

July 12, 2022

### REQUIRED ANNUAL NOTICE

*This notice is being sent to the correspondence address on file, but we ask that you share it with all practice locations. You may also find a copy of this notice on our website at [www.bluecrossvt.org/provider/communications](http://www.bluecrossvt.org/provider/communications).*

Dear Provider,

Each year, we are required to share specific information with our providers. Please find some helpful information below and in the pages that follow, you'll find information about:

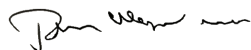
- Helping your patients get the most out of their coverage, including:
  - Locating our members' rights and responsibilities statement
  - Our case management process including eligibility criteria and how to refer your patients
- Our utilization review process including:
  - How to get a copy of our utilization management criteria
  - Discussing a medical necessity denial with a Plan physician or pharmacist
- How we're ensuring access for our members and tackling rising healthcare costs including:
  - Results of our geographic access analysis
  - Our standards for appointment access
  - Reporting suspected fraud, waste and abuse to our Special Investigations Unit

#### Reminders and Important Links

- **Provider Directory Information:** Have you verified your provider directory information this quarter? If not, look for an email from [noreply@onbaseonline.com](mailto:noreply@onbaseonline.com) and follow the instructions to make your updates today.
- **Provider Handbook:** [www.bluecrossvt.org/documents/provider-handbook](http://www.bluecrossvt.org/documents/provider-handbook)
- **Medication Lists:** Find the most up to date formulary information for Vermont Blue Rx<sup>SM</sup> members at [www.bluecrossvt.org/pharmacies-medications/lists-covered-medications](http://www.bluecrossvt.org/pharmacies-medications/lists-covered-medications)
  - In addition to the formulary, you can locate medications which are covered, excluded, require prior authorization, and/or classified as specialty.
- **Clinical Practice Guidelines:** We adopt nationally recognized guidelines, developed by experts in their field, for preventive health, chronic health conditions and mental health disorders. Find them at [www.bluecrossvt.org/providers/provider-policies](http://www.bluecrossvt.org/providers/provider-policies)

If you have any questions about this information, please contact your Provider Relations Consultant. If you are not sure who that is, please email [providerrelations@bcbsvt.com](mailto:providerrelations@bcbsvt.com) or call (888) 449-0443, option 1. Business hours are Monday through Friday from 8 a.m. to 4:30 p.m., except holidays. Thank you for your continued partnership in making health care work better for Vermonters.

Sincerely,



Tom Weigel, MD | Senior Medical Director

# Helping Your Patients Get the Most Out of Their Coverage

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## MEMBER RIGHTS AND RESPONSIBILITIES

In order for Blue Cross and Blue Shield of Vermont (Blue Cross) and The Vermont Health Plan (TVHP) members to get the most from their benefit plan, they must follow certain guidelines, known as our Member Rights and Responsibilities statement. A complete copy of our Member Rights and Responsibilities is available on our website, <http://www.bluecrossvt.org/members/member-rights-responsibilities>. To request a paper copy, please contact your provider relations consultant.

## INTEGRATED CASE MANAGEMENT

### SERVICES AND PROCESS

Under the umbrella of integrated case management, Blue Cross combines services typically administered separately: maternity wellness, chronic and rare condition management, coordination and continuity of care, and complex case management, including support for those with mental health and substance use disorder (MHSUD) conditions. Our case managers serve members at all ages and stages—from pregnancy and newborn arrival through end of life. Our intent is to complement and enhance provider capacity to address the full range of factors that may impact a member's (or caregiver's) ability to effectively follow a provider's treatment plan, and to help providers align treatment plans with member benefits/member ability to cover the costs of care.

Our focus is on delivering member-centered care that prioritizes the person's preferences, needs, and values. Blue Cross case managers are licensed and/or certified clinical professionals who are expected to build relationships with members through their initial cross-disciplinary assessment, and work with members to achieve their goals and overcome barriers to health improvement in multiple domains – medical, behavioral, social, and health system. For those with high health complexity, we place particular emphasis on understanding the interaction between physical and mental health conditions and the role of social and health system factors that affect the person's ability to manage their conditions and be well.

Care plans typically address: access to medical and MHSUD evidence-based care; coordination across specialties and health-related systems; personal, social (family), and financial upheaval; and difficulties in communication among providers.

While there is some variation by service and case complexity, our process includes the following elements, modeled directly after the Case Management Society of America's (CMSA) Standards of Practice for Case Management:

- Identification
- Outreach and Screening
- Assessment
- Care plan development
- Care delivery, documentation, and evaluation
- Care graduation and case closure

In addition to working with their case manager by phone, members in case management have the option to download an application to their mobile phone or a tablet to take a more proactive approach in caring for their health. The app has a secure text function to allow members to communicate asynchronously with their case manager—when it is best for them. The app also includes content and tools for general wellness, maternal wellness, and transitions of care (30-days post inpatient stays for medical, surgical, and mental health care).

