SCOPE | Provider Updates

Independent Health

July 2022

What's New?

COVID-19 provider updates: billing guidance, testing/vaccine coverage, reimbursement summary and more

Clinical Matters

Colorectal Cancer Screening: Evidence based interventions

Office Matters

Upcoming Independent Health medical record chart requests

Submit 2022 Gaps in Care Corrections through the provider portal

What is a restricted recipient?

New provider portal password requirements upcoming

Pharmacy Update

June 2022 policy updates

Community Health Matters

Providing fun, healthy ways to run, walk, bike, eat and more across WNY!

COVID-19 provider updates

Independent Health has a comprehensive preparedness plan in place to deliver coverage and services to our members without interruption.

Our COVID-19 provider website pages include the most current information about the following:

- Billing guidance
- Testing coverage
- Vaccination, Coverage and Reimbursement Summary
- FAQs and tip sheets on topics of telethealth, lab testing, diagnosis codes, etc.

Visit our COVID-19 provider website pages accessible online at https://www.independenthealth.com/providers/covid-19-coronavirus-provider-updates

Colorectal Cancer Screening: Evidence based interventions

Among both men and women colorectal cancer (CRC) is the second leading cause of cancer in the United St ates (US). The Center for Disease Control and Prevention (CDC) administers the Colorectal Cancer Control Program (CRCCP) to increase CRC screening in those areas with low rates. CRC screening rates among the Federally Qualified Health Centers (FQHC) averaged 44.1% in 2018. In a recent study of efforts to increase (CRC) screening rates among 336 clinics across the US the goal was to better understand the effectiveness of CRCCP program components. Many of the clinics in this 2-year study were FQHC1.

The results showed that implementation of the following interventions drove increased patient CRC screening rates:

- Patient reminders – text based (letter, postcard, phone call advising patients are due or overdue)

…continued

Colorectal Cancer Screening: Evidence based interventions continued …

- Implementing provider assessment and feedback-evaluating providers for offering and delivering screening to patients and sharing the results with the providers
- Having CRC screening champions-this person takes a leadership role in education about CRC screening. They would also monitor the frequency of CRC screening rate and frequency of implementation support to the clinic

The researchers noted that having a CRC screening champion was the most effective strategy. The champion promoted and prioritized screening efforts guided by a vision and commitment to the community/practice.

Independent Health Colorectal Screening Strategies:

- For all lines of business, members who have an open gap for colorectal screening will receive a letter in June then again September from Independent Health reminding the member of the importance of having this screening.
- Members with an active email address on file will also receive an eblast of the importance of having colorectal cancer screening.
- Members with health insurance from State (Essential Care, Medisource, HARP) will receive notification of a financial incentive of $25.00 for completing colorectal cancer screening.
- Commercial and Medisource members that appear have a 2-year gap in care for colorectal screening (no historical claim or record of CRC) will receive an outbound call from our Red Shirt servicing team to encourage members to check with their physician to clarify if they are due for CRC screening.
- Common CRC screenings recommended by USPSTF for adults 45 to 75 years at average risk include:
  - Colonoscopy: Every 10 years
  - Multitarget stool DNA-FIT test (e. g. Cologuard): Every 1-3 years
  - High-sensitivity gFOBT or FIT: Every 1 year

Reference:
https://doi.org./10.1016/j.amepre.2021.03.002

Upcoming Independent Health medical record chart requests

Each year, Independent Health is required to conduct medical record chart reviews on an ongoing basis to meet federal requirements and encounter attestation standards. In response to your feedback and to minimize disruption to your practice/facility, we are:

- Providing this notice prior to sending the medical record chart requests
- Combining the Commercial ACA and Medicare chart requests as close together as possible to be most efficient
- Providing multiple secure chart retrieval options (remote access is preferred)
- Providing increased support to you and our vendor partners during the retrieval process

In the next few weeks, medical record chart requests will be sent for the Commercial ACA and Medicare lines of business **for benefit year 2021**. Please note we utilize separate authorized partners due to the Independent Validation Audit (IVA) CMS requirements. The following partners will be sending requests:

- For Medicare members: **Advantmed**
- For Commercial Qualified Health plan members: **DxSelect**

The Independent Health Participating Provider agreement states "Participating Provider agrees that books and records pertinent to Independent Health Members including medical records and charts, encounter data, billings records, and financial data and reports, may be examined and copied at no charge by Independent Health when lawfully requested."

