Preventive care and your patients

Helping patients understand preventive services

By Tim Simard

The importance of preventive care has gained a lot of prominence in the past few years. The federal Affordable Care Act (ACA), as part of its many sweeping changes, mandated that some preventive care services had to be covered at no cost by health plans. Today, with many Vermonters enrolled in the exchange plans mandated by the ACA, the public is learning more and more about what preventive care is and the importance of routine physicals and early screenings.

The increased awareness of preventive care has also created a perception of what constitutes a preventive service and what does not. It’s also causing confusion on what services require no costs to members versus services that are preventive in nature, but still require member cost share—like co-payments or co-insurance or amounts applied towards deductibles.

Dr. Robert Wheeler, chief medical officer at Blue Cross and Blue Shield of Vermont, says the challenge of providers and health plans is to educate members on the distinction between the various preventive services and screenings.

"Blue Cross and Blue Shield of Vermont provides benefits for a very broad range of preventive services," Wheeler explains. "At the same time, we provide benefits for some services at no cost to the member."

The services BCBSVT covers at no cost for plans not grandfathered with respect to the ACA are very specific—only those services rated A or B by the United States Preventive Services Task Force (USPSTF) require no cost-sharing for those plans.

"Grandfathered plans"—health plans that existed before the passage of the ACA—feature different preventive care provisions and do not use the USPSTF...
ratings as guidelines. While some plans, like The Vermont Health Plan’s BlueCare product, feature preventive care at no cost to the members, we do not use the USPSTF ratings, so members in those plans may receive a different set of services at no cost. To review a full list of A and B rated preventive services, visit the USPSTF website at uspreventiveservicestaskforce.org.

If you have questions about which services your patients on grandfathered plan receive without cost-sharing, please call our customer service department or your provider relations representative.

As BCBSVT continues to educate its members about preventive care, providers can take an active role in setting patient expectations about services. For instance, many members believe that any service received during a routine physical or other preventive screening will come at no cost. Lab work, follow-up tests and other diagnostic procedures, however, often take place during or after a preventive service and may require cost-shares.

Also, if a patient has a history with a particular disease, a screening for that disease would be diagnostic for that patient and may require cost-sharing. In a different individual, that same screening may be preventive.

“These types of services would be considered preventive services that are not (USPSTF) level A or B,” Dr. Wheeler says. Determining a no-cost preventive screening service versus a diagnostic or surveillance service that requires cost sharing can get tricky. In a routine mammogram procedure, for instance, if a provider discovers a potentially cancerous lump, the mammogram would still be considered preventive at no cost. If tests discover breast cancer, however, further diagnostics and future procedures will not be preventive.

“Understanding preventive care is a collaborative effort between health plans, providers and members, and helps save money, time and confusion.”

Dr. Robert Wheeler
Here are other examples found in our “Understanding Preventive Care” guide:

- A 30-year old woman without symptoms has an annual physical. It includes a breast exam, a Pap smear, cholesterol and glucose screening and screening for sexually transmitted diseases. The Pap smear shows an irregularity. The first exam will be paid at the preventive level, provided the doctor or hospital still considers the test preventive. A follow-up exam, done at a later date because of the irregularity of the Pap, will be paid subject to cost-sharing.

- A patient with no known or suspected health issues has a lipid test and a metabolic test at their annual physical. They do not have to pay cost-sharing for the lipid test, but since the metabolic test does not appear on the USPSTF’s list of A- and B-rated services, they must share in the cost of the metabolic test.

“The United States Preventive Services Task Force ratings aren’t something most members know about,” Dr. Wheeler adds. “It’s worthwhile to become familiar with what the federal government considers level A or B to help your patients understand how these services work.”

To ensure BCBSVT correctly processes preventive services, it’s helpful to understand how to code a claim to receive accurate payment and guarantee your patients incur the correct cost-sharing. Please see the sidebar for preventive care coding tips.

Dr. Wheeler says that understanding preventive care is a collaborative effort between health plans, providers and members, and helps save money, time and confusion. BCBSVT created a helpful brochure for members that describes preventive care and specifically highlights these services for men, women and children. If you’re office is interested in copies of “Understanding Preventive Care,” contact our provider relations department. You can find online copies here: [www.bcbsvt.com/preventive](http://www.bcbsvt.com/preventive). We also have a brochure for providers that lists exactly which CPT codes the USPSTF considers preventive.

