WINTER 2018

the Inside Story

Scott&White
HEALTH PLAN

the Inside Story

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New Medicare Part D Opioid Overutilization Policies for 2019

CMS finalized new policies for Medicare drug plans to follow starting on January 1, 2019. The new policies include improved safety alerts when opioid prescriptions are dispensed at the pharmacy, and drug management programs to better coordinate care when chronic high-risk opioid use is present.

Specific to prescription opioids, beginning in January 2019, Medicare Part D plans will employ the following new safety alerts at the pharmacy:

- 7-day supply limit for opioid naïve patients: Part D plans are expected to implement a hard safety edit to limit initial dispensing to a supply of seven days or less. A hard safety edit stops the pharmacy from processing a prescription until an override is entered or authorized by SWHP. This policy will affect Medicare patients who have not filled an opioid prescription recently (within the past 120 days) when they present a prescription at the pharmacy for an opioid pain medication for greater than a 7-day supply.

  A pharmacist can dispense partial quantities of an opioid prescription consistent with state and federal regulations. However, if a prescriber believes that an opioid naïve patient will need more than a 7-day supply initially, the provider can proactively request a coverage determination on behalf of the patient attesting to the medical need for a supply greater than seven days. Additionally, if a provider assesses upon re-evaluation that a patient will need additional opioid therapy, subsequent prescriptions will not be subject to the 7-day supply limit, as the patient will no longer be considered opioid naive.

- Opioid care coordination alert: This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative morphine milligram equivalent (MME) per day across all of their opioid prescription(s) reaches or exceeds 90 MME. Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater. It is the prescriber who writes the prescription that triggers the alert who will be contacted by the pharmacy even if that prescription itself is below the 90 MME threshold.

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Opioid Overutilization cont'd

This is not a prescribing limit. In reviewing the alert, the pharmacist may need to consult with the prescriber to confirm medical need for the higher MME. The pharmacist can then indicate that the prescriber was consulted so the prescription claim can pay. Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the pharmacist does not have to consult with the prescriber on every opioid prescription written for the same patient after that unless the plan implements further restrictions.

Listed below are additional opioid edits that will be implemented for SWHP Medicare Part D plans:

• **30-day opioid dispensing limit:** Opioid drug claims will be limited to a 30-day supply unless the claim is for an opioid naïve patient as described above.

• **Hard safety edit when exceeding 200 MME:** A hard safety edit will trigger when a Medicare patient presents an opioid prescription at the pharmacy and their cumulative morphine milligram equivalent (MME) per day across all of their opioid prescription(s) reaches or exceeds 200 MME. A hard safety edit stops the pharmacy from processing a prescription until authorized by the SWHP.

• **Drug-Drug Interaction Screenings:** Listed below are drug-drug interaction edits that will trigger a soft safety edit. Soft safety edits can be overridden by the dispensing pharmacist if determined to be clinically appropriate after consulting with the prescriber.

- Buprenorphine + Opioid: Claim for an opioid AFTER a buprenorphine claim has paid
- Opioid + Benzodiazepine
- Opioid + Prenatal Vitamins

• **Exclusions:** Residents of long-term care facilities, those in hospice care, and patients being treated for active cancer-related pain are exempt from opioid edits.

Drug Management Programs

CMS adopted a regulation so that Part D plans may implement a drug management program that limits access to certain controlled substances that have been determined to be "frequently abused drugs" for patients who are considered to be at-risk for prescription drug abuse.

Potential at-risk patients are identified by their opioid use which involve multiple doctors and pharmacies. One of the key components of a drug management program is prescriber involvement in case management. If a provider prescribes opioids or benzodiazepines for a patient who is identified as a potential at-risk patient, the provider will be contacted to review the patient's total utilization pattern of frequently abused drugs.

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Opioid Overutilization cont'd

Listed below are potential limitations that can be implemented at a member level based on the outcome of the case management process:

1. **Patient-specific point of sale (POS) claim edit:** This is an individualized POS edit for the specific patient. It limits the amount of frequently abused drugs that may be dispensed to the patient. This limitation could be a restriction on all frequently abused drugs or limitations to specific drugs and/or specific amounts, which will be determined on a case by case basis as a result of the case management review.

2. **Pharmacy limitation (also known as "pharmacy lock-in"):** This limitation will require the patient to obtain prescriptions for frequently abused drugs at a certain pharmacy(ies). Patients can choose which pharmacy(ies) they prefer to use and may update those preferences as needed.

3. **Prescriber limitation (also known as "prescriber lock-in"):** A limitation that will require the patient to obtain their prescriptions for frequently abused drugs from a certain prescriber(s). SWHP will obtain the prescriber's agreement to be a prescriber and confirm the prescriber's selection for this limitation. Patients can choose which prescriber(s) they prefer to use and may update those preferences as needed.

After case management is conducted with prescribers, and before implementing a limitation, the patient will be notified in writing that coverage of opioid and/or benzodiazepine medication(s) will be limited, or if the patient must obtain these prescriptions from certain prescriber(s) or pharmacy(ies). The prescriber will also receive a copy of this notification. The prescriber and patient will have the opportunity to provide a response to this written notice and the requested information within 30 days.

After this 30-day time period, a second written notice confirming the specific limitation and its duration will be sent. The initial limitation period could be for a maximum of 12 months and extend to an additional 12 months. Alternatively, if SWHP determines that the patient is not at-risk, it must send a written notice confirming that a coverage limitation will not be implemented after all.

As new opioid safety alerts are implemented in 2019, on-going communication between pharmacists, SWHP, and prescribers will be critical. Physicians and other prescribers can protect their patients' access to medically necessary drugs by responding to pharmacists' or case management notices. Providers will also want to initiate coverage determinations or exceptions, when clinically appropriate. To resolve opioid safety alerts expeditiously and avoid withdrawal or disruption of therapy, CMS encourages prescribers to respond to pharmacists' outreach in a timely manner and give appropriate training to on-call prescribers when necessary.

