NETWORK NEWS AND UPDATES

BlueCross BlueShield of Western New York

Physical Accessibility of Provider Sites for People with Mobility Impairment

In accordance with the Americans with Disabilities Act (ADA), we want to ensure that health care services rendered by participating providers are readily accessible and usable by individuals with disabilities.

When a health care provider applies for participation with BlueCross BlueShield of Western New York, we ask if the office (location) is wheelchair or handicapped accessible. Physical accessibility includes entry to a provider's office and access to services within the site, such as exam tables and medical equipment.

If the office is not physically accessible, a documented plan should be in place and submitted promptly to BlueCross BlueShield for review, to be certain that a reasonable alternative site and/or services are available.

It is our responsibility to provide the most up-to-date, accurate information for members regarding the practice status of our participating providers, including the physical accessibility of the office. Our Participating Provider Directory includes information for members regarding wheelchair accessibility of offices, with alternate plans for those locations that are not accessible.

If you have not notified us of the handicapped accessibility status of your practice location(s), or if there has been a change, please fax your information to the Provider Enrollment Department at (716) 887-8886.

If you have any questions or concerns, please contact your Provider Network Management and Operations Specialist at (716) 887-2054 or 1-800-666-4627.

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Opting Out of Medicare

Federal regulations prohibit Medicare Advantage Organizations, including BlueCross BlueShield of Western New York, from paying for services rendered by physicians or providers who have opted to not participate in the Medicare program, except in limited circumstances.

A Medicare Advantage organization may contract only with physicians who are approved for participation in the Medicare program and who have not opted out of providing services to Medicare beneficiaries. (See Social Security Act § 42 CFR § 422.220.) Opting out is not the same as "nonparticipating." Physicians or practitioners who opt out of Medicare cannot participate in our Medicare Advantage networks: Senior Blue HMO and Forever Blue Medicare PPO.

Current Medicare rules do not allow providers to reapply for participation with Medicare until the end of the two-year opt-out period. BlueCross BlueShield will not cover any services rendered by physicians or their sponsored mid-level practitioners on or after the effective date that they opt out of Medicare, unless it is demonstrated that the service was eligible for payment as an emergency or urgently needed under applicable Medicare standards.

The Centers for Medicare and Medicaid Services (CMS) have specific rules providers must follow regarding opting out of Medicare. Some of the rules could affect your business financially, such as the requirements under Social Security Act §1848(g)(1) and/or 1848(g)(3).

CMS regulations for opt-out providers also require a "private contract" between the Medicare beneficiary and the provider who opted out of Medicare. The private contract must include certain language, such as but not limited to, that the Medicare beneficiary agrees to give up Medicare payment, including payment from Medicare Advantage plans, for services furnished by the opt-out provider and to pay the provider for said services directly.

The requirements and possible exceptions concerning opting out are outlined in the *CMS Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services*. Chapter 15 can be accessed online at **cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs**.

If your status with Medicare changes, you must notify your Provider Network Management and Operations Specialist promptly at 1-800-666-4627.

More information regarding New York State providers who opt out of Medicare is available from the local Medicare Administrative Contractor, National Government Services, at **ngsmedicare.com**.

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Perceived Denials

We appreciate and support your efforts to manage the care of your BlueCross BlueShield of Western New York **Medicare Advantage (Senior Blue HMO and Forever Blue Medicare PPO)** patients in a prudent, cost-effective manner.

The Centers for Medicare & Medicaid Services (CMS) require that when a member perceives a denial of treatment or care, he/she is entitled to certain appeal rights under federal law. This includes situations in which the member's request is made **directly** to the provider and one of the following conditions exists:

- The member disagrees with the prescribed course and/or type of treatment.
- The provider declines to render a course of treatment and/or type of treatment that the member is requesting.
- The member does not agree with the provider's decision to discontinue or reduce a course of treatment.

