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Blue Care Network offers 19 products for individual marketplace in 2018

Blue Care Network is offering 19 products for the 2018 Marketplace. We are offering six products in 63 rural counties, nine products in three southeast Michigan counties and 13 products in 17 urban counties.

BCN has modified some plans and made deductible and out-of-pocket changes for the majority of plans. We're closing 12 plans: Personal Plus, Preferred HMO Bronze, Select HMO Gold and Select HMO Bronze Extra, Metro Detroit HMO Bronze Extra and all Partnered HMO plans, effective Dec. 31, 2017. We are adding four new plans: Preferred HMO Bronze Saver HSA, as well as three off Marketplace-only plans in the Preferred, Select and Metro Detroit networks.

Please see [BCN products](#), continued on Page 3

Direct reimbursement available to limited licensed psychologists and licensed marriage and family therapists beginning June 1, 2018

Starting June 1, 2018, limited licensed psychologists and licensed marriage and family therapists will have the opportunity to participate as Blue Care Network providers. Participating LLPs and LMFTs can receive direct reimbursement for covered behavioral health services within the scope of their licensure.

BCN is allowing LLPs and LMFTs to enroll as part of a group starting in March 2018.

In March, the enrollment forms and contract documents will be available at bcbsm.com/providers. Complete these steps:

1. Click *Join our network*.
2. Click **Provider Enrollment Forms**.

Please see [Direct reimbursement](#), continued on Page 2

Inside this issue...

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Direct reimbursement, continued from Page 1

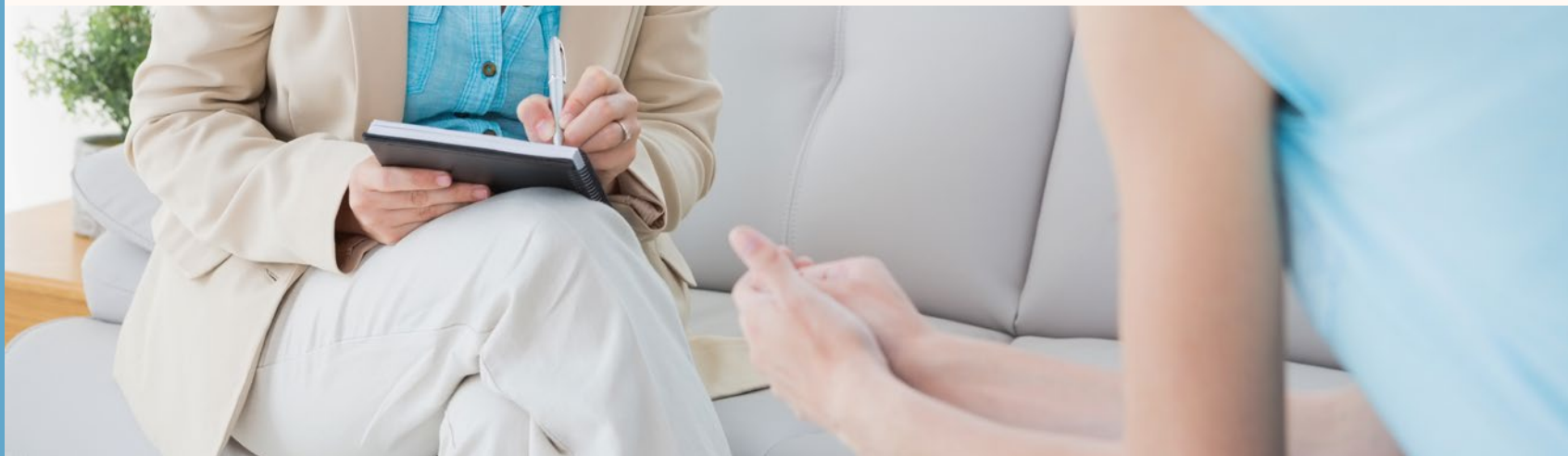
Specific qualification requirements will be identified within each agreement. We'll share more detailed enrollment instructions in an upcoming newsletter.

All applicants must pass a credentialing review prior to participation. We'll notify applicants in writing of their approval status.

LLPs and LMFTs who practice in a substance abuse/outpatient psychiatric clinic setting may continue to do so and do not have to go through any additional application process. As a reminder, marriage counseling is not a covered benefit for BCN members, but LMFTs may provide other covered behavioral health services within the scope of their licensure. In addition, the clinical supervision requirements for LLPs aren't changing.

An updated version of the **Requirements for providing behavioral health services to BCN members** will be available on the web in the spring of 2018. This document provides guidelines for various types of BCN behavioral health providers. It's located in the BCN section at **ereferrals.bcbsm.com**. Click *BCN* and then click *Behavioral Health*. Scroll down and click to open the document under the "Other resources" heading.

Information will also be provided in the spring of 2018 about how to transition authorizations for services by these practitioners.



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BCN products, continued from Page 1

Some of the key product changes for 2018 for individual products include:

- Limited BlueCard coverage to urgent and emergency only
- Adjusted specialty prescription coinsurance from 20/25 percent for preferred/non-preferred to 40/45 percent to achieve coverage parity with competitors
- Limited the Gold Metal tier to the Preferred Network.
- Modified Silver Extra to conform with the 2018 version of the Centers for Medicare & Medicaid Services Silver Standard Plan
- Closed the Bronze (basic) Health Savings Account option, leaving the only individual HSA option to be the Bronze Saver plans
- Opened a Bronze (basic) plan that isn't HSA-eligible in the local networks. It covers primary care physician visits, laboratory services and urgent care, before the deductible.
- All Preferred plans are now available statewide

For the Silver Extra plan (the CMS standard plan), a prescription drug deductible has been added that applies only to specialty prescription drugs. The specialty drug deductible is separate from the medical deductible. Generics, preferred brand and non-preferred brand medications are covered with a copayment and no deductible.

We're continuing to monitor changes being made to the Affordable Care Act.

As always, check member eligibility and benefits at every visit before providing services. You can do this through web-DENIS or by calling our **Provider Automated Response System**.

Ask to see the latest member ID card when you see patients

Some member ID cards will be reissued for individual products in 2018. Ask to see the latest member ID card and make sure it matches the coverage listed on web-DENIS.



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BCN Service Company will no longer administer self-funded plans

Effective Jan. 1, 2018, BCN Service Company will no longer administer self-funded employer benefit plans. They will be administered by Blue Care Network. BCN Service Company provides administrative services, including claims payment, in support of self-funded health care coverage for employer groups. BCN Service Company also distributes capitation to physician groups and pays claims to providers. Recent changes in the Michigan Insurance Code allow HMOs to self-fund; therefore, BCN Service Company is no longer required.

We mailed a letter explaining this change to self-funded and Health Reimbursement Arrangement employer groups. The letter included the new BCN bank ID they'll need to provide to their financial institutions for 2018 payments. Checks and electronic Remittance Advices will also reflect the name change. We're also adding the HRA designation and new bank account number to applicable checks.

There are no changes to members' coverage and benefits, only the entity that administers the plan. We'll issue new member ID cards throughout December and January. We'll replace existing BCN Service Company certificates and riders with BCN certificates and riders. Members will be able to see these updated documents by logging in to their bcbsm.com accounts.

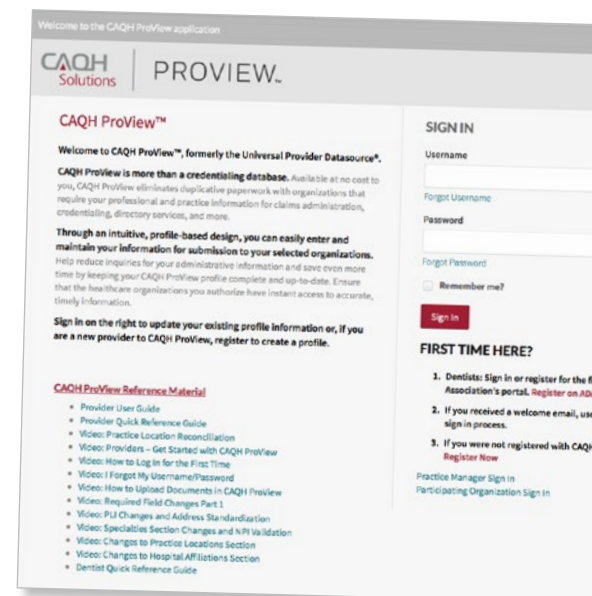
Complete your attestation through CAQH

As communicated via web-DENIS in October, Blue Cross Blue Shield of Michigan and Blue Care Network have transitioned from the PRIME-Hub website to CAQH ProView for the quarterly attestation process.

Health care providers and practice managers should use CAQH to review and confirm their demographic data instead of going to the Atlas PRIME-Hub website.

New and existing users can access the **CAQH ProView Provider portal** to register, log in and validate existing information in their CAQH account. If you haven't done so already, please create a CAQH account, validate your existing provider information that's listed in CAQH and continue to submit changes through the Provider Self-Service tool.

The **CAQH website** has resources to help providers and practice managers use CAQH ProView. If you have questions or need support with completing your attestations, contact CAQH at 1-888-599-1771 or your provider consultant.



Quality Rewards introduced

Blue Cross Blue Shield of Michigan and Blue Care Network are combining the 2018 Performance Recognition Program and Physician Group Incentive Program into one *2018 Quality Rewards* booklet. Primary care physicians can find it on BCN Health e-BlueSM in the *Resources* section.

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What you need to know about the new Healthy *Blue* Living HMO options

In the November-December 2017 *BCN Provider News*, you learned about two new wellness options that Blue Care Network is offering starting Jan. 1, 2018: Healthy *Blue* Living HMO BasicSM and BCN Wellness Rewards TrackingSM. Here are some important tips on identifying these members and what to expect when they visit your office.

- Healthy *Blue* Living Basic members and those participating in the BCN Wellness Rewards Tracking program are required to visit their primary care physician within 90 days of their plan year for a BCN Qualification Form visit. After this exam, their doctor needs to electronically submit their qualification form through Health e-BlueSM.
- Once in Health e-Blue, you will see the member's name listed under the *Healthy Blue Living Qualification Form* panel. You can also identify them by checking their eligibility in web-DENIS. Here, BCN Healthy *Blue* Living HMO Basic will be listed at the top of their virtual ID card image. For Wellness Rewards Tracking participants, a qualification form message will appear on their Member Eligibility/Coverage page.
- A cotinine test to check for tobacco use is part of the qualification form. Neither Healthy *Blue* Living Basic subscribers nor Wellness Rewards Tracking participants are required to complete this. You will see a message in red in Health e-Blue indicating that results are not required for the tobacco question.

Instructions on filling out the qualification form will be available in January 2018 under the Supporting Documents section at the bottom of the Health e-Blue home page. If you don't have access to Health e-Blue, please contact your provider consultant. You can also find more information in the comparison chart on the *BCN Publications and Resources* web-DENIS page under *BCN Products*, then Healthy *Blue* Living.

Blue Care Network is closed for holidays in December and January

Blue Care Network offices will be closed Dec. 22, 25 and 26 for the Christmas holidays, Jan. 1 for New Year's Day and Jan. 15 for Martin Luther King Day.

When BCN offices are closed, call the BCN After-hours Care Manager Hot Line at 1-800-851-3904 and listen to the prompts for help with:

- Determining alternatives to inpatient admissions and triage to alternative care settings
- Arranging for emergency home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Emergency discharge planning coordination and authorization
- Expedited appeals of utilization management decisions

Note: Calls for clinical review for admissions to skilled nursing facilities and other types of transitional care services should be made during normal business hours unless there are extenuating circumstances that require emergency placement.

The after-hours care manager phone number can also be used after normal business hours to discuss urgent or emergency determinations with a plan medical director.

