Excellus

Newsletter for our Participating Provider Partners

March 2018

CONNECTION



In this issue:

STATE HIV TESTING LAW UPDATED

REMINDER: MEMBER PAYMENTS

PHARMACY NEWS

A nonprofit independent licensee of the Blue Cross Blue Shield Association

What's Inside:

Click the title below to go directly to the article.

News You Can Use	pg. 3
March is Colorectal Cancer Month	pg. 4
Policy Regarding Patient Discrimination	pg. 4
State HIV Testing Law Updated	pg. 4
Member Payments	pg. 5
Staff Training	pg. 5
Pharmacy News	pg. 6
Coding Corner	pg. 8
Medical Policy Updates	pg. 10

Don't Keep the Latest News & Updates to Yourself...

Share this newsletter with your coworkers via the "Forward this email to a Friend" option in the eAlert!

Stay in the Know!

Visit the Provider Updates area on our website to review recent communications.

Save this page as an online "favorite" for easy access.

2017 APEX® AWARDS FOR PUBLICATION EXCELLENCE



Web Self-Service Tools

We know how busy your work day can be. That's why we remind you of the time-saving tools and information available on our website, ExcellusBCBS.com/Provider.

They are quick, convenient and available 24/7!

We require the use of our web self-service tools to check member eligibility and benefits. Learn more.

NEWS YOU CAN USE



Updated Primary Care Provider Selection Form

Please be sure to use our newly updated PCP Selection Form for Safety Net Members, found on ExcellusBCBS.com/Provider > Print Forms. If you have printed copies of the old version, please discard them. We suggest accessing the form from the website for each use to ensure that you're submitting the most up-to-date version.

Approved Vaccine Schedule

You never outgrow the need for vaccines! Click here to access easy-to-read schedules for currently recommended vaccines for all ages.

Change to PT/OT Visit Approval Process

Please be aware of an upcoming change to the number of physical/occupational therapy visits that receive automatic approval when entered into the Clear Coverage preauthorization system or calling into customer care.

Effective with requests entered on or after April 8, 2018, the first 10 visits will be approved automatically. Requests for visit 11 and beyond will suspend for medical necessity review. Please see our January 8, 2018 bulletin for more information.

Access and Availability Standards

We follow appointment availability standards established by the New York State Department of Health. These standards, which apply to all lines of business, are used to improve patient access to routine, urgent, preventive and specialty care. We also follow 24-hour access standards to measure after-hours access. Learn more by accessing our Access and Availability tip sheet and Behavioral Health Access and Availability tip sheet.

Prenatal Incentive Program Reminder

As you may know, we provide an incentive to participating physicians and nurse midwives providing prenatal care to members enrolled in "Safety Net" (Child Health Plus, HMOBlue Option, Blue Choice Option, Premier Option and Premier Child Health Plus) products through our Prenatal Incentive Program.

Excellus BCBS would like to remind you to use the Prenatal Incentive Registration Form when submitting your claim. You can find the form in the Print Forms section of our website, ExcellusBCBS.com/Provider > Print Forms.

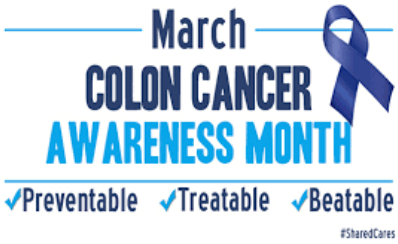
Keep Your Practice Information Current

Have you reviewed your practice information lately to ensure it is up-to-date? You can check the current listing for your practice by clicking here.

Be sure to verify that your **office hours** and **accepting new patients** statuses are accurate. This information should be reviewed every 90 days. If your office anticipates challenges meeting New York state visit time frames, you should consider changing your accepting new patients status to "**Closed to New Patients"** until timely visits are available.

If revisions are needed, click here to access our Update Practice Information form.

MARCH IS COLORECTAL CANCER MONTH



March is **National Colorectal Cancer Awareness Month**. Colorectal cancer screening can be a life-saver. Please talk to your patients who are due for this important screening. You can discuss a number of screening options based on what's best for your patients – and the screenings are free!