Examples of denial

Some examples of a perceived denial are:

- A patient asks to be referred to a radiologist for an MRI, but the provider is of the opinion that an MRI is not necessary.
- An older patient asks that a new prescription medication be ordered. The provider declines to write the prescription because the American Medical Association and the Food and Drug Administration do not support use of the medication in the senior population.
- A patient asks to be referred to a dermatologist for the treatment of a rash. The provider declines to refer the patient because he or she believes they can effectively treat the patient directly.
- A patient is receiving physical therapy services and the provider determines that physical therapy is no longer necessary.

Your responsibility

When a perceived denial occurs, the following must take place:

- You must contact the Utilization Management Department the day that the denial occurs to inform us of the situation.
- **You must ensure that our members are informed of their right to appeal.**

Our responsibility

We will then issue a letter with the details of the denial, including a description and reason for the denial. A copy of the letter will be sent to you as well. The letter will inform the member of:

- the clinical rationale,
- their right to obtain reconsideration, and
- the procedure for requesting reconsideration.

The member will be advised that he/she can appeal if they do not agree with our decision about the service in question.

If you have any questions about perceived denials, please contact our Utilization Management Department at (716) 884-2942 or 1-800-677-3086. ∞

Out-of-Plan Referral Guidelines

Out-of-plan (OOP) referrals should be requested for BlueCross BlueShield of Western New York patients **only** when:

- The patient is outside his or her service area
- Participating providers in the area **cannot** provide the necessary services

Services must be requested by the patient's primary care physician or participating specialty provider. A request form for OOP coverage is available **here**.

The following information is **required**:

- Office notes, consultation reports, diagnostic studies, and **in-plan provider** documentation that supports the need for the patient to be seen by an OOP provider
- OOP provider name (requesting provider, assistant surgeon, co-surgeon)
- OOP provider address
- OOP provider specialty
- Planned services CPT® codes, if applicable
- OOP provider assistant/co-surgeon information

Definitions:

Non-participating provider (NPP): A provider (e.g., facility, vendor, physician, or other clinician) who does not participate with any BlueShield plans; claims submitted by a non-participating provider (NPP) would process to the patient's out-of-network benefit unless an out-of-plan referral is on file.

Out-of-network provider (OONP): A provider (e.g., facility, vendor, physician, or other clinician) who does not participate with the patient's home plan, but does participate with the BlueCross/BlueShield plan in the provider's local area. Claims submitted by an OONP will process to the patient's out-of-network benefit unless an out-of-plan referral is on file.

Out-of-Network (OON) benefits: Coinsurance, copay, and/or deductible that the patient is financially responsible for when receiving services from a NPP or OONP. Typically, when a patient uses his or her out-of-network benefit, he or she will incur higher out-of-pocket costs.

Health Care Proxies: Helping Your Patients Plan Ahead

Help patients plan for future care
Life is full of unexpected events. Make sure your patients are prepared with a health care proxy in the event that they cannot communicate their health care wishes.

When your patient completes a Health Care Proxy Form, they are telling you, other doctors, and family members what their decisions are for treatment even if they are unable to communicate them.

What you should do
Discuss your patient's wishes and encourage them to:

- Think about what's important to them and how they want to receive care
- Help them choose a person to speak for them if and when they can't speak for themselves
- Discuss their health care wishes with family and caregivers
- Put their choices in writing using the **New York State Health Care Proxy Form**
- Ask them to provide copies of the completed form to you, their caregiver(s), and/or family

For all adults (age 18 and over), be sure documentation of the signed Health Care Proxy Form, or a discussion of it, is included in the patient's medical record.

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Palliative Care for Symptom Management

Patients with serious illnesses typically choose aggressive treatments. These treatments have side effects that may include dehydration, pain, and multiple trips to the emergency room.

A palliative care service can assess the patient and family in their home environment, intervene to obtain needed equipment and services, and be available to answer any questions. They can also interact with the patient's doctors and keep them informed.

Palliative Care Service in Action
A 79-year old female patient was admitted to palliative care service. Her health history included breast cancer with metastasis to her spine, sacrum, and liver. The patient was receiving chemotherapy at the time of admission.

