Blue Cross of Idaho uses our One to One Newsletter to notify and highlight upcoming, important information or required actions that may be required by the provider community.

The information is in categories based on whether the article is Informational (for education only) or an Action (requires action on your part).

Topics in this edition of the Provider Newsletter include:

**Informational**
- 2019 holidays
- 2019 home visit program
- Colorectal cancer screening
- Fall prevention – open discussion with your patients
- Fraud, waste and abuse
- HPV vaccination
- Idaho Medicaid Plus
- Medical policy changes
- Medicare Advantage Healthcare Quality Patient Assessment Form (HQPAF) program
- New faces
- Office satisfaction survey results
- Office/outpatient evaluation and management (E/M) updates
- Promoting cervical cancer awareness
- Return of external Provider Relations Representatives
- Spotlight on migraines

**Actions**
- 2019 Healthy Rewards program for Medicare Advantage Members
- BetterDoctor
- Blue Cross of Idaho is partnering with Illuma Care Connections for diabetic retinal eye exams
- CMS Medicare Preclusion List
- How to request clinical criteria
- Self-service online tools
- Taxonomy requirements
2019 Blue Cross of Idaho Holidays

Presidents Day: Monday, February 18
Memorial Day: Monday, May 27
Independence Day: Thursday, July 4
Labor Day: Monday, September 2
Veterans Day: Monday, November 11
Thanksgiving Day: Thursday, November 28
Day after Thanksgiving: Friday, November 29
Christmas Day: Wednesday, December 25
2019 Home Visit Program

Each year Blue Cross of Idaho offers select Medicare Advantage-covered patients an in-home health assessment. We will soon be sending letters to these selected members inviting them to participate.

This year, the in-home health risk assessments will be conducted by licensed nurse practitioners from Episource, a Blue Cross of Idaho contracted provider. We will be forwarding the assessment results to each member’s selected primary care provider. We ask that you review the results and discuss them with your patient should you receive an assessment.

We want to share some of the details of the program:

• This program is designed to support and complement the care you already provide, not to replace it. The purpose is to gather additional health and quality data from the member that will assist us in providing additional services to your patient, such as services from Case Management and Disease Management. We respect that all medical decisions rest with you and your patient.

• This is a voluntary program for the patient. The visit will not affect his or her eligibility, change his or her benefits or impact the cost of coverage.

• The assessment will include a review of care provided by other physicians and specialists. Medical history, course of treatments and current medications will be reviewed and documented by Episource providers.

• The entire health assessment will last approximately one hour and includes a brief physical exam of listening to the heart and checking blood pressure.

• You will receive a summary of the home health assessment unless the patient objects.

If you have questions about this program or the letter sent to the patient, please call Blue Cross of Idaho’s Provider Service Department at 888-494-2583 (TTY users should call 800-377-1363), 8 a.m. - 6 p.m. MT, Monday through Friday.
Colorectal Cancer Screening: Patient Choice Now Includes the FIT-DNA Test

Blue Cross of Idaho has recently approved the FIT-DNA test – brand name Cologuard – for colorectal cancer screening.

The U.S. Preventive Services Task Force (USPSTF) recommends FIT-DNA testing to be done every one to three years, the frequency being your clinical decision.

The USPSTF recommends colorectal cancer screening to begin at age 50 and continue until age 75. The decision to screen between ages 76 and 85 is a decision you and your patient should make. Screening at this age is most appropriate for patients that are healthy enough to receive treatment in the event that cancer is found.

This preventive guideline is the basis for the annual Healthcare Effectiveness Data and Information Set (HEDIS) measurement audit that is conducted by all health plans that use HEDIS reporting for National Committee for Quality Assurance (NCQA) accreditation. This is also the criteria by which your practice is evaluated.

The HEDIS measurement criteria recognizes the FIT-DNA testing method if it is done every three years.

While a colonoscopy is the gold standard to meet HEDIS criteria for colorectal cancer screening, patients have options, increasing the likelihood they will get screened.

Talk to your patients who may be at a higher risk for colorectal cancer to determine the best screening option and schedule for them.

The 2019 HEDIS measurement criteria for colorectal cancer screening:

The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer. Exclusions include a history of colorectal cancer or total colectomy.

Fall Prevention – Open Discussion With Your Patients

Fall prevention may not be the primary topic of conversation you have with your patients during a visit, but it can be important in preventing costly fall injuries. According to the Centers for Disease Control and Prevention,¹ one in five falls causes a serious injury, such as a broken bone. More than 800,000 patients per year require hospitalization due to falls that primarily result in a head or hip injury. In 2015, treatment for falls accounted for approximately $50 billion in medical costs, with a large share being paid for by Medicare and Medicaid.

Your patients may not tell you that they have fallen or that they may be having issues with balance. Therefore, your patients can benefit from your education on exercise, bone health, vision screening and home safety to reduce their fall risk and prevent future falls.

