funded employer group headquartered in Washington, will transition from Regence BlueShield to RGA, **wa.accessrga.com**.

RGA is a wholly owned subsidiary of Regence that provides third-party administrative services to self-funded employer groups. RGA will provide claims administration.

Quantum Health, **quantum-health.com**, will be the single point of contact for eligibility, benefits and claims inquiries for members and providers. In addition, Quantum Health will provide medical management, including pre-authorization and utilization review, for these members.

For dates of service on and after January 1, 2023, the following will apply to the foundation members.

Group number

Each entity for the foundation will have a new group number:

- **Bill & Melinda Gates Foundation**: 020541A
- **Bill & Melinda Gates MRI**: 020541B
- **Bill & Melinda Gates Ag One**: 020541C

Identifying members

Easily identify members of the foundation by the RGA logo and foundation references on their ID cards.

Front of card

Back of card

Eligibility, benefits, claim status and medical management

Verify eligibility by submitting an ANSI 270 transaction (eligibility) to RGA.

Access member eligibility and benefits, claim information and pre-authorizations via the Quantum Health provider resource portal at **ccbyqh.com**. You may also call Quantum Health at (888) 417-4919.

Note: Pre-authorizations submitted before January 1, 2023, for dates of service on or after January 1, 2023, will be transferred from Regence to Quantum Health.

Submit claims

Submit claims for these patients with your other RGA patients electronically to Availity Essentials with Payer ID Code: ID RGA01. Payment will be sent to providers from RGA.

Quantum Health will provide education and gathering of pertinent information for subrogation claims.

Appeals

Quantum Health will support provider appeals.

Customer Service

Quantum Health is available at:

- **Providers**: (888) 417-4919
- **Members**: (866) 989-3036

Pharmacy benefits

CVS Caremark will administer the pharmacy benefits for retail and mail order prescriptions.

Pre-authorization updates

Medicare Advantage	
Procedure/medical policy	**Added codes effective November 1, 2022**
Transcatheter Heart Valve Procedures (Surgery #221)	• 0484T
Procedure/medical policy	**Added codes effective December 1, 2022**
Genetic and Molecular Diagnostics – Next Generation Sequencing and Genetic Panel Testing (Genetic Testing #64)	• 0288U

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

Biomarker testing exempt from pre-authorization in Washington

Engrossed Substitute House Bill (HB) 1689 requires health plans issued or renewed in the state of Washington on or after January 1, 2023, to exempt biomarker testing from pre-authorization for fully insured members with:

- Stage 3 or 4 cancer; or
- Recurrent, relapsed, refractory or metastatic cancer

The biomarker testing must be:

- Recommended in the latest version of nationally recognized guidelines or biomarker compendia
- Approved by the FDA or a validated clinical laboratory test performed in a clinical laboratory certified under the Clinical Laboratory Improvement Amendments or in a CMS-approved laboratory program
- A covered service
- Prescribed by an in-network provider

Notes:

- HB 1689 does not mandate coverage of biomarker testing.
- A health plan may require a biomarker test prior to approving a drug or treatment.
- CPT 81401-81408 and 81479 may require pre-authorization; please review our pre-authorization lists for all updates and pre-authorize services accordingly.

Our commercial and UMP Pre-authorization lists have been updated to reflect this exemption.

Specialty medication pre-authorization updates

Effective March 1, 2023, HCPCS J0219 and J9144 will be added to the pre-authorization lists for CHG Healthcare Services (group #70000004) 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.

Reminder: Fax additional form with gastrointestinal requests

Our *Surgical Site of Service – Hospital Outpatient* (Utilization Management #19) commercial and Medicare Advantage medical policies require pre-authorization for gastrointestinal procedures performed at a hospital outpatient place of service:

- **Colonoscopy**: CPT 45378-45381, 45384-45386, 45390 and 45398
- **Endoscopy**: CPT 43235-43239, 43242, 43245-43251 and 43254

As a reminder, providers faxing these pre-authorization requests should include the *Surgical Site of Service Additional Information Form*, available on our Pre-authorization lists. Failure to submit this form will delay review of faxed requests.

Requests submitted through Availity Essentials do not require the attestation form because the process incorporates additional questions related to site of service.

Changes to radiology program

Requests for supporting documentation

Beginning March 1, 2023, AIM Specialty Health (AIM) may request additional clinical information for radiology pre-authorization requests for commercial members.

If requested, providers will need to submit documentation from the patient's medical record to ensure services are clinically appropriate. AIM will request this documentation only for select procedures when certain clinical indications are present.

AIM revising clinical guidelines

Effective April 9, 2023, AIM will revise the following radiology guidelines:

- Imaging of the Brain
- Imaging of the Head and Neck
- Imaging of the Chest
- Imaging of the Abdomen/Pelvis
- Oncologic Imaging
- Cardiac Imaging
  - Stress testing with imaging
  - CT coronary angiography (CCTA)
  - Fractional flow reserve from CCTA (FFR-CT)
  - Stress cardiac MRI
  - Resting cardiac MRI
  - Resting transthoracic echocardiography (TTE)

View the revised guidelines: **aimguidelines.wpengine.com/category/coming-soon**.

Fewer imaging services to require an order number

Ordering providers may notice in 2023 that fewer advanced imaging services require an order number from AIM. Providers should continue to check Availity Essentials to determine whether services for a particular member require an order number.

AIM will continue to review radiology requests for medical necessity.

View a complete list of codes included in our radiology program on our Pre-authorization lists.