A palliative care team consisting of a registered nurse (RN) and social worker (SW) assisted with the following:

- Setting up a bedroom on the first floor of her home for her safety
- Working with her insurance company to obtain a hospital bed, commode, and wheelchair in the home for comfort and safety
- Arranging for home health aides to assist with activities of daily living due to the patient's progressive weakness

During the palliative care service, the on-call RN received a weekend phone call from the patient complaining of new onset bilateral lower extremity (BLE) edema and asking if she should seek emergency care.

The nurse made a visit to the home and contacted the patient's primary doctor for collaboration. The patient was seen the next day in the doctor's office and placed on antibiotics for BLE cellulitis, avoiding an emergency room visit.

The RN followed up the next day and updated this episode. Two weeks later, the patient's caregiver contacted the on-call RN with concerns about the patient's behavioral changes and new onset of agitation. The RN performed a home visit to assess these changes. Collaboration took place between the specialist and the RN. Haldol® was prescribed to manage her symptoms, and an ER visit was avoided.

The next day, the specialist saw the patient in the office and discussed the disease progression and prognosis; the patient was referred to hospice at that time. The primary RN collaborated with hospice admissions and the patient was admitted to hospice the next morning; she is currently receiving hospice care in the comfort of her home.

You can refer patients with serious illnesses to the Palliative Care Case Management Program by calling 1-877-878-8785, option 2.

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What is Care Management?

Care management is a service provided to help your patients achieve better health outcomes if they are diagnosed with an acute or chronic illness. After looking at each case individually and considering the member's benefits, we connect the patient and their caregiver with the necessary medical care and psychosocial support.

When you enroll a patient in care management, they receive:

- Health care support from a registered nurse (health coach)
- A care plan developed based on your plan
- Assistance from pharmacists, social workers, and dietitians, as needed
- Information and resources about their illness
- Help coordinating services with all of their providers
- Assistance in finding community services

We offer the following programs:

- **General case management:** Targets members with multiple or complex conditions to obtain access to care and services, and coordinate their care.
- **Maternity:** Assists women by providing education and coordination of services in an effort to maintain a healthy full-term pregnancy.

- **HIV/AIDS:** Educates and coordinates appropriate care and services in an effort to improve the quality of life and minimize health complications.
- **Transplant:** The health coach acts as a resource regarding transplant information, cost issues, community resources, and care options.
- **Palliative care:** Helps members with serious illness control symptoms and avoid unnecessary emergency room visits.
- **Oncology:** Helps members navigate through the cancer network of providers and shares information that will help them understand and manage their condition.
- **Chronic kidney disease:** Links members with specialized nephrology services to maintain optimal health.
- **Frail elderly:** Facilitates in-home medical care and community social services.
- **Depression/substance abuse:** Encourages adherence to the medical regime and adequate follow-up with the treating health care practitioner to assess the effectiveness of treatment for conditions such as depression, substance abuse, and other mental health-related disorders.

If you feel that your patients would benefit from care management services, please call us at 1-877-878-8785, option 2.

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Diabetes Testing and Diagnosis Criteria

More than 29 million people — or 9.3% of the U.S. population — are estimated to have diabetes. Of those, 8.1 million do not know they have the disease. In addition, the Centers for Disease Control and Prevention estimates that 86 million U.S. adults, more than one in three, have prediabetes.

Undetected or uncontrolled diabetes can lead to serious health complications, such as heart disease, stroke, kidney disease, blindness, amputations of the legs and feet, and even death.

Early detection is the key to reducing the morbidity and mortality associated with this disease.

According to the American Diabetic Association's (ADA) *2017 Standards of Medical Care in Diabetes*, clinicians should use the following criteria for screening asymptomatic adults for diabetes or prediabetes:

1. Testing should be considered in all adults of any age who are overweight or obese (BMI ≥25 kg/m^{2,} or ≥23 kg/m^2 in Asian Americans) and have additional risk factors:
   - physical inactivity
   - first-degree relative with diabetes
   - high-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
   - women who were diagnosed with gestational diabetes mellitus
   - hypertension (≥140/90 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)

- women with polycystic ovary syndrome
- A1C ≥5.7% (39 mmol/mol), IGT, or IFG on previous testing
- other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
- history of CVD

2. For all patients without known risk factors, testing should begin at age 45.
3. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results (e.g., those with prediabetes should be tested yearly) and risk status.