Advantmed and DxSelect serve as a Business Associate of Covered Entities as defined by the Health Insurance Portability and Accountability Act (HIPAA) and are in compliance with our internal Risk Office rigorous review and assessments. This enables them to perform activities involving the use or disclosure of Protected Health Information (PHI) on behalf of Independent Health and will treat your patients' PHI with the highest level of protection and confidentiality.

If you have any questions, please contact Independent Health's Provider Relations department by phone at (716) 631-3282 or 1-800-736-5771, Monday through Friday from 8 a.m. to 6 p.m. or email providerservice@servicing.independenthealth.com

Submit 2022 Gaps in Care Corrections through the Provider Portal

Gaps in Care Corrections for 2022 can now be submitted through the provider portal.

Gaps in Care Correction allows for submitting medical record documentation to "correct" inaccuracies in quality measure results due to a variety of reasons, including:

- Encounters or lab values not available to the health plan
- Exclusions from a historical event (e.g., mastectomy)
- Service that was rendered under a different payer

If the correction is accepted, it will be reflected in an update to your, and Independent Health's, quality rates, which allows for:

- A more accurate depiction of the quality of care that was rendered
- More accurate quality program reporting
- More targeted quality improvement effort

Additional information about the Gaps in Care Correction process, including the Gaps in Care Correction Process User Guide, Correctible Measures for 2022 and a webinar about the Gaps in Care Correction Process, is available on the Quality page accessible when selecting the Resources tab in the top red menu bar when logged in to our secure provider portal.

If you have questions about the gaps in care correction process, performance reports or anything related to our provider portal:

- Contact your Independent Health Physician Engagement Specialist
- Email ProviderPortal@independenthealth.com

New provider portal password requirements upcoming

To further enhance the security of your practice access to Independent Health's provider portal, new requirements for resetting the password will become effective the first time the existing password expires after July 7, 2022.

…continued

New provider portal password requirements upcoming continued …

The new password requirements are as follows:

- Not be easily guessed or obtained using personal related information (e.g., names, telephone numbers, dates of birth)
- Be free of multiple consecutive identical characters (e.g., "aaa")
- Consists of at least twelve (12) characters
- Contains the following:
  - English uppercase characters (A through Z)
  - English lowercase characters (a through z)
  - Base 10 digits (0 through 9)
  - Non-alphabetic characters (for example, !, $, #, %)

You may update your password to align with the new requirements at any time before July 7, 2022. To do so, simply log into the provider portal, select Change Password in the My Profile page below your name.

What is a restricted recipient?

A Restricted Recipient is a Medicaid member who has engaged in abusive practices or demonstrated a pattern of misuse of a category of Medicaid benefits and has been restricted by either the Medicaid Managed Care Plan or the Office of the Medicaid Inspector General (OMIG) to receive certain services only from an assigned provider.

When a restriction is in place, the restricted recipient may only access the restricted service through the RRP Provider(s), except where the member is referred to an alternate provider authorized by the RRP (PCP) Provider.

The amount, duration and scope of the Medicaid benefit is not reduced. If restricted, a member will be identified as "restricted" on their Independent Health member ID card and in ePaces.

More information about the Restricted Recipient Program and responsibilities of other providers, pharmacies and hospitals is available near the end of this printable edition of Scope.

Formulary and Policy Changes

The following are available near the end of this printable edition of Scope:

1) Formulary changes for Medicare Advantage individual and group members effective July 1, 2022.

2) Formulary changes for Pharmacy Benefit Dimensions members using their 5-Tier formulary effective July 1, 2022.

3) Formulary changes for Pharmacy Benefit Dimensions members using their 3-Tier formulary effective July 1, 2022.

Independent Health's drug formulary

To obtain a hard copy, please contact Independent Health Provider Relations by calling (716) 631-3282 or 1-800-736-5771, or via email at at providerservice@servicing.independenthealth.com, Monday through Friday from 8 a.m. to 6 p.m.

June 2022 policy updates

Our policies are updated, revised, discontinued or reviewed often, so check these pages frequently. Look on the Policies page under Policies & Guidelines on the top red menu bar of the provider portal.