In-home sleep studies will no longer require pre-authorization

In-home sleep studies performed on or after January 1, 2023, will no longer require pre-authorization. Facility-based sleep studies will continue to require pre-authorization.

Our Sleep Medicine program, managed by AIM, improves clinical appropriateness of sleep testing and therapy services, and helps members find the highest-value place of service for these services.

Cardiac program launching

As a reminder, non-emergency cardiac services for fully insured commercial and Medicare Advantage members delivered on or after January 1, 2023, will require pre-service medical necessity review through AIM.

Providers can begin contacting AIM on December 19, 2022, for these services using AIM's ProviderPortal, **providerportal.com**, or by calling AIM at (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT).

Program details are available on our provider website: Programs>Medical Management>Cardiology.

Services requiring review

Contact AIM to obtain an authorization number for the following non-emergency, outpatient cardiac tests and procedures:

- Diagnostic coronary angiography with or without right or left heart catheterization
- Arterial duplex
- Physiologic study arterial
- Percutaneous coronary intervention (e.g., coronary stents and balloon angioplasty and atherectomies); post-service review will be performed within 10 days of the service

The following cardiograph services will continue to require pre-authorization as part of our radiology program:

- Stress echocardiography (SE)
- Resting echocardiography (TTE)
- Transesophageal echocardiography (TEE)

Resources and training

AIM has resources to help your practice get started with the cardiology program with useful information and tools, such as checklists and clinical guidelines: **aimprovider.com/cardiology**. To view upcoming webinars, click **Webinar Training Calendar**.

Admission and discharge notification

As a reminder, effective January 1, 2023, we will require notification of all admissions and discharges for hospitals and inpatient hospice within 24 hours. We will remove the 24-hour exemptions for holidays and weekends from our pre-authorization lists.

Continue to submit notifications as you do today.

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 October 2022 issue of *The Bulletin* about our new *Biofeedback* (Allied Health #32) medical policy, which is effective January 1, 2023.

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

All medical policies are available on our provider website: Policies & Guidelines>Medical Policy.

Reimbursement policy updates

We provided 90-day notice in the October 2022 issue of *The Bulletin* about the following reimbursement policies, which are effective January 1, 2023:

- *Cellular and Gene Therapy Products* (Medicine #112)
- *Diabetic Supplies* (Administrative #128)
- *DME Purchase and Rental Limitations and Reimbursement* (Administrative #131)
- *Non-Reimbursable Services* (Administrative #107)
- *Transportation of Portable X-Ray Equipment* (Administrative #147)

We provided 90-day notice in the November 2022 issue of *The Bulletin* about the following reimbursement policies, which are effective February 1, 2023:

- *Cellular and Gene Therapy Products* (Medicine #112)
- *Timely Receipt of Records* (Administrative #145)

Our reimbursement policies are reviewed on an annual basis.

View our *Reimbursement Policy Manual* on our provider website: Policies & Guidelines>Reimbursement Policy.

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

Reimbursement policy reminders

Billing for chiropractic and osteopathic treatments

We evaluate claims for proper reimbursement of chiropractic and osteopathic treatments based on coding guidelines, and diagnoses and documentation provided.

As a reminder, when billing for chiropractic and osteopathic treatments, all CPT codes must include a supporting ICD-10-CM diagnosis code for the level of care provided.

Note: If a claim has been submitted without the proper diagnosis code, you must submit a corrected claim to include the required diagnosis code rather than submitting an appeal.

Billing for allergy immunotherapy

As a reminder, for professional services of the provision of antigens for allergy immunotherapy, CPT 95165, units billed should reflect the actual number of doses the provider plans to administer as the patient's course of treatment when the antigen is initially prepared.

For more information, review our *Chiropractic and Osteopathic Treatments* (Administrative #138) and *Allergy Immunotherapy* (Administrative #100) reimbursement policies on our provider website: Policies & Guidelines>Reimbursement Policy.

Clinical Practice Guidelines update

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

We renewed the *Management of Heart Failure in Adults* Clinical Practice Guideline, effective October 1, 2022, and updated the hyperlink to the guideline with no changes to the guideline recommendation.

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 on the effective date of the addition or change.

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. 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 15, 2022	Description
New medication policy	
Pluvicto, lutetium Lu 177 vipivotide tetraxetan, dru722	• Limits coverage to patients with prostate-specific membrane antigen (PSMA)-positive, metastatic castration-resistant prostate cancer after progression of disease on taxane-based chemotherapy and at least one prior androgen receptor inhibitor
Revised medication policies	
Chimeric Antigen Receptor (CAR) T-cell Therapies, dru523	• Added coverage criteria for the use of Kymriah in relapsed or refractory follicular lymphoma, a newly FDA-approved indication; the criteria mirror the follicular lymphoma (FL) criteria for coverage of Yescarta • Added coverage criteria for the use of Breyanzi in relapsed or refractory diffuse large B cell lymphoma (DLBCL), a newly FDA-approved indication; the criteria mirror the DLBCL criteria for coverage of Yescarta • Use in patients who are transplant ineligible is considered investigational and cannot be covered because of the lack of meaningful health outcomes evidence
Opdivo, nivolumab, dru390	• Added coverage criteria for Opdivo as a combination therapy (with chemotherapy or Yervoy [ipilimumab]) for first-line treatment of locally advanced or metastatic esophageal squamous cell cancer (ESCC), based on new evidence and a new FDA-approved indication; limits coverage to ESCC that is not amenable to therapy with curative intent when used in the front-line setting in combination with standard-of-care chemotherapy or ipilimumab and when tumor PD-L1 expression is >1%
Prolia, denosumab, dru223	• Added criteria for coverage of "very-high risk of fracture," despite completion of a full course of an anabolic bone medication