Signs that your patient might be at risk for a fall:

- Lower body weakness
- Walking or balancing difficulties
- Vision impairment
- Side-effects of certain medications, such as tranquilizers, sedatives or antidepressants

The Idaho Department of Health and Welfare offers an exercise-based fall prevention program – Fit and Fall Proof™. You can recommend this resource to your patients, who can find a listing of classes available at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov). Your patients can also call the Idaho Care Line at 211 to hear a listing of classes in their area.

¹ [https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html](https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html)
Fraud, Waste and Abuse

Blue Cross of Idaho contracts with you to provide medically necessary, cost-effective and quality care to our members. You exert significant influence over what services your patients receive. You control the documentation that describes what services they received, and your documentation serves as the basis for claims sent to us for services provided. While the vast majority of hard-working providers are ethical, the actions of a minority of providers raise the cost of healthcare for all. In doing your part to prevent fraud, waste and abuse, here are a few common types of health fraud to watch for:

**Phantom billing** – Adding otherwise legitimate charges for services never performed or fabricating claims

**Upcoding** – Charging for a more expensive service – such as a high-level office visit – but actually providing a short, low-level office visit

**Providing unnecessary care** – Ordering unnecessary tests, surgeries and other procedures

**Misrepresenting services** – Performing non-covered services but billing for different services that are covered

**Unbundling** – Charging separately for procedures or tests that are actually part of a single procedure

**Masquerading as healthcare professionals** – Delivering healthcare services without proper licenses

**Doctor shopping** – Members bouncing from one doctor to another to obtain multiple prescriptions for controlled substances

**Identity theft** – Using another person’s health insurance card or identification to obtain healthcare or other services or impersonating that individual

**Enrollment fraud** – Knowingly misrepresenting health status or dependent status, or purposely failing to report a divorce, marriage or change in dependent(s)

We encourage anyone who suspects possible fraudulent activity to report it to us – you have the option to remain anonymous. Call the fraud hotline at 800-682-9095 or email fraudreporting@bcidaho.com.
HPV Vaccination

Since the introduction of the Human Papillomavirus (HPV) vaccine in 2006, more than 100 million doses of have been distributed nationally.¹ While the Centers for Disease Control and Prevention (CDC) recommends all 11- to 12-year-old girls and boys receive the HPV vaccine, as of 2016, only 49.5 percent of girls and 37.5 percent of boys in the U.S. had completed the HPV vaccine series.¹ In an effort to increase awareness and HPV vaccinations, the Department of Health and Human Services has introduced a goal of reaching a vaccination rate of 80 percent for both girls and boys by the year 2020.¹

Inadequate vaccination is a public health threat. It’s important for providers to work closely with patients to educate them on the importance of vaccinations, including the HPV vaccine. Research shows that there are barriers to overcome in order to improve vaccination rate, such as the lack of recommendations from physicians or the lack of knowledge of parents. For instance, many parents may not know that the HPV vaccine protects against several types of cancer in both men and women.¹

Parents look to their health care professionals for recommendations and base their decisions to vaccinate their children on those recommendations.² The CDC encourages providers to recommend HPV vaccines as they do all other childhood and adolescent vaccines.³ It is also important to help break down the barriers of talking with preteens about HPV, a sexually transmitted illness. What you say and how you say it are important. Research has shown that when providers engage with hesitant parents and address their concerns, it can lead to same-day HPV vaccination.⁶

We encourage you to talk with your patients in order to increase both awareness of and the vaccination rate for HPV.

https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/hpv/trend/index.html

2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4538997/
6. http://pediatrics.aappublications.org/content/141/6/e20172312

Table 1. Human papillomavirus (HPV) vaccination coverage among adolescents 13-17 years by State, HHS Region, and the United States, National Immunization Survey-Teen (NIS-Teen), Idaho, 2017
Idaho Medicaid Plus

Idaho Medicaid Plus is a plan for individuals who are eligible for both Medicare and Medicaid services and coordinates most of their Medicaid benefits through a single health plan. The Idaho Department of Health and Welfare (IDHW) is partnering with two health plans to administer the program, Molina Healthcare of Idaho and Blue Cross of Idaho. Idaho Medicaid Plus launched in Twin Falls County on November 1, 2018, for qualified individuals not already enrolled in the Idaho Medicare Medicaid Coordinated Plan (MMCP).

The Idaho Medicaid Plus program will be expanded into Bannock, Bingham and Bonneville counties on April 1, 2019. Dual-eligible individuals in those counties received an IDHW enrollment letter in early January. The letter informed them of both the MMCP and Idaho Medicaid Plus programs and included next steps in their enrollment and plan selection process. Eligible individuals have 90 days before coverage goes into effect to select a health plan and 90 days after enrollment to change plans. IDHW will auto-assign a health plan to individuals who have not selected a plan within the 90-day timeframe. All eligibility, enrollment and plan changes are administered through the IDHW.

