BlueCross BlueShield of Montana

BLUE REVIEW℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS

THIRD QUARTER 2016

Provider Portal Assistance Line

Providers in need of assistance with registering for or accessing the Provider Portal may call **1-800-447-7828**, extension **6100.** This is a message line; however, one of our specialists will respond to you with a solution within two business days.

ALERT: Retail Policy Paid-To Dates Now Available!

Beginning August 15, 2016, providers will have the ability to retrieve retail member paid-to dates by verifying eligibility and benefits through their preferred online web vendor including Availity, Passport Nebo and HeW. Previously, we only returned paid-to dates when the member was in their second month of the advance premium tax credit, (APTC), grace period. Now, we will return paid to dates on all active individual retail eligibility and benefit responses, regardless of APTC grace period involvement. For additional information, please email our Provider Education Consultants at PECS@bcbsil.com.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSMT. Aerial, iExchange and Medecision® are trademarks of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSMT makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

HeW is a separate company that operates a health information network to provide electronic information exchange services to medical professionals. HeW provides administrative services to BCBSMT. BCBSMT makes no endorsement, representations or warranties regarding any products or services offered by third party vendors. If you have any questions or concerns about the products or services the vendor offers, you should contact the vendor directly.

PLEASE CONTACT YOUR PROVIDER NETWORK REPRESENTATIVE IF YOU HAVE ANY QUESTIONS AND/OR IF YOU NEED ADDITIONAL INFORMATION.

Western Region:

Christy McCauley, 406-437-6068, Christy_McCauley@bcbsmt.com

Leah Martin, 406-437-6162, Leah_Martin@bcbsmt.com

Central Region:

Floyd Khumalo, 406-437-5248, Thamsanqa_F_Khumalo@bcbsmt.com

Eastern Region:

Susan Lasich, 406-437-6223, Susan_Lasich@bcbsmt.com

Troy Smith, 406-437-5214, Troy_Smith@bcbsmt.com

INSIDE THIS ISSUE

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Air Ambulance Services

Blue Cross and Blue Shield of Montana (BCBSMT) is working with our network hospitals and providers in the state to mitigate the impact of the health care costs that continue to reach unprecedented levels for Montanans. Among those contributing factors is the use of out-of-network providers, which can create avoidable financial hardships for your patients, our members. To address that issue, BCBSMT is currently focusing on the immediate concerns with air ambulance services by creating a directory of our participating air ambulance providers to assist our members and your patients in seeking quality, affordable care.

To ensure our members receive the full air ambulance benefits of their BCBSMT health care plan, we urge you to transport our members via in-network air ambulance providers whenever possible, potentially saving your patients thousands of dollars.

Thank you for all you do to ensure the health and well-being of our members, and we appreciate your further collaboration to ensure that your patients continue to receive the best care possible without the adverse impacts of out-of-network costs.

Should you have any questions about this communication, please contact us at **1-800-447-7828**, Extension 6100 or at HCS-X6100@bcbsmt.com.

Blue Cross and Blue Shield of Montana (BCBSMT) Air Ambulance Network			
Provider	**Phone Number**	**Rotor**	**Fixed Wing**
Benefis Healthcare	Mercy Flight Communication Center at 1-800-972-4000	•	•
Billings Clinic Hospital	1-800-325-1774		•
Kalispell Regional Hospital	1-866-302-9767	•	•
MT Medical Transport	406-457-8205		•
Northeast Stat Air	Dispatch Line: 1-800-992-7828 (Montana toll-free); 406-228-3500 (Out of State)		•
St Vincent's Healthcare	1-800-JET-HELP (1-800-538-4357)	•	•

Disclaimer: A provider's participation status may change.
Contact Customer Service using the phone number on the back of the members health plan ID card to obtain the most up to date information.

Update Your Information

The Centers for Medicare & Medicaid Services is placing a renewed focus on Medicare Advantage plan provider networks, with emphasis on both online provider directories and network adequacy. Having accurate provider data is critical for your practice to ensure our members, your patients, are able to find you in our provider directory. Please notify us promptly of any changes by going to our website bcbsmt.com/provider, under Education and Resources, Forms and Documents.

BCBSMT proactively conducts quarterly communications with contracted providers to ensure that the required information in the directory is accurate. Additionally, to be consistent with Marketplace rules, we are defining the previous requirement that online directories be updated in real time to mean within 30 days.

"Required information" is defined in section 100.4 of the Medicare Marketing Guidelines as:

- Provider Name and Title
- Phone number/Appointment number
- Accepting New Patients
- Office Fax Number
- Email Address
- Office Hours
- Practice location
- Specialty – Primary and Secondary
- Tax ID
- Street address
- City/State/ZIP

Comprehensive Primary Care Plus Program (CPC+)

By Dr. Jonathan Griffin, Medical Director

In July, BCBSMT and Blue Cross Blue Shield of Oklahoma (BCBSOK) were selected as payer participants in the CMS Comprehensive Primary Care Plus program (CPC+). Montana and Oklahoma were designated as two of 14 CPC+ regions throughout the country to participate in this five-year program. The CPC+ is essentially CMS's Patient Center Medical Home (PCMH) program, and it strongly supports BCBSMT's value-based care program strategy. CPC+ is also a major opportunity for providers to more successfully move along the value-based care program continuum through promoting the transform of primary care. Broadly, the model aims to achieve better health care in Montana, smarter spending and healthier Montanans.