REMINDER TO PCP's with a Group Contract: Please submit monthly rosters

Participating primary care physicians in group contracts are required to submit monthly rosters to Independent Health, as indicated in their contact:

"Upon execution of this Agreement, Group shall provide a list of all Group Physicians and Group Providers, which shall be are attached hereto as Schedule A. The Group shall update Schedule A monthly by emailing a current roster of Group Physicians and Group Providers to IHC on or before the third Friday of each month to NetworkOperations@Independenthealth.com. If Group adds or terminates a Group Physician or Group Provider, the Group shall notify IHC within 2 business days."

…continued

REMINDER TO PCP's with a Group Contract: Please submit monthly rosters continued…

The template for the rosters is accessible when logged-in to our provider portal under Popular Documents and is named, "Group Physician and Group Providers Roster" in the Office Forms, Administration category.

If you have any questions, please contact Independent Health's Provider Relations department by phone at (716) 631-3282 or 1-800-736-5771, Monday through Friday from 8 a.m. to 6 p.m. or email providerservice@servicing.independenthealth.com

---

Thank you for reading Scope, Independent Health's newsletter containing provider updates. Please consider printing copies to share this with others at your practice who may not have access to Scope through our provider portal.

Comments or questions about Scope can be submitted via email at scope@independenthealth.com

Restricted Recipient Program

Recipient Restriction Program (RRP) means the Contractor's program whereby selected Enrollees with a demonstrated pattern of abusing or misusing Benefit Package services may be restricted to one or more RRP Providers for receipt of medically necessary services included in the Benefit Package.

If one of your patients is assigned to you as a restricted recipient provider, your responsibilities as the primary care physician include:

- Identifying the specific health care needs of your patient. As with any MediSource member, you will be providing a majority of the medical services rendered.

- Developing an appropriate treatment plan, including consultation and referral to other medical providers as necessary. A Restricted Recipient must receive a referral from you to obtain services from specialty or ancillary providers, clinics, or hospitals. For a detailed list of specialties, visit www.eMedNY.org. Your provider number must accompany any referral to another provider to receive an authorization for service and for payment of claims.

- Arranging any medically necessary non-emergency transportation. A Restricted Recipient requiring non-emergency transportation is not permitted to arrange their needed transportation. Any non emergency transportation must be arranged by you by contacting Medical Answering Services (MAS).

  For more information on arranging this non-emergency transportation, go to www.medanswering.com. This policy was put in place to prevent Medicaid (MA) paying for transportation services for enrollees seeking medical/prescription drug services outside of their RRP primary care assignments and to support compliance within the program.

Responsibilities of other providers/pharmacies/hospitals

- When a restriction is in place, the restricted recipient may only access the restricted service through the RRP Provider(s), except where the member is referred to an alternate provider authorized by the IHA or the RRP (PCP) Provider.

- Such other RRP providers may include Dental, DME, a single retail pharmacy location and if needed, one specialty pharmacy location, inpatient facility.

- An inpatient hospital is responsible for all covered non-emergency inpatient services or arranging referrals for specialty care to the restricted recipient.

- If an inpatient admission is required following an emergency department visit, the member should be admitted to/transferred to the restricted member's inpatient hospital.

- A pharmacy is responsible for providing all covered and authorized drugs and pharmaceutical supplies.

- A dentist or dental clinic/group responsible for providing or arranging referrals for all dental care

Medicare Advantage Individual and Group Formulary Changes				
Brand Drug Name	**Type of Change**	**Generic Alternative**	**Reason**	**Effective**
Chantix starter pack	Formulary Deletion	varenicline tartrate pack	Generic Alternative on T2	7/1/2022
Ferriprox 1000 mg tab	Formulary Deletion	deferiprone 1000mg tab	Generic Alternative on T5	7/1/2022
Restasis individual vials NDC 00023-9163-**	Formulary Deletion	cyclosporine 0.05%	Generic Alternative on T3	7/1/2022

*Restasis in the MultiDose bottle (NDC 00023-5301-**) is remaining on-formulary at T3. There is no generic for the MultiDose bottle.*

How do I request coverage determination, including an exception?
To request a coverage determination, including an exception, you may contact us in any of the following ways:

- Mail your coverage determination request to: Independent Health's Pharmacy Department, 511 Farber Lakes Drive, Buffalo, NY 14221
- Fax: (716) 631-9636 or 1-800-273-7397
- Phone: (716) 250-4401 or 1-800-665-1502, we are available Monday through Friday between the hours of 8 a.m. and 5 p.m.