Members who enroll in the Blue Cross Idaho Medicaid Plus (BCIMP) will receive a new member ID card (see below) for their Medicaid-covered services. Providers will use this card to bill for Medicaid services.

Enrolled BCIMP members will need to use in-network providers for their Medicaid-covered services. During the first 90 days of enrollment, members have a transition-of-care period to allow for all services to continue with their current provider. During this period, non-participating providers are encouraged to contract with the plan.

We encourage all providers to review their contract status with Blue Cross of Idaho. To learn more or to begin contracting, please call our Provider Network Management team at 986-224-3116 or email ProviderAncillarySpecialist@bcidaho.com.

To learn more about the available Blue Cross of Idaho coordinated care plans, please visit us online at www.bcidaho.com/bcidahomedicaidplus or www.truebluesnp.com.
# Medical Policy Changes

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Title</th>
<th>Summary of changes to policy statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.04.147</td>
<td>Next Generation Sequencing for the Assessment of Measurable Residual Disease</td>
<td>Added to medical policy library, effective January 25, 2019.</td>
</tr>
<tr>
<td>7.01.163</td>
<td>Absorbable Nasal Implant for Treatment of Nasal Valve Collapse</td>
<td>Added to medical policy library, effective January 25, 2019.</td>
</tr>
<tr>
<td><strong>Revised Policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.01.68</td>
<td>Laboratory Tests for Heart and Kidney Transplant Rejection</td>
<td>Effective January 25, 2019: Policy statement added “The use of peripheral blood measurement of donor-derived cell-free DNA in the management of patients after renal transplantation, including but not limited to the detection of acute renal transplant rejection or renal transplant graft dysfunction, is considered investigational.” Title changed from “Laboratory Tests For Heart Transplant Rejection.”</td>
</tr>
<tr>
<td>2.03.07</td>
<td>Hyperthermic Intraperitoneal Chemotherapy for Select IntraAbdominal and Pelvic Malignancies</td>
<td>Effective January 25, 2019: Hyperthermic intraperitoneal chemotherapy may be considered medically necessary for the treatment of newly diagnosed stage III ovarian cancer. Policy title changed from “Cytoreductive Surgery And Perioperative Intraperitoneal Chemotherapy For Select Intra-Abdominal And Pelvic Malignancies.”</td>
</tr>
<tr>
<td>2.04.08</td>
<td>Genetic Testing for Lynch Syndrome and Other Inherited Colon Cancer Syndromes</td>
<td>Effective December 15, 2018: Rationale section revised to add juvenile polyposis syndrome and Peutz-Jeghers syndrome indications. Policy section revised to add policy statements indicating that genetic testing for SMAD4, BMPR1A, or STK11 gene variants may be considered medically necessary for juvenile polyposis syndrome and Peutz-Jeghers syndrome.</td>
</tr>
<tr>
<td>2.04.45</td>
<td>Molecular Analysis for Targeted Therapy of Non-Small-Cell Lung Cancer</td>
<td>Effective January 25, 2019: The policy section on EGFR Testing was changed given the new evidence in support of testing for additional variants in the EGFR gene; policy statements on other variants unchanged.</td>
</tr>
<tr>
<td>2.04.52</td>
<td>Molecular Testing for the Management of Pancreatic Cysts, Barrett Esophagus, and Solid Pancreatic Lesions</td>
<td>Effective January 25, 2019: Policy revised with an additional indication “Individuals with solid pancreaticobiliary lesions who do not have a definitive diagnosis after first line evaluation.”. Policy statements otherwise unchanged. Policy title changed from “Molecular Testing for the Management of Pancreatic Cysts or Barrett Esophagus.”</td>
</tr>
<tr>
<td>5.01.10</td>
<td>Immune Prophylaxis for Respiratory Syncytial Virus</td>
<td>Effective August 20, 2018: Policy statements amended to clarify RSV prophylaxis in children with Down syndrome.</td>
</tr>
<tr>
<td>6.01.46</td>
<td>Dynamic Spinal Visualization and Vertebral Motion Analysis</td>
<td>Effective December 15, 2018: “Vertebral Motion Analysis” added to policy statement as investigational. Policy title changed from “Dynamic Spinal Visualization.”</td>
</tr>
</tbody>
</table>
### 7.01.151 Prostatic Urethral Lift
Effective August 20, 2018: The medically necessary policy statement regarding must be a surgical candidate for a Transurethral Resection of Prostate (TURP) procedure was removed.

### 7.01.154 Radiofrequency Ablation of Peripheral Nerves to Treat Pain
Effective December 15, 2018: Investigational policy statements added regarding cryoneurolysis for knee osteoarthritis or total knee arthroplasty and on radiofrequency ablation for occipital neuralgia and cervicogenic headache.

