Provider Newsletter

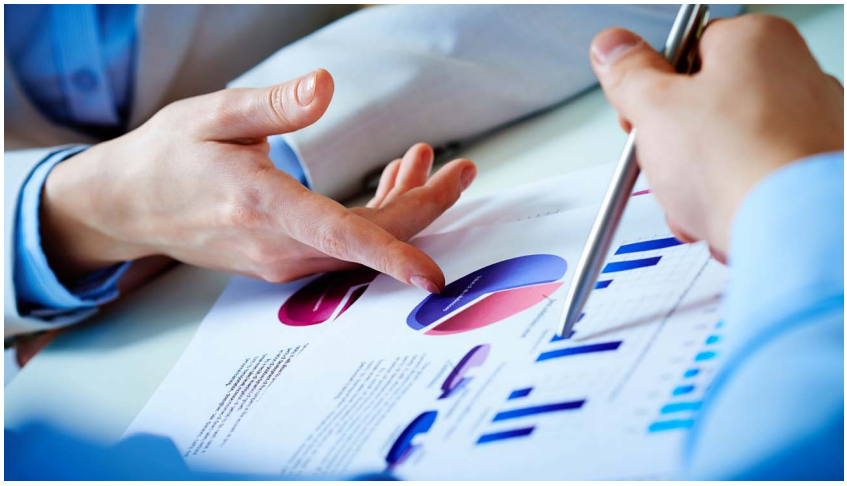
myBlue— Florida Blue New Product

You may have noticed that you're beginning to see Florida Blue members with a new card with the name "myBlue". Please be reminded that myBlue is a new Marketplace Exchange product that is managed by Eye Management, Inc for Ophthalmology services. **Please do not turn away any patients with this new card.**

Availity™

Have you signed up with Availity?

Availity is Florida Blues' trusted information exchange partner enabling the movement of business and clinical information in real-time. By signing up with an account you will be able to verify eligibility, benefits, and more – all online and at your fingertips. For more information, including online demonstrations or to register, please visit Availity's website at www.availity.com or call (800) AVAILITY (282-4548).



Utilization Management and the Climbing Healthcare Costs

With all the attention that the soaring cost of healthcare has been getting, it's easy to assume that this is a new phenomenon, and that back in the "old days", it wasn't a concern.

Although health insurance firms had been concerned over high medical costs which they identified as being at least partly the result of unnecessary procedures and hospital stays, it was the creation of the Social Security Act of 1965 for Medicare and Medicaid Title XVII and XIX that provided the impetus for a focus on methods to standardize admission and hospital stay decisions.

During this time, there was significant variation between physicians, hospitals, and regions on the use of procedures or inpatient admissions, and it was typical for patients to be admitted for weeks or even months for observation or for procedures that would currently require less than a week or even be performed on an outpatient basis.

The Social Security provisions required clinical evaluation and review, but did not set criteria. In the early 1970's a Congressional subcommittee estimated that were over two-million unnecessary surgeries per year

continued from page 1

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across the US. As a result, there was a growing requirement for standards regarding procedures and inpatient admissions.
To give a context of scale, physicians who fail to follow evidence-based clinical criteria add a $500 billion cost burden to U.S. healthcare by providing overly aggressive or ineffective care. [2] In a study of contribution to cost by cases that do not meet clinical guidelines, Cutler et al found that patient demand was not a significant contributor, but that physician preferences unsupported by clinical evidence accounted for 36% of end-of-life spending, and 17% of total health care spending.

One approach to reducing costs and controlling the "exuberance" of a free market that would naturally tend towards increasing use of medical products and services, is to have clinical episode of care criteria. Utilization Management criteria can be used prior to encounters (prospective review), as part of the triage and episode of care decisions (concurrent review), or as a quality improvement tool to assess episode of care after the case (retrospective review).

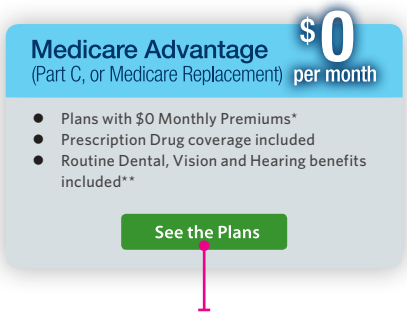
With this backdrop of cost burden, it is clear that UM plays a critical role in provision of appropriate care. UM adds value by reducing the incidence of unnecessary care, and by placing the patient at the most appropriate level of care with the least possible delay. Effective UM supports efficient scheduling of inpatient admissions and procedures by reducing the number of unnecessary admissions, and providing an evidence-based mechanism for admission decisions. Modern UM balances Cost vs. Care through a systematic process and evidence-based criteria.

2016 Florida Blue Co-Payment in Miami-Dade County

MIAMI-DADE COUNTY

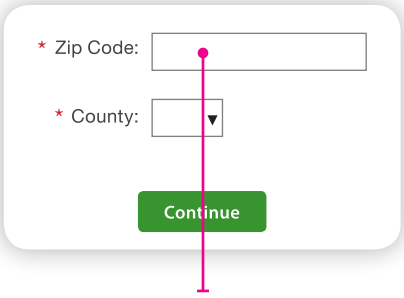
As of January 1, 2016 Florida Blue Miami-Dade county Medicare members now have a $12 specialist co-payment. This co-payment has been set for the benefit year January 1, 2016-December 31, 2016. Please continue verifying member eligibility and benefits through Availity to ensure the correct co-payment is being collected at the time of visit. Below you will find the steps to view the Medicare Advantage plans.