Don't use this number to notify BCN of an admission for commercial or BCN AdvantageSM members. Instead, use e-referral the next business day.

As a reminder, when an admission occurs through the emergency room, we ask that you contact the primary care physician to discuss the member's medical condition and coordinate care before admitting the member.

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Blue Cross and Blue Care Network Medicare star ratings remain solid

Blue Cross Blue Shield of Michigan and Blue Care Network have received an overall 4-star rating from the Centers for Medicare & Medicaid Services. Blue Cross and BCN remain some of the most consistently higher-performing plans in our state.

The Medicare star program is nationally recognized, providing an overall rating of a health plan's quality and performance for the types of services each plan offers. It ranges from 1 to 5 stars. The 2018 star ratings reflect health plan measurements from 2016.

The 2018 ratings provide us with a renewed opportunity to review factors that could be improved, and we have already determined some innovative steps to help with future ratings. We will continue our focus on member experience as it is critical to communicate effectively with members. It's also important to stay focused on clinical measures as higher scores across the board in this area weigh heavily on the overall rating.

BCN Advantage will focus on making improvements in these areas:

- Getting appointments and care quickly
- Care coordination ("Doctors following up with test results" and "Doctors discussing taking medicines" were two questions showing the biggest decline.)
- Ease of getting prescription drugs

We've also identified two areas for improvement from the BCN Advantage Health Outcomes Survey.

- Monitoring physical activity
- Maintaining physical health



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Your patients may qualify for the Medicare Diabetes Prevention Program that goes into effect April 1

Blue Care Network and Blue Cross Blue Shield of Michigan have partnered with an outside vendor, Solera, to provide a diabetes prevention program to our prediabetic members.

The Medicare Diabetes Prevention Program is a structured intervention with the goal of preventing progression to Type 2 diabetes in individuals with an indication of prediabetes. The program includes education and support, and is proven to help participants lose weight, adopt healthy habits and reduce their risk of Type 2 diabetes. The program begins April 1 and is part of all members' Part B coverage.

We're offering this program in response to a challenge to health plans from the Centers for Medicare and Medicaid Services to take on diabetes by providing Medicare Part B beneficiaries with access to evidence-based diabetes prevention services.

To qualify for the program, members must have a prediabetic diagnosis based on the following:

- BMI of at least 25 (23 if of Asian descent)
- One of three blood glucose test results:
 - Hemoglobin A1c between 5.7 and 6.4 percent
 - Fasting plasma glucose of 110-125 mg/dL
 - Two-hour post-glucose of 140-199 mg/dL (oral glucose tolerance test)

Additional qualification requirements:

- No previous or current diagnosis of Type 1 or Type 2 diabetes (nongestational)
- Doesn't have end-stage renal disease

The Medicare Diabetes Prevention Program

There is no additional cost to Part B members who enroll in the program, but they do have to adhere to the following requirements:

- Attend 16 weekly program sessions over six months in a group-based, classroom-style setting from a CDC-recognized provider (Curriculum focuses on long-term dietary changes, increased physical activity and behavior change strategies for weight control.)
- A second year of maintenance sessions is available for those who meet a 5 percent weight-loss goal

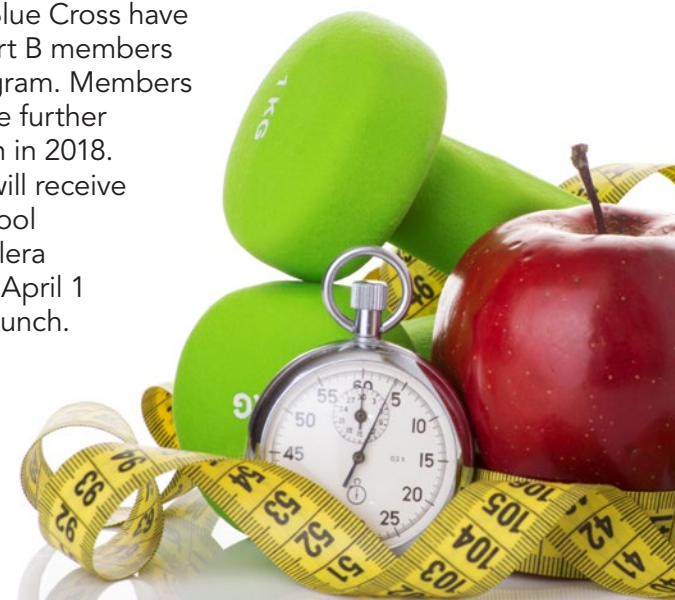
Additional participant support includes:

- A lifestyle health coach to help set goals and keep participants on track
- A small support group to encourage progress

How to enroll

Members may self-enroll or providers may recommend their patients to the program.

BCN and Blue Cross have notified Part B members of the program. Members may receive further information in 2018. Providers will receive an MDPP tool kit from Solera before the April 1 program launch.



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Reminder: Using place of service codes for skilled nursing facilities

Providers should use place of service code 31 for a skilled nursing facility. This is covered under Medicare Part A. A skilled nursing facility primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services. It doesn't provide the level of care or treatment available in a hospital and is short-term in nature.

Use place of service code 32 when billing for a nursing facility, non-skilled care or when the patient doesn't have Part A SNF benefits. A nursing facility primarily provides custodial or personal care and includes assistance with activities of daily living such as, bathing, dressing, eating, grooming, getting in and out of bed, and bathroom assistance. These services are considered non-skilled care and are typically long-term in nature.

Providers must submit functional limitation G codes for BCN Advantage PT, OT and ST services

When billing outpatient physical, occupational and speech therapy services for BCN AdvantageSM members, you must report the nonpayable functional limitation G codes and their applicable modifiers.

See full article on **Page 37**.

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UAW Retiree Medical Benefits Trust coverage changing for Medicare members in 2018

Effective Jan. 1, 2018, the UAW Retiree Medical Benefits Trust will transition coverage for its Medicare primary members in Michigan from the Blue Cross Blue Shield Traditional Care Network plan to the Blue Cross Medicare Plus BlueSM PPO. This means that on Jan. 1, 2018, many of your patients who receive coverage through the Trust will be enrolling in a Blue Cross Blue Shield of Michigan Medicare Advantage PPO plan.

There are several advantages to enrolling in the Blue Cross Medicare Plus Blue PPO plan:

- No monthly contributions to the Trust required
- Free fitness club membership in the Silver Sneakers fitness program
- Lower deductibles than the TCN plan
- No referrals required to visit the doctor, specialist or hospital of your choice

You'll likely continue to see these same retirees, who will be Blue Cross Blue Shield Medicare Advantage members beginning Jan. 1, 2018. If you're part of the Blue Cross Medicare Advantage PPO network, these members will be able to find your practice or facility in our online provider directory.

While most of our health care providers are familiar with our Blue Cross Medicare Plus Blue PPO, there are some differences in benefits and care management. See our [website](#) for more information about the plan.

As always, it's important to ask your patients about recent changes in insurance carriers and benefits, and request a copy of their member ID card when they come for services. You can also check member benefits and eligibility on web-DENIS.

While referrals aren't required for the Blue Cross Medicare Plus Blue PPO, members may need authorization prior to receiving certain hospital services. You'll want to review the authorization guidelines and criteria on the [e-referral](#) site.

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Adult pneumococcal vaccine guidelines

Physicians can improve payment rates by choosing appropriate vaccine and using correct coding

By Robert Goodman, D.O.



A national survey completed in 2012 revealed that providers reported concerns regarding payment as one barrier to offering adult vaccinations.¹ We examined Blue Care Network commercial claims data (from the first quarter of 2014 to the third quarter of 2015) for rates of vaccine dose non-payment (defined as a BCN allowed amount of \$0) and evaluated individual claims for vaccine type and reasons for non-payment.

One notable result: The rate of non-payment was substantial for the conjugate pneumococcal vaccine administered in the physician office setting. These denials were driven by clinical editing. These edits are included in initial automated claim processing that checks for diagnoses on the submitted claim that allow for payment; the absence of diagnoses results in a denial.

According to anecdotal reporting from the BCN pharmacy department, about 75 percent of these denials *that are subsequently appealed* don't have support in the actual medical record. Providers send physician charts as part of the appeal process, while the diagnosis code clinical edits are applied to administrative claims data only. Past BCN educational efforts may have been too general in nature and not sufficiently explicit.

The guidelines from the Centers for Disease Control and Prevention support Pevnar-13® in the 19 to 64 age group only for very specific reasons, which are reflected in BCN claim processing clinical edits. The CDC indications for coverage for Pevnar-13 in the 19-to-64 age group can't be extrapolated or otherwise viewed as broad categorical buckets subject to individual physician interpretation of what conditions can be included.

The current CDC guidelines for Pevnar-13 (conjugate pneumococcal vaccine) for adults 19 to 64 are: cerebrospinal fluid leaks; cochlear implants; sickle cell disease or other hemoglobinopathies; congenital or acquired asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; leukemia; lymphoma; Hodgkin disease; generalized malignancy; iatrogenic immunosuppression; solid organ transplant; multiple myeloma. Providers can improve the rate of initial payment for Pevnar-13 by including the ICD-10 code for the above indications in the claim, if indeed applicable to the member.

The 23-valent polysaccharide pneumococcal vaccine (Pneumovax®) is the vaccine supported for members 19 to 64 years of age with the common conditions typically seen on denied Pevnar-13 claims: chronic heart or lung disease, diabetes mellitus, alcoholism, chronic liver disease, and includes adults who smoke cigarettes. This likely is the disconnect and confusion that led to the high denial rate for Pevnar-13 in the under-65 population, when Pneumovax would be the appropriate choice.

Dr. Goodman is a medical director at Blue Care Network.

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From the medical director, continued from Page 10

Check the **CDC website** for guidelines for pneumococcal vaccine timing. We hope that sharing this specific link to the guidelines and pointing the specific nature of the Prevnar-13 indications in the 19 to 64 population will lead to more appropriate vaccine administration, as well as greater member and treating physician satisfaction due to fewer denials for administered vaccines.

An additional aspect of these two vaccines worth noting relates to the 65 and older age group. These individuals should have Prevnar-13 *before* their Pneumovax vaccination. Even though 12 of the 13 serotypes present in Prevnar-13 are also present in the Pneumovax product, the latest literature indicates that Prevnar-13 primes the immunologic pump and when followed by Pneumovax (as per guideline schedule) results in an enhanced level of patient immunity.²⁻⁵

Hopefully these additional details will assist BCN providers in successfully navigating the complicated guidelines regarding adult pneumococcal vaccination with the correct vaccine type for a member's age and any applicable medical conditions.

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On the front line: Battling the opioid epidemic



CDC says doctors should talk to patients about opioid use

The Centers for Disease Control and Prevention advises doctors to **educate patients** about opioid use.

Doctors and patients should talk about:

- How opioids can reduce pain during short-term use, yet there is not enough evidence that opioids control chronic pain effectively long term
- Nonopioid treatments (such as exercise, nonopioid medications and cognitive behavioral therapy) that can be effective with less harm
- Importance of regular follow-up
- Precautions that can be taken to decrease risks, including:
 - Checking drug monitoring databases
 - Conducting urine drug testing
 - Prescribing naloxone if needed to prevent fatal overdose
 - Protecting your family and friends by storing opioids in a secure, locked location
 - Safely disposing unused opioids

Source: CDC factsheet

Patient Care



What patients should know before taking opioids

By Kristyn M. Gregory, D.O.

Dr. Gregory is a medical director at Blue Care Network.

Opioid abuse and overdose has become a nationwide epidemic. According to the Centers for Disease Control and Prevention, **91 Americans** die each day as a result of an opioid overdose. However, many patients may still be unaware that opioids carry serious risks of addiction and overdose, especially with prolonged use.

