BlueCross BlueShield of Montana

BLUE REVIEW℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS **FOURTH QUARTER 2018**

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BCBSMT Expansion or Changes to Preauthorization Requirements Beginning Jan. 1, 2019

Effective January 1, 2019, benefit plans, managed by Blue Cross and Blue Shield of Montana (BCBSMT), will be updating preauthorization requirements.

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit information includes membership validation, coverage status and, preauthorization requirements. To obtain fast, efficient, detailed information for BCBSMT members, please access the Availity® Eligibility and Benefits tool located at www.availity.com/ resources/support/provider-portal-registration. Please note that you must be registered with Availity to gain access to this free online tool. Additional tip sheets are available on the Claims and Eligibility section of the BCBSMT Provider website at the following link: www.bcbsmt.com/provider/claims-and-eligibility/predetermination-and-preauthorization

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Contact Us

Confused about where to go for answers? Use our online Provider contact reference guide to help guide you to the best point of contact for your answer.

https://www.bcbsmt.com/provider/network-participation/contact-us

Our *Blue Review* provider newsletter is produced quarterly for participating professional and institutional providers across all lines of business (commercial and government programs). The newsletter serves as a vehicle to communicate **timely, consistent and relevant messaging** related to:

- New products, programs and services available at BCBSMT
- Notification of changes as required by contract or other mandates
- Member initiatives and patient resources

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Below is a list of the newly impacted care categories that may need preauthorization for various plans effective 1/1/2019:

- **Advanced Imaging** - Advanced imaging services: MRI, Magnetic Resonance, Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine (excludes Advanced Cardiac Imaging)
- **Air Ambulance** (fixed wing & rotary) for non-emergent medical transportation
- **Orthopedic Procedures**
  - Artificial Intervertebral Disc
  - Functional Neuromuscular Electrical Stimulation (FNMES)
  - Lumbar Spinal Fusion
- **Pain Management Procedures:**
  - Spinal Cord Stimulation
  - Percutaneous and Implanted Nerve Stimulation and Neuromodulation
- **Sleep Studies**
  - Adult and pediatric facility-based polysomnography
  - Adult and pediatric facility-based PAP titration
- **Specialty Pharmacy** - Refer to 2019 Specialty Drugs Preauthorization List for Infusion Site of Care at https://www.bcbsmt.com/static/mt/provider/pdf/soc-ndc-list-010119.pdf

Not all requirements apply to each plan using the BCBSMT networks (Blue Focus POS℠, Blue Options℠ POS, Blue Preferred PPO℠, Managed Care and Traditional. It is imperative that providers check eligibility and benefits and verify preauthorization requirements through Availity.

A 2019 comprehensive list of services that **may** require preauthorization is available under Claims & Eligibility then Predetermination and Preauthorization on the BCBSMT provider website. https://www.bcbsmt.com/static/mt/provider/pdf/mt_comprehensive-pa-list_01012019.pdf

Watch for future detailed updates including a list of the Advanced Imaging procedure codes and available training sessions. These will be posted on www.bcbsmt.com/provider/education-and-reference/news-and-updates.

Please feel free to contact a Network Management Consultant, with questions or if you need additional information. For your convenience, here is a list of the BCBSMT Network Management Consultants:

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Helpful Links:

- 2019 comprehensive list of services that may require preauthorization: www.bcbsmt.com/static/mt/provider/pdf/news/mt_comprehensive-pa-list_01012019.pdf
- Availity Eligibility and Benefits tool: www.availity.com/resources/support/provider-portal-registration
- Additional Preauthorization tip sheets: https://www.bcbsmt.com/provider/education-and-reference/news-and-updates

EFFECTIVE 1/1/2019: New HCPCS Level III Codes for Applied Behavior Analysis (ABA)

Effective 01/01/2019 the HCPCS Level III codes for Applied Behavior Analysis (ABA) will be replaced with new CMS CPT codes. BCBSMT will provide complete compensation information, including fee allowance on the BCBSMT Secure Provider Portal (SPP).

New 'Pre-Authorization Info' Tab on the Availity Provider Portal Eligibility and Benefits Results

As part of an ongoing initiative to enhance the provider experience, Eligibility and Benefits Inquiry results on the Availity Portal will display benefit preauthorization requirements in a new dedicated information tab, effective Nov. 12, 2018.