The following bullet points outline the ADA's criteria for the diagnosis of diabetes:

- Fasting plasma glucose (FPG) ≥126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 hours*, or
- 2-h plasma glucose ≥200 mg/dL (11.1 mmol/L) during an oral glucose tolerance test (OGTT). The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water*, or
- A1C ≥6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the Diabetes Control and Complications Trial (DCCT) assay*, or
- In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (11.1 mmol/L)

* In the absence of unequivocal hyperglycemia, results should be confirmed by repeat testing.
For more information, visit **professional.diabetes.org/content/clinical-practice-recommendations**.

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2017-18 Seasonal Flu Vaccine

According to updated recommendations from the Centers for Disease Control (CDC), all persons at least six months of age should have routine annual influenza vaccination unless they have specific contraindications. The more people who are vaccinated for the flu, the increased chance of protection from the flu especially at risk populations.

For 2017-18, three-component vaccines are recommended to contain:

- an A/Michigan/45/2015 (H1N1)pdm09-like virus
- an A/Hong Kong/4801/2014 (H3N2)-like virus
- a B/Brisbane/60/2008-like (B/Victoria lineage) virus

Four-component vaccines, which protect against a second lineage of B viruses, are recommended to be produced using the same viruses recommended for the trivalent vaccines, as well as a B/Phuket/3073/2013-like (B/Yamagata lineage) virus.

For additional information regarding flu prevention with vaccination, go to: **cdc.gov**.

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The Appropriate Use of Imaging for Spinal Injuries

A Journal of the American Medical Association (JAMA) study, released March 17, 2015, found that older adults who had spine imaging within six weeks of their initial primary care visit did not have better outcomes one year later compared to those who did not have early imaging.

The patients who had early imaging had substantially higher health care use and cost than those who did not undergo this early imaging. To access the journal abstract, visit **ncbi.nlm.nih.gov/pubmed/25781443**.

If you have a patient dealing with neck or lower back pain, our trained professionals can help. The BlueCross BlueShield of Western New York Spine Program was developed to guide patients through the complicated treatment options available for spinal injuries. You may enroll your patient in our Spine Program online at **bcbswny.com** or by calling 1-877-878-8785, option 2.

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Eliminating Elective Deliveries Before 39 Weeks

The last few weeks of pregnancy are critical to a baby's health because important organs, including the brain and lungs, are not completely developed until the end of pregnancy.

According to the March of Dimes, complications from non-medically indicated (elective) deliveries between 37 and 39 weeks may include increased:

- neonatal intensive care unit (NICU) admissions
- transient tachypnea of the newborn (TTN)
- respiratory distress syndrome (RDS)
- ventilator support
- suspected or proven sepsis
- newborn feeding problems and other transition issues

There are many reasons to stop elective deliveries before 39 weeks. This initiative has become one of the national benchmarks for perinatal safety and quality and is supported by many professional organizations including, but not limited to:

- College of Obstetricians and Gynecologists (ACOG)
- Centers for Medicare & Medicaid Services (CMS)
- U.S. Department of Health & Human Services (HHS)
- The Joint Commission
- Leapfrog Group
- National Quality Forum (NQF) measures
- March of Dimes

There is a definite benefit in reducing neonatal complications without compromising the health of the mother. Unless medically indicated, a baby's birth should not be scheduled before 39 weeks gestation.

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Colorectal Cancer Screening: 80% by 2018

BlueCross BlueShield of Western New York is committed to doing its part to support the *80% by 2018* initiative. This national goal is to have 80% of adults, age 50 and older, screened for colorectal cancer by 2018.

Excluding skin cancers, colorectal cancer is the third-most common cancer diagnosed in both men and women. In 2017, the American Cancer Society estimates 135,430 new colorectal cancer cases will be diagnosed in the United States. In addition, colorectal cancer is expected to cause 50,260 deaths in 2017.

Through proper screening, precancerous polyps can be found and removed before they become cancerous. Screenings can also detect cancer early, when treatment is most effective. Unfortunately, one-third of adults 50 or older have not been screened as recommended.