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**Billing and Coding Tips Q & A**

### What is the difference between a preventive visit (CPT® codes 99381-99397) and an office visit (CPT codes 99201-99215)

A preventive visit is when the patient is asymptomatic and comes in with no chief complaints, but wants a complete physician examination.

- There will be no history of present illness.
- The preventive medicine exam is multi-system and is based on the age and gender of the patient and the risk factors identified.
- For preventive medicine services, medical decision making is not determined as it is not part of the criteria for these coded.
- Remember always to bill preventive medicine service with an appropriate “V” code.
- Preventive medicine services include counseling, anticipatory guidance and risk factor reduction interventions you provide at the time of the initial or periodic comprehensive medicine examinations.

### What services should you not report separately during a preventive care exam?

- Pelvic exam including obtaining of the pap smear;
- Breast exam; and
- Testicular and/or prostate rectal exam.

### What services should you report separately with a preventive medicine service?

Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures or screening tests (e.g. vision, hearing, developmental) identified with a specific CPT codes.

**Can preventive visits and office visits be billed together?**

Preventive and regular office visits can be billed together. There are times when a patient comes in for a preventive medicine visit and, while doing the exam, the physician discovers another problem.

CPT instructs that if you find an abnormality or address a preexisting problem in the process of performing the preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, you should also report the appropriate Office/Outpatient code 99201-99215. Add modifier 25 to the Office/Outpatient code to indicate that you provided a significant, separately identifiable evaluation and management service on the same day as the preventive medicine service. Whenever you bill both types of visits together, be sure that you link the appropriate diagnosis with the correct type of visit. Link the well diagnosis with the preventive visit, and the diagnoses that are being treated with the office visit.

**Remember…**

If you perform any portion of the history or exam to satisfy the preventive service, do not use that same portion of work to calculate the additional level of E/M service. When selecting the additional E/M level of service, use only the work you perform “above and beyond” what would have been performed during the preventive service to calculate the additional E/M level.
By Cory Gustafson

It was another eventful legislative session this year. Although the Legislature did not produce as large a number of health care-related bills as it has in years past, health care issues were at the forefront of much debate.

The Legislature, which wrapped up on May 10, began its session with a visit from Gov. Peter Shumlin. In a rare act, Gov. Shumlin addressed both the Senate and House Committees on Health Care in a joint hearing. He told them that despite the rocky roll out of Vermont Health Connect, the state would forge ahead in achieving a universal, publicly financed health care system. At that time, the governor asked the members of the committees and the rest of the Legislature to prepare for the financing plan conversation that would begin when his administration offered different financing options later in the session.

Perhaps heeding the governor’s recommendation, the health care committees initially spent more time examining the current health care system than taking up legislative proposals. The number of bills that eventually made it onto committee walls bears this out too; the House Health Care Committee received only three bills from the Senate side at the session midpoint, and two of those bills came from the Senate Finance Committee. One of those bills was S.252, which became the session’s most substantive health care reform legislation after the governor announced in early March that financing alternatives would not be forthcoming as promised. The administration’s change of plan intensified the general assembly’s focus on S.252.

S.252 left the Senate as a collection of provisions and requests for reports intended to bring clarity to lawmakers about critical and outstanding issues involved with the implementation of Green Mountain Care. With limited time left in the session and few bills to use as vehicles for other legislative proposals, the House Health Care Committee chose to add sections unrelated to Green Mountain Care. The committee expanded the bill’s scope by adding language about pharmacy benefit management transparency, the health implications of adverse childhood experiences and regulating urgent care centers. In the end, the House additions made it difficult for the House and Senate Conference Committee representatives to agree on a final version of the bill. The delay in reaching agreement put the bill at risk of failing to be approved by both chambers before the session adjourned. In the end, consensus was reached, but in order to cross the finish line the language was put onto a different piece of legislation, H.596.

Although the number of bills taken up and passed out of committee was limited this session, there was no shortage of issues or proposals with implications for Blue Cross and Blue Shield of Vermont members. The following is a list including a brief outline of the issue and our efforts on each:

- **Claims edit standards:** Act 79 of 2013 included a provision that the Green Mountain Care Board (GMCB) would establish a standardized set of claims edits for all payers to use by Jan. 1, 2015. The plan was to follow the lead of a project in Colorado that has all the players at the table and considerable funding behind it. The Colorado project, however, is not as far along at this point as projected and the GMB has nothing to put into rule. GMB requested a two-year extension, but the legislature approved only a one-year extension until Jan. 1, 2016 as part of H.596.