The new Pre-Authorization Info tab will include a red badge that shows the total number of services submitted that require benefit preauthorization. Information displayed within the Pre-Authorization Info tab will specify if benefit preauthorization is or is not required for the submitted benefit/service type. Contact information for completing the benefit preauthorization request and other important details will also be included.

The launch of the Pre-Authorization Info tab will not change how you submit requests for eligibility and benefits currently. Continue to submit these requests on the Availity Portal using the Eligibility and Benefit Inquiry tool.

As a reminder, services that require benefit preauthorization through BCBSMT may be submitted online via iExchange®. Registered Availity users may enroll for iExchange single sign-on access through the Availity Portal, or by visiting the iExchange page on our Provider website.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.

iExchange, a separate company, offers collaborative health care management solutions for payers and providers and are solely responsible for the products and services that they provide.

Documentation Guidelines for Urine Drug Testing

BCBSMT processes and reimburses claims for urine drug testing in accordance with BCBSMT Medical Policy MED207.154, "Drug Testing in Pain Management and Substance Use Disorder Monitoring." BCBSMT only reimburses claims for urine drug testing that meet criteria for medical necessity under that medical policy. BCBSMT requires that urine drug testing claims be properly documented, and that the documentation reflect the medical necessity of the testing. The provider that submits the claim is responsible for submitting such documentation upon request. Incomplete or insufficient records can result in a denial of payment for services.

This guidelines document is intended to assist providers in understanding BCBSMT's documentation and medical necessity requirements for urine drug testing claims.

Medical Necessity Criteria for Quantitative or Definitive Drug Testing

Generally, whether quantitative (or definitive) urine drug testing for a particular drug is medically necessary depends on (1) the patient's qualitative (or presumptive) testing results for that drug and (2) whether the drug has been prescribed for the patient. Specifically, Medical Policy MED207.154 explains that quantitative testing for a particular drug is considered medically necessary if one of the four following criteria is met:

- Qualitative testing was positive for a prescription drug that is not prescribed to the patient;
- Qualitative testing was negative for a prescription drug that is prescribed to the patient;
- Qualitative testing was positive for an illicit drug; or
- A qualitative test for the relevant drug is not commercially available.

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Prostate Cancer Screening Benefit Level Change

Currently, BCBSMT covers prostate cancer screening at no member cost share when billed with a preventive diagnosis.

Beginning Jan. 1, 2019, this screening will no longer be covered at the no member cost share level. Instead it will be treated as a standard medical benefit, and any applicable cost sharing (copay, coinsurance and deductible) may apply, based on the member's health plan.

This initiative applies to all non-grandfathered retail and group members. It does not apply to members who have Medicaid or Medicare plans.

What does this mean for you?

- You may now need to seek payment from both BCBSMT and the member.

Note: Some groups may elect to continue coverage at the no member cost share level. Members may confirm their coverage by calling the number on the back of their customer ID card.

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Urine drug testing for pain management or substance abuse monitoring is not medically necessary if none of the above criteria is met. Similarly, routine screenings (performed as part of a clinician's protocol for treatment, without documented individual patient assessment) and tests given pursuant to standing orders (non-individualized, routine orders that are not used in the management of the patient's specific medical condition and are given to a population of patients) are not medically necessary.

Medical necessity must be met for each drug or drug class for which a quantitative test is ordered.

Providers that order or perform drug testing should carefully review BCBSMT Medical Policy MED207.154. Medical policies are updated regularly, so it is important to visit BCBSMT's website, bcbsmt.com/provider, often for the most up-to-date medical policy information. Medical policies can be found by visiting the Medical Policy page in the Standards and Requirements section of our website.

Documentation Requirements

For a urine drug testing claim to be properly reimbursable, the documentation must meet BCBSMT's requirements. In particular, the documentation must be patient-specific and must accurately reflect the need for each test ordered; each drug or drug class being tested for must be indicated by the ordering clinician in a written order and documented in the patient's medical record; and the laboratory's or ordering provider's medical records or other documentation must be sufficient to show that the testing performed was medically necessary.