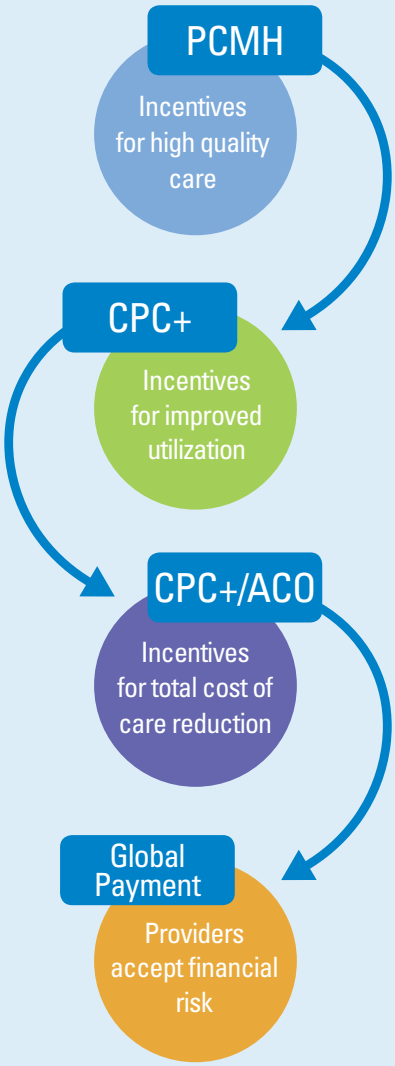
For the purposes of this model, the entire state of Montana will be a CPC+ region. Multi-payer partnership is an essential goal of CPC+, as it makes full practice level transformation of care delivery possible. Recognizing the impact of any one payer alone is limited, BCBSMT has committed to partner with CMS, Montana Medicaid and PacificSource Health Plan to establish an approach that aligns the way that primary care practices are financially supported to promote care delivery transformation and enhanced primary care. Additionally, the payers have all agreed to share cost, utilization and quality information with practices at regular intervals to facilitate their ability to manage patient population health.

CMS has outlined its reimbursement model and practice requirements for CPC+ and eligible primary care practices throughout the state have been invited to apply for participation in the program. BCBSMT, Montana Medicaid and PacificSource Health Plans have agreed to align their primary care value-based care programs with the CPC+ design to maintain consistency regarding reimbursement structure, clinical delivery requirements, and quality reporting specifications.

Involvement in the CPC+ is a validation of the approach BCBSOK and BCBSMT are taking in the healthcare market. We are leading the way in value based care program development and value based care is how we align provider financial incentives with high value health care services – care quality, member experience and cost.

Currently, BCBSMT has 520 providers contracted as PCMHs with over 48,000 attributed members. BCBSMT is also aligning PCMH with a Medicare Advantage value-based care program, which will add another 20,000 eligible members. In 2016, BCBSMT launched Montana's first commercial ACO, and specialty value-based care programs are also in development. The CPC+ program will accelerate and strengthen BCBSMT's objectives to be the best provider partner and lead in value-based care.

*ACO – Accountable care organization



What Is "Blue Options?"

Providers, especially hospitals, have been continually asked by employers, TPAs, and insurers for greater discounts to support their health plans as health care costs and trends have gone unabated. As an example, reference-based pricing ("RBP") was introduced in the state of Montana several years ago. In the past year, hospitals have been asked to accept a percentage of Medicare compensation. However, what happens down the road when these types of arrangements and discounts have not adequately addressed cost trends and have not delivered the cost predictability that employer groups need?

BCBSMT believes there is a better model, predicated on the tenets of value-based care. "Blue Options" will be introduced in the large group market effective January 1, 2017 and could well be the first attempt to combine the synergistic effects of a "tiered network," member and provider accountability, fixed and incentive compensation, and value-based care, such as patient centered medical homes and CMS's CPC+, in which BCBSMT is participating. It is this combination of levers which may improve the health status of Blue Cross and Blue Shield of Montana members, drive the coordination of care, make members and providers more informed and accountable participants in the seeking and the delivery of health services, and mitigate cost trends for members and employers. Ever increasing provider discounts are not the "silver bullet" for creating rational, coordinated, and cost effective care.

As we communicated to you early this year, BCBSMT rolled out a similar POS product, "Blue Focus POS℠," as a retail (individual) product January 1st, 2016. Below is a quick view of their differences and similarities:

	Blue Focus POS	Blue Options
Effective date	1/1/2016	1/1/2017
Policy type	Retail	51+ employers
Design	2 Tiers	3 Tiers
Network	POS	POS
PCP selection required	Yes	Yes
Referrals required	No	No
Out of network benefits	Yes, but higher out of pocket costs	Yes, but higher out of pocket
Geographies filed*	Areas surrounding Missoula and Billings	Areas surrounding Missoula, Billings, Great Falls, and Anaconda

* Pending approval

Important: In order to provide a smooth customer experience with lowest out-of-pocket costs, please ensure you are referring Blue Options and Blue Focus POS patients/members to their respective in-network providers, given these products are predicated on tiered networks. Those provider network lists can be found at: https://public.hcsc.net/providerfinder/search.do?corpEntCd=MT1

It is hoped these products, with the help of these in-network providers, will begin to transform the delivery of health care in the state of Montana. Ultimately the goal is to improve the health status of BCBSMT members, to improve the delivery of cost effective, efficacious care, to address cost trends in a sustainable manner, and to produce much needed cost predictability for health care consumers and employers.