Step 1



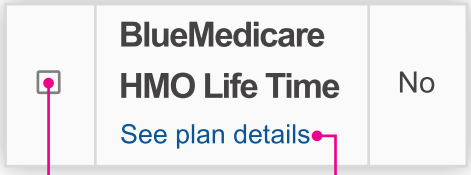
Select "See the Plans"

Step 2



Enter the zip code and press continue

Step 3



Check the BlueMedicare HMO box.

Click on "See plan details" Towards the bottom of the page you will see all the plan documents and summary of benefits for all counties.

eye notes

FROM THE MEDICAL DIRECTOR

Dear Doctor,

Thank you in advance for your continued participation in the Eye Management network. I want to update you on two aspects of our eye care.

I review numerous requests for upper lid blepharoplasty and ptosis repair. My review process involves three aspects all of which need to be submitted prior to determination. First, there needs to be an actual patient complaint such as my eyelids are heavy or droopy, I cannot see well above, or I cannot keep my eyes open. Writing simply "here for ptosis evaluation" is not a patient complaint. Secondly, taped and untaped visual fields showing an upper field defect extending to within 20 degrees of fixation and improving by 20 degrees with taping is needed. Finally, face front patient looking straight ahead photos showing the lids at or below the top of an undilated pupil are required. Submit the above requirements meeting the guidelines and your lid surgery will be approved.

As you know, as Florida Blue Eye Physicians we play a vital role in ensuring that every eligible member receives their annual diabetic retinal exam. This continues to present a challenge for the health plan as many of the members do not get this exam. We realize that the primary care physicians are in the best position to refer their patients annually and we are encouraging them to do that. We can assist by prompting our computer systems to search out our patients with the diagnosis of diabetes or BDR and encourage them to return for a yearly dilated retina exam. Remember to fully document this exam including found retinopathy or "no evidence of diabetic retinopathy". Please address any questions to Marjorie Auguste, Provider Relations Representative, at 305-614-0100, ext 4536 or contact me on my cell at 954-559-8687 with any questions, concerns, or problems.

Alan Silbert, M.D.
Medical Director, EMI

“As you know, as Florida Blue Eye Physicians we play a vital role in ensuring that every eligible member receives their annual diabetic retinal exam. This continues to present a challenge for the health plan as many of the members do not get this exam.”

Fraud, Waste, and Abuse (FWA)

To detect and prevent Fraud, Waste, and Abuse (FWA), it is important to know the laws. Two laws that are important for Providers to understand are the Anti-Kickback Statute and the Stark Statute (Physician Self-Referral Law).

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including Medicare Program). For more information, refer to 42 U.S.C. Section 1320A-7b(b) on the internet.
The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest; or
- A compensation arrangement (exceptions apply.

For more information, refer to 42 U.S.C. Section 1395nn on the internet. Below is a further breakdown of these two laws/ regulations, as provided by the Office Inspector General (OIG).

	THE ANTI-KICKBACK STATUTE (42 USC § 1320a-7b(b))	**THE STARK LAW (42 USC § 1395nn)**
Prohibition	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business	• Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies • Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral
Referrals	Referrals from anyone	Referrals from a physician
Items/ Services	Any items or services	Designated health services
Intent	Intent must be proven (knowing and willful)	• No intent standard for overpayment (strict liability) • Intent required for civil monetary penalties for knowing violations
Penalties	Criminal: • Fines up to $25,000 per violation • Up to a 5 year prison term per violation Civil/Administrative: • False Claims Act liability • Civil monetary penalties and program exclusion • Potential $50,000 CMP per violation • Civil assessment of up to three times amount of kickback	Civil: • Overpayment/refund obligation • False Claims Act liability • Civil monetary penalties and program exclusion for knowing violations • Potential $15,000 CMP for each service • Civil assessment of up to three times the amount claimed
Exceptions	Voluntary safe harbors	Mandatory exceptions
Federal Health Care Programs	All	Medicare/Medicaid

*This chart is for illustrative purposes only and is not a substitute for consulting the statutes and their regulations.

We're Just A Phone Call Or Click Away

If you have any changes to your practice, including demographic or provider additions/ terminations, please notify your EMI Provider Relations Representative.

Marjorie Auguste
Provider Relations Representative

305-614-0100 x4536
800-595-9631 x4536
Fax: 305-614-0171
augustem@healthnetworkone.com

Authorizations

800-595-9631 Option 1
Fax: 305-614-0165
Fax: 866-646-1772

Claims

305-614-0133 Option 3
954-335-8130 Option 3

To report suspected Fraud, Waste, and Abuse, or any Compliance issue:

1-866-321-5550

Appointment Availability

Appointment availability is monitored to ensure Services are received from the authorized provider in a timely manner, which facilitates the desired outcome of the treatment.

HS1 & Affiliated Covered Entities will annually review network provider's average appointment wait times to ensure services comply with the established standards.

Appointment access is monitored by:

- Quality Improvement Referrals received related to access to care.
- Complaints received from health plan partners related to access to care.

Action: A corrective action plan is developed and implemented for any measures that fall below the goal established by health plan partners, regulatory or accrediting bodies.