BCBSMT does not require billing laboratories to recover and submit medical records from ordering providers. Nevertheless, if BCBSMT conducts an audit or review of a urine drug testing claim and finds that there is insufficient documentation, that claim will be denied. The provider that submits the claim is responsible for providing, upon request, documentation sufficient to support all services submitted on the claim form.

Laboratories that submit urine drug testing claims should possess, at a minimum, (1) a signed, valid requisition form from the ordering provider that specifies the tests being ordered, and (2) complete results of the tests performed. The requisition form must include the following:

- A list of the specific drugs or drug classes being tested. Reference to a standard order or a "custom panel" is not acceptable;
- The identity of the patient;
- The identity of the ordering provider, including full name, credentials, and National Provider Identifier (NPI);
- A legible signature from the ordering physician (not a stamp or photocopy, and it is not acceptable to state that the physician's signature is on file);
- The facility and location where the sample was collected (e.g., office, home, hospital, residential treatment center);
- The type of sample (i.e., urine);
- The date and time the sample was collected;
- The identity of the individual who collected the sample; and
- The date and time the sample was received in the laboratory.

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Federal Employee Program (FEP) PPO Networks Proper Documentation of Obstetrical Care

Communication between health care professionals during the course of a patient's pre-pregnancy, pregnancy, and postpartum medical journey is important. It is recommended that when caring for the patient, the following be documented in the patient's chart to ensure effective coordination and continuity of care:

- **Prenatal Visit in First Trimester:**
  - Prenatal risk assessment with counseling to include education, complete medical and obstetrical history, physical exam (e.g. ACOG Form)
  - Prenatal lab reports (OB panel/ TORCH antibody panel/Rubella antibody test/ABO/ Rh)
  - Ultrasound, EDD

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For claims submitted by laboratories, if the laboratory's requisition form (and/or any other supporting documentation) is insufficient to show the medical necessity of the testing, it will be necessary for the laboratory to submit additional records or documentation upon request (or upon appeal of the claim denial). To avoid this need for additional documentation, the laboratory should include the following additional information in its requisition form or other supporting documentation. This information is necessary for BCBSMT to assess the medical necessity of the quantitative testing performed. Without the following information, reimbursement of the claim may be denied:

- Information about any relevant qualitative point-of-care or screening testing performed, including the date of the testing, what drugs or drug classes were tested, and the results; and
- A list of medications prescribed to the patient, to the extent the medications are relevant to the tests ordered.

A laboratory's documentation of the results of the testing performed must include:

- The complete identification of the entity performing the testing, including name, address, and Clinical Laboratory Improvement Amendments (CLIA) number;
- The patient's name and date of birth;
- The ordering provider's name and NPI;
- Facility name, if applicable;
- The date the sample was collected;
- The date the sample was received in the laboratory;
- The date the test results were reported; and
- Complete test results, including validity testing if performed.

Of course, beyond the documentation of the services performed, other factors can affect whether a claim is reimbursable by BCBSMT, including but not limited to the member's benefits and eligibility.

In the event an ordering physician's medical records do not support the laboratory's records, the ordering physician's patient medical record shall prevail. For example, if an ordering physician's medical records contradict the laboratory's requisition or are silent as to any testing, the medical record will determine the review/audit findings.

Laboratories should be mindful of requests for testing they receive from inpatient and intensive outpatient behavioral health facilities or residential treatment centers. Laboratory services are included in rates paid to such entities, so laboratory services should not be unbundled and submitted separately for reimbursement. In those instances, separate reimbursement for laboratory services may be denied.

Finally, independent laboratory claims should be submitted to the Blue Cross Blue Shield plan in the state where the referring/ordering provider is located, regardless of where the testing laboratory is located. Failure to abide by this requirement may similarly result in a denial of payment for a claim.

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- **Duration of Prenatal Visits:**
  - Prenatal flow sheet (ACOG, EMR, or other)
  - All progress/visit notes for duration of pregnancy
  - Ultrasound reports and all consult reports
- **Delivery:**
  - Documents, such as hospital delivery records, verifying member had a live birth
  - If the patient had a non-live birth, records that document the non-live birth
- **Postpartum:**
  - Documentation of a postpartum visit on or between 21-56 days after delivery
  - Postpartum office visit progress notation that documents an evaluation of weight, blood pressure, breast exam, abdominal exam, and pelvic exam

Thank you for your partnership with us in the care of Blue Cross and Blue Shield Service Benefit Plan members.