### 4.02.510 Genetic Diagnostic Testing for Recurrent Pregnancy Loss
Effective November 15, 2018: Blue Cross of Idaho adopted additional genetic tests as investigational tests: (1) mitochondrial DNA variations analysis; (2) prolactin receptor gene polymorphism testing; (3) serum anti-heat shock protein antibodies (e.g., anti-HSP60 and anti-HSP70) levels; and (4) serum anti-Mullerian hormone levels. Added codes: 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81460, 83516, and 82397. References 5, 7, 9, and 10 added.

### Archived Policies

<table>
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<tr>
<th>Code</th>
<th>Policy</th>
<th>Policy change event date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.02.501</td>
<td>Methadone Treatment for Opiate Addiction</td>
<td>Policy will no longer be used, and was archived from the medical policy library on November 15, 2018.</td>
</tr>
<tr>
<td>4.01.04</td>
<td>Endometrial ablation</td>
<td>Policy will no longer be used, and was archived from the medical policy library on January 25, 2019.</td>
</tr>
<tr>
<td>5.01.07</td>
<td>Acute and Maintenance Tocolysis</td>
<td>Policy will no longer be used, and was archived from the medical policy library on January 25, 2019.</td>
</tr>
<tr>
<td>10.01.510</td>
<td>Robotic-Assisted Surgery</td>
<td>Policy will no longer be used and was archived from the medical policy library on August 30, 2018.</td>
</tr>
</tbody>
</table>

*This summary of changes to medical policies is for informational purposes only. The list does not replace medical policies and it is not used to determine benefits.*
Medicare Advantage Healthcare Quality Patient Assessment Form Program

It is that time of year for the Healthcare Quality Patient Assessment Form (HQPAF) program. This program promotes early detection and ongoing assessment of chronic conditions for Medicare Advantage (MA) members. Qualifying primary care providers (PCPs) receive HQPAFs for a portion of their assigned MA members based on data-driven analytics. Blue Cross of Idaho has partnered with Optum to administer this program. Beginning in February 2019, Blue Cross of Idaho’s provider engagement specialists and Optum will contact providers of targeted MA members who require these assessments.

During the member assessment, all conditions – including acute and chronic conditions – should be evaluated and documented in the patient’s medical record to the highest level of certainty or specificity. Routine exams and screenings can be helpful in identifying and detecting chronic conditions often before the patient has any symptoms. These annual assessments are an important part of providing quality care and helping to maintain the quality of life for your patients.

In addition, the HQPAF/PAF program supports a variety of the Centers for Medicare & Medicaid Services (CMS) programs, including the Healthcare Effectiveness and Information Data Set (HEDIS) and the Five-Star Quality Rating System.

MA-contracted providers are obligated to participate in these programs as outlined in the Blue Cross of Idaho Utilization, Quality Management and Quality Improvement Programs portion of their contract and referenced in the MA Provider Administrative Policy MAPAP 200. There is a financial incentive to return the forms. The administrative reimbursement rate will be determined by the timeliness of the submission of the HQPAF to Optum.

New Faces

Provider Contracting

- Julie Hilliard – Provider Network Manager
- Matt Haight – Provider Contract Specialist

Managed Service Organization

- Niki Venem – Manager, Managed Service Organization
- Deb Bjork – Clinical Transformation Manager
- Philicia Peterson – Care Manager
- Lisa Poole – Care Manager

Provider Relations

- Leah Hulse – Supervisor, Provider Relations
- Sarah Hatfield – Provider Post Claim Resolution Representative

Government Funding Operations

- Leah Hannum – Director, Government Funding Operations
Office Satisfaction Survey Results

Blue Cross of Idaho asked select office administrators to participate in an office satisfaction survey. To show our appreciation, participants were entered into a drawing for one of 10 $100 VISA® gift cards upon completing the survey.

Listed below are our winners:

<table>
<thead>
<tr>
<th>Recipient name</th>
<th>Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Amy P.</td>
<td>Meridian, ID</td>
</tr>
<tr>
<td>2 Lori H.</td>
<td>Lewiston, ID</td>
</tr>
<tr>
<td>3 Chris K.</td>
<td>Boise, ID</td>
</tr>
<tr>
<td>4 Penny K.</td>
<td>Boise, ID</td>
</tr>
<tr>
<td>5 Jan L.</td>
<td>Lewiston, ID</td>
</tr>
<tr>
<td>6 Anne H.</td>
<td>Meridian, ID</td>
</tr>
<tr>
<td>7 Zipporah R.</td>
<td>Idaho Falls, ID</td>
</tr>
<tr>
<td>8 Laurie M.</td>
<td>Boise, ID</td>
</tr>
<tr>
<td>9 Marilyn S.</td>
<td>Meridian, ID</td>
</tr>
<tr>
<td>10 Misty D.</td>
<td>Soda Springs, ID</td>
</tr>
</tbody>
</table>

Watch for future surveys that may qualify participants for a chance to win gift cards.

