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Updating Your Provider Information

Having current provider information helps us maintain accurate provider directories, ensuring that you are easily accessible to our members.

Additionally, health plans are required by Centers for Medicare & Medicaid Services (CMS) to have accurate information in provider directories for certain key provider data elements and accuracy of directories are routinely reviewed and audited by CMS, as well as the New York State Department of Health.

Since it is the responsibility of each provider to inform health plans when there are changes, we remind you to notify BlueCross BlueShield of Western New York of any demographic changes or other key pieces of information, such as a change in your ability to accept new patients, street address, phone number or any other change that affects patient access to care.

For BlueCross BlueShield to remain compliant with federal and state requirements, **changes must be communicated to us minimally 30 days prior to the change or as soon as possible** so that members have access to the most current information in the Provider Directory.

Key data elements
The data elements required by CMS and crucial for member access to care are as follows:

- Physician name
- Location (address, suite, city, state, ZIP code)
- Phone number
- Accepting new patient status
- Hospital affiliations
- Medical group affiliations

Health plans also are encouraged (and in some cases required by regulatory/accrediting entities) to include up-to-date information for the following provider data elements:

- Participation status (retirement, moving out of area, available as on-call or covering only)
- Physician gender
- Languages spoken
- Office hours
- Specialties
- Physical disabilities accommodations (e.g., wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, other accessible equipment)
- Indian health service status
- Licensing information (e.g., medical license number, license state, national provider identifier)
- Provider credentials (e.g., board certification, place of residency, internship, medical school, year of graduation)

- Email addresses for:
  - Office manager
  - Credentialing manager
  - Clinician(s)
- Website address
- Hospital has an emergency department, if applicable
- Any change that may materially impair your ability to carry out the duties and obligations of your agreement

How to update your information
You should routinely check your current practice information by going to **bcbswny.com**.

If you need to make any changes, please go to *Tools & Resources* > *Forms* and select *Provider Demographic Change Form* under the *Practice Administration* heading. You can also email us directly at **provider_data_mgmt@healthnow.org**. Please include your NPI in the subject line.

All practice changes also should be reflected on your Council for Affordable Quality Healthcare (CAQH) application.

If you have any questions, please contact Provider Service at 1-800-950-0051 or (716) 884-3461.

In accordance with Section 2.4.2 of the Participating Physician Agreement:

> Participating Physician shall not close his or her panel to new patients and/or referrals, as applicable, except on **thirty (30) days prior written notice** to BlueCross BlueShield of Western New York, provided that, in such event, Participating Physician shall not accept new patients or referrals of persons who are covered by or enrolled in any other entities that provide, arrange or pay for health care services.
>
> Participating Physician acknowledges and agrees that any closure of his or her panel shall not apply to any of Participating Physician's existing or prior patients who become Covered Persons. Participating Physician further agrees to provide BlueCross BlueShield written **notice** prior to opening his or her panel to new patients or referrals, as applicable.

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The Physician's Role in Managed Care for Members with Special Needs (Including Medicare Advantage Dual-Eligibles)

For planned and unplanned transitions between care settings — for example, home to hospital, or hospital to skilled nursing care — the referring provider is expected to:

- share the care plan with the receiving setting within one business day of notification of the transition;
- inform the member (or the member's responsible party) of the care transition process and about changes to their health status and plan of care.

Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual-eligible program which exempts individuals from Medicare cost-sharing liability (see Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997).

Balance billing prohibitions also may likewise apply to other dual-eligible beneficiaries in Medicare Advantage (MA) plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost-sharing.

In addition, Medicare Advantage enrollees cannot be discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Discrimination based on "source of payment" means, for example, that MA providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.

Members who are eligible for both Medicare and Medicaid (dually eligible) may have certain services covered by the Medicaid programs. To find out which benefits are covered by the member's Medicaid benefit, please call Provider Service at 1-800-950-0051 or (716) 884-3461.

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Opting Out of Medicare

Federal regulations prohibit Medicare Advantage (MA) organizations, including BlueCross BlueShield of Western New York, from paying for services rendered by providers who have chosen not to participate in the Medicare program, except in limited circumstances.

An MA organization may contract **only** with providers 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 MA 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 opt-out date, **unless** it is demonstrated that the service was eligible for payment as an emergency or urgently needed under applicable Medicare standards.