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Prior Authorization – **Drug Requests and Process Changes**

Beginning January 1, 2019

Effective January 1, 2019, prior authorization (PA) requests for drugs obtained under the PHARMACY drug benefit will no longer be processed by Scott and White Health Plan (SWHP). PA requests for drugs obtained under the pharmacy benefit must be submitted to OptumRx.

Initial / Renewal prior authorization requests

- Submit PA requests for drugs obtained under the PHARMACY benefit to OptumRx.
- Submit PA requests for drugs obtained under the MEDICAL benefit to SWHP Health Services.
  - Direct MEDICAL benefit drug requests to the NEW fax number noted below

    or
  - Submit MEDICAL benefit drug requests through the online provider portal

Appeals

- Submit appeals (redetermination requests) for Part D drugs to OptumRx.
- Submit Commercial and Medicare Part B drug appeals to SWHP Appeals and Grievances (A&G) Department.

Additional Details

PHARMACY BENEFIT DRUGS

Effective January 1, 2019, for any prescription drugs that will not be billed under the medical benefit, submit prior authorization requests to OptumRx via the following methods:

- Online through one of the following portals:
  - CoverMyMeds: **http://go.covermymeds.com/OptumRx**
  - SureScripts: **https://providerportal.surescripts.net/providerportal/**
  - PreCheck MyScript: **https://provider.linkhealth.com/#/**
- Fax: (800) 527-0531
- Phone:
  - Commercial plan: 855-205-9182 (OptumRx)
  - Medicare Part D plan: 844-230-9357 (OptumRx)

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Prior Authorization cont'd

MEDICAL BENEFIT DRUGS

Effective January 1, 2019, SWHP Health Services will be administering the authorization review process for medical drugs (i.e. injectables billed on a medical claim). You may submit requests via the following methods:

- Online at **https://portal.swhp.org/ProviderPortal/#/login**
  - For online submissions, please log into the secure Provider Portal to complete and submit the Prior Authorization form found on the SWHP website.
- Fax: (800) 626-3042

It is critical that you:

1. Direct prior authorization requests for drugs to the appropriate entity (SWHP or OptumRx) dependent upon how the drug will be billed.

Initial / renewal PA requests

- Drug to be billed on a MEDICAL CLAIM → Send PA to SWHP
- Drug to be billed under member's PHARMACY BENEFIT → Send PA to OptumRx

Appeal requests

- Part D drug appeal → Send request to OptumRx
- Commercial or Medicare Part B drug appeal → Send to SWHP A&G Dept.

2. Update your standard office procedures in accordance with these changes.

- Your office staff can reference Table 1 and Table 2 as job aids to ensure appropriate routing of PA and appeal requests.

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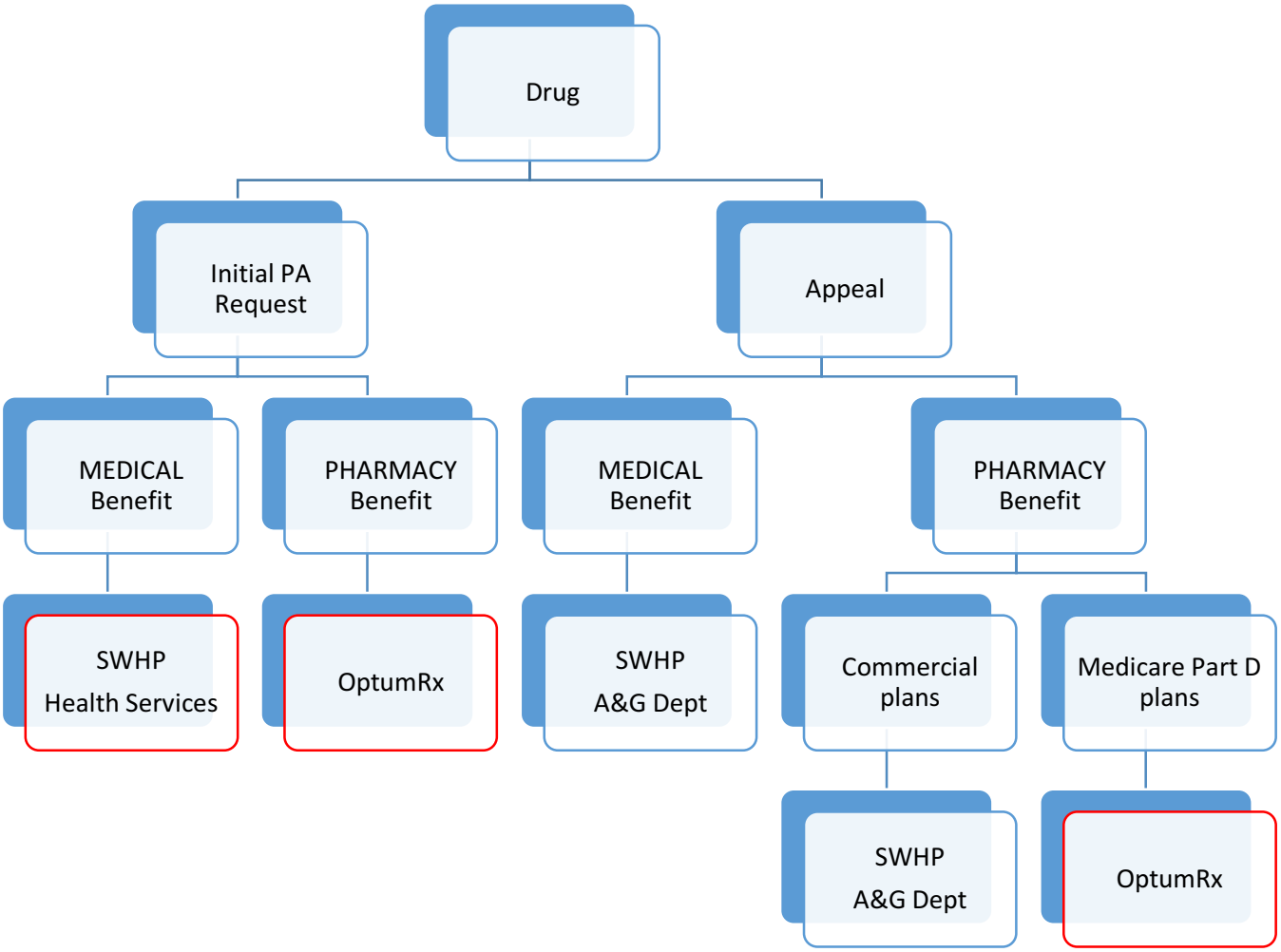
Prior Authorization cont'd

Table 1 – Drug PA & Appeal Requests – Review Entities



A&G – Appeals & Grievances

Red lines highlight review entity changes effective in 2019.