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Effective October 15, 2022	Description
Revised medication policies (continued)	
Yervoy, ipilimumab, dru238	• Added coverage criteria for Yervoy in combination with Opdivo (nivolumab) for first-line treatment of locally advanced or metastatic ESCC based on new evidence and a new FDA-approved indication; limits coverage to ESCC that is not amenable to therapy with curative intent when used in the front-line setting in combination with nivolumab and when tumor PD-L1 expression is > 1% • Added use of Yervoy as a neoadjuvant therapy (prior to surgical excision) for resectable melanoma, either alone or in combination with other medications, as investigational; there is insufficient evidence to support this use at this time
Effective December 1, 2022	**Description**
New medication policies	
Rearranged During Transection (RET) Inhibitors, dru726	• New combination policy replacing individual policies for Retevmo (dru643) and Gavreto (dru653) with no change to criteria intent
Tyrosine Kinase Inhibitors (TKIs) for Gastrointestinal Stromal Tumors (GIST), dru725	• New combination policy replacing individual policies for Ayvakit (dru624) and Qinlock (dru644) with no change to criteria intent
Vijoice, alpelisib, dru730	• Limits coverage to patients with severe, life-threatening manifestations of PIK3CA-related overgrown spectrum (PROS) that are PIK3CA mutation positive, when prescribed in consultation with a specialist, when medical interventions (including sclerotherapy, surgery, laser, or radiotherapy) are not an option or have been ineffective, and prior therapy with sirolimus was ineffective, not tolerated or contraindicated
Ztalmy, ganaxolone, dru732	• Limits coverage to the treatment of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) when at least 2 prior anti-convulsants have been ineffective or not tolerated
Revised medication policies	
Dupixent, dupilumab, dru493	• Added coverage criteria for the newly FDA-approved indication for eosinophilic esophagitis (EoE). Limits coverage to patients with symptomatic biopsy-confirmed EoE steroids when prescribed by a specialist after highest tolerated dose of proton pump inhibitors (PPIs) and topical steroids have been ineffective or are contraindicated
Growth Hormone, dru015	• Simplified laboratory criteria for confirmation of growth hormone (GH) deficiency with no change to intent
Lynparza, olaparib, dru389	• Added coverage criteria for newly FDA-approved indication; limits coverage to patients with HER2-negative, early-stage breast cancer that is BRCA1/2 mutated, when prescribed by or in consultation with an oncologist, for patients who have previously received either neoadjuvant or adjuvant chemotherapy and are considered high risk
Non-preferred Testosterone Replacement Therapy Products, dru548	• Added newly FDA-approved testosterone undecanoate products (Tlando and Kyzatrex) to policy as non-preferred

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Effective December 1, 2022	Description
Revised medication policies (continued)	
Opzelura, ruxolitinib cream, dru679	• Use for the newly FDA-approved indication vitiligo will be considered cosmetic per contract definitions
Pituitary Disorder Therapies, dru488	• Added newly FDA-approved self-administered product Recorlev to policy; limits coverage to patients with endogenous Cushing's syndrome when prescribed by or in consultation with an endocrinologist, where surgery is not an option or has not been curative, and prior therapy with ketoconazole was ineffective • Added newly available generic single source lanreotide to policy; coverage aligns with brand Somatuline • Removed step through octreotide (Sandostatin LAR) in acromegaly for pediatric patients • Simplified initial authorization quantity limits on octreotide (Sandostatin LAR)
Tagrisso, osimertinib, dru441	• Broadened coverage for EGFR-susceptible mutations to include rare mutations based on National Comprehensive Cancer Network (NCCN) guideline updates
Tibsovo, ivosidenib, dru558	• Added coverage criteria for patients with newly diagnosed acute myeloid leukemia with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation, a newly FDA-approved indication
Trientine-containing Products, dru417	• Added newly FDA-approved Cuvrior (trientine tetrahydrochloride) to policy • The use of Cuvrior is considered not medically necessary and therefore not covered because of the lack of proven additional benefit versus lower-cost similar agents
Xalkori, crizotinib, dru265	• Added coverage criteria for immune myofibroblastic tumor (IMT)
Archived medication policy	
Vizimpro, dacomitinib, dru581	• Vizimpro will no longer require pre-authorization

Effective January 1, 2023	Description
Revised medication policies	
Non-preferred Intra-Articular Hyaluronic Acid Derivatives, dru351	• Adding Synojoynt (1% sodium hyaluronate) to policy as non-preferred
Non-preferred Pegfilgrastim Products, dru563	• Adding newly approved biosimilar Stimufend (pegfilgrastim-fpgk) to policy as non-preferred • **Related**: See *Pegfilgrastim coverage change* on page 17.

Effective March 1, 2023	Description
Revised medication policies	
Medications for Hereditary Angioedema (HAE), dru535	• Clarifying criteria for acute treatment • Removing requirement for step therapy through attenuated androgens • Adding step therapy requirement for Ruconest through Berinert • Adding Sajazir (icatibant) to policy
CDK 4/6 Inhibitors for Breast Cancer, dru611	• Removing step therapy requirement on Kisqali • Adding step therapy requirement for Ibrance through Kisqali or Verzenio

Pegfilgrastim coverage change

As a reminder, **beginning January 1, 2023, Fulphila and Ziextenzo will be our preferred pegfilgrastim products; they will be the only pegfilgrastim products that do not require pre-authorization**.