Excellus BlueCross BlueShield can provide educational materials about important preventive screenings. If you would like us to send helpful information to your patients about colorectal cancer screening, contact our Member Care Management team at 1-800-434-9110.

REMINDER: POLICY REGARDING PATIENT DISCRIMINATION

Our Health Plan observes the provisions of the Affordable Care Act, Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. We have procedures in place to ensure that a member is not discriminated against in the delivery of health care services consistent with the benefits covered in the member's policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

We remind you to ensure that your office policies and procedures do not discriminate against or refuse service to a Health Plan member who may receive assistance with Medicare cost sharing from a state Medicaid program.



STATE HIV TESTING LAW UPDATED

The New York State Department of Health has issued key updates to the HIV testing law. The updates are designed to minimize barriers and facilitate routine testing in clinical settings.

Be reminded of the following:

- A one-time offer of HIV testing is still mandated, and should be offered, to every person aged 13 and older; however, the maximum age limit of 64 years for routine testing has been removed. Testing must be offered to patients in inpatient, outpatient, freestanding practices and emergency department settings.
- Express consent is no longer a requirement for HIV testing.
- Minors may consent to HIV treatment and prevention.
- Notification must be made prior to ordering an HIV-related test. Patients have the right to decline the test. The offer of the test must be documented in the medical record. A patient refusal should be documented in the record, although it is not mandatory.

We hope that you find this information helpful as you deliver care to our members.



REMINDER: MEMBER PAYMENTS

We remind you that, except in limited circumstances, you may not charge and/or collect a deposit from or pursue reimbursement from our members, including:

- Billing a member for services above the applicable member responsibility (copay, coinsurance, deductible), with the exception of limited circumstances, including but not limited to non-covered services. Please refer to your participating agreement with Excellus BCBS for additional information regarding when you may bill a member for amounts other than the applicable member responsibility. In these circumstances, the member may be asked to pay for the full charge at the time the services are rendered.
- Charging a member when the member is covered by two health plans. For example, if our health plan is primary and a balance remains after we have reimbursed our allowed amount for covered services, you must bill the secondary carrier.
- Charging a member for administrative fees, such as completing claim forms or triplicate prescriptions that are standard overhead costs. Providers may bill a member if the member fails to show up for an appointment, but only if this policy is prominently displayed in the office and communicated to the physician's patients. We will not pay for missed appointments.

You **may** collect applicable copayments, coinsurances, or unmet deductibles associated with covered services.

STAFF TRAINING



TRAINING NEW STAFF - *NAVIGATING THE BLUES*

Do you have new staff that needs Excellus BCBS training? Sign them up for our **Navigating the Blues** educational series. The training provides valuable information about Excellus BCBS products, BlueCard®, how-to instructions and much more.



Visit **ExcellusBCBS.com/StaffTraining** today to select your region and seminar dates.

READY TO BECOME SPINE PATHWAY TRAINED? GET REGISTERED!

Spine pathway training is an important element of Excellus BlueCross BlueShield's spine care program. It is designed to improve the quality of care and health outcomes for our members.

We continue to receive positive feedback about the care provided by our spine pathway-trained providers and we are exploring benefit designs that will encourage members to obtain care from spine pathway-trained providers.

All sessions are 9 a.m. – 4 p.m. daily. It is important that you attend **all four days** of training (both two-day weekend sessions).

You can register online by clicking the links below:

Rochester Sessions:

March 10th and 11th

April 14th and 15th

Cooperstown Sessions:

March 24th and 25th

April 28th and 29th

~Cost - $200 per person~

~Earn 24 Continuing Education Credits~

~Light breakfast and full lunch provided~



PHARMACY NEWS

TIPS FOR SUBMITTING PRESCRIPTION PRIOR AUTHORIZATION REQUESTS

We know how busy you are, so we'd like to share the following five tips to simplify the prescription prior authorization (PA) process. We hope you find these tips helpful as you work with us to get your requests approved.

1. **Check to make sure you're using the right PA form.** Submitting the **correct PA form** and making sure it's the **most current version** is extremely important. Please don't keep a supply of outdated forms in your office. Our prescription prior authorization forms are available at ExcellusBCBS.com/Provider > Prior Authorization Forms (under "Quick Links").

2. **Don't leave form fields blank.** Be sure to complete the **entire form** and **double-check** that all fields are completed before submitting.