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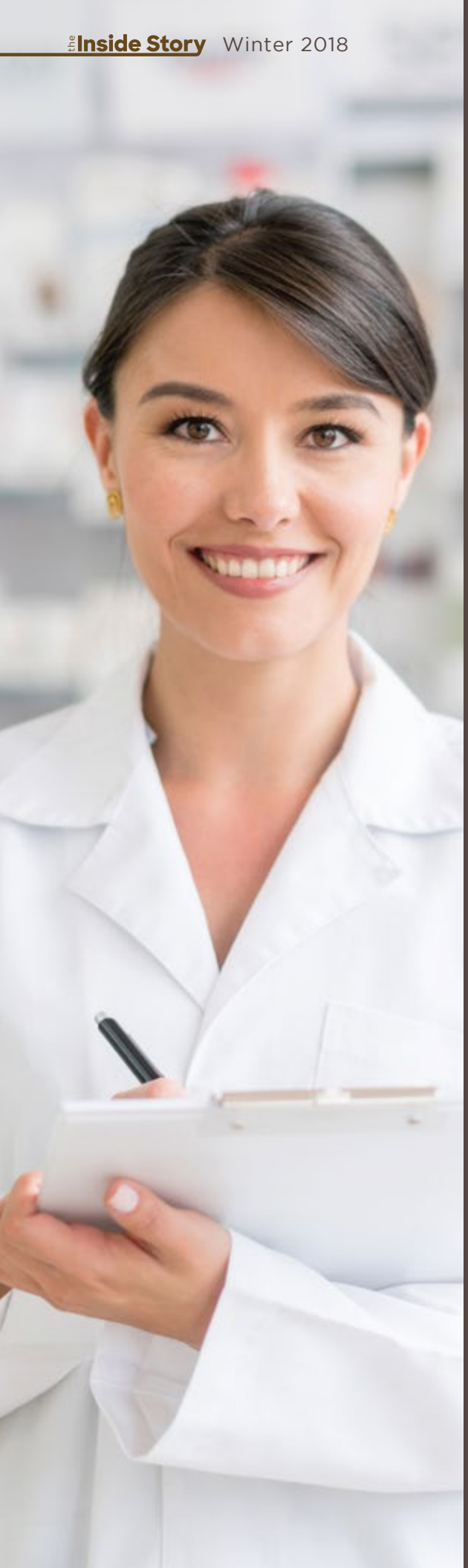
Prior Authorization cont'd

Table 2 - Drug PA & Appeal Requests – Submission Details

Pharmacy Benefit Drug	Medical Benefit Drug (i.e. drug to be billed on a medical claim – "buy and bill")
Initial / Renewal PA request	
ONLINE (Optum RX) **CoverMyMeds** http://go.covermymeds.com/OptumRx **SureScripts:** https://providerportal.surescripts.net/providerportal/ **PreCheck MyScript:** https://provider.linkhealth.com/#/	**ONLINE (SWHP)** https://portal.swhp.org/ProviderPortal/#/login/
FAX 800-527-0531 **(OptumRx)**	**FAX** 800-626-3042 **(SWHP)**
PHONE **Commercial plan:** 855-205-9182 **(OptumRx)** **Medicare Part D plan:** 844-230-9357 **(OptumRx)**	**PHONE** 1-800-321-7947 **(SWHP)**
MAIL OptumRx Attn: Prior Auth Exceptions P.O. Box 25183 Santa Ana, CA 92799	
Appeals (Redeterminations)	
FAX **Commercial plan:** 254-298-3663 **(SWHP)** **Medicare Part D plan:** 877-239-4565 **(OptumRx)**	**FAX** 254-298-3663 **(SWHP)**
PHONE **Commercial plan:** 1-800-321-7947 **(SWHP)** **Medicare Part D plan:** 888-403-3398 **(OptumRx)***	**PHONE** 1-800-321-7947 **(SWHP)**
MAIL **Commercial plan:** SWHP c/o Appeals and Grievances 1206 West Campus Drive Temple, TX 76502 **Medicare Part D plan:** OptumRx Prior Authorization Department c/o Appeals Coordinator P.O. Box 25184 Santa Ana, CA 92799	**MAIL** SWHP c/o Appeals and Grievances 1206 West Campus Drive Temple, TX 76502

*Standard Medicare Part D redetermination (appeal) requests must be submitted in writing and cannot be initiated via phone. If you believe waiting 7 days for a standard Medicare Part D redetermination decision could seriously harm the member's life, health, or ability to regain maximum function, you can ask for an expedited decision; expedited Medicare Part D redetermination requests can be initiated via phone.



SWHP Pharmacy
Formularies and Locations

SWHP is committed to maintaining a lowest net-cost formulary strategy for all of our plans by promoting the use of safe, effective medications while decreasing the use of higher-priced, low-value drugs.

On January 1, 2019, the following SWHP formularies will be in effect:

Medicare Part D

- 2019 Medicare Formulary

ACA Compliant Plans
(individual/family plans and small group)

- 2019 Essential Health Benefits Formulary

Large Group Formularies

- 2019 Group Value Formulary
- 2019 Group Choice Formulary

To view the formularies, please visit:
https://swhp.org/en-us/prov/resources/pharmacy-services

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Opioid Safety Programs for 2019

This is to inform you of Scott and White Health Plan's opioid coverage effective January 1, 2019, including point of sale edits and prior authorization requirements for your commercial SWHP patients.

In the United States, there has been a dramatic increase in overdose deaths and hospitalizations due to prescription opioid pain medications. In March of 2016, the CDC released Guidelines for Prescribing Opioids for Chronic Pain. To help manage the appropriate prescribing and utilization of opioids while improving pain management and patient safety, please take some time to review how your patient's coverage may be impacted.