Government Programs: Interpreting the 'PLB' Segment on the 835 Electronic Remittance Advice (ERA)

Reversals and corrections may occur when claim adjudication results have been modified from a previous claim report. The method for revision is to reverse the entire claim and resend with modified data. Provider level adjustments are reported in the PLB segment within the 835 ERA from BCBSMT for the following lines of business:

- Blue Cross Medicare Advantage (HMO)SM
- Blue Cross Medicare Advantage (PPO)SM

Below are additional details regarding adjustment codes that may appear in the PLB segment, in accordance with the requirements as specified within the Health Insurance Portability and Accountability Act of 1996 (HIPAA)-mandated Technical Report Type 3 (TR3).* This document also includes information on PLB segment definitions and examples, as well as how to locate overpaid claims on the ERA and paper Provider Claim Summary (PCS).

Questions regarding 835 ERA files produced by BCBSMT may be directed to our Electronic Commerce Service Center at ecommerceservices@bcbsmt.com or 800-746-4614. (Note: BCBSMT's Electronic Commerce Service Center does not support or resolve issues related to or documented by proprietary ERA or payment summary reports generated by practice management system vendors.)

Please share this document with your practice management/hospital information system software vendor, and/or your billing service or clearinghouse, if applicable.

Additional Details Regarding Adjustment Codes For PLB Segment	
FB – Forward Balance	This code is used to inform you that we have identified an overpayment. We recommend checking your books to confirm details. You may elect to submit a refund to BCBSMT, or do nothing, in which case the payment recovery will occur automatically in 90 days. If you disagree, overpayment disputes/appeals must be submitted within 90 days from the date of the report. Example: PLB*15483NN082*20181231*FB:T18148E02399999*-1156 The dollar amount in the PLB segment is a total of the claims on this remittance that are set to be recovered at a future date. If this is a new 835 ERA with a new forward balance amount, the reference number in the Adjustment identifier field (i.e., PLB03-2) will contain the same number as the trace/check number assigned to this 835 ERA transaction. Refer to the remittance with the reference number in the Adjustment identifier field (i.e., PLB03-2) for overpayment details. **Notes:** • PLB FB segments do not reference the individual claim control number of the overpaid claim. • Balance forward only occurs at the transaction level and not at the claim level.
WO – Overpayment Recovery	After 90 days, if you do not send in the refund, the PLB segment with a positive dollar amount will appear on an 835 ERA transaction indicating the automatic recovery of a previous payment. The payment amount of the corresponding remittance/check will be reduced by this dollar amount. Money Withheld from Check Example: PLB*154837NN82*20181231*WO:SMITH001 181580099999*37.4~
72 – Authorized Return	If you refund the money within 90 days, the PLB segment with a positive and a negative dollar amount will appear on the 835 ERA transaction acknowledging receipt of the refund. The positive "WO" adjustment amount and negative "72" adjustment amount will offset each other resulting in a net 0 impact to the current payment. This is BCBSMT's process of acknowledging receipt of the refund. This segment should be ignored during posting if you have already made the necessary adjustments to the patients account when issuing the refund. Provider Refunded Money Example: PLB*154837NN82*20181231*WO:SMITH001 CHKNO 4873500*57.58 *72:SMITH001 CHKNO 4873500*-57.58~