Because this epidemic is so far-reaching, open communication between doctors and their patients is important to help patients understand the risks and benefits of opioids and to promote safe use.

Share this key information with your patient when prescribing an opioid:

First, know the level of your patient's health literacy to make sure he or she understands your directions.

Set the stage

- Opioids can reduce pain during short-term use, yet there isn't enough evidence that opioids control chronic pain effectively long term.
- Nonopioid treatments such as exercise, nonopioid medications, including ibuprofen, acetaminophen, select antidepressants, as well as cognitive behavioral therapy can be effective with less harm.

Explain what patients can expect

- Opioids aren't meant to completely eliminate pain. Patients often have the misconception that opioids are used to stop pain altogether.
- Everyone experiences pain differently and it's not possible to predict how long someone will experience pain. Your patient likely will have some leftover medications that will need to be disposed of safely and appropriately.

Risks and side effects

- Combining opioids with alcohol or other prescription or over-the-counter medications can lead to serious consequences like overdose and death.
 - Medications of most concern: benzodiazepines, muscle relaxants, hypnotics
- Encourage your patient not to change the amount of medication he or she takes. Patients should always be encouraged to call you if they notice side effects or the pain medication doesn't seem to be as effective.
- Tolerance and physical dependence are normal responses to opioid therapy; this doesn't mean addiction. It can happen even when medication is taken as directed.
 - Tolerance is a need to take more of a medication for the same pain relief.
 - Dependence is when symptoms of withdrawal occur when the medication is stopped.

Protect family and friends

- Serious consequences can occur if opioids get into the wrong hands. It's important to keep them in a secure location to avoid access to children or teens in the household and prevent an accidental overdose.
- Properly dispose of leftover medication. The perfect opportunity to safely dispose of any prescription drugs is a community take-back facility. Patients can find a local drug disposal facility at the **U.S. Drug Enforcement Administration** website.

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As part of our commitment to provide you with information to address opioid abuse, this section features the latest research and news on the opioid epidemic.

For information on Blue Cross Blue Shield of Michigan and Blue Care Network task force on opioid abuse, see the **Medical director column** in the Nov.-Dec. 2017 issue.

Guidelines to prescribe opioids safely

Prescribing opioids is a delicate and difficult balancing act but Howard Marcus, M.D., FACP, says the health care industry must prevent opioid misuse while protecting the wellbeing of patients affected by severe or long-lasting pain. In an article published in *The Doctor's Advocate*, Marcus lists not only the challenges involved in managing opioid use but also **guidelines** doctors should follow when prescribing them.

Study: Patients with mental disorders get half of all opioid prescriptions

Adults with a mental illness receive more than 50 percent of the 115 million opioid prescriptions in the U.S. annually, according to a new study published in the *Journal of the American Board of Family Medicine*. It's a worrisome finding because people with mental illnesses are more likely to become addicted. Doctors recommend alternative treatment for many opioid patients but particularly for those with mental health issues. Read the **findings**.

HEDIS measures updated to combat opioid addictions

In a recent change, the National Committee for Quality Assurance is updating its Healthcare Effectiveness Data and Information Set to combat opioid-related addictions. One new measure addresses high dosages for long-term treatment. Another one focuses on the rate of adult health plan members that are prescribed opioids from multiple providers and pharmacies. For details, see the article in **Healthcare Finance**.

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University of Michigan details recommendations for using fewer opioids for specific surgeries



In an effort to reduce opioid abuse, the University of Michigan developed a guide that details recommendations for 11 common surgeries based on pain control and surgical quality research as well as data from patient surveys.

The Michigan Opioid Prescribing Engagement Network, or Michigan-OPEN,, in collaboration with the Michigan Surgical Quality Collaborative, both based at the U-M Institute for Healthcare Policy and Innovation, created the guide.

Many of the patients factored into the recommendations had their operations at the 72 hospitals taking part in MSQC, which gathers and analyzes surgery-related data to help surgical teams find ways to improve and learn from others. Funded by Blue Cross Blue Shield of Michigan, MSQC provided a rich source of information about what patients were prescribed, what they used and how they fared after surgery.

Michigan-OPEN researchers have previously shown that when patients are prescribed fewer pills, they consume less with no changes in pain or satisfaction scores.

The first prescribing recommendations focus on a range of common operations, including hysterectomy, colon surgery, appendectomy and breast biopsy, and detail the amounts of hydrocodone, oxycodone, tramadol and codeine or acetaminophen to prescribe in an easy-to-print chart.

The amounts represent the maximum opioid use reported by three-quarters of surgery patients. Most patients took far less, from zero to five pills, even when their surgeon or another provider prescribed more.

The recommendations are meant specifically for patients who have never taken opioid painkillers before.

Read the full article at [uofmhealth blog](#).

Download the [opioid prescribing recommendations](#).

Read more about [M-OPEN](#).

Source: Michigan Medicine



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Choosing Wisely — Avoid prescribing antibiotics for upper respiratory infections

We first introduced you to Choosing Wisely® in 2015. Our partnership with Greater Detroit Area Health Council on Choosing Wisely continues. Choosing Wisely is an initiative of the American Board of Internal Medicine Foundation that aims to promote conversations between physicians and patients to discuss medical tests and procedures that may be unnecessary and, in some instances, harmful. In this issue, we discuss antibiotic use for upper respiratory infections.

Most acute upper respiratory infections are viral and antibiotic treatment is ineffective, inappropriate and potentially harmful. Confirmed infection by Group A Streptococcal disease (Strep throat) and pertussis (whooping cough) should be treated with antibiotics. Treatment for URIs consists of treating the symptoms. It's important that health care providers educate patients about the consequences of misusing antibiotics for viral infections, which may lead to increased costs, antimicrobial resistance and adverse effects.

Choosing Wisely has **downloadable materials** available on the appropriate use of antibiotics. **More information** about appropriate use is also on their website.

Consumer Health Choices offers a **5 Questions to ask your doctor before you take antibiotics** flyer that you can print and give to your patients and posters that you can use in your office. These materials will help you have conversations with your patients about why antibiotics may not be needed.

For additional information on *Choosing Wisely*, visit **choosingwisely.org**.



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Criteria corner

Blue Care Network uses McKesson's InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and Local Rules, BCN provides clarification from McKesson on various topics.

Question:

A patient has abdominal pain of unknown etiology. Would it be appropriate to use General Medical Intermediate criteria: General, "IV medication administration" to meet for an inpatient admission?

Answer:

There are criteria in the General Medical subset at the Observation Level of Care for Abdominal Pain of Unknown Etiology. If a higher level of care is needed for the patient with abdominal pain, the Intermediate criteria for the administration of IV medications may be applied if the following apply:

1. Medication is an analgesic or sedative and excludes patient controlled analgesia.
2. Administration, bolus every three to four hours and monitoring: This criteria point can only be applied if the analgesic is ordered and given at least every three to four hours for all or most of the day being reviewed. It may be applied as needed for medications that are given at the required frequency, but shouldn't be applied when only a few doses are given (for example two doses). The doses must be given at the required frequency for all or most of the day being reviewed, as the need for the higher level of care is validated by the need for frequent dosing with IV analgesics; in the patient for whom a cause of the abdominal pain is unknown.
3. Another important point to remember is that the General Medical subset can't be used if the abdominal pain is due to an issue addressed in another subset, or due to trauma or if the patient is to be taken to surgery.

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February focus is on heart health

In support of American Heart Month in February, Blue Care Network is reminding providers to screen patients for conditions that can affect heart health. BCN supports Michigan Quality Improvement Consortium guidelines, including those for screening and management of high cholesterol, high blood pressure, overweight and obesity and tobacco control.

High blood pressure is a serious condition and, if left untreated, can lead to coronary heart disease, kidney disease and possibly stroke. About one in three adults in the United States has hypertension and it usually starts from the ages of 35 to 50, according to the Centers for Disease Control and Prevention. There are no symptoms or warning signs and it can affect anyone regardless of race, age or gender.

Risk factors that can't be controlled

- Age (45 and older in men, 55 and older for women)
- Family history of early heart disease

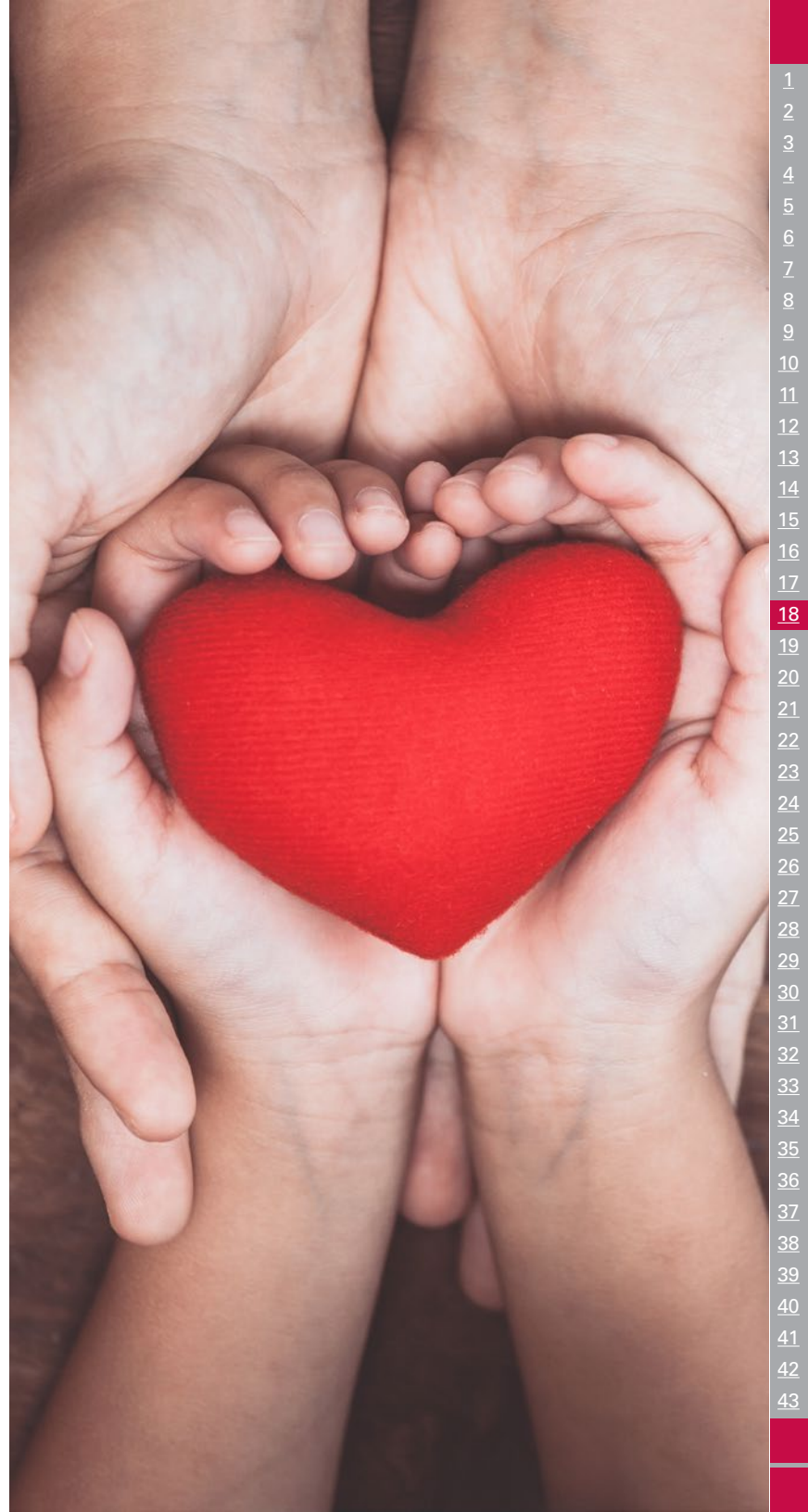
Risk factors that can be controlled by the member with guidance from the provider

- High cholesterol (high LDL or "bad" cholesterol)
- Low HDL ("good" cholesterol)
- Smoking
- High blood pressure
- Diabetes
- Obesity, overweight
- Physical inactivity

Factors that determine LDL ("bad") cholesterol level

- Heredity
- Diet
- Weight
- Physical activity and exercise
- Age and gender
- Alcohol
- Stress

Please see [Heart health](#), continued on Page 19



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Heart health, continued from Page 18

Some highlights from the MQIC guidelines are noted below. For the complete guidelines, visit [MQIC](#).