Providers must follow the Centers for Medicare and Medicaid Services (CMS) rules 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 language such as, but not limited

to, agreement that the Medicare beneficiary gives up Medicare payment — including payment from MA plans — for services furnished by the opt-out provider, as well as to pay the provider for 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**

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) requires 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 does not believe that an MRI is necessary
- An older patient asks that a new prescription medication be ordered, but 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, but the provider declines to refer the patient because he or she believes they can effectively treat the patient themselves
- 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 our 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.

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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 BlueCross/BlueShield plans; claims submitted by an 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 OON benefit, he or she will incur higher out-of-pocket costs.

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Member Rights and Responsibilities

Our members have rights to help protect them and certain responsibilities that we ask them to assume. We encourage you to review these policies.

The most current version of our *Member Rights and Responsibilities* is available at **bcbswny.com**.

Paper copies are available upon request by contacting Provider Service at 1-800-950-0051 or (716) 884-3461.

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Provider Administrative Policies

Provider administrative policies are applicable to your office practice. They are reviewed annually and updated as necessary. For your convenience, the following administrative policies are available on our website at **bcbswny.com/provider** under *Policies & Guidelines > Office Administration*.

Information can also be found in the *Provider and Facility Reference Manual*, *Section 11, Provider Practice Policies,* under:

- Access to Care
- Information Exchange Policy for Primary Care Physicians/Specialists/Facilities
- Medical Record Review
- Medical Record Retention
- Medical Record Transfer for Primary Care/Specialist Providers
- Medical Record Documentation Standards
- Patient Confidentiality in the Physician's Office

A change has been made to the *Access to Care Policy* specific to accessibility of specialist appointments as follows:

- Appointment for non-acute symptomatic conditions in new and established patients are scheduled within 1-4 weeks based on symptoms
- Routine non-urgent or preventive care visits are scheduled within 4 weeks
- Urgent medical problems are scheduled within 24 hours based on symptoms and practitioner judgement
- Follow-up after an emergency or hospital discharge for a medical condition is scheduled within 5 days of discharge or as clinically indicated

These access standards are in accordance with the New York State Department of Health (NYSDOH) and were added to facilitate measurement of specialty access for high volume and high impact specialists in keeping with National Committee for Quality Assurance (NCQA) requirements.

An additional update to the *Patient Confidentiality in the Practitioner Office Policy* was made to indicate that patients should sign a HIPAA compliant Release of Information form prior to release of records by the practitioner office.

Provider Administrative Polices are reviewed and approved annually by the Quality Management Committee.

For questions or requests for paper copies, contact the Health Care Quality Improvement Department at 1-877-878-8785, option 3; click *Contact* on our website; or write to us at:

BlueCross BlueShield of Western New York
Quality Improvement Department
PO Box 80
Buffalo, NY 14240

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Culturally and Linguistically Appropriate Services (CLAS)

Effective communication is a critical skill for any health care provider; it can determine whether a patient understands and complies with your recommendations. But what if your patient speaks a different language or comes from another culture?

We can help you improve your cultural, language, and health literacy so that you and your staff can better serve diverse consumers and communities.

We assess race, ethnicity, and language diversity of our membership annually. To meet the needs of our diverse membership, **we offer interpreter services in more than 170 languages**. We also offer translated health-related information on a variety of topics for members engaged in our health management programs.

In addition, the National CLAS Standards provide a framework to health and health care organizations for the delivery of culturally respectful and linguistically responsive care and services. By tailoring services to an individual's culture and language preference, health care professionals can help bring about positive health outcomes for diverse populations.

You can view online health literacy courses at **bcbswny.com/provider** under *Tools & Resources* > *Cultural & Language Resources*.

By working together to ensure culturally and linguistically appropriate services, we can advance health equity, improve quality, and help eliminate health care disparities.

For more information on our language assistance services or translated health resources, call 1-877-878-8785, option 2.

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Timely Health Information Exchange Improves Care

Timely information exchange during transitions in health care is an essential component in safe, coordinated, cost-effective patient care. In 2017, our Health Care Quality Improvement Department conducted the following quality initiatives to identify opportunities for improvement in continuity and coordination of care.