Should you have any questions on Blue Options and/or Blue Focus POS, please contact your Provider Network Representative.

Exceptional Health Care. Reduced Costs.

The Blue Options product will be offered to self-funded and fully insured employers with 51 or more employees. This product is based on the following hospital service tiers, which create varying member benefits, with Tier 1 being the most advantageous for the member:

Tier 1

Providers that participate in a "tiered network," create significant premium advantages, and are largely compensated on a variety of fixed compensation methodologies, will be in Tier 1. In addition, the hospital and/or professional practitioners must participate in BCBSMT's PCMH/CPC+ program (which incidentally could qualify the hospital for CMS's MACRA incentives, which illustrates the power of the Blue Options' design).

Tier 2

Current PPO and BlueCard® networks. This tier is considered in network as it offers the member a typical benefit (e.g., 60/40 health plan).

Tier 3

Out-of-network with 50% of allowable compensation with deductibles approximately doubled.

Informed Choice. Cost Management. More Options. (Member Liability Estimator)

Provider Finder® is an innovative tool using the nation's largest claims database that helps our members, find in-network doctors and hospitals, compare the costs and quality for more than 1,500 procedures, and estimate out-of-pocket costs before making treatment decisions. Provider Finder helps members to:

- Find a network primary care physician, specialist or hospital.
- Filter search results by doctor, location, specialty, ZIP code, language and gender – even get directions from Google Maps™.
- Estimate the cost of a provider's procedures, treatments and tests – and estimate their out-of-pocket expenses.
- Determine if a Blue Distinction® Center is an option for treatment.
- View patient feedback and add a provider review.
- Check the clinical quality data from Blue Cross and Blue Shield as well as independent third parties.
- Search in Spanish.

SEARCHES ON PROVIDER FINDER ARE:

Accurate. This tool helps members estimate the overall cost of procedures, treatments, and tests, while calculating their out-of-pocket expenses, all based on the search parameters they choose.

Members are able to compare estimated costs between different providers, based on typical episodes of care. With information on over 20,000 health care facilities and more than 400,000 professional providers, as well as cost information for more than 1,500 treatment categories, Provider Finder is a robust database.

Personal. This tool provides information and costs that apply to a specific member's health benefit plan to estimate the cost of care. This means members can instantly see how much they will need to pay in deductible, coinsurance or copayments, in addition to seeing how much their plans may pay.

Data are presented in a format that's easy to navigate and helps members better understand how their benefits work.

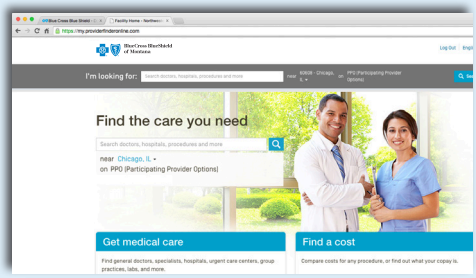
ACTIVE, ENGAGED EMPLOYEES LOWER HEALTH CARE COSTS

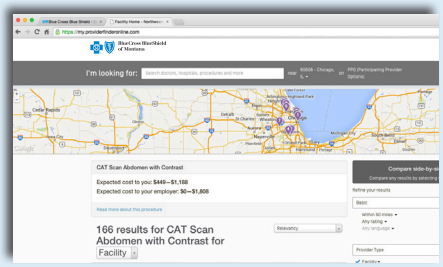
Provider Finder – giving accurate, transparent and personal information based on the member's specific benefit plan. This tool is available on mobile as well, helping members where they are and when they need access to this information

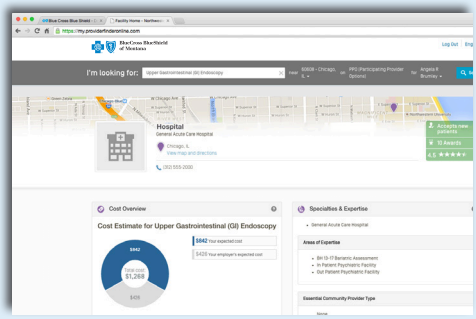
BCBSMT currently has 27 employer groups enrolled in the Member Liability Estimator (MLE). The Employer Groups can elect to participate in the program. They have the option to select between MLE Lite which only provides the total estimate and does not break the detail down by benefits, or out of pocket. MLE Full provides a complete cost breakdown of the member, employer, and total cost. Including coinsurance and accumulators. Currently, the MLE is not available for products that have tiered benefits.

