NETWORK NEWS AND UPDATES

BlueCross BlueShield of Western New York

Table of Contents

More Preauthorization Codes Lifted 2
2018-19 Seasonal Flu Vaccine 2
Landmark Partnership Extending Care Offerings 3
Updated Drug Therapy Guidelines and Changes for Opioid Management 4
Pneumococcal Vaccination for Older Adults 5
Breast Cancer Screening 5
Updating Your Provider Information 6
Updated Recommendation for PSA-Based Screening for Prostate Cancer in Men 8
Member Rights and Responsibilities 9
Eliminating Elective Deliveries Before 39 Weeks 10
Medicare Advantage Provider Education (MAPE) Available Online 11
No Referrals for Healthy NY and Essential Plan 12
Health Care Proxies: Helping Your Patients Plan Ahead 12
Palliative Care Program 12
Out-of-Plan Referral Guidelines 13
Medical Protocol Updates Now on Our Website 14
Coding Advisor 15
Urinary Incontinence 15
The Appropriate Use of Imaging for Spinal Injuries 16
Opting Out of Medicare 16
Perceived Denials 17
The Physician's Role in Managed Care for Members with Special Needs (Including Medicare Advantage Dual-Eligibles) 18
What is Population Health Management? 19
FEP Coverage Changes for Infliximab 20

More Preauthorization Codes Lifted

To reduce the administrative burden on providers, BlueCross BlueShield began removing preauthorization requirements for certain medical procedures, services, and durable medical equipment (DME) in February 2017. As of August 1, 2018, we have removed preauthorization from 517 codes, representing a significant reduction.

We are able to simplify the process of these particular procedures and services because of value-based reimbursement, which has focused efforts on patient-centered health care and has reduced our reliance on preauthorization as a medical management tool. While preauthorization has been removed from these codes, medical protocols remain in effect.

You can find a full list of the more than 200 codes most recently removed from preauthorization by logging in at **bcbswny.com/provider** and following the link on the provider dashboard. We continue to evaluate the appropriateness and effectiveness of preauthorization policies on a monthly basis, so please continue to check "code and comment" by logging into our secure provider website (above).

Please note that this decision affects all products except Medicaid and Child Health Plus. As always, preauthorization requirements for ASO products are contract-specific.

∞

2018-19 Seasonal Flu Vaccine

The Centers for Disease Control and Prevention (CDC) recommends all persons six months of age and older receive an annual influenza vaccination, unless they have specific contraindications.

For 2018-19, the trivalent vaccine contains:

- an A/Michigan/45/2015 (H1N1)pdm09-like virus
- an A/Singapore/INFIMH-16-0019/2016 A(H3N2)-like virus
- a B/Colorado/06/2017-like (B/Victoria lineage) virus

The quadrivalent vaccine recommendation includes the trivalent vaccine viruses as well as a B/Phuket/3073/2013-like (B/Yamagata lineage) virus.

In February 2018, the Advisory Committee on Immunization Practices (ACIP) decided to make LAIV4 available for the 2018-19 flu season, based on indirect study data from the manufacturer, which suggested their new formulation would be effective, as well as a review of other published research. However, upon review of the same data, the American Academy of Pediatrics (AAP) recommends children receive the injectable inactivated influenza vaccine (IIV), which was shown to be more consistently effective against most strains of the flu virus over the past several flu seasons (AAP Advises Parents Choose the Flu Shot, 2018).

For those children who would otherwise receive no flu vaccine, the AAP says the nasal spray vaccine can be given as a last resort, though it could leave them at higher risk for flu than if they had received the flu shot. The nasal spray vaccine is not recommended for children under 2 years, or children with chronic medical conditions, such as asthma.

Finally, although flu vaccine effectiveness can vary from year to year, there is an added benefit to receiving the vaccine even if the patient gets the flu. According to the CDC, a new study in the journal *Clinical Infectious Diseases (CID)* showed that flu vaccination reduced deaths, intensive care unit (ICU) admissions, ICU length of stay, and overall duration of hospitalization among hospitalized flu patients. This study is an important first step in better understanding whether flu vaccines can reduce severe flu outcomes, even if they fail to protect against infection (Influenza (Flu), 2018).