Prescriber Edits

- Checks for providers without DEA scope of practice authority

Prescription Edits (as of 1/1/2019)

- Opioid prescriptions are limited to a 30-day supply

Short-Acting Opioid Policies

Patient Edits (as of 1/1/2019)

Dispensing Pharmacists have the ability to override these limits after appropriate consultation and review with prescribers as needed.

- Drug-drug interaction screening
  - Patients taking benzodiazepines and opioids (goal: decrease the risk of overdose death)
  - Patients taking prenatal vitamins and opioids (goal: prevent the rapidly rising incidence of Neonatal Abstinence Syndrome)
  - Patients taking Medication Assisted Treatment and opioids
- Cumulative acetaminophen dose check with opioid-containing drugs (goal: not to exceed 4 gm acetaminophen/day)
- Cumulative Morphine Milligram Equivalent (MME) dose check across all opioid prescriptions
  - Total daily doses exceeding 90 MME must be reviewed for clinical appropriateness

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- New to Therapy: Patients who are new to opiate therapy, as evidenced by having no opioid prescription in their fill history for the past 120 days, will be subject to a limit of two 7-day supplies of short-acting opiates within a 60-day period, along with a cumulative dose limit of 49 morphine milligram equivalents (MME) per day.
- Treatment Experienced: Patients who are opioid treatment experienced, as evidenced by having an opioid prescription in their fill history for the past 120 days, will be subject to a cumulative dose limit of 90 MME per day, with a maximum of two short-acting opiate fills within a 60-day timeframe. Patients will not be subject to the 7-day supply limit.

Oncology patients: Patients with an antineoplastic agent fill within the last 365 days or with an oncology medical diagnosis will be exempt from the edits and will not require an override or prior authorization (PA).

Palliative/Hospice patients: Patients with a hospice diagnosis will be excluded from the edit and will not require an override or Prior Authorization (PA).

Long-Acting Opioid Policies

- Long-acting opioid prescriptions require prior authorization.
- Prior use of short-acting opioid is required.
- Maximum daily dose (quantity limits) apply to all long acting opioids.

Oncology patients: Patients with an antineoplastic agent fill within the last 365 days or with an oncology medical diagnosis will be exempt from the edits and will not require an override or prior authorization (PA).

Palliative/Hospice patients: Patients with a hospice diagnosis will be excluded from the edit and will not require an override or Prior Authorization (PA).

Changes to Coverage of Antitussives Containing Opioids

- PA required for patients 18 years of age and younger
- Prescription limits apply to all ages
  - Not more than 240 ml per fill
  - Not more than 7-day supply for solid oral dosage forms
  - Not more than 2 fills in a 60-day time period

Thank you for your shared commitment to helping prevent opioid addiction among your Commercial SWHP patients. If you have questions about the opioid coverage changes, please call 1-800-728-7947.

For more information on CDC guidelines, opioid risks, and educational materials, see the following links:

https://www.cdc.gov/drugoverdose/prescribing/providers.html
https://www.cdc.gov/drugoverdose/prescribing/patients.html
https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

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Pharmacy Specialty Network

The SWHP Specialty Pharmacy Program offers the choice of two specialty care pharmacies to help manage and access specialty drugs: the Baylor Scott & White Specialty Care Team pharmacy or BriovaRx® specialty pharmacy.

For specialty medications obtained through a pharmacy, the Baylor Scott & White Specialty Care Team pharmacy or BriovaRx® specialty pharmacy must be used to fill the prescription.

The Baylor Scott & White Specialty Care Team service can be reached at 1-844-288-3179, or in person, located at 425 University Blvd. in Round Rock, TX.

To access BriovaRx® please call 1-855-4BRIOVA (1-855-427-4682) or visit **BriovaRx.com**.

For additional information, please refer to **https://swhp.org/en-us/prov/resources/pharmacy-services**.

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Provider Directory Accuracy

Accurate, updated practice data enables us to market you in our provider directories and more importantly, provide members with information they need to access care. In addition, SWHP is required by federal and state laws to convey accurate directory information on all providers to our members. In the absence of updated provider information, we may be required to suppress your organization in our directories.

We are working with LexisNexis Risk Solutions and the American Medical Association (AMA) Business Solutions to outreach to each provider to confirm directory related information. These collaborators will send you an email on our behalf requesting your attestation in the Verify Healthcare Portal. This is a secure website, where you will be able to update your pre-populated information easily and quickly.

You may complete this activity yourself or forward the email to a delegate to complete on your behalf. If your data has changed, please be sure to update it in the portal. Attestations are due within two weeks of receipt of the request. Should you have questions on the portal and need help, the letter will provide you with contact information to address.

Please contact your SWHP Provider Relations Representative if you have any questions. To locate your SWHP Provider Relations Representative's contact information, please visit our website at **https://swhp.org/en-us/prov**.

Thank you for your continued partnership with SWHP.

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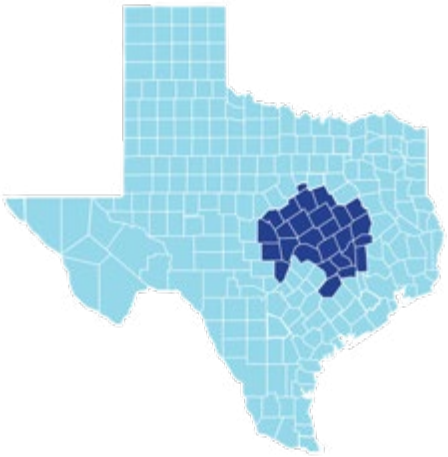
UPDATE: SeniorCare Advantage will replace SeniorCare Cost for most members starting Jan. 1, 2019

- SeniorCare Cost plans are changing. Effective January 1, only members in the following counties are eligible for continued coverage:

  Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington, Williamson

- Most eligible members have been auto-enrolled into a SeniorCare Advantage plan for an effective date of January 1, 2019, and have been notified of that transition. **EXCEPTION: Members with prescription drug coverage through a carrier other than Scott and White Health Plan must actively enroll in SeniorCare Advantage.**



- Members who are not eligible for continued coverage received information in October on how to find other Medicare plans for 2019. There are no Medicare products available with Scott and White Health Plan other than in the counties listed above.

