NETWORK NEWS AND UPDATES

BlueCross BlueShield of Western New York

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Thank you!

Back in January, we asked for your help with ensuring that our Medicare Advantage members get their Annual Wellness Visit (AWV) – an important annual benefit to help direct their care for the rest of the year, as well as identify gaps in care. We want to thank all of you who answered the call and performed AWVs for your patients in 2018.

An AWV offers an opportunity to make a plan for prevention and wellness, and can be combined on the same date of service as an annual physical to save time for you and your patients. To get the most out of an AWV, we recommend using the Vatica Well365 tool. The Vatica tool provides computer-assisted diagnostic coding, CPT-II code entry, and a 10-year screening schedule that's created automatically. It also captures ICD-10 codes, so you may receive fewer chart review requests when you include complete diagnosis codes on your claims submissions. Please reach out to your practice account manager with any questions about AWVs or Vatica.

Again, we thank you for your commitment to your BlueCross BlueShield patients, and we look forward to working with you in 2019.

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Getting Your 1099

To get your 1099, you need to let us know if your mailing address associated with your Tax Identification Number has changed in the last year. If you don't, we may not be able to deliver your 1099 paperwork. Here's what you need to do:

- Go to **bcbswny.com/provider** **>** *Tools & Resources > Forms* and download or print the Provider Demographic Change Form
- Fill out Sections I and III
- Check and complete the "Address Change Only" in Section II, and sign the form
- Fax the signed form, along with your W-9 form, to (716) 887-8886.

Thank you for helping us keep your information current, and ensuring that you get your important tax forms.

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Only ADA 2012 Dental Claims Accepted

Effective December 1, 2018, we will only accept the 2012 version of the American Dental Association (ADA) dental claim form. Older forms can no longer be processed by our system, and will be returned.

If you cannot submit dental claims to us electronically, you can arrange to do so through Administrative Services of Kansas EDI (ASK) online. Most practice management systems can generate electronic claims. Your software vendor can tell you if your system will support electronic claim transactions. You can fill out the enrollment form found at **ask-edi.com** > *Getting Started*.

If you will still need to submit paper claims, go to **ada.org** to order 2012 dental claim forms.

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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[1]. 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.

[1] *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**

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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 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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Physical Accessibility of Provider Sites for People with Mobility Impairment

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

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

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

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

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

If your office is not wheelchair accessible, we ask that you promptly submit a documented plan for how you will accommodate persons with disabilities. If you have any questions or concerns, please contact your Provider Network Management and Operations Specialist at 1-800-666-4627.

For further information regarding ADA requirements and "Access to Medical Care for Individuals with Mobility Disabilities", you may visit the ADA website at **ada.gov**.

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Chlamydia Screening

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

In 2016, nearly 1.6 million cases of chlamydia were reported to the Centers for Disease Control and Prevention (CDC) from all 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 in younger adults, ages 15 to 24. It is estimated that 1 in 20 sexually active young women between the ages of 14 and 24 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 25 years and older, if at increased risk
- Retest during the third trimester for women who are 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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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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Palliative Care Program

We offer care and support at home for patients and families facing serious, progressive illness regardless of the patient's age or stage of illness. We understand a patient's quality of life is directly affected by good symptom management and a better understanding of disease. We can work with you and your patients to coordinate medical care and linkage to community services. 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
- A registered nurse case manager
- A social worker/counselor
- A palliative care consulting doctor

Who is eligible?
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, whether or not the patient is continuing with treatment
- 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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Provider Administrative Policies

The Healthcare Quality Improvement policies are reviewed and updated annually, and approved by our Quality Management Committee. These administrative policies apply to your office practice and are available on our website. You can access these policies by going to **bcbswny.com/provider** *Menu> For Providers > Policies & Guidelines > Office Administration,* or you can go to the "Quicklinks" at the bottom of the Provider page and click on the *Provider & Facility Reference Manual* (*Section 11 - Provider Practice Policies).* You will find information about the following policies:

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

Access to Care policy was revised to add a "General Guidelines" section applicable to all practitioner offices and updated information regarding adherence monitoring as follows:

General Guidelines:
Members with an appointment should not routinely be made to wait longer than one (1) hour.

Telephone access for physician offices:

- Phones should be answered promptly.
- If the office has an automated telephone directory, there should be a prompt for emergency situations that allows the caller to speak to someone.

- If the caller is to be placed on hold, the person answering the telephone must assess for an emergency before placing the caller on hold.
- Callers should not be on hold for more than three (3) minutes without someone checking on them.

Adherence to this policy is monitored during the provider office compliance attestation process, on-site review, or after-hours audits, as well as by member complaint evaluations and member satisfaction surveys.

Medical Record Review policy was clarified to indicate the number of records to be reviewed if a single practitioner record fails the Medical Record Documentation Standards.

- Should the single record fail review for standards, a random sample of three (3) to five (5) additional medical records will be requested from the practitioner. A full review against Medical Record Documentation Standards will follow.

Medical Record Documentation Standards were clarified to indicate that the provider specialty will be included in the specifications for the file pull. In addition, sources were updated.

Criteria for file pull:

- Members identified also have had a visit with a specialist during the past 12-month period (provider specialty is chosen by the clinical team).