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

Sources:

AAP Advises Parents Choose the Flu Shot. (2018, May 21). America Academy of Pediatrics:
https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Advises-Parents-to-Choose-the-Flu-Shot-For-2018-2019-Flu-Season.aspx

Influenza (Flu). (2018, May 25). Retrieved June 1, 2018, from CDC Centers for Disease Control and Prevention:
https://www.cdc.gov/flu/spotlights/vaccine-reduces-severe-outcomes.htm

∞

Landmark Partnership Extending Care Offerings

BlueCross BlueShield's Care at Home℠ program has been offering in-home medical visits and 24/7 support for our eligible Medicare Advantage members through a partnership with Landmark Health. Since its inception in 2014, Care at Home has offered peace of mind and an extra level of security to thousands of our members and their families. Due to the success of Care at Home, we recently expanded the pool of eligible members, so even more of your patients can have access to this 24/7 in-home support at no cost to them.

In addition, Transitions of Care was launched in April, offering short-term care (up to 30 days) for our Medicare Advantage members who are transitioning from inpatient settings to home. The program is expected to result in better outcomes and reduced readmissions.

Eligibility requirements for Transitions of Care include that members are:

- Not already receiving home-care services from the Care at Home program
- Being discharged to either home or an assisted living setting

Members must also have experienced any of the following:

- Been in the hospital more than once in the last 30 days, or more than twice in the last 90 days
- Admitted to the hospital for longer than 10 days
- In a skilled nursing facility or rehab facility for more than 21 days

For more information about Transitions of Care or Care at Home, call Provider Service at 1-800-950-0051 or (716) 884-3461.

∞

Updated Drug Therapy Guidelines and Changes for Opioid Management

Updated drug therapy guidelines are available at **bcbswny.com/provider > *MENU > For Providers > Policies & Guidelines >Drug Therapy Guidelines.***

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 November 1, 2018, preauthorization (PA) will be required for any opioid prescription that contributes to a patient's first time exceeding a threshold of 90 mg of cumulative morphine equivalent dosing (MED) per day. This MED monitoring strategy empowers pharmacists with visibility to patients' actual cumulative use – across all claims, at all pharmacies – using conversion factors to convert every opioid dispensed to the equivalence of oral morphine. The 90 mg MED threshold was determined using recommendations from the Centers for Disease Control and Prevention (CDC) published in 2016.

This strategy is meant to give greater consideration to patients whose current opioid use is less than 90 mg MED per day, but who are issued a new prescription or dose increase that would result in opioid usage that exceeds 90 mg MED per day. **With that goal in mind, members who already have a daily MED of 90 mg or more prior to November 1, 2018 will not be subject to this limit.** To further avoid disruption, patients who are currently using 60 mg to 89 mg MED per day will be issued an informative mailing explaining the new requirements that may impact them if their MED usage increases.

Preauthorization requests for exceeding 90 mg MED per day can be submitted to the plan via the regular PA process for consideration.

∞

Pneumococcal Vaccination for Older Adults

Approximately one million adults in the U.S. 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 contract it (National Foundation of Infectious Diseases). The Advisory Committee on Immunization Practices (ACIP) recommends adults 65 and older receive:

- Pneumococcal conjugate vaccine (PCV13 or Prevnar 13®) **and**
- Pneumococcal polysaccharide vaccine (PPSV23 or Pneumovax®)

In addition, 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.

Speak with your patients about their risk, and encourage those that meet the age and/or medical condition requirements to complete the vaccination series.

Source:
Why vaccinate against pneumococcal disease? Retrieved June 22, 2018, from National Foundation of Infectious Diseases:
http://www.adultvaccination.org/pneumococcal_vaccine_vaccination_adult_immunization.htm

∞

Breast Cancer Screening

Regular screening is the most reliable way to find breast cancer early. The Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force recommend:

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

Despite the importance of early detection, only 65.3% of women 40 years of age and older reported having a mammogram within the past two years (National Center for Health Statistics, 2016). Barriers to mammography screenings may include:

- Low income (or worry about cost)
- Lack of access to care (such as lack of a local, or easy to get to mammography center, or lack of transportation to a mammography center)
- Lack of a usual health care provider
- Lack of a recommendation from a provider to get mammography screening
- Low education level

- Lack of awareness of breast cancer risks and screening methods
- Lack of child care
- Lack of sick leave or unable to miss work
- Fear of bad news or pain from the procedure
- More recent migration to the U.S. (born outside the U.S. and living in the U.S. for less than 10 years)
- Cultural and language differences

These barriers may explain some of the disparities in mammography screening rates among certain populations of women, such as women from different racial and ethnic groups. If a patient is resistant to screening, try to determine, and then address, any concerns or barriers to screening.