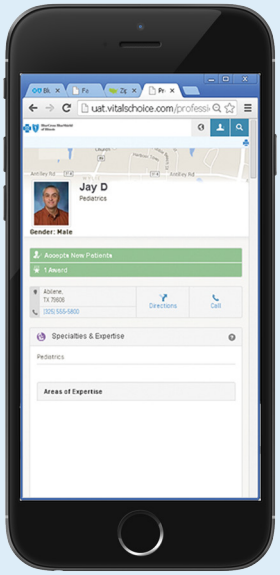
Provider Finder helps members choose providers as well as estimate and manage their health care costs.

It's easy, immediate, secure – and available at bcbsmt.com.









Get it on the go!

Screen shots are for illustrative purpose only.

Medicare Marketing Guidelines for Providers

The 2017 Centers for Medicare & Medicaid Services (CMS) Annual Election Period for beneficiaries is fast approaching. For those providers who have contracted with BCBSMT to provide services to our Blue Cross Medicare Advantage (HMO)SM or Blue Cross Medicare Advantage (PPO)SM members, it's important to keep in mind the rules established by CMS when marketing to potential new members.

You may not be planning specific marketing activities, but what if a patient asks for information or advice? Remaining neutral when assisting with enrollment decisions is essential. See below for a partial listing of additional "Dos" and "Don'ts" for contracted providers, as specified within the CMS Medicare Marketing Guidelines (MMG) for contract year 2017 (excerpted from the section on Provider-Based Activities):

DO:	DON'T:
• Provide the names of Plans/Part D Sponsors with which [you] contract and/or participate (see MMG section 70.11.2 for additional information on provider affiliation) • Provide information and assistance in applying for the LIS* • Make available and/or distribute plan marketing materials in common areas • Refer [your] patients to other sources of information, such as SHIPs** plan marketing representatives, [the] State Medicaid Office, local Social Security Office, CMS' website at http://www.medicare.gov/ or **800-MEDICARE** • Share information with patients from CMS' website, including the 'Medicare and You' Handbook or 'Medicare Options Compare' (from http://www.medicare.gov), or other documents that were written by or previously approved by CMS	• Accept Medicare enrollment applications • Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider • Mail marketing materials on behalf of Plans/Part D Sponsors • Offer inducements (e.g., Free Health Screenings, Cash, etc.) to persuade beneficiaries to enroll in a particular plan or organization • Accept compensation directly or indirectly from the plan for enrollment activities • Distribute materials/applications within an exam room setting

The above lists provide just a sampling of important points for your convenience. For a more in-depth review of the guidelines that are applicable to providers, please refer to the Provider Medicare Marketing Guidelines Excerpt located in the Network Participation/Related Resources section of our website at bcbsmt.com/provider.

If you have questions about these guidelines or are planning marketing activities, please refer to the Managed Care Marketing page located under Health Plans, in the Medicare section of the CMS website, at cms.gov.

*LIS refers to low income subsidy

**SHIPs are Senior Health Insurance Assistance Programs

This material is provided for informational purposes only and is not the provision of legal advice. If you have any legal questions with respect to CMS rules or regulations, you should seek the advice of legal counsel.

New Preauthorization Requirements through eviCore

Effective October 3, 2016, BCBSMT will use eviCore healthcare (eviCore), an independent specialty medical benefits management company, to provide preauthorization review for outpatient molecular and genomic testing, in addition to the current outpatient radiation therapy services. Details regarding the BCBSMT lines of business included in the preauthorization program will be outlined in the coming months and available on the BCBSMT website under Claims and Eligibility, Predetermination and Preauthorization section of the provider portal.

Providers should request preauthorization through eviCore for dates of service beginning October 3, 2016. Services performed without authorization may be denied for payment, and you may not seek reimbursement from our members.

Note: Beginning September 26, 2016, providers will be able to contact eviCore for more information regarding preauthorization for outpatient molecular and genomic testing, in addition to the current outpatient radiation therapy programs. At that time, providers can reach eviCore at evicore.com. Access to eviCore's preauthorization call center is available from 7 a.m. to 7 p.m. Mountain time, Monday through Friday at **1-(855) 252-1117** (toll-free).

You may continue to use iExchange® for these preauthorization requests for lines of business not serviced by eviCore.

Both BCBSMT and eviCore will be providing additional information, including education and training, in the coming months on the Provider website at bcbsmt.com/provider and in Blue Review. You may also contact your Provider Network Representative for more information.

Our automated preauthorization tool — Aerial™ iExchange® (iExchange) — supports direct submission and provides online approval of benefits for inpatient admissions, as well as select outpatient, pharmacy and behavioral health services 24 hours a day, seven days a week — with the exception of every third Sunday of the month when the system will be unavailable from 10 a.m. to 2 p.m. (MT). iExchange is accessible to physicians, professional providers and facilities contracted with BCBSMT.

Reminder: Corrected Claim Request Change, Effective July 11, 2016

As announced in previous communications, effective July 11, 2016, corrected claim requests for previously adjudicated claims must now be submitted as electronic replacement claims, or on the appropriate professional (CMS-1500) or institutional (UB-04) paper claim and Claim Review Form.

