Provider Newsletter

Healthy Blue

Medicaid Managed Care

https://providers.healthybluela.com

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Healthy Blue is the trade name of Community Care Health Plan of Louisiana, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

2019 U*tilization Management Affirmative Statement* concerning utilization management decisions

All associates who make utilization management (UM) decisions are required to adhere to the following principles:

- UM decision making is based only on appropriateness of care and service and the existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service.

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Members' Rights and Responsibilities Statement

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Healthy Blue has adopted a *Members' Rights and Responsibilities Statement*, which you can locate within the provider manual.

If you need a physical copy of the statement, call us at **1-844-521-6942**.

BLA-NL-0127-19

Substance use disorder requirements in the *Audit Protocol*

As a part of the Healthy Blue Provider Monitoring Program, we audit providers according to National Committee for Quality Assurance (NCQA) standards, Louisiana Department of Health (LDH) required elements, *Clinical Practice Guidelines* and additional standards as applicable.

New *Audit Protocol* requirements

Due to recent changes in audit requirements for treatment of substance use disorder (SUD), Healthy Blue now includes SUD requirements in our *Audit Protocol*. These requirements can be found via the **LDH Behavioral Health Services Manual**.

The new audit elements can also be found on LDH's **website** under Provider & Plan Resources > **Provider Monitoring Report (358)**.

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Healthy Blue

Clinical Criteria updates

On August 17, 2018, October 9, 2018, and November 16, 2018, the pharmacy and therapeutic (P&T) committee approved *Clinical Criteria* applicable to the medical drug benefit for Healthy Blue. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the Healthy Blue provider website, and the effective dates are reflected in the **Clinical Criteria updates notification**. Visit the **Clinical Criteria website** to search for specific policies.

Email for questions or additional information.

BLA-NL-0115-19

Why do patients stop taking their prescribed medications, and what can you do to help them?

You want what's best for your patients' health.
When a patient doesn't follow your prescribed treatment plan, it can be a challenge. Approximately 50% of patients with chronic illness stop taking their medications within one year of being prescribed.[1] What can be done differently?

The missed opportunity may be that you're only seeing the tip of the iceberg, that is, the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline — the giant, often invisible, patient self-talk that may not get discussed aloud — can create a misalignment between patient and provider.

We've created an online learning experience to teach the skills and techniques that can help you navigate these uncharted patient waters. After completing the learning experience you'll know how to see the barriers, use each appointment as an opportunity to build trust and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence — and you'll earn continuing medical education credit along the way.

Take the next step.
Go to **MyDiversePatients.com** > T*he Medication Adherence Iceberg: How to navigate what you can't see to enhance your skills*. The course is approximately one hour and accessible by smart phone, tablet or desktop at no cost.

1 Centers for Disease Control and Prevention. (2017, Feb 1). *Overcoming Barriers to Medication Adherence for Chronic Conditions*. Retrieved from **https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm**.

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Healthy Blue

PCP patient reassignment

Healthy Blue has updated its *Member PCP Linkage Analysis and Reassignment Policy*. This ensures the member's assigned PCP is the one most involved with treatment of the member, which will promote health outcomes and access to care.

What is the new procedure?

On a quarterly basis, Healthy Blue will initiate an analysis of PCP panel data to identify members eligible for PCP reassignment and prospectively reassign members as outlined in the full bulletin.

To whom does this policy apply?

This policy applies to:

- All in-network PCPs.
- All members who have been assigned to their current PCP for at least 90 days.
- Members who have not seen their assigned PCP in the last 12 months.

Read more online.

When is a member eligible for PCP reassignment?

A member will only be eligible for PCP reassignment if they meet the policy criteria outlined above and have visited an unassigned PCP at least once in the last 12 months.

If the member has an established relationship with an unassigned PCP, the member will be prospectively reassigned to that PCP if they are in-network with a valid primary care specialty. Unassigned PCPs meeting these specifications will have closed panel status overridden to complete member reassignment if necessary.

Please note: If the member has seen an unassigned PCP with the same TIN as their assigned PCP, the member will not be reassigned.

How can one dispute a reassignment?

If a provider is identified as having members eligible for PCP reassignment, the provider can dispute. To dispute a reassignment:

- Submit valid documentation demonstrating you have seen the member within the last 12 months via communication method outlined in the notification message.
  - Examples of valid documentation include medical records, proof of billed claims, third-party liability, etc.
- Provide documentation within 15 business days.

BLAPEC-1221-19

Important information about utilization management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization. Our medical policies are available on our **provider website**.

You can request a free copy of our UM criteria from our Medical Management department. Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the numbers listed below. You can access UM criteria **online**.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

Precertification requests:

- Phone: **1-844-521-6942**
- Fax: **1-800-964-3627**
- Online: **https://www.availity.com**

Questions?

Call our Clinical team at **1-844-521-6942**
24 hours a day, 7 days a week.

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Complex Case Management program

Managing an illness can be a daunting task for our members. It is not always easy to understand test results or know how to obtain essential resources for treatment or who to contact with questions and concerns.

Healthy Blue is available to offer assistance in these difficult moments with our Complex Case Management program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals who support members, families, primary care physicians and caregivers. The Complex Case Management process utilizes the experience and expertise of the Case Coordination team to educate and empower our members by increasing self-management skills. The Complex Case Management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the Member Services number located on their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

Contact Case Management by email (la1casemgmt@healthybluela.com) or phone (**1-844-521-6942**). Business hours are Monday to Friday from 8 a.m. to 5 p.m. Central time.

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Prior authorization requirements

Musculoskeletal procedure (29892)

Effective July 1, 2019, prior authorization (PA) requirements will change for the musculoskeletal procedure noted below. This procedure will now require PA by Healthy Blue for Healthy Louisiana and LaCHIP members.

PA requirements will be added to the following:
- 29892 — Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)

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Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/ exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

Please use one of the following methods to request PA:
- **Web: https://www.availity.com**
- **Fax: 1-888-822-5595** (inpatient); **1-888-822-5658** (outpatient)
- **Phone: 1-844-521-6942**

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers through **Availity** or **https://providers.healthybluela.com** > Login. Providers who are unable to access Availity may call us at **1-844-521-6942** for PA requirements.

Policy Update

Durable Medical Equipment (Rent to Purchase)

(Policy 06-052, effective 09/01/2019)

Healthy Blue allows reimbursement for durable medical equipment under specific guidelines. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

The following are circumstances affecting rental reimbursement:

- Rental periods that contain a break in coverage of more than 60 days will start the limitation count over.
- On the occasion a member changes suppliers during the rental period, a new rental period will not start over.

Effective September 1, 2019, Healthy Blue will consider oxygen equipment to be a 10-month rental.

For additional information, please refer to the *Durable Medical Equipment (Rent to Purchase) Reimbursement Policy* at **https://providers.healthybluela.com**.

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