- **Blueprint for Health:** The Blueprint annual report released in January highlighted millions in savings in health care costs financed by private insurers. Legislators considered increasing the Blueprint payments to providers, given that the program was reporting such strong performance. While emphasizing BCBSVT’s historical support of the Blueprint, we recommended that before increasing per member per month payments the state should ensure:
  - Strategic integration with other reform initiatives (as requisite for further investment);
Principles in mind; language in H.596 to examine the Blueprint with these principles in mind; language in H.596 requests a report from the administration that is due on Oct. 1, 2014.

- **Claims assessment:** The governor proposed increasing the tax on health insurance claims by 1 percent in order to raise $14 million to fill a hole in the Health Care Resources Fund that pays for Medicaid claims. BCBSVT opposed the increase because it would increase the cost of health insurance and increase the cost shift. The tax committees had the same opinion and chose not to include the provision in their revenue packages instead opting to expand the employer assessment to businesses with full-time employees who are still on Medicaid.

- **Medicaid rate increase:** The governor proposed a 2 percent rate increase at the start of the session. Most legislators supported the increase but budgetary pressures put the increase at risk. The House passed a 0.75 percent increase while the Senate appropriations committee opted to fund the full 2 percent. In the negotiation between House and Senate Conferees, an agreement was reached that would increase Medicaid rates by 1.6 percent. BCBSVT supported the rate increase throughout the process.

- **Immunization Program:** The Vermont Department of Health proposed language that would expand immunization purchasing from a pilot to a statewide program. The program buys vaccines for children and adults at significantly reduced costs and provides them free of charge to our members. BCBSVT has supported the pilot and the expansion to a full program as good health policy but requested language changes that would accurately attribute the cost of the program by the number of adult and pediatric lives covered by each payer. The Legislature agreed to accept BCBSVT’s recommendations and included our language in the appropriations bill, H.885.

- **Prescription Synchronization:** S.236 as introduced would have simply mandated that plans could not deny prescription refills. The intent was to allow patients to organize their prescriptions so that refills would all happen at the same time. BCBSVT told the Senate Health and Welfare Committee that BCBSVT could implement a synchronization program without a legislative mandate. The Senate committee accepted the BCBSVT proposal and the bill did not move forward.

- **Lyme Disease:** H.123 was introduced with the intent of providing patients suffering from tick-borne illnesses easier access to treatment including long-term antibiotics. The bill had included a mandate for health insurance coverage but that provision was removed.

- **Optometry:** S.281: The bill as passed requires that payers reimburse optometrists the same as ophthalmologists for the same services within their scope of practice. It also prohibits health plans from extending contracted discounts for members with vision plans to other plan members who do not have vision services as part of their health insurance.

- **Statutory Purposes:** S.221 examined all the tax exemptions in Vermont statute and defined the purpose or benefit of each to Vermonter's. As a nonprofit organization, BCBSVT has been exempt from all taxes. The Senate Finance Committee felt BCBSVT should not be exempt from the rooms and meals tax when paying for catered events and the repeal was not contested.

- **Vermont Health Connect:** Throughout the session, legislative committees received updates on the exchange. Commissioner Mark Larson offered weekly updates to the House Health Care Committee on the progress Vermont Health Connect has made in terms of individuals signed up and system functionality. BCBSVT has offered its perspectives on several occasions with the focus of its testimony centering on how continued system issues are negatively affecting individuals who have purchased health insurance on the exchange. Due to the limitations in system functionality and the on-going issues BCBSVT fully supported the administration’s decision to allow small businesses to directly enroll with insurers in exchange qualified health plans. Language allowing small groups to buy 2015 coverage directly from insurers in H.596 demonstrates the Legislature’s support.