Sources:

- *CMS: 1997 Documentation Guidelines for Evaluation and Management Services (updated 8/2017)*

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

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

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Anticoagulant Management for Patients Taking Warfarin

We provide coverage of anticoagulant management for patients taking warfarin, which can be billed under the code 93793. As a reminder, this service should include:

- Review and interpretation of a new home, office or lab international normalized ratio (INR) test result
- Patient instructions
- Dosage adjustment, as needed
- Scheduling of additional test(s), when performed

If you have any questions, please contact your account manager.

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Clinical Practice Guidelines

The following Clinical Practice Guidelines have been reviewed and approved by our Quality Management Committee (QMC) and are now available by logging on to **bcbswny.com/provider** > *Policies & Guidelines* > *Practice Guidelines.*

The following guidelines had no content changes:

- 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)
- Stroke
- Substance Use Disorder
- Tobacco Cessation

The following guidelines had content changes:

Spine – revisions include recommendations for:

- Initial Evaluation
- Imaging
- Education
- Heat Therapy
- Cold Therapy
- Spinal Manipulation
- Acupuncture
- NSAIDs
- Acetaminophen
- Muscle Relaxants
- Opioids
- Epidural Injections

In addition, updated preventive health guidelines are available on our website for:

- Men
- Women
- Birth to 18 years

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

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Spirometry Testing

The signs and symptoms of asthma and chronic obstructive pulmonary disease (COPD) are similar; 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), please call Respiratory Services of Western New York at (716) 683-6699.

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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) 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 **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.

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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 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.

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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 physicians or practitioners who have chosen to opt out of the Medicare program, except in limited circumstances.

A 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 and 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 or 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/practitioner 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/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 physicians or practitioners 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, they are 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 they believe 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 they 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. ∞

End the Epidemic

End the Epidemic is Governor Andrew Cuomo's 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

- Identify 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.
- Link and retain persons diagnosed with HIV to health care; begin anti-HIV therapy to maximize HIV virus suppression, remain healthy, and prevent further transmission.
- Focus 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.
- Provide 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, PrEP, includes 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 six months
- Anyone who is not in a mutually monogamous relationship with a partner who recently tested HIV-negative
- Heterosexual men or women who do not regularly use condoms with partners of unknown HIV status who are at substantial risk of HIV infection
- 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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Timely Health Information Exchange Improves Care

The timely exchange of information during transitions in health care is an essential component in providing safe, coordinated and cost-effective patient care. In 2018, our Health Care Quality Improvement (HCQI) department conducted an information exchange survey and a medical record review for timeliness and quality of information to identify opportunities to improve the continuity and coordination of care.

Information Exchange Survey
The 2018 behavioral health (BH) and primary care providers (PCPs) surveys were distributed using a new online methodology. The results identified opportunities for improvement in frequency, timeliness, and process for information exchange between all provider types measured.

Primary care providers reported that:

- Specialists, urgent care centers and emergency departments usually notified them when patients were treated.
- Most PCPs responded they are only sometimes or never notified of patients admitted to a behavioral health facility and clinical information received was usually or sometimes timely.
- The electronic health record (EHR) and E-prescribing revealed strong utilization and use of Health Information Exchange (HIE) steadily increased.

Behavioral health providers reported that:

- Sharing of clinical information from PCPs to BH specialists has shown marginal improvement since 2017.
- The survey indicated that emergency departments, urgent care centers and specialists need improvement in communicating with BH providers.
- Use of the electronic health record (EHR) has steadily increased and use of HIE is slow but trending upward.

We heard you…
Thank you for your valuable feedback. Many of you voiced the importance of bi-directional communication between BH, primary care, specialists and health care facilities to deliver optimal care to your patients. Other feedback identified barriers as:

- Confusion related to PHI and HIPAA
- Need for EHR training and information on the benefits of HIEs
- Lack of unified systems
- Administrative burden relative to information requests
- Lack of standardized communication forms and sound information sharing methods for small/solo practices

Medical Record Review for Timeliness and Quality of Information
The 2018 Medical Record Review for timeliness and quality of information exchange between specialists and PCPs was performed. A sample of 106 PCP records were reviewed for members who had two PCP visits within

a 24-month period, with at least one PCP visit within the last 12 months and a minimum of one specialist visit within the last 12 months.

	Records reviewed	% of specialist records present	% of specialist records received timely	% if records with evidence that PCP reviewed the record
Ophthalmology	66	36%	83%	33%
OB-GYN	40	38%	60%	20%
Total	106	37%	27%	10%

How to improve communications

- Continue to educate your patients about the importance of information sharing and ask if there are providers who should receive their health information.
- Participate in your regional HIE, such as HEALTHeLINK, and encourage your patients to sign consent to give you real-time electronic access to their medical information.
- Consider other approaches, such as direct messaging, which is secure email that allows health providers to securely exchange clinical information. Direct messaging is a functionality of your electronic health record (EHR) and available through regional HIEs.

Information exchange policy

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. This policy is posted at **bcbswny.com/provider** > *Policies & Guidelines* > *Office Administration Guidelines*.

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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, they will incur higher out-of-pocket costs.

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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 January 1, 2019, 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** > *Policies and Guidelines* > *Medical Protocols*

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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.

FEP Formulary Reminders
The Federal Employee Service Benefit Plan (FEP) drug formularies are updated quarterly and are available at:
https://www.caremark.com/portal/asset/z6500_drug_list.pdf (Standard Option Formulary)
https://www.caremark.com/portal/asset/z6500_drug_list807.pdf (Basic Option Formulary)

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Fraud Awareness and 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 at **bcbswny.com** > *Home* > *About Us* > *Deficit Reduction Act*.

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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