Note: This change does not impact BCBS FEP members.

Pegfilgrastim pre-authorization (PA) requirements effective January 1, 2023

Medication	PA required?	HCPCS code
Fulphila (pegfilgrastim-jmdb)	No	Q5108
Ziextenzo (pegfilgrastim-bmez)	No	Q5120
Nyvepria (pegfilgrastim-apgf)	Yes	Q5122
Fylnetra (pegfilgrastim-pbbk)	Yes	unlisted
Stimufend (pegfilgrastim-fpgk)	Yes	unlisted
Udenyca (pegfilgrastim-cbqv)	Yes	Q5111
Neulasta (pegfilgrastim)	Yes	J2506
Neulasta Onpro (pegfilgrastim)	Yes	J2506

If your patient has an existing pre-authorization for one of the non-preferred medications (e.g., Neulasta) that extends past January 1, 2023, you do not need to submit a new pre-authorization request.

Members who currently use Udenyca will not be grandfathered. To continue to use pegfilgrastim without pre-authorization, you can prescribe either Fulphila or Ziextenzo. If the preferred products are not a treatment option and your patient needs to continue Udenyca beyond December 31, 2022, you must submit a pre-authorization request.

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

Related: See *Medication policy updates* on page 16.

Avoid antibiotics for acute bronchitis and bronchiolitis

Over-prescribing antibiotics can have detrimental effects on the overall population and individuals, resulting in an increase of antibiotic-resistant infections and exposing people to avoidable adverse events. The CDC reports that more than 2.8 million antibiotic-resistant infections occur in the U.S. each year, and more than 35,000 people die as a result.

Acute bronchitis/bronchiolitis is a common condition that is generally self-limiting yet is often inappropriately treated with antibiotics.

A Healthcare Effectiveness Data and Information Set (HEDIS®) measure was created to monitor the antibiotic prescribing rate for acute bronchitis/bronchiolitis. This measure reports the percentage of members three months and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription on the date of diagnosis or within three days of diagnosis. A higher rate indicates appropriate treatment for the condition (i.e., the percentage of episodes that were not prescribed an antibiotic).

Our providers rate well on the HEDIS measure for treating upper respiratory infections, but there is opportunity to improve rates for treatment for acute bronchitis and bronchiolitis. Our data indicates that more than 50% of acute bronchitis and bronchiolitis cases are not treated appropriately. Please consider this in your approach to treating acute bronchitis and bronchiolitis. Here are a few best practices to follow:

- Help patients and caretakers understand the difference between bacterial and viral infections.
- Educate patients and caretakers on home treatment to relieve acute bronchitis/bronchiolitis symptoms.
- For patients with a comorbid condition requiring an antibiotic prescription, be sure that documentation and coding accurately reflect the diagnosis code for the comorbid condition (or bacterial infection). Some examples of comorbid conditions include HIV, malignant neoplasm, emphysema, chronic obstructive pulmonary disorder (COPD) and immune system disorders.

If you would like copies of our *Using Antibiotics Wisely* and *Treatment for Acute Bronchitis/Bronchiolitis* flyers, available in English and Spanish, email us at **Quality@regence.com**.

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.

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

New forms for ABA and TMS services

New forms are now available for ABA and TMS pre-authorization requests:

- *Applied Behavioral Analysis (ABA) Initial Request Form*
- *Applied Behavioral Analysis (ABA) Concurrent Request Form*
- *Transcranial Magnetic Stimulation rTMS Request Form*—for both initial and concurrent TMS requests

These forms replace our previous *Behavioral Health Pre-Authorization Request Form* and are available in the Forms & Documents section of our provider website.

Peer support program launching soon

Hospitals and freestanding facilities can begin referring Regence BCBSO Medicare Advantage HMO and PPO members younger than 65 to our peer support program beginning December 15, 2022.

Peer support offers acceptance and validation to people recovering from mental health conditions and substance use disorders (SUD). It allows people with lived experience to help others develop goals and strategies through non-clinical, strengths-based support. Peer support is evidence-based, demonstrating specific improvements in patient engagement and treatment retention.

We encourage providers to consider referring their eligible Regence BCBSO MA HMO and MA PPO patients to this supportive program. To refer a member to our peer support program, call our Provider Contact Center.

AbleTo offers personalized virtual therapy

Members 18 and older can access AbleTo's Therapy+ program, a structured, eight-week series of one-on-one therapy by phone or video with a licensed therapist and digital tools for support between sessions. People who have used AbleTo's services have reported clinically significant declines in depression, anxiety and stress, as well as dramatic improvements in workplace productivity.

This virtual cognitive behavioral therapy (CBT) program helps patients recognize and change behavior patterns. In 2023, AbleTo will add a digital self-help program available 24/7 to its Therapy+ program.

In addition to Therapy+, some administrative services only (ASO) groups offer AbleTo's Therapy360 program, which includes weekly therapy and behavioral health coach sessions. It supports people with behavioral health needs who are managing another chronic health condition, such as diabetes or heart disease.

AbleTo's programs include the option for additional care, if needed; follow-up assessments; and self-care tools.

Providers and members can search "AbleTo" in our Find a Doctor tool for contact information.

Members can also learn more about the program and schedule their first appointment at **ableto.com**.