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PLB Segment Definitions and Examples		
Segment	**Definitions**	**Additional Information and/or Examples**
PLB	Segment ID	
PLB01	Provider ID	1234567894 = National Provider Identifier (NPI)
PLB02	Providers Fiscal Year End Date = CCYYMMDD	20181231 = Provider Fiscal Year End BCBSMT will default to Dec. 31 of the current year
PLB03-1	Adjustment Reason Code	FB = Forwarding Balance, WO = Overpayment Recovery, 72 = Authorized Return Refer to the ASC X12 Health Care Claim / Payment Advice (835) TR3 for a complete list of codes.
PLB03-2	Provider Adjustment Identifier	When the Adjustment Reason Code = FB, this field will contain the TRN02 (trace number/check or Electronic Funds Transfer (835 EFT) number of the current 835 ERA transaction (1234554) where the forward balance is initially reported. **Example:** PLB*1234567894*20001231*FB:**1234554***-200~ When the Adjustment Reason Code = WO, this field will contain the CLP01 (Patient Control Number) from the original claim – followed by a "space" – followed by the CLP07 (Payer Claim Control Number) for the original claim (SMITH001 181580099999). **Example:** PLB*1234567894*20001231*WO:**SMITH001 181580099999***200~. When the Adjustment Reason Code = WO, appears in conjunction with a Reason Code "72" – this field will contain the CLP01 (Patient Control Number) from the original claim – followed by a "space" – followed by "CHKNO" another "space" and the provider's refund check number (4873500). **Example:** PLB*154837NN82*20181231*WO:**SMITH001 CHKNO 4873500***200*72:SMITH001 CHKNO 4873500*-200~ When the Adjustment Reason Code = 72, this field will contain the CLP01 (Patient Control Number) from the original claim – followed by a "space" – followed by "CHKNO" another "space" and the provider's refund check number (4873500). **Example:** PLB*154837NN82*20181231*WO:**SMITH001 CHKNO 4873500***200*72:SMITH001 CHKNO 4873500*-200~
PLB04	Provider Adjustment Amount	-200 or 200 = Payment/Dollar amount of the adjustment This is the amount of money associated with the Adjustment Reason Code in PLB03-1 (FB, WO, 72).

Note: Net positive amounts indicate a reduction in payment, and negative amounts indicate an increase in payment.

Locating Forward Balance Claims on the ERA:

To locate the overpaid claim(s) on the ERA associated with the forward balance indicator (FB), isolate the Claim Payment Information (CLP) loops and look for the claim details that appear twice on the remittance. The presence of these two claims (CLP segments, one positive and one negative) on the ERA will identify the amounts included in the PLB04 segment, as indicated in the below example:

CLP*SMITH001*22*-285*-173.45**MC*180050B99990*11~	Negative	$173.45
CLP*SMITH001*1*285*157.83**MC*180050B99991*11~	Positive	$157.83
	Net Negative	$15.62

The first occurrence of the claim (CLP segment) will contain the original adjudication information with negative dollar amounts, which indicates the reversal of funds (CP03 = "-173.45"). The second occurrence of the claim (CLP segment) will contain the updated adjudication information with positive dollar amounts (CLP03 = "157.83"). The net difference between these two payment amounts (-15.62) will result in either an additional payment (if net positive dollar amount) or a refund amount owed to the payer (if net negative dollar amount). The net positive amount will be included in the payment amount, and the net negative amount (-15.62) will be reflected in the PLB04 with the Reason Code "FB."

In the example above, the net negative amount of $15.62 will be included in the PLB FB segment with any other net negative CLP amounts.

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Locating Forward Balance Claims on the Paper PCS:

To locate the overpaid claim(s) on the paper PCS associated with the forward balance, look for the claim details that appear twice on the remittance. The claim details will display in the body of the remittance as an adjustment to the original claim with an adjusted payment amount.

In the following example, the adjusted payment amount is 0:

Servicing Provider Name: ABC HEALTH SYSTEMS (0009999999) **Payee Name:** ABC HEALTH SYSTEMS (0009999999)

Servicing Provider NPI: 1234567890

Patient and Services Information													
Account Number 9999999999		**Subscriber #** 1234567890			**Plan Name** Blue Cross Medicare Advantage								
Patient Name DOE, JANE		**Claim Id** 123456ABCD01											
Date of Service		**Proc/Rev Code**	**Amount Billed**	**Amount Allowed**	**Adjusted**	**Primary Payor Pmt**	**Patient Responsibility**				**Interest Owed**	**Plan Payment**	**Remarks**
							Co Pay	**Co Ins**	**Ded Amt**	**Non Cvrd**			
11/8/17	11/8/17	J7620	6.00	0.00	6.00	0.00	0.00	0.00	0.00	0.00	..	0.00	H06
11/8/17	11/8/17	J1100	8.00	0.00	8.00	0.00	0.00	0.00	0.00	0.00	..	0.00	H06
11/8/17	11/8/17	94640	53.00	0.00	53.00	0.00	0.00	0.00	0.00	0.00	..	0.00	H06
11/8/17	11/8/17	9921325	119.00	0.00	119.00	0.00	0.00	0.00	0.00	0.00	..	0.00	H06
Claim totals: 123456ABCD01			186.00	0.00	186.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