Lipid screening and management

- Initial screening to include fasting lipid profile (total cholesterol, LDL-C, HDL-C, triglycerides). Repeat every four to six years if normal.
- Screening of LDL-C levels at least annually for member with a cardiac event (AMI, PTCA, CABG) or diagnosis of ischemic vascular disease.
- Treatment based upon presence of clinical atherosclerotic cardiovascular disease (ASCVD); 10-year ASCVD risk calculation for patients 40 to 75 without clinical ASCVD, diabetes mellitus (type 1 or 2) or LDL-C > 190 mg/dl. (See [ASCVD Risk Estimator Tool](#) from MQIC.)
- Statin dosing intensity based upon ASCVD presence and risk.
- Educate about therapeutic lifestyle changes such as losing weight if indicated, increasing exercise to moderate to vigorous activity for 40 minutes per day, three to four days of the week, and following a diet emphasizing vegetables, fruits, whole grains, low fat dairy, poultry, fish, legumes, nontropical vegetable oils and nuts, limited sweets and sugar sweetened beverages, and red meats.

Management of overweight and obesity in adults

- If BMI >30 or >27 with other risk factors or conditions, consider referral to a program that provides guidance on nutrition, physical activity and psychosocial concerns.
- Pharmacotherapy only for patients at increased risk because of their weight and coexisting risk factors or comorbidities.
- BMI >40 or >35 with uncontrolled comorbid conditions, consider weight loss surgery.

Providers can encourage healthy lifestyles by reminding patients to do the following:

- Develop a healthy eating pattern, which includes eating foods low in saturated fat and cholesterol.
- Reduce salt and sodium. (The CDC reports a potential of 11 million fewer cases of hypertension just by reducing sodium intake from the average 3,400 mg daily to 2,300.)
- Maintain a healthy weight.
- Get regular physical activity for at least 30 minutes most days of the week.
- Limit alcohol.
- Quit smoking.
- Take blood pressure medication as prescribed.

Providers can also refer members to the [National Heart Lung and Blood Institute](#) website for information about heart disease.

References:

[MQIC.org](#)

Lipid Screening and Management

Management of overweight and obesity in adults

National Heart Lung and Blood Institute (<http://www.nhlbi.nih.gov/>)

<http://www.cdc.gov/bloodpressure/facts.htm>

Medical policy updates

Blue Care Network's medical policy updates are posted on web-DENIS. Go to *BCN Provider Publications and Resources* and click on *Medical Policy Manual*. Recent updates to the medical policies include:

Noncovered services

- Cryoablation of peripheral nerves
- Spectral analysis of prostate tissue

Covered service

- Radiofrequency ablation of primary or metastatic liver tumors
- Home cardiorespiratory monitoring – Pediatric



Medical Policy Updates

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Five steps to avoid prescription medication abuse in teens

A nationwide survey among eighth-, 10th- and 12th-graders shows that teens perceive less risk in trying prescription drugs like Vicodin and OxyContin than in previous years. As the opioid crisis continues to affect communities across the country, it's important to note changing attitudes toward substance abuse often precedes changes in reported use.

Prescription medications are among the most commonly abused drugs in the United States. Unfortunately, many teenagers assume medications prescribed by the doctor are safe to take under any circumstances. Among those abused most often are Vicodin and OxyContin, two opioid drugs regularly used to control post-treatment dental pain.

In 2013, nearly 42,000 students from 389 public and private schools participated in a *Monitoring the Future* survey funded by the National Institute on Drug Abuse and conducted by the University of Michigan. The study measures drug, alcohol and cigarette use and related attitudes among eighth-, 10th- and 12th-graders nationwide.

When used as directed, narcotics like Vicodin and OxyContin are important and effective painkillers. However, when they're taken in ways other than prescribed, they can be deadly. The death rate from unintentional drug overdose has skyrocketed in the past decade, driven by deaths associated with prescription painkillers. Of those who die of an opioid overdose, almost two-thirds of the drugs used were originally prescribed for someone else.

While the **survey** showed non-medical use of prescription narcotics had dropped since 2009, there were still causes

for concern—including the finding that teens perceive less risk in trying prescription drugs like Vicodin and OxyContin than in previous years. Further research suggests that the abuse of prescription opioids like Vicodin and OxyContin is responsible for a recent spike in heroin use in suburbia.

Both Vicodin and OxyContin can also be most tempting for teens who may not have a personal interest in using them, but recognize the street market value. In 2014, a single hydrocodone or oxycodone tablet ranged from \$1 to \$80 in Michigan.

Adults play an important role in keeping prescription drugs from being abused by teens. Providers should remind adult patients receiving any treatment that requires the use of a prescription pain medication to take the following steps to prevent abuse of these medications:

1. **Discuss the danger of legal prescription drugs misuse and how it compares closely to the use of illegal street drugs.**
2. **Monitor dosage and quantities to ensure all pills are accounted for in the household.**
3. **Keep prescription drugs in a secure location that isn't readily accessible to teens.**
4. **Dispose of any unused prescriptions at a **safe collection site** near you.**
5. **Talk with families, friends and neighbors about how teens are misusing prescription drugs and what can be done to prevent teens from becoming victims of drug abuse.**

Source: MI Blues Perspectives blog, Blue Cross Blue Shield of Michigan

Know member rights and responsibilities

Blue Care Network members have certain rights and responsibilities. Providers should be aware of these rights. They are available at our **website**.

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Patient Safety Awareness Week

The National Patient Safety Foundation has designated March 11-17, 2018, as National Patient Safety Week. This is designed to increase awareness about patient safety among health professionals and their patients.

Blue Care Network supports the efforts of the Patient Safety Foundation and encourages its provider community and members to get involved.

Studies show that patients who are more involved in their health care have better outcomes.

Communication between patients and their health care providers play an important role. Encourage your patients to become active participants in their health care.

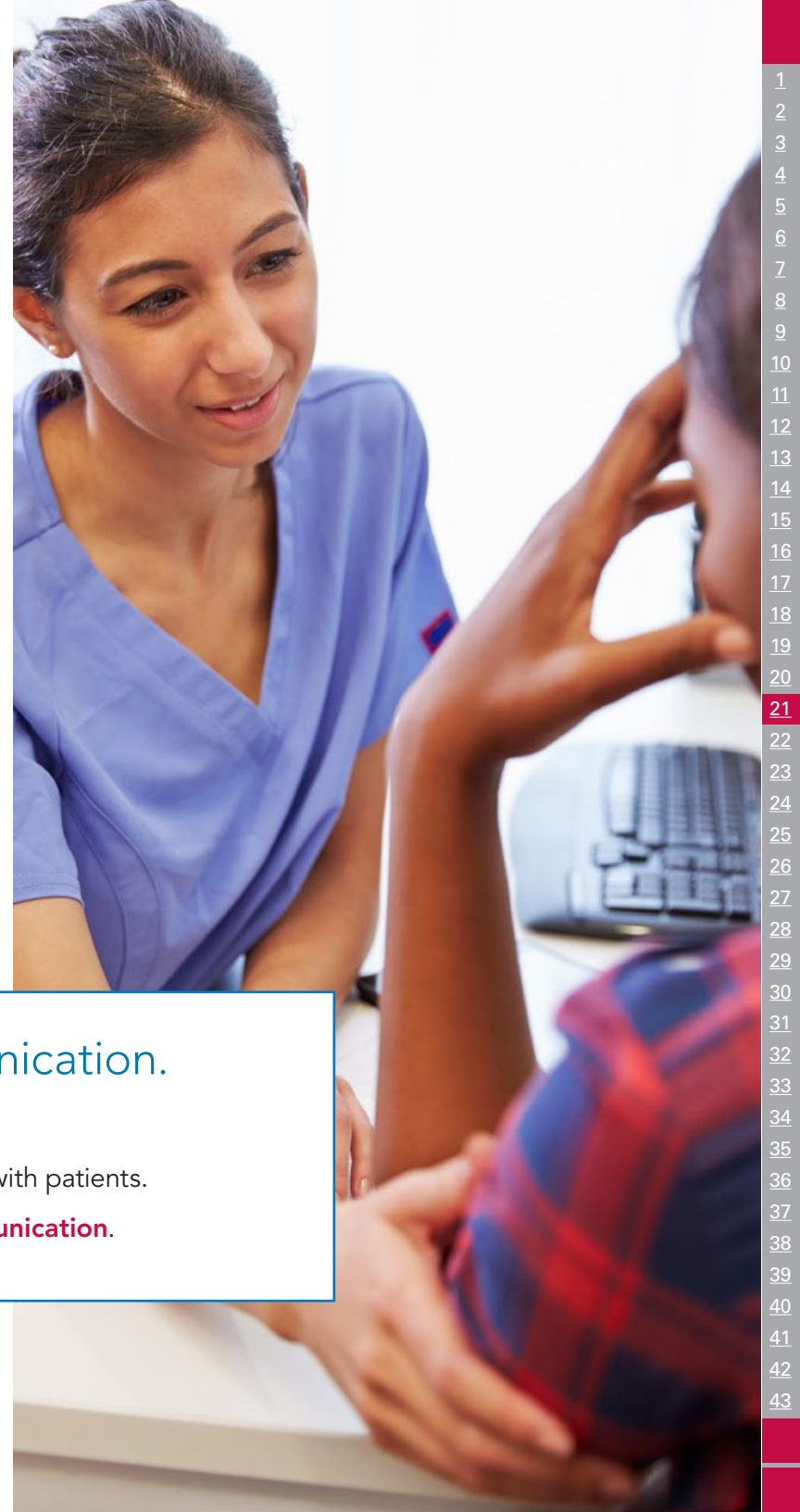
- Provide an environment where patients feel comfortable talking openly.
- Provide information about your patients' care in a manner that is understandable to them.
- To learn more, visit the **National Patient Safety Foundation** website.

Learn more about patient communication.

Listen to what patients say is important to them.

See how doctors balance busy schedules and spend time with patients.

Watch our video at brainshark.com/bcbsm/patientcommunication.



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Help patients get annual health screenings

Here's a checklist to help patients start off the New Year by taking care of their health.

- Record a body mass index for every patient. All patients under 20 years old need a BMI percentage, including height and weight. For children 3 to 17, provide counseling for nutrition. Complete the checklist verifying the discussion. Don't forget to provide counseling for physical activity and complete the checklist verifying the discussion.
- For diabetics, check HbA1c, nephropathy monitoring (urine for protein **or** on ACE/ARB meds, **or** renal diagnosis), blood pressure and encourage patient to schedule a diabetic eye exam. Schedule follow-up visits as results indicate.