Behavioral health facility credentialing

Effective immediately, behavioral health agencies and facilities specializing in crisis services are eligible to apply for credentialing and contracting in Washington state. This includes providers in Clark, Asotin and Garfield counties. Our organizational credentialing criteria will be updated to reflect this change.

As a reminder, we require behavioral health facilities providing residential, substance use and alcohol and drug treatment to meet at least one of the following requirements:

- State licensure and/or certification (if applicable)
- Accreditation designation for the covered level of service being provided

We require all providers to meet our credentialing criteria prior to contracting and to remain in compliance with those criteria. *View our Organizational Credentialing Criteria for Participation and Termination* on our provider website: Contracting & Credentialing>Credentialing.

Get reimbursed for integrated care

We recognize the value of behavioral health integration (BHI) and encourage providers to participate in the Collaborative Care Model (CoCM) approach to treat and support members with complex needs.

According to the American Psychiatric Association (APA), among the BHI models, the CoCM has the most evidence demonstrating "its effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes and increasing patient satisfaction in a variety of primary care settings—rural, urban and among veterans."

The model consists of a team of three individuals delivering care: A PCP, a behavioral health care manager and a psychiatrist. Its integrated behavioral health services include the following types of care:

- Counseling
- Medication support
- Care planning for behavioral health conditions
- Ongoing assessment of the patient's condition
- Other recommended treatment, if needed

We encourage integration of behavioral health providers into primary care homes and reimburse behavioral health services provided in the primary care setting, including CoCM codes CPT 99492-99494 and HCPCS G2214.

Resources

- Review our *Collaborative Care Codes* (Behavioral Health #100) reimbursement policy on our provider website: Policies & Guidelines>Reimbursement Policy.
- The *Behavioral Health Integration Services* booklet from CMS discusses the roles of care team members and CoCM service components, as well as providing full code descriptors: **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf**.
- The APA has information about the CoCM and reducing inequities in care, as well as providing CoCM training for PCPs, behavioral health care managers and psychiatrists: **psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn**.

Help your patients stop smoking

Tobacco use is the leading cause of preventable disease, disability and death in the U.S., accounting for more than 480,000 deaths per year, according to the CDC. Cigarette smoking is linked to diseases of nearly all organs of the body, particularly cardiovascular, metabolic and pulmonary diseases.

As a health plan, the rate at which our members are advised to quit smoking is measured. Currently, our score for this measure is lower than national benchmarks, indicating that this is an area of opportunity for us. Our providers play a key role in helping patients decrease tobacco use by encouraging them to use smoking cessation tools and resources.

A team approach is the best way to treat tobacco use and dependence. Integrating treatment into the routine clinical workflow and engaging the entire health care team in treatment delivery can make a difference. Here are some suggestions:

- Advise patients to quit.
  - Talk to patients at every visit about their tobacco use. Even brief advice can influence a patient's decision to quit smoking.
  - Advise patients that quitting is one of the most important things they can do to improve their health and prognosis.
  - Remind patients that it is never too late to quit smoking. Quitting is beneficial at any age.
  - Provide patients support, regardless of their readiness to quit.
- Offer a combination of counseling and medications for treatment.
- Refer patients to additional support (e.g., cessation resources and programs in your health system and community).
- Follow up.
  - Assess your patients' progress over time and provide additional support. It may take several attempts for them to quit smoking.
  - Try new strategies (e.g., new medications the patient hasn't tried, medication combinations or new approaches to handling triggers).
  - Provide ongoing support to encourage members to quit.

Resources

Healthwise Knowledgebase flyers

The Healthwise Knowledgebase has several helpful resources for you and your patients:

- *Quitting Smoking: My Quit Plan*
- *Quitting Smoking: My Reasons to Stop*
- *Quitting Smoking: Track Your Triggers*
- *Smoking: Should I Take Medicine to Quit*

The flyers are designed to reinforce learning objectives after a coaching encounter. They use motivational interviewing and behavioral science techniques to help members. They can also be made available for patients to review in the waiting room before an appointment. For copies of these Healthwise materials, available in English and Spanish, email **Quality@regence.com**.

CDC website

The CDC also has information about tobacco use, including resources to help people quit using tobacco: **cdc.gov/chronicdisease/resources/publications/factsheets/tobacco.htm**.

Tobacco cessation resources for Blue Cross and Blue Shield Federal Employee Program members

The BCBS FEP tobacco cessation program helps members quit smoking by providing tools and resources to keep them motivated along the way. When members enroll in the Blue Cross and Blue Shield Service Benefit Plan Tobacco Cessation Incentive Program, they receive daily tips and support from the Online Health Coach and free tobacco cessation drugs. They may also be eligible to earn wellness incentives. FEP Blue Focus, Basic Option and Standard Option members can attend smoking and tobacco cessation classes at no charge when provided by a preferred provider. The program also covers nicotine dependence on e-cigarettes.

To participate, members will need to:

- Set a goal to quit with an online health coach at **fepblue.org** by selecting a quit date within the benefit year and completing all seven quit plan questions.
- Obtain a prescription from their provider for their eligible tobacco cessation drugs, including over-the-counter (OTC) products, after completing step one above.
- Pick up their free medication at a preferred retail pharmacy. Members should allow 7 to 10 days after they set their goal before visiting the pharmacy.