For more information, visit **https://www.cdc.gov/cancer/index.htm**

Source:
National Center for Health Statistics. Health, US, 2016: With Chartbook on Long-term Trends in Health 2017. **https://www.cdc.gov/nchs/data/hus/hus16.pdf#070**

∞

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) and other regulatory entities 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 us 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 us 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:

- Provider/physician name
- Practice name
- Practice location(s) (address, suite, city, state, ZIP code)

- Practice phone number(s)
- Accepting new patient status
- Provider practicing specialty
- Office staff awareness of provider's/physician's participation in our network

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:

- Anticipated changes in provider participation with health plan, e.g., retirement, moving out of area, available as covering only
- Provider/physician gender
- Languages spoken
- Office hours for seeing patients
- 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
- Provider credentials, e.g., place of residency and fellowship
- Board certification
- Email addresses for:
  - Office manager
  - Credentialing manager
  - Clinician(s)
- Website address
- Any change that may materially impair your ability to carry out the duties and obligations of your agreement with us
- Hospital affiliation
- Provider type, e.g., MD, DO, DDS
- National Provider Identifier (NPI)

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 *View Forms* and select *Provider Demographic Change Form* under the *Practice Administration* heading. You can also email us at **provider_data_mgmt@bcbswny.com** Please include your individual 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. 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.

∞

Updated Recommendation for PSA-Based Screening for Prostate Cancer in Men

Prostate cancer is the most commonly diagnosed form of non-skin cancer among men in the United States, and it's estimated that it will cause 29,430 American deaths in 2018 (Cancer Facts & Figures, 2018). The U.S. Preventive Services Task Force (USPSTF) recently updated its recommendation regarding prostate-specific antigen (PSA)-based screening.

For men ages 55 to 69, the USPSTF recommends individualized decision-making about PSA-based screening for prostate cancer after discussion with a clinician. This discussion affords men the opportunity to understand the potential benefits and harms of screening, and to incorporate their values and preferences into the decision.

According to the USPSTF, screening offers a small potential benefit of reducing the chance of death from prostate cancer in some men. However, men can experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction.

Patients and clinicians should consider the balance of benefits and harm on the basis of family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harm of screening and treatment-specific outcomes, and other health needs.

USPSTF still recommends against PSA-based screening for prostate cancer in men 70 and older.

For more information, visit:
https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1

Source:
Cancer Facts & Figures (2018). Retrieved May 8, 2018, from American Cancer Society:
https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2018/cancer-facts-and-figures-2018.pdf

Member Rights and Responsibilities

As partners in health care, each of us has rights and responsibilities that we must follow in order to make the most of our members' health benefits. The following rights and responsibilities apply to our members:

Member Rights

Members have the right to:

- Receive information about the health plan, its services, its practitioners and providers, and member rights and responsibilities
- Treatment with respect, consideration, dignity and privacy
- Information about all services available through the health plan, including how to obtain emergency and after-hours care
- Confidentiality of their medical records
- Candid discussions concerning appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage
- Voice complaints or appeals about the health plan or the care provided
- Request to see the physician selected for their primary care services instead of another member of his/her office staff for an office visit, if they are willing to wait for an available appointment
- Make recommendations regarding the health plan's member right and responsibilities policies

Patient Rights

As a patient, our members have a right to expect the following from their physicians or other providers:

- To participate in decisions concerning their healthcare
- To refuse treatment to the extent permitted by law, and to be informed of the medical consequences of that action
- To obtain from their physician or other health care provider complete and current information concerning a diagnosis, treatment, or prognosis, in terms they can reasonably be expected to understand; when it is not advisable to give such information to a member, the information shall be made available to an appropriate person on their behalf
- To receive information from their physician or other provider necessary to give informed consent prior to the start of any procedure
- To know the name and qualifications of all their caregivers; information can be obtained from the provider or the administrator of any health care facility

If a member feels that their physician has not given them the kind of service they have the right to expect, our members have the right to follow the complaint procedure for Quality of Care Access Review. They can refer to their member handbook or contact customer service.

Member Responsibilities

- Establish themselves as a patient of the physician they have selected for their primary care services
- Follow the instructions and guidance of health care providers
- Provide honest and accurate information concerning their health history and status
- Participate in understanding their health problems and developing mutually agreed upon treatment goals
- Follow carefully the health plan's policies and procedures as described in their member handbook and their contract(s) and rider(s)
- Be sure that their primary care physician coordinates any health care they receive in order to receive the highest level of benefits, if applicable under the terms of your plan coverage
- Carry their member ID card with them and present it when seeking health services
- Advise their health plan of any changes that affect them or their family such as birth, change of address, or marriage
- Submit all bills they receive from a non-participating provider within one year from the date of service
- Notify their health plan when anyone included in their coverage becomes eligible for Medicare or any other group health insurance
- Keep their health plan informed of their concerns about the medical care they receive
- Pay appropriate copayment/deductible/coinsurance or other patient responsibility to providers when services or supplies are received

The most current version of our *Member Rights and Responsibilities* is available at **bcbswny.com/provider** Paper copies are available upon request by contacting Provider Service at 1-800-950-0051 or (716) 884-3461.