For prevalent chronic conditions—asthma, diabetes, COPD, coronary artery disease and heart failure—we proactively identify the highest risk members for participation in our program based on analysis of claims data. Our target population is members who may need additional support to manage their condition(s) based on recent health events, complication, and gaps in care.

For rare conditions, Blue Cross partners with Accordant® to provide specialty nurse case management for specific rare conditions. The Accordant clinical team evaluates and coordinates treatment progress, working closely with providers and our integrated health team as needed to make sure members receive the most appropriate care for them based on their health status, context, and goals. Accordant has NCQA accreditation and their services are nationally recognized.

## **ELIGIBILITY**

All Blue Cross/TVHP members are eligible for case management support. For condition-specific programs, the only criteria are that the member's benefit plan with us is active, and that the member has the condition. Depending on the member's health complexity and needs, we may direct them to other programs and services that are best suited to their situation and goals. We look forward to partnering with providers and their team, members and their families, and other practitioners in the community to provide high quality, cost-effective care for your patients.

## **MAKING A REFERRAL**

We encourage providers to refer Blue Cross/TVHP members directly into our integrated case management team by calling us toll free at (800) 922-8778, option 3, Monday through Friday from 8 a.m. to 4:30 p.m, or by sending a secure email to [IHMTriage@bcbsvt.com](mailto:IHMTriage@bcbsvt.com). Our triage staff will record the information and complete outreach to the member for enrollment.

In addition to provider referrals, we accept referrals directly from members and their families, other health and social service providers, schools, and community organizations. We would be happy to work with you and your partners to raise awareness of our services, provide information about case management to your patients, and facilitate ease of referral and access.

# Utilization Reviews

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## A NOTE ABOUT FINANCIAL INCENTIVES

Blue Cross bases its utilization management (UM) decisions on the appropriateness of care and service, and whether the member has coverage. Blue Cross and its affiliate, The Vermont Health Plan, do not reward practitioners or other individuals for issuing denials of coverage or service care. We also do not offer financial incentives to our UM decision makers for issuing denials or making decisions that result in under-utilization. We do not make decisions about hiring, promoting or terminating practitioners or other staff based on the likelihood, or perceived likelihood, that they will support denials of benefits.

## WE BASE DECISIONS ON CLINICAL REVIEW CRITERIA

We use nationally recognized health care guidelines, MCG (formerly Milliman Current Edition), and the locally approved health care guidelines developed internally to reflect national and local standards of care. Our Utilization Management department shares the appropriate MCG Optimal Recovery Guidelines with the utilization reviewers from participating facilities and attending providers when questions arise about clinical rationale and application of criteria. Upon request, we make the applicable MCG and internal Blue Cross medical policies available to members and providers. Each of the participating hospitals has a copy of the MCG Inpatient Health Care Guidelines. We review these guidelines on an annual basis to assure relevance with current practice.

Providers and members may request a copy of the applicable criteria from the Utilization Management department by:

- Phone - (800) 922-8778
- Fax - (866) 387-7914
- Mail - Blue Cross /TVHP, P.O. Box 186, Montpelier, VT, 05601-0186.

## YOU MAY SPEAK WITH A REVIEWER ABOUT YOUR DENIAL

Blue Cross and TVHP provide practitioners with the opportunity to discuss utilization review denial decisions based on medical necessity with a Plan physician or pharmacist reviewer. If a provider wants to discuss a medical necessity UM denial with a Plan physician or pharmacist, they can call us toll free at (800) 922-8778, Monday through Friday from 8 a.m. to 4:30 p.m. An administrative coordinator or member of the clinical support staff will schedule a time for the requesting provider to speak with the appropriate reviewer.

## INDEPENDENT, EXTERNAL REVIEW AVAILABLE

Members may request an external review of the decision by an independent review organization with the State of Vermont by calling (800) 964-1784, or by writing to 89 Main Street, Montpelier, VT 05602-3101. The state will determine if the case is appropriate for review.

# Efforts to Ensure Access to Care and Fight Rising Healthcare Costs

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## BLUE CROSS PRACTITIONER AVAILABILITY

Annually, Blue Cross monitors compliance with practitioner availability standards. We monitor practitioners that serve as primary care providers by specialty and in aggregate. We define the following areas as primary care: pediatrics, internal medicine, family practice, general practice, naturopaths, nurse practitioners, and geriatrics. Blue Cross also monitors high-volume and high-impact specialties. In 2021 we monitored obstetrics and gynecology (OB/GYN), a high-volume specialty, and oncology, a high-impact specialty. In addition, we evaluate availability of mental health and substance use disorder practitioners.