***- This is an adjustment of Claim Number: 123456ABCD00, which was previously paid for $15.88 on 12/04/2017 with check # 123456. Overpayments are explained in greater detail at the end of this Remittance.**

Current Payment Amount:	$0.00
Provider Sequestration Amount:	$0.00
Prior Paid Amount:	$0.00
Net Payment Amount:	$0.00

The original claim number referenced in the message will appear in the "Negative Balance Details" section at the end of the paper remittance and reflect the overpayment amount (-15.88):

4/18/18	**Medical Overpayment**	**Patient Name: DOE, JANE** **Date of Service:** 11/08/2017 - 11/08/2017 **Patient Account#:** 1234567890 **Original Claim Control#:** 123456ABCD00 **Original Check #:** 123456 **Original Check Date:** 12/04/2017	$15.88	$0.00	$0.00	$15.88

In the example above, the net negative amount of $15.88 is included in the Forward Balance amount.

Claims listed in the "Negative Balance Details" section that do not have corresponding claim adjustments indicate previous overpayments that are pending reimbursement/recoupment. Notification of these overpayments is sent to providers via U.S. mail. To correlate the overpayments pending reimbursement/recoupment to the notification letters you received, match the "Creation Date" (letter generation date) on the letter with the claim details (e.g., original check date, check number, and claim control number) provided on the paper PCS. These overpayments will continue to appear on the PCS until refund checks are received or recoupments occur.

At this time, the total Forward Balance amount is not reflected on the paper PCS from BCBSMT; it must be calculated.

Posted Sept. 2018

*The HIPAA mandated ASC X12 Health Care Claim / Payment Advice (835) TR3 is available for purchase on the Washington Publishing Company (WPC) website at wpc-edi.com. WPC is an independent third-party vendor that is solely responsible for its products and services.

So Blue Cross and Blue Shield of Montana is launching a statewide Big Blue Sky Initiative℠ to help fight opioid abuse, rising suicide rates and meth and heroin epidemics that can get in our way of living healthier, fuller lives. The Big Blue Sky Initiative is ready to put resources in the hands of the communities we serve, so we all get through this together.

By bringing health care providers, community groups and state government together to fight this fight, we can set a positive example for years to come. Because with everyone's help, there's hope.

Together the blue sky is the limit to what we can do to make everyone happy and healthy.

BlueCross BlueShield of Montana

Learn more at:
bigblueskyinitiativemt.com

Close Hedis® Gaps Easily Through the Availity Provider Portal

Providers may now quickly comply with Healthcare Effectiveness Data and Information Set (HEDIS) measures using Availity's new Clinical Quality Validation (CQV). CQV will allow providers to electronically document their patient's care and assessments to close quality HEDIS gaps for Blue Cross and Blue Shield of MT (BCBSMT) members. Additionally, CQV helps support BCBSMT's Centers for Medicare & Medicaid (CMS) star rating for HMO and PPO Blue Cross Medicare Advantage℠ plans.

This new validation process will also verify that the data submitted by the provider is supported in the medical record.

CQV Functionality:

- Captures quality-related medical documentation to close quality HEDIS gaps
- Ensures quality measures documented in medical records are captured accurately for submission to CMS for Stars ratings
- Will display care gaps that BCBSMT provides to Availity
- Provides alerts of care gaps, directing providers to access their work queue

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BCBSMT Introduces New HEDIS Tip Sheets for Meeting Guidelines

What is HEDIS?

HEDIS is an acronym for Health Effectiveness Data Information Set. HEDIS was developed by the National Committee for Quality Assurance (NCQA) and is a widely used set of performance measures in the managed care industry. BCBSMT is required by state law to meet minimum standards of network adequacy and quality of care and use HEDIS measures. HEDIS measures are an essential tool in ensuring that our members are getting the best possible health care.

The tips sheets define criteria for meeting the HEDIS guidelines for important measures. They serve as a guide for the common questions regarding what HEDIS requires for documentation, and timing of health care screening and follow up. This new resource is available on the BCBSMT Provider website at https://www.bcbsmt.com/provider/clinical-resources/hedis

Why Does BCBSMT Collect HEDIS Data?

