NETWORK NEWS AND UPDATES

BlueCross BlueShield of Western New York

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Introducing *Blue Bulletin*

This edition of our quarterly *Network News and Updates* will be our last, as we introduce a new monthly communication, the *Blue Bulletin*. As part of our ProviderFirst strategy, we hope this will help to improve how we communicate with you. This new approach has been developed to better integrate into your busy office workflow.

The *Blue Bulletin* will arrive in your email every month, offering brief summaries of articles that you can "click" on to read. This "news you can use" can also be forwarded to anyone in your office. The full articles will be accessible by phone or desktop and can be easily printed or saved as a PDF. We are delivering *Blue Bulletin* by email because many of you have told us this is your preferred way of hearing from us.

The *Blue Bulletin* will be our primary vehicle for communicating important updates and useful tips to you, our valued provider partners. By combining what used to be multiple communications into a once-a-month email, we will provide predictable, reliable, and timely updates meant to improve how we work together.

Please watch for the first edition of the *Blue Bulletin* at the end of April, then at the end of every following month. We look forward to delivering meaningful information to you in this easy-to-access format.

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Osteoporosis Management

Approximately 54 million people in the United States either have osteoporosis or are at an increased risk due to low bone density.[i] [ii] The U.S. Preventive Services Task Force (USPSTF) recommends screening for osteoporosis in women 65 years or older and in younger women at increased risk.[iii] Despite the prevalence and adverse effects of the condition, osteoporosis is often undertreated. If one of your patients with osteoporosis has had a recent fracture, the current standard of care based on Healthcare Effectiveness Data and Information Set (HEDIS) standards is to:

- Order a bone mineral density (BMD) test (if one has not been completed in the past two years), or
- Prescribe and fill a medication to treat osteoporosis within six months post the initial fracture date

The current standard for evaluation of BMD is a dual-energy X-ray absorptiometry (DEXA) scan. Bisphosphonates and other medications, such as Calcitonin and Raloxifene, are available to help treat osteoporosis.

In an effort to reach our members, BlueCross BlueShield of Western New York has partnered with local vendors to perform in-home BMD tests. If you have a patient with transportation or mobility concerns, please

[i] Osteoporosis: **https://www.bones.nih.gov/health-info/bone/osteoporosis**
[ii] Debunking the myths: **https://www.nof.org/preventing-fractures/general-facts/**
[iii] **https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/vitamin-d-calcium-or-combined-supplementation-for-the-primary-prevention-of-fractures-in-adults-preventive-medication**

call our Health Management Program Development Department at (716) 887-6717 to schedule an in-home appointment with our partnered vendors. The vendor will provide you with the test results.

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

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Importance of Dental Visits During Pregnancy

Please remember to counsel pregnant women under your care about the importance of good oral health during pregnancy.

While women usually know to take good care of their bodies during pregnancy, they often skip their dental visits. Research suggests that the importance of good oral health care in pregnancy is often misunderstood by women and their doctors. In fact, pregnant women with periodontal disease are at increased risk of preterm birth, as well as having children with a greater likelihood of cavities and tooth decay.

The Bright Futures Oral Health Guide, found at **mchoralhealth.org/pocket**, offers helpful information about pregnancy and oral health.

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Assessing Sepsis: Help for Your Staff

Did you know?

- One in three people who die in the hospital have sepsis.[i]
- A 2016 study revealed that 72% of patients hospitalized for severe sepsis or septic shock had symptoms up to 30 days prior to hospitalization. [ii]

IPRO, the Atlantic Quality Innovation Network and The Centers for Medicare and Medicaid Services (CMS), developed an **educational webinar (train the trainer)** to assist clinical office staff with:

- Identifying high-risk populations
- Recognizing early signs and symptoms
- Knowing appropriate treatment strategies for sepsis

There is no cost for this 30-minute webinar.
For more information, go to: **atlanticquality.org/initiatives/sepsis-initiative/**

[i] *Sepsis*. (2017, August 25). Retrieved January 16, 2019, from Centers for disease control and prevention: **https://www.cdc.gov/sepsis/datareports/index.html**
[ii] *Sepsis*. (2017, August 25). Retrieved January 16, 2019, from Centers for disease control and prevention: **https://www.cdc.gov/sepsis/datareports/index.html**

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Colorectal Cancer Screening

Colorectal cancer is one of the most frequently diagnosed cancers and the second-leading cause of cancer deaths among men and women combined. According to the American Cancer Society, in 2018, approximately 9,080 people in New York State were diagnosed with colorectal cancer and about 2,970 died from this disease.