- For patients with hypertension, follow-up on medication regime, document lifestyle changes and do blood pressure checks to ensure appropriate management
 - 18 to 59 years old BP 139/89 or less
 - 60 to 85 years old with a diagnosis of diabetes BP 139/89 or less
 - 60 to 85 years old without a diagnosis of diabetes BP 149/89 or less
- Review history and order colon cancer screening test, if needed (age 50 to 75, colonoscopy every 10 years). For patients who refuse a colonoscopy, suggest they complete a FOBT.
- For all females from 50 and 74, order a mammogram (if haven't had one for 27 months). Order cervical cancer screening for females 21 to 64 (if they haven't had one in three years or five years). If last Pap and HPV test were done together on the same date of service, patients must be 30 years old on the date of service of the Pap/HPV to meet the five-year interval requirement.
- Discuss the need for physical exercise – 30 minutes a day
- Talk to seniors about their fall risks and offer tips for a safe home environment.
- Do a depression assessment.
- Check immunization records for children and adolescents on MCIR and schedule visits to complete immunizations.

Blue Care Network appreciates your efforts to keep our members healthy.

For information on preventive services, please call Quality and Population Health at HEDIS message-line at 1-855-228-8543.

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Blue Care Network and Blue Cross to cover online behavioral health visits

We're adding mental health services to our Blue Cross® Online VisitsSM to offer members an alternative to in-person behavioral health office visits, effective Jan. 1.

Blue Cross Online Visits will increase access to mental health services, especially in rural counties where there's limited access. It's also useful for patients who aren't as comfortable with counseling in a face-to-face setting.

Health care practitioners in our networks can continue to conduct telemedicine visits with an authorization as they do now. Physicians who already provide or want to provide their own telemedicine services should review the Blue Cross **Telemedicine** policy and the BCN **eVisits** and **Telemedicine** policies.

Blue Cross Online Visits, formerly called 24/7 online visits (powered by AmericanWell®), will include scheduled appointments with therapy and psychiatry providers. Video-only sessions will last 45 minutes; phone options aren't available. In most cases, members will have the same cost-share as their current outpatient behavioral health benefit. The one exception is Blue Cross Community Blue groups — the cost share for online mental health visits must be *equal to or less than* the office visit cost share.

A new online app — BCBSM Online Visits — will replace the Amwell app that we previously used for medical online visits.

Online visits offered through this service don't include treatment for substance abuse disorders or urgent and emergency behavioral health issues.

Members talk with a practitioner through a secure web-based video application that's compliant with the Health Insurance Portability and Accountability Act. Visits are confidential and compliant with the federal mental health parity rules.

Who is eligible?

- Therapy: Children 10 and older by appointment from 7 a.m. to 11 p.m., seven days a week.
- Adults (therapy and psychiatry) 18 and older by appointment only. (Extended hours during evenings and on weekends may be available.)

Psychiatrists can conduct diagnostic interviews and prescribe and manage medications. American Well doctors, however, don't write prescriptions for controlled substances or lifestyle medications.

Please see [Online visits](#), continued on Page 24

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Online visits, continued from Page 23

Who doesn't have access to Blue Cross Online Visits:

- Medicaid; Medicare Advantage (group and individual); MiChild
- Non-exact fill Medicare Supplemental; Medigap
- PPO Federal Employee Program
- FlexLink groups
- Specialty products, such as dental, vision and hearing.

Reminder: Behavioral health documentation guidelines now available

Contracted behavioral health providers must follow guidelines we recently published when documenting behavioral health services provided to members. These guidelines apply to services for BCN HMOSM (commercial), BCN AdvantageSM, Blue Cross PPO (commercial) and Blue Cross Medicare Plus BlueSM members. They were developed for all products to make it easier for providers to locate and follow.

For details, see the **article** in the Nov.-Dec. 2017 issue.

Check web-DENIS for coverage

Follow these steps to verify that your **Blue Care Network patient** has coverage for online behavioral health visits and find the office visit copay:

1. Go to web-DENIS.
2. Under *Subscriber Info.*, click *Eligibility/Coverage/COB*, type in the contract number, check the Blue Care Network Line of Business and click *Enter*.
3. Click on the member's name.
4. Click *Medical Benefits*.
5. Scroll down to *Mental Health Outpatient* to view the benefits.

To check coverage for **Blue Cross members**:

1. Log in to web-DENIS.
2. Type the member's ID for eligibility and click on the detailed benefits button that takes you to Benefit Explainer.
3. Enter the procedure code to verify that the procedure is payable.

Or you can check benefits through the Provider Automated Response System, or PARS, at 1-800-344-8525.

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Blue Care Network to continue Behavioral Health Incentive Program in 2018

Blue Care Network will continue the Behavioral Health Incentive Program in 2018. The measures are the same, but we are phasing out manual submissions. Manual submissions for both the therapeutic alliance measure and the PCP contact measure will be accepted through June 30, 2018. After that date, only electronic submissions will be accepted.

As part of the phase-out process, incentive amounts for manual submissions will decrease slightly.

We encourage providers who are not yet submitting self-reported forms electronically to review instructions for electronic submission on web-DENIS. You may also reach out to your provider consultant with any detailed questions. We are committed to helping providers with this transition.

Quality Incentive Measures	Payment	Intake period	Provider Action
Follow-up after hospitalization	\$100	1/1 – 10/31/18	None – claims data
Anti-depressant medication management — acute	\$75	1/1 – 4/30/18	None – claims data
Anti-depressant medication management — continuation	\$100	1/1 – 4/30/18	None – claims data
Pharmacotherapy adherence for bipolar disorder	\$100	1/1 – 12/31/18	None – claims data
Appropriate glucose monitoring	\$100	1/1 – 12/31/18	None – claims data
Use of first-line psychosocial care for children and adolescents on antipsychotics	\$100	1/1 – 12/31/18	None – claims data
Therapeutic alliance — MANUAL submission	\$15	1/1 – 6/30/18	Submit forms
-OR-			
Therapeutic alliance — ELECTRONIC submission	\$35	1/1 – 12/31/18	Submit data via Excel
Primary care physician contact — MANUAL submission	\$30	1/1 – 6/30/18	Submit forms
-OR-			
Primary care physician contact — ELECTRONIC submission	\$50	1/1 – 12/31/18	Submit data via Excel

The 2018 booklet, forms, and instruction guides will be available on web-DENIS starting in January. To find the documents:

- Log into web-DENIS and go to *BCN Provider Publications and Resources*.
- Click on *Behavioral Health* under Resources.
- Scroll down to Behavioral Health Incentive Program.

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Best Practices

Team approach keeps breast cancer screening rates high

A unique approach to caring for patients has resulted in a near-perfect breast cancer screening rate at Briarwood Medical Group in Ann Arbor. Using a team-based approach to care means specific staff members work in dedicated care teams with the physicians to provide care for patients' screening needs and chronic conditions.

"One of the most important things we did a few years ago was to transition to a team-based approach to care," says Dr. Linda Terrell, medical director at Briarwood Medical Group, an outpatient general medicine clinic that is part of Michigan Medicine.

"My medical assistant, nurse, the LPN and case manager work together to manage a panel of patients. It's not possible for one person to be responsible for ensuring the quality of care for more than a thousand patients."

As part of the team approach, the medical assistant reviews the schedule with the doctor at the beginning of each day to see which health screenings or tests the patients need. "The assistant queues up those orders and reminds me to discuss it with the patient," says Dr. Terrell.

The practice has 12,000 patients and 10 physicians. Transitioning to team-based care first meant getting the buy-in of all the physicians, nurses and staff in the practice. "It was a big leap of faith," says Dr. Terrell. Moving to a new approach to care also necessitated physical moves within the practices so doctors' offices could be near their care teams, rather than the doctors being peripherally located.

"There's a lot to gain by having consistency of communication and staffing," she says. "My patients know



**Dr. Linda Terrell
and patient Lesa Huget.**

my nurse and medical assistant are speaking for me. Prior to this team-based approach, we had a nurse call center and patients might talk to a different nurse each time they called.

"The team approach is also a significant patient satisfier," continues Dr. Terrell. "My patients know my medical assistant by name and she greets them at each of their visits with me. They know who to connect with and that she represents me. Therefore, it's very important that team members are strong and committed to excellent patient care."

The team approach is also valuable in this particular practice because the office serves an older population. Many of Dr. Terrell's patients are of Medicare age. Therefore, a lot of time is spent managing acute medical issues as well as on chronic disease management, she explains.

Screenings are still a priority at the practice, though. Dr. Terrell uses the Epic-based electronic medical records to track when patients are due for screenings. "We also pick a focus quality measure of the month that we're working on at the clinic level to help keep the staff motivated toward pursuing a specific goal," she says.

One challenge to screening is the recent controversy about the appropriate interval for breast cancer screening, says Dr. Terrell. This can become confusing for patients and often takes some time to explain in detail.

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"Regular breast cancer screening may not be right for everyone," she says. "There are some who don't care to do the screening, and part of being a PCP is understanding each patient's values. We review family history, current health status, patient priorities and other risk factors to help determine the intervals that are appropriate for that particular patient."

Dr. Terrell is a proponent of yearly visits and she believes it's critical to a rich, long-term doctor-patient relationship. "Those visits provide a time and format to explore patients' beliefs and values, discuss the importance of lifestyle interventions in health and disease, deliver patient education and establish a dialogue surrounding management of their chronic health issues," she says.



From left, Carly Ross, RN; Meghan Moore, administrative manager; Dr. Linda Terrell; and Mandi Urbanski, medical assistant.

MQIC releases new guidelines for opioid use in adults

The Michigan Quality Improvement Consortium has issued a new guideline, *Opioid Use in Adults Excluding Palliative and End-of-Life Care*. The guideline is sourced from the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.

MQIC's vision remains as a collaborative approach to develop and implement evidence-based clinical practice guidelines. Its mission is to provide a core set of guidelines, achieve consistent delivery of evidence-based services and, most importantly, better health outcomes. The guideline provides concise recommendations to encourage appropriate prescribing, or discontinuation of opioids.

You can review it at the [MQIC](#) website.

January is Cervical Cancer Awareness Month

Please remind your female patients 21 to 64 years old about the benefits of routine cervical cancer screenings.

Recommendation	When
Cervical cancer screening	<ul style="list-style-type: none"> Ages 21 to 64: Perform cervical cytology every three years Ages 30 to 64: Perform cervical cytology and human papillomavirus co-testing every five years. Hysterectomy with no residual cervix, cervical agenesis or acquired absences of cervix any time during the patient's history will exclude them from the cervical cancer screening recommendations. <p>*Reflex HPV tests are not considered co-testing.</p>
Chlamydia screening	<ul style="list-style-type: none"> Ages 16 to 24: Perform chlamydia testing on sexually active females annually

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Quality Improvement program information available upon request

We provide you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all Blue Care Network primary care physicians, primary care groups and specialists. Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

- Log into web-DENIS.
- Click on *BCN Provider Publications and Resources*.
- Click on *Clinical Practice Guidelines*.

The **Michigan Quality Improvement Consortium guidelines** are also available on the organization's website. BCN promotes the development, approval, distribution, monitoring and revision of uniform evidence-based clinical practice guidelines and preventive care guidelines for practitioners. We use MQIC guidelines to support these efforts. These guidelines facilitate the delivery of quality care and the reduction in variability in physician practice and medical care delivery.

Our Quality Improvement Program encourages adherence to MQIC guidelines and offers interventions focusing on improving health outcomes for BCN members. Some examples include member and provider incentives, reminder mailings, telephone reminders, newsletter articles and educational materials. We use medical record reviews and quality studies to monitor compliance with the guidelines.