BCBSMT is required by state law (MCA 33-36-101, et. Seq., The Managed Care Plan Network Adequacy and Quality Assurance Act) to meet minimum standards of network adequacy and quality of care and to use HEDIS measures.

HEDIS data allows BCBSMT to demonstrate the performance of BCBSMT provider networks relative to other managed care organizations operating in Montana and nationally.

HEDIS data allows managed care organizations to identify opportunities for improvement and to implement appropriate interventions.

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Existing Availity users do not have to complete an additional registration to access CQV. However, Availity administrators need to ensure their users are assigned the Medical Staff and Office Staff roles.

CQV Benefits:

- Improved engagement, health outcomes
- Offers an easy, consistent completion process
- Improves quality of information collected
- Maintains document integrity and security

Learn More About CQV:

- A CQV Tip Sheet is available on our Provider website for quick reference and navigational assistance.
- Refer to Availity's Quick Start Guide for Clinical Quality Validation.
- Registered users may log on to the Availity Provider Portal for an on-demand webinar. Once you log on, select "Help & Training," then "Get Trained" and search for the Clinical Quality Validation recording.

Note: This new feature is offered as an added service and does not replace manual processes currently in place. Not yet registered with Availity? Visit availity.com to get started.

If you need assistance, you may contact Availity Client Services at **800-282-4548**.

At this time, electronic medical record request and submission process through CQV are only available for closing quality HEDIS care gaps and are not available for medical record requests resulting from utilization review activities or the claims adjudication process

Important HEDIS Guidelines:

- A measure description
- Information on exclusions from the measure
- Tips for HEDIS scores
- Billing codes related to each measure

Substance Use Disorder – Opioid Use in Montana

Opioid use is the primary driver of drug overdose deaths in Montana.

- From 2003 to 2015, 44 percent of all drug overdose deaths were attributable to Opioids
- An estimated 64,000 Montanans have a Substance Use Disorder (SUD)
- 90 percent of Montanans with SUD are not receiving treatment
- In 2016, Montana had 70 opioid prescriptions for every 100 residents

Tens of thousands of individuals in our state are impacted by this issue; in a rural/frontier state like Montana, access to robust, evidence-based systems to prevent, treat, and manage substance use disorders are limited. Through a collaborative process with partners statewide in the summer of 2016, the Montana Department of Public Health and Human Services (DPHHS), received three years of funding under the Data-Drive Prevention Initiative cooperative agreement from the Centers for Disease Control and Prevention. The primary objectives for the grant include improving data collection and analysis around opioid overdose; developing strategies that affect behaviors driving prescription opioid dependence; and working with communities to develop more comprehensive opioid overdose prevention programs.

ADDRESSING OPIOID AND SUBSTANCE USE DISORDER (SUD) IN MONTANA – STRATEGIC PLAN

A primary activity in 2017 included the development of a Montana Strategic Plan as a "living" and changeable document. The Montana DPHHS formed the above task force with more than 100 people representing more than 80 organizations – ranging from medical professionals, law enforcement, public health and education, state agencies, and non-profit workers – to work collectively to develop solutions for our communities at five strategic planning meetings. With the main goal to reduce drug overdose deaths and increase awareness of SUD in Montana, the plan's goals include six key areas the task force implemented to address these issues;

- Partnerships,
- Prevention and Education,
- Enforcement,
- Monitoring,
- Treatment, and
- Family and Community Resources.

In 2018, four strategic planning meetings were held in Helena with more and more stakeholders joining these meetings as the plan moves forward.

PARTNERSHIPS

With a Memorandum of Understanding (MOU) between Montana DPHHS, Department of Corrections (DOC), and Board of Pharmacy, an increased number of data systems were accessed and analyzed. Stakeholders convened regularly between programmatic and data leaders in a variety of agencies and disciplines with the formation of Montana Epidemiology Outcomes Workgroup (MEOW). Addictive and Mental Disorders Division

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Tobacco Cost to Montanans

Despite the continued decline in smoking prevalence among Montana adults, tobacco use remains the number one preventable cause of death with 1,600 deaths occurring annually in Montana.[1] For every person who dies because of smoking, at least 30 people live with a serious smoking-related illness.[2]