ELECTRONIC SUBMITTERS

Electronic replacement claims should be submitted to BCBSMT with the appropriate claim frequency code. Frequency code 7 will result in BCBSMT adjudicating the original claim number (sometimes referred to as a Document Control Number, or DCN) with the corrections. The replacement claim will be issued a new BCBSMT claim number and will subsequently deny based upon the re-adjudication of the original claim.

Note: Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSMT claim number will not be adjudicated. For details on claim frequency codes, including guidelines to assist you with when and how to use them for making corrections to electronic claims submitted to BCBSMT, consult our quick reference guide.

PAPER SUBMITTERS

More than 98 percent of the claims BCBSMT receives from providers are submitted electronically. BCBSMT encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer Web vendors available to providers. If you are a registered HeW Portal user, you have access to submit direct data entry replacement claims electronically, at no additional cost.

As of July 11, 2016, any changes to a claim that are specified **only** on the Claim Review Form or via a letter will be returned with a notice advising resubmission on the appropriate CMS-1500 or UB-04 paper claim form. Paper claim submitters must indicate "corrected claim" on the paper claim form and the accompanying Claim Review Form.

For additional information on this corrected claim request change, view the answers to frequently asked questions (FAQs), The FAQs and the quick reference guide mentioned above are available in the Claims & Eligibility/Claim Submission section of our website, under the Related Resources.

iExchange® Now Accepts Electronic Medical Record Attachments

We are pleased to announce that enhancements have been made to iExchange, our online tool that supports online benefit preauthorization requests for inpatient admissions, medical, behavioral health and clinical pharmacy services. Effective August 1, 2016, iExchange now accepts electronic medical record attachments when necessary in support of benefit preauthorization requests. Electronic medical record documentation also may be submitted via iExchange for predetermination of benefit requests. With these enhancements, iExchange offers providers and facilities a secure, online alternative to faxing their patients' protected health information.

Join us for an iExchange webinar! Do you have questions? Would you like training on how to use iExchange? We welcome the opportunity to share more information about iExchange with you and your staff. Our webinars spotlight recent enhancements, as well as navigation tips and key features of the online tool.

Not enrolled for iExchange? Sign up now. iExchange is accessible to independently contracted physicians, professional providers and facilities that are participating in the various health benefit products offered by BCBSMT. For details and to sign up online, visit the Education and Reference Center/ Provider Tools section of our website at BCBSMT.com/provider.

As a reminder, it is important to check eligibility and benefits, prior to rendering services. This step will help you determine if benefit preauthorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the Claims and Eligibility/ Prior Authorization section of our Provider website.

CDC Guidelines for Prescribing Opioids for Chronic Pain

Parts 2 and 3 of a 3-part series describing the new CDC guidelines for prescribing opioids. Part 1 was published as a News & Updates article on our provider website in May 2016.

In March of 2016, the Centers for Disease Control and Prevention (CDC) issued new recommendations for prescribing opioid medications for chronic pain, excluding reasons for cancer, palliative and end of life care.[1] These recommendations were in response to an increased need for provider education due to a nationwide epidemic of opioid overdose and opioid use disorder.

The CDC has developed 12 recommendations, grouped into three areas of consideration:

1. Determining when to initiate or continue opioids for chronic pain
2. Opioid selection, dosage, duration, follow-up and discontinuation
3. Assessing risk and addressing harms of opioid use

The second area of consideration – Opioid selection, dosage, duration, follow-up and discontinuation – is described below.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP AND DISCONTINUATION

1. According to the new guidelines released in March 2016, the CDC recommends that providers start with prescriptions for immediate-release (IR) opioids instead of extended-release/long-acting opioids (ER/LA) when initiating treatment for chronic pain.
   - Immediate release opioids include codeine, hydrodone, hydromorphone, morphine and oxydocone.
   - Extended-release/long-acting opioids include methadone, transdermal fentanyl and ER versions of oxycodone, oxymorphone, hydrocodone and morphine.
   - ER/LA medications should be reserved for severe, continuous pain and should only be used in patients who have received IR opioids daily for at least one week.
2. The guidelines also state that providers should start opioid therapy with the lowest effective dosage. Morphine milligram equivalents (MME) more than 50 MME/day should be used with caution, and MME dosages more than 90 MME/day should be avoided when possible, or carefully justified.
   - Opioid therapy lower than 50 MME/day has been associated with reduced risk of overdose.
   - A morphine equivalent dose calculator can be found at agencymeddirectors.wa.gov/mobile.html.
3. Knowing that long-term opioid use often begins with opioid treatment of acute pain, the CDC recommends that providers use the lowest effective dose of an immediate release product when opioids are being used to treat acute pain. For example, three days of opioid treatment for acute pain is often sufficient but more than seven days may be too much.
   - Evidence has shown that a greater amount of early opioid exposure can be associated with a greater risk of long-term opioid usage.
   - Experts have noted that each day of unnecessary opioid use can increase the likelihood of physical dependence without any additional benefit to the patient.
   - Prescribing opioids for fewer days can also help minimize the number of extra medication that may be available for potential misuse.
4. Finally, the guidelines are that providers should follow up with patients and evaluate their pain within one to four weeks of starting opioid therapy for chronic pain, or after a dose increase. Continued opioid therapy should be evaluated at least every three months to determine the benefits or potential harmfulness. If the benefits do not outweigh the harmfulness, providers should consider tapering the opioid dosing and consider other possible therapies.
   - Contextual evidence has found that patients who do not experience pain relief with opioids in one month are unlikely to experience pain relief with opioids at six months.
   - Providers should re-evaluate patients with potential risk of opioid use disorder or overdose more frequently than every three months.