The practitioner availability standards are:

- **Primary Care:** Choice of at least two age-appropriate network PCPs, who are accepting new patients within 30 minutes travel time.
- **High-Volume Specialty:** Choice of at least one OB/GYN practitioner within 60 minutes travel time.
- **High-Impact Specialty:** Choice of at least one oncology practitioner within 60 minutes travel time.
- **Mental Health:** Choice of at least one mental health practitioner within 30 minutes travel time.
- **Substance Abuse:** Choice of at least one substance abuse practitioner with 30 minutes travel time.
- **Performance against Goal:** In 2021, we monitored the Blue Cross PPO/EPO, Blue Cross HMO/POS and TVHP networks. Each of the networks exceeded our performance goals.

## BLUE CROSS ACCESSIBILITY OF SERVICES

Blue Cross annually measures compliance with the expected standards for accessing care. We monitor health care practitioners, including mental health and substance use disorder (MHSUD) practitioners.

The access standards for practitioners providing medical services are:

- Urgent care within 24 hours, or a timeframe consistent with the medical urgency of the case.
- Non-emergency, non-urgent care within 14 days.
- Preventive care (including routine physical examinations) within 90 days.
- Routine laboratory, imaging, general optometry and all other routine services within 30 days.

We require primary care providers, high-volume specialties (OB/GYN), and high-impact specialties (oncology) to provide 24-hour, seven day a week access to members by means of our on-call or referral system. Practitioners should return after-hours telephone calls from members regarding urgent problems in a reasonable time, not to exceed two hours of receipt. Please refer to the *Accessibility of Services and Provider Administrative Service Standards Policy* for acceptable mechanisms of after-hours care.

The access standards for practitioners providing MHSUD services are:

- Care for a non-life threatening emergency within six hours.
- Urgent care within 48 hours.
- Initial visit for routine care within 10 business days.
- Routine follow up visit within seven business days.

Blue Cross expects all MHSUD practitioners to work with patients to develop individualized crisis plans to outline options for crisis care during and after typical office hours. Blue Cross expects these crisis plans to identify opportunities for members to access care from the MHSUD practitioner as a first course of action in the event of a non-life threatening emergency, but Blue Cross also advises all MHSUD practitioners to direct members with a non-life-threatening emergency to go directly to their local emergency room or to the appropriate emergency services available if the MHSUD practitioner is not available to provide care.

## FRAUD, WASTE AND ABUSE

Studies have determined that healthcare fraud is the single largest contributor to the increase in healthcare costs. It's a serious crime and accounts for an estimated 3-10% of all healthcare spending. We take it very seriously and are committed to fight against it.

### COMMON EXAMPLES OF FRAUD, WASTE AND ABUSE

Fraud, waste and abuse (FWA) occurs in a variety of ways. The most common include:

- Provider Actions
  - Billing for services or supplies not provided or needed
  - Filing a claim for a more expensive procedure than was actually performed
  - Billing for a covered service when the true service was non-covered
  - Omitting or misrepresenting information about a condition, symptom or service performed
- Member Actions
  - Using an insurance ID card that belongs to someone else
  - Adding someone to a policy who is not eligible for coverage
  - Receiving narcotic prescriptions from several physicians, through deceit
  - Forging or altering bills or receipts

### HOW WE FIGHT AGAINST FRAUD, WASTE & ABUSE

At Blue Cross, we take a proactive approach to detecting and investigating potential fraud, waste and abuse.

- We have a special investigative unit dedicated to preventing, detecting and investigating fraud, waste and abuse, staffed with trained professionals who have many years of health care and health insurance experience.
- We use sophisticated software to continually analyze our healthcare claim patterns and investigate red-flag situations where provider billing exceeds normal ranges.
- We partner with industry-leading firms who specialize in identifying “outlier” claims and auditing provider’s records to ensure billings are correct.
- We maintain an active fraud hotline where our members and providers may report suspected fraud.
- We recover millions of dollars in erroneous and unsupported claims every year.

### WHAT YOU CAN DO

Help us control rising healthcare costs. If you suspect fraud, waste, or abuse in the healthcare system, you should report it to Blue Cross, and we will investigate. Your actions may help to improve the healthcare system and reduce costs for our members, customers and business partners.

You may remain anonymous if you prefer. The Blue Cross FWA Special Investigations Unit (SIU) will treat all information received or discovered as confidential, and we will only discuss the results of investigations with persons having a legitimate reason to receive the information.

- Call our Fraud Hotline - (833) 225-3810
- Email - [Fraud\\_issues@bcbsvt.com](mailto:Fraud_issues@bcbsvt.com)
- Write to us - Blue Cross and Blue Shield of Vermont, PO Box 186, Montpelier, VT 05601-0186, Attn: Payment Integrity Department