- **Miscellaneous Amendments to Health Care Laws:** H.596 started as a Green Mountain Care financing bill with the bill number S.252. As the new name suggests, the bill became a collection of health care related provisions including multiple reports intended to inform future decisions around Green Mountain Care. The following is a list of relevant sections not yet covered:
  - Reserves Report—The Department of Financial Regulation has been asked to identify the legal and financial considerations involved in the event that a private health insurer ceases doing business in this state, including appropriate disposition of the insurer’s surplus funds. (Due July 15, 2014)
  - Contract for Administration of GMC Report—Secretary of Human Services is to report the elements of Green Mountain Care, such as claims administration and provider relations, for which the Agency plans to solicit bids for administration, as well as the dates by which the Agency will solicit bids for administration of those elements and by which it will award the contracts. (Due Jan. 15, 2015)
  - Independent Physician Practices Report—Secretary of Administration will recommend whether the state should prohibit health insurers from reimbursing physicians in independent practices at lower rates than those at which they reimburse physicians in hospital-owned practices for providing the same services. (Due Dec. 1, 2014)
  - Increasing Medicaid Reimbursement Rates Report—Secretary of Administration in consultation with the Green Mountain Care Board will report the impact of increasing Medicaid reimbursement rates to providers to match Medicare rates. The issues to be addressed in the report will include the amount of funds needed and the projected impact of the increase on health insurance premiums. (Due Jan. 15, 2015)
**OTC coverage expands for certain drugs**

Blue Cross and Blue Shield of Vermont expanded its coverage for limited and specific over-the-counter (OTC), non-prescription medications effective May 1, 2014. BCBSVT will add Nasacort® OTC to our OTC Program. Previously, Prilosec OTC™- and Prevacid®24, for reflux disorders; and Claritin®, Claritin-D®, Zyrtec®, Zyrtec-D®, Allegra® and Allegra-D®, for allergies, were the only OTC product included in the program.

Although these medications do not usually require a prescription, your patient must obtain a written prescription for the medication from you in order to have these drugs covered under the BCBSVT pharmacy benefits.

*How it works:* if your patient needs medication for the treatment of reflux disorders or allergies and requires medication to control these conditions, just write a prescription for the OTC version. The patient will take the prescription to the pharmacy and will be dispensed a 30-day supply of the medication at the generic co-payment.

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### RationalMed® providing results

*By Tim Simard*

A new health and safety program available for Blue Cross and Blue Shield of Vermont members has already produced results within its first six months. RationalMed, an Express Scripts® program with which BCBSVT has partnered, identified more than 10,000 potentially dangerous drug-related risks in BCBSVT members. These identified issues meant members may have been taking medications that could complicate other medical problems they have or create new ones, according to Brian Murphy, director of BCBSVT’s pharmacy program.

“This has been a great program for patient safety even in its first six months,” says Murphy.

Providers took action on 15 percent of the more than 10,000 identified potential risks. That means a doctor changed a patient’s treatment or altered their medication to avoid further health complications, Murphy explains.

RationalMed identifies previously undetected prescription drug health risks across the entire BCBSVT member population. Express Scripts’s parent company, Medco®, created the program to work in conjunction with other existing clinical and pharmacy management programs. By analyzing medical, pharmacy and lab data, RationalMed allows providers to know if their patients need drug therapy intervention based on the medications they take.

"It identifies people on the verge of a medical event," explains Brian Murphy.

When RationalMed identifies a member with a potential need for drug-therapy intervention, it immediately sends a letter to the member’s primary care physician and gives him or her an actionable recommendation.

For instance, a local provider recently prescribed an estrogen supplement for a patient, not knowing that this member was already taking medications for hypertension. RationalMed noticed that both drugs used together could increase the risk of a cardiac event. The program notified the provider and adjusted the patient’s medications accordingly.

Murphy believes even more stories like this will come to light as BCBSVT continues working with the RationalMed program.

"As more and more information gets fed into the RationalMed system, we can expect to see a climb in actionable cases," he says.
Clinical Integration discussed at joint meeting

The integration of health care management and coordination of services were the key topics discussed during an important summit in May. Blue Cross and Blue Shield of Vermont’s clinical advisory committee and Vermont Collaborative Care’s provider advisory group held one of their regular meetings on May 21 to discuss best practices of integrated health management and other various topics. This meetings are part of the ongoing partnership between BCBSVT and the Brattleboro Retreat, which together established Vermont Collaborative Care.

The attendees discussed how to improve integration practices through three topics: theory-based integration for improved health outcomes, developing infrastructure and processes to support integration and the “nuts and bolts” of how to implement.