[1]Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. MMWR Recomm Rep 2016; 65:1-49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1.

CDC Guidelines for Prescribing Opioids for Chronic Pain

Part 3 of a 3-part series describing the new CDC guidelines for prescribing opioids.

The first and second areas of consideration were discussed previously. The third area of consideration – Assessing risk and addressing harms of opioid use – is described below.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

1. Before starting opioid therapy and during treatment, providers should assess the risk for opioid-related harms. Providers should evaluate strategies, such as offering naloxone, if there is an increased risk of opioid overdose due to history of overdose, high opioid dosages or concurrent benzodiazepine use.

- Special populations that may be at higher risk of opioid related harms include patients with sleep-disordered breathing, including sleep apnea, pregnant women, patients with renal or hepatic insufficiency, patients aged 65 years or older, patients with mental health conditions, patients with substance abuse disorder and patients with prior nonfatal overdose.
- Naloxone, an opioid antagonist that can reverse severe respiratory depression, can save lives if used properly for opioid overdose. Friends and family who administer naloxone must be properly trained. Experts agree that providers should consider offering naloxone when prescribing opioids to patients at increased risk of opioid overdose, including patients with a history of overdose, substance abuse disorder or taking benzodiazepines with opioids. Resources for prescribing naloxone in primary care setting can be found through Prescribe to Prevent at prescribetoprevent.org.

2. Providers should utilize state prescription drug monitoring program (PDMP) data and assess patient opioid history to determine whether or not there are any dangerous drug combinations occurring or if the patient is receiving unsafe quantities of controlled substances.

- PDMPS are state-based databases that collect information on controlled prescription drugs dispensed by pharmacies and in some cases by dispensing physicians. The Montana Prescription Monitoring Program is located at app.mt.gov/pdr.
- Before an opioid prescription is written and dispensed, providers and pharmacists should review PDMP data to see if the patient is receiving high total opioid dosages or dangerous combinations that put the patient at risk for overdose.

3. Before starting opioid treatment providers should use urine drug testing to assess whether or not the patient is already on controlled or illicit substances. The provider may want to consider urine testing at least annually as well.

- Opioid pain medications in combination with other opioid pain medications, benzodiazepines or illicit substances can put the patient at increased risk of overdose and opioid related harms. Urine drug tests can provide information that the patient does not provide and can help detect drug seeking behaviors.
- Providers can use urine drug test results to help with patient safety by tapering or discontinuing opioids if the member is at risk of opioid use disorder, offering naloxone or referring for behavioral treatment for substance use disorder.

4. As much as possible, providers should avoid prescribing opioid pain medication and benzodiazepines concurrently.

- Concurrent benzodiazepine and opioid use can cause central nervous system and respiratory depression.
- If opioid treatment is needed, providers should taper benzodiazepines gradually to prevent rebound side effects.

5. For patients with opioid use disorder, providers should offer to help with evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone combined with behavioral therapies.

- Clinical evidence has found that opioid dependence in primary care setting is between three and 26 percent among patients with chronic pain on opioid therapy.
- Contextual evidence has found opioid agonist or partial agonist treatment with methadone maintenance therapy or buprenorphine may be helpful in preventing relapse in patients with opioid abuse disorder. Behavioral therapy with medication treatment is also recommended by clinical practice guidelines.
- Physicians must be certified to provider buprenorphine in an office-based setting. Physicians can receive training to receive a waiver from the Substance Abuse and Mental Health Services Administration.

[1]Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain-United States, 2016. MMWR Recomm Rep 2016; 65:1-49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1.

Pharmacy Benefit Tips, Guidelines and Reminders

For BCBSMT members with prescription drug benefits administered by Prime Therapeutics, BCBSMT employs a number of industry-standard management strategies to help ensure appropriate utilization of prescription drugs. These strategies may include formulary management, benefit design modeling, specialty pharmacy benefits, clinical programs, among others. You can help support these initiatives by following the tips, guidelines and reminders below.

1. **Prescribe drugs listed on the member's formulary**
   The BCBSMT formularies are provided as a guide to help in the selection of cost-effective drug therapy. Every major drug class is covered, although many of the formularies cover most generics and fewer brand name drugs. The lists also provide members with criteria for how drugs are selected, coverage considerations and dispensing limits. While these drug lists are a tool to help members maximize their prescription drug benefits, the final decision about what medications should be prescribed is between the health care provider and the patient.

   BCBSMT formularies are regularly updated and can be found on the Pharmacy Program section of our website at bcbsmt.com/provider.