The U.S. Preventive Services Task Force recommends screening all average-risk, asymptomatic adults starting at age 50 and continuing until age 75. Unfortunately, one-third of adults 50 or older have not been screened as recommended.

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

Screening strategies include:

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

Visit **cdc.gov/cancer/colorectal** or click **here** for more information.

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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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Importance of Lead Screening

Today, childhood lead poisoning is considered the most preventable environmental disease among children. Yet approximately half a million U.S. children have blood lead levels above 5 micrograms per deciliter, the reference level at which Centers for Disease Control and Prevention (CDC) recommends public health actions be initiated.

Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized until it's too late. New York State Public Health Law and Regulations require health care providers to test all children for lead at age one 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.

If a child has an elevated lead level, the health care provider must make certain the child has follow-up testing. Providers must also provide guidance on lead poisoning prevention, risk reduction and nutritional counseling to the parent or caregiver.

For more information, please visit: **health.ny.gov/environmental/lead/health_care_providers/index.htm**

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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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The Importance of Well Child and Adolescent Visits

The American Academy of Pediatrics (AAP) provides recommendations regarding preventive health care for newborns to age 21. Generally speaking, most newborns should have six or more well child visits with their pediatrician or primary care provider during their first 15 months of life. Visits should also occur at 18, 24 and 30 months, age 3, and then annually.

Assessing physical, emotional, and social development is important at every stage of life, 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 evaluations, 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. It also serves as an opportunity to screen for risky behaviors and provide anticipatory guidance and brief counseling. Practitioners can also 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. 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.

Go to **brightfutures.aap.org/clinical_practice.html** for additional information and resources.

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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, 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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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 eligible for participation in the Medicare program and who have not opted out of Medicare. (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 the service was eligible for payment as an emergency or urgently needed under applicable Medicare standards.

The Centers for Medicare and Medicaid Services (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 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.

Physicians and practitioners must follow CMS rules regarding opting out of Medicare. The requirements and possible exceptions are outlined in the *CMS Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services*, accessible online at **cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html**

If your status with Medicare changes, you must notify us promptly by calling 1-800-666-4627. More information for New York State physicians and practitioners is available from the local Medicare Administrative Contractor, National Government Services, at **ngsmedicare.com**.

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Updating Your Provider Information

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

Health plans are required by Centers for Medicare & Medicaid Services (CMS) and other regulatory entities to have accurate information in provider directories, which are routinely reviewed and audited. As noted in Section 2.6 of your agreement, "Participating Providers shall promptly notify Health Plan in writing of any change in his or her practice."

Key data elements
Data elements required by CMS and crucial for member access are:

- Provider/physician name and National Provider Identifier (NPI)
- Practice location(s) and Group Name (phones number, fax numbers, address, suite, city, state, ZIP code)

- Office hours
- Patient acceptance
- Practicing specialty
- Awareness of provider's participation in our network

Health plans also should include up-to-date information for the following:

- Anticipated changes in participation with health plan (e.g., retirement, moving out of area, available as covering only)
- Languages spoken
- Physical disabilities accommodations
- Indian health service status
- Licensing information
- Provider credentials
- Board certification
- Email addresses
- Any change that may materially impair your ability to carry out the duties and obligations of our agreement
- Hospital affiliation

How to update your information
Current practice information can be reviewed on our online provider finder at **bcbswny.com/provider**.

Updates can be submitted by completing a Provider Demographic Change Form
View Forms and select *Provider Demographic Change Form* under the *Practice Administration* heading. You can also email us **provider_data_mgmt@bcbswny.com**. Please include your individual NPI number in the subject line.

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.

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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. QMB is 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, MA 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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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.

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Perceived Denials

We appreciate and support your efforts to manage your BlueCross BlueShield of Western New York **Medicare Advantage** patients' care in a prudent, cost-effective manner.

The Centers for Medicare & Medicaid Services (CMS) requires that members who perceive denial of treatment or care 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/type of treatment
- The provider declines to render a course/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 perceived denials:

- A patient asks to be referred to a radiologist for an MRI, but the provider does not believe that an MRI is necessary
- 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, you must:

- Contact our Utilization Management Department the day the denial occurs to inform us
- **Ensure our members are informed of their right to appeal**

Our responsibility:
We will issue a letter with details of the denial, including 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:

- Clinical rationale
- Their right to obtain reconsideration
- Procedure for requesting reconsideration

The member will be advised that they can appeal if they do not agree with our decision.

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

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