The following prescription drugs and OTC products are covered through this program when members use a preferred retail pharmacy:

- **Generic drugs**
  - Bupropion ER, 150 mg tablet
  - Bupropion SR, 150 mg tablet

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- **Brand-name drugs**
  - Chantix, 0.5 mg tablet
  - Chantix, 1 mg continuing month pack
  - Chantix, 1 mg tablet
  - Chantix starting month pack
  - Nicotrol cartridge inhaler
  - Nicotrol NS spray, 10 mg/ml
- **OTC products**
  - Nicorette gum
  - NicoDerm CQ patch
  - Commit lozenges

To receive benefits for OTC smoking and tobacco cessation drugs, members must have a physician's prescription for each OTC drug, which must be filled at a preferred retail pharmacy. Regular prescription drug benefits will apply to smoking and tobacco cessation drugs not meeting these criteria.

More information can be found at **fepblue.org**.

Help patients manage their weight

As a provider, you play a vital role in helping patients better understand how maintaining a healthy weight can reduce the risk of diseases and health conditions, including type 2 diabetes, heart disease, high blood pressure, arthritis, sleep apnea and stroke.

Patients may have a hard time talking about their weight. You may want to start with mentioning the health risks associated with obesity and being overweight and ask if you could talk to them about how weight impacts their overall health. Mental and emotional health are also factors in maintaining a healthy weight. Consider connecting patients to in-network behavioral health providers. Members can find in-network behavioral health providers and vendors that offer virtual care services by logging in to their member account on **regence.com**. **Related**: See *On-demand care options* on page 22.

Measuring your patients' body mass index (BMI) regularly may help you identify who may benefit from weight loss information and counseling. Your electronic medical record system may include an alert that will automatically calculate the BMI. When coding for obesity, code for both the obesity diagnosis (e.g., ICD-10 E666.1-E666.3, E666.8 and E66.9), as well as the BMI Z codes.

The Healthwise Knowledgebase has several helpful resources for you and your patients. For copies of Healthwise materials about weight management, available in English and Spanish, email **Quality@regence.com**.

Changes to DME coverage for CGMs

As a reminder, DME coverage for continuous glucose monitors (CGMs) will transition to a pharmacy-only benefit in 2023. This change will apply to fully insured Individual and group members with both medical and pharmacy benefits through Regence.

As plans renew on or after January 1, 2023, medical benefits will state that non-therapeutic CGM machines are excluded as a treatment option and cannot be billed as medical. Pharmacy benefits will also only cover therapeutic machines and supplies.

- Beginning January 1, 2023, Medtronic will no longer be a covered CGM supply brand.
- Dexcom and Freestyle Libre are comparable products and can be conveniently purchased from a pharmacy without pre-authorization.
- Members using a Guardian CGM will need to switch to Dexcom or Freestyle Libre by January 1, 2023, and members will need to request a new pharmacy prescription from their provider.

Exceptions:

- Children younger than six who meet criteria for an insulin pump
- Certain ASO groups with customized benefits that have elected to include DME coverage under their medical benefit

Simplifying formulary tier names

Drug tier names have historically described the category of medications found in each tier, such as generic, brand and specialty. However, basing formulary design on value and efficacy rather than drug category allows for more flexibility in formulary design to provide the highest value medications for members while containing medication costs. Effective January 1, 2023, tiers will no longer be categorized by type and may include both brand and generic medications, depending on efficacy and value.

On-demand care options

We offer members several options for access to medical care via phone, video, chat or at the member's location. These options can be affordable alternatives to the ER or urgent care for some health needs.

Our members have coverage for telehealth services provided through in-network providers. In addition, we contract with vendors to provide members on-demand urgent, primary and behavioral health virtual care options.

Doctor on Demand and MDLIVE are national telehealth vendors that provide urgent medical care services, 24/7/365, across all 50 states, as well as scheduled behavioral health services for talk therapy and psychiatry. All providers are licensed and board certified. Available via audio or video, Regence members can access these services using a web browser or mobile device. The telehealth providers can send prescriptions to a local pharmacy and in some cases, send lab orders. In 2023:

- Virtual Primary Care (VPC) via Doctor on Demand will be on some Individual plans; embedded in small and mid-sized employer group plans; and as a buy up option for large employer groups.
- Medicare Advantage members will have access to Doctor on Demand for urgent care, behavioral health and nurse triage services.

Nurse Triage, is available for commercial members. Board-certified nurses can triage members to appropriate care settings, whether it be virtual or in-person, or recommend a home care plan. The service is available 24 hours a day, seven days a week and is accessible via chat or telephonic, depending on the plan.

With **DispatchHealth**, **dispatchhealth.com**, members can avoid a trip to the ER and receive urgent medical attention from the comfort of their home. After requesting care, a team of trained emergency medical professionals, a physician assistant or nurse practitioner and a medical technician, will arrive at the member's location.

Among the conditions DispatchHealth can treat are chronic obstructive pulmonary disease and exacerbations; severe cold and flu symptoms; urinary tract infection; breaks, sprains and bruises; lacerations, abrasions and infections; mild to moderate stomach pains, nausea, vomiting and dehydration. The medical team can run onsite labs and order additional services such as X-rays and prescriptions. It is a reliable, convenient way for members to receive in-home care at a similar cost to receiving services at an urgent care facility.

DispatchHealth is available in the following areas:

- Boise, Idaho
- Portland, Oregon
- Olympia, Washington
- Seattle, Washington
- Spokane, Washington
- Tacoma, Washington

Heal is a program that offers timely and convenient medical care for members in the greater Seattle, Washington, area from caring and qualified providers in the privacy of their own home. Each provider arrives with a medical assistant to help take care of the patient during the house call. Heal providers are fully equipped to care for any issue typically seen in a provider's office or urgent care facility. Heal providers are available 8 a.m. to 8 p.m., 365 days/year, typically within two hours of the member's request.