1. **Information Exchange Survey for Continuity and Coordination of Care**
   The 2017 Behavioral Health and Primary Care surveys measured information exchange between urgent care centers, specialists, behavioral health, and primary care providers. The results identified an opportunity for improvement in rate, timeliness, and process for information-sharing between all provider types. Specifically, we looked at:

   - Primary Care Providers (PCPs) sharing the following information with Behavioral Health (BH) providers
     - Relevant clinical information
     - Medical history (summary)
     - Medications
     - Pertinent labs and consult reports

   - Specialists sharing the following information with PCPs
     - Initial consult or visit summary
     - Change in the medication/condition/treatment plan
     - Annual update (if care is ongoing)

   - BH providers sharing the following information with PCPs
     - Initial consult/visit summary
     - Change in medication/condition/treatment plan
     - BH inpatient discharge summary
     - Diagnosis

- Significant risk/compliance issues
- Annual update (if care is ongoing)

2. Medical Record Review for Timeliness and Quality of Information
In 2017, the Medical Record Review for timeliness and quality of information exchange between specialists and PCPs was performed. Due to historically low rates of information exchange, both ophthalmologists and OB-GYNs were selected. A sample of 58 PCP records from all lines of business (HMO and PPO) were reviewed for members who have had two PCP visits in a 24-month period, with at least one PCP visit within the last 12 months and a minimum of one specialist visit in the last 12 months.

	Records reviewed	% of specialist records present	% of specialist records received timely	% of records with evidence that PCP reviewed the record
Ophthalmology	32	41%	100%	69%
OB-GYN	26	31%	88%	38%
Total	58	36%	95%	57%

What you can do to improve communications

- Continue to educate your patients about the importance of information sharing in relation to receiving quality care; ask if there are other practitioners that need to know about their health information
- Participate in your regional health information exchange, HEALTHeLINK™, and encourage your patients to sign a consent form to give you electronic access to their medical information through your regional health information exchange
- Conduct an internal review of your information-sharing process
  - Do you have a process for ensuring timely communication of pertinent health information to other health care providers?
  - What is your process for reviewing and incorporating incoming information about your patient's record/plan of care?
  - Do you monitor your performance for gaps and act on opportunities for improvement?

Information exchange policy for primary care physicians, specialists, and facilities
Our Information Exchange Policy is designed to ensure practitioners and facilities have the needed health care information to provide coordinated quality health care services to members. All practitioners, including behavioral health and facilities providing health and behavioral care services to members, must ensure timely exchange of pertinent medical information. This policy is posted at **bcbswny.com/provider**.

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Palliative Care Program

We offer care and support at home for patients with a life-limiting illness who have had two or more emergency room visits or hospital stays in the past six months. We work with the patient's doctors to coordinate medical care and community services. There is no fee for the program.

What is palliative care?
Palliative care provides services that help patients and their families to maintain independence and comfort during a progressive illness. Team members include:

- The patient's doctor
- A registered nurse case manager
- A social worker/counselor
- A palliative care consulting doctor

Who is eligible for the program?
In-home support is available for members residing in Western New York who meet the criteria. The case management support is offered to any member who is facing a progressive illness including, but not limited to:

- Advanced heart disease, including congestive heart failure (CHF)
- Advanced lung disease, including chronic obstructive pulmonary disease (COPD) and pulmonary fibrosis
- Cancer, even if the patient is undergoing active treatment with radiation or chemotherapy
- Progressive neurological diseases such as Parkinson's disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), and stroke
- Repeated hospitalizations or emergency department visits

Members can enroll by calling toll-free 1-877-878-8785 option 2 (TTY 711)
Monday-Friday, 8:30 a.m.-5 p.m.

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Osteoporosis Management

In the United States, more than 53 million people either have osteoporosis or are at an increased risk due to low bone density.[1,2]

Fifty percent of women and 21% of men older than fifty years of age will have an osteoporosis-related fracture in their lifetime, and New York residents are at an increased risk of osteoporosis due to vitamin D deficiency.[2]

Despite the prevalence and adverse effects of the condition, osteoporosis is often undertreated. A survey performed by the National Osteoporosis Foundation showed that 86% of women with osteoporosis had never discussed its prevention with their physicians.[2]

The current standard for evaluation of bone mineral deficiency is a dual-energy X-ray absorptiometry (DXA) scan. Bisphosphonates and other medications are available to help treat osteoporosis. The measurement of 25-OH-D (referred to as the vitamin D assay) is becoming increasingly important in the management of patients with disorders of calcium metabolism such as postmenopausal osteoporosis. Please consider adding vitamin D testing when ordering patient blood work.