Enrollment Information

- Members can call 1-800-782-5068 to speak to a licensed insurance agent.
- The Annual Enrollment Period ended December 7, but SeniorCare Cost members qualify for a Special Enrollment Period through February 28, 2019.

Scott and White Health Plan is one of only two health plans in the state to make *U.S. News & World Report's* elite list. And the only one in Central Texas.

Scott&White HEALTH PLAN

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SWHP is BUZZING with changes as they welcome a new Credentialing Verification Organization

Introducing Aperture and Availity

The Uniform Managed Care Contract (UMCC) now requires all Medicaid health plans to utilize the Texas Association of Health Plans-contracted Credentialing Verification Organization (CVO), Aperture Credentialing, LLC. Scott and White Health Plan/RightCare has decided to use this CVO for all lines of business.

Contracted RightCare/SWHP provider group; adding a provider to your contract:

- Go to swhp.org and choose the Provider tab. Scroll down to "Provider Resources" and click on "Manage Provider Account." Choose "Add Provider to Existing Contract" to complete and submit the Add a Provider form.
- A RightCare/SWHP representative will contact you via email to request that you fill out and return a Provider Information Form (PIF). The information listed on the PIF is entered into our database, which generates a file that is sent to Aperture Credentialing, LLC.
- Aperture Credentialing, LLC will contact you via mail with instructions on how to fill out a credentialing application through the Availity online portal or submit a paper application via email or fax. RightCare/SWHP does not currently utilize CAQH. If you are currently utilizing CAQH for your application information, you can download your application from the CAQH website. Along with your application, a current copy of your license, malpractice insurance, DEA, CLIA and Radiation certificate, (if applicable) is needed. Please ensure that your attestation pages are signed and currently dated. This application can be faxed or mailed to Aperture.
    - Fax: 1-866-293-0421.
    - Mail: Aperture Credentialing
P.O. Box 221049
Louisville, KY 40252-1049

  Please include the request letter from Aperture with your submission, as it includes bar code identification to aid in processing time.
- Once a full application is received by Aperture and your license has been verified, RightCare/SWHP will add you to the network as an "Expedited Provider." While practicing as an Expedited Provider, you will not be listed as a Primary Care Provider (PCP) or be included in the provider directory. You will be listed after you have successfully completed the full verification process.

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BUZZING continued

- Aperture will return fully verified information to RightCare/SWHP and your file will go to the RightCare/SWHP Credentialing Committee for final approval.

Aperture Questions? Customer Service for Providers: 1-855-743-6161, option # 3.
Availity Questions? 1-800-Availity (1-800-282-4548)

Non-contracted groups that want to be contracted with SWHP/RightCare:

- Go to swhp.org, choose the Provider tab and click the "Join our Network" button.
- You'll find some helpful links to information about joining the RightCare/SWHP network and the credentialing processes.
- Select "Join Now" to complete the New Provider Contract Request form, attach files (if needed), and select "SUBMIT." You will then be contacted by a RightCare/SWHP representative for the next part of the contracting process.

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eviCore Prior Authorization Program

As part of Scott and White Health Plan's (SWHP) ongoing commitment to provide our members with access to high-quality, cost-effective care, eviCore healthcare has been contracted to provide benefits management services for selected covered services requiring prior approval. eviCore is an independent company that provides specialty medical benefits management for SWHP.

SWHP members enrolled in SWHP's Commercial and Medicare Advantage programs will require prior authorization by eviCore for the following covered services (except in an emergency). This applies to services provided after the dates shown for each category below.

- Advanced Imaging (PET/MRI/CT) and Nuclear Medicine
- Cardiology Imaging and Certain Procedures
- Joint, Spine, and Pain Management Procedures

You'll find the eviCore orientation presentation, CPT Codes, FAQ, a Quick Reference Guide, and other resources at: https://www.evicore.com/healthplan/scottandwhite.

How to Request Authorization

We are keeping it simple! The SWHP Provider Portal is the quickest, most efficient way to obtain an authorization. Just click on the eviCore link to initiate a case, view case/ authorization details, verify eligibility, and more. Log on to the Provider Portal here.

For urgent requests: If service is required in less than 48 hours due to a medically urgent condition, please call eviCore at 1-888-209-5762 to request an expedited authorization review. Be sure to tell the representative the authorization is for medically urgent care.

When to Request Authorization

We recommend that ordering physicians or their delegate secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. Authorizations will contain authorization numbers and one or more CPT codes specific to the services authorized. To ensure accurate claims processing, please incude the provider authorization number on your claim. It is important that the requested service matches the service that has been authorized. If it does not, additional review and authorization will be required prior to service and claim submission. In addition, it is always a good idea to refer to the SWHP Prior Authorization List to determine if a medical service, procedure, or supply requires prior authorization. Request forms for prior authorizations not handled by eviCore are on the provider page at swhp.org.

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eviCore Prior Authorization Program cont'd

Eligibility

Prior to rendering service, you may check member eligibility and benefits online or by calling SWHP Customer Service at 888-316-7947. This will also help determine if preauthorization is needed through eviCore or SWHP.

Resources and Information

You'll find the eviCore orientation presentation, CPT Codes, FAQ, a Quick Reference Guide, and other resources at: https://www.evicore.com/healthplan/scottandwhite.

Please contact your SWHP Provider Relations Representative if you have any questions, need more information or would like to request an onsite training session. To locate your representative's contact information, please visit the provider page at swhp.org.

Additional information on non-eviCore authorizations and policies for clinical programs and pharmacy services may be found on the Provider Home Page at swhp.org, under the heading Authorizations and Policies.

Important information for oncology providers

Scott and White Health Plan (SWHP) has partnered with Oncology Analytics (OA) throughout the state of Texas to provide a comprehensive Oncology Benefits Management program for Commercial Group, Individual and Medicare members.

The program includes support for a prior authorization program for the following items when billed under the medical benefit: genetic molecular testing, chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs.

