# Medical Office Update

April

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## Start colorectal cancer screenings at 45

The American Cancer Society has updated its guidelines for first-time colorectal cancer screenings, now recommending them to start at age 45 instead of 50. This change is because more younger and middle-aged people are getting colorectal cancer, with deaths in individuals under age 55 increasing by 1% from 2008-2017.

April is Colorectal Cancer Awareness Month, and we urge you to offer colorectal cancer screenings to patients starting at age 45, and continue to have regular screenings thereafter. Finding colorectal cancer early makes it easier to treat.

While more people are learning how important regular testing is, we're still seeing lower rates of colorectal cancer screenings in members ages 45-49 compared to those 50-75.

As your patients' trusted source of medical knowledge, you play a big part in helping them know about their screening options and what might be best for them.

**NCQA suggests these tests options to close colorectal cancer screening gaps:**

- FOBT/FIT — Once every year
- FIT DNA (Cologuard) — Once every 3 years
- Flexible Sigmoidoscopy — Once every 5 years
- CT Colonography — Once every 5 years
- Colonoscopy — Once every 10 years

**More about the COL measure**
Like many quality measures, colorectal cancer screenings are now an NCQA measure that's also available in Electronic Clinical Data Systems (ECDS) format. This means plans can collect and report standard electronic clinic data for HEDIS quality measurement and improvement by leveraging data sources like EHR, PHR, HIE, and case management systems. Learn more about making the most of reporting opportunities with ECDS-eligible options here.

Visit the CDC's website for more information about colorectal cancer screenings and statistics.

## Have your patients get vaccinated at a pharmacy

To make it easier and faster for your Medicare Advantage patients to get reimbursed for Part D (drug) vaccines, please encourage them to get their vaccines from a pharmacy. Here's why.

While most vaccines for Medicare patients are covered by their prescription drug plan (Part D), general medical clinics are not able to bill Pharmacy Benefit Managers (PBMs) directly because the claim types and systems are different than medical claims. Also, PBMs are not set up to reimburse medical providers directly. Their focus is on managing Pharmacy networks, not medical provider networks.

This means that when Medicare patients receive Part D (drug) benefits in a medical clinic setting, the provider cannot bill their service to the PBM, which is not set up to pay the provider directly.

As a result, the patient must pay the provider up front, then submit reimbursement form to their health plan. This process takes time and creates additional work for the patient, including:

1. They must cover the initial cost
2. They have to submit the paperwork to their health plan
3. The reimbursement process is longer than if a provider/pharmacy sends the bill for them

Since pharmacies are able to bill PBMs directly and get reimbursed, we recommend encouraging your Medicare patients to get their Part D vaccines from a pharmacy whenever possible for a better patient experience.

Visit our formulary page to see if a vaccine is a Plan D benefit.

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## Measure before you cut

When taking on a big home project, it's often been said to, "Measure twice and cut once." This isn't just good advice for DIY tasks, it's just as important for healthcare, too. Yet, we don't use it when delivering care as much as research says we should.

Good healthcare providers want the best for their patients, often bringing optimism, deep understanding, and positive energy to their work. But focusing solely on physical symptoms isn't enough. While symptoms are what typically drive patients to seek care, understanding or managing symptoms doesn't guarantee patients will get through their treatment successfully. If their symptoms increase, patients can think, "What good is this doing?" ...and may drop out. Or if the symptoms go away, they can think, "I'm doing fine. I don't need to keep seeing my provider."

Instead, studies show that patients are more likely to commit to their treatment and reach their goals when they have a good relationship with their provider. By checking how your patients feel about their treatment, you can spot any problems early and make needed adjustments to prevent them from stopping their treatment.

Ironically, even the best doctors, with all of their optimism, knowledge and care for their patients, can sometimes miss when their patients aren't feeling good about their treatment. By regularly asking patients how they are doing, we can change how we care for them, making sure they stay on track with their treatment goals.

**We appreciate all you do to keep our members safe and healthy.**

## April Additional Information

Looking for additional information about this month's topics? Click the button below for our new comprehensive document. This month it will contain:

- Reimbursement Policy Manual updates for Jan 2024 – Apr 2024
- Medical Necessity Criteria

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