∞

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:

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

There is a 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.

∞

Medicare Advantage Provider Education (MAPE) Available Online

In response to the Centers for Medicare and Medicaid Services (CMS) requirement, we have introduced 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 MAPE page 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 education documents have been reviewed, the physician/office manager must submit the attestation statement form to us within five (5) business days in order to remain in our Medicare Advantage health plans. Please contact your practice account manager or network specialist if you have any questions.

∞

No Referrals for Healthy NY and Essential Plan

Effective September 1, 2018, BlueCross BlueShield will no longer require referrals for the Healthy NY and Essential Plans.

∞

Health Care Proxies: Helping Your Patients Plan Ahead

In life, sometimes you need to expect the unexpected. Make sure your patients are prepared with a health care proxy in the event that they cannot communicate their health care wishes.

When a 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.

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,** available in seven different languages at: **https://www.health.ny.gov/professionals/patients/health_care_proxy/**
- Ask them to provide copies of the completed form to you, their caregiver(s), and/or family
- For adult patients (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
- Provide copies to family, caregiver, and health care proxy in case of an emergency

∞

Palliative Care Program

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

What is palliative care?

Palliative care provides services that help patients and their families maintain independence and comfort during a progressive illness.

Team members include:

- The patient's provider
- Registered nurse case manager
- Social worker/counselor
- Palliative care consulting doctor

Services include:

- 24/7 on-call visits for managing pain and symptoms
- Provider visits for symptom assessments
- Education and advice on living with the illness
- Assistance from a social worker to connect with community services
- Help with developing goals
- Strategies for coping with side effects from treatments
- Assistance with advanced care plans
- Frequent contact to check on the patient and answer questions

Who is eligible for the program?

- In-home support is available for members who meet the criteria. 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

For more information, or to enroll your patient in the Palliative Care program, please call: 1-877-878-8785 option 2 (TTY 711). We are available to assist you Monday – Friday, 8:30 a.m. – 5 p.m.

∞

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.

∞

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 October 1, 2018, 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: **bcbswny.com/provider** > *Medical Protocols.*

∞

Coding Advisor

Proper coding is an ongoing challenge. We recognized the difficulty in determining which level of CPT code appropriately reflects the complexity of an office visit. Because the use of Evaluation and Management (E/M) codes constitutes a high percentage of billing mistakes, BlueCross BlueShield is working with Change Healthcare to provide guidance through their Coding Advisor solution.

Coding Advisor will review the use of E/M codes, psychotherapy assessments, and the billing modifier 25 for submitted claims. The program's aim is to provide useful data insights to providers, maximize coding accuracy through education, and reduce the burden associated with traditional audits.

Beginning in September, 2018, Coding Advisor will initiate an outreach campaign to qualifying providers. This outreach will involve communications including notification letters, education-based phone calls and clearinghouse-level claim status messaging. Coding Advisor will monitor billing practices and send updated reports periodically. Change Healthcare may contact your practice to clarify any coding discrepancies and to perform one-on-one coding education as part of this program.

∞

Urinary Incontinence

Urinary incontinence (UI) is a significant problem, affecting tens of millions of Americans. UI can cause a wide range of morbidity in the elderly, including pressure ulcers, urinary tract infections (UTIs), social withdrawal, and depression.

Patients may not report incontinence to their primary care providers due to embarrassment or misconceptions regarding treatment. Since incontinence is often treatable, it is imperative that health care professionals be adept at identifying patients who might benefit from treatment.

To initiate discussion about UI, it's important to:

- ask patients 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.

∞

The Appropriate Use of Imaging for Spinal Injuries

Adult patients age 18 and older who have symptoms of low back pain or radiculopathy with the absence of "red flags" at the initial visit should not have imaging ordered. Once serious underlying conditions, neurological deficits and non-spinal causes of back pain are ruled out, conservative treatment options should be explored.

Studies have shown that early imaging (before six weeks of onset) does not result in improved outcomes. But patients who have early imaging have substantially higher health care use and cost than those who do not undergo early imaging.