Requests for coverage of a non-formulary drug, or an exception to a coverage rule, require a supporting statement. For non-formulary drug requests, your statement must show that the requested drug is medically necessary for treatment, because all other drugs on our formulary would be less effective or would have adverse effects for the patient. For prior authorization or other coverage rule requests, your statement must show that the coverage rule wouldn't be appropriate given your patient's condition or would have adverse effects for your patient.

For expedited requests, we must notify you of our decision no later than 24 hours from when we receive your request. For standard requests, we must notify you of our decision no later than 72 hours from when we receive your request.

For exceptions, the time-frame begins when we obtain your statement. We will expedite your request if we determine, or you tell us, that your patient's life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

Pharmacy Benefit Dimensions
An Independent Health company

Pharmacy Benefit Dimensions PDP 5 Tier Formulary Changes				
Brand Drug Name	**Type of Change**	**Generic Alternative**	**Reason**	**Effective**
Chantix starter pack	Formulary Deletion	varenicline tartrate pack	Generic Alternative on T2	7/1/2022
Ferriprox 1000 mg tab	Formulary Deletion	deferiprone 1000mg tab	Generic Alternative on T5	7/1/2022
Restasis individual vials NDC 00023-9163-**	Formulary Deletion	cyclosporine 0.05%	Generic Alternative on T3	7/1/2022

*Restasis in the MultiDose bottle (NDC 00023-5301-**) is remaining on-formulary at T3. There is no generic for the MultiDose bottle.*

How do I request coverage determination, including an exception?

To request a coverage determination, including an exception, you may contact us in any of the following ways:

- Mail your coverage determination request to: Independent Health's Pharmacy Department, 511 Farber Lakes Drive, Buffalo, NY 14221
- Fax: (716) 631-9636 or 1-800-273-7397
- Phone: (716) 250-4401 or 1-800-665-1502, we are available Monday through Friday between the hours of 8 a.m. and 5 p.m.

Requests for coverage of a non-formulary drug, or an exception to a coverage rule, require a supporting statement. For non-formulary drug requests, your statement must show that the requested drug is medically necessary for treatment, because all other drugs on our formulary would be less effective or would have adverse effects for the patient. For prior authorization or other coverage rule requests, your statement must show that the coverage rule wouldn't be appropriate given your patient's condition or would have adverse effects for your patient.

For expedited requests, we must notify you of our decision no later than 24 hours from when we receive your request. For standard requests, we must notify you of our decision no later than 72 hours from when we receive your request.

For exceptions, the time-frame begins when we obtain your statement. We will expedite your request if we determine, or you tell us, that your patient's life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

Pharmacy Benefit Dimensions
An Independent Health company

Pharmacy Benefit Dimensions PDP 3 Tier Formulary Changes				
Brand Drug Name	**Type of Change**	**Generic Alternative**	**Reason**	**Effective**
Chantix starter pack	Formulary Deletion	varenicline tartrate pack	Generic Alternative on T1	7/1/2022
Ferriprox 1000 mg tab	Formulary Deletion	deferiprone 1000mg tab	Generic Alternative on T1	7/1/2022

How do I request coverage determination, including an exception?
To request a coverage determination, including an exception, you may contact us in any of the following ways:

- Mail your coverage determination request to: Independent Health's Pharmacy Department, 511 Farber Lakes Drive, Buffalo, NY 14221
- Fax: (716) 631-9636 or 1-800-273-7397
- Phone: (716) 250-4401 or 1-800-665-1502, we are available Monday through Friday between the hours of 8 a.m. and 5 p.m.

Requests for coverage of a non-formulary drug, or an exception to a coverage rule, require a supporting statement. For non-formulary drug requests, your statement must show that the requested drug is medically necessary for treatment, because all other drugs on our formulary would be less effective or would have adverse effects for the patient. For prior authorization or other coverage rule requests, your statement must show that the coverage rule wouldn't be appropriate given your patient's condition or would have adverse effects for your patient.

For expedited requests, we must notify you of our decision no later than 24 hours from when we receive your request. For standard requests, we must notify you of our decision no later than 72 hours from when we receive your request.

For exceptions, the time-frame begins when we obtain your statement. We will expedite your request if we determine, or you tell us, that your patient's life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.