2. **Remind patients about covered preventive medications**
   Many BCBSMT health plans include coverage at no cost to the member for certain prescription drugs, women's contraceptive products and OTC medicines used for preventive care services.*

   *Not available for all plans. Members should call the customer service number on their ID card to help determine what benefits may be available, including any requirements, limitations or exclusions that apply. Please refer to the member's certificate of coverage.

3. **Submit necessary prior authorization requests**
   For some medications, the member's plan may require certain criteria to be met before prescription drug coverage may be approved. You will need to complete the necessary prior authorization request and submit it to BCBSMT. More information about these requirements can be found on the Pharmacy Program section of our website at bcbsmt.com/provider.

4. **Assist members with formulary exceptions**
   If the medication you wish to prescribe is not on your patient's drug list or the preventive care lists, a formulary exception can be requested. You can call the customer service number on the member's ID card to start the process, or complete the online form at www.myprime.com/en/coverage-exception-form.html.

Note:

For members with Medicare Part D coverage, the drug lists can be found on the Blue Cross Medicare Advantage website:

www.bcbsmt.com/medicare/mapd_drug_coverage.html

Visit the Pharmacy Program section of our website at bcbsmt.com/provider for more information.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSMT contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSMT, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2016

Drug List (Formulary) Changes

Based on the availability of new prescription medications and the Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some revisions were made to the BCBSMT standard drug list and generics plus drug list effective July 1, 2016.

BRAND MEDICATIONS ADDED TO THE STANDARD AND GENERICS PLUS DRUG LISTS, EFFECTIVE JULY 1, 2016

Preferred Brand[1]	Drug Class/Condition Used For
Adynovate	Hemophilia
Brilinta	DVT, Stroke and Embolism Prophylaxis
Coagadex	Hemophilia
Depen	Wilson's Disease, Cystinuria
Narcan	Opiate Overdose
Uptravi	Pulmonary Arterial Hypertension

BRAND MEDICATIONS ADDED TO GENERICS PLUS DRUG LISTS, EFFECTIVE JULY 1, 2016

Preferred Brand[1]	Drug Class/Condition Used For
Eliquis	DVT, Stroke and Embolism Prophylaxis

Dispensing Limit Changes

The BCBSMT standard and generics plus prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. Food and Drug Administration (FDA) approved dosage regimens and product labeling.

EFFECTIVE JULY 1, 2016, DISPENSING LIMITS FOR THE FOLLOWING DRUGS WERE ADDED TO THE STANDARD LIST

Drug Class and Medication[1]	Dispensing Limit
Irritable Bowel Syndrome	
Viberzi	60 tablets per 30 days
Ophthalmic Immunomodulators	
Restasis	60 vials per 30 days

Utilization Management Program Changes

Effective July 1, 2016, several drug categories and/or targeted medications were added to the current Prior Authorization (PA) and Step Therapy (ST) programs for standard pharmacy benefit plans.

DRUG CATEGORIES ADDED TO THE PHARMACY PA STANDARD PROGRAMS, EFFECTIVE JULY 1, 2016

Drug Category	Targeted Medication(s)[1,2]
Ophthalmic Immunomodulators	Restasis

TARGETED DRUGS ADDED TO CURRENT PHARMACY PA STANDARD PROGRAMS, EFFECTIVE JULY 1, 2016

Drug Category	Targeted Medication(s)[1,2]
Therapeutic Alternatives	Kadian, Northera, Onmel, Sporanox, Spritam, Zegerid, Zyflo/Zyflo CR

DRUG CATEGORIES ADDED TO THE PHARMACY ST STANDARD PROGRAMS, EFFECTIVE JULY 1, 2016[3]

Drug Category	Targeted Medication(s)[1,2]
Atypical Antipsychotics	Abilify, Abilify Discmelt, Abilify Maintena, Aripiprazole ODT, Aristada, Clozaril, Fanapt, Fazaclo, Clozapine ODT, Geodon, Invega, Invega Sustenna, Invega Trinza, Latuda, Rexulti, Risperdal, Risperdal M-Tab, Risperdal Consta, Saphris, Seroquel, Seroquel XR, Versacloz, Zyprexa, Zyprexa Zydis, Zyprexa Relprevv

Targeted mailings were sent to members affected by dispensing limit and prior authorization program changes per our usual process of member notification prior to implementation. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our website at bcbsmt.com/provider.

[1]Third party brand names are the property of their respective owners

[2]These lists are not all inclusive. Other medications may be available in this drug class.

[3]Members on a current drug regimen will be grandfathered from participation in the ST program.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

HELP Plan Update

During the 2015 Legislative session, the Montana Legislature enacted the Montana Health and Economic Livelihood Partnership (HELP) Act which expands health care coverage for state residents between the ages of 19 and 64, whose household income is 138% or less of the federal poverty level (HELP Plan). The HELP Plan creates affordable health plan coverage and access to providers for this segment of the state's population. BCBSMT was selected as the third party administrator (TPA) for the HELP Plan to administer claims for those participants between 51% and 138% of the Federal Poverty Level.

For general information on participant eligibility, benefits, coverage and claims processing, please refer to the BCBSMT.com website/Providers/NetworkParticipation/TheHELP Plan. A slide presentation, providing an overview of the HELP Plan is also available on this site, in the Updates section.