“Having medical and mental health professionals take time to come together to talk about ways to work collaboratively to make treatment better for Vermonters is crucial,” says Peter Albert, president of Vermont Collaborative Care. “Blue Cross and Blue Shield of Vermont is committed to working with clinicians to find ways that we can support their work.”

Dr. Jaskanwar S. Batra, medical director for the Vermont Department of Mental Health, presented an overview of health care integration. His presentation highlighted the benefits of integrating mental health care in the overall care of an individual. Most chronic diseases, which account for 75 percent of health care costs, have a tight correlation and co-morbidity with mental health problems. Therefore, improving coordination of mental health care for people with chronic illnesses increases the success of treatment and outcomes in chronic care, Batra said during the meeting.

A panel of practitioners and care managers that work alongside mental health professionals discussed the benefits and challenges of their practice models. Everyone agreed that coordinating all types of care for patients and their families in a central location reduced wait times for services, improved communication between practitioners and community resources and provided an environment that supports a whole-person approach to health care. Some of the challenges faced in these models included a cultural shift for physicians in having multiple care providers involved in their patients’ treatment plans and lack of reimbursement for care coordination staff and services.

Throughout the meeting, participants exchanged many ideas and challenges in coordinating services between medical providers and mental health and substance abuse practitioners. Questions included:

- What are the roles of various parties: medical practitioners and practices, mental health and substance abuse practitioners and practices, health insurance payers, community resources and hospitals?

The meeting’s participants expressed a positive energy and requested more collaboration that will support the best patient outcomes.

“Any efforts that attempt to create a better model of integration for medical, mental health and substance abuse treatment engage a process fraught with complexity,” says Kevin Gallagher, a licensed clinical mental health counselor. “Blue Cross and Blue Shield of Vermont has taken on that challenge.”

Gallagher continues: “Over the time I have been involved, it’s been a diverse group of people with widely varying opinions all gathered to help ultimately create something workable and effective. The layers of thinking that overlap one another, from pediatric medicine to diabetes care for the elderly, to heroin use, to depression, to school avoidance, across multiple populations, compounded by issues such as poverty, transportation, child care, truancy and language all make for a very multi-systemic problem to be addressed. I’m not sure who else in the state right now is trying to do that level of thinking except Blue Cross and Blue Shield of Vermont. And it’s clear from my involvement that it will require more than just their work to make it successful.”
Grace periods for exchange products continue

Please note that some of our members currently on exchange plans are entitled to grace periods for premium payment. When members fail to pay premiums for products on Vermont Health Connect, grace periods will sometimes work differently than those in our other products. Members who receive federal premium tax credits, also known as subsidies, to help pay for the cost of insurance are entitled to a three-month grace period from the day payments are due before coverage will be cancelled. In order to avoid cancellation of coverage, however, a member must pay all premium due by the end of the third month. Partial payment of overdue amounts will not reinstate coverage or restart a member’s grace period. If a member fails to pay the premium in full within three months, the state will notify us and we will cancel coverage retroactively to the 31st day after the last month of fully paid coverage. We will not pay medical claims the member incurs after day 31 and the member will be responsible for those costs. For members who do not receive federal tax credits, for example those who purchase insurance through an employer, we allow a 10-day grace period for payment. For more information, contact your provider relations consultant or visit our website at bcbsvt.com/provider.

FEP Corner

Tips on serving members enrolled in our Federal Employee Program, also known as FEP.

Medicare claims

FEP is not set up as a Medicare crossover plan; please submit Medicare primary claims on paper with the explanation of Medicare benefits.

Radiology services

Radiology services do not require prior approval for most BCBSVT members, but FEP members do need it for many services. You can find which services require prior approval by visiting the FEP website at FEPBlue.org.

ID cards

Only the subscriber’s name appears on FEP ID Cards. You can verify dependant coverage by using the eligibility search feature on the provider portal at bcbsvt.com.

Caremark® prescriptions

Caremark is the pharmacy benefit manager for FEP members. FEP members should use retail pharmacies and the mail order pharmacy in Caremark’s network. For prior approvals for prescription medications or general questions concerning prescriptions you can contact Caremark at (800) 624-5060 or for mail order (800) 262-7890.

Reminder about referrals

FEP does not require referrals for specialty care.