In 2017, BCN (commercial HMO) ranked in the top 10 percent of all health plans nationally on the following HEDIS measures that address important health improvement goals:

- Adult BMI assessment
- Weight assessment and counseling for nutrition and physical activity for children/adolescents
- Comprehensive diabetes care – nephropathy and BP control

- Non-recommended cervical cancer screening in adolescent females
- Pharmacotherapy management of COPD – systemic corticosteroids
- Persistence of beta blocker treatment after a heart attack
- Follow-up care for children prescribed ADHD medications
- Postpartum care
- Use of spirometry testing in the assessment and diagnosis of COPD

Some measures that scored as needing improvement included:

- Pharmacotherapy management of COPD – bronchodilator
- Initiation and engagement of alcohol and other drug dependence treatment

In 2017, BCN Advantage received 4 or 5 stars in the CMS Star rating or the NCQA 90th percentile on the following HEDIS measures that address important health improvement goals:

- Adult BMI assessment
- Breast cancer screening
- Colorectal cancer screening
- Use of spirometry testing in the assessment and diagnosis of COPD
- Comprehensive diabetes care – blood sugar controlled, eye exams and nephropathy
- Osteoporosis management in women who had a fracture
- Medication reconciliation post discharge
- Plan all-cause readmissions

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Quality Improvement, continued from Page 28

Some measures that scored as needing improvement included:

- Potentially harmful drug-disease interactions in the elderly
- Pharmacotherapy management of COPD – bronchodilator
- Comprehensive diabetic care – HbA1c testing
- Persistence of beta blocker treatment after a heart attack

As a part of our focus on achieving positive health outcomes, the quality improvement program addresses potential quality of care concerns such as patient safety, medical errors and serious adverse events for all products to ensure investigation, review and timely resolution of quality issues.

To ensure accessibility of care to our members, BCN has access and availability standards for the following types of appointments: Preventive care, routine primary care, non-life threatening emergent and urgent care, and after-hours access. Access monitoring is conducted throughout the year by quality management staff. Physicians who are noncompliant with access standards are given the opportunity to correct their noncompliant status. More information is available in the *BCN Provider Manual*. Log in to web-DENIS, click on *Provider Manual* and open the *Access to Care* chapter.

If you'd like additional information about our programs or guidelines, please contact our Quality Management department via email at BCNQIQuestions@bcbsm.com. You may also call us at 248-455-2714.

Prepare for HEDIS record reviews

Annual HEDIS® 2018 data collection will start the first week in February and continue through the last week in April. Blue Care Network nurses and medical coders will contact some of our affiliated practitioner locations, either by telephone or fax, to request copies of medical records or schedule a visit to review medical records.

Thank you for your contribution toward providing quality care to our members and for allowing the BCN staff to conduct medical record reviews.

If you have any questions related to HEDIS, call the Blue Care Network HEDIS message line at 1-855-228-8543.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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Controlling high blood pressure and A1c testing

Hypertension and diabetes are two of many HEDIS® accreditation measures for health plans.

The Controlling High Blood Pressure measure looks at members 18 to 85 years of age with a diagnosis of hypertension and a blood pressure reading of:

Reading	Age
138/89 mm Hg or less	18-59
138/89 mm Hg or less	60-85 with diabetes
149/89 mm Hg or less	60-85 without diabetes

Blood pressure readings

- A representative blood pressure is the most recent BP reading taken during the measurement year (by Dec 31) and it occurs after the date of service in which the diagnosis of hypertension occurred. If multiple readings occur in a single visit, the lowest systolic and lowest diastolic is the representative blood pressure and determines BP control.
- Reported blood pressure readings taken by your patient are not considered accurate in diagnosing hypertension.
- Record all blood pressures taken during a visit and if initial BP is high (140/90 or 150/90 or higher for age/condition range), make sure to record second BP reading, if taken.
- Do not round up blood pressure readings.
- Do document lifestyle modifications and treatment changes in member's medical record, for example changes in medication dosage, diet, exercise and smoking cessation.

- Initiate pharmacologic anti-hypertensive treatment that includes angiotensin-converting enzyme inhibitor (ACEI), or angiotensin receptor blocker (ARB) if lifestyle changes are not effective.
- Make sure the correct cuff size is used:

Indications	Arm circumference (inches)	Arm circumference (cm)
Small adult	9-10	22-26
Standard adult	11-13	27-34
Large adult	14-17	35-44
Adult thigh	18-21	45-52

- Calibrate blood pressure device regularly according to manufacturer's recommendations.

Diabetic HbA1c testing

- For the Comprehensive Diabetes Care measure, members age 18 to 75 identified as having diabetes should have a HbA1c test every six months with a goal of at least 7.9 or below.
- Follow-up visits and testing should be done every three months until the goal is reached.

If you would like more information about HEDIS, call the BCBSM Quality & Population Health department HEDIS message line at 1-855-228-8543.

References:

http://millionhearts.hhs.gov/Docs/NYC_HHC_Hypertension_Protocol.pdf

HEDIS® 2018 Technical Specifications for Health Plans

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Blue Cross, BCN won't cover some drugs effective Jan. 1

To address the high cost of drugs and provide the best value for our members, while maintaining quality care, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans are removing select drugs from our Custom Select drug list that have more cost-effective therapeutic alternatives available.

To the right we've listed the drugs that we're removing from our Custom Select drug list effective Jan. 1, 2018, along with some covered alternatives.

This change:

- Affects high-cost drugs for which more cost-effective therapeutic alternatives are available
- Provides the best value for our members

As part of this ongoing initiative, Blue Cross and BCN will continue to identify select high-cost drugs and will stop covering them when there are more cost-effective alternatives available for our commercial members.

Common drug use/ drug class	Drug not covered beginning Jan. 1, 2018	Alternatives
Vaginal antifungal	AVC[®] vaginal cream	<ul style="list-style-type: none"> • Fluconazole (Diflucan[®]) oral • Terconazole (Terazol[®]) vaginal cream and suppository
Urinary antispasmodic	Enblex[®]	<ul style="list-style-type: none"> • Oxybutynin (Ditropan[®], Ditropan[®] XL) • Tolterodine (Detrol[®], Detrol[®] LA) • Trospium (Sanctura[®], Sanctura[®] XR)
Migraine treatment	Ergomar[®]	<ul style="list-style-type: none"> • Dihydroergotamine (D.H.E. 45[®], Migranal[®]) • Ergotamine/cafeine (Cafergot[®], Migergot[®])
Pain management	Fenortho[®] 200mg, 400mg	<p>Generic oral nonsteroidal anti-inflammatories (NSAIDs)</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Diclofenac (Voltaren[®]) • Etodolac (Lodine[®], Lodine[®] XL) • Fenoprofen 600mg (Nalfon[®]) • Ibuprofen (Motrin[®] – Rx only) • Meloxicam (Mobic[®]) • Naproxen (Naprosyn[®]) • Piroxicam (Feldene[®])
Gastrointestinal	Kristalose[®]	Lactulose
Respiratory treatment	Nebusal[®]	Generic sodium chloride inhalation 3%, 7% and 10%
Bowel preparation and cleansing	Osmoprep[®] Prepik[®]	Generic polyethylene glycol-electrolyte solution (Colyte [®] , Golytely [®] , Halflytely [®] -bisacodyl, Nulytely [®])
Digestive enzymes	Pancreaze[®] Pertyze[®] Viokace[®]	Pancrelipase (Creon [®] *, Zenpep [®] *)
Vitamin	Phytonadione syringe	Phytonadione ampule
Insomnia	Seconal[®]	<ul style="list-style-type: none"> • Eszopiclone (Lunesta[®]) • Temazepam (Restoril[®]) • Zaleplon (Sonata[®]) • Zolpidem (Ambien[®], Ambien[®] CR)
Topical antiviral	Zovirax[®] cream	<ul style="list-style-type: none"> • Penciclovir cream (Denavir[®]*) • Famciclovir tablets (Famvir[®]) • Valacyclovir tablets (Valtrex[®])

*Indicates that there is no generic version of the alternative drug currently available

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Blue Cross and Blue Care Network will no longer cover hyaluronic acids, starting April 1

To provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans will not cover hyaluronic acids, beginning April 1, 2018.

Hyaluronic acids, also known as viscosupplements, are used to treat osteoarthritis of the knee.

A large body of evidence from randomized controlled trials and national guidelines have examined the effect of hyaluronic acids on pain and function. The combined data shows:

- A lack of defined meaningful clinical improvements over placebo
- Well-characterized biases among trials
- Publication bias
- Missing study results

These contributing factors conclusively determine there is insufficient evidence that hyaluronic acid therapy improves the net health outcome in patients with knee osteoarthritis.

J code	Drug description
J7320	Hyaluronan or derivative, GenVisc® 850 for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, Hyalgan® for Supartz™ for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis® for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa® for intra-articular injection, per dose
J7324	Hyaluronan or derivative, Orthovisc® for intra-articular injection, per dose
J7325	Hyaluronan or derivative, Synvisc® or Synvisc-One® for intra-articular injection, 1 mg
J7326	Hyaluronan or derivative, Gel-One® for intra-articular injection, per dose
J7327	Hyaluronan or derivative, Monovisc® for intra-articular Injection, per dose
J7328	Hyaluronan or derivative, Gel-Syn™ for intra-articular injection, 0.1mg

Blue Cross and BCN will continue to provide coverage for first-line alternative therapies based on guideline recommendations for treatment of pain in knee osteoarthritis.

To get information on the types of covered drug therapy for pain management, refer to our approved **drug list**.

Note:

- These changes do not apply to Medicare and Medicaid members.
- If you've been prescribing hyaluronic acid therapies, be sure to complete all regimens prior to April 1, 2018. After April 1, 2018, no further coverage will be provided for these injections.



Blue Cross and BCN not covering select high-cost insulins that have comparable alternatives

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans won't cover all formulations of the following insulin products for the Custom Select drug list, effective Jan. 1, 2018:

- Apidra®, Apidra® Solostar®
- Humalog® (except Junior KwikPen), Humalog® Mix
- Humulin® (except U-500), Humulin® Kwikpen®

Members currently using these insulin products can continue to fill prescriptions for them through Feb. 28, 2018 so they have time to talk to their providers about treatment options.

Insulin products of the same type are interchangeable and work the same to lower A1c. The following table includes covered comparable alternatives available at a lower cost to the member:

Insulin products not covered beginning Jan. 1, 2018	Cost to Blue Cross (PPO) member	Cost to BCN (HMO) member
Apidra®, Apidra® Solostar	Full cost (not covered)	Full cost (not covered)
Humalog® (except Junior KwikPen), Humalog® Mix		
Humulin® (except U-500), Humulin® Mix		
Covered alternatives	Cost to Blue Cross member	Cost to BCN member
Novolin® (all forms)	Preferred brand copayment	Generic copayment
Novolog®, Novolog® Mix		

BCN limits first fills of short-acting opioids to five days

In response to the opioid crisis, Blue Care Network continues to look for ways to combat the overuse and over-prescribing of opioid painkillers. Last year BCN limited opioid pain relievers to a 30-day supply and first fills of short-acting opioids to 15 days for commercial members.

Effective Feb., 1, 2018, BCN will lower the first fill limit of 15 days down to five days for short-acting agents such as Vicodin® and Tylenol #3®. Subsequent fills can be up to a 30-day supply.

Studies have shown that taking opioids for only a matter of days can lead to long-term use. Each additional day of therapy increases the risk for chronic opioid use. Initial opioid prescriptions of at least one day, eight days or 10 days can lead to long-term use in 6 percent, 13.5 percent

and 20 percent of patients respectively. To simplify, one in five patients receiving an initial 10-day supply opioid prescription will continue to use long-term.¹ Opioids should be limited to the shortest duration possible, and for acute pain less than seven days (ideally ≤ three) according to Centers for Disease Control and Prevention guidelines.