Promoting Cervical Cancer Awareness

The American Cancer Society estimates that approximately 13,000 new cases of invasive cervical cancer were diagnosed in 2018. The disease is preventable with appropriate screenings and human papillomavirus (HPV) vaccinations. Yet, many women do not get the recommended screenings. Studies have shown that patients with multiple, chronic conditions are even less likely to get screened.

We encourage you to educate your patients about the importance of this screening.

1https://www.cancer.org/content/dam/CRC/PDF/Public/8599.00.pdf
2https://www.cdc.gov/pcd/issues/2016/16_0225.htm
Office/Outpatient Evaluation and Management Updates

In early 2018, Centers for Medicare & Medicaid Services (CMS) proposed new rules and regulations related to the office/outpatient evaluation and management (E/M) code sets and structures. Final policies around these proposals were published on November 23, 2018.

Changes that were finalized for calendar year (CY) 2019 are unrelated to payment and coding. There will be a two-year delay in the implementation to final policies that significantly impact code sets and structures, such as reducing levels 2-4 E/M office/outpatient visits to a single payment rate, to be in place by CY 2021. This two-year delay will allow adequate time for provider and staff education, clinical workflow transitions, payer policy adoption and adjustments time for CMS to further refine their policies.

Blue Cross of Idaho follows current Medicare billing guidelines when processing Medicare Advantage claims. Below is a summary of the changes addressed in the Federal Register:

- For CY 2019 and 2020, providers are to continue to use either the 1995 or 1997 E/M Documentation Guidelines when coding and billing E/M visits. These guidelines are available on the CMS website.

  - Exception: Policy to Eliminate Redundant Data Recording This policy was expanded to include ways to simplify documentation of history and exam for established E/M office/outpatient visits. As stated in the Federal Register: “Accordingly, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need no re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.”

  (It is important to note that this exception is optional and that providers may choose to continue current documentation processes. Continuing with current processes may be important to those who were unable to make respective documentation workflow/template changes by January 1, 2019.)

- Beginning in 2019, policy change was made to remove the requirement to document the medical necessity for a visit occurring in the patient’s home rather than the traditional office setting.

- CMS is finalizing the following modified changes to their proposal for 2021:
  - A single rate page for E/M office/outpatient visit levels 2, 3 and 4, one rate for established patients and another for new patients. E/M office/outpatient level-5 visits will not be included in the single payment rate.
  - Documentation for levels 2-4 visits will allow providers to choose their documentation method: the current framework, master data management (MDM) or time. Minimum supporting documentation standards associated with a level-2 visit will apply to levels 2-4 visits.
Documentation for level-5 visits under the pay-for-service (PFS) payment model will allow providers to use the current documentation requirements. They can also document using time (to include documentation of the medical necessity of the visit). Documentation using time for a level-5 visit must support that the provider spends a minimum face-to-face time of 40 minutes with an established patient or 60 minutes for a new patient.

Establish add-on HCPCS G-codes that may be reported with E/M office/outpatient levels 2-4 visits to account for the additional resources related to primary care as well as certain specialized medical care. These add-on codes will not be required or restricted by physician specialty.

Establish a new extended visit (additional 30 minutes) add-on HCPCS G-code to be reported with E/M office/outpatient levels 2-4 visits.

Payment rates will be finalized for levels 2-4 visits using the average weight of the most recent five years of utilization data for each code (including inputs from work relative value units [RVUs], direct PE, time and specialty mix).

Payment rates will be finalized for levels 1 and 5 E/M office/outpatient visits based on current inputs.

The proposal to establish separate coding for podiatric E/M visits was not finalized and will not be included in implemented CY 2021 changes.

CMS stated several times throughout the Rules and Regulations for E/M Visits their intent to engage with the public further to refine their policies for 2021.

To learn more, you may access this final rule on the Federal Register at www.federalregister.gov/d/2018-24170.

1Centers for Medicare & Medicaid Services. “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program-Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program-Accountable Care Organizations-Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.” Federal Register, 25 November 2018, https://www.federalregister.gov/d/2018-24170 (Centers for Medicare & Medicaid Services 59635)
Return of External Provider Relations Representatives

Blue Cross of Idaho is pleased to announce the return of external Provider Relations representatives! This new team will spend most of their time conducting in-office trainings, offering customized large-group and specialty-specific informational seminars and hosting online training webinars.

There will be a total of four external reps who will cover the various regions of the state. Two will cover the west-central territory spanning from Riggins to Twin Falls to Sun Valley, the greater Treasure Valley and Oregon counties that border Idaho. We are currently recruiting a Northern Idaho rep who will cover the territory from the upper-Idaho border to Grangeville and bordering Washington and Montana counties. We are also recruiting a Southern Idaho rep who will cover the territory from Burley to Preston to Saint Anthony and bordering Nevada, Utah and Wyoming counties. All reps will live in their respective areas and will be on hand to visit provider offices and promptly answer questions.

