NETWORK NEWS AND UPDATES

BlueCross BlueShield of Western New York

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"Closing the Behavioral Health Gap Through Collaboration" Panel Discussion - April 18

A panel discussion for primary care providers (PCPs) will address behavioral health issues in Western New York and how PCPs can collaborate with the behavioral health community. To achieve optimal population health, closing the behavioral health gap is essential to ensuring physical, social and mental well-being. Participants will be able to engage with the presenters through a structured panel discussion on ways to improve collaboration, barriers, and challenges, along with ways to work toward community solutions.

BlueCross BlueShield of Western New York
257 West Genesee Street, Buffalo, NY 14202
Wednesday, April 18 from 5:30 to 9 p.m.

Community health experts will cover a variety of topics:

- Behavioral health and the role it plays in population health management
- Screening Brief Intervention and Referral to Treatment (SBIRT)
    - An overview
    - How to receive training
- Behavioral health services – when, where, and how to access them

For more information, or to RSVP by April 11, go to **behavioralhealthbcbswny.eventbrite.com**

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Prioritizing Annual Wellness Visits

Annual wellness visits (AWVs) for our Medicare Advantage members are an annual benefit that resets on January 1, so there's no need to wait 365 days. Performing AWVs early will help you direct your patients' care for the rest of the year, as well as identify gaps in care.

We recommend using the Vatica Well365 tool. Well365 can ensure that you and your patients get the most out of an AWV with the added advantage of computer-assisted diagnostic coding, CPT-II code entry and a 10-year screening schedule that's created automatically. And because the Well365 tool helps to capture ICD-10 codes, you may receive fewer chart review requests when you include complete diagnosis codes on your claim submissions. You earn additional incentives when you use Well365 for the AWV on eligible Medicare Advantage patients. Please click here for details
www.bcbswny.com/content/WNYprovider/my_account/annual-wellness-visit.html

Vatica offers a no-cost 30-minute webinar on Well365 Plus. Vatica's clinical consultants can help you with:

- Patient eligibility verification
- Appointment scheduling
- Entering documentation that includes chronic conditions, reconciling medications, lab results, imaging studies, vaccine history, and family/medical/social history into the Well365 tool directly from your EMR

We recommend that AWVs be conducted by a physician's assistant or nurse practitioner, but they can be done by a physician (M.D. or D.O.) or clinical nurse specialist as well.

For more information, contact Jennifer Murawski at (716) 887-7524, or email her at
murawski.jennifer@bcbswny.com

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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. Accuracy of directories are routinely reviewed and audited by CMS, as well as the New York State Department of Health.

Because 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/provider**

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 National Provider Identifier (NPI) number 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.
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> 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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Utilization Management Updates

Coverage decisions based on appropriateness of care

BlueCross BlueShield of Western New York bases medical necessity decisions on the appropriateness of care and services. Coverage decisions are based on the benefits and provisions contained in members' contracts. BlueCross BlueShield does not reward or offer incentives to practitioners, providers, or staff members for issuing denials or for encouraging inappropriate under-utilization of care.

Discussing an adverse determination

Practitioners who would like to discuss a denial decision based on medical necessity with our physician reviewers may do so by calling 1-800-677-3086.

You may also discuss the adverse determination with our physician reviewers at the time you are notified by phone of our determination. You may request the criteria used by Utilization Management to render our decisions by calling the number above or sending a written request to:

BlueCross BlueShield of Western New York
Attn: Utilization Management
PO Box 80
Buffalo, NY 14240-0080

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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 the end of 2018.

In New York state, colorectal cancer is one of the most frequently diagnosed cancers and the second leading cause of cancer deaths among men and women combined. Each year in New York state, almost 4,600 men and about 4,500 women are diagnosed with colorectal cancer and about 3,200 die from this disease.

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 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 following strategies provide a greater net benefit; therefore, it is important to discuss all screening options with your patients and help them decide which test is right for them.

Screening strategies include:

- gFOBT or FIT (annually)
- FIT-DNA test (every 3 years)
- Flexible sigmoidoscopy (every 5 years, or every 10 years if combined with annual FIT testing)
- CT colonography (every 5 years)
- Colonoscopy (every 10 years; more often if polyps are found)

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

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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New Medicare Beneficiary Identifier Numbers Required by 2019

To better protect the identities of Medicare beneficiaries, the Centers for Medicare and Medicaid Services (CMS) is changing all Medicare and Medicare Advantage members to a new Medicare Beneficiary Identifier (MBI). The MBI will replace the Health Insurance Claim Number (HICN) currently in use, which is based on the beneficiaries' social security number (SSN).