Oncology Analytics specializes in advising health plans and providers about the most appropriate use of services, drugs, and diagnostic options based upon objective assessments of efficacy, safety, and cost effectiveness. SWHP is dedicated to using experts in the field to advise us about the appropriate use of resources so our members can obtain care that is based on current evidence as interpreted by specialists who have well established credentials in the field of oncology.

When submitting prior authorization requests, you must provide Oncology Analytics with all clinical information to support services being requested, which may include but is not limited to pathology reports, initial consultation, laboratory studies, clinical notes and records.

If you have any additional questions, please do not hesitate to contact Oncology Analytics Provider Relations Team at 1-888-916-2616 Ext. 806; provider-relations@oncologyanalytics.com; Fax: 1-844-893-7886.

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Updated
Prior Authorization List

Effective 11/01/18

SWHP will be updating our Prior Authorization List for our Commercial, Medicare Advantage, Medicaid and Baylor Scott & White Health Employee plans. This update will be effective on 11/01/18. We will post an updated copy of the list on our website prior to 11/01/18. Our Prior Authorization Lists are located at:

http://swhp.org/en-us/prov/auth-referral/medical

https://rightcare.swhp.org/en-us/prov/authorizations

Please note that if a service or procedure is not on the Prior Authorization List, then it does not require prior authorization. All attempts are made to provide the most current information on the Pre-Auth Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. Also, all services or procedures performed by non-participating providers require prior authorization. Please review the Prior Authorization tool found on your Provider Portal before submitting your requests to the SWHP Health Services Department.

It is also important to use the most current SWHP Prior Authorization Request Form and Fax Cover Sheet when submitting your requests. The request form and fax cover sheet is available on the SWHP website at the URL listed in the above paragraph.

If you have any questions regarding SWHP's prior authorization requirements, please do not hesitate to contact the SWHP Customer Advocacy Department at: 1-800-321-7947 or 254-298-3000

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Submit redeterminations online through the SWHP provider portal.

Good news! No more printing forms, finding stamps, and waiting for your redetermination requests to go through the mail. You can now submit redetermination requests online through the SWHP Provider Portal at **https://portal.swhp.org/ProviderPortal/#/login/**.

Simply log in to the portal and locate your claim to submit a request with supporting documentation. It will be processed within 30 days of receipt, and you can follow the status of your claim online.

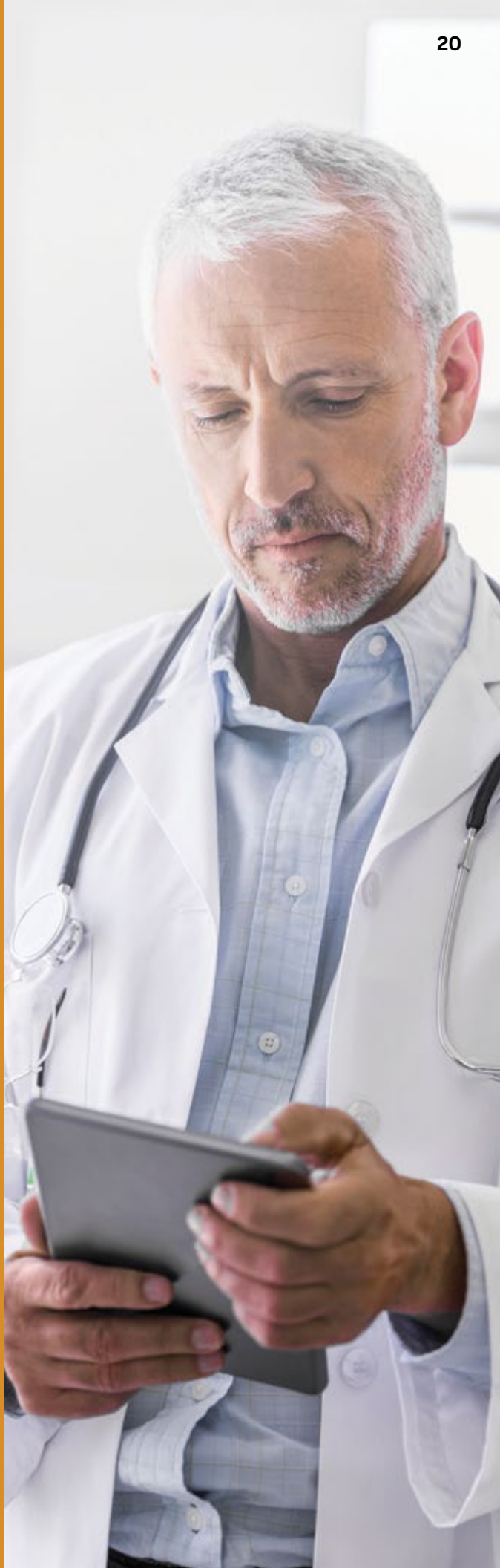
Redeterminations should be submitted within 90 days from the original date of determination or payment made by SWHP, unless they are:

- Medicare Advantage Claims (submit within 120 days)
- From an Out-of-State provider (submit within 1 year)

A redetermination can be filed for claims based on filing limits, code editing, contracted rate of payment policy, coordination of benefits (COB), data entry error, overpayment or underpayment, or any other reasons you may encounter.

For more details on the redetermination process, please visit **https://swhp.org/Portals/0/Files/Forms/Prov_FormsGuides/Provider-Claim-Redetermination-Request.pdf**

Note: This is NOT the process for Medicare Part D redetermination requests which must be submitted to OptumRx.



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Evaluation & Management Coding Reviews

In order to ensure adherence to Evaluation and Management (E/M) coding guidelines, SWHP has started evaluating claims for potential over-coding in E/M billing. For provider practices found to have billing patterns that significantly differ from the national averages, **SWHP will begin editing claims that appear to be over-coded; SWHP will directly notify each individual provider or group that is placed under enhanced review**.

Documentation supporting each E/M service billed is required to meet the standard elements for Chief Complaint, History, Physical Exam and Medical Decision Making for the E/M level of service billed based on the standard documentation guidelines for E/M services.

You must ensure that the E/M code selected properly reflects the level of Medical Decision Making required and that reported diagnoses reflect the acuity of the patient.

Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services. General principles of medical record documentation apply to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, these general principles help ensure that medical record documentation for all E/M services is appropriate.

Please contact your SWHP Provider Relations Representative if you have any questions or need more Information. To locate your SWHP Provider Relations Representative's contact information, please visit our website at **https://swhp.org/Portals/0/Files/Forms/ProviderNews/SWHP-Provider-Relations-Representative-Territory-Map.pdf**.

Federal Prohibition for Providers of Qualified Medicare Beneficiaries (QMB)

SWHP would like to remind you of certain laws under the Social Security Act that prohibits providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.)

The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays.

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QMB cont'd

Despite these billing rules, a July 2015 CMS study ("Access to Care Issues Among QMBs") found that those in the QMB program are still being wrongly billed and that confusion about billing rules continues. CMS is sharing this information to help you understand the QMB program and its billing rules.

For detailed information on billing requirements affecting people in the QMB program, please visit the Centers for Medicare & Medicaid Services website at **https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html**.

Skilled Nursing Facility

Provider Information Updates

The Scott and White Health Plan has noticed an influx of Skilled Nursing Facilities that are updating their Tax ID numbers and in some cases both the Tax ID number and NPI number. It is extremely important this information is shared with the Scott and White Health Plan as soon as possible. This change may require additional credentialing, and the facility may lose their "in-network" status if there is a delay in processing this change.

If you are updating your Tax ID number and/or NPI number, please contact your Provider Relations Representative, and they will advise you of the process to get this information updated.

You can find the representative territory map on our website **here**.

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Do Drug Coupons Really Impact Pharmacy Cost Reductions?

What are Drug Coupons?

Drug coupons are dispersed by pharmaceutical companies through online outlets, providers and pharmacists. Drug coupons are intended to help patients save on prescription drugs; however, most coupon programs require that a member have commercial insurance. Government programs, such as Medicare, do not allow the use of coupons.

How Do Drug Coupons *Really* Affect Costs and Overall Patient Health?

Drug Coupons...

Shield Patients from True Health Care Costs. Drug coupons may initially reduce a patient's prescription co-pay or out-of-pocket costs, **but do not reduce overall cost of the drug** to the insurer or employer plan. This often leads to higher costs for the patient in the form of increased insurance premiums.

Reduce Incentives to Choose Generics. An evidence-based list or formulary is utilized by insurers/employer plans to drive equally effective lower cost generics or alternatives. When a drug coupon is applied, **the patient is more likely to choose a brand name drug** over a lower cost alternative of equal efficacy.

Decrease Patient Involvement. Using drug coupons can decrease the role patients play in their own health care decision making. Patients should be aware of how their choices can impact health care costs and be informed of the alternatives available.

How Can You Help?

- Prescribe the lower cost generic alternatives or equivalents when appropriate or available
- Consider the use of coupons only when the high cost specialty medication does not have a generic alternative
- Educate patients on how drug coupons may affect their insurance co-pay or reimbursement

Did You Know?

Higher drug costs mean higher health insurance premiums for all of us. Prescribing a generic medication can reduce health plan costs.

Example

Switching **25 members** from Crestor to the generic Rosuvastatin would **result in approximately $15,000 in employer plan savings per year** (see table).

	Crestor (brand)	*Rosuvastatin (generic)*
Average total cost/month	$390	$25
Patient copay w/insurance	$195	$3
Patient copay after coupon	$5	-
Total cost paid by employer plan/insurance	$195	$22

Costs are based on Scott & White Health Plan costs for BSWH employees

This educational flyer is intended for health care professionals. A companion educational flyer for patients will be available soon.

Fraud Protection and Prevention

Scott and White Health Plan's Special Investigative Unit (SIU) and auditors utilize fraud detection software for medical and prescription claims, investigate any suspicious claims, and follow necessary actions.

Because healthcare fraud costs millions of dollars annually, Scott and White Health Plan proactively seeks opportunity to minimize fraudulent activity through education, timely identification of issues, and ongoing monitoring efforts.

If you suspect fraud, you can contact the Scott and White Health Plan Ethics line or contact the Compliance Officer directly. The hotline offers a confidential means of reporting information.

Scott and White Health Plan Provider Helpline: 1- 866-245-0815
Scott and White Health Plan Helpline: 1-888-484-6977

Scott and White Health Plan - Compliance Department
1206 West Campus Drive
Temple, TX 76502

Fax: 1-254-298-3508

Utilization Review Criteria for Inpatient Services

The Scott and White Health Plan (SWHP) Evidence of Coverage/ Insurance Company of Scott and White (ICSW) Insurance Policy, also known as Evidence of Coverage (EOC) or Summary Plan Description (SPD), is the contract for coverage of the healthcare services that an individual self-purchased or an employer has purchased for employees. SWHP/ ICSW provides a variety of benefit plans in order to meet the needs of our members.

Benefit plans include benefits required by law, SWHP/ICSW, as well as purchaser preference (Administrative Services Only or ASO). The purpose of SWHP/ICSW's Utilization Management (UM) Program is to manage services according to the terms contained in the EOC/SPD. All benefit plans require coverage to be contingent upon medical necessity. SWHP/ICSW's UM Committee adopts and/or develops evidence-based criteria to determine medical necessity. Annually, SWHP/ICSW provides proposed criteria to selected physician directors of Baylor Scott and White Health's Medical Services Divisions and contracted network physicians for review and feedback. SWHP/ICSW evaluates the feedback provided. The resulting approved final criteria sets and any other internally developed criteria are forwarded to the SWHP/ICSW UM Committee for review and approval.

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Utilization Review Criteria for Inpatient Services cont'd

2018 criteria include InterQual®, internal policies, criteria developed and approved during Technology Assessment meetings, and medical coverage policies.

The approved criteria are used by the UM Staff as a guideline only. SWHP/ICSW medical directors make all medical necessity and experimental and investigational denial determinations. UM decisions, including formulary determinations, are based on appropriateness of care and services and are subject to the terms and limitations of the insurance policy. SWHP/ICSW does not offer incentives, including compensation or rewards, to practitioners or other individuals conducting utilization management to encourage denials of coverage of services or offer financial incentives that encourage decisions that result in underutilization of services. SWHP/ICSW does not use incentives to encourage barriers to care and services.