These external reps will work with the internal provider relations reps who, at this time, respond to incoming provider emails and phone calls. These external reps will also conduct credentialing site visits and Centers for Medicare & Medicaid Services-required new Medicare Advantage provider visits. They will also hold yearly mandatory training seminars for cultural compliance, fraud, waste and abuse and anti-discrimination education.

We invite you to take part in a brief survey to tell us about what learning formats you prefer and what topics you want to learn more about. [You can access this 10-minute survey here.]

Your responses will help us customize our 2019 education plans so we can focus on specific provider groups and/or provider types (such as primary care providers, specialists, dentists, chiropractors, etc.). Your feedback will also give us insight as to how we can improve our provider website.

Thank you for your participation!

Western Central Idaho Reps:
Heather Beard, CPC, CPB, CRC, CEMC, CGIC
heather.beard@bcidaho.com
P: 800-274-4018 Ext 5776
P: 986-224-5776

Makenzie Ekman
makenzie.ekman@bcidaho.com
P: 800-274-4018 Ext 6927
P: 986-224-6927

Southern Idaho Rep: To Be Determined

Northern Idaho Rep: To Be Determined

Counties: Ada, Adams, Blaine, Butte, Camas, Canyon, Custer, Elmore, Gem, Lemhi, Owyhee, Payette, Twin Falls, Valley, Washington and contiguous Oregon counties

Counties: Bannock, Bear Lake, Bingham, Bonneville, Caribou, Cassia, Franklin, Fremont, Gooding, Jefferson, Jerome, Lincoln, Madison, Minidoka, Oneida, Power, Teton and contiguous Nevada, Utah and Wyoming counties

Counties: Benewah, Bonner, Boundary, Clearwater, Idaho, Kootenai, Latah, Lewis, Nez Perce, Shoshone and contiguous Montana and Washington counties
Spotlight on Migraines

Migraines are a debilitating and costly disorder that affect up to 12 percent of adults in the U.S. They are also among the top 5 reasons for visits to the emergency room and account for nearly $36 billion in total costs due to treatment and lost productivity. Most migraines are characterized by severe throbbing headaches that may include nausea, vomiting and sensitivities to light or sound.

Historically, the most efficacious treatments have been predominately abortive medications. These medications help patients get rid of a migraine after it starts. Medications to prevent migraines from happening have been less effective overall. Most are predominately used to treat other conditions such as depression, seizures and high blood pressure.

However, a new class of drugs called calcitonin gene-related peptide (CGRP) inhibitors has recently been approved by the Food and Drug Administration (FDA) to treat migraines. These drugs target the CGRP molecule in the brain and spinal cord, which researchers have shown is connected to pain generation and vasodilation. There are currently three FDA-approved CGRP inhibitor medications (Erenumab, Fremanezumab and Galcanezumab). Several more products in this drug class are in development.

Compared to a placebo, these drugs are associated with an average reduction of about one to two headache days per month. While this level of effectiveness is not much better than existing treatments, the side effect profiles are much better. Additionally, in the 12- to 24-week clinical trials, some patients were able to achieve complete remission of their migraine headaches. Across the trials, about 40 percent of patients were able to achieve at least a 50 percent reduction in their monthly headache days. While longer-term studies for safety and efficacy will be useful to better evaluate these drugs, they provide a promising alternative for patients who suffer from migraines and have been unable to achieve relief with other medications.

The Blue Cross of Idaho Pharmacy and Therapeutics Committee is a group of physicians and pharmacists from across the state of Idaho. Our goal is to provide Blue Cross of Idaho members and their prescribers with quality medication choices that represent the best value in efficacy, safety and cost. When new medications are approved by the FDA, we evaluate the medical literature and use best-practice standards for evidence-based medicine in the decision-making process. All three of these medications have been added to the Blue Cross of Idaho commercial and Qualified Health Plan formularies with a prior authorization requirement to evaluate for medical necessity.
2019 Healthy Rewards Program for Medicare Advantage Members

Blue Cross of Idaho recently launched the 2019 Healthy Rewards program where Medicare Advantage (MA) members can earn rewards for taking care of their health. The 2019 program includes 11 healthcare activities. Members can earn gift cards valued between $10 and $50 per activity. Activities must be completed and redeemed by December 31, 2019.

Members must complete the healthcare activities that are recommended for them through the program to earn the rewards. Recommended activities are based on the member’s gap in care; therefore, not all members will be eligible to take part in every activity. There will be targeted outreach to ensure members are getting basic preventive services.

Members can sign up for the healthy rewards program one of three ways: 1) online at bcidaho.com/healthyrewards, 2) by phone or 3) by mail. Online is the fastest and easiest way to sign up and redeem rewards.

Members who get preventive screenings can help their providers detect problems early and limit exposure to long-term, potentially debilitating health issues. We encourage you to discuss the importance of getting these preventative screenings.

Call Trisha Catti at 986-224-3252 to learn more.