Whether or not you use tobacco, you are paying for it. Every year, smoking costs Montanans $440 million in direct health care expenditures and $81 million in Medicaid dollars.[1] Nationally, each pack of cigarettes sold costs $19.16 in direct health care expenditures and lost workplace productivity.[3]

According to the U.S. Surgeon General, raising the price on tobacco products is one of the most effective ways to prevent initiation of tobacco use and encourage current tobacco users to quit.[4] Low income adults, youth and pregnant women are especially likely to quit or reduce their smoking when the price increases. It is estimated that a 10% increase in the price of cigarettes decreases overall cigarette consumption by 3-5%. Kids are particularly sensitive to price increases. A 10% increase in the price of cigarettes reduces the number of youth who smoke by 6-7%.[5]

For more information on the toll of tobacco in Montana, visit tobaccofree.mt.gov.

[1] Campaign for Tobacco-Free Kids. "The Toll of Tobacco in Montana." https://www.tobaccofreekids.org/problem/toll-us/montana. Accessed April, 2018.

[2] Centers for Disease Control and Prevention. Smoking & Tobacco Use: Fast Facts. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm. Accessed April, 2018.

[3] Campaign for Tobacco-Free Kids. "Toll of Tobacco in the United States of America." https://www.tobaccofreekids.org/assets/factsheets/0072.pdf. Accessed April, 2018.

[4] 1 U.S. Department of Health and Human Services (HHS), The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General, Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014, https://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html.

[5] Campaign for Tobacco Free Kids. "Raising Tobacco Taxes: A Win-Win-Win." http://www.tobaccofreekids.org/research/factsheets/pdf/0385.pdf. Accessed April, 2018.

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finalized certification for the Peer Mentoring Program. 133 Peers have attended in-person training and 178 individuals have attended 13 webinars since August 17, 2018, examples of topics include Trauma Informed Care, Burnout Self-Care, and Resiliency.

PREVENTION AND EDUCATION

Communities that Care Project was funded with help from the Montana Healthcare Foundation. Also, $75,000 dollars in evidence-based prevention DDPI grants was provided to 16 communities to reduce prescription drug abuse and/or overdose deaths in Montana. These grants implemented positive change related to drug overdose morbidity and mortality across Montana. Fact sheets were created to promote awareness and education surrounding SUD in Montana, Medicated-Assisted Treatment (MAT), Stigma, Prevention Resource Center, Strategic Targeted Response (STR Grant), and the Impact of Medicaid Expansion (HELP) on SUD Prevention and Treatment in Montana. In response to the opioid epidemic, HB333 passed into law as the Help Save Lives Overdose Act. DPHHS Naloxone Master "Train the Trainer" program contracted with Best Practice Medicine to fulfill DPHHS requirement of the Act to TEACH others to administer Naloxone. There are 256 Master Trainers and 883 Authorized Users.

ENFORCEMENT

Local communities are starting to implement peer support/crisis diversion programs with local law enforcement agencies. Medicaid and DOC partner, to ensure Medicaid eligibility is for individuals released from protective custody. There are 31 Drug Treatment Courts in Montana.

MONITORING

The Montana Board of Pharmacy developed, implemented, and operates the Montana Prescription Drug Registry (MPDR) program to monitor controlled substances dispensed to Montana residents. The number of providers registered with the MPDR continues to increase. DPHHS has limited access to MPDR data that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and the use of controlled substance prescriptions for Montana residents.

TREATMENT

The number of providers with Buprenorphine waivers went from 38 in 2017 to 79 as of June 2018. The Hub and Spoke Model for comprehensive MAT care and education was developed and launched. Medicaid Expansion funds SUD treatment. As of October 2018, 298 clients have been served to date at the five hubs/spokes.

FAMILY AND COMMUNITY RESOURCES

Legislation in the 2017 session expanded Naloxone administration access to emergency responders, school nurses and the public. Naloxone (Narcan) is a prescription medication that can reverse an overdose caused by an opioid drug. In support of these acts, materials such as the Naloxone Standing Order, Naloxone Implementation Guide and an informational Naloxone brochure were developed. As of October 2018, 163 Montana pharmacies are participating in the Naloxone Standing Order. Statewide public education campaign with billboards and TV spots promoting the slogan, "Addiction is a Disease. Recovery is Possible," over 100,000 medication disposal bags distributed across the state.

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