Provider Newsletter — Summer 2017

We hope you find this edition of the Blue Cross® Blue Shield® of Arizona Advantage (HMO) (BCBSAZ Advantage) Provider Newsletter helpful.

Quarterly editions of our newsletter will be placed on the "Provider" page of our website, www.azbluemedicare.com/providers. Please contact your Provider Relations Representative if you have any questions.

Member Eligibility Update

Effective 04/01/2017, all eligibility inquiries must be directed to our website www.azbluemedicare.com/providers. This website requires no login or password. We encourage all providers to begin using this option as telephone requests will not be available in the future. All that is required is at least two pieces of information related to the member such as name, member ID number or birthdate. Through our eligibility website, you will be able to gather information including but not limited to:

- Effective date/Plan Name
- PCP assignment
- Copays/Coinsurance
- Out-of-Pocket maximum

Member Eligibility Information

Provide member details to check member eligibility and benefit information with this online tool.

Check Member Eligibility Information

Disclaimer: Eligibility verification is not a guarantee of payment. Benefits are subject to all contract limits, Medicare guidelines and the member's eligibility on the date of service when claims are processed.
A Message from
Darren Wethers, MD, FACP
BCBSAZ Advantage Chief Medical Officer

Message from the CMO  Let me take a moment to thank you for the care that you provide our members. The quality scores which we have access to reflect the thoughtful and considered care you deliver, and for that we are grateful.

The summer can be a difficult time for members to make it to the doctor’s office. Please use any encounters you have during these months to remind the members of important self-care items: sunscreen, adequate hydration, appropriate nutrition and well-timed activity.

Although many patients may not seek to complete health screenings such as colonoscopy and mammogram during the summer, you may be able to schedule these activities to be completed during the more temperate months to come in autumn. Most importantly, we want to avoid an end of year rush to fill care gaps.

If you have questions regarding which gaps in care your members may have, feel free to contact our quality department for aggregate physician and individualized member reports. Those of you in large groups may already receive them regularly, but if any providers would care to receive a report, please let us know, and we will prepare one for you.

BCBSAZ Advantage Network
Pharmacy Options

This article aims to highlight the various avenues in which your BCBSAZ Advantage patients can fill prescriptions via local, mail and specialty pharmacies including highlighting one particular pharmacy that can help caregivers and non-adherent patients stay on track. We offer 90-day supplies for all medications except Specialty so please take advantage of this offer when writing prescription for chronic diseases to improve adherence.

- Retail – almost all local pharmacies are in our network including Walgreens, CVS, Target, Fry’s, Walmart, Bashas, Costco, Sam’s Club, Safeway and Banner Family Pharmacy, to name a few.
- Mail Order – Postal Prescription Services 1-800-552-6694 or www.ppsrx.com
- Specialty – almost all specialty pharmacies are in our network including Banner Specialty Pharmacy, Accredo, Senderra, Avella and more.
- Spotlight – PillPack Pharmacy. This is a great option for caregivers or patients that need help remembering to take their medicine. Morning, lunch, evening and nightly doses are in individual, tear-off packages with the name and direction for each OTC and rx drug printed on the front. The packages are linked together on a roll (think county fair or festival tickets) and can be torn off and taken with the patient if he or she is on the go. Call 1-855-745-5725 or visit www.pillpack.com for more information.
Quality Measures and HCC Coding

This time of year HOS and CAHPS surveys are in full bloom. Patients are being queried about whether their doctor has inquired about their wellbeing, encouraged them to exercise, and asked about balance, sleep and symptoms of depression or anxiety. It is important to ask these questions of all your patients throughout the year, and to remind them that you have reviewed this with them, as memory tends to fade with time.

I was asked last week why it was important for physicians to code their visits as completely as health plans encourage; isn’t the benefit just for the health plan’s profits? This is a commonly held misconception, and an important one to dispel. Risk adjusted funds are provided by CMS to Medicare Advantage plans to cover additional costs the complexity of care demands; to wit, all risk adjusted funds must be implemented for benefit of the member, through improved access to care, reduced cost share, broader networks. The providers are asked to document only what is substantiated by the medical record; to do otherwise is fraudulent (as is alleged in lawsuits against a major insurer). Please be certain that your coding is substantiated by your documentation.