The CMS transition to the new MBI numbers will take place from April 1, 2018 until December 31, 2019. There will be a phased-in approach and New York state is scheduled to be phased-in during June, 2018. **Either the new MBI or the HICN will be accepted during the transition period**. CMS has stated that it will have its processes and systems ready to accept the new MBIs as soon as April 1, 2018, and will begin a phased card issuance to beneficiaries. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established the requirement for CMS to remove SSNs from all Medicare cards by April, 2019. For more information, go to: **https://www.cms.gov/Medicare/New-Medicare-Card/** ∞

Diabetes Prevention Program and Prediabetes Intervention

In 2018, Medicare is expanding its Diabetes Prevention Program and the goal is to prevent individuals with prediabetes from going on to develop diabetes. Individuals with prediabetes are at increased risk for developing type 2 diabetes, heart disease, and stroke. Prediabetes is a condition in which fasting blood glucose is 100-125 mg/dl. Other names for prediabetes are impaired glucose tolerance (IGT) and impaired fasting glucose (IFG). For some people with prediabetes, early treatment can return blood glucose levels to normal range.

Medicare Diabetes Prevention Program (MDPP)

- Consists of a minimum 16 weekly didactic group sessions over a 6-month period of time
- 6 in-person sessions over a 6-month period of time
- Members who achieve and maintain weight loss and attendance can receive additional monthly maintenance sessions for 12 months

In order to be eligible for MDPP, your patient must be a Medicare Advantage member diagnosed with prediabetes. Referrals can be made by a PCP or patients can self-refer. Members may call the number on the back of their insurance card to find an MDPP provider near them. The program is set to begin in April 2018. For more information, visit **innovation.cms.gov/initiatives/medicare-diabetes-prevention-program**

Benefits may also be available to non-Medicare Advantage members through our Blue Life Program. Enrollment and classes are currently underway.

Prediabetes intervention

BlueCross BlueShield of Western New York has developed a prediabetes team (known as the prediabetes pod) that is a specialized group of BlueCross BlueShield clinical staff that educates eligible members on the risk factors and potential long-term consequences associated with IGT and diabetes. The pod supports members in making positive lifestyle changes, as well as decreasing glucose and A1c levels. Telephone contact by an outreach associate, certified diabetic educator (CDE) and clinical health coach provides education and encouragement to members to adhere to guidelines, including the following:

- physician interaction
- obtaining required lab work
- weight loss
- exercise
- stress management
- obtaining applicable preventive health screenings

Frequency of pod staff calls with members will be based on the member's individual needs and preferences, supporting a member-centric approach. Outreach will occur at a minimum of every 30 days. Eligibility for support from the prediabetes pod includes:

- 18 years and older
- Hemoglobin A1C of 5.7-6.4%
- BMI of greater than 25
- ICD code for IGT

Referrals to this program can be initiated by a PCP, or members can enroll themselves by calling the customer service phone number on the back of their card.

Community Prediabetic and Diabetic Resource Guide
There is help for your patients who are trying to manage their prediabetes and diabetes. The Niagara and Orleans County ADA Collaborative has created a resource guide to assist people diagnosed with prediabetes and diabetes. The booklet was designed through the collaboration of clinical professionals in the Western New York area, and provides information about diagnoses, common definitions, and tips for healthy living and community organizations. These links provide program information that assists your patient with copays, sharps removal, nutritional assistance, and more.

To access a copy, or for further information about the guide, log onto:

niagaracounty.com/Portals/4/Docs/Niagara%20and%20Orleans%20County%20Resource%20Guide%20-%20Final.pdf?ver=2017-11-03-083818-630

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Medical Protocol Updates Now on Our Website

Recently reviewed medical protocols are now available online. New or changed protocols available at this time will have an effective date of April 1, 2017 unless otherwise noted.

- Please refer to the cover letter for brief summaries of new or changed protocols.
- 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 1-800-950-0051 or (716)884-3461.