If you have a patient dealing with 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.

Sources/more information:
Jarvik, JG. "Association of Early Imaging for Back Pain with Clinical Outcomes in Older Adults." ***Ncbi.nlm.nih.gov*****, JAMA, 17 Mar. 2015, ncbi.nlm.nih.gov/pubmed/25781443**

https://www.aafp.org/patient-care/clinical-recommendations/all/cw-back-pain.html

∞

Opting Out of Medicare

Federal regulations prohibit Medicare Advantage (MA) organizations, including BlueCross BlueShield of Western New York, from paying for services rendered by physicians or practitioners who have chosen to opt out of the Medicare program, except in limited circumstances.

An MA organization may contract **only** with physicians or practitioners 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 HMO or PPO networks.

BlueCross BlueShield will not cover any services provided by physicians/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.

Physicians and practitioners 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 physicians and practitioners also require a "private contract" between the Medicare beneficiary and the physician or practitioner 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 physician or practitioner, as well as to pay the physician/provider for services directly.

A physician or practitioner may cancel opt out by submitting written notice to the Medicare Administrative Contractor not later than 30 days before the end of the current two-year opt-out period. If a physician or practitioner wants an early termination of their opt-out status, there are specific Medicare requirements that must be met timely and the physician or practitioner must not have previously opted out. 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/downloads/bp102c15.pdf**

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 physicians or practitioners who opt out of Medicare is available from the local Medicare Administrative Contractor, National Government Services, at **ngsmedicare.com**.

∞

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
- 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.

∞

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 beneficiary deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) Program, a dual-eligible program that 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 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.

∞

What is Population Health Management?

Population Health Management is a service provided to help your patients with general wellness, acute or chronic illnesses achieve better health outcomes. After looking at each case individually and considering the member's plan benefits, we connect the patient and their caregiver with the necessary medical care and psychosocial support.

When you enroll a patient in Population Health Management, they receive:

- Health care support from a registered nurse (health coach)
- A care plan based on your plan
- Assistance from a pharmacist, social worker, respiratory therapist, chiropractor, behavioral health specialist, and dietitian, 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:

Asthma: Helps to improve the health status for members with asthma using a multi-disciplinary, population-based approach and to manage health care costs by promoting evidence-based treatment while assisting members to achieve optimal control of their disease.

Cardiac: Meets the needs of members with cardiac disease through education, self-management, empowerment, linkage to community resources, and support**.**

Chronic Kidney Disease: Links members with specialized nephrology services to maintain optimal health.

Chronic Obstructive Pulmonary Disease (COPD): Assists members in understanding COPD, promotes self-management skills and develops a collaborative relationship that can decrease COPD complications while also reducing health care costs.

Depression/Substance Use: 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 use, and other behavioral health-related disorders.

Diabetes: Helps members with diabetes identify barriers and develop objectives for improving the quality of clinical care, patient education, knowledge, quality of services, and outcomes.

General Case Management: Targets members with multiple or complex conditions to obtain access to care and services, and coordinate their care.

Hip and Knee: Assists members in the management of osteoarthritis of the hip and knee. The objective is to reduce pain, improve function and quality of life of members with osteoarthritis (OA), who have elected conservative management of their joint signs/symptoms, or who are waiting to undergo elective lower extremity joint replacement surgery.

HIV/AIDS: Educates and coordinates appropriate care and services in an effort to improve quality of life and minimize health complications.

Maternity: Assists women by providing education and coordination of services in an effort to maintain a healthy full-term pregnancy.

Oncology: Helps members navigate through the cancer network of providers and shares information that will help them understand and manage their condition.

Palliative care: Helps members with serious illness control symptoms and avoid unnecessary emergency room visits.

Spine: Raises awareness and improves outcomes about the cause, treatment, and management of spine-related conditions with both our providers and members.

Transplant: The health coach acts as a resource regarding transplant information, cost issues, community resources, and care options.

If you feel that your patients would benefit from Population Health Management services, please call us at 1-877-878-8785.

∞

FEP Coverage Changes for Infliximab

Beginning January 1, 2019, Federal Employee Program (FEP) benefit procedures will change for the autoimmune infusion drug infliximab (brand names Remicade®, Inflectra® and Renflexis®). Members currently receiving the drug may be covered under either pharmacy or medical benefits. However, members who receive a first infusion on or after January 1, 2019, can only receive the drug under medical benefits. Members who receive infliximab under pharmacy benefits prior to January 1, 2019, will continue receiving it under pharmacy benefits.

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