Educating your patients on the risks associated with osteoporosis and by providing them with the information on osteoporosis testing, medication options, lifestyle changes, diet and supplements can help decrease the impact of this condition. For further information on guidelines, visit **bcbswny.com/provider.**

1 Osteoporosis: **https://www.bones.nih.gov/health-info/bone/osteoporosis**

2 Debunking the myths: **https://www.nof.org/preventing-fractures/general-facts/**

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Clinical Practice Guidelines

The following Clinical Practice Guidelines are available at **bcbswny.com/provider** > *Policies & Guidelines > Practice Guidelines.*

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Cardiovascular disease (includes CHF)
- Chronic kidney disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Falls prevention
- Hip and knee
- HIV/AIDS
- Obesity
- Palliative care
- Right Start maternity
- Sexually transmitted diseases (STDs)
- Spine
- Substance use disorder
- Tobacco cessation

Updated Preventive Health Guidelines are available on our website for:

- Men
- Women
- Birth to 18 years

To request a paper copy, call 1-877-878-8785, option 2. Leave your name, address, and the specific guideline you are requesting.

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End the Epidemic

In July 2014, Governor Andrew Cuomo introduced *End the Epidemic*, a three-point plan to end the AIDS epidemic in New York state by the year 2020. The plan includes reducing new HIV infections annually from 3,000 to 750 and reducing the rate at which persons diagnosed with HIV progress to AIDS by 50%.

Strategies include:

- Identifying persons with HIV who remain undiagnosed and link them to health care. New York state mandates testing for all individuals over the age of 13, regardless of risk factors; HIV testing should be regarded as a health maintenance issue in hospitals and private practices.
- Linking and retaining persons diagnosed with HIV to health care; begin anti-HIV therapy to maximize HIV virus suppression, remain healthy, and prevent further transmission.
- Focusing on treatment as prevention, as multiple studies show when positive individuals know their status, are on treatment, and HIV levels become undetectable, transmission is less likely.
- Providing access to pre-exposure prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

About PrEP

PrEP is part of a menu of evidence-based interventions to prevent HIV transmission. A "blueprint" has been completed that outlines plans to accomplish these strategies; the newest being PrEP, giving HIV negative individuals a daily medication, Truvada, to prevent transmission. Target populations would include discordant couples, gay or bisexual men who do not use a condom or have been diagnosed with an STI in the past 6 months, anyone who is not in a mutually, monogamous relationship with a partner who recently tested HIV-negative, a heterosexual man or woman who does not regularly use condoms with partners of unknown HIV status who are at substantial risk of HIV infection, and injection drug users who share needles.

PrEP is part of a comprehensive approach to preventing HIV that includes:

- Taking one pill (Truvada) once every day
- Regular HIV testing
- Condom use to avoid STIs
- Education about safer sex practices and options
- Frequent screening for sexually transmitted infections

Complete PrEP guidelines can be viewed at **hivguidelines.org**.

Erie County Medical Center staff is available for consultation and to provide PrEP. Call (716) 898-4119 and ask for the PrEP Team.

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Right Start

To support our valued providers and members, our care management team provides:

- Care coordination from the time pregnancy begins until six months after the baby is born
- Education on pregnancy and infant care
- Educational materials, tools, and resources to assist with pregnancy-related conditions
- Intervention and home visits from a prenatal nurse for high-risk mothers, when applicable

When you see pregnant patients and refer eligible participants to our Right Start Program prior to the 15th week of gestation, you will be reimbursed $100 for each **high-risk** referral.

You can refer patients to the program by calling 1-877-878-8785, option 2, online at **bcbswny.com/provider**, or by faxing the prenatal risk screening form to (716) 887-7913.

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Spirometry Testing

The signs and symptoms of asthma and chronic obstructive pulmonary disease (COPD) are similar, which is why spirometry testing is important in determining a differential diagnosis.