Your attention is requested in coding specificity for diabetes; coding the coexistent conditions and complications for the patient is critical in establishing the disease severity. It must be stated each year which complications the member has (i.e., peripheral artery insufficiency, chronic kidney disease, and late-effects of CVA). Care of the diabetic patient impacts many HEDIS and STAR measures; referrals for eye exams, lab work to check HgbA1c, lipids and urine microalbumen must be done yearly.

Other important screenings required regularly include breast and colon cancer screening, screening for osteoporosis in women who have suffered a fracture (must be done within 6 months of the event); please document these in your records as they are completed.

A new measure to be aware of is medication reconciliation after discharge from an acute care setting; I am sure all of you perform this, but there must now be an explicit statement in the record that you have reviewed the current and discharge medication list and reconciled them. CPT II 1111F should be submitted when this reconciliation is performed.

Your cooperation with our quality staff members in completing the proper coding and screening activities is appreciated; they are there to assist, educate and facilitate your staff in completing these tasks. Please encourage an open door policy in your office; let’s work together to assure the best outcomes for your patients in 2017!

- Dr. Darren Wethers, MD, FACP

Compliance in Action

Federal regulations 42 C.F.R. §§ 422.503(b)(4)(vi), 422.504(i), 423.504 (b)(4)(vi) and 423.505(i) indicate that every delegated administrative or health care service in the Medicare Advantage system is required to have a robust Compliance/Fraud, Waste and Abuse (FWA) Program. A robust Compliance/Fraud, Waste and Abuse (FWA) program fully implements the seven elements of an effective compliance program.

Compliance Elements

1. Written policies, procedures and standards of conduct that articulate the Organization’s commitment to comply with all Federal and State regulations related to Medicare Advantage
organizations. This includes a Compliance/FWA Program and work plan that operationalizes objectives listed in the policies;
2. The designation of a Compliance Officer and a Compliance Committee that are accountable to senior management;
3. Effective training and education for the Company’s employees and other covered persons, and First Tier, Downstream and Related Entities (FDRs);
4. Effective lines of communication between the Compliance Officer, CEO, Board of Directors, employees and FDRs;
5. Enforcement of standards through well-publicized disciplinary guidelines;
6. Provisions for internal monitoring and auditing; and
7. Provisions for prompt response to detected offenses and the development of corrective action plans.

Internal auditing and monitoring is a critical component of an effective Compliance Program. Good examples of auditing and monitoring activities in physician services may include the following:

1. Ensuring that procedure codes are accurate when submitted for payment in fee-for-service arrangements, as well as in capitated arrangements.
2. Ensuring that documentation fully describes the services rendered to the patient on the dates performed.
3. Ensuring that patient chart documentation is not incorrectly duplicated from service date to service date.
4. Ensuring that the rules for “incident to” billing are followed when submitting claims for mid-level providers who are billing under the physician’s NPI number.

To find out more information, please see the article from “Physician Practice” describing how a physician’s office might approach auditing and monitoring in the health care system, at http://www.hcpro.com/content/32179.pdf.

Please Keep Us Posted

Moving? Changing TINs? Have a new phone number? The sooner you let us know, the sooner we can update our system and avoid any delay in the processing of your claims and ensure that our members always know where to find you.

If a provider leaves your practice, please let us know that as well. If you have any updates, notify your provider relations representative. You can call them at: 602-567-1239 or email at Providerrelations@azbluemedicare.com

Provider Claims Call Center

Our Provider Claims Call Center is staffed with friendly and knowledgeable representatives, Monday – Friday from 8:00 am – 5:00 pm. This call center is dedicated to serving our providers with requests including but not limited to:
2017 Prior Authorization List and Guidelines

Contracted Providers are responsible to furnish or arrange health care services with other participating healthcare providers or facilities. Prior authorization requests are the responsibility of Contracted Providers. For services listed below the provider must obtain prior authorization from BCBSAZ Advantage, providers can go [Here](#) for the most recent list of services that require Authorization.