Members can view a list of in-network providers, including behavioral health providers, and view their on-demand care options through their **regence.com** member account and checking their Resources.

2023 FEP benefit changes

The changes below will be made to the Blue Cross and Blue Shield Service Benefit Plan effective January 1, 2023.

Changes to all service benefit plan options

Health and wellness updates

- Expanding coverage for CT screenings for lung and colorectal cancer
- Lowering the age for covering medically necessary bariatric surgery to 16
- Increasing the number of covered visits for treating pregnancy-related depression
- Removing the limit for number of non-full sibling donor screening tests for transplants
- Adding coverage for one year of sperm and egg storage for members facing infertility
- Removing age requirement for covered medical foods in treatment of inborn errors of amino acid metabolism

Medical benefit updates

- Prior approval will now be required for certain high-cost drugs (Onpattro, Tegsedi, Oxlumo, Givlarri, Vyvgart, Soliris), proton beam therapy and stereotactic radiosurgery therapies.

Pharmacy changes

- Covering generic nasal spray up to a 90-day supply per year
- Covering weight loss medication to treat obesity when obtained through a pharmacy drug program
- Expanding OTC condom coverage with prescription from provider

Option-specific changes

Standard Option change

- Changing coverage of insulin from coinsurance to a flat copay
- Changing the approved drug lists (formularies)

Basic Option changes

- Increasing copays for diagnostic tests, inpatient admission, outpatient services and emergency services
- Expanding the number of covered acupuncture visits
- Increasing copays for covered drugs in tiers 1, 2 and 3
- Changing the approved drug lists (formularies)

Blue Focus changes

- Waiving the calendar year deductible for all overseas services
- Changing the approved drug lists (formularies)

For detailed information about these and other benefits, please refer to the *Service Benefit Plan Brochure* at **fepblue.org**.

Outpatient kidney dialysis benefit change for UMP members

As a reminder, for dates of service on or after January 1, 2023, UMP members will begin paying kidney dialysis at the standard rate. This change will not impact members if they receive dialysis services from an in-network provider.

However, if they receive dialysis services from an out-of-network provider, their cost-share for kidney dialysis may increase.

MA Quality Incentive Program

Our 2023 MA Quality Incentive Program (QIP) remains focused on rewarding PCPs who meet specific goals to improve health outcomes for our MA members. The 2023 program is very similar to our 2022 program.

Incentive structures for the following categories will stay the same in 2023:

- Preventive care visits (PCV)
- Supplemental data submission
- Risk adjustment gap review (formerly called Hierarchical Condition Category (HCC/chronic condition gap closure)

Medicare Star Rating measures

No Medicare Stars Rating measures are being added to or deleted from the program; we are changing some incentive amounts.

Notes:

- The measures included for Utah providers are different from those for Idaho, Oregon and Washington providers. The measures in the Utah program also remain the same.
- We are re-naming the Regence-unique measures. They will be called member-experience measures.

Medication adherence updates

- The incentive amount for each medication adherence measure will increase to $26.
- We are adding a 4-Star threshold to earn incentives for the following medication adherence measures:
  - Medication adherence–cholesterol (MAC)
  - Medication adherence–diabetes (MAD)
  - Medication adherence–hypertension (MAH)

Transitions of care (TRC) measures

- In recognition of the work that PCPs put in to closing these gaps, we are doubling the incentive amount for the following two measures to $20:
  - Notification of inpatient admission (NIA)
  - Receipt of discharge information (RDI)
- **Note**: These measures are only included for Idaho, Oregon and Washington providers.

Personalized care support measures

- We are increasing the threshold to earn the Advance Care Planning incentive to 30% of your Medicare Advantage-attributed patients. To support gap closure for this measure, we will continue to allow you to report CPT II codes with visits where your patient's wishes may only require a review and not a full conversation that justifies reporting CPT 99497.

Hybrid CAHPS/HOS survey

- We are removing rating of drug plan from this incentive category.
- We are adding the following measures to this category:
  - Getting needed care
  - Getting needed prescription drugs
- We are changing the incentive amounts for all hybrid CAHPS/HOS survey measures:
  - 4-star performance pays $24 per attributed survey-eligible member
  - 5-star performance pays $30 per attributed survey-eligible member

CGMA improvements and updates

The QIP operations team works continuously to improve your user experience and expand the data available to you in the Care Gap Management Application (CGMA).

In 2022, we added these features:

- **Mark As Reviewed**—the ability to mark gaps and move them to a separate section while you're waiting for a claim to close them
- **Service Events**—the ability to submit evidence throughout the year on gaps that may be affected by multiple events

In 2023, we're working to bring you more program data:

- 2023 member rosters will be available to download from the CGMA in February.
- Star Rating and risk adjustment gaps will be available in March.
- Enhanced pharmacy gap reporting will be available.
- New reporting functionality will allow you to run a report that includes gap statuses other than "open".

We will add 2023 program information to our provider website by January 6, 2023: Programs>Medicare Quality Incentive Program.

If you have questions, please email us at **QIPQuestions@regence.com**.