BCN recommends providers continue to use the Michigan Automated Prescription System when prescribing opioid prescriptions. Registration for **MAPS** online takes only a few minutes and reports can be requested at any time.

These changes don't apply to BCN AdvantageSM members.

1. Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: <http://dx.doi.org/10.15585/mmwr.mm6610a1>.

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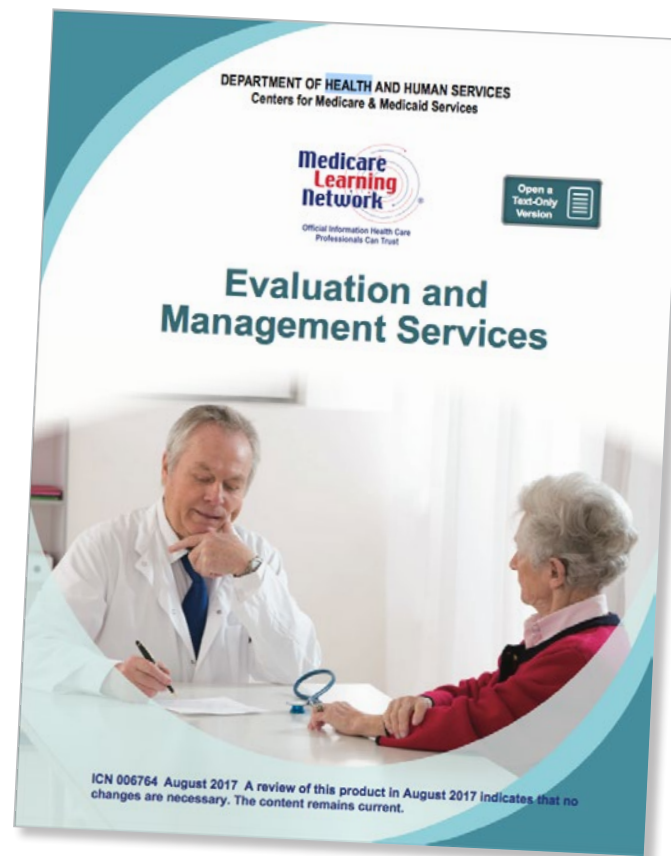
Blue Care Network mails letters to physicians to address over-coding

In December 2015, Blue Care Network instituted a clinical editing program to address the high incidence of over-coding for certain evaluation and management services. The program is evaluated periodically and includes only those physicians that are identified as outliers.

The program was updated Feb. 15, 2017, and will again be updated Jan. 3, 2018. Updates will occur every six months. BCN has mailed letters to newly selected physicians explaining the clinical editing process. We're not making any changes for physicians currently in the program.

BCN recommends that physicians carefully code each service provided according to national guidelines and that the office documentation supports the code reported. Learn more about the coding guidelines, including the evaluation and management documentation, in the Center for Medicare & Medicaid Services ***Evaluation and Management Services Guide***.

If you disagree with a clinical edit on an evaluation and management service, you have a right to file an appeal. Follow the clinical editing appeal process as described in the *BCN Provider Manual Claims* chapter. BCN will review the medical records submitted and assess the intensity of service and complexity of decision-making for the evaluation and management services documented. BCN will make a determination based on the documents and the medical necessity of the evaluation and management service.



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[Feedback](#)**Question:**

Some of the codes I bill have time units. It's not always clear in the record how much time was spent providing the service. For example, our office will do nutrition counseling. How do I know which code to report or how much time to document?

Answer:

First, the service being provided must be clearly documented in the patient's record. Second, the time spent providing that service must also be documented. While the record does not need to record a start and end time, it does need to state the amount of time devoted to that service. For a time-based code to be reported, the time spent providing the service must exceed half of the time described in the code. For example, a code that describes 30 minutes, the provider must spend and document at least 16 minutes providing the service.

In the example you provided, two of the codes for nutrition counseling, the individual initial assessment and the individual reassessment, are both timed codes at 15 minutes. In identifying which code to report, you would need to identify if this was the first nutritional review with the patient and how much time was spent with the patient. It needs to be documented in the medical record.

See the following examples.

Example 1: "Reviewed patient's dietary sheet and made recommendations for changes to meal plans." This documentation does not provide enough information to allow for separate coding of nutrition counseling. Information lacks detail and does not provide time components.

Example 2: "Spent 24 minutes reviewing patient's dietary sheet, subsequent to last visit when education was provided regarding diabetic education. Noted better compliance, but still needs improvement with coordinating meals due to work schedule. Recommendations provided. Will follow-up at next visit and review next diet sheet."

Example 2 indicates that the provider was doing a reassessment and would need to report two units of the nutrition counseling code. The reason for the two units: Each unit is 15 minutes and while the provider did not go the full 15 minutes for the second unit, the time spent exceeded half the time.

Question:

I am a behavioral health provider, but sometimes my claims seem to get held up. Most seem to be when the diagnosis falls out of the behavioral health ICD-10 range, but is still related. One example that seems to cause an issue is the diagnosis of suicidal ideation. That is one we report, but it will not pay without an inquiry. What do we need to do?

Answer:

Suicidal ideation is not a diagnosis code that falls within the "Mental, Behavioral and Neurodevelopmental Disorders" Chapter of the ICD-10-CM Manual. This chapter outlines the diagnosis codes which have been defined by our plan as the ones that should be reported as the primary diagnoses for behavioral health and substance abuse conditions.

While suicidal ideation, which is represented by ICD-10 code R45.851, is experienced by patients seeking behavioral health services, it is considered to be a symptom of an emotional state. As such, the appropriate primary diagnosis needs to be reported.

To facilitate timely and accurate claims processing of behavioral health and substance abuse claims, the primary diagnosis reported should be from the "Mental, Behavioral and Neurodevelopmental Disorders" Chapter of the ICD-10-CM Manual and fall between F01 and F99. Other supporting codes, indicating signs and symptoms the patient may be experiencing, should be reported as secondary diagnoses.

Please see [Billing Q&A](#), continued on Page 36

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Billing Q&A, continued from Page 35

Question:

I do billing for a specialist. If he sees a patient in a nursing home, sometimes I need to get an authorization, but sometimes I don't. Is there an easy way for me to know when I need to call in or have the primary care physician get an authorization, so I can do the billing for the care my specialist is providing to the patient?

Answer:

To help know what type of authorization is required you need to determine if the patient is in a skilled nursing placement or a basic or custodial care setting and if the patient has commercial or BCN Advantage coverage.

When a patient with commercial or BCN Advantage coverage is in a skilled nursing care facility and an authorization has been provided for the patient's inpatient stay, a separate authorization isn't required for most professional services. If we have authorized the inpatient care, medically necessity for the patient's care falls under that authorization. The place of service for skilled nursing care is reported as location 31.

If a patient with commercial coverage is in a basic or custodial nursing home placement, this is reported as location 32. In many instances, this is considered the patient's home. It's not an authorized or covered admission by the health plan, and will require that a referral be issued by the patient's PCP.

When a patient with BCN Advantage coverage is in a basic or custodial nursing home placement, no referral is required.

It's important to note that the above information is related to standard visits provided in a nursing facility. Any services or procedures that are subject to pre-authorization (for example, potentially cosmetic services) would still require clinical review by the health plan.

Question:

Is there a new BCN medical policy for Lemtrada® (alemtuzumab)?

Answer:

For BCN commercial members, Lemtrada® requires prior authorization. The authorization for these members is handled within the Novologix tool.

In general, the guidelines for administration provide diagnosis and age restrictions, ordering physician qualifications, as well as a need for lab results and treatment history. For specific and current information regarding criteria, please refer to the "Drugs Covered Under the Medical Benefit" page on [e-referral](#).

Currently, Lemtrada requires pre-authorization for BCN commercial members, but not for BCN Advantage members.

Have a billing question?



If you have a general billing question, we want to hear from you. Click on the envelope icon to open an email, then type your question. It will be submitted to *BCN Provider News* and we'll answer your question in an upcoming column, or have the appropriate person contact you directly. Direct urgent questions to your provider consultant. Don't include any personal health information, such as patient names or contract numbers.

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Providers must submit functional limitation G codes for BCN Advantage PT, OT and ST services

When billing outpatient physical, occupational and speech therapy services for BCN AdvantageSM members, you must report the nonpayable functional limitation G codes and their applicable modifiers.

It's important to report the modifiers for the nonpayable G codes as secondary to the modifiers for the primary codes. If you report these modifiers as primary, it will cause an error in our payment system and the claim will be denied.

Here's an example of the how to report these codes and modifiers correctly:

- 1 Report as primary:** In the line item, report the BCN Advantage modifier for the type of therapy (physical, occupational or speech) along with the G code.
- 2 Report as secondary:** In the "Additional Modifiers" box, report the required Centers for Medicare & Medicaid Services modifier.

Functional G codes and their modifiers tell us about the member's status throughout the episode of care as compared to his or her goals. They give us a fuller picture of the member's conditions, expected and actual outcomes, and expenditures.

At one time, reporting functional limitation G codes and their modifiers were optional for BCN Advantage. However, we've made payment system updates that make it necessary to report these codes. We'll revise the *BCN Provider Manual* and related documents to show this change.

If you have questions, call your provider consultant.

1 04/12/2017 04/12/2017 0420 TPM G8991GP 1 \$0.00 E11622

2 Additional Modifiers

Line	From	To	Rev	Tos	Dx	Proc	Charges	Units
7	04/12/2017	04/12/2017	0420	TPM	E11622	G8991GP	\$0.00	1

Modifier

2nd ☒ CK 3rd ☐ PO 4th ☐

OK Cancel Previous Next Help

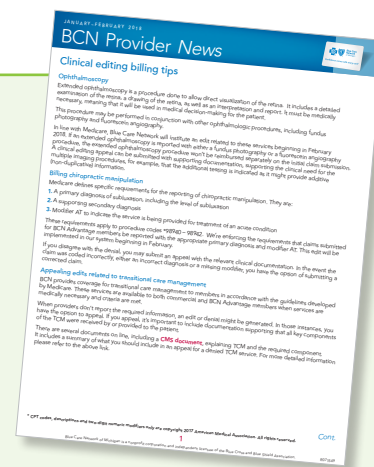
Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

To view the full content of the tips, click on the *Clinical editing billing tips* below.

This issue's billing tips include the following:

- Ophthalmoscopy
- Billing chiropractic manipulation
- Appealing edits related to transitional care management



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The Centers for Disease Control and Prevention reports that approximately 15.7 million Americans have been diagnosed with chronic obstructive pulmonary disease. The prevalence of COPD, coupled with the increased specificity required by ICD-10-CM, makes documenting the disease and any respiratory conditions currently associated with it imperative to ensure the appropriate diagnosis code is applied.

The two common forms of COPD are emphysema and chronic bronchitis. However, many patients diagnosed with COPD have both emphysema and chronic bronchitis.

Important tips to remember

- Always document and code to the highest level of specificity and report diagnosis codes at their highest number of characters available. For example, if the provider documents “acute bronchitis” or “chronic bronchitis” (both unspecified), then report ICD-10-CM codes J20.9 and J42, respectively. However, if the provider doesn’t indicate whether the bronchitis is acute or chronic, the appropriate ICD-10-CM code would be J40 (bronchitis not specified as acute or chronic). It’s important to indicate, through coding, whether the condition is acute, chronic or in acute exacerbation.
- Since COPD-related conditions can be coded in a variety of ways, the final code selection must take into account the specific details of the patient’s condition as documented by the health care provider.
- ICD-10-CM code J44.9 (chronic obstructive pulmonary disease, unspecified) should only be used if the information in the medical record is insufficient to assign a more specific code.
- When COPD with an acute exacerbation is documented **without** acute bronchitis, then report ICD-10-CM code J44.1 (chronic obstructive pulmonary disease with acute exacerbation).
- Code J44.0 (chronic obstructive pulmonary disease with acute bronchitis) is assigned when the medical record supports acute bronchitis and COPD. (An additional code is used to identify the infection.)