The U.S. Preventive Services Task Force recommends screening all average-risk, asymptomatic adults between the ages of 50 and 75. Individuals at higher risk may need to be screened earlier, later, or more often.

Multiple screening strategies, with different levels of evidence to support their effectiveness as well as unique advantages and limitations, are available. There is no empirical data to demonstrate that any of the below strategies provide a greater net benefit; therefore, it is important to discuss all screening options with your patients and help them to decide which test is right for them.

Screening strategies include:

- gFOBT or FIT (annually)
- FIT-DNA test (every three years)
- Flexible sigmoidoscopy (every five years, or every ten years if combined with annual FIT testing)
- CT colonography (every five years)
- Colonoscopy (every 10 years; more often if polyps are found)

For more information, click **here** or visit **cdc.gov/cancer/colorectal.**

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The Importance of Mammography Screenings

Breast cancer is the most common cancer among women in New York. It is also the second-leading cause of cancer-related death in New York women. The American Cancer Society estimates there will be more than a quarter million new cases of invasive breast cancer in 2017 and about 40,000 women will die from it.

Inconsistencies in guideline recommendations about screening ages and intervals have resulted in confusion for patients and practitioners, which can lead to delayed or missed diagnoses.

The Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force recommend:

- Women between the ages of 50 and 74 should have a screening mammogram every two years.
- Women between the ages of 40 and 49 should be assessed based on their medical circumstances to determine when to begin mammography screenings.

Physicians can reduce confusion and ensure appropriate follow-up by:

- Communicating guideline recommendations with patients.
- Reviewing and recommending mammography screenings based on the patient's breast-related medical history and breast cancer risk factors.
- Ensuring an adequate follow-up system for mammogram reports is in place.
- Communicating test results to the patient in a timely manner and ensuring the patient understands the significance of the findings and recommendations.

For more information, visit **cancer.org**.

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Urinary Incontinence

Urinary incontinence (UI), or the unintentional loss of urine, is a condition that affects between 10 and 30 percent of adults. An estimated 13 million Americans suffer from bladder control problems; 85 percent of which are women. The prevalence of UI increases with age — up to 35 percent of people 60 years of age and older are incontinent. Despite this statistic, UI should not be considered a normal part of aging.

UI can cause a wide range of morbidity in the elderly, including pressure ulcers, urinary tract infections (UTIs), social withdrawal, and depression.

Since patients are often too embarrassed to initiate discussion about urinary leakage, it's important to:

- ask if they have experienced urine leakage in the past six months
- assess if the leakage made them change their daily activities or interfered with their sleep
- discuss treatment options to manage their current leakage problem

For more information on UI, visit the **American Urological Association** and the **Annals of Internal Medicine** websites.

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Medical Services Protocol Updates Now on Our Website

Medical protocols that have recently undergone an annual review are now available online. Two new protocols have been added. The effective date of these changes is October 1, 2017, unless otherwise noted.

To view the protocols and cover letters, visit **bcbswny.com**.

Please note that some of the protocol updates may not pertain to the members to whom you provide care.

If you need assistance obtaining specific protocol updates, please contact Provider Service at 1-800-666-4627 or (716) 884-3461.

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Updated Drug Therapy Guidelines

Updated drug therapy guidelines are available on our provider website at **bcbswny.com**.

Our Pharmacy and Therapeutics Committee approved these updates after conducting its annual review and quarterly new drug evaluations.

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Medicare Part D Preauthorization Update

Effective January 1, 2018, all BlueCross BlueShield of Western New York Medicare Part D preauthorization requests must be faxed to Express Scripts, Inc. at 1-877-251-5896.

If you prefer, you may continue to submit your preauthorization requests by calling 1-800-935-6103 or going to **express-scripts.com/pa**.

PHONE DIRECTORY

BlueCross BlueShield of Western New York

Provider Service	1-800-950-0051 or (716) 884-3461 (Traditional) 1-800-950-0052 or (716) 882-2616 (Managed Care) 1-877-327-1395 (Government Programs)
Network Management	1-800-666-4627
Utilization Management	1-800-677-3086 or (716) 884-2942