BCBSVT to credential physician assistants

When a Blue Cross and Blue Shield of Vermont member uses the services of a BCBSVT contracted provider, they have the added security of knowing the provider has met very strict requirements. They expect and appreciate this additional benefit. It is in that spirit we will begin to require full credentialing of physician assistants immediately.

Physician assistants who are new to BCBSVT will need to complete the Council for Affordable Quality Healthcare (CAQH) profile in addition to the enrollment form. Full details on enrollment and credentialing are available in section 1 of our on line Provider Manual located on our provider website at bcbsvt.com/provider.

If you are a physician assistant who is currently enrolled with BCBSVT, you need to make sure your CAQH profile exists, is updated, has recent re-attestation and allows BCBSVT access. Doing so will eliminate the need for BCBSVT to interrupt you and your practice with a phone call to obtain necessary information or provide reminders. If you have questions about this change, contact your provider relations consultant.
BCBSVT and TVHP Preferred Brand-name Drugs  
(effective July 2014)
Member rights and responsibilities

In order for Blue Cross and Blue Shield of Vermont and The Vermont Health Plan 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, bcbsvt.com. To request a paper copy, please contact your provider relations consultant.

We want your feedback

As always, we welcome input and feedback regarding our quality improvement plans. The Plan has adopted the nationally recognized guidelines for the treatment of congestive heart failure, chronic obstructive pulmonary disease, substance use disorders and major depression. Nationally recognized experts in each condition developed these guidelines. The guidelines are available for you to read or print on the following websites:

- Adult Preventive Immunization, Centers for Disease Control and Prevention: cdc.gov/vaccines/schedules/hcp/adult.html
- Pediatric Preventive Immunizations, Centers for Disease Control and Prevention: cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- USPSTF Recommended Adult Preventive Guidelines, U.S. Preventive Services Task Force: uspreventiveservicestaskforce.org/uspreventive.html
- Guidelines for the Treatment of Patients with Substance Abuse, Opioid Abuse, American Psychiatric Association: psychiatryonline.org/guidelines.aspx
- Guidelines for Treatment of Patients with Depressive Disorder, American Psychiatric Association: psychiatryonline.org/guidelines.aspx
- Evaluation and Management of Congestive Heart Failure in the Adult, American College of Cardiology and American Heart Association: cardiosource.org

The Plan has adopted nationally recognized preventive health and clinical practice guidelines for adult and pediatric preventive immunizations, adult and children and adolescent clinical preventive services, and treatment of substance abuse, opioid abuse and depressive disorder. Nationally recognized experts developed these guidelines. The guidelines are available for you to read or print on the following websites:

- Adult Preventive Immunization, Centers for Disease Control and Prevention: cdc.gov/vaccines/schedules/hcp/adult.html
- Pediatric Preventive Immunizations, Centers for Disease Control and Prevention: cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- USPSTF Recommended Adult Preventive Guidelines, U.S. Preventive Services Task Force: uspreventiveservicestaskforce.org/uspreventive.html
- Guidelines for the Treatment of Patients with Substance Abuse, Opioid Abuse, American Psychiatric Association: psychiatryonline.org/guidelines.aspx
- Guidelines for Treatment of Patients with Depressive Disorder, American Psychiatric Association: psychiatryonline.org/guidelines.aspx

In addition to the nationally recognized preventive health and clinical practice guidelines listed above, BCBSVT bi-annually adopts new clinical practice guidelines and reviews clinical guidelines that the Plan previously adopted. The Plan has adopted guidelines for the treatment of chronic heart failure, chronic obstructive pulmonary disease, diabetes, asthma, overweight and obesity, and hypertension.

The guidelines may be evidence-based guidelines or consensus guidelines developed by providers. These guidelines are available on our Provider Resource Center, by calling Customer Service at (800) 924-3494 or by emailing customerservice@bcbsvt.com.

Referring members to BCBSVT/TVHP case management

BCBSVT designed its specialty case management program as a member-centered, proactive program to identify at-risk members as early as possible. The program focuses on typically high-cost chronic diseases, oncology, end-of-life and hospice care, along with mental health and substance abuse.

By applying the four primary functions of case management—advocacy, assessment, planning and facilitation—the case manager identifies barriers to the member obtaining appropriate, timely and quality care. The program organizes efforts to identify potentially high-cost and high-risk members as early as possible, assess alternative treatment options, assist in stabilizing or improving the member’s health care outcomes and manage health care benefits in the most cost-effective manner.