3.**Ensure that the form is legible.** Please print clearly and use dark-colored ink.

4. **Provide all clinical information requested.** Don't forget to include additional reports when indicated and if relevant (e.g., lab reports, growth charts, sleep studies, progress notes). If the patient has seen a specialist, include that report.

5. **Make sure the physician signed and dated the form.** Unsigned, undated forms cannot be processed and will be returned.

If you have questions about our prior authorization process, don't hesitate to contact Customer Care.

GENERIC FOR LYRICA® (PREGABALIN) EXPECTED TO BE AVAILABLE JUNE 2018

We would like you to be aware that pregabalin, the generic of Lyrica®, is expected to be available in June 2018. In the meantime, if you have patients asking to switch from Lyrica to Lyrica CR, please consider the following before prescribing:

- Lyrica CR is only approved to treat postherpetic neuralgia and diabetic peripheral neuropathy; while Lyrica is approved to treat postherpetic neuralgia, diabetic peripheral neuropathy, fibromyalgia, neuropathic pain associated with spinal cord injury, and partial-onset seizures as adjunctive therapy.
- Since Lyrica CR does not carry all the same indications as Lyrica, these medications are not always interchangeable:
  - When prescribing Lyrica CR, we require prior authorization, including a diagnosis to help ensure that the medication is being used appropriately and not being routinely prescribed for conditions it is not approved to treat. A trial of gabapentin or duloxetine AND a trial of immediate release pregabalin are also required before consideration of coverage.
- Lyrica CR may increase your patient's pill burden and add expense:
  - Some doses require up to three tablets daily.
  - If the patient requires the same number (or greater number) of dosage units, his or her therapy will be more expensive because Lyrica CR costs AWP $15.34/tablet, whereas Lyrica is AWP $8.91/capsule.
- Lyrica CR's cost is substantially higher than Lyrica, and other than being dosed once daily, no distinct clinical advantages have been shown.

PHARMACY NEWS, CONTINUED FROM PAGE 6



ELECTRONIC PRIOR AUTHORIZATION OF PRESCRIPTION DRUGS

We've heard your requests to simplify the prescription drug prior authorization (PA) process.That's why we're working to provide you with the convenience of completing and submitting your prescription drug PA requests directly from your electronic medical record (EMR) or via the CoverMyMeds® web portal.

ePA is an automated process for the electronic completion and submission of PA requests for prescription drugs that are part of our Health Plan's pharmacy utilization management programs. Once implemented, ePA will be available for most members whose pharmacy benefits are administered by our Health Plan.

Prescription Drug ePA Submissions:

- **Electronic Medical Record (EMR) System**: You'll have the ability to submit ePAs to our Health Plan directly from your EMR system if that system has ePA capability. Many EMR systems now have ePA ability, and we recommend that you can contact your EMR vendor for more information about this functionality.
- **CoverMyMeds Web Portal**: You'll be able to submit ePAs through the CoverMyMeds ePA web portal. With CoverMyMeds, you'll enter the member's plan name or his or her pharmacy BIN and PCN number, to ensure you have the correct PA request form. In addition, you'll be able to submit supporting medical documentation electronically (if needed for the review). This web tool is HIPAA-compliant and offered free of charge. Take a tour of CoverMyMeds at www.covermymeds.com.

We think you'll welcome the efficiencies and real-time responses gained with ePA.

Stay tuned! Additional information regarding our ePA implementation is coming soon.

INFLECTRA®- PREFERRED INFLIXIMAB PRODUCT FOR NEW STARTS ONLY



We recently notified you of clinical policy changes regarding the use of the biosimilar Inflectra. After further consideration, we have modified our clinical criteria requirements for prescribing Inflectra, in place of Remicade® and Renflexis™, as follows:

- **Effective February 1, 2018**, for members enrolled in commercial, Exchange, Medicaid managed care and Child Health Plus lines of business, the biosimilar **Inflectra** is the **preferred therapy** for **new starts** when infliximab is used to treat rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, plaque psoriasis, **adult** ulcerative colitis, and other compendium-supported diagnoses.
  - Prior authorization is **not** required for members enrolled in commercial, Exchange and Medicare lines of business, but it **is** required for Medicaid managed care and Child Health Plus enrollees who are **new starts** on Inflectra.
  - In rare cases when an initial trial of Inflectra is ineffective for a patient, you may request medical necessity review for an alternate therapy.
- This change **DOES NOT apply** to members who are **currently prescribed** Remicade or Renflexis at this time; however, we strongly encourage you to consider switching your patients to Inflectra when you feel it is the right course of therapy.

Please see the **February 6, 2018** bulletin for more information.

CODING CORNER

IMPROVING DOCUMENTATION SPECIFICITY FOR SKIN ULCERS



This month, we will review how to improve documentation specificity for skin ulcers.

Codes for pressure ulcers and non-pressure chronic ulcers are located in ICD-10-CM Chapter 12: Diseases of the Skin and Subcutaneous Tissue. Ulcers are caused by skin breakdown from pressure or other chronic conditions; wounds are due to trauma, burns or surgery.

ICD-10	
IDC-10	**Description**
L89.---	Pressure ulcers
L97.---	Non-pressure chronic ulcer of lower limb
L98.4--	Non-pressure chronic ulcer of skin, not elsewhere classified

Pressure Ulcers

The codes for pressure ulcers are located in Category L89 and are combination codes that identify the site, stage, and (in most cases) the laterality of the ulcer. The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, unspecified stage and unstageable. Staging may be based on medical record documentation from clinicians, (i.e., nurses, physician or other qualified healthcare practitioners involved in the care of the patient); however, the associated diagnosis (such as pressure ulcer) must be documented by the provider.

Stage 1: Skin changes limited to persistent focal edema

Stage 2: An abrasion, blister, and partial thickness skin loss involving the dermis and epidermis

Stage 3: Full thickness skin loss involving damage and necrosis of subcutaneous tissue

Stage 4: Necrosis of soft tissues through the underlying muscle, tendon, or bone

Unspecified: When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage.

Unstageable: Ulcer covered by eschar or that has been treated with skin or other graft, or is documented as a deep tissue injury, but not due to trauma. Assignment of the codes for unstageable pressure ulcer should be based on the clinical documentation.

Non-Pressure Chronic Ulcers

Non-pressure chronic ulcers are similar to pressure ulcers in that they require documentation of the site, severity, and laterality. Category L97 and L98.4-- are for non-pressure ulcers and have an instructional note to code first any associated underlying condition, such as:

- Associated gangrene
- Atherosclerosis of the lower extremities
- Chronic venous hypertension
- Diabetic ulcers
- Post-phlebetic syndrome
- Post-thrombotic syndrome
- Varicose ulcers

CODING CORNER, CONTINUED FROM PAGE 8

Severity depth of non-pressure ulcers is also required to be documented:

- Limited to breakdown of skin
- Fat layer exposed
- Necrosis of muscle
- Necrosis of bone
- Muscle involvement without evidence of necrosis
- Bone involvement without evidence of necrosis

To properly code skin ulcers, the documentation in the medical record must specify:

- The site, the stage and the laterality for **pressure ulcers**
- The site, severity depth and laterality for **non-pressure chronic ulcers**

Indicate the cause of the non-pressurechronic ulcer (i.e. diabetes or peripheral vascular disease).

- Any instructional notes in ICD-10 that instruct us to code also any associated gangrene (I96).

IMPORTANT REMINDERS

- All diagnoses submitted on a claim should be supported by the **M**onitoring, **E**valuation, **A**ssessment and/or **T**reatment of the condition in the medical record documentation.
- For more information, please contact Practitioner Education Manager Caroline Mei at 585-453-6465.



To report potential fraud, waste or abuse, please call our **Fraud Hotline** at **1-800-378-8024** or click here to visit our website to complete and submit our Fraud Reporting form.

All fraud, waste and abuse referrals are **confidential** and can be made **anonymously**.

MEDICAL POLICY UPDATES

We work to ensure that the development of corporate medical policies occurs through an open, collaborative process. We encourage participating providers to become actively involved in medical policy development. Each month, draft policies are available on our website for review and comment. To access the draft policies, click here. Providers now have the capability of attaching supporting documentation related to their comments.

Current Policies Recently Updated with Changes

Genetic Testing for Susceptibility to Hereditary Cancers (updated policy) may be approached by a focused method that involves testing for well-characterized mutations based on a clinical suspicion of which gene(s) may be the cause of the familial cancer. Panel testing involves testing for multiple mutations in multiple genes at one time. Hereditary cancers usually have a high penetrance (high probability of developing cancer), autosomal dominant inheritance pattern and early age of onset. Examples of highly penetrant gene mutations are PTEN, associated with Cowden syndrome; TP53, associated with Li Fraumeni syndrome; and germline mutations of CDH1 which are associated with hereditary diffuse gastric cancer. Genetic testing for susceptibility to hereditary cancers has been medically proven to be effective and therefore medically appropriate for Cowden Syndrome (germline mutations of PTEN) and Li Fraumeni Syndrome (germline mutations of TP53) and for diffuse gastric cancer (germline mutations of CDH1) for specific indications outlined in the medical policy. Genetic testing for mutations in other high to moderate and low penetrance genes associated with breast and ovarian cancer (e.g., ATM, BARD1, BRIP1, CDH1, CHEK2, NBN, PALB2, RAD50, RAD51C, and STK11) which are part of next generation sequencing panels (e.g., BRCAplus, BreastNext™, CancerNext™, OvaNext™, Panexia®, Melaris®, Prolaris®, OncoGene Dx and myRisk™Hereditary Cancer) is considered medically appropriate when specific criteria are met as outlined in the medical policy. The following policy statement has been added with this year's policy revision: Based upon our criteria and assessment of the peer-reviewed literature, genetic testing for mutations in other high to moderate and low penetrance genes associated with breast and ovarian cancer (e.g., ATM, BARD1, BRIP1, CDH1, CHEK2, NBN, PALB2, RAD50, RAD51C, and STK11) which are part of next generation sequencing panels (e.g., BRCAplus, BreastNext™, CancerNext™, OvaNext™, Panexia®, Melaris®, Prolaris®, OncoGene Dx, and myRisk™Hereditary Cancer) is considered **medically appropriate** when an individual meets criteria for BRCA, Cowden syndrome, LiFraumeni syndrome, hereditary diffuse gastric cancer, and any inherited colorectal cancer syndrome.

Sleep Studies (updated policy) policy defines various diagnostic methods used in the diagnosis of patients with disorders of sleep and daytime alertness and provides indications and coverage statements for polysomnography (PSG), home/portable sleep studies, EEG topography, multiple sleep latency test/maintenance of wakefulness test, nocturnal oximetry, PAP-Nap (Positive Airway Pressure Nap) and actigraphy. This year's update included the following: Acoustic pharyngometry (e.g., Eccovision Acoustic Pharyngometer), versions of the SNAP testing system using fewer than three channels, rhinomanometry, acoustic rhinometry, and optical rhinometry are considered investigational for screening, diagnosis, or treatment planning in persons with suspected or known obstructive sleep apnea (OSA) and for all other indications.

Current Policies Updated With Minimal Changes

The following policies required only minimal changes (e.g., updating of references, changing language to meet legal needs). The coverage intent of the policies was not altered. The following updated policies were recently approved by the Health Plan's medical directors and are available on our website:

- Automated Percutaneous and Endoscopic Discectomy
- Bronchial Thermoplasty
- Electromagnetic Navigation Bronchoscopy
- Genetic Assay of Tumor Tissue to Determine Prognosis of Breast Cancer
- Genotyping- Cytochrome p459 (CYP450) for Drug Metabolism
- Lumbar Fusion for Adults
- Measurement of Exhaled Markers of Airway Inflammation in Patients with Asthma
- MAZE Procedures for Atrial Fibrillation and Flutter
- Osteochondral Grafting
- Peptide Receptor Radionuclide Therapy (PRRT)
- Sacral Nerve Stimulation

Recently Archived Medical Policies

Policies are archived either because the technology has become standard of care or because there has been little utilization or few requests. Archived policies are available on our website (see link below).

- Genotyping or Phenotyping for Thiopurine Methyltransferase (TPMT) for Patients Treated with Azathioprine (6-MP)

A complete library of our medical policies can be found on our website at ExcellusBCBS.com/ProviderMedicalPolicies.