To view the protocols and cover letters, go to:

https://bcbswny.com/content/WNYprovider/policies-and-guidelines/medical-protocols.html

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Medicare Advantage Provider Education (MAPE) Available Online

In response to the Centers for Medicare and Medicaid Services (CMS) requirement, we have launched an educational tool -- the Medicare Advantage Provider Education (MAPE) page. CMS requires that physicians who **are newly enrolled** in our Medicare Advantage plans (Senior Blue HMO or Forever Blue Medicare PPO network) review our Medicare Advantage Provider Education. Those providers must then fill out the attestation form on the page to ensure compliance with the Code of Federal Regulations *42 CFR 422.202*. The education can be accessed by visiting **bcbswny.com/mape**

The following information is available on our MAPE page:

180-day adjustment policy
Annual visit checklist
BlueCard® program
Case and Disease Management (1, 2, 3)
Chronic Obstructive Pulmonary Disease action plan
Communicating with your senior patients
Fall risk checklist
Fraud, Waste and Abuse
Medicare perceived denials
Medication management (1, 2, 3, 4)
Opting out of Medicare
Palliative care program
Physician's role in dual-eligibles
Provider and Facility Reference Directory
Star ratings: measuring quality

After review of the education documents has been completed, the physician/office manager will need to submit the attestation statement form to us within five (5) business days in order to remain participating in our Medicare Advantage health plans. **Please contact your practice account manager or network specialist if you have any questions.**

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The Importance of Well Child and Adolescent Visits

The American Academy of Pediatrics (AAP) provides recommendations regarding preventive health care for newborns to individuals 21 years of age. Generally speaking, most newborns should have six or more well child visits with their pediatrician or primary care practitioner during their first 15 months of life. Visits should also occur at 18 and 24 months, three years of age, and then annually.

Assessing physical, emotional, and social development is important at every stage of life, but particularly with children and adolescents. Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood. Well child visits provide an opportunity for clinicians to identify

and address physical, developmental, emotional, social, or other problems that may impede optimal development.

Beginning with anticipatory guidance during prenatal care, these visits include vaccinations, developmental and sensory assessments, evaluation of nutrition and oral health, guidance about parenting, and other preventive services.

For adolescents, a well care visit assesses similar physical, developmental, and social indicators, but also serves as an opportunity to screen for risky behaviors and provide anticipatory guidance and brief counseling. The visit also gives practitioners the opportunity to review the adolescent's immunizations to ensure they are up to date.

Each child and family is unique; additional visits may be necessary if circumstances suggest variations from normal health. Developmental, psychosocial, and chronic disease issues for children and adolescents may require counseling and treatment visits separate from preventive care visits.

Due to their frequency and conflicting information in the media, some parents skip well child visits and immunizations. Therefore, it's necessary to educate parents on the importance of these visits. Patient reminder systems can also assist in identifying under-compliance and help to increase preventive care visits.

For additional information and resources, go to **brightfutures.aap.org/clinical_practice.html**

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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 "non-participating." 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/Internet-Only-Manuals-IOMs.html**

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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The Importance of Lead Screening

Lead poisoning is the **number one** environmental health threat to children in the United States. Today, at least four million households have children who are being exposed to lead; half a million children, ages one through five, have blood lead levels above five micrograms per deciliter (µg/dL), the level at which the Centers for Disease Control and Prevention recommends public health actions be initiated.

Unfortunately, because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized until it's too late. New York state requires health care providers to test all children for lead at one year of age, and again at age two. In addition, at every well child visit up to age six, health care providers must ask parents about any contact their child might have had with lead. If there's a chance of contact, providers are required to test for lead again.

Lead from paint, including lead-contaminated dust, is one of the most common causes of lead poisoning. In addition, soil in the yard or on playgrounds can become contaminated and cause lead poisoning. Between 83 and 86% of all homes built before 1978 contain lead-based paint. The older the house, the more likely it is to contain lead-based paint, and the higher the concentration.

No safe blood lead level in children has been determined. Lead exposure can produce adverse effects on virtually every organ and system in the body. Lead poisoning in pregnant women can result in reduced fetal growth and premature birth.

To determine if your patients are at risk, have parents complete a Lead Poisoning Home Checklist. A copy can be found on our website and at the following address:

https://www.epa.gov/sites/production/files/documents/parent_checklist3.pdf

For more information, visit **cdc.gov/nceh/lead/**

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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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Updated Drug Therapy Guidelines

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

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

Changes to Drug Therapy Guideline for Opioid Management:

Effective April 1st, 2018, long-acting opioids will require preauthorization when being billed to the plan for the first time. The purpose of this change is to encourage the safe start of long-acting opioids. Please note this change does not impact Medicaid or Medicare D members.

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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