2022 MA QIP reminders

We'd like to remind you of the following program deadlines to close gaps for the 2022 program:

- December 31, 2022—Last day to perform services
- February 28, 2023—Last day to submit supplemental data
- February 28, 2023—Last day to work in the CGMA
- March 31, 2023—Last day to submit medical or pharmacy claims

The CGMA will continue to display 2022 data through February 2023 to allow you to submit your final 2022 documentation.

Earn incentives through our Commercial QIP

Our Commercial Quality Incentive Program (QIP) rewards PCPs who provide timely, evidence-based preventive care to Individual on-exchange patients. PCPs can earn a per gap incentive for closing care gaps in the program's Quality Rating System (QRS) measures.

As a PCP, you can review identified quality care gaps for Individual on-exchange patients attributed to you as part of your pre-visit planning by using our Care Gap Management Application (CGMA) through Novillus LLC.

Dates to remember

As a reminder, our 2022 Commercial QIP program ends December 31, 2022. Providers currently participating in the program should continue to close gaps through December 31, 2022. We will issue incentive payments by June 30, 2023, for the 2022 Commercial QIP.

The 2023 Commercial QIP will begin January 1, 2023, and will provide incentives for gaps closed during 2023. There are no changes to the program and the same list of incentives will be used.

Identifying and closing gaps

To identify and close gaps for this program:

- Locate each patient in the CGMA as part of your pre-visit planning. The tool will identify care gaps for Individual on-exchange patients attributed to you to help you schedule screenings or chronic condition management services.
- Refer your patient for any procedures or tests that cannot be completed in your office.
- Ensure that your medical record documentation for each visit is complete.
- Submit a claim for the date of service with all appropriate diagnosis and procedure codes that were part of the visit. Most QRS gaps for Individual on-exchange members must be closed via claim submission.

How to access the CGMA

If you are a current CGMA user for our Medicare QIP, your login allows you to access both the Medicare and Commercial QIP gap information.

If you do not currently have access to the CGMA, email **QIPQuestions@regence.com** the following information about the new CGMA user:

- First and last name
- Title
- Phone number
- Email address
- Provider group name
- Provider group TIN(s)

Learn more

For more information about the program, including the list of individual incentive measures, eligibility and gap closure tips, visit our provider website: Programs>Commercial Quality Incentive Program.

Hospice VBID Model survey results

We want to thank the hospice and palliative care providers in Oregon, Utah and Clark County, Washington, who have partnered with us during our first year participating in CMS' Hospice Value-Based Insurance Design (VBID) Model. This program aims to improve patient care and the experience of beneficiaries at one of the most difficult times in their health care journey.

Over 1,500 Medicare Advantage PPO members have received care through our Hospice VBID Model program this year.

We recently surveyed participating hospice providers to learn what has worked well with the program and where we can better support our providers to improve our program for next year.

Hospice VBID Model survey results

- **Notice of Elections (NOEs)**: Respondents indicated they have been able to submit the required NOE within five calendar days of the member's election of hospice. **Note**: This requirement will be enforced in 2023.
- **Transitional concurrent care (TCC)**: Respondents indicated that they have been able to operationalize TCC. TCC is a benefit for our Medicare Advantage members participating in the Hospice VBID Model that combines hospice and curative/restorative care.
- **Extra benefits**: Not all respondents were aware that our Medicare Advantage members have access to extra services and supplies (e.g., no-cost meals for people with chronic conditions through Mom's Meals, companionship through Papa Pals, a personal response system provided by Best Buy Health/ Great Call).
- **Claims issues**: Respondents indicated that one of the primary reasons for having a claim denied was because it was billed with an incorrect code. View the *Hospice VBID Model Billing Quick Reference Guide*, available on our provider website: Forms & Documents>Medicare>Hospice VBID Model.
- **Resources**: Respondents indicated that they are accessing the tools, resources and forms on our provider website. Use these links to quickly find the information you need:
  - Program and benefit information: Products>Medicare>Hospice VBID Model
  - Forms and guides: Forms & Documents> Medicare>Hospice VBID Model

We look forward to continuing our partnership next year.

BCBS National Coordination of Care℠ program

The Blue Cross and Blue Shield (BCBS) National Coordination of Care program aims to increase the quality of care BCBS MA members receive.

To better support all BCBS MA PPO members in our service area, we are working with providers to improve care for these members by including them in our Medicare Quality Incentive Program (QIP) and consolidating medical record requests to capture a complete understanding of the members' health status.

Medicare QIP

BCBS MA PPO members who reside in our service area are included in our Medicare QIP. Information about Medicare Stars and risk adjustment gaps for these members is included on the CGMA.

Medical records requests

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.

Note: As a reminder, your agreement with us requires you to respond to requests in support of risk adjustment, HEDIS and other government-required activities within the requested timeframe.

HIPAA/privacy

Consistent with HIPAA and any other applicable laws and regulations, Regence and our vendor partners 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. Consistent with your current practices, patient-authorized information releases are not required for you to fulfill medical records requests and support closure of Medicare Stars and/or risk adjustment gaps received as part of this care coordination program.

You can identify MA PPO members by the member address in our service area and the following logo

included on their Blue Plan ID cards:

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 on our provider website: Programs>Risk Adjustment.
- The Medicare QIP information on our provider website, Programs>Medicare Quality Incentive, will help you understand:
  - Documentation and criteria for gap closure
  - Eligible claims for 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 in Forms & Documents on our provider website will help you understand the ways you can impact your patient's feedback on the *Consumer Assessment of Health Care Providers and Systems (CAHPS)* and *Health Outcomes Survey (HOS)*.

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.

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