<table>
<thead>
<tr>
<th>HealthCare Activity</th>
<th>Reward Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit</td>
<td>$25</td>
</tr>
<tr>
<td>• Monitor Your Physical Health, Fall Prevention</td>
<td></td>
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<tr>
<td>• Improve Bladder Control</td>
<td></td>
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<tr>
<td>Colon Cancer Screening</td>
<td></td>
</tr>
<tr>
<td>1. FOBT/FIT (at-home kit)</td>
<td>$15</td>
</tr>
<tr>
<td>2. Flexible Sigmoidoscopy (Clinical screening)</td>
<td>$25</td>
</tr>
<tr>
<td>3. Colonoscopy (Clinical screening)</td>
<td>$50</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>$25</td>
</tr>
<tr>
<td>Diabetes Eye Exam</td>
<td>$15</td>
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<tr>
<td>Diabetes Kidney Exam</td>
<td>$25</td>
</tr>
<tr>
<td>Diabetes Blood Test (A1C) Screening 1</td>
<td>$25</td>
</tr>
<tr>
<td>Diabetes Blood Test (A1C) Screening 2</td>
<td>$25</td>
</tr>
<tr>
<td>Osteoporosis Screening</td>
<td>$25</td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management</td>
<td>$25</td>
</tr>
<tr>
<td>Flu Shot</td>
<td>$10</td>
</tr>
<tr>
<td>Taking Care of Your Overall Health</td>
<td>$10</td>
</tr>
</tbody>
</table>
BetterDoctor (Quest Analytics)

The Centers for Medicare & Medicaid Services (CMS), The National Committee for Quality Assurance (NCQA) and Blue Cross Blue Shield Association (BCBSA) require health plans to verify their network physicians’ directory information each quarter. Blue Cross of Idaho has contracted with BetterDoctor to streamline this verification process.

BetterDoctor’s online verification tool makes it easy for Blue Cross of Idaho-contracted physicians to verify or update their information. BetterDoctor collects practice data in one place for multiple health plans, making the process more efficient for administrative office staff. We use the data feeds provided by BetterDoctor to update our provider file, which is used to update the provider directory.

You may receive calls to verify the physicians practicing at your location. BetterDoctor may contact physician practices by fax, mail, email and/or telephone to request a review and direct them to BetterDoctor’s online verification tool. Physicians are encouraged to respond to ensure an accurate directory for our members.

Some common discrepancies identified in directories include:

• The provider does not practice at the office
• The provider is not accepting new Medicare Advantage patients
• The phone number is incorrect or disconnected

If you would like to set up a single point of contact for all of your locations or need technical assistance with the BetterDoctor verification process, visit the BetterDoctor’s help center at www.betterdoctor.desk.com, email at support@betterdoctor.com or call 844-668-2543, 9 a.m. to 5 p.m. CT. Monday – Friday.
Diabetic Retinal Eye Exams Key to Preventing Blindness

Diabetic retinopathy is found to be a leading cause of blindness among 24- to 75-year olds. It costs approximately $500 million dollars annually in lost income and required services.\(^1\) Diagnosis and treatment of diabetic retinopathy requires a team approach between primary care providers (PCPs), endocrinologists, ophthalmologists and other specialties as needed.

While blindness can be a part of diabetes, it doesn’t have to be. A diabetic retinal exam (DRE) can detect diabetic retinopathy early so it can be treated.

Talk with your diabetic patients and help make sure they get their comprehensive DREs. The PCP-patient relationship is the foundation of quality medical care, as a PCP acts as an educator and coordinator of care. PCPs focus on many aspects of diabetic care and are front-line experts and key in directing their patients to receive the appropriate screening for diabetic retinopathy.

For more information on Illuma Care Connections, please call Trisha Catti at 986-224-3252.

\(^1\) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863606/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863606/)

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**CMS Medicare Preclusion List Effective April 1, 2019**

In accordance with requirements issued by the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage (MA) plans will be prohibited from paying for any item, service or prescription drug that originates with a provider/prescriber who is included in the Preclusion List, which is created monthly by CMS. Precluded providers are ineligible to receive payment for MA items and services or Part D drugs prescribed to Medicare beneficiaries.

For more information on the Preclusion List, visit [cms.com](http://cms.com).
How to Request Specific Clinical Criteria

Blue Cross of Idaho makes our clinical review criteria available to providers and members upon request.

Medical policies are posted on our provider portal at providers.bcidaho.com. To access:

- Select Policies & Procedures
- Select Medical Policies then select Continue
- Refer to MP 5.01.501 for information about the criteria used in the review of pharmacologic therapies. Blue Cross of Idaho also has obtained a license for the Change Healthcare InterQual® Level of Care Criteria.

Providers and members may request a copy of the specific clinical criteria or medical policy that was used to make coverage decisions for the member by completing the Clinical Criteria Request Form. All information on this form is necessary to send you the correct criteria.