Please see [Coding Corner](#), continued on Page 39

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ICD-10-CM code	ICD-10-CM Nomenclature
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.9	Emphysema, unspecified
J44.-	Other chronic obstructive pulmonary disease J44.0 COPD with acute lower respiratory infection J44.1 COPD with (acute) exacerbation J44.9 COPD, unspecified
J45.-	Asthma (additional fifth and/or sixth characters required) J45.2- Mild intermittent asthma J45.3- Mild persistent asthma J45.4- Moderate persistent asthma J45.5- Severe persistent asthma J45.9- Other and unspecified asthma
R09.02	Hypoxemia
Z43.0	Encounter for attention to tracheostomy
Z93.0	Tracheostomy status
Z99.81	Dependence on supplemental oxygen

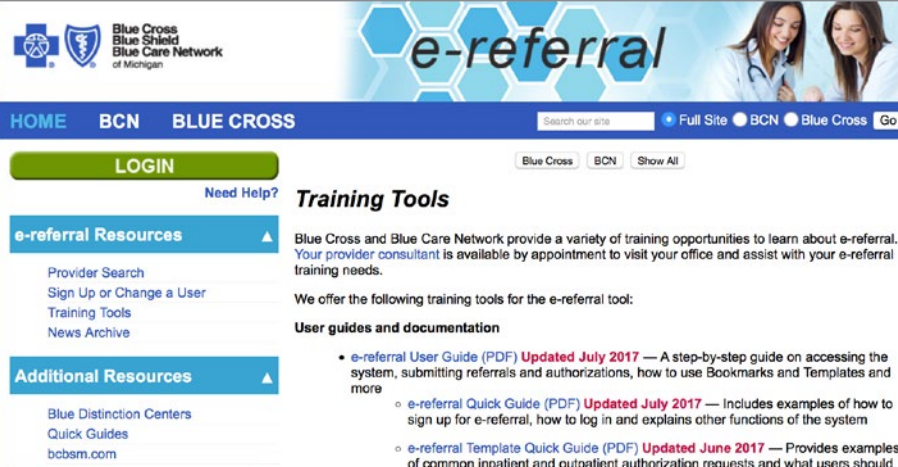
It's important to review the *ICD-10-CM Chapter Specific Coding Guidelines* (Chapter 10: Diseases of Respiratory System J00-J99) and any instructional notes under the various COPD subcategories and codes in the tabular list of the ICD-10-CM manual to select the correct code. In addition to the codes listed above, you may need to use additional codes to identify current or previous tobacco usage and dependence or other environmental exposure.

Note: ICD-10-CM coding for all conditions should follow the ICD-10-CM Official Guidelines for Coding and Reporting.

ICD-10-CM diagnosis codes and ICD-10-CM Official Guidelines for Coding and Reporting are subject to change. It's the responsibility of the provider to ensure that current ICD-10-CM diagnosis codes and the current ICD-10-CM Official Coding Guidelines for Coding and Reporting are reviewed prior to the submission of claims.

Keep in mind that none of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

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Have questions about our e-referral tool? Check out our training tools

Recently, we've received some questions from health care providers seeking assistance with the e-referral tool used to submit referrals and authorizations. Here's a list of the many training opportunities available on the **e-referral** site.

On the **Training Tools** page, you'll find the:

- **e-referral User Guide** (PDF), a step-by-step guide on accessing the system, submitting and more
- **e-referral Quick Guide** (PDF), a simple how-to guide on getting started
- **Behavioral Health User Guide** (PDF), a step-by-step guide for behavioral health providers
- **Blue Cross® Physician Choice PPO User Guide** (PDF), specifically for Physician Choice PPO authorizations
- **FAQs for using the e-referral system** (PDF), a useful guide for Blue Cross providers
- Online **self-paced learning** modules
- Physician Choice PPO **online training** presentation

If you still have questions after reviewing these resources, reach out to your **provider consultant**.

We're changing the way we describe care management

We're changing the way we use care management terms to make it easier for you to find the information you need.

Here are some examples of the changes we're making in the *BCN Provider Manual*:

- "Clinical review requirements" are now called "authorization requirements."
- "Utilization Management" is the new name of BCN's Care Management department.

During the first months of 2018, you'll see these wording changes in all chapters of the *BCN Provider Manual* and in related BCN documents.

Here are other examples of changes we're making:

- *BCN Referral and Authorization Requirements* is the new name for the *BCN Clinical Review & Criteria Charts* document.
- *Woman's Choice Referral and Authorization Guidelines* is the new name for the *Woman's Choice Referral and Clinical Review Guidelines* document.

You can find both these documents at **ereferrals.bcbsm.com**. Click *BCN* and then click *Authorization Requirements & Criteria*, which is the new name for the Clinical Review & Criteria Charts page.

These changes are just the first in a series being released throughout 2018 designed to bring greater consistency across lines of business to the language in our provider manuals and in the other documents we use to communicate with you about how to do business with Blue Cross and BCN.

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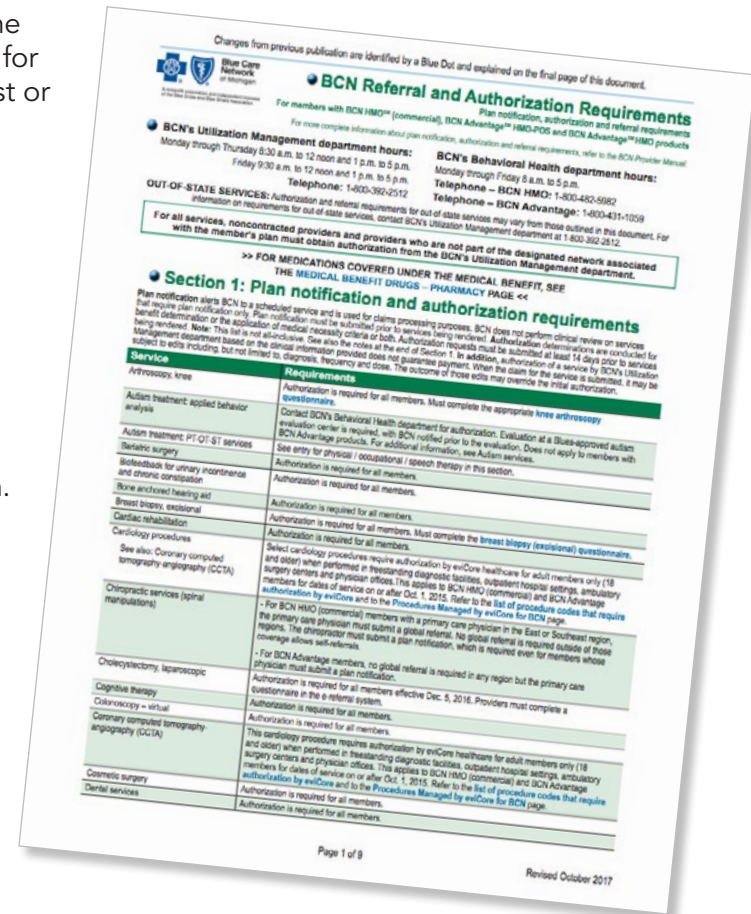
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How regional authorization and referral requirements apply

As a rule, physicians must follow the authorization and referral requirements that apply to the region in which their medical care group headquarters is located. This means, for example, that a physician office located in the Mid or West region must follow the authorization and referral requirements for the East or Southeast region if the headquarters for their medical care group is located in the East or Southeast region.

Because the authorization and referral requirements differ from region to region, it's important that physicians are aware of which requirements they must follow. These requirements are summarized in the **BCN Referral and Authorization Requirements** document. This document is available online at ereferrals.bcbsm.com. Click **BCN** and then click **Authorization Requirements & Criteria** in the left navigation. Finally, click **BCN Referral and Authorization Requirements** to open the document.



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How to upload clinical information when re-entering the eviCore healthcare online provider portal

You can now upload and submit clinical documentation for a pending authorization request through the eviCore online portal even after you've left the case. The eviCore provider portal has always allowed clinical information to be attached when you're first submitting the authorization request, after the case is pended. But now you can attach it after you've left the case and returned to it.

This applies to authorization requests submitted for both Blue Cross and BCN members.

Here's how to upload clinical information online when you've left the portal and returned to a case that's been pended.

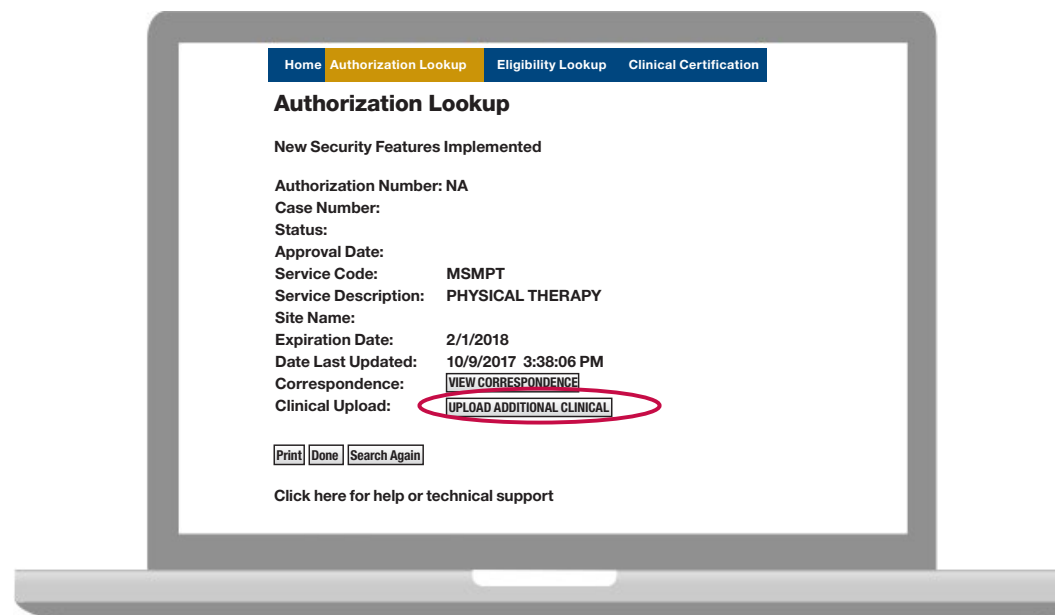
1. Log in to the eviCore portal as you normally would.
2. Click on the *Authorization Lookup* tab to search for the existing authorization request.
3. Select the request.
4. Verify that the status of the request is "pending."
5. Select *Upload Additional Clinical Information* in the Clinical Upload field.

You can upload clinical information only for pending requests. Once the request is in a final status (approved, denied, partially approved, withdrawn or expired), you'll have the option to upload additional clinical information.

Also, this information is specific to the eviCore health portal. It does not apply to requests to authorize physical, occupational and speech therapy by therapists (for BCN HMO and BCN Advantage) and physical medicine services by chiropractors (for BCN HMO only), which are handled through the provider portal at www.LMhealthcare.com.

As a reminder, eviCore healthcare is an independent company that provides clinical review services for Blue Cross and Blue Care Network. For additional information related to requesting authorization from eviCore, visit ereferrals.bcbsm.com. Then –

- For BCN HMO and BCN Advantage, click *BCN*. Then click **eviCore-Managed Procedures**.
- For Blue Cross PPO (commercial) and Medicare Plus Blue PPO, click *Blue Cross*. Then click **eviCore-Managed Procedures**.



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