We encourage providers to refer BCBSVT/TVHP members directly into our case or disease management programs by calling (800) 922-8778, option 1. Our intake triage staff will record the information and complete outreach to the member for enrollment. Members may self-refer to the case management program. Family members and caregivers may also refer members to the program.

If we determine that the member has the potential to benefit from case management, we send a welcome packet defining case management’s role and the member’s rights and responsibilities in participation. Once the member consents to participate, our case manager and the health care team complete a comprehensive assessment of the member’s condition. The member, case manager and provider then develop a member-specific case management plan of care to support the member’s clinical plan of care. The plan includes a member self-management plan as well as short- and long-term goals and discharge criteria.
Blue Cross and Blue Shield of Vermont wants to remind providers of our Blue HealthSolutions program, which we’ve designed for patient-focused, disease-specific care. BCBSVT provides participants with user-friendly and results-oriented resources to help them live long, healthy lives. Participation is free and completely voluntary for all eligible Blue HealthSolutions program members.

The program’s care team, led by registered nurses, provides support to help patients comply with their providers’ treatment plans, and encourages them to take a more proactive role in the management of their overall health. This is a covered service for your Blue HealthSolutions program patients and does not require you to issue referrals in order for your patients to participate. Rest assured that BCBSVT keeps the information, such as medical or pharmacy claims information needed to administer the program’s specialized services, in the strictest confidence. BCBSVT only uses the information in compliance with HIPAA regulations.

You will continue to direct your patient’s treatment plan. The added support of the program’s registered nurse-led care team will reinforce your efforts to help enhance clinical outcomes and patient satisfaction.

BCBSVT designed every aspect of the program to provide maximum support and benefit to providers and patients.

Through the program’s support, providers and patients have access to the following:

**Physician resources:**
- Care team professionals who work with patients to reinforce treatment plans, increase patient compliance and improve clinical outcomes
- Program overview, patient support and educational materials, including quarterly newsletters and care guides available online at [healthways.com/physician_portal_docs](http://healthways.com/physician_portal_docs)
- Access to the program through the toll-free number, 24 hours a day, seven days a week

**Patient resources:**
- Regular telephone contact from care team professionals to review their health status, discuss their concerns, suggest possible lifestyle changes and encourage compliance with provider treatment plans
- Educational mailings, such as workbooks and newsletters, to help patients better understand and manage their condition
- Periodic reminders encouraging patients to obtain recommended laboratory tests and exams
- Periodic review of a patient’s success in following a prescribed treatment plan

BCBSVT looks forward to future collaborations as these enhanced disease management services become available to patients. The company welcomes any comments and questions providers may have about the program. Please call toll free at (866) 612-0285, option 3 (option 4 for FEP), anytime Monday through Friday, 8:30 a.m. to 5 p.m.

**BCBSVT practitioner availability**

Blue Cross and Blue Shield of Vermont annually measures compliance with the practitioner availability standards. We monitor specialists that serve as primary care providers by specialty and in-aggregate. We define the following areas as primary care practices: pediatrics; internal medicine; family practice, general practice and naturopaths. BCBSVT selected specialty care practitioners for evaluation based on the volume of services provided to members in the previous year. Taking into consideration the types of services provided, we gave specialties that generally treat conditions associated with life-threatening conditions a higher priority. We re-evaluate specialty care providers annually. In 2013, we monitored the following high volume specialty practitioners that provide key services to members: obstetricians and gynecologists; orthopedic surgeons; ophthalmologists; cardiovascular disease and dermatologists; mental health and substance abuse practitioners.

The practitioner availability standards are:
- Choice of at least two age-appropriate network PCPs, who are accepting new patients within 30 minutes travel time.
- Choice of at least one network practitioner from each of the specialties selected for monitoring within 60 minutes travel time.
- Choice of at least one mental health practitioner within 30 minutes travel time.
- Choice of at least one substance abuse practitioner within 30 minutes travel time.

**Performance against goal:**

In 2013, we monitored of Vermont Freedom Plan, Vermont Health Partnership and The Vermont Health Plan networks. With the exception of naturopaths for primary care, where results ranged from 80 to 84 percent availability, each of the networks exceeded our performance goals.