SWHP/ICSW does not base medical directors' compensation on utilization of services and does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

SWHP/ICSW monitors for evidence of underutilization, overutilization, and misuse through the Quality Improvement (QI) Subcommittee's review of HEDIS® measures, QI team measures, and complaint data. Evidence of underutilization, overutilization, and misuse will be discussed with the individual physician, as well as targeted member outreach as appropriate. Individual coverage requests are discussed with the individual physicians making the request on behalf of a member.

SWHP\ICSW UM staff, including medical directors, is available by telephone 24 hours/ seven days per week at 254-298-3088 or toll-free at 1-888-316-7947 or by appointment to discuss UM and/or coverage determinations, including benefit provisions, guidelines, criteria, or the processes used to make determinations. UM staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues. The SWHP "on-call" nurse who has access to an SWHP medical director who is available after-hours.

Appeal rights, including expedited appeals, reconsideration rights, and/or independent review organization (IRO) options are always provided with any denial issued. Practitioners may request to review criteria at any time, including at the time of a case-specific determination. **Criteria will be provided by fax, phone, and email or through an onsite appointment with the Health Services Division (HSD) management staff or their designees. HSD can be reached by calling 1-888-316-7947 (toll –free) or 254-298-3088 (directly).**

In an effort to improve communications with non-English speaking members, SWHP/ICSW uses interpretive services. Members do not have to call a special line for this service. When contacting SWHP/ICSW, members may notify the HSD staff and/ or Customer Advocacy of their primary language and the call will be completed with the help of an interpreter at no charge to the member. HSD staff follows established internal SWHP/ICSW policies related to provision of interpretive services for SWHP/ICSW members.

SWHP/ICSW utilizes a toll-free number (TTY:711) to assist with communication services for members with hearing or speech difficulties. The TTY number is listed on the SWHP webpage at **swhp.org**.

Additionally, since spring 2017, HSD has an electronic prior authorization form on the **swhp.org** website. This form can be filled out electronically and submitted to HSD, eliminating the need to fax or call the HSD to submit requests for prior authorization.

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SWHP Case Management

SWHP Case Management reviews member quality and utilization to assign a disease or case manager, who connects regularly for ongoing service coordination. The SWHP case manager develops an individualized plan of care using a member-centric approach. The plan of care incorporates a range of services, all of which ultimately help with the quality and cost of care. They include:

- Facilitating calls between the member, physician, and care manager as needed to clarify treatment plans, medication regimens, or other urgent issues
- Monitoring medication compliance
- Assessing the member's daily activities and cognitive, behavioral, and social support
- Evaluating the member's risk for falls and providing education on fall prevention
- Connecting members and their families with professionals who can help with medical, legal, housing, insurance, and financial issues
- Assisting members in obtaining home health and durable medical equipment
- Helping caregivers access support and respite care
- Arranging transportation, meal delivery programs, and advance directive preparation services
- Assisting members transition from Pediatrics care to Adult care SWHP case managers have access to a 360-degree, comprehensive view of each member that includes all of the member's care, diagnoses, labs, and more. Case managers are most effective when collaborating with treating physicians. The opportunity for providers is to leverage these existing health plan resources on behalf of their patients and integrate them into the patient care team.

SWHP provides general high-risk, complex case management, and specialized services such as:

- Pediatrics
- Behavioral health and substance abuse
- Transplants
- NICU
- MOMS

Providers can send referrals to SWHP Case Management via direct contact at 888-316-7947 or via our online Case Management referral form at **https://portal.swhp.org/#/referral**

Disease Management Program

For information about our Disease Management Program and how SWHP works with your patients in the program, including instructions on how to leverage the SWHP Disease Management Program to improve health outcomes, visit:

https://swhp.org/en-us/prov/resources/clinical-programs/disease-management

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Out-of-Network Referrals

Our Scott and White Health Plan (SWHP) members rely on their healthcare physicians to assist them with obtaining in-network medical care, especially when they are facing a difficult medical situation. Members referred to out-of-network physicians and providers incur a greater financial burden, often when they cannot afford it. Also, coordinating with out-of-network providers for a patient's care details may prove to be more difficult for you and the rest of the in-network medical team. You can assist our members and your patients by referring them to physicians and providers that are in-network with SWHP, especially for inpatient, imaging, and laboratory services.

While we understand that SWHP members may request to go out-of-network, and at times may need to go out-of-network, we want to encourage you to help them understand the implications of obtaining healthcare services from an out-of-network physician or provider. The most critical implication is impeding our ability to ensure members receive efficient, high-quality care. The second most critical implication is for them to understand that when they use out-of-network providers, even if approved as in-network, there can be balance-billing because there is not a contract with the providers to hold the Member harmless.

To find SWHP in-network physicians and providers, please visit the SWHP 'Find a Provider' online search located at: https://portal. swhp.org/#/search.

We also want to remind you that all out-of-network services require prior authorization. To review the SWHP Prior Authorization Lists and obtain a copy of the Authorization Request Forms, please visit our website at: https://swhp.org/ en-us/prov/auth-referral/medical. If members do not obtain the required prior approval, they are taking a risk of having their benefits reduced (under their out-of-network benefits) or having their healthcare services denied.

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Provider Relations
Representative Territory Map

Who is your RightCare Provider Relations Representative (“PR Rep”)? To identify who your PR Rep is, please use the following map, which lists the name and cell phone number of each PR Rep, along with a color-coded legend that shows the counties that each PR Rep covers. The PR Reps serve as your liaison with RightCare. They are available to assist you with information regarding policies, procedures, questions, and issues or concerns.

Bobbie Weakly	254-780-7834		Neha Patel	214-617-8992
Claudia Santillan	214-814-1392		Provider Relations	254-298-3064
Crystal Cochran	254-654-4142		Provider Relations	254-298-3064
Louis Limas	817-221-0682		Provider Relations (Statewide)	254-298-3064
Matthew Munoz	254-374-0900			

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