Submit the completed form to:

Email: HCOMedicalPolicy@bcidaho.com
Fax: 208-286-3588
Mailing Address: Blue Cross of Idaho
Attn: Medical Policy Operations Specialist
P.O. Box 7408
Boise, ID 83707

Taxonomy Requirements

Taxonomy codes are administrative codes that identify your provider type and area of specialization. It is a unique, ten-character alphanumeric code that enables you to identify your specialty.

Taxonomy codes are assigned at both the individual practitioner and organizational provider level. Taxonomy codes have three distinct levels:

- Level I is Provider Type
- Level II is Classification
- Level III is Area of Specialization

Individuals should select a taxonomy code for their actual specialty not one that represents a facility.

Physicians should avoid choosing the very general taxonomy codes. For example, if you are a nurse with an advanced practice degree, do not select “Registered Nurse” as a taxonomy code. Your taxonomy code should reflect that you have an advanced practice nursing degree to ensure accurate identification of what you do.

Our Provider Enrollment Applications have been updated to list taxonomy codes to ensure we are capturing accurate specialties. It is important for all practitioners to keep National Plan & Provider Enumeration System (NPPES) updated with current taxonomy codes and practice locations. You can make these updated by visiting nppes.cms.hhs.gov.
Self-Service, Online Tools

Blue Cross of Idaho is working to respond to emailed questions faster. We’ve found that many of the emailed questions relate to claim status. To quickly learn of the status of claims, you can find this information on our secure provider portal at providers.bcidaho.com.

Register as a user

You must be a registered user to access claim information. If you need to register:

- Visit providers.bcidaho.com
- Select Register at the top of the page and follow the prompts
- Receive an email within one to five days with your access information
  - If your Tax Identification Number is not in our system, you will need to submit additional information. Please contact your Provider Relations representative by selecting Contact and Provider Relations at top of the page.

Check claim status

To check claims status once you’ve registered:

- Select Eligibility & Claims and select Claim Status
- Enter the date of service in the Begin Date section
- Select the name of the servicing provider by choosing Select Provider
- Search for individual claims by entering the member’s last name and subscriber identification number
- Select Search
  - Claims showing “processed” indicate that claim has been finalized and you are able to see processing details.
  - Claims showing “in process” indicate that the claim is still being reviewed by Blue Cross of Idaho.
  - If you do not see your claim, please resubmit for processing.
Review remittance advices

Remittance advices are generated for in-network providers. Out-of-network providers can access the claim details on our secure provider portal or contact the member directly for claim details. Medicare Advantage is an exception.

Updated remittance advises are posted on our website every Monday. To review a remittance advice:

- Log on to our secure provider portal at providers.bcidaho.com
- Hover over Tools and Reports
- Select Remittance Display
- Select the appropriate provider within the rectangle box in the center of the page
- Enter a start and end date and click Submit
- Choose line of business desired (remittances will display per line of business)
- Open selected line of business in Adobe Acrobat Reader

Find Provider Administrative Policies

Find information on submitting claims to Blue Cross of Idaho in our Provider Administrative Policies. These policies are available on our website at providers.bcidaho.com.

- Select Policies & Procedures at the top of the page
- Select the line of business under Provider Administrative Policies
- Select Continue on the Use & Disclosure of Data page
- Select the desired policy

Claims can be submitted electronically through your software/clearinghouse or through the Direct Claims Entry tool available on the secure provider portal at providers.bcidaho.com.

If you have any questions or if you need help using the Direct Claims Entry tool, please call Provider Relations at 866-283-5723 or email PRproviderrelations@bcidaho.com.
Any Questions?

MEDICAL MANAGEMENT
Questions regarding managed health care/review, preadmission/admission certification or individual benefits management and case management:
- Call: 208-331-7535 or 800-743-1871 (voicemail available after office hours and on holidays and weekends)

MEDICAL POLICY
Questions regarding medical policy and clinical criteria:
- Email: HCOMedicalPolicy@bcidaho.com

BLUE CROSS OF IDAHO HELP DESK
Questions regarding electronic billing errors, error and acceptance reports:
- Email: edihelpdesk@bcidaho.com

PROVIDER CONTACT CENTER
Questions regarding benefits, coverage and authorization:
- Call: 208-286-3656 or 866-482-2250 between 7 a.m.-7 p.m. MT Monday-Friday, EXCEPT closed 2-3 p.m. MT Thursday

For post-service claim questions, log on to our secure website at providers.bcidaho.com and select Contact Us.

PROVIDER RELATIONS
Questions regarding coding, contracting or need website training:
- Call: 866-283-5723 or 208-286-3602
- Email: PRproviderrelations@bcidaho.com

FRAUD, WASTE AND ABUSE
We encourage anyone who suspects possible fraudulent activity to report it to us. You have the option to remain anonymous. Call the fraud hotline at 800-682-9095 or email fraudreporting@bcidaho.com.