The HELP Plan Provider Manual is now located under the Resources section of the HELP Plan page and has been updated as of August, 2016.

The following is contact information for the HELP Plan:

HELP Plan Contacts	
Health-e-Web (HEW)	**1-877-565-5454** http://www.hewedi.com/
Behavioral Health	**1-877-296-8206**
BCBSMT Claims Address (Submission of Paper Claims)	HELP Plan Claims P.O. Box 338 Scranton, PA 18505
DPHHS (Submission of Paper Claims)	Claims Processing P.O. Box 8000 Helena MT 59604
Health Care Management	**1-877-296-8206**
Dental Services	**1-800-624-3958**
BCBSMT Electronic Claim Questions or Problems	**1-800-447-7828**, Extension **6100**
Fraud Hotline BCBSMT Special Investigations Department (to report suspected fraud and abuse)	**1-800-543-0867**, TTY/TOD **711**
Language Interpreter Line	**1-800-225-5254**
Relay (TTY Deaf, hearing, and/or speech impaired)	**1-800-833-8503** Voice, **406-444-1335** Voice TTY
Bilingual (English-Spanish) Customer Service	**1-877-233-7055** TTY/TDD **711**
Transportation Services	**1-800-292-7114**
BCBSMT Network Service Representatives	**1-800-447-7828**, Extension **6100**
BCBSMT Provider Resources	https://www.bcbsmt.com/provider/network-participation/the-HELP-plan
Utilization Management (UM)	**1-877-296-8206**
Utilization Management Participant Appeals	**1-877-233-7055**
Pharmacy @ DPHHS	**1-800-624-3958**
Provider Customer Service (Claims, benefits, etc.)	**1-877-296-8206**
DPHHS/XEROX	**1-800-624-3958** MTPRHELPdesk@xerox.com http://medicaidprovider.mt.gov/
BCBSMT Appeals	BCBSMT Appeals P.O. Box 27838 Albuquerque, NM 87125-9705 Phone **1-877-232-5520** Fax: **1-866-643-7069**
Eligibility Questions	Montana Public Assistance Help Line (OPA) **888-706-1535**
Corrected Claims	HELP Plan Claims P.O. Box 3387 Scranton, PA 18505 Fax: **1-855-206-9202**

Prevent Diabetes STAT – Screen, Test, Act Today

HOW CAN YOU HELP PREVENT TYPE 2 DIABETES?

You likely know which of your patients is at high risk for diabetes. Now you can do something to help them stop the progression from prediabetes to type 2 diabetes.

- One-third of your patients over age 18, and half over age 65, are at risk for diabetes.
- You can help your patients reduce their risks by:
  - Screening and identifying patients for prediabetes.
  - Referring at-risk patients to an evidence-based Diabetes Prevention Program (DPP) in your area.

WHAT IS THE EVIDENCE BASE FOR THE DPP?

Over the last 15 years, a number of scientific studies have evaluated the design and effectiveness of intensive lifestyle change interventions such as the DPP to prevent or delay diabetes. Among overweight or obese adults with prediabetes, the DPP showed:

- 58% reduction in the number of new cases of diabetes overall
- 71% reduction in new cases for those over age 60

These results were achieved through reducing calories, increasing physical activity, and a weight loss of 5 to 7% of body weight—10 to 14 pounds for a person weighing 200 pounds.

WHICH ORGANIZATIONS ENDORSE THE DPP?

- The Community Preventive Services Task Force (thecommunityguide.org) recommends the DPP.
- The American Medical Association adopted a policy encouraging hospitals to offer the program to their patients and supporting use of community benefit dollars to cover the costs of the DPP.

IS THERE REIMBURSEMENT FOR THE DPP SERVICE?

Yes, insurance providers are starting to cover the DPP.

- Montana Medicaid and Medicaid HELP (expansion) cover DPP services.
- Medicare coverage was proposed by the Centers for Medicare & Medicaid Services, and this ruling is currently open to public comment.
- Private and employer-based insurers may also cover the DPP.

WHERE CAN YOU ACCESS RESOURCES FOR SCREENING, TESTING, AND REFERRAL?

- The Prevent Diabetes STAT – Screen. Test. Act Today™ Toolkit can help physician practices easily screen and refer. Visit preventdiabetesstat.org.
- Montana's Community Health Program Guide and Interactive Map of Sites provides a fact sheet and locations near you: http://dphhs.mt.gov/publichealth/chronicdisease/CommunityBasedPrograms

For more information, please contact the Montana Department of Public Health & Human Services at **1-844-MT-HLT-4U** (1-844-684-5848) or ChronicDiseasePrevention@mt.gov.

Blue Review is a quarterly newsletter published for institutional and professional providers contracting with Blue Cross and Blue Shield of Montana. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our website at *bcbsmt.com/provider.*

The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

BLUE REVIEW
Blue Cross and Blue Shield of Montana
Attn: Julie Sakaguchi
P.O. Box 4309
Helena, MT 59604
Email: *Julie_Sakaguchi@bcbsmt.com*
Website: *bcbsmt.com*