If you suspect, or are uncertain if a patient has COPD:

- Order spirometry testing
- Educate and assist in smoking cessation, when applicable

Our disease management program offers dedicated nurse health coaching to educate and help patients manage chronic conditions. To enroll your patient in our disease management program, call 1-877-878-8785, option 2.

For patients who are not able to obtain spirometry testing in an office setting, an in-home spirometry service can be arranged. A written order from the physician is required.

To coordinate this service for your patient(s), call Respiratory Services of Western New York at (716) 683-6699.

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Chlamydia Screening

Chlamydia is the most frequently reported bacterial sexually transmitted disease (STD) in the United States.

In 2015, 1,526,658 cases of chlamydia were reported to Centers for Disease Control and Prevention (CDC) from 50 states and the District of Columbia; an estimated 2.86 million infections occur annually.[1] In addition, a large number of chlamydia cases are not reported because most people are asymptomatic and do not seek testing.

Chlamydia is most common among young people. Almost two-thirds of new chlamydia infections occur among youth aged 15-24 years. It is estimated that 1 in 20 sexually active young women aged 14-24 years has chlamydia.

In June 2015, the CDC published *Sexually Transmitted Diseases Treatment Guidelines*.

The screening recommendations for chlamydia are:

Women

- Sexually active women under 25 years of age
- Sexually active women aged 25 years and older, if at increased risk

Pregnant women

- All pregnant women under 25 years of age
- Pregnant women aged 25 years and older, if at increased risk
- Retest during the third trimester for women under 25 years of age or at risk

Men

- Consider screening young men in high prevalence clinical settings or in populations with high burden of infection, e.g., men who have sex with men (MSM)

Men who have sex with men (MSM)

- At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use
- Every three to six months, if at increased risk

Persons with HIV

- For sexually active individuals, screen at first HIV evaluation and at least annually thereafter
- More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology

To learn more about these and other STD screening recommendations, go to **cdc.gov/std/tg2015/default.htm**.

[1] Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention.

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New 2018 HEDIS® Measure:
Pneumococcal Vaccination Coverage for Older Adults

Each year, between February and May, data from the prior calendar year is collected on a number of Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures. Most of these measures remain the same year after year. Occasionally, HEDIS measures may be retired and new measures are added.

This year, the National Committee for Quality Assurance (NCQA) added a new HEDIS measure for 2018, Pneumococcal Vaccination Coverage for Older Adults. This measure will assess the percentage of health plan members 65 years and older who received the recommended series of pneumococcal vaccines: 13-valent pneumococcal conjugate vaccine (PCV13) and 23-valent pneumococcal polysaccharide vaccine (PPSV23).

The addition of this measure supports the updated guidance from the Advisory Committee on Immunization Practices (ACIP) regarding pneumococcal vaccination. The measure also will use electronic data and will, one day, supplant the current survey-based metric.

Approximately one million U.S. adults get pneumococcal pneumonia every year. In its worst form, pneumococcal disease kills one in every four to five people over the age of 65 who contracts it. Speak with your patients about the risk and encourage them to complete the vaccination series if they meet the age and/or medical condition requirements.

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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. One new protocol has been added. The effective date of these changes is January 1, 2018 unless otherwise noted.

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

To view the protocols and cover letters, go to **bcbswny.com/provider** > *Policies and Guidelines* > *Medical Protocols*.

If you need assistance obtaining specific protocol updates, please contact Provider Service at 1-800-950-0051 or (716) 884-3461.

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FEP Formulary Reminders

The Federal Employee Service Benefit Plan (FEP) drug formularies are updated quarterly and are available at:

caremark.com/portal/asset/z6500_drug_list.pdf (Standard Option Formulary)
caremark.com/portal/asset/z6500_drug_list807.pdf (Basic Option Formulary)

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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**.

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Fraud Awareness per Deficit Reduction Act (DRA)

Health care organizations subject to Section 6032 of the Federal Deficit Reduction Act of 2005 (DRA) are required to educate their providers and contractors about the False Claims Act as well as the organization's policies and programs for detecting and preventing fraud, waste, and abuse. This information is available for your review on **bcbswny.com/provider** under *Policies & Guidelines > Compliance & Quality Information > Deficit Reduction Act*.

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PHONE DIRECTORY

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