The new form is available. Please use the new updated Prior Authorization Form found [here](#).

What is the Quality Care Gap Report?

The quality care gap report provides patient-level information for selected NCQA HEDIS/CMS Star rating measures that are important to AZ Blue Advantage. These members are past due for certain care, preventive exam or medications based on the claims we received.

How are the measures chosen?

AZ Blue Advantage selects measures for the quality care gap report that are considered the highest priority based on populations, impact on patients, and current performance. The data are collected through claims coding.

How can I obtain a copy of Quality Care Gap Report? The report is produced monthly on around the 8th of each month. You can contact your PR to obtain a hard copy. Or provide us the email address. AZ Blue Advantage can send you in an encrypted and secure file.
- Adults’ Access to Preventive/Ambulatory Health Services (AAP) Member who had an ambulatory or preventive care visit
- Adult BMI Assessment (ABA) Member who had an outpatient visit and whose body weight and BMI was documented
- Breast Cancer Screening (BCS) Member who had a mammogram
- Colorectal Cancer Screening (COL) Member who had colorectal cancer screening - FOBT, FIT, Cologuard, CT colonography, Flexible sigmoidoscopy or colonoscopy
- Controlling High Blood Pressure (CBP) Member whose BP is adequately control <140/90 mmHg
- Statin Therapy for Patients with Cardiovascular Disease (SPC) Member who were diagnosed of ASCVD and dispensed at least one high or moderate intensity statin
- Comprehensive Diabet es Care (CDC) Member who had Diabetes and had the following:
  - HBA1C test / control A1C <9
  - Medical attention for nephropathy – urine test for protein, ACE/ARB
  - Retinal eye exam for retinopathy
- Statin Therapy for Patients with Diabetes (SPD) Member who had Diabetes and dispensed at least one low intensity statin
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) Members who were diagnosed with rheumatoid arthritis and dispensed at least one DMARD
- Osteoporosis Management in Women Who Had a Fracture (OMW) Female members who had fracture and had either

My patient has a quality care gaps but they have completed the service? Why is this? Quality care gap data are coming from the claims, encounters and any supplemental data (aka Pseudo-Claim) you submitted to AZ Blue Advantage. Claims may take up to 90 days to be reflected in reporting.

How can I provide information for closing the quality gap? The simple way is submitting the appropriate code for the specific quality measures as soon as the service completed or result is available.

How do I learn more about the codes used for these measures? AZ Blue Advantage offers HEDIS Documentation and Coding guidelines for your reference.

Do you provide further support to our practice in closing the quality care gap? Yes. AZ Blue Advantage provides full support to our network providers in many ways in order to providing good quality of care to our members. Please contact Lucille Baxter, Star Program Manager directly for further information.

Who can I contact if I have further questions? Please feel free to contact Lucille Baxter, Star Program Manager. You can reach her at Lucille.Baxter@azbluemedicare.com or Phone: 602-427-6984.
DEXA or prescription for osteoporosis in 6 months after fracture

- Medication Reconciliation Post Discharge (MRP) Members' current and discharged medications were reconciled and documented within 30 days after discharge from hospital/in-patient facility

Billing S and T Codes

Each year, in the United States, health care insurers process over 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential.

Codes not used by Medicare will be denied. An example of that would be S and T codes that aren't approved for use on Medicare members.

Contact Us

Member Eligibility: 800-446-8331
Website Eligibility Link: [https://www.azbluemedicare.info/member_elig_check.html](https://www.azbluemedicare.info/member_elig_check.html)

Claims Service Center: 800-446-8331
Claims Service Center Email: Contact.Claims@azbluemedicare.com

Prior Authorization (PA): 855-839-4844
Pharmacy PA – Med Impact: 800-788-2949

Provider Relations: 602-567-1239
Provider Relations Email